Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR RAVI SUBRAMANYA BHAT

I, Dr Ravi Subramanya Bhat, Divisional Clinical Director, of the Goulburn Valley Area Mental Health Service (**GVAMHS**), Goulburn Valley Health (**GV Health**), in the State of Victoria, say as follows:

1 I am authorised by GV Health to make this statement on its behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Professional Background

3 I am a legally qualified medical practitioner registered with the Australian Health Practitioners Regulation Agency as a specialist in Psychiatry.

4 I graduated in medicine with an MBBS from MR Medical College, Gulbarga, India.

5 I completed a Diploma in Psychological Medicine (**DPM**) – from Christian Medical College (**CMC**), Vellore, India and then a Doctorate in Medicine (**MD**) from Central Institute of Psychiatry (**CIP**), Ranchi, India.

6 CMC was established in 1918. The Department of Psychiatry was established in 1957 by the Canadian Psychiatrist Dr Florence Nichols. Family members stayed with patients admitted into the ward, which allowed for a greater understanding of family dynamics and needs as well as providing education to the family about their loved one's illness and the nuances of mental health care. Family participation was central to its philosophy and thus informed my development as a psychiatrist.

7 CIP was established in 1918 to treat Europeans in India with serious mental illnesses. It has what is arguably the finest psychiatric library anywhere in the world. I was awarded the MD in 1997. The training at CIP was critical to the development of my understanding of the needs of people with serious mental illness, including those with complex co-morbidities such as substance use disorders and organic brain disorders such as epilepsy.

8 My training in India has given me a very broad understanding of many aspects of mental health. After 1997, I learned about management in complex systems at the CIP.

I had experience of child and adolescent psychiatry at the CMC with a Victorian-trained child psychiatrist.

9 I was recruited to the position of Staff Specialist in Psychiatry at GV Health in October 1999. I worked with the Lower Hume Community Mental Health Team and with the Aged Persons Mental Health Service Working across community and inpatient settings. This was vital to developing an understanding of the challenges of working outside the hospital.

10 I became a Fellow of the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) in 2002.

11 I became Acting Clinical Director and Authorised Psychiatrist of GVAMHS in February 2004 and was later confirmed in the role. In 2012, the role was renamed as Divisional Clinical Director.

12 I trained in Psychiatry of Old Age under the supervision of Professor Edmond Chiu and was awarded the Certificate of Advanced Training in Psychiatry of Old Age by the RANZCP in 2006.

13 I was appointed as Associate Professor of Psychiatry in the Department of Rural Health at the University of Melbourne in 2006.

14 I have been in some capacity or the other, a member of the GV Health Executive in recent years. Now, I continue to play a key advisory role to the Executive.

15 I have spent much of the past 15 years building the capacity of the mental health service, focusing initially on medical capacity. In early 2004, there were three full-time consultant psychiatrist positions and a Child and Adolescent Psychiatrist visiting the service weekly. GVAMHS offered opportunities for trainees from Melbourne to spend time in rural practice. The service has grown to include two locally-based Child and Adolescent Psychiatrists and one Consultation-Liaison Psychiatrist.

16 This allowed GVAMHS to be accredited by the RANZCP for specialist training in psychiatry in 2012. It is now accredited by RANZCP for stages 1 and 2 and for stage 3 training in General Adult Psychiatry, Child and Adolescent Psychiatry, Psychiatry of Old Age and more recently in Consultation-Liaison Psychiatry.

17 In 2018, Professor Edward Ogden PSM was appointed as Addiction Medicine Specialist for Goulburn Valley. We have developed a collaborative working model that enables trainee psychiatrists to have supervised experience in addiction medicine. We have been successful in obtaining funding for Specialist Training in Addiction Psychiatry, which will commence from 2020.

18 The capacity building work has extended beyond GVAMHS. For example, we have worked with the Rumbalara Aboriginal Cooperative to establish the Spiritual and Wellbeing Clinic for the Aboriginal and Torres Straits Islander peoples with mental health problems. We have helped develop telehealth clinics to support general practitioners across the GVAMHS catchment area that provide consultant psychiatrist diagnostic assessments and management planning.

19 I worked as Deputy Chief Psychiatrist at the Office of Chief Psychiatrist, Department of Health and Human Services (**DHHS**) between 2008 and 2009. I was a member of the Chief Psychiatrist's Quality Assurance Committee from 2008 to 2014. I have subsequently assisted both the Office of the Chief Psychiatrist (**OCP**) and DHHS in service reviews/evaluations. I have been involved in clinical reviews conducted by the OCP. I was the Victorian representative on the Australian Mental Health Outcomes and Classification Network, Older Persons National Mental Health Information Development Expert Advisory Panel 2010. I was appointed as a member of the Victorian Mental Health Expert Taskforce during 2015 and 2016.

20 In my role as Associate Professor of Psychiatry with the Department of Rural Health, the University of Melbourne, I have been responsible for the implementation of psychiatric teaching to medical students. I have published around 40 papers that include peer reviewed publications and book chapters. I am interested in complex problems and interested in research into the care of vulnerable groups of people, with a focus on delirium in older adults, suicide and access to treatments.

21 I was a member of the Delirium Clinical Care Standards Topic Working Group of the Australian Commission of Safety and Quality in Healthcare during 2014 and 2015.

22 I have recently commenced a PhD at the University of Melbourne under the supervision of Professor Nicola Lautenschlager, and Dr Rosie Watson and Professor Kenneth Rockwood as co-supervisors. My topic is on the diagnosis of delirium, a common condition that especially affects frail older adults and unfortunately either unrecognised or is misdiagnosed.

23 My current role with GV Health is divided between the administrative role of Divisional Clinical Director and Authorised Psychiatrist of GVAMHS and a clinical role as the Consultant Psychiatrist with the GVAMHS Aged Psychiatry Assessment and Treatment Team (**GV-APATT**). My duties include but are not limited to:

(a) managing the clinical governance of GVAMHS and its clinical programs. This involves overseeing programs covering the entire range of age-based mental health services from child and adolescent, adult, and aged persons mental health services;

(b) ensuring that the *Mental Health Act 2014* (Vic) is applied appropriately and its principles and spirit are upheld at GVAMHS;

(c) ensuring the appropriate assessment, treatment and care of patients of GV-APATT; and

(d) participating in the Consultant Psychiatrist on-call roster for GVAMHS.

24 Clinical governance is being "accountable to patients and the community for assuring the delivery of health services that are safe, effective, high quality and continuously improving".

Attached to this statement and marked '**RB-1**' is a copy of Australian Commission on Safety and Quality in Health Care, *Clinical Governance*.

25 Over time, I have reviewed various GVAMHS programs to ensure this. For example, we reviewed the GVAMHS Child and Adolescent Mental Health Service (**GV-CAMHS**) in 2013. We initially implemented the Choice and Partnership Approach (**CAPA**), which is a flow management approach used with some success in the UK. This approach did not work locally, so we used a co-design approach to implement the model that is currently operational in GV-CAMHS.

26 These experiences have informed an approach within me that accepts the reality of the present challenges, yet keeps me motivated to continually improve.

Goulburn Valley Area Mental Health Service

27 GVAMHS is a designated mental health service under the *Mental Health Act 2014* (Vic), which forms part of GV Health, a public health service under the *Health Services Act 1988* (Vic).

28 GVAMHS is a state-funded specialist mental health service that provides community-based and inpatient care for three main population groups in its catchment area:

(a) children and adolescents (0–18 years);

(b) adults (16–64 years); and

(c) older people (older than 65 years).

29 GVAMHS' clinical services focus on assessment and treatment of people with a mental illness living in its catchment area.

30 GVAMHS is one of Victoria's:

(a) 21 government-funded adult mental health services (**AMHS**);

(b) 17 aged persons mental health services (**APMHS**); and

(c) 13 child and adolescent mental health services (**CAMHS**).

Attached to this statement and marked '**RB-2**' is a copy of GV Health, 'Mental Health Service' (Goulburn Valley Area Mental Health Service, 2015).

31 GVAMHS has the following bed-based services.

32 Wanyarra, a 20-bed inpatient psychiatric unit (**IPU**), a 10-bed adult Prevention and Recovery Care program (**PARC**), and a 10-bed Specialist Residential Rehabilitation Program (**SRRP**). Each of these is located in Shepparton. The PARC at Shepparton was established in 2003, and was the first PARC in Australia. SRRP was established in 2001 and provides residential rehabilitation and recovery services. Both PARC and SRRP were established and continue to be conjointly with Wellways, which is a Mental Health Community Support Service (**MHCSS**).

33 The GVAMHS covers the local government areas (**LGAs**) of Greater Shepparton, Strathbogie, Mitchell, Murrindindi and Statistical Local Area of Moira-East.

34 GVAMHS' catchment area is characterised by geographic and cultural diversity.

35 The catchment area extends from the NSW border to the peripheries of Melbourne. This area is exposed to droughts, particularly in its farming areas to the north and bushfires, especially in the hilly regions to the south.

36 Greater Shepparton has the highest population of Aboriginal and Torres Straits Islander peoples outside of metropolitan Melbourne. It also has one of the largest numbers of resettled refugee groups from Iraq, Afghanistan, Congo and Sudan, and elsewhere.

Attached to this statement and marked '**RB-3**' is a copy of Murray PHN, 'Needs Assessment 2017/18' (Assessment Policy, Murray PHN, 2018), 8.

37 Two of the LGAs in the GVAMHS catchment area, Greater Shepparton and Mitchell also have a higher number of children between the ages of 0 to 14 years compared to the national average. These LGAs also have high rates of developmental problems in children between the ages of 0 to 5 years.

Attached to this statement and marked **RB-4** and **RB-5** is a copy of the Australian Early Development Census Community Profile 2018 for Greater Shepparton, 13 and Mitchell, 17.

38 The catchment area has areas of considerable socio-economic disadvantage. For example, Moira is in the top 10 most disadvantaged LGAs in the state as outlined at paragraph 101.

39 All members of the community are able to contact GVAMHS via its centralised triage telephone number, 1300 369 005. People can refer themselves or be referred by a health professional, including those based in the GV Health Emergency Department (**ED**).

40 When people contact GVAMHS directly, they first reach a centralised triage service and discuss their mental health concerns with the triage mental health clinician.

41 A triage decision will be made in accordance with the Victorian Mental Health Triage scale. The Victorian Mental Health Triage Scale is risk-based. The triage mental health clinicians make an assessment over the telephone regarding the presence of mental health problems and associated risk in categorising mental health service response. Possible outcomes of the mental health triage service include:

(a) Triage Code A (emergency services response);

(b) Triage Code B (high urgency mental health response);

(c) Triage Code C (urgent mental health response);

(d) Triage Code D (semi-urgent mental health response);

(e) Triage Code E (non-urgent mental health response);

(f) Triage Code F (referral to alternative provider); and

(g) Triage Code G (information only/No further action).

42 If the person requires a non-urgent assessment, their information will be sent to the relevant aged based mental health team who will contact them to arrange the assessment.

43 If they require an urgent assessment, then a discussion with the person or the referrer is arranged at a suitable time and location (for example, the ED, their home, or the police station).

44 GVAMHS has received an average of just over 6,000 referrals per year over the past five years. More than a third of all referrals to GVAMHS over this period were categorised as requiring an Emergency Services response (category A) to semi-urgent mental health response (category D). Approximately, another third of all referrals were deemed as requiring a non-urgent mental health response (category E).

45 If a person presents at the ED, they are initially assessed by the clinical staff in the ED to identify the urgency of their entire health condition (physical and mental). The staff will identify the urgency of each person's health condition (which will dictate the

recommended time when treatment should commence) in accordance with the five triage categories designated by the Australasian College of Emergency Medicine.

Attached to this statement and marked '**RB-6**' is a copy of Australasian College for Emergency Medicine, 'Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments' 4 (2016), *Australasian College for Emergency Medicine*, 5-8.

46 The ED clinical staff provide medical treatment where necessary and should the person need a mental health response, they refer the patient to GVAMHS centralised triage once the patient is medically stabilised.

47 If the patient has been referred to GVAMHS centralised triage:

(a) during regular working hours, a mental health clinician (such as, a registered psychiatric nurse, a psychologist, a social worker, or an occupational therapist) from the relevant aged based program (CAMHS, AMHS or APMHS) will attend to the patient to conduct a mental health assessment; and

(b) after regular working hours, a member of the AMHS Acute Response or the GVAMHS centralised triage will attend to the patient to conduct a mental health assessment.

48 The purpose of the assessment is to determine what the mental health problem is, why it is happening to this person at this point in time, and the risk arising from the person's mental health problems either to themselves or to others.

49 After conducting the assessment, the mental health clinician will discuss the assessment with the Psychiatry Registrar or the team Consultant Psychiatrist (during regular working hours), or the on-call Consultant Psychiatrist (after regular working hours). In any event, the assessment is raised at the next Clinical Team Review for further discussion and treatment planning.

50 Since the GVAMHS catchment borders on catchment areas of other designated mental health services, people who reside around the borders of the GVAMHS catchment area may present with mental health crises to emergency departments closest to their residence. Where a person has been apprehended by the police, they may be brought to the nearest designated mental health service, which may not necessarily be at GV Health. In such instances, the other public mental health service (**PMHS**) will conduct the assessment and provide immediate treatment and care, including admission to their IPUs and transfer such patients to GVAMHS as soon as it is appropriate and feasible.

51 GVAMHS provides treatment and care of people across inpatient, other bed-based services such as PARC and SRRP, as well as community settings. People being

provided mental health treatment and care in the community may receive care either where they reside or via outpatient clinics. Community based mental health treatment and care involves both medications and psychosocial interventions.

52 Community-based care is particularly important when treating people with a serious mental illness, which can be distressing, debilitating and disabling for them. The person's condition can fluctuate and require review of treatments at regular intervals. It also takes time getting to know another person, and for them to get to know you. This is crucial for the development of a trusting therapeutic relationship. It may also take time to understand which medication is suitable for an individual. I am currently treating people suffering from serious mental illnesses whom I have had the privilege of getting to know over a 15 year-period. They have mental health clinicians who see them once a month and I see them once every three months or so. As and when required their treating mental health clinicians bring up issues regarding their mental health, treatment and care to the weekly GV-APATT clinical team meetings. This type of ongoing treatment and care has been vital for many people to flourish in their lives and avoid relapses of their illness or at least minimise the impact of a relapse.

53 In addition to direct treatment and care, various GVAMHS programs collaborate with other service providers and offer secondary consultations as necessary. GVAMHS has a long history of partnering with other agencies.

54 For nearly two decades, GVAMHS has partnered with Wellways (formerly known as Schizophrenia Fellowship and MIFellowship) to provide clinical services, SRRP (since 2001) and PARC (since 2003).

55 GV Health is the lead agency for Shepparton headspace and is responsible for its clinical governance and coordination of the local consortium. Shepparton Headspace acts as a one-stop-shop for people who need help with mental health, physical health (including sexual health), alcohol and other drugs or work and study support.

56 Despite the model of service delivery and such partnerships, it was evident to us that there were many people with mental illnesses, especially adults, whose conditions were particularly complex and challenging for general practitioners (**GPs**) to manage but did not meet the Victorian Mental Health Triage Scale criteria for specialist mental health response. This was in part due to very limited access to private mental health practitioners in the GVAMHS catchment area.

57 Since 2012, we have been running a series of consultant psychiatrist led clinics into some local general practices to provide expert diagnostic assessments. When GPs require such assessments they refer their patients to GVAMHS centralised triage for an

assessment through Medicare. The triage service will make an assessment in accordance with the triage scale, and if appropriate, will book in the assessment with a consultant psychiatrist to take place at the local general practice clinic. The patient may attend the assessment in person or via the telephone.

58 GVAMHS consultant psychiatrist-led clinics see 500 to 700 people per year, constituting around 10% of all referrals to GVAMHS centralised triage. While this model has been well received according to an independent evaluation by the Department of Rural Health, at the University of Melbourne, it is under threat as revenues generated through the MBS are not sufficient to sustain ongoing operations.

Attached to this statement and marked '**RB-7**' is a copy of Associate Professor David Pierce, 'Goulburn Valley Area Mental Health Service – Community Liaison Psychiatry Evaluation Report' (Evaluation Report, University of Melbourne, 15 December 2016).

59 GVAMHS is a state-funded specialist mental health service. A small proportion of its funding for specialist training positions in Psychiatry and the revenue from the clinics noted earlier is derived from the Commonwealth Government.

Historical and Current System Context

60 In considering whether current state-funded mental health services are well placed to meet the demands of people affected by mental illness for clinical treatment, it is important to clarify what is meant by state-funded specialist services.

61 It is also of assistance to understand the historical and temporal context.

62 Further, the mental health needs of rural communities cannot be considered in isolation of this context. Rural state-funded specialist mental health services such as GVAMHS are a special case of Victorian state-funded specialist mental health services given their geography and rural locale.

Attached to this statement and marked '**RB-8**' is a copy of Lisa Bourke et al, 'Understanding Drivers of Rural and Remote Health Outcomes: A Conceptual Framework in Action' 20 (2012) *Australian Journal of Rural Health* 318.

Design

63 Current existing state-funded specialist mental health services were designed for deinstitutionalisation in the mid-1990s.

Attached to this statement and marked '**RB-9**' is a copy of Victoria's Mental Health Service – The Framework for Service Delivery – 93/0255 – March 1994, 4.

64 As such the focus of such state-funded specialist mental health services has been upon assessment, treatment and care of people with serious mental illnesses.

65 This move to deinstitutionalise was a radical reform that resulted in two major outcomes – a shift to community based psychiatric care, and the mainstreaming of IPUs. The move to deinstitutionalisation and shift to community based psychiatric care focussed on people with serious mental illnesses affording them the same rights as everyone else. The mainstreaming of IPUs attempted to introduce psychiatry as part of the rest of main-stream medicine.

66 The resulting framework was thus designed to meet the needs of people with serious mental illnesses who had been incarcerated in mental institutions or would have been incarcerated in such places had those institutions continued to exist.

67 In order to suitably meet these needs, the AMHS program was created and in my view, the AMHS was well designed. People with serious mental illness in crises would be treated by Crisis Assessment and Treatment Services (**CAT**). A person requiring in-home care would be supported by Continuing Care, Clinical and Consultancy Services (**CCT**). Homeless people with serious mental illnesses would be supported by Mobile Support and Treatment Services (**MST**), residential and non-residential rehabilitation services, as well as acute IPU and Secure/Extended Care Inpatient services (**SECU**).

68 In my opinion, the design of APMHSs was well informed as they attended to the needs of a wide variety of older adults, such as patients with long-standing mental illnesses, late-onset mental illnesses, and psychiatric disturbances associated with dementia.

69 However, in my opinion, CAMHS was not as appropriately designed. Unlike AMHS and APMHS, CAMHS was developed without the benefits of prior institutional reference points.

70 The overall design also did not adequately consider the needs of people with both serious mental illnesses, and alcohol and drug use disorders. Those with serious mental illnesses on one hand, and those with alcohol and drug use disorders on the other hands were separated into two distinct services around that time.

Funding

71 The state-funded system was funded on the basis of input, which is otherwise known as block-funding. Block-funding entails providing an area mental health service with a fixed amount of funds. The area mental health service is responsible for determining how it will utilise those funds, specifically who it will provide services to within the boundaries of the model.

Workforce

72 While the roles of the medical and nursing staff were well defined in **RB-9**, the roles of allied health staff was less well defined. For example, on page 57, **RB-9** states, 'In community settings, nursing and allied health staff will have a lead role in the provision of case management. Individual professionals will, at the same time, offer specific expertise relevant to their discipline." This, amongst other factors, diminished the role and importance of allied health clinicians as they were less able to utilise their discipline-specific skills.

Review

73 Since 1994, there has not been a whole-of-system design review. Instead, reviews and reforms that have occurred have focused on particular parts of the system, in response to specific problems or to new ideas in specific areas of practice resulting in the:

(a) further fragmentation of mental health services. For example, in response to the low number of children in out-of-home care who had access to CAMHS, a new service, Take2 was created in addition to CAMHS, rather than reviewing the existing CAMHS model of care.

Attached to this statement and marked '**RB-10**' is a copy of Berry Street, *Take Two*.

(b) integration of core services for people with serious mental illnesses, which occurred as a response to insufficient resources. For example, as a result of integrating a number of services, some state-funded services have ceased offering MSTs, which were crucial in the care of homeless people with a serious mental illness.

74 Each new program that was trialled in these two-and-half decades, when seen in isolation from the whole-of-system, was an adequate to good response to the issue, problem or idea in focus. For example, PARC services were developed in response to the dramatic increase in ≤48-hour admissions, which occurred in the five years following deinstitutionalisation.

Attached to this statement and marked '**RB-11**' is a copy of 'Revitalising Acute Inpatient Services' (Report of the Review of Adult Acute Inpatient Mental Health Services), 'Revitalising Acute Inpatient Services' (Report of the Review of Adult Acute Inpatient Mental Health Services).

75 However, the new programs referred to at paragraph 73(a) had mixed results. Some were trialled in only limited sites, some were discontinued, and some were continued with no systematic evaluation of either efficacy or examination of their return on

investment. As a result, there was a lack of consistency with respect to access to services.

Attached to this statement and marked '**RB-12**' is a copy of John Lally et al, 'Remission and recovery from first-episode psychosis in adults: systematic review and meta-analysis of long-term outcome studies' (2017) *The British Journal of Psychiatry*, 350-358.

76 It is likely that the same set of factors that motivated the development of PARCs also led to the development of Primary Mental Health Teams (**PMHT**) in the early 2000s. The focus of PMHT was to build capacity of and in primary care as well as provide treatment and care to people with so-called high-prevalence disorders that were too complex for GPs to manage. A combination of factors, including changes to Commonwealth funded mental health programs to funding decrements at a state level have led many state-funded services to integrate their programs leading to the diminution of PMHTs.

77 Many women had access to good quality assessment and care under the Peri-natal Emotional Health Program (**PEHP**), which was discontinued. However, a program with a similar name has recommenced.

Population change and funding formula review

78 Since 1994, there have been dramatic changes to both Victoria's population and the needs of its population.

79 Victoria's population has grown by approximately 2 million people. This growth has resulted in an increase in demand for state-funded specialist mental health services. Given the funding formula has been based on input, unlike Victoria's acute health services, funding increases for state-funded mental health services (where they have occurred) have not kept up with increase in demand.

Population needs

80 The needs of people with mental illnesses in Victoria have also changed. The focus of state-funded mental health services has broadened to include people presenting with other complex mental health problems. For example, a typical case would be that of a young adult who has suffered from adverse childhood experiences (**ACEs**), problems with drugs and alcohol, mental health problems, and social issues, who now presents with either a mental health crisis or suicidal ideation, self-harm or attempted suicide.

81 This shift is evidenced by the following published papers that examine mental health presentations to Victorian emergency departments.

82 The first paper examines mental health presentations of 0 to 19 year olds from 2008 to 2015, and shows an annual rate of increase in such presentations to Victorian emergency departments of 6.5% in the study period. It also shows that more than 50% of the presentations were suicidal ideation/attempt, stress and anxiety disorders and mental and behavioural disorders due to use of substances.

Attached to this statement and marked '**RB-13**' is a copy of Harriet Hiscock et al, 'Paediatric Mental and Physical Health Presentations to Emergency Departments, Victoria, 2008-15' (2018) *Medical Journal of Australia*, 343-348.

83 The second paper examines mental health presentations across all ages and found similar results. Of note, is that presentations of the kind envisaged by the original design of the system such as schizophrenia remained the same, while that of psychosis actually halved in the same period.

Attached to this statement and marked '**RB-14**' is a copy of Peter Alarcon Manchego et al, 'Management of Mental Health Patients in Victorian Emergency Departments: a 10 Year Follow-Up Study' (2015) *Emergency Medicine Australasia* 529.

84 The problems of the youth have their genesis in childhood; the evidence is strong that all these problems – suicidal ideation/attempts, stress and anxiety disorders and mental and behavioural disorders due to drug and alcohol problems – are all higher in those with ACEs.

Attached to this statement and marked '**RB-15**' is a copy of Charlotte Björkenstam et al, 'Childhood Adversity and Risk of Suicide: Cohort Study of 548,721 Adolescents and Young Adults in Sweden' (2017) *BMJ* 357.

85 While we, as a society, have to take a hard look at ourselves, we in the health profession should also take care in not to medicalise some of these problems. The evidence also indicates that mitigating the effects of ACEs can have highly beneficial effects and we should be focussed on providing support and resources to do this. The original design of the system did not contemplate on providing this support.

Attached to this statement and marked '**RB-16**' is a copy of Ariane Marie-Mitchell and Rashel Kostolansky, 'A Systematic Review of Trials to Improve Child Outcomes Associated With Adverse Childhood Experiences' (2019) *American Journal of Preventive Medicine* 756.

86 The changes identified at paragraph 78 have altered the focus and operation of state-funded mental health services, especially those areas of services that are involved in initial assessment and immediate management, which have not seen an increase in

funding commensurate with their activity. These services now mainly provide urgent assessments and manage risks.

87 Each mental health assessment takes between one to two and a half hours, which in the face of increased demand can take almost all available time and lead to increased waiting times.

Attached to this statement and marked '**RB-17**' is a copy of Louise Stebbins and George Hardman, 'A Survey of Psychiatric Consultations at a Suburban Emergency Room' (1993) *General Hospital Psychiatry* 234.

88 Perception of risk, perhaps enhanced by the language of the Victorian Mental Health Triage Scale has become the language of response. People presenting with mental health crises and some sort of risk get admitted to IPUs or are followed up by CAT teams or Acute Response (as in GVAMHS). When the risk is perceived to be at an appropriate level, patients are then discharged from the service because the next group of patients with similar problems and risk are awaiting assessment.

89 In the absence of sufficient resources (both human and financial), state-funded mental health services divide the available time they have between the new demands of assessing and managing people presenting with complex mental health problems and the needs of people with a serious mental illness, which is the reason why the system was set up in the first place.

90 People who present with complex problems (some combination of suicidal ideation/attempt, drug and alcohol problems, stress and anxiety disorders etc.) are assessed and their immediate risks are managed, but in my opinion, they could benefit from more suitable treatment, such as psychotherapy.

91 The majority of the latter group, those with serious mental illnesses receive critically important treatments such as medications, support and care coordination, but in opinion they could benefit from added intensive recovery-oriented psychosocial interventions.

92 People with co-occurring mental illness and alcohol or drug (**AOD**) use disorders either:

(a) have to wait for long periods to receive appropriate treatment from either mental health services or AOD services;

(b) are shuttled between services; or

(c) fail to receive appropriate treatment.

93 In my opinion, decisive action needs to be taken to cease the separation of mental health and AOD services.

Population ageing

94 The original separation of mental health and AOD services is now adversely affecting not just adults, but older adults as well. Population ageing and increased longevity have resulted in two changes for which the system is ill-prepared. Firstly, an increase in rates of people aged ≥65 years with mental health and AOD problems. Secondly, the compression of morbidity into the advanced ages has resulted in high levels of frailty, dementia and related disorders in the oldest cohort of aged patients (i.e., ≥85 years). Frailty in this context is the accumulation of multiple problems.

95 The absence of a whole-of-system design review, an antiquated funding formula, and the fragmentation of services do not provide adequate support or treatment to those who are the most in need and who are also the very quiet Australians – the people with serious mental illnesses, the very young, and the very old.

Mental health needs of rural communities

Prevalence of mental illness in rural communities

96 A meta-analysis undertaken in 2010 suggests that mental illnesses are more prevalent in urban areas.

Attached to this statement and marked '**RB-18**' is a copy of J Peen et al, 'The Current Status of Urban-Rural Differences in Psychiatric Disorders' (2010) *Acta Psychiatrica Scandinavia* 84.

97 However, a recent study from the US that used more nuanced definitions of rurality suggests that there were no urban or rural differences in prevalence of mental illnesses. If anything, they found a slightly higher prevalence in small urban and semi-rural areas relative to large urban areas.

Attached to this statement and marked '**RB-19**' is a copy of Joshua Breslau, 'Are Mental Disorder More Common in Urban than Rural Areas of the United States?' (2014) *Journal of Psychiatric Research* 50.

98 The recently completed population health study from Shepparton, the Crossroads II study, found a slightly higher level of psychological distress in the study participants.

Attached to this statement and marked '**RB-20**' is a copy of Lisa Bourke et al, 'Crossroads II: A Repeated Population Health Study in Shepparton and Mooroopna 2016-2018' (Shepparton Crossroads Report, May 2019).

99 In interpreting these findings one has to be mindful of language. Urban does not equate with metropolitan; the United Nations have defined an urban locality as having at least

20 000 people, and a city as having at least 100 000 people. This means that many parts of rural Victoria would be classified as urban. Professor Fiona Judd and colleagues have pointed this out in an older paper that "most [researchers] use a 'one size fits all' definition of urban and rural, which assumes location is the key issue." In turn this hides the nuances of mental health needs of rural communities.

Attached to this statement and marked '**RB-21**' is a copy of Fiona Judd et al, 'High Prevalence Disorders in Urban and Rural Communities' 36(1) (2002) *Australia and New Zealand Journal of Psychiatry* 104.

100 Professor Judd state in the paper, which is worthy of being quoted in its entirety, that factors such as "poverty, unemployment, being female, not being married, lower socioeconomic class, women who were separated or never married, self-related alcohol problems, history of childhood sexual abuse, poor social networks, life event in previous 12 months, size of primary support group, marital status, low perceived social support, employment status, and sex" are more powerful than location of residence.

Please see, **RB-21** at 111.

101 A simple perusal of the Australian Bureau of Statistics' Socio-Economic Indicators for Areas (**SEIFA**), Index of Relative Socio-economic Advantage and Disadvantage (**IRSAD**) shows that the eight of the 10 most disadvantaged LGAs in Victoria are either inner regional or outer regional (RA2 and RA3) Australia. In sharp contrast, eight of the 10 least disadvantaged LGAs are in Melbourne (RA1). Disadvantage is associated with most of the factors that Professor Judd states in her article and this in turn is likely to be associated with increased rates of mental illnesses in such areas.

102 Rates of mental illnesses may also be different between specific groups of people. For example, the rates of mental illnesses in Aboriginal and Torres Straits Islander peoples may be higher. Indigenous males are also twice as likely as non-Indigenous males to report recent suicidal ideation and more than three times likely to report a suicide attempt in their lifetime.

Attached to this statement and marked '**RB-22**' is a copy of G Armstrong et al, 'Suicidal Behaviour in Indigenous Compared to Non-Indigenous Males in Urban and Regional Australia: Prevalence Data Suggest Disparities Increase across Age Groups' (2017) Australia and New Zealand Journal of Psychiatry 1240.

Of note, is that the study authors did not find differences by location.

103 Refugees are also likely to have higher rates of mental distress, including serious mental illnesses such as schizophrenia.

Attached to this statement and marked '**RB-23**' is a copy of Anna-Clara Hollander et al, 'Refugee Migration and Risk of Schizophrenia and Other Non-Affective Psychoses: Cohort Study of 1.3 Million People in Sweden' (2016) *BMJ*.

104 Marginalised groups of people such as these are less likely to access services given the need for a sense of safety and possible cultural, social and other personal barriers to help seeking assistance.

Attached to this statement and marked '**RB-24**' is a copy of Wright et al, 'Why don't younger people from refugee backgrounds call a rural early psychosis service? an investigation' (2019) Unpublished.

Suicides in rural communities

105 While urban/rural differences in prevalence of mental illnesses may be contentious, the increased rates of suicides by rurality and remoteness is not.

Attached to this statement and marked '**RB-25**' is a copy of Tanya Caldwell et al, 'Suicide and Mental Health in Rural, Remote and Metropolitan Areas in Australia' (2004) *Medical Journal of Australia* 181.

106 It is well established that suicide rates increase with remoteness and almost all of this is accounted for by increased rates of suicide in males.

Attached to this statement and marked '**RB-26**' is a copy of Kari Kõlves et al, 'Ten Years of Suicide Mortality in Australia: Socio-Economic and Psychiatric Factors in Queensland (2015) *Journal of Forensic and Legal Medicine* 136.

Access to mental health services

107 The evidence for accessing mental health services by rurality and remoteness is variable. There is more research on access to health services in general; for example, a study from South Australia found no differences in rates of access to primary care by remoteness. However, having better access appears to help; Professor Judd and her colleagues found that people living in rural areas with better access to mental health care had higher levels of subjective wellbeing. When barriers to access to mental health care are examined, the following issues are evident.

108 Geography – people residing in rural areas have to travel longer distances. Transport disadvantage is higher in rural areas. Car ownership rates in Australia is high; however, it reduces both by remoteness and increasing socioeconomic disadvantage as it becomes harder for people from low-income households to maintain cars. In rural areas, this problem is amplified because of the need to travel longer distances. All of this has a direct impact on the issue of access to care. Even when a person is able to

access, the long distances associated with travel time have a significant impact on the person's daily life, in terms of taking time off from work and other responsibilities.

109 Privacy and stigma – while there is no association between mental health literacy and remoteness, privacy and stigma are important factors in impeding access to mental health care by people living in rural areas.

110 While there are broad similarities between services provided by state-funded mental health services in metropolitan areas and rural areas, there are also considerable differences.

111 Even in 1994, rural state-funded mental health services did not receive all the elements of the design of AMHS. There are disparities in the availability of services or programs between rural state-funded mental health services. Some services don't have High Dependency Units in their IPUs; others either don't have SECUs or have poor access to SECUs elsewhere. Even the availability of IPU beds varies between rural and metropolitan services and between rural services.

112 It is estimated that Victoria has 22 IPU beds per 100,000 population.

Attached to this statement and marked '**RB-27**' is a copy of Stephen Allison, et al, 'Victoria's low availability of public psychiatric beds and the impact on patients, carers and staff' (2017) *Australian & New Zealand Journal of Psychiatry* 191-192.

113 Most rural state-funded mental health services have a considerably lower number of beds than the above quoted figure. While, rural state-funded mental health services generally have good inpatient local access, they have lower bed occupancy than metropolitan state-funded mental health services. This may be due to less movement of people outside of rural catchment areas.

Attached to this statement and marked '**RB-28**' is a copy of Victoria Government, 'Adult Mental Health Quarterly KPI Report: 2017-2018 Q4' (KPI Report, Department of Health and Human Services, 11 July 2018).

However, this may simply reflect the fact that people accessing IPUs in metropolitan areas are more likely to move around a relatively smaller geographical area that has better public transport.

114 Rural state-funded mental health services struggle to consistently access state-wide specialist mental health services such as eating disorders services, and the like, since they are all based in Melbourne.

115 Crisis teams are often restricted in their work to the area closest to the base and even there, at the emergency department based at the large regional hospital. There has been limited exploration of utilising telehealth for triages and urgent assessments. The GVAMHS Adult Model of Care, which is currently in the process of implementation, is exploring the possibility of providing this to people presenting to smaller rural hospitals in its catchment area.

116 Current funding arrangements for rural state-funded mental health services do not necessarily take into account the combination of travel times and dispersed population, which does not incentivise assertive community-based mental health treatment and care. Instead, care becomes focused on seeing people in clinics who may require people to travel long distances, medications, and monitoring and risk management.

117 Despite the challenges, rural state-funded mental health services are more likely to respond to unique locale-based problems. Often this is done with limited resources, and when resources are further constrained, these services are more likely to suffer negative effects. For example, in response to local needs, GVAMHS in collaboration with Rumbalara Aboriginal Cooperative developed a Spiritual and Wellbeing Clinic with a GV Health-employed consultant psychiatrist and senior psychiatric nurse. This clinic is focused on the need for indigenous adults. Over time, not only have the plans to expand the clinic to include Child and Adolescent Psychiatry support not occurred but the Adult Consultant Psychiatrist time has had to be reduced in the face of increased demand for Adult MHS services generally.

118 Rural state-funded mental health services do not have local CAMHS IPUs and as a result, they are required to access metropolitan based CAMHS IPUs. This often results in children and adolescents with serious mental health problems being managed either in local emergency departments or paediatric inpatient units. The delay in access can exacerbate their mental health problems.

119 Rural state-funded mental health services also have difficulties with access to state-wide specialist mental health services for people with the most severe and complex mental illnesses. However, some recent attempts to address this issue of access include the Forensic Clinical Specialist positions and the Personality Disorder Initiative positions (that are well supported by state-wide specialist mental health services such as Forensicare and Spectrum).

120 The needs of people affected by mental illness in rural areas are no different to those in metropolitan areas. Problems that affect the entire state are typically amplified in rural state-funded mental health services. The supply is not keeping up with the demand. However, the gaps are larger in rural state-funded mental health services and they have less redundancy built into its systems. As a result, there is a greater impact on service

provision when there are funding cuts or even if a single staff member leaves the service.

Workforce

121 There are major workforce issues across the state. In rural areas recruitment is harder with fewer incentives for trained staff to move to regional towns.

122 Training needs of staff also needs to be considered. For example, psychiatric nurses are the backbone of state-funded mental health services. The changes to the training of psychiatric nurses, over the decades, have reduced focus on psychiatric nursing in university nursing courses. This has also meant that psychiatric-nurses-in-training have comparatively less in-practice training than their predecessors who had trained in mental institutions. This has led to an imbalance in skill capacity in the workforce.

123 Many state-funded mental health services' community teams are not genuinely multidisciplinary. Over time the discipline-specific skills of allied health staff have been subsumed for the need for generic case managers. It is vital to have discipline specific roles for psychologists, occupational therapists, social workers and potentially even other roles for the future. For example, given the physical health needs of people with a serious mental illness it is vital to have a physiotherapist or exercise physiologist in a team.

124 Rural state-funded mental health services are not incentivised to develop and sustain local training programs. Even when they exist, they have little support for sub-speciality training such as that in Eating Disorders, Neuropsychiatry etc.

Technology

125 Technology should play a very important role in the delivery of mental health services in rural communities. However, this does mean that localised human resources should be entirely supplanted by technology – the human connection is of particular importance in rural settings.

126 Telepsychiatry has been well investigated in Australia. Even locally within the GVAMHS catchment, GVAMHS has utilised and reviewed the use of telepsychiatry consultations, which have been well-received by both GPs and patients.

127 GVAMHS is also planning to trial video triaging and urgent assessments from the ED in the main campus in Shepparton to small rural hospital EDs as part of its implementation of the AMHS model of care. This has already been trialled in New South Wales and found to be successful as it prevents people from having to be removed from their homes to access a PMHS.

Attached to this statement and marked '**RB-29**' is a copy of Emily Saurman et al, 'No Longer "Flying Bling": How Access Has Changed Emergency Mental Health Care in Rural and Remote Emergency Departments, A Qualitative Study' (2015) *BMC Health Services Research* 156.

128 Videoconferencing is also crucial in building capacity. A well-established model is Project ECHO, which is an innovative academic health centre-led program of health care delivery and clinical education for the management of complex, common, and chronic diseases in underserved areas, using hepatitis C virus as a model. This has now been expanded to include other chronic conditions. At GV Health, Professor Ed Ogden has now included GV Health in Project ECHO for substance use disorders.

Attached to the statement and marked '**RB-30**' is a copy of Sanjeev Arora et al, 'Academic Health Center Management of Chronic Diseases through Knowledge Networks: Project ECHO' (2007) *Academic Medicine* 154.

A recent systematic review found that "Project ECHO is an effective and potentially cost-saving model that increases participant knowledge and patient access to health care in remote locations, but further research examining its efficacy is needed."

Attached to this statement and marked '**RB-31**' is a copy of Carrol Zhou et al, 'The Impact of Project ECHO on Participant and Patient Outcomes: A Systematic Review' (2016) *Academic Medicine* 1439.

129 While these are exciting developments, the main barrier is the availability of suitable infrastructure. As indicated above, it is essential that we retain local human resources that allow mental health clinicians to form relationships, both with primary care providers, and with people with mental illness and their family members. This will allow us to build trust with patients to use such technologies.

Mental health system and reform

130 Short of major sociological changes to our society, given the rates of ACEs in our communities, we can expect that the presentation rate of mental crises, suicidal ideation/attempts, problems with AOD use, and stress and anxiety disorders as outlined earlier will continue to rise. At the same time, as a result of increased longevity and population ageing, such problems will also shift to later ages. The oldest group of aged patients are likely to present with mental health problems alongside increasing levels of frailty and cognitive impairment.

131 In my opinion, I doubt that any change will bring about lasting improvements, simply due to our very limited human capacity to apprehend complexity and predict the future. However, we can shape the future by ensuring that any change to the system is

undertaken with a clear statement of expected outcomes, which has an end date, should such outcomes not materialise in the expected time frame. I believe that it is not necessary to invent new services. Instead, we can build on the solid foundations of state-funded mental health services that were created in the mid-1990s.

Attached to this statement and marked '**RB-32**' is a copy of Boustani, et al, 'Developing the Agile Implementation Playbook for Integrating Evidence-Based Health Care Services Into Clinical Practice' (2019) *Academic Medicine* 556-561.

Review of whole-of-system design

132 Similar to the review undertaken in the early 1990s in Victoria, a whole-of-system design review needs to consider the current realities and plan state-funded mental health services to meet those needs, especially the needs of those who are the most vulnerable. Specific concepts from the new design then should be implemented locally through *co-production*, that is, through consultation with consumers and carers.

Attached to this statement and marked **RB-33** is a copy of The University of Melbourne, *Co-production: putting principles into practice in mental health contexts*.

133 We need to reimagine and re-purpose services that recently existed to meet current needs. For example, PMHTs could be redeveloped to provide psychotherapy to people presenting to the emergency department. A team delivering such care is vital because team based approaches help by assisting individuals to apprehend complexity by offering perspectives not always available to an individual clinician. They also support an individual clinician to deliver therapy to ensure that the person with the problem gets the best possible care.

134 All state-funded mental health services should have adequate IPU beds to deliver care. In addition, they also need bed-based capacity to provide rehabilitation and recovery services for people with serious mental illnesses.

135 We also need to focus on developing capacity to provide recovery oriented services. For example, SRRP and its partnership based approach has been evaluated and found to be highly successful in reducing the number and duration of inpatient admissions for people with serious mental illness. The majority of participants achieved their individual goals at the time of exit from the SRRP. The marriage of two perspectives, the clinical and the social community welfare is central to the success of the SRRP.

Attached to this statement and marked '**RB-34**' is a copy of GV Health, 'Outcomes of Unique Residential Rehabilitation Program from Rural Australia' (Report Snapshot).

Defragmentation of state-funded mental health services and related services

136 We need to make access and navigation through services easier for people.

137 This could be achieved by strengthening CAMHS by integrating services that were either fragmented over time, such as Take 2, or services traditionally not associated with CAMHS, such as Perinatal Psychiatry. This would give a special focus to infant mental health services to mitigate, where possible, the effects of ACEs and provide expert treatment and care to children and their parents. The return on investment made during the prenatal and early childhood years average between 7 and 10 percent greater than investments made at older ages.

Attached to this statement and marked '**RB-35**' is a copy of G Huebner et al, 'Beyond Survival: The Case for Investing in Young Children Globally' (Discussion Paper, National Academy of Medicine, 16 June 2016).

138 There should be an explicit framework guiding the three main agencies coming into contact with children – CAMHS, Child Protection, and the Department of Education and Training.

139 The CAMHS framework should also review the tiered approach to care and consider adopting a convergent approach, as has been used by the Tulane Early Childhood Collaborative. The Tulane Early Childhood Collaborative program provides consultation to paediatric primary care providers to promote mental health in young children.

Attached to this statement and marked '**RB-36**' is a copy of Tulane Early Childhood Collaborative, *Tulane Early Childhood Collaborative, TECC* (19 June 2019).

140 Easier access and navigation of services can also be achieved by bringing together state-funded mental health services and AOD services in a consistent and coordinated manner.

Workforce planning

141 Workforce planning is critical to any such venture. Services should be provided with support and capacity to train locally. Focus should also be on ensuring that staff develop and advance their assessment and therapeutic skills. Rural services would especially benefit from support to develop localised training programs that encourage people from rural areas to train locally.

142 It is vital to ensure that state-funded mental health services are truly multidisciplinary. Discipline specific roles need to be clearly articulated.

Funding

143 In my opinion, funding needs to be based on activity, along with a component for locale based needs. Activity Based Funding (**ABF**) can at the very least account for increasing activity over time and may reduce the fear of treating people outside a particular catchment area. Locale based funding would be especially important for rural state-funded mental health services to develop and evaluate programs to meet the specific needs of their catchment areas. However, ultimately, if we have to focus on recovery any form of ABF needs to shift to an outcome based funding model such as Value-Based Health Care (**VBHC**). Currently, the infrastructure for the data requirements for VBHC is in its infancy for state-funded mental health services in Victoria.

Attached to this statement and marked '**RB-37**' is a copy of The Economist, 'Value-Based Healthcare: A Global Assessment' (Executive Summary, 2016).

Information Systems

144 State-funded mental health services require a considerable upgrade in their information systems. We currently have a state-wide Patient Administration System (**PAS**) that is two decades old, and each service has different types of clinical records, from paper-based records to an electronic medical record (**EMR**). Paper based clinical records make it difficult for rural services to have access to timely information. There is a need for a state-wide mental health services PAS/EMR. This will help ensure that information is available across services and within a rural service in real-time. It will also assist with the clinical governance of smaller teams in far-flung locations of a state-funded mental health service. Importantly, it will go some way towards meeting VBHC requirements.

Telehealth

145 It would be important for the whole state to have good connectivity to implement telehealth services; this will be critical for access to assessment and treatment for rural state-funded rural mental health services.

146 In summary, any change should not arise in isolation and should avoid the hubris that this generation necessarily has all the answers. Instead, it should consider the historical and temporal context of service development in designing the system to meet today's needs. We need to ensure any change has the ability to respond to evolving needs.

147 I recently had the privilege of listening to the premiere of Eumeralla, a creation of Deborah Cheetham, AO, a Yorta Yorta woman, soprano, composer and educator. It was an extraordinary performance that resonated with me. Cheetham's lyrics written in the Gundjitmara language close to the end state:

noombapee-ngeeye kaleekeetoo

noombapee-ngeeye malangeepa

noombapee-ngeeye kaloo

have mercy on our past

have mercy on our future

have mercy on our present.

sign here ►

print name Dr Ravi Subramanya Bhat

date 4 JULY 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RB-1

This is the attachment marked '**RB-1**' referred to in the witness statement of Dr Ravi Subramanya Bhat dated 4 July 2019.

Published by the ACSQHC - www.safetyandquality.gov.au

1. Clinical Governance

Leaders of a health service organisation have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are patient centred, safe and effective.

Intention of this standard

The Clinical Governance Standard aims to ensure that a clinical governance framework is implemented to ensure that patients and consumers receive safe and high-quality health care.

This standard aims to ensure that there are systems in place within health service organisations to maintain and improve the reliability, safety and quality of health care. This standard, together with the Partnering with Consumers Standard, set the overarching requirements for the effective implementation of all other standards. The Clinical Governance Standard recognises the importance of governance, leadership, culture, patient safety systems, clinical performance and the patient care environment in delivering high quality care.

Criteria

Governance, leadership and culture

Leaders at all levels in the organisation set up and use clinical governance systems to improve the safety and quality of health care for patients.

Governance, leadership and culture

Action 1.1 Action 1.2

Organisational leadership

Action 1.3 Action 1.4 Action 1.5

Clinical leadership

Action 1.6

Patient safety and quality systems

Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.

Policies and procedures

Action 1.7

Measurement and quality improvement

Action 1.8 Action 1.9

Risk management

Action 1.10

Incident management systems and open disclosure

Action 1.11 Action 1.12

Feedback and complaints management

Action 1.13 Action 1.14

Diversity and high-risk groups

Action 1.15

Healthcare records

Action 1.16 Action 1.17 Action 1.18

Clinical performance and effectiveness

The workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients.

Safety and quality training

Action 1.19 Action 1.20 Action 1.21

Performance management

Action 1.22

Credentialing and scope of clinical practice

Action 1.23 Action 1.24

Safety and quality roles and responsibilities

Action 1.25 Action 1.26

Evidence-based care

Action 1.27

Variation in clinical practice and health outcomes

Action 1.28

Safe environment for the delivery of care

The environment promotes safe and high-quality health care for patients.

Safe environment

Action 1.29 Action 1.30 Action 1.31 Action 1.32 Action 1.33

There is further information in regards to Clinician Fact Sheets on the NSQHS Standards for this standard

View More Information

There is further information in regards to User Guide for Acute and Community Health Service Organisations that Provide Care for Children for this standard

View More Information

Background to this standard

Patients and the community trust clinicians and health service organisations to provide safe, high-quality health care.

Clinical governance is the set of relationships and responsibilities established by a health service organisation between its department of health (for the public sector), governing body, executive, workforce, patients and consumers, and other stakeholders to deliver safe and high-quality health care. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services.

Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, high quality and continuously improving.

Each health service organisation needs to put in place strategies for clinical governance that consider its local circumstances.

To support the delivery of safe and high-quality care for patients and consumers, the Australian Commission on Safety and Quality in Health Care (the Commission) has developed the National Model Clinical Governance Framework. The framework has five components based on the criteria in the Clinical Governance Standard and the Partnering with Consumers Standard. Health service organisations should refer to the framework for more details on clinical governance, and the associated roles and responsibilities.

See the National Model Clinical Governance Framework[1] and *National Safety and Quality Health Service Standards Guide for Governing Bodies.*[2]

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Last updated 30th May, 2018 at 08:47pm

REFERENCES

Australian Commission on Safety and Quality in Health Care. National Model Clinical Governance Framework. Sydney: ACSQHC; 2017.

Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards guide for governing bodies. Sydney: ACSQHC; forthcoming.

ISBN: 978-1-925665-07-9

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RB-2

This is the attachment marked '**RB-2**' referred to in the witness statement of Dr Ravi Subramanya Bhat dated 4 July 2019.

Referral

Referral to any of the Goulburn Valley Area Mental Health Services can be made in person, telephone and/or letter.

- By yourself.
- Your family and friends.
- Your General Practitioner.
- By other services providing assistance to you.

Contact - Who to Call First

GVAMHS Triage - 1300 369 005

24 hours a day, 7 days a week

Tell us what you think

We value your feedback about the care and services we provide. Please ask as staff member for a feedback form or you can access a form from the GV Health website.

GV Health

Goulburn Valley Health Area Mental Health Service Campuses:

Adult

Monash Street, Shepparton VIC 3630
Ph: (03) 5832 2111 Fax: (03) 5832 2100

Beta Street, Seymour VIC 3660
Ph: (03) 5735 0333 Fax (03) 5799 0946

Centre for Older Persons Health (COPH)

91-99 Knight Street, Shepparton VIC 3630
(APATT) - Ph: (03) 5823 6060 Fax: (03) 5823 6061
(PMH) - Ph: (03) 5823 6000 Fax: (03) 5821 7345

Child & Adolescent Mental Health Service (CAMHS)

GV Health, Graham Street, Shepparton VIC 3630
Ph: (03) 5832 3170

GV Health is a smoke free environment
For more information about services provided by GV Health, visit www.gvhealth.org.au

GV Health Publication - GVAMHS GVH0020
Produced By: GVAMHS Policy & Planning Committee
Date Approved: August 2015

Goulburn Valley Area Mental Health Service

Mental Health Service

GV Health

Healthy Communities

Mental Health Service

The Goulburn Valley Area Mental Health Service (GVAMHS):

- is a department of GV Health, which is accredited by the Australian Council of Health Care Standards and affiliated with the University of Melbourne and Latrobe University.
- is funded by the Victorian State Government. The services provided are generally free of charge.
- provides an innovative range of services for those individuals suffering from, or at risk of, serious mental health problems requiring short and long term support and care.
- provides services to the municipalities of Mitchell, Murrindindi, Strathbogie, City of Greater Shepparton and Moira.

The GVAMHS aims to reduce the impact of mental illness for individuals, families and our community by providing services that:

- uses a recovery based approach for people with mental health problems and illness to realise their full potential.
- establish highly visible and readily accessible pathways of care between mental health and physical care.
- better prepare the community to recognise mental health concerns and seek help and support early.

Staff and facilities

GVAMHS is staffed by an experienced professional team comprised of consultant psychiatrists, medical officers, psychiatric nurses, psychologists, social workers and occupational therapists, committed administrative staff provide treatment, support and secretarial services.

All facilities have disabled persons access and short-term public parking available.

Services available

Child & Adolescent Mental Health Service (CAMHS)

Provides a service for children and young adults between the ages of 0-25 and their families. CYMHS is an outpatient service and provides assessment, treatment and support where there are serious problems with behaviour, emotions, thoughts or learning. Services are provided from both GV Health's Graham St, Shepparton campus and and Beta Street Seymour. A weekly outreach service to Cobram and Wallan is also available.

Early Psychosis

Hume Region Early Psychosis Service seeks to engage young people 16-25 experiencing a first episode of psychosis early so as to reduce the period of untreated psychosis and promote recovery.

Adult Mental Health Service

This service is provided to people aged between 18 and 64 years of age. The inpatient service is located on the GV Health Campus in Shepparton. Community services are available to provide assessment, acute care and case management from teams based at Beta Street Seymour and Monash Street Shepparton.

Aged Persons Mental Health Service

This service provides assessment, treatment and case management for people aged 65 years and over. Five acute beds are available at Wanyarra and care is also provided at Grutzner House which is a residential psychogeriatric aged care facility located at GV Health. The Aged Psychiatry Assessment & Treatment Team (APATT) is located at the Centre for Older Persons Health (COPH), 91-99 Knight Street Shepparton, (03) 5823 6000.

Primary Mental Health

This is a specialist multi-disciplinary team which supports the work of a primary healthcare providers, including General Practitioners. Assessment, treatment planning and short-term intervention are provided for consumers of all ages experiencing a high prevalence disorder within a shared model of care. The service is located at COPH, 91-99 Knight Street Shepparton.

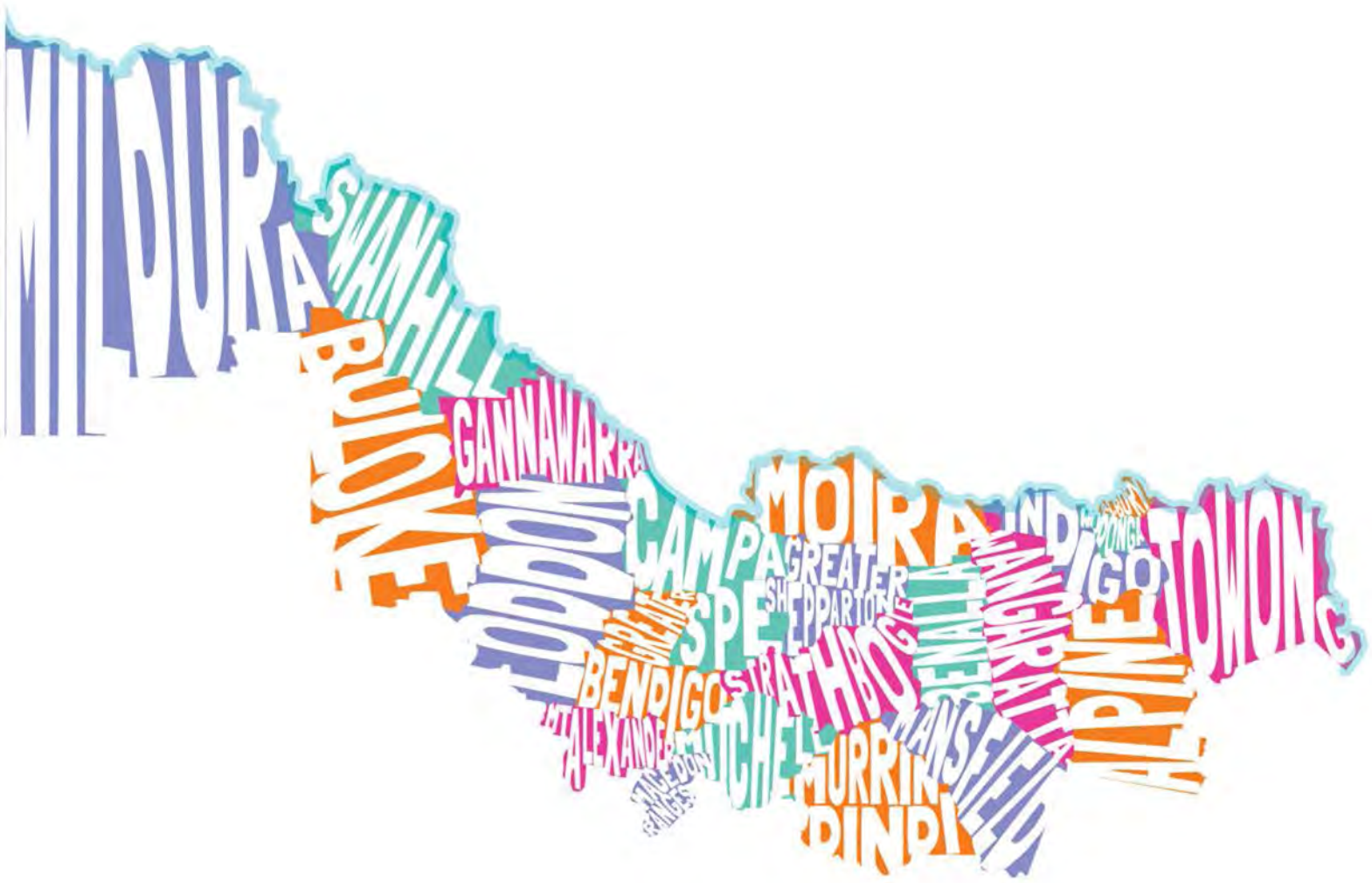
GVAMHS services include:

- Psychiatric assessment and treatment
- Carer and family support and education
- Outreach services to outlying areas of the region
- Ability to link in to statewide services for specialty consultation
- Education and consultancy services to other agencies
- Dual diagnosis services
- Court Liaison Officer
- Aboriginal Liaison Officer
- Consumer & Carer Consultants
- Autism Spectrum Assessment Team
- Private mental health clinics in Shepparton, Seymour, Cobram, Yea, Nathalia and Yarrawonga.
- Residential aged mental health care
- Acute adult and aged inpatient care
- Families where a Parent has a Mental Illness coordinator

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RB-3

This is the attachment marked '**RB-3**' referred to in the witness statement of Dr Ravi Subramanya Bhat dated 4 July 2019.



phn
MURRAY

An Australian Government Initiative

NEEDS ASSESSMENT

2017/18

CONTENTS

INTRODUCTION

To understand the health of our population, we gather, interpret and layer data to provide a detailed and full picture of our communities. The information is published annually, helping us to identify priority health and service needs within our region.

Our analysis of data is informed by foresight methodology (Voros, 2001) that moves from problem/gap identification through to options and opportunities. Looking at what is, and what might happen, to what needs to be done and how.

Since our first assessment in 2016, we have strengthened our future capability through knowledge management. Our population health knowledge base - Murray Exchange - has been a significant milestone in the assembly of quality health-related information that is contemporary, meaningful and accessible for stakeholders and to our communities.

To drive improvements in GP data quality, we have designed and tested an automated report, for GP practices working with Murray PHN. The report displays 15-month trends, regional and catchment-wide comparisons and creates benchmarks across practices in our region. We have begun tracking disease prevalence (cardiac, pulmonary and diabetes disease trends), count of patients by MBS data, cancer screening rates, mental health trends and Aboriginal and Torres Strait Islander patients' health assessment status. The report also provides us with de-identified patient data for population health planning.

Murray PHN has been informed by the Aboriginal and Torres Strait Islander, clinical and community advisory councils established across the catchment. We have also created Health Voices: a network of community members who can respond and advise Murray PHN of local health barriers and opportunities. They add a deeper dimension to our understanding of health at the local level. Our councils and voices are referred to in this document as 'Community Voice'.

The 2017/2018 Needs Assessment supports the planning, design and commissioning of services that provide accessible and affordable, efficient and effective primary health care in our region.

OUTCOMES OF HEALTH NEEDS ANALYSIS

This section summarises the findings of the health needs analysis to date, with a particular focus on health priorities.

The summaries will continue to be developed in consultation with the service providers, communities and advisory structures. The summary is not presented as an exhaustive list or comprehensive evidence base, as it has sought to strategically build on existing local knowledge and professional judgment as to what matters most for future planning.

Outcomes of the health needs analysis - key areas:

- Population health
- Aboriginal and Torres Strait Islander health
- Aged care
- Mental health
- Child and adolescent mental health
- Suicide prevention
- Alcohol and other drugs (AOD)
- Childhood immunisations
- Cancer screenings
- Chronic disease conditions: diabetes and cardiac-related admissions.

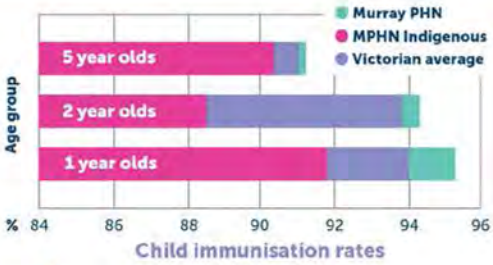
Our region at a glance

The Bendigo Easter Fair began in 1871 and is Australia's oldest ongoing festival

151,000 of us are obese

More than 14 Aboriginal language groups

371,000 have a long-term health condition



105,000 people smoke

1 in 5 experience a mental illness in any year

The Murray River is the third longest navigable river in the world

The largest Murray Cod **1.8m long and 113 kg** (a critically endanged species)

13,600 Aboriginal and Torres Strait Islander people

400+ Health Voices

4 Pink Lakes

177,000 have high blood pressure

2,530km The length of the Murray River

237,000 physically inactive

373,000 haven't seen a dentist in the past year

348,000 don't have private health insurance

Indigenous Australians have lived in the Murray River valley for at least 40,000 years

Greater Shepparton's 90 life-sized, fibreglass cows celebrate the region's agricultural industry

331,000 don't meet daily recommended fruit and vegetable consumption

22 Doctors in secondary schools appointed

388,000 people misuse alcohol

Bowel Cancer Screening Rates

43.1% Murray PHN **38.9%** National

The Murray River is more than 60 million years old

Champion race horse Black Caviar was born in Nagambie

644,460 Murray PHN total population

Cervical Cancer Screening Rates

63.5% Murray PHN **56.4%** National

Mt Bogong is Australia's second highest mountain and Victoria's highest at **1,986m**

Home to half of Victoria's wine regions

A royal commission in 1903 recommended Albury as the site of Australia's capital but Parliament chose Canberra in 1908

50 Stop Mental Illness Stigma signed pledges

69% of Australia's almonds and 48% of Australia's pistachios are grown in the North West region

Breast Cancer Screening Rates

56.8% Murray PHN **53.7%** National

122,000 went to an emergency department for treatment

We have the highest and lowest record temperatures in Victoria

Highest 50.8°C Mildura 6 January 1906

Lowest -12.8°C Mt Hotham 30 July 1931

The world's largest canoe race, the Murray Marathon, is held on the Murray River each year **5 days 404kms**

Leadership Collaboration Knowledge Innovation Accountability

Population health

Summary points

- Higher avoidable mortality rates (than the Victorian rate) exist for 15 of the 22 LGAs within the Murray PHN catchment
- GP workforce sustainability and retention is a significant issue.
- Cardiovascular disease, diabetes and chronic obstructive pulmonary disease are significant contributors to hospital admissions
- Cardiovascular disease, diabetes, cancer and mental illness are the most significant direct contributors to the life expectancy gap between Aboriginal and non-Aboriginal Victorians.
- There are emerging issues regarding women's health across the catchment
- New settler and refugee arrivals are significant for the Murray PHN

Consultation

(A) Murray PHN regional team – community interaction (Nov 2016-July 2017)
(B) Murray PHN Clinical, Community and Indigenous health councils (Nov 2016-July 2017)
(C) Murray Health Voices – community voice feedback (July 2017)
(D) Population Health Planning Network (July 2017)

Community voice

(D) Integration and effectiveness of services is a major consideration of service providers across the catchment. (C) (B) and (A) Workforce capacity and retention is a significant issue in remote and regional areas.

Key issues

- Need for increased access to services, and need for improved access for young people with a disability to supported care.
    - Options for access to after-hours support including improved awareness of supports available for Ageing in Place – care in the home models.
    - Access to specialist service providers and greater flexibility for better models of coordinated care.
    - Discharge planning processes from metro and regional hospitals and improved after care services are required and need GP coordination.
- Health data establishes that four preventable chronic conditions - cardiovascular disease, diabetes, cancer and mental illness - are the most significant direct contributors to the life expectancy gap between Indigenous and non-Indigenous Victorians.

- In some communities, particularly rural local government areas such as the Shire of Gannawarra and the Shire of Strathbogie, people aged over 65 years represent more than one quarter of the total local government area population.
- An increased number of people and proportion of the population over 65 years and over 85 years means all services need to take more account of the needs of the aging and the very elderly.
- A further analysis of Australian Institute of Health and Welfare (AIHW) indicators shows that for certain conditions and service use activity, there are a number (of indicators) for Murray PHN which fall detrimentally outside of AIHW comparative data.
- Potentially preventable hospitalisations for COPD and complications arising from diabetes are significantly higher across the PHN catchment with the highest numbers per standardised population rate in the Central Victoria and Goulburn Valley regions (AIHW 2016).
- Limited public dental clinics are available throughout many rural areas.
- There are major transport issues, including access, timetabling, small towns into regional centres/services and costs as identified in local transport plans and reports.

Description of evidence

- Murray PHN had a total population of approximately 644,457 persons in 2016. The catchment is projected to experience steady population growth over the next ten years. In round figures, Central Victoria has 230,400, North East 175,400, Goulburn Valley 157,800 and North West 80,600.
- Approximately 13,591 persons identify as Aboriginal and Torres Strait Islander. This represents 28% of the total Victorian Aboriginal and Torres Strait Islander population. Murray PHN has significant proportions residing in Swan Hill, Mildura and Greater Shepparton regions.
- Fifty-five of the 68 Statistical Areas (SA2 level) in the Murray PHN catchment have SEIFA scores less favourable than the Victorian average.
- Specific communities of significant disadvantage include California Gully – Eaglehawk (903), Cobram (904), Seymour (899), Upper Yarra Valley (846) and Robinvale (872).
- In 2014, Murray PHN's catchment population was noticeably more likely to receive the Centrelink income support payments, age pension, disability support payment or the sole parent payment (females only) compared with the Victorian average. North West had the highest proportion of population receiving any three of these Centrelink income support payments.
- Avoidable mortality (0-74 years):
    - Central Victoria has five of six LGAs well above the Victorian rate
    - Goulburn Valley all five LGAs are above - notably Murrindindi at 276.4 is more than double the Victorian rate
    - North East has five of eight LGAs above the Victorian rate
    - North West has all three LGAs above the Victorian rate per 1,000.
- Those receiving disability support payments is approximately 30,000 persons (16 – 64 years) across the catchment, representing 7.9% of the population.
- For those receiving instances of assistance through Home and Community Care (HACC), two areas have significant variance to the Victorian population rate. For Gannawarra it is more than double at 372, and for Loddon it is 560 compared with the Victorian rate of 142.
- For all causes of premature mortality, excluding cerebrovascular diseases, Murray PHN has higher premature mortality than for all conditions in metropolitan Melbourne.

Aboriginal and Torres Strait Islander health

Summary points

- Approximately 13,591 persons identify as Aboriginal and Torres Strait Islander (28% of the Victorian total) with significant proportions residing in Greater Shepparton (4.6 % of the Victorian total) Mildura (4.3% of the Victorian total), and Swan Hill (1.7% of the Victorian total).
- There is an over-representation of Aboriginal and Torres Strait Islander people in the hospital separation data. Hospital separations by Aboriginal and Torres Strait Islander status show Aboriginal and Torres Strait Islander rates in the North West region to be nearly twice the average rate recorded for Victoria.
- Aboriginal and Torres Strait Islander people experience Emergency Departments (ED) presentations for psychiatric illness at a rate of 76% higher than non-Aboriginal and Torres Strait Islander Australians.

Consultation

Community consultation has been undertaken through the following:

(A) Murray PHN regional team – community interaction (Nov 2016-July 2017)
(B) Murray PHN Clinical, Community and Indigenous health councils (Nov 2016-July 2017)

Aboriginal and Torres Strait Islander voice

The following themes emerged during consultation with the Aboriginal and Torres Strait Islander community:

- Build capacity for dual diagnosis response.
- Increase GP mental health expertise. (A)
- Lack of specialist children's counselling services. (A)
- More communication required between services and the prison system.
- Need to improve cultural sensitivity. (A)
- Lack of accessible and affordable treatment options. (A)
- Build capacity of mainstream providers particularly with complex needs clients. (A)
- The stigma of mental health is a barrier to accessing services.

Key issues

- Nationally, disease rates for Aboriginal and Torres Strait Islander people are higher for diabetes complications (4.1 times the national rate), Chronic Obstructive Pulmonary Disease (five times the national rate) and heart failure (2.7 times the national rate).
- Higher rates are recorded for cellulitis (three times the national rate) and kidney and urinary tract infections (2.2 times the national rate).
- Unacceptably high rates of morbidity and chronic disease across the Murray PHN Aboriginal and Torres Strait Islander population.
- Lower life expectancy and increased disadvantage (income rates, education and housing).
- Higher ED presentation rates overall compared with the Victorian Aboriginal population rate.
- A need to work in close partnership with Aboriginal health services and community organisations to identify needs and provide screening, assessment and early intervention programs more collaboratively - especially in chronic disease management and smoking cessation.
- Increased risk factors for social determinants of health, increased family violence, increased complexity and chronicity, and a lack of acknowledgment of the importance of culture within models of care – increasing the need for assistance for older community members such as health literacy issues and transport needs.
- The need for Aboriginal children and their families to participate in special activities aimed at teaching and celebrating their culture.
- Aboriginal children are over-represented in Out-of-Home Care and through child protection data, with increasing concern about levels of risk.
- Concern about dental health conditions for young Aboriginal children and over-representation in some communities for children with dental conditions in avoidable hospital admission data.
- Population immunisations - whole of life approach implementation needs to include:
    - residential aged care facilities immunisations for residents and staff
    - immunisation programs for people aged over 65
    - Aboriginal and Torres Strait islander state funded activity for Aboriginal children
    - chronic disease high risk groups
    - pregnant women
    - hospital staff immunisation
    - staff of childcare facilities.

Description of evidence

- Hospital separations for Aboriginal and Torres Strait Islander population in the North West is notably higher.
- Difference in ED presentation rates between non-Aboriginal and Torres Strait Islander and Aboriginal and Torres Strait Islander populations are 89% higher for Goulburn Valley, 52% more in North West, 44 % for North East and 18% difference in Central Victoria.
- Aboriginal and Torres Strait Islander ED presentation rates for respiratory system illnesses (2011/12 to 2013/14) are higher in all areas of Murray PHN than Victoria. The difference between Aboriginal and Torres Strait Islander and total population is especially high in Goulburn Valley (130% compared with 81%).
- Hospital separations by Aboriginal and Torres Strait Islander status show Aboriginal and Torres Strait Islander rates in the North West region to be nearly twice the average rate recorded for Victoria.

- Aboriginal and Torres Strait Islander population hospital separation rates for respiratory system diseases and disorders were higher for the Murray PHN catchment than the Victorian average (19.6 compared with 15.9 per 100,000).
- HACC clients - (2012/13) Aboriginal and Torres Strait Islander clients as a percentage of Aboriginal and Torres Strait Islander population are higher in Central Victoria and Goulburn Valley than Victoria.
- Aboriginal and Torres Strait Islander people experience 76% higher Victorian ED presentations for psychiatric illness than non-Aboriginal and Torres Strait Islander Australians.
- Emergency department presentations for psychiatric illness by Aboriginal and Torres Strait Islander status are 1.5 times higher in North West than for the total Murray PHN catchment.
- Public hospital separations for intentional self-harm injuries by Aboriginal and Torres Strait Islander status show Aboriginal and Torres Strait Islander rates are slightly higher in Goulburn Valley than Victoria.

- In Albury, the admission rates (2012/13) for mental health related conditions for Aboriginal and Torres Strait Islander persons are more than double the Victorian Aboriginal persons rate.
- Admissions for circulatory system diseases are double the Victorian rate for Aboriginal persons in Swan Hill.
- GP data primary diagnoses for Aboriginal and Torres Strait Islander persons are depression, asthma, osteoarthritis and anxiety.
- Antenatal visits in the first trimester for Aboriginal and Torres Strait Islander women (2010/2011) were significantly less than the population average when compared with like Aboriginal and Torres Strait islander communities in other PHN regions.
- In the general population, there are 44% more people who are registered mental health clients in the Murray PHN catchment area than the Victorian average (15.7 clients per 1,000 population) with higher rates experienced noticeably in Mildura (25.5) and Benalla (24.3). Rates were also substantially higher in Alpine, Wangaratta, Wodonga, Greater Bendigo, Greater Shepparton, Indigo and Swan Hill. North West had rates above the state average in two out of three LGAs.

Aged care

Summary points

- The aged population across the Murray PHN catchment of 65+ years (range 17-19%) is higher than the Victorian average of 14.8%.
- Five LGAs have 25% of their population above 65 years compared with the Victorian average of 15%.
- In some communities, particularly rural local government areas, such as the shires of Gannawarra and Strathbogie, people aged over 65 years represent more than one quarter of the total local government area population.
- Generally lower rates of annual health assessments by GPs for persons 75 and over (2009/10) with LGAs Moira, Indigo, Towong, and Wodonga having significantly lower rates.
- Ambulance call out rate of 53% to residential aged care facilities in Bendigo were classified as emergency hospitalisation for external injuries caused by falls.

Consultation

Community consultation has been undertaken through the following:

(A) Murray PHN regional team – community interaction (Nov 2016-July 2017)
(B) Murray PHN Clinical, Community and Indigenous health councils (Nov 2016-July 2017)

Community voice

The following theme emerged through consultation with the community:

- Advocacy services are required to support client access to the National Disability Insurance Scheme (NDIS) particularly in small rural communities. (A)
- There are emerging issues about how people are transitioned from the NDIS to My Aged Care as the NDIS continues to roll out across our region. (A)
- Advance care plan (ACP) completion rates are low and there is currently no reliable system of communicating ACP between services in a timely manner to ensure the ACP can be acted upon if or when required. (A)
- Accessibility, medication review and advocacy issues. An emerging issue in this space in the commencement of new Advance Care Directive legislation, the *Medical Treatment Planning and Decisions Act (2016)* in March 2018 in Victoria. (B)

Key issues

- There is a need for a broader primary health focus to support community and aged care resident needs (including social and lifestyle measures/interventions).
- A need to support general practice to accommodate types of patient care required by older persons such as simple structured assessment and attention to underlying frailties i.e. mobility, undernutrition, pain, incontinence, and cognitive and sensory impairments that limit ability and independence.
- Lack of communication between patients, staff and relatives in aged care regarding health and care needs.
- The need to ensure health issues in the elderly are identified in a timely way and appropriate care is accessible.
- Improved transport options, especially for those living in isolated areas.
- Need for a consistent, safe medications management strategy.
- Early assessment and intervention in functional decline and complex care coordination.
- Need for improved home based/or residential aged care facility (RACF) palliative care support, to reduce unnecessary 'end of life' hospital transfers/admissions.
- Need to reduce avoidable emergency department presentations through improving and promoting access to primary health care (including palliative care and in-home services).
- Need to understand the implications of:
    - a significant increase in the number of older people
    - an increasing incidence of age-associated disability and disease (e.g. dementia, stroke, COPD, diabetes), along with complex morbidities.

Description of evidence

- 2016 ABS population estimates indicate there are now five LGAs in the Murray PHN catchment with more than 25% of the population being people aged over 65. They are Strathbogie (28.4%), Buloke (28%) Gannawarra (27.6%), Loddon (26.8%), Benalla (26.1%), and Towong (25.7%). The Victorian average is 15.56%.
- The number of high level care places in residential aged care available across regions are: Central Victoria 955, Goulburn Valley 669, North East 887, and North West 351.
- The number of low level care places in residential aged care available across regions are: Central Victoria 1234, Goulburn Valley 870, North East 874, and North West 446.
- The number of community places in residential aged care available across regions are: Central Victoria 431, Goulburn Valley 585, North East 472, and North Wes: 356.
- For annual health assessments by GPs for persons 75 and over (2009/10), areas where the rate per population was lower than Victoria include: Gannawarra, Loddon, Mount Alexander, Mitchell, Benalla, Albury, Mansfield and Mildura. The following have significantly lower rates: Moira, Indigo, Towong and Wodonga.
- Rural Ambulance Victoria data reveals that in 2015, only 53% of call outs to RACFs in Bendigo were classified as emergency hospitalisation for external injuries caused by falls.
- For persons over 65 years, of all fall hospitalisations for the period 2011/12-2013/14 indicates that the catchment has an overall higher average than the Victorian rate, and Central Victoria, North East and North West are individually higher.

Mental health

Summary points

- Five LGAs have populations with identified high and very high levels of psychological distress significantly higher than the Victorian rate of 12.6%.
- Aboriginal and Torres Strait Islander people experience 75% higher Victorian ED presentations for psychiatric illness.
- 33% of Mental Health (MH) Treatment Plan activities were for a review of the plan.
- There are over 45% more registered mental health clients in Murray PHN compared with the Victorian average.
- Murray PHN expects that up to 67 people from the PIR target group in the Loddon NDIS region, 55 in Murrumbidgee, 65 in Ovens Murray and 29 in Mallee will need the organisation's support to access the NDIS as it rolls out across the PIR regions.

Consultation

Community consultation has been undertaken through the following:

(A) Murray PHN regional team – community interaction (Nov 2016-July 2017)

(B) Murray PHN evaluation and feedback from GP continuing professional development sessions (Nov 2016-July 2017)

(C) Murray PHN community consultation – needs assessment planning Sept – Oct 2017)

(D) Murray PHN Clinical, Community and Indigenous health councils (Nov 2016-July 2017)

(E) Murray Health Voices – community voice system (July 2017).

Community voice

The following themes emerged during consultation with the community:

- Access. (D)
- Rurality. (D)
- Workforce sustainability (ageing GP workforce, part time work preferences and mobility of female GPs). (B)
- Stigmatisation. (C)
- Lack of cultural sensitivity. (C)
- Cross-border demand on services. (C)

- Long waiting times for service and comorbidity of conditions. (C)
- Barriers to timely access to adolescent mental health services. (C)
- Co-payments and costs are barrier to access. (C)
- Funding models need to be more flexible. (C)
- Uncertainty exists regarding the implementation impact of the National Disability Insurance Scheme (NDIS) (D) for the workforce. General practices require support to assist with NDIS implementation. Private allied health may also require more support for transitioning to the NDIS. Impact on Partners in Recovery clients was also identified as an area of focus. (D)
- Advocacy services are required to support client access to the NDIS particularly in small rural communities. (C)
- The NDIS also brings a focus on certain conditions and has the potential to decrease holistic care and also potentially decrease career satisfaction for the worker. (D)
- Tertiary institutions need to do more to support health professional careers in rural areas. (C)
- A need to increase telepsychology/psychiatry services (including nursing staff) and training for the use of the platform. (D)
- Better to provide services in appropriate settings such as schools, outreach areas and homes. (D)
- Private service options are also sometimes overlooked. (D)
- PHN collaboration to systematise state-wide and cross-border discharge planning for mental health is needed. (D)
- Predictive modelling could guide placement of services. (C)
- Competitive tendering for services was viewed as counterproductive especially in small remote areas. KPIs which encourage service to work together are needed. (C)
- Dual diagnosis – comorbidity - more support needed for GPs, colocation and integration of services (Australian Community Support Organisation - ACSO) workers, Mental Health Nurse Incentive Program (MHNIP) and GPs and flexibility of working hours.
- There may be underreporting of mental health services by GPs. (C)
- A need for mental health training for lay counsellors. Peer working with lived experience are an untapped resource, community organisations and personal helper and mentor models and family support groups should be investigated. (C) (D)
- Community mental health literacy needs to be further supported to encourage those with low level mental health needs to access services. (C) (D)

Aboriginal and Torres Strait Islander voice

The following themes emerged during consultation with the Aboriginal and Torres Strait Islander community:

- Build capacity. (A)
- Dual diagnosis response. (A)
- Increase GP mental health expertise. (A)
- Lack of specialist children's counselling services. (A)
- More communication required between services and the prison system. (A)
- Need to improve cultural sensitivity. (A)
- Lack of accessible and affordable treatment options. (A)
- Build capacity of mainstream providers particularly with complex needs clients. (A)
- The stigma of mental health is a barrier to accessing services. (A)

Key issues

- Based on ABS Census 2016 data, the Murray PHN catchment population is estimated as 644,457 people. It is estimated that 19.6% of the population (aged 18 to 85 years) will experience mental ill health. This equates to approximately 126,314 people across the Murray PHN catchment. Of this group, estimates indicate 20,841 people will have moderate to low mental health needs and 4420 people will have severe and persistent mental illness with complex needs, although only a proportion of these people will access services (as defined in a stepped model of care).
- There is significant variation between Local Government Areas (LGAs), across the catchment, in terms of rates of registered mental health clients, hospitalisations, chronic conditions and those receiving alcohol and drug treatment services. There are also variations between LGAs for risk factors which include socioeconomic status, psychological distress rates, remoteness, new settler arrivals and homelessness.
- This variation does show areas of greater need for resources, but should not be viewed in isolation. There is significant need in all the Murray PHN regions and therefore services should be available across all the catchment. Some areas have received more consideration and have been weighted, based on a greater need (MHNIP only). Presently some locations do not have any resource allocation in either MHNIP or Psychological Therapy Services (PTS) services.
- A significantly higher lifetime prevalence of depression and anxiety was reported among people with the following characteristics:
    - Unemployed or not in the labour force
    - Total annual household income less than $40,000
    - Moderate, high or very high levels of psychological distress
    - Current smoker
    - Fair or poor self-reported health status
    - Diabetes
    - For women: living in rural areas, were ex-smokers (Goulburn Valley region study)
    - For men: long-term risk of alcohol-related harm and/or were obese.
- A significant proportion of LGAs in the Murray PHN are in the 20 most socio-economically disadvantaged within Victoria.
- More than 20% of Victoria's Aboriginal and Torres Strait Islander population live within the Murray PHN catchment.

Description of evidence (indicators)

Registered mental health clients

Description: The rate per 1,000 of aged standardised population and the Victorian ranking by LGA of clients who are registered by the state to receive clinical mental health services (therefore with a diagnosis).

Areas of note:

- Benalla (26.3) followed by Mildura (24) have the highest rates of registered mental health clients per 1,000 for Murray PHN, more than double the Victorian average (11.9) and are ranked 4th and 6th highest in Victoria respectively.
- Wangaratta, Indigo and Wodonga are all significantly higher than the Victorian average and ranked within the top 10 LGAs in the state for registered mental health clients.

Mental health overnight hospitalisations rate per 100,000 (2014-15)

Description: Number of mental health overnight hospitalisation rates per 100,000 age standardised by SA3 level based on the patient's postcode.

Areas of note:

- Albury at an SA3 level is ranked second in the Murray PHN catchment for mental health overnight hospitalisations bed day rate per 100,000 (2014-15), and ranked sixth in Murray PHN for mental health overnight hospitalisations rate per 100,000 (2014-15).
- Wangaratta – Benalla, Murray River - Swan Hill, Heathcote – Castlemaine - Kyneton, Loddon-Elmore and Bendigo SA3 areas are also above the Murray PHN average for mental health overnight hospitalisations bed day rate per 100,000 (2014-15) and mental health overnight hospitalisations rate per 100,000 (2014-15).

Index of relative socio-economic disadvantage
Description: Victorian state ranking of LGAs for socio-economic disadvantage.

Areas of note:

- Loddon is ranked the second most disadvantaged LGA in Victoria.
- Mildura (ranked 4th) and Swan Hill (10th) are in the 10 most disadvantaged LGAs in Victoria.
- Greater Shepparton (13th), Moira (15th), Benalla (16th), Gannawarra (18th) and Campaspe (20th) are ranked within the 20.

Proportion (%) of adult population with high or very high psychological distress
Description: Using the Kessler 10 measure of psychological distress, the percentage of the population with rates of high or very high psychological distress can indicate a higher need for psychological therapy services rather than the need for care coordination. This measure is used to identify possible hotspots for greater Psychological Therapy Services (PTS).

- Campaspe (18.3%), Mount Alexander (17.2%), Murrindindi (16.4%), Wangaratta (15.2%) and Mitchell (14.8) are significantly above the Victorian average (12.6%) for population reporting high/very high psychological distress (2014).

Description of evidence (risk factors)

The following risk factors have been considered relevant for either psychological therapy service planning or for services for people living with severe mental illness.
Aboriginal and Torres Strait Islander population sizes (risk factors for mental illness include being an Aboriginal and Torres Strait Islander person).

Communities that have the most significant population sizes, based on LGA 2013 and ABS 2016 data include:

- Shepparton 2661
- Mildura 2332
- Wodonga 2131 - this is deemed to be higher with residents of NSW and surrounding areas not included in these numbers.
- Bendigo 1843
- Swan Hill 1081
- Campaspe 992 (LGA 2013 data) or 878 (ABS Census 2016 data) - this is deemed to be higher with residents of Moama and surrounding areas not included in these numbers.

Clients receiving drug and alcohol treatment services (severe)
Description: Clients receiving drug and alcohol treatment services per 1000 of the population.

Areas of note:

- Gannawarra is ranked the highest LGA in Victoria for clients receiving drug and alcohol treatment services.
- Swan Hill (5th) and Mildura (10th) are also ranked in the top 10 highest LGAs in Victoria for clients receiving drug and alcohol treatment services.

Chronic conditions (physical co-morbidities)
Description: Chronic conditions per 1000 population ranking.

Areas of note:

- Gannawarra (29.5), Buloke (25), Loddon (24.7) and Swan Hill (23.5) have a significantly higher proportion of the population with chronic conditions than the Victorian average (13.5).

Availability of services in rural and remote areas (severe and moderate)
The following LGAs have a Modified Monash Model (MMM) classification of 5 defined as 'other rural' with a population below 10,000 people. Services to target these populations such as tele-psychiatry and clinical-led web-based psychological interventions should be considered:

- Alpine
- Buloke
- Gannawarra
- Indigo
- Loddon
- Macedon Ranges
- Mansfield
- Murrindindi
- Strathbogie
- Towong.

New settler arrivals per 100,000 population rank (PTS)
Studies identify intercountry resettlement due to humanitarian reasons as being an indicator for the need of mental health services.

The following areas have both high numbers of new settler arrivals (per 100,000 population) and high percentage of humanitarian new settler arrivals:

- Greater Bendigo
- Mildura
- Greater Shepparton
- Wodonga
- Swan Hill.

MBS rates for focused psychological strategies (Better Access)
Description: The total number of MBS patients seen by clinical psychology, social work and psychologists (mental health clinicians) as a rate per 1,000 for SA3 (2015-16).

Areas of note:

- Moira and Murray-Swan Hill (SA3 areas) were significantly below the Murray PHN average number of MBS patients seen by a mental health clinician. Both SA3 areas are also two of the most disadvantaged Victoria LGAs.
- Campaspe and Wodonga-Alpine (SA3 areas) is below the Murray PHN average number of MBS patients seen by a mental health clinician.
- Loddon had no recording of allied health and thus their population was not included in the Murray PHN average and is ranked the second-most disadvantaged LGA in Victoria.
- Bendigo and Heathcote-Castlemaine-Kyneton (SA3 areas) have a significantly higher number of mental health providers than the Murray PHN average.
- Moira, Campaspe and Murray River-Swan Hill (SA3 areas) have a significantly lower number of MBS mental health providers than the Murray PHN average. These SA3 areas are also two of the most disadvantaged Victoria LGAs.

Rates of GP Mental Health Treatment Plans
Description: The rates of GP Mental Health Treatment Plans (MHTPs) per SA3 have been calculated as a rate per 1000 of the population and then compared against the Murray PHN average. The MBS item for attendance was compared. As were the percentage of reviewed plans as a proportion of attended sessions to indicate those GPs that were reviewing patients' plans.

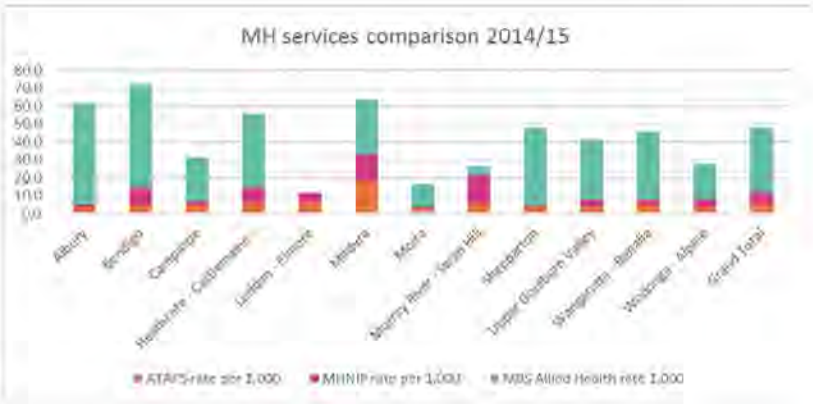
Areas of note:

- Shepparton (281), Bendigo (209), Mildura (175), Moira (169) and Wodonga-Alpine (162) had higher rates of MHTPs than the Murray PHN average (151).
- In contrast to those that had higher levels of MHTP conducted the following LGAs had a higher rate of MHTP reviews (as a percentage of MHTPs attended): Heathcote - Castlemaine – Kyneton (68%), Loddon – Elmore (59%), Wodonga – Alpine (50%), Upper Goulburn Valley (49%), Wangaratta – Benalla (44%). These are all above the Murray PHN average of 33% reviews as a proportion of attended MHTPs.

Comparison of Access to Allied Psychological Services (ATAPs), MHNIP and Better Access programs
Description: Comparison of ATAPs, MHNIP and Better Access services for 2014/15 as a rate of 1000 per population (not age standardised).

Areas of note:

- The SA3 areas of Bendigo, Heathcote-Castlemaine-Kyneton, Murray-Swan Hill and Wodonga-Alpine had higher MHNIP rates per 1000 than ATAPs.
- The Loddon-Elmore's ATAPS and MHNIP account for 100% of services when combined with Better Access focused psychological strategies.



Clients receiving drug and alcohol treatment services (per 1000 population 2014/15)

- Gannawarra is ranked the highest LGA in Victoria for clients receiving drug and alcohol treatment services.
- Swan Hill (5th) and Mildura (10th) are also ranked in the top 10 highest LGAs in Victoria for clients receiving drug and alcohol

Aboriginal and Torres Strait Islander people
Experience:

- 76% higher Victorian ED presentations for psychiatric illness than non-Aboriginal and Torres Strait Islander Australians. The highest rate of presentations was experienced in the North West.
- Emergency department presentations rates for:
    - depression for Murray PHN was 17% higher than the Victorian rate
    - anxiety was 37% above the Victorian rate
    - mental status alterations were 64% above the Victorian rate
    - suicide risk was 80% higher than the Victorian rate. (VEMD data 2015/16)

Partners in Recovery

Description of evidence (indicators)
National Disability Insurance Scheme (NDIS) roll-out schedule Partners in Recovery (PIR) client data (note: the PIR target group are people with severe and persistent mental illness and complex needs).

Description: Evidence of the needs of the PIR target group in Murray PHN's PIR regions for support to enter the NDIS.

Areas of note:

- Murray PHN leads two Partners in Recovery (PIR) programs in its region: Loddon Mallee Murray (LMM) and Hume.
- The LMM and Hume PIR programs have regional coverage that is slightly divergent to Murray PHN's footprint, operating in four NDIS rollout regions: Loddon, Murrumbidgee, Ovens Murray and Mallee.
- The Loddon NDIS region including the LGAs of Campaspe, Greater Bendigo, Loddon and Mount Alexander began NDIS rollout on 1 May 2017.
- The Murrumbidgee NDIS region including the LGAs of Albury, Berrigan, Conargo, Corowa, Deniliquin, Greater Hume Shire, Jerilderie, Murray, Urana, and Wakool began NDIS rollout on 1 July 2017.
- The Ovens Murray NDIS region including the LGAs of Alpine, Benalla, Indigo, Mansfield, Towong, Wangaratta and Wodonga began NDIS rollout on 1 October 2017.
- The Mallee NDIS region including the LGAs of Buloke, Gannawarra, and Swan Hill will begin NDIS rollout on 1 January 2019.
- Up to 271 clients can be supported by the PIR programs combined at any one time. It is expected that the programs will run at full capacity through the 18/19 period.
- It is estimated that 70 to 80% of PIR clients will be eligible for the NDIS: a range of 190 to 216 clients.

Suicide prevention

Summary points

- Avoidable deaths for suicide and self-inflicted injuries in the Murray PHN region were 40% above the state average (Victorian Health Atlas).
- Females account for 69% of all self-harm injury hospital admissions.
- The rate of self-harm injury for Aboriginal and Torres Strait Islander people is approximately 50% more than the total Murray PHN rate.
- Definition of a registered mental health client: when a public mental health service accepts a person's referral for service delivery or intervention, the person becomes a registered mental health client of the service and is registered in the Client Management Interface/Operational Data Store (CMI/ODS) system.

Consultation

One project underway is a place-based suicide prevention initiative in conjunction with the Victorian government. There are two trial sites, Benalla and Mildura, in the catchment. Each one will facilitate local responses and evidence-based strategies with multi-sectorial suicide prevention groups developing and implementing local strategies.

The aim is to use an evidence-based suicide prevention approach, drawing on available collective impact approaches and mental health specific approaches. The strategies will be built around the nine evidence-based strategies for communities. Communities have driven the development of the local plans, based on identified needs. The interventions focus on capacity building and enhancing system effectiveness rather than service expansion or new services.

Community voice

Themes from the community consultation include:

- ensuring strong representation and support of people with lived experience to actively participate in the project
- regular knowledge sharing and support
- multi-sectoral involvement with a shared model of understanding
- plans should be shaped by the community within cultural frameworks
- open and transparent communication.

Key issues

- Significant rates of suicide are experienced in Murray PHN regions of North West, Goulburn Valley and North East, with significantly high rates of ambulance attendance to suicide attempts in these regions.
- Rates of hospital separations for intentional self-harm is high compared with the state average in two of four regions within Murray PHN.
- The rate of hospital separations for intentional self- harm for Aboriginal and Torres Strait Islander people is significantly higher than the non-Aboriginal and Torres Strait Islander population.

Description of evidence

- Annual frequency, overall frequency and average annual rates of suicide by LGA indicate that Benalla, Mansfield, Indigo and Mount Alexander are the highest. There is an increasing trend in Benalla and Mount Alexander in the years 2009–2015.
- Avoidable deaths for suicide and self-inflicted injuries in the Murray PHN catchment area were 24.4% above the state standardise ratio of 86. (A standardised ratio (SR) is a comparison to the Australian ratio that is assigned a value of 100)
- Females accounted for 69% of all Murray PHN catchment hospital separations for self-harm injuries.
- Compared with the Victorian standardised ratio of 86, all Murray PHN LGAs except Campaspe have a higher rate of avoidable deaths from suicide and self-inflicted injuries.
- Strathbogie had the highest rate of avoidable deaths from suicide and self-inflicted, followed by Benalla (161), Murrindindi (156). Followed by Macedon Ranges (150) and Albury (140).
- North West region of Murray PHN experienced the highest rate of public hospital separations for intentional self-harm which is 13% higher than the state average. The next highest region was Goulburn Valley which is also above the state average.
- Across Murray PHN, Aboriginal and Torres Strait Islander communities have a rate of separations which is 127% higher than the non-Aboriginal and Torres Strait Islander population. Particular communities of concern that experience the highest rate are within Goulburn Valley (131%), Central Victoria (127%) and North West (79%).

Alcohol and other drugs (AOD)

Summary points

- Murray PHN had rates for smoking (above 18yrs) at 26% above the state average.
- Alcohol consumption for increased lifetime risk of alcohol related harm is 6.5% above the Victorian average with significant increased numbers in eight LGAs.
- The North West region has considerably higher than other regions within Murray PHN and the Victorian average rate for alcohol related assaults.
- Emergency department presentations for co-occurring AOD and mental health disorders are higher than the Victorian average, particularly for the North West region.

Consultation

Community consultation has been undertaken through the following:

(A) Murray PHN regional team – community interaction (Nov 2016-July 2017)

(B) Murray PHN evaluation and feedback from GP Continuing Professional Development sessions. (Nov 2016-July 2017)

(C) Murray PHN community consultation – needs assessment planning Sept–Oct 2017)

(D) Murray PHN Clinical, Community and Indigenous health councils (Nov 2016-July 2017)

(E) Murray Health Voices – community voice system (July 2017)

(F) Murray PHN AOD sector consultation (Dec 2016)

Community voice

The following themes emerged during consultation with the community:

- The community noted that stigmatisation of alcohol and other drug clients was often greater than that experienced by mental health clients. (D)
- A need for more specialist services. (A) (B)
- A need for general practitioner skills training, a strengthening of existing services and more early intervention options. (A) (B)
- A need to better link pharmacies into the system. (C)
- Better access to addiction specialists and pain management services is required. (C)
- Some services have long waiting periods. (C)

- Health professionals are also treating comorbid conditions such as diabetes when delivering AOD services. (C)
- Support for health practitioners to provide non-judgemental treatment for both AOD issues and co-occurring chronic diseases. (C)
- Sector priorities were 1. place based withdrawal 2. dual diagnosis, 3. alcohol brief intervention in primary care settings and 4. AOD service pathways. Other areas identified were vulnerable youth, the use of technology for specialist consult, and appropriate staff supervision. (F)
- Advocacy services are required to support client access to the National Disability Insurance Scheme (NDIS) particularly in small rural communities. (D)
- The NDIS also brings a focus on certain conditions and has the potential to decrease holistic care and also potentially decrease career satisfaction for the worker. (D)
- PHN collaboration to systematise state-wide and cross-border discharge planning from detoxification facilities is needed. (D)

Key issues

- Smoking rates for Murray PHN are considerably higher than the Victorian average.
- The rates of alcohol consumption and related harm indicate an enduring need to be comprehensive in the strategic effort and cognisant of rural community culture and subsequent impacts.
- Trends in illicit drug use, especially involving amphetamine use, require further planning of a comprehensive, catchment-wide approach with focus on the North West and Goulburn Valley regions.
- Goulburn Valley region however shows the highest rate in the catchment for specifically drug dealing and trafficking.
- In providing current AOD needs data and priority issues, it is viewed that the category has intrinsic overlap with related and broader priority issues; especially mental health.

Description of evidence

Smoking rates
Description: Proportion percentage of current smokers.

- Murray PHN had rates for smoking for those over 18 years that were 26% above the Victorian average.

Proportions of the adult population across Murray PHN who consume alcohol at a level that leads to alcohol related harm over their lifetime
Description: Prevalence of lifetime risk of alcohol related harm

Consumption of alcohol recorded in 2014 at levels leading to harm over the lifetime was 6.5% greater than the state average of 59.2 per 1000 persons. Eight LGAs have populations who consume alcohol at a level that leads to alcohol related harm over their lifetime above the Victorian rate, they are:

- Indigo (74.3 per 1000 persons)
- Murrindindi (73.4 per 1000 persons)
- Alpine (71.5 per 1000 persons)
- Wodonga (71 per 1000 persons
- Mansfield (69.8 per 1000 persons)

- Towong (68.5 per 1000 persons)
- Moira (68.1 per 1000 persons)
- Campaspe (65.6 per 1000 persons)

Alcohol related hospitalisations
Description: Alcohol related hospitalisations per 10,000 population

Rates for Murray PHN were significantly greater the Victoria rate in three LGAs:

- Wangaratta (24% greater)
- Benalla (12% greater)
- Mount Alexander (7.5% greater)

Alcohol related ambulance attendances and serious road injuries (SRI)
Description: Alcohol related ambulance attendances.

- Murray PHN reported 21,602 alcohol related ambulance attendances in 2014/15.

Alcohol related serious road injuries
Description: Alcohol related serious road injuries

In 2014/15, 1885 alcohol related serious road injuries occurred in the PHN. Rates across Murray PHN were significantly above the Victorian rate (3.2 per 10,000 people) in 12 LGAs:

- Loddon (13.6 per 10,000 people)
- Strathbogie (12.2 per 10,000 people)
- Murrindindi (10.3 per 10,000 people)
- Alpine (9.2 per 10,000 people)
- Mitchel (per 10,000 people)
- Mansfield (7.8 per 10,000 people)
- Benalla (6.6 per 10,000 people)
- Indigo (5.2 per 10,000 people)
- Campaspe (4.3 per 10,000 people)
- Gannawarra (5.9 per 10,000 people)
- Mount Alexander (6.1 per 10,000 people)
- Macedon Ranges (5.6 per 10,000 people)

Alcohol related assaults
Description: Alcohol related serious assaults.

The number of alcohol related assaults recorded for the Murray PHN catchment 5839. The following 13 LGAs have rates from 1.1 to 78 times greater than the Victorian rate:

- Gannawarra (78 times greater)
- Loddon (53 times greater)
- Mildura (35 times greater)
- Buloke (21 times greater)
- indigo (12 times greater)
- Greater Shepparton (9 times greater)

- Mount Alexander (7.6 times greater)
- Swan Hill (5.2 times greater)
- Benalla (4 times greater)
- Mitchell (3.2 times greater)
- Mansfield (1.9 times greater)
- Moira (1.9 times greater)
- Murrindindi (1.1 times greater)

Alcohol related family violence
Description: Definite alcohol related family violence rates

Definite alcohol related family violence rates were also disproportionately higher when compared with the Victorian rate (10.7 per 10,000 people):

- Mildura (44.9 per 10,000 people)
- Swan Hill (42.8 per 10,000 people)
- Wangaratta (26.6 per 10,000 people)
- Wodonga (24.1 per 10,000 people)
- Gannawarra (23.7 per 10,000 people)
- Mitchell (23.6 per 10,000 people)
- Greater Shepparton (20.7 per 10,000 people)
- Benalla (19.1 per 10,000 people)
- Buloke (18.1 per 10,000 people)
- Murrindindi (17.6 per 10,000 people)
- Greater Bendigo (17.2 per 10,000 people)
- Campaspe (16.8 per 10,000 people)
- Loddon (16.3 per 10,000 people)
- Indigo (15.6 per 10,000 people)
- Moira (15.3 per 10,000 people)
- Mansfield (13.4 per 10,000 people)

Alcohol related deaths
Description: The rate of alcohol-related deaths

- The rate of alcohol-related deaths in the Murray PHN catchment, including in each of its four regions, were greater than the Victorian average. The highest rates were recorded in Central Victoria (2.4 times greater) and North West (1.4 times greater).

Alcohol related episodes of care
Description: Alcohol and drug episodes of care for alcohol-related problems.

- Compared with the Victorian average rate of 28.8, the rate of alcohol and drug episodes of care for alcohol-related problems was notably higher for the Murray PHN catchment 34.23 (18.8% greater), including each of its four regions. The North West and Central Victoria regions had the highest rates both were substantially higher than the Victorian average.

Illicit drug related episodes of care
Description: The rate of AOD episodes of care for illicit drug related problems

- The rate was notably higher for the North West and Central Victoria regions of the catchment, having a substantially higher rate than the Victorian average (38.9 per 10,000 people).
- Mildura (83.5 per 10,000 people)
- Gannawarra (79.5 per 10,000 people)
- Greater Bendigo (63.8 per 10,000 people)
- Campaspe (48.8 per 10,000 people)
- Greater Shepparton (47.9 per 10,000 people),
- Swan Hill (46.6 per 10,000 people).

Illicit drug related hospitalisation and ambulance attendance rates
Description: Hospitalisation rates for illicit drug use and hospital separations for alcohol/drug use and alcohol/drug use induced organic mental disorders.

- Hospitalisation rates for illicit drug use was higher for when compared with the state average rate for eight LGAs within Murray PHN with Mount Alexander being particularly high (33% greater).
- The rate of hospital separations for alcohol/drug use and alcohol/drug use induced organic mental disorders is at or below the Victorian average in all Murray PHN regions.
- Description Illicit drug related ambulance attendances.
- 9038 illicit drug related ambulance attendances (2011-12/2013-14).

Illicit drug use and possession crime rates
Description: Rates for drug use and possession crime and possession and cultivate or manufacture criminal offences.

- Compared with the Victorian average, rates for drug use and possession crime are especially high in the North West region and above the average in Goulburn Valley. These two regions also show higher rates for cultivating and manufacturing drugs.
- The rate of drug use and possession and cultivate or manufacture criminal offences were above the Victorian average in Goulburn Valley and North West.

Co-occurring mental health and AOD disorders
Description: Emergency department presentations for co-occurring AOD and mental health disorders.

- Rates of presentations to emergency departments are higher than the Victorian average, particularly for the North West region, which is distinct from the lower rates of the other Murray PHN regions.

Notes on data interpretation from *Methamphetamine in the Murray Primary Health Network* paper, 2017:

- Australia has one of the highest per capita rates of methamphetamine use in the world (United Nations Office on Drugs and Crime, World Drug Report 2016).

- Service usage data is one measure treatment demand but do not capture the number of unique users. Increased rates of service use may reflect (to varying degrees) unknown changes (increases) in the availability and purity of methamphetamine. Similarly, changes in police reported methamphetamine offences may reflect enhanced surveillance and/or reporting. There is no source of data that accurately measures other societal, physical and psychological harms to methamphetamine users and others.
- Rural Australians demonstrate higher rates of risky health behaviour, including risky alcohol and illicit drug use. This may suggest more complex use trends of methamphetamine use among those living in rural and regional locations.

Methamphetamine related Alcohol and Drug Information System, (ADIS) episodes of care 2010-2015
Description: The number of ADIS episodes of care for illicit drug related problems.

- Greater Shepparton (19.3%) Mildura (18.9% and Greater Bendigo (17.1%) comprise over 55% of the total Murray PHN catchment in terms of ADIS episodes of care delivered.

Methamphetamine offences 2010-2016
Description: The number of methamphetamine offences.

- Murray PHN's catchment accounted for 9.5% of all Victorian methamphetamine offences.
- For the period 2010-2016, the rate of methamphetamine offences ranged from 9.5/100,000 in 2010 in Swan Hill to 168/100,000 population in Greater Shepparton in 2016. For the period 2014-2016, the biggest rates of change were seen in Mildura (63%), Greater Shepparton (61%) and Greater Bendigo (60%). This compares to a state-wide increase of 174% for the same period.

Oral health

Summary points

- 14 of the 21 LGAs within Murray PHN have higher rates of people delaying visits to dental professional's due to cost.
- Ambulatory care sensitive conditions for dental conditions was higher for approximately half Murray PHN LGAs, with Mildura, Gannawarra and Buloke having the highest.
- Towns currently without fluoridation exist across Murray PHN including Cohuna, Cobram, Numurkah, Myrtleford, Tatura, Bright, Woodend, Broadford, Mansfield and Alexandra.

Consultation

Community consultation has been undertaken through the following:

(A) Murray PHN regional team – community interaction (Nov 2016-July 2017)

(B) Murray PHN evaluation and feedback from GP Continuing Professional Development sessions. (Nov 2016-July 2017)

(C) Murray PHN community consultation – needs assessment planning Sept-Oct 2017)

(D) Murray PHN Clinical, Community and Indigenous health councils (Nov 2016-July 2017)

Community voice

The following themes emerged during consultation with the community:

- Value is in 'soft screening' with kindergarten children the focus, along with changes in school policies (encouraging healthy eating and water as first beverage choice) and incorporating achievement programs like healthy living. (A)
- There is a need for more oral health education, this could reduce hospital admissions. (D)

Key issues

- Access to public dental health services is very limited in many rural communities, and private dental service fees present a barrier to access.
- Number of potentially preventable hospital admissions related to children with caries needing extractions points to lack of oral health literacy, barriers such as cost, and rural/remote access to providers.
- The Royal Flying Doctor Service has a mobile dental care program that provides dental services to people that live more than 50 km from a public dental clinic.

Description of evidence

- Further investigation is required to understand catchment level data however Ambulatory Care Sensitive Conditions data indicates that hospital rates for dental conditions were higher than the Victorian rate in four of six areas in Central Victoria, one of five in Goulburn Valley, three of seven in North East, and all three of North West (2013/14).
- Across the catchment, 14 of 21 LGAs report higher rates of persons delaying visiting a dental professional due to cost (2011/12) and every area indicates a lower than Victorian percentage of persons visiting a dental professional in the previous 12 months (2011/12).
- Approximately half of the Murray PHN LGAs had populations that described their dental health as fair or poor. Within the catchment, Murrindindi, Swan Hill Rural City, Gannawarra, Mount Alexander, Benalla and Mitchell all had a notably higher rate compared with the Victorian average.
- Compared with the Victorian average, all Murray PHN LGA populations were less likely to have visited a dental professional in the last 12 months. The lowest proportion was seen in Gannawarra, followed by Campaspe then Moira.
- The ambulatory care sensitive condition rate for dental conditions was higher than the Victorian average in approximately half of the Murray PHN catchment LGAs. Mildura Rural City had the highest rate, followed by Gannawarra then Buloke.
- The number of people who saw a dentist, hygienist or dental specialist in the preceding 12 months were comparable to other regional peer groups, however rates were 5% lower in the Loddon Mallee Murray Medicare Local catchment (within the Murray PHN catchment) than a metropolitan peer group comparator.
- Towns without fluoridation in our catchment include Cohuna, Cobram, Numurkah, Tatura, Myrtleford, Bright, Woodend, Broadford, Mansfield and Alexandra (10). Many others are using tank water as their primary water source.
- The percentage of persons consuming sugar sweetened soft drink was higher across central Victoria, Mitchell, Moira, Strathbogie, Alpine, Benalla, Towong, Wangaratta, Wodonga, Buloke and Swan Hill.
- Children from low socio-economic areas are 70% more likely to have poor oral health than children in higher socio-economic areas.
- Particular postcodes have come into focus: Donald and surrounds (postcode 3480) and Swan Hill and surrounds (postcode 3585) as persistent hotspots for ear, nose and throat hospital admissions. Mildura (postcode 3500) and Hattah and surrounds (postcode 3501) as persistent hotspots for dental hospital admissions.

Cancer screening rates

Summary points

- Victorians living in regional and remote locations have a poorer cancer survival expectancy less than 4% lower survival rate than those who live in Melbourne.
- More than 50% of LGAs within Murray PHN's catchment have cancer screening participation rates that are lower for breast, cervical and bowel cancer compared with the Victorian average.
- PENCAT data will be used in the future to assess cancer screening participation rates.
- General data quality issues exist for many GP practices across the catchment. There is opportunity for Murray PHN, through its established relationship with general practice to work toward a better understanding of the GP practice in improving cancer screening.
- Further engagement opportunities exist for Murray PHN and peak bodies such as the Cancer Council about timely access to data.

Consultation

(A) Murray PHN Clinical, Community and Indigenous health councils (Nov 2016-July 2017)

Community voice

(A) Cancer incidence in the Goulburn Valley region was identified by the GV Clinical Council as an issue for further investigation.

Key issues

- Although cancer is a chronic disease, many health services including secondary and primary health services don't use existing chronic disease systems to support this patient population.
- Data obtained from peak bodies is often delayed. There is a need for more current data on a regular basis.
- There is a need to develop systems to record cancer survivorship.

Description of evidence

- Across the Loddon Mallee region, on average over the past five years, the cancer that killed most people was prostate cancer (17.1%), bowel cancer (14.4%) and breast cancer (11.6%).
- Current research about residents of the Loddon-Mallee region indicates a 4% lower five-year survival rate (65%) than those in Melbourne (69%

- Cervical cancer screening rates by location (2013-2014) lower proportion in Gannawarra, Loddon (Central Victoria), Greater Shepparton, Mitchell, Moira, Murrindindi (Goulburn Valley) than Victoria.
- Bowel cancer screening participation rates (Cancer Council data 2016) across the Murray PHN catchment were lower proportion in Loddon, Mildura, Mitchell, Moira, Swan Hill and Towong. All are slightly above the state average.
- Compared with the 2016 State average of 8.1%, rates of new diagnosis of those screened for Bowel cancer were greatest in Loddon (11.2%), Gannawarra (11.1%), Swan Hill (9.9%), Moira (9.8%), Greater Shepparton (9.5%) and Mitchell (9.4%).
- Breast cancer screening (Cancer Council data 2016) lower in Loddon (Central Victoria), Alpine, Indigo, Towong, Wodonga than Victoria.
- PATCAT software currently being deployed across general practices will enable regular reports for the following on a three-monthly basis:
    - Pap smears, mammograms and faecal occult blood tests (FOB)
    - Health checks – MBS Items 715, 45 – 49 years and 75+.

Chronic disease conditions

Summary points

Murray PHN works closely with state-funded health provider organisations and local government authorities. Generally, these bodies work to address chronic disease prevention and reduction of community risk factors, for example: obesity, wellness and smoking rates. Murray PHN's approach to chronic disease focuses on the priority areas of diabetes, cardiovascular and chronic obstructive pulmonary disease and the impact these conditions have on the acute sector.

Murray PHN has a role in supporting knowledge sharing between providers where common conditions are being addressed. There is opportunity for catchment-wide projects.

General data quality issues exist for many GP practices across the catchment. There is opportunity for Murray PHN, through its established relationship with general practice, to work toward holistic, multi-disciplinary, team-based management of chronic diseases in the primary care setting.

Population immunisations - whole of life approach implementation needs to include:

- Residential aged care facilities immunisations for residents and staff
- Immunisation programs for over 65s
- Aboriginal and Torres Strait Islander state funded activity for Aboriginal children
- Chronic disease high risk groups
- Pregnant women
- Hospital staff immunisation
- Staff of childcare facilities.

Consultation

Community consultation has been undertaken through the following:

(A) Murray PHN regional team – community interaction (Nov 2016-July 2017)

(B) Murray PHN evaluation and feedback from GP continuing professional development sessions. (Nov 2016-July 2017)

(C) Murray PHN Clinical, Community and Indigenous health councils (Nov 2016-July 2017)

(D) Murray Health Voices – community voice system (July 2017)

Community voice

The Murray PHN clinical and community councils had input into the design and development of appropriate models of care for COPD and cardiovascular disease throughout 2017.

- There is a national issue regarding food labelling, and a need to link with other local initiatives.
- Strengthen health partnerships and transparency of information for groups involved in patient care.
- Greater support with health coaching and improved psychological support is needed for those with chronic conditions.
- There are gaps in services to transition from paediatric to adult.
- More patient health information sharing would improve care.
- More support for professional development and the use of video conferencing should be promoted.
- More support to improve practitioner understanding of patient health literacy.
- After-hours access to services to suit families would improve service usage.

Key issues

The specific conditions are diabetes, COPD and cardiac related admissions.

Diabetes

- Diabetes and related complications are listed in the top 10 presentations for ambulatory care sensitive conditions, therefore improvements to the integration between discharge planning services from hospital services into primary care settings in a way that connects patients to general practice, allied health and community support structures will be important to mitigate readmission.
- General practitioners do not review care plans as frequently as required by best practice principles. General data quality issues exist for many GP practices across the catchment.
- Opportunity to enhance practice capacity to better identify patients at risk of, or with chronic disease and to strengthen the multidisciplinary coordination of care of patients in a way that fits with patient needs and contexts.

Chronic Obstructive Pulmonary Disease (COPD)

- The impact (rates of hospital admissions multiplied by average number of bed days per admission) is higher than the state average in 13 of Murray PHN's LGAs.
- LGAs with higher impact rates (rates of hospital admissions multiplied by average number of bed days per admission) are spread across the PHN catchment. Postcodes are in focus through the Perils of Place report (Grattan Institute 2016) which identifies Wodonga (postcode 3690) as a persistent hotspot for hospital admissions.
- Specific engagement with hospital emergency departments is required to identify COPD population sub groups (at a diagnostic related group level), readmission rates and system gaps in terms of planning and care coordination.

Cardiac related admissions

- Cardiac related admissions (including hypertension, congestive heart failure and angina) account for approximately 26% of all Ambulatory Care Sensitive Conditions (ACSC) separations within hospital services.
- The number of cardiac related presentations has increased each year since 2012/2013.
- 50% of all LGAs are assessed to be in the highest risk category of heart health.

Description of evidence

Diabetes

- Prevalence is highest in the Shire of Gannawarra, with National Disability Insurance Scheme (NDIS) reporting prevalence of 7.5% (against national average of 5.3% and PHN average of 5.7%).
- Complications arising from diabetes is the largest ACSC presenting within hospital services across the Murray PHN catchment area (20.8 % of all separations); increasing each year for the past three years.
- Despite this, MBS activity associated with GP management planning and review (MBS item numbers 721, 723, 729 and 731) have remained relatively constant, and in some instances declined, over the same period.
- Preliminary GP clinical audit tools suggest opportunity to improve practice quality specific areas to better identify and manage patients with diabetes. Specific areas of focus include:
    - Recording of HbA1c results; with 23% of patients diagnosed with diabetes having HbA1c results recorded.
    - Cholesterol results are not recorded in 20% of patients with diabetes.
    - Recording of foot exam at six and 12 months.
- Postcodes have come into focus through the Perils of Place report (Grattan Institute 2016) which identifies Robinvale, Annuello and surrounds (postcode 3549) and Murrindindi and surrounds (postcode 3717) as persistent hotspots for diabetes complications hospital admissions.

Chronic Obstructive Pulmonary Disease (COPD)

Description: Hospital admission and bed day rates.

- When using the 'impact' measure of rate of hospital admissions multiplied by the average number of bed days per admission, compared with the state average (20.16 per 1000 population), the burden of COPD on the acute hospital system is highest in:
    - Campaspe (36 per 1000 population)
    - Moira (26.86 per 1000 population)
    - Benalla (24.45 per 1000 population)
    - Wodonga (24.16 per 1000 population
    - Loddon (23.84 per 1000 population)
    - Mildura (23.84 per 1000 population).
- Aboriginal and Torres Strait Islander prevalence rates of COPD are five times the national rate. This is significant for approximately 13,591 persons who identify as Aboriginal and Torres Strait Islander (28% of the Victorian total) with significant proportions residing in Mildura 15%, Greater Shepparton 7% and Swan Hill 6%.
- The Perils of Place report (Grattan Institute 2016) identifies Wodonga (postcode 3690) as a persistent hotspot for COPD hospital admissions.

Cardiac related admissions

- Victorian Admitted Episodes Dataset (VAED) has been sourced from Victorian public hospital information and does not include private hospital admissions. Specific characteristics include:
    - More than half of all admissions enter via emergency department (52.8%). LGA areas of significant emergency department points of interest are Swan Hill (66.4%), Mildura (63%) and Wangaratta (56%)
    - 83% of admissions are aged over 60 years
    - 43% of patients have no referral or support services arranged before discharge.
- Early, indicative evidence from clinical audit tools within general practice identify that 11.6% of patients are diagnosed with hypertension.

Child and adolescent health

Summary points

- One in seven (13.9%) of 4-17 year-olds were assessed as having mental disorders in the previous 12 months.
- Almost one third (30.0% of all 4-17 year-olds) of children and adolescents with a disorder had two or more mental disorders at some time in the previous 12 months
- School based mental health services provided 40.2% of services.
- 7.2% of all people accessing headspace services were young people from culturally and linguistically diverse (CALD) communities.
- Teenage pregnancy rate is 17.9 per 1000 as opposed to the Victorian average of 10.4 per 1000 = 75% difference.

Consultation

Community consultation has been undertaken through the following:

(A) Murray PHN regional team – community interaction (Nov 2016-July 2017)

(B) Murray PHN Clinical, Community and Aboriginal and Torres Strait Islander Councils (Nov 2016-July 2017)

(C) Murray Health Voices – community voice feedback (July 2017)

(D) Population Health Planning Network (July 2017)

Community voice

The following themes emerged through community consultation:

- Further comprehensive assessment is required in the early years' service sector, including investigation of models of care, best practice models, gap analysis and propositions for the future. (B) (D)

Key issues

- Increasing support for GPs to meet mental health needs of children and young people (all regions).
- Increasing support for GPs to ensure the complex assessment and management and appropriate referral of children living in out of homecare.
- Develop better access to mental health promotion for children and adolescents (all regions).

- Improve coordinated planning across sectors and service systems – complex service environment (all regions).
- Review of approach to culturally and linguistically diverse groups, as CALD groups are underrepresented in the data (all regions).
- Increase mental health service access rates for Aboriginal and Torres Strait Islander youths (4-17 years) in the Central Victoria and Goulburn Valley regions, looking at earlier intervention for children who have experienced traumatic events.
- More Aboriginal and Torres Strait Islander young people are accessing services than their non-Aboriginal and Torres Strait Islander peers.
- Lack of services for CALD children and young people.

Description of evidence

- Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (June 2015).
- Almost one in seven (13.9%) 4-17-year-olds were assessed as having mental disorders in the previous 12 months. This is equivalent to 560,000 Australian children and adolescents.
- Males were more likely than females to have experienced mental disorders in the 12 months prior to the survey (16.3% compared with 11.5%)
- Attention deficit hyperactivity disorder (ADHD) was the most common mental disorder in children and adolescents (7.4%), followed by anxiety disorders (6.9%), major depressive disorder (2.8%) and conduct disorder (2.1%).
- Based on these prevalence rates it is estimated that in the previous 12 months 298,000 Australian children and adolescents aged 4-17 years would have had ADHD, 278,000 had anxiety disorders, 112,000 had major depressive disorders and 83,600 had conduct disorders.
- Almost one third (30.0% or 4.2% of all 4-17 year-olds) of children and adolescents with a disorder had two or more mental disorders at some time in the previous 12 months.
- Schools provided mental health services to 40.2% of the children and adolescents with mental disorders who attended them: 28.4% received individual counselling, 9.2% attended.
- A group counselling or support program: 13.1% used a special class or school, 5.6% had seen a school nurse and 17.1% received other school services.
- headspace services in Murray PHN report seeing a higher percentage of young people in the 12-17 age group category than the national totals.
- Aboriginal and Torres Strait Islander young people are accessing headspace at rates higher than the local Aboriginal and Torres Strait Islander population in a number of centres within the Murray PHN catchment.
- Aboriginal and Torres Strait Islander young people are accessing headspace centres in the North West and North East at a higher rate than the national average.
- 7.2% of all people accessing headspace services were young people from CALD communities.
- Higher than state average rates of teenage pregnancy.
- Bullying is a frequently reported issue for young people across Murray PHN.
- Across Murray PHN there are communities of children who are particularly vulnerable and at risk of poorer mental health outcomes as a result.

Child immunisation rates

Key issues

- Immunisation rates across Murray PHN generally are above the 'herd' immunisation rate of 90%.
- Data should be viewed with caution as actual numbers of participants in each location may be low.
- Coverage rate is above the 90% indicator, but specific populations and communities are below: need better targeted interventions as this indicates decrease in timeliness of immunisations and impacts on increasing reported cases of pertussis.
- Potential impact of implementing 'no jab, no pay' strategy on families regarding income and child care supports.

Description of evidence

- Time series data available catchment wide indicates that:
    - 12<15-month year old full immunisation rates fell slightly below either Victorian or Australian averages in Buloke, Mildura, Gannawarra, Mount Alexander, Macedon Ranges, Mitchell, Benalla and Towong LGAs
    - 24<27-month year old full immunisation rates fell slightly below either Victorian or Australian averages in Swan Hill, Buloke, Macedon Ranges, Mount Alexander, Campaspe, Mitchell, Moira, Yarra Ranges, Murrindindi, Greater Shepparton, Alpine and Mansfield LGAs
    - 60<63-month year old full immunisation rates fell slightly below either Victorian or Australian averages in Swan Hill, Gannawarra, Macedon Ranges, Mount Alexander, Yarra Ranges, Murrindindi, Albury, Benalla, Wangaratta and Towong LGAs.
- Culturally and linguistically diverse young people received fewer services at headspaces within Murray PHN compared with the national figures.
- The rate of teenage pregnancy across Murray PHN of 17.9 is significantly higher than the Victorian rate of 10.4 births per 1000 females, with hot spots across the whole catchment, North West (25.9) being the most significant hot spot.
- While adolescents from all LGAs have reported being bullied with a higher than rural Victorian rate of 20.8%, rates are higher in Mitchell (29.4%), Wodonga (25.7%) and Swan Hill (25.7%). Three-fifths (62.8%) of young people with a major depressive disorder had been bullied in the previous 12 months and were bullied more often.
- Rate of substantiated child abuse is higher than the rural Victorian average rate of 9.5 per 1000 population in Benalla (14.10) Wodonga and Mildura (both 13.2).
- Rate of children on child protection orders is higher than the rural Victorian average rate of 8.8 per 1000. Population in Swan Hill (16.1 per 1000 and ranked third in the state), Mildura (15 per 1000) and Benalla (14.4 per 1000).
- Benalla has the highest and double the rural Victorian rate of children in out of home care per 1000. Population at 14.4, followed by Swan Hill at 10.8, both of which are above the rural Victorian state average of 7.7.
- The percentage of children with emotional or behavioural problems at school entry in Benalla is the highest in the state (10.8%) and is close to double the rural Victorian rate of 5.6%, Wodonga is also high at 8.1% and ranks third in the state.

OUTCOMES OF THE SERVICE NEEDS ANALYSIS

This section summarises the findings of the service needs analysis in the table below. For more information refer to Table 2 in '5. Summarising the Findings' in the Needs Assessment Guide on health.gov.au/PHN

Outcomes of the service needs analysis:

- Understanding our catchment profile
- Access to GPs or primary care providers
- Mental health services
- Suicide prevention
- Alcohol and other drugs services (AOD)
- Access to allied health practitioners
- Access issues for aged population
- Service coordination
- Referral
- Effective and efficient chronic disease management systems:
    - Diabetes
    - Cancer
    - Heart related conditions
- After hours
- Potentially preventable hospital admissions
- Patient/client information management systems and eHealth
- Health workforce

Understanding our catchment profile

Key issues

- Central Victoria has six local government areas being Loddon, Campaspe, City of Greater Bendigo, Gannawarra, Mount Alexander, and shares the Macedon LGA with North Melbourne PHN and Western Victoria PHN. The total population is approximately 225,834 with a total land mass of 21,221 square kilometres.
- North East has eight local government areas being Albury, Alpine, Benalla, Indigo, Mansfield, Towong, Wangaratta and Wodonga. The total population is approximately 170,780 with a total land mass of 24,080 square kilometres.
- Goulburn Valley has five local government areas being Moira, Greater Shepparton, Strathbogie, Mitchell and Murrindindi. The total population is approximately 151,237 with a total land mass of 16,522 square kilometres.
- North West has three local government areas being Buloke, Mildura and Swan Hill - total population is approximately 67,729 with a total land mass of 34,066 square kilometres.

Description of evidence

- Central Victoria region has 71 general practices, one large regional health service, 13 small rural health services, two bush nursing hospitals and 12 community health sites. The Central Victoria office is in Bendigo. ACCOs within the catchment operate two general practices
- North East region has 47 general practices, three regional and rural health services, and a range of small rural health services. ACCOs operate one general practice. The North East office is in Albury.
- Goulburn Valley region consists of approximately 42 general practices, a large regional health service, an Aboriginal Community Controlled Health Organisation, 11 small rural health services - three of which are fully funded community health services – six are associated with the small rural health services. ACCOs operate one general practice. The Goulburn Valley office is in Shepparton.
- North West region has 34 general practices, one large regional health service and a range of small rural health services. It also includes two Primary Care Partnership (PCP) regions. ACCOs operate two general practices. The North West office is in Mildura.
- Within the catchment there are significant settlement programs of recent arrivals in Swan Hill, Bendigo, Shepparton and Wodonga.

Access to GPs and primary care providers

Key issues

- Need for GPs in rural areas with impact of shortage in identified communities:
    - Increased use of urgent care centres and emergency departments in hospitals.
    - Need for and impact of access to GP after hours for smaller communities and residential aged care facilities and implications when the GP has no admitting rights to hospital.
    - Need for and impact of lack of 'in hours' GP services in smaller rural communities.
    - Impact on GPs now that local government no longer undertakes child immunisation programs (Albury).
    - Need and impact of access for patients with complex care needs such as: requiring bariatric support, access to interpreter services and respite care/aged care.
    - GP fatigue regarding after hours - refer to after-hours section.
    - GP isolation and lack of peer support.
    - Support for navigating transitioning patients back into primary care in their local service system is required.
- Financial burden of paying for health care.
- New graduate doctors (interns) and hospital medical officers (doctors who have completed their internship but are yet to pursue a speciality) in the vast majority of cases work in the hospital system.
- International medical graduates (who have general practice experience overseas and have come to Australia to complete their GP fellowship) and GP registrars (doctors who are undertaking their training towards GP fellowship without having had GP experience elsewhere) often rotate through regional and rural training posts. These doctors account for approximately one third of our medical workforce in Murray PHN's regions and you wouldn't expect them to have a detailed understanding of the local service system.
- Aged care MBS billing remains difficult to navigate.
- Many rural and small regional centres are struggling to retain and attract procedural GPs (GPs who have advanced skills in obstetrics, anaesthetics, small surgeries, emergency etc.)
- Extremely complex patients need shared a care approach from primary and secondary health services but access to these services can be limited.
- Inadequate secondary services discharge planning.
- Lack of collaborative care across the treatment continuum, namely in discharge from acute mental health services into community, and poor feedback and collaborative care between GPs and specialist services (psychological services and mental health service providers).

Description of evidence

- Distinct districts of the General Practice Workforce Shortage in 2015 are: Mildura, Ouyen, Murrayville, Boort, Wedderburn, Rushworth, Yea, Numurkah, Moyhu, Corryong, Wangaratta, Bethanga.
- 84% of people saw a GP in the previous 12 months (ranked 10 of 31 PHNs).
- 14% of people in Murray PHN saw a GP in the previous 12 months for urgent medical care (ranked five of 31 PHNs).

- Compared with the Victorian average, more than half of Murray PHNs LGA populations were more likely to report they had not visited a GP in the last 12 months.
- 81.8% of GP attendances were bulk billed, compared with 84.3% nationally.
- 15% of people were admitted to hospital in preceding 12 months (Murray PHN, ranked fifth of 31 PHNs).
- Low use of after-hours GP services with 5% of people seeing a GP after hours (Murray PHN ranked 25 of 31 PHNs).
- 15 out of 22 LGAs within the Murray PHN catchment reported experience with transport limitation in the last 12 months.
- All three LGAs in the North West region recorded rates of fair or poor self-assessed health that were higher than the state average.
- In 2011-12, 18 out of 21 Victorian LGAs in the Murray PHN catchment had a higher proportion of population that assessed their health as fair or poor. Within the catchment, Mildura, followed by Loddon then Greater Shepparton and Swan Hill, had the highest proportion of persons who assessed their health as fair or poor.

Access to specialist providers

Key issues

- There are excessively long wait lists and extended waiting times reaching into years for some specialties.
- There are complexities and barriers to accessible, informed referral to specialist clinics.
- A lack of access for women's health specialists across life-course needs and specifically for fertility, sexual and reproductive health needs.
- Specific specialties identified as having relative impacts across most of the catchment are rheumatology, gerontology, dermatology, endocrinology, speech pathology, pain management specialists and psychiatry, including:
    - Paediatric care; access to specialist services for paediatricians – long waiting lists (years).
    - Paediatric diabetes, with transition to adult diabetes services.
    - Mental health related services to support children 10-14 years with medium to severe behaviours - mental health issue or paediatric issue.
    - Rehabilitation services for pulmonary care in Benalla and transport options.
    - A need for increased access through telehealth to specialists and addressing problems around.
    - Financial burden and transport barriers, especially with non-bulk billing facilities.
    - Many rural and small regional centres are struggling to retain and attract procedural GPs (GPs who have advanced skills in obstetrics, anaesthetics, small surgeries, emergency etc.)

Description of evidence

- Rate of referral to medical specialists rose from 5.6 per 100 problems managed in 2005–06 to 6.2 per 100 in 2014-15.
- Average number of specialist attendances per person is lower than the national average.
- According to the Department of Health and Human Services (DHHS) performance monitoring, there is up to a two-year wait to be seen by a specialist, for example: urology, ear, nose and throat (ENT) and orthopaedics.
- There are almost 170 medical specialists and 25 allied health professionals providing some level of outreach service through specialist clinics within the catchment.

Mental health

Key issues

Consumers and carers experience

- Mechanisms to support greater and more effective consumer and carer participation at an individual and systemic level across the continuum of need.
- A lack of consultative mechanisms for gaining feedback and input from mental health consumers and carers who use the primary mental health service system.
- Stigma impacts negatively upon the health and wellbeing of people who experience mental illness within the catchment, including stigma from providers of mental health services.

Rural and remote communities

- There continues to be a lack of access to services for those living in rural and remote communities.

Access

- Lack of access to care coordination for people with severe mental illness being managed in a primary care setting.
- Potential service access limitations associated with mental health nurses located within specific general practices.
- Access to psychological therapy services and state funded mental health services is limited in some smaller regional areas.
- Access to early identification, intervention and care options for children and adolescents is limited.

Description of evidence

- Partners in Recovery (PIR) needs assessment (through a consultative process with consumers, carers and feedback from PIR clients).
- Report: Contributing Lives, Thriving Communities - Review of Mental Health Programs and Services, National Mental Health Commission (2015).
- PIR consumer and carer feedback and consultations from regions. Feedback from GP workforce engagement events.
- Murray PHN community, clinical and Aboriginal and Torres Strait Islander councils provide feedback and consultation.
- Engagement with identified consumer and career groups across the Murray PHN catchment identified:
    - Lack of service response in acute circumstances
    - Frustration with discharge and re-entry processes at the specialist mental health level
    - Frustration with lack of information sharing between care team and consumers and carers
    - The system is difficult to navigate.
- Engagement with key stakeholders including service providers identified:
    - Access to private psychiatry is limited
    - Lack of transport is a barrier to service access

  - Outreach is limited and some communities have absence of local service provision
  - Access to bulking billing GPs is limited in some areas.
- Refer to geo-mapping of Mental Health Nurse Incentive Program services across the Murray PHN catchment area.
- Refer to spatial mapping of ATAPS and Mental Health Services Rural and Remote Areas (MHSRRA) services across Murray PHN catchment.
- La Trobe University PIR report: Where do I start? Mental health service access in small rural communities in the Southern Mallee catchment.
- Summary of findings:
  - Stigmatising attitudes are evident in small rural communities
  - Barriers to service access included a lack of understanding of mental illness among community members, health professionals and emergency service staff
  - Participants stated that the only way they could get help was in a crisis situation
  - A lack of discharge planning and inadequate service coordination
  - Perceptions of being excluded from care were consistent among family members.
- Distance and transport issues in rural and remote areas still pose significant barriers to access to services for clients and their families.

Key issues

Services for people who experience severe mental illness

- Significant barriers for people with severe and persistent mental illness in accessing the community, resulting in social exclusion and lack of participation.
- Dual diagnosis is poorly understood.
- Poor transition and integration across multiple sectors with limited coordination.
- Lack of available longer-term case management.
- Shortage of skilled workforce.
- Missing those who fall through the gap between primary care and specialist mental health services.

Child and Young Persons Mental Health (CYMS)

- There is a lack of services for children and young persons' mental health outside the locations where there is a headspace centre in operation. There is a lack of providers specialising in child and youth mental health in a primary care setting.

CALD communities

- Barriers in accessing support and intervention for people from culturally and linguistically diverse communities.

Aboriginal health services

- Intensive work is required to engage and maintain contact with Aboriginal and Torres Strait Islander people for follow up of primary mental health.
- The risk to not investing time and effort in engaging and applying culturally safe practices results in poorer health outcomes for this group and higher demand on the emergency and primary health care systems.

- Accessing mainstream services that are not culturally safe - many services lack cultural awareness.
- A shortage of Aboriginal and Torres Strait Islander health workers.
- Aboriginal Community Controlled Health Organisations (ACCHOs) report that people often present to them in crisis and have high needs for service coordination across sectors.
- Lack of targeted services for young people.
- Limited access to dual diagnosis services.
- Community dynamics can challenge service access and complicate treatment and support.

Description of evidence

- Local Camberwell Assessment of Need Short Assessment Scale (CANSAS) data from Murray PHN's PIR programs confirm unmet needs:
    - Daytime Activities and Company are consistently within the top four highest areas of unmet needs in both programs from 2013-2016 (CANSAS).
- Pathways through the Jungle PIR Project Report - Hume PIR.
- Program documentation - Northwest (PIR and Mental Health Community Support Services (MHCSS) and Loddon Mallee Murray and Hume PIR regions).
- Timely discharge from inpatient units is compromised due to lack of supported accommodation options in rural communities.
- Engagement with key stakeholders including service providers identified:
    - Gap in services for eating disorders
    - Lack of collaboration between services means that the potential benefits of headspace is not realised.
    - Lack of outreach limits the accessibility to the youth community
    - Lack of skilled clinicians
    - Lack of targeted services in some areas including specialist mental health, primary mental health and school based services
    - There is a missing middle between current primary care services and Child and Youth Mental Health Services (CYMS) for complex presentations.
- Feedback to Hume PIR from local migrant communities in Wangaratta.
- Goulburn Valley Mental Health Community Support Services Catchment Plan.
- Lower usage of translation services associated with provision of ATAPS/MHSSRA and MHNIP services in communities with high CALD populations, including new settlers.
- PIR client files (Hume).
- Engagement with Aboriginal health services and workforce.

Suicide prevention

Key issues

- Limited access to integrated suicide prevention services across the catchment area.
- Prevention services exist in some areas but are not well integrated or known.
- Identifying the at-risk person is inconsistent and often missed.
- Training in risk assessment and safety planning is indicated.
- Poor discharge practices.
- Communities and front-line worker need awareness raising and training.
- Referral processes are variable.
- Lack of targeted services for minority groups such as lesbian, gay, bisexual, transgender and intersex community (LGBTI) people and people from CALD backgrounds.

Description of evidence

- Above average suicide rates are experienced in Murray PHN's regions of North West and Goulburn Valley, with significantly high rates of ambulance attendance to suicide attempts in these regions.

Alcohol and other drugs services (AOD)

Key issues

Generally, there is:

- An absence of platforms for meaningful and effective consumer and carer engagement across the catchment area.
- Low uptake of web-based treatment and support options in rural areas - largely influenced by gaps in telecommunication coverage and internet bandwidth.
- A lack of appropriate responses for the complexities of methamphetamine use that include social, clinical and environmental considerations.
- Access to appropriate, safe and affordable housing.

Coordination and integration

- The service system is fragmented with multiple entry points for various treatment service types.
- Inadequate support and treatment options for people who experience co-morbid mental illness and substance misuse.
- Shared-care arrangements are variable, while there are pockets of good practice, coordination and mechanisms to support shared care are generally lacking.
- General increased demand and increased need for access to opioid replacement treatment programs.
- Not all communities across the catchment have access to bulk billing GPs.
- Access to brief intervention, residential rehabilitation and family support services is limited.

Treatment services

- Limited access to bed-based withdrawal.
- Availability of targeted youth services is disparate across the Murray PHN catchment area.

Description of evidence

- AOD catchment plans.
- Independent Review of New Arrangements for the delivery of Mental Health Community Support Services and Drug Treatment Services found:
    - Access to services in rural communities limited due to availability of skilled clinicians and service options - communities are underserviced
    - Poor use of technology to support service access
    - Lack of family support services
    - Lack of funding within services to respond to crisis situations
    - Lack of tracking with clients between intake, assessment and treatment
    - Homelessness and lack of crisis accommodation has subsequent impact on treatment options
    - Lack of funding and activity in prevention and early intervention
    - Appropriate facilities to deliver services difficult to access due to perceptions and stereotypes
    - Lack of transport and/or cost, limited options to reach services.

- Themes from PHN consultation with AOD treatment services and other key stakeholders:
    - Difficulty in navigating system (including central intake via contracted service provider) - reluctance to make referrals
    - Assessment/intake is complex and disengages clients
    - Due to central intake, treating agencies often need to undertake an additional (second) assessment
    - A sense that since central intake commenced referrals have dropped
    - No common data system - lack of central data or client management system for dual diagnosis
    - Clients can impact care coordination, impeded by less than strong professional relationships
    - Limited outreach results in people not being treated earlier
    - Coordination of care is not funded
    - Roles of services in treatment can be poorly defined
    - GPs are often the starting point for system entry but engagement and relationships less developed where previously direct referral capacity from GP strengthened GP/AOD worker relationships
    - Discharge notifications from emergency departments and mental health services are inconsistent.
- Service system mapping indicates that access to specialist services such as Aboriginal and Torres Strait Islander specific, youth and withdrawal is largely determined upon place of residence.
- Harm Reduction Victoria - consultations.

Key issues

Workforce development

- Lack of professional development opportunities in rural areas for AOD workforce, including general practice.
- Need to support GPs in managing AOD, particularly opioid and ice related issues.

Aboriginal and Torres Strait Islander people

- Families lack support.
- Lack of wrap-around service provision.
- Lack of culturally safe service provision outside of Aboriginal and Torres Strait Islander services.
- Poor understanding of mental health, AOD and dual diagnosis among the community.
- Lack of accessible and appropriate rehabilitation and detoxification services for ice and poly-drug use.
- Psychiatric services lack the capacity to respond to drug-related mental health problems.
- Lack of systematic alcohol and drug awareness education in schools.
- AOD sector workforce and organisational capacity constraints.

Description of evidence

- Sources include: consultation with AOD service providers and other key stakeholders, AOD catchment plans:
    - Access to professional development and education for workers - metro courses are prohibitive to attend.
- Consultations with ACCOs and other key stakeholders.
- Consultation with Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

Access to allied health practitioners

Key issues

- An increased demand for and lack of access to exercise physiology.
- An increased demand for high risk foot services (increasing diabetes rates with diabetes complications).
- Improved continuity of service required, especially for when MBS visits have been used up.
- Bulk billed allied health care is not widespread.
- Lack of public funded allied health for lower income persons.
- Lack of access to primary dental care.
- Need for extended hours for allied health and dialysis services.
- Opportunity for increased, supported telehealth services.
- Need for market development and incentives in some rural communities for allied health providers.

Description of evidence

- Bettering the Evaluation and Care of Health (BEACH) survey: GP rate of referral to allied health services increased from 2.0 per 100 problems managed in 2005-06 to 3.3 in 2014-15. Referrals to psychologists rose four-fold and those to podiatrists doubled.
- Shortages of access to specific practitioners or specialists related to chronic disease management (CDM) identified through regional consultations:
    - pain management specialist services (all regions)
    - dietetic services, especially for young people (North East)
    - occupational therapists (North West)
    - ophthalmologist (Robinvale)
    - endocrinologist (Robinvale, Buloke, Gannawarra)
    - general physician (Robinvale)
    - counsellors (North West)
    - physiotherapist (Sea Lake, Seymour, Alexandra)
    - neurological physiotherapist (Lower Hume)
    - paediatricians (all regions)
    - exercise physiologists (Kerang, Sea Lake)
    - dentist - public (Gannawarra, Buloke, Murrindindi)
    - podiatrists – public (Kerang, Gannawarra)
    - high risk foot clinics – all areas access issues
    - diabetes educator (Buloke, Sea Lake, Seymour, Kinglake)
    - mental health practitioners (all regions)
    - dermatologist (Goulburn Valley).
- Two-to-three month waiting periods for appointments with a dietician, podiatrist or physiotherapist in parts of the catchment. Longer waiting periods for speech pathology in some areas. (especially for paediatric needs).
- Ambulatory Care Sensitive Conditions (ACSC) data shows very high admission rates for dental conditions. This can be interpreted in part to a lack of access to and or uptake of primary dental care. (ACSC 2014/15, Murray Exchange).

- There is significant lack of paediatric allied health services catchment wide - especially for paediatric occupational therapy and physiotherapy. (Murray PHN regional team – sector interaction).
- High emergency department presentation and admission rates for cellulitis - this is often preventable with sufficient access to allied health.
- Gangrene causes the highest number of bed days in Goulburn Valley and North West regions. This is highly preventable with adequate access to primary care services.

Access issues for aged population

Key issues

- Ageing rural populations exist across the Murray PHN region, placing increasing pressure on access to health resources.
- Ageing workforce has resulted in reduced hours of work.
- Transport limitation presents barriers to access and leads to inappropriate emergency department presentations.
- GPs are not familiar enough with aged care MBS items.
- Limited access to geriatricians in aged care.
- Limited access to technology for the elderly.
- GPs and general practices may not manage patients in an aged care facility or provide home visits.
- An expected relative decline in the number of informal carers.
- Access to other health care services, including allied health and pharmacy.
- Access to home based palliative care requires further investigation and support (incorporating palliative care for chronic diseases other than cancer).

Description of evidence

- BEACH: those aged 65+ years accounted for an increasing proportion of GPs' workloads (from 27% to 31% of encounters). This change affected all aspects of general practice as older patients are more likely to have multiple issues, particularly chronic conditions and are more likely to have co-morbidities.
- 60% of adults in the Murray PHN region report having long term health conditions
- Hospitalisations for external injuries that occurred in an aged care residential facility (2011-12 to 2013-14) show significantly higher rates in Central Victoria than Victoria, while Goulburn Valley, North East and North West are lower than the Victorian average.
- The rate of persons aged 75 years and over who have annual GP assessments is lower than the Victorian average for many LGAs within Murray PHN, including most of the LGAs in the North East region. The lowest rates were recorded for Towong (one quarter of the Victorian average) and Indigo, Wodonga, Mount Alexander (all less than half the Victorian average.
- 15 out of 22 LGAs within the Murray PHN catchment area reported experience with transport limitation in the last 12 months.
- Number of bulk billed GP attendances is lower in the Murray PHN region than the national average.
- GP attendances in aged care homes is lower in the Murray PHN region than the national average.
- The rate of high-level residential aged care places per population aged 70 years and over was higher than the Victorian average in the North East region; while the rate for low-level residential aged care places was higher in Goulburn Valley, Central Victoria and North West regions. The rate of community places was higher in the Goulburn Valley and North West regions.
- Rates of Home and Community Care (HACC) service delivery to clients aged 70 years and over were higher for all Murray PHN LGAs except Greater Shepparton and Mitchell. The highest rates were recorded at Gannawarra, Loddon and Buloke and this reflects the very high proportion of older population living in these locations. Prolonged waiting times for assessments compromise care planning.

Service coordination

Key issues

- Discharge, planning, admission processes and acute stay periods need better alignment and coordination.
- Implementation of the My Health Record 'opt out' emphasises the need for integration with the acute sector.
- Significant number of children living out of home, with a high number being from Aboriginal and Torres Strait Islander backgrounds.
- Poor sector engagement in service coordination for vulnerable populations.
- Transition to the Commonwealth Home Support Program (CHSP) and NDIS requires significant 'navigation of the health system' by the patient/ individual and this in itself can create an access issue, which has the potential to adversely impact isolated communities.
- Lack of resourcing for community development in rural areas.

Description of evidence

- Victorian DHHS Service Coordination Survey 2015 indicates that a considerable number of agencies across the catchment have used e Referral to:
    - increasingly support referral and shared care
    - access a range of secure messaging/communications systems that interact to varying capabilities with organisational client/patient information management systems.
- Shared Care planning was supported in the DHHS Loddon Mallee region through local agreements between three or more service providers in 66% of respondents, and in DHHS Hume region 55%.
- Communications with GPs was less developed/implemented, occurring in approximately half of these arrangements.
- Information conveyed was primarily patient/consumer information.
- There is significant involvement of multiple providers, but consistent lack of service coordination for this at-risk vulnerable population.

Referral

Key issues

- Lack of inter-operability between health services systems.
- Health Service IT infrastructure remains fragmented. 'Patchy' access to regional broadband internet remains a significant barrier to interoperability. (Murray PHN regional team – community interaction)
- There are a number of legacy systems that don't engage patient or consumers in their own care.
- Improvements are required to enhance e-messaging systems and secure messaging systems performance.
- Lack of workforce knowledge regarding referral systems to family violence services including:
    - Children's services
    - District nursing services
    - Diagnostics services.
- Need to improve health professionals' understanding of the billing eligibilities and constraints around diagnostic services:
    - For example, if a specialist orders an MRI for a health care card holder, it is bulk billed, but if the specialist requests the GP to order an MRI for the patient, it can result in an out-of-pocket cost of $200.
- Improvements are needed in the communication of changes to service provision between agencies (day, frequency, eligibility, referral method).
- Timely and accurate information provision about costs and service eligibility is not effectively communicated.
- Significant variances across referral pathways and processes within and between service providers.

Description of evidence

- MBS evidence identifies increase of 18% of GPs using the telehealth, overall contributing to a 37% growth in telehealth consultations.
- Episodic use of telehealth to support discharge planning and shared care arrangements within the areas of cancer survivorship, dermatology and cardiology has been reported.
- Telehealth referrals have increased over the last three years with higher use of the MBS financial incentives.
- Delays through redirected triage and timeframe reflected was six to eight weeks.
- Demand for podiatry services was particularly high (waiting times can be as great as four months).
- Criteria and method to access the service has been reviewed in order to manage the demand, however the level of complexity and acuity continues to increase, and affects waiting times.

Effective and efficient chronic disease management systems

Key issues

- There is a need for systematic approaches to the diagnosis, care planning and service coordination of chronic diseases across each region of Murray PHN.
- Requirement for a planned approach to improvements in individual service system inefficiencies (identified through evidence).

Required notable flexible service possible responses

- Multidisciplinary clinics: to support good patient care with coordinated care specialist, allied health, nursing, prosthetics, counselling.
- Local governments are exploring opportunities for foot care nurses/allied health assistants.
- Foot care teams including a podiatrist, foot care nurse, and allied health assistants and referral from GP for a podiatrist's assessment and for ongoing team care including patient education/self-management (Kerang).
- Local health and community services use video conferencing for case management (Mallee Track).
- Need to increase patient knowledge about physical activity and diabetes management in rural communities.
- Identification of barriers to physical activity in rural communities and the available options for older adults.
- Exploration of applicability of group based sessions.

Challenges in provision and coordination of outreach and visiting services

- Services in rural and outlying communities are limited.
- Address the challenges of maintaining programs with limited resources, community interest, in smaller communities with less facilities.
- Address identified inefficiencies and duplication of services and the lack of coordination (dieticians from three different services that visit community).
- Need for GPs to assess and refer patients to a range of allied health services and or for multiple treatments within the one GP consultation.
- Improvement to communication between service providers and the public regarding changes to a service.
- Address workforce capacity needs to maintain appropriate service levels.
- Transport limitations are a barrier to access.

Description of evidence

- BEACH: consultation rates - as a proportion of all MBS/DVA-claimable recorded consultations; short surgery consultations, chronic disease management items, health assessments, and GP mental health care all increased significantly while standard surgery consultations decreased significantly.
- Over the last 10 years the most frequently managed GP consultations were for hypertension, check-ups and upper respiratory tract infection.
- Significant increases occurred in management rates for general check-ups, depression, back complaints, prescriptions, gastro-oesophageal reflux disease, anxiety, test results,

administrative procedures, vitamin/nutritional deficiency, and atrial fibrillation.

- The management rate for chronic conditions in 2014-15 did not differ from the rate in 2005-06 and the most commonly managed conditions were non-gestational hypertension, depressive disorder, non-gestational diabetes, chronic arthritis and lipid disorders.
- Increased management rates occurred for depressive disorders, oesophageal disease, atrial fibrillation/flutter, chronic back pain and unspecified chronic pain.
- Opportunities to be pursued to build evidence through project funding and collaborations with service providers across the care continuum.
- Albury has a higher percentage of amputation - above the state average. This may, in part, be attributed to lack of diabetes care.
- All users of electronic database systems are generally under-used thus reducing the capability to support shared care.

Diabetes

Key issues

- Loddon Mallee Region Diabetes Pathways identifies twenty health disciplines, of which an average of nine of these professionals may be included in the cycle of care for a person with diabetes.
- Diabetes service system analysis across Buloke, Gannawarra and Swan Hill identifies where service provision is and is not available.
- There are predominantly fewer services as identified in the Loddon Mallee Region Diabetes Pathways as being required in the diabetes cycle of care available in the Buloke LGA than Swan Hill and Gannawarra.
- All services identified in the Loddon Mallee Region Diabetes Pathways are available in Swan Hill city including public and private providers and with specialist services attending on a cyclic basis.
- All regions within Murray PHN's catchment report a lack of access to endocrinology services.

Description of evidence

- The rate of potentially avoidable hospitalisations for diabetes complications is slightly higher overall for the Murray PHN region compared with the national rate (210 compared with 183 per 100,000).
- Estimated population aged 18 years and over with diabetes mellitus, (2011-13) rates in all LGAs of Murray PHN lower or same as Victoria (positive).
- However, the potentially avoidable hospitalisations rate for diabetes complications by SA3s is 40% higher than national rates in Murray River-Swan Hill and 30% higher than national rates in Wodonga- Alpine, Upper Goulburn Valley and Campaspe. Albury, Moira and Wangaratta-Benalla are slightly higher than national averages.
- Avoidable deaths from diabetes, persons aged 0 to 74 years (2009-12) higher rates in Campaspe, Gannawarra Greater Bendigo, Loddon, Mount Alexander (Central Victoria), Greater Shepparton, Mitchell, Moira (Goulburn Valley), Albury, Wangaratta, Wodonga (North East), Mildura, Swan Hill (North West) than Victoria.

Cancer

Key issues

- This disadvantage may be explained by poorer access to cancer services and community support structures.
- Data is currently lacking on cancer staging and treatments.
- This is anecdotally supported by health and community agencies across the Southern Mallee and Northern Loddon regions who report lack of health service capacity and patient access as key barriers to achieving quality cancer survivorship care.

Description of evidence

- Avoidable deaths from cancers, persons aged 0 to 74 years (2009-12) shows higher rates in Campaspe, Greater Bendigo, Loddon, Mount Alexander (Central Victoria), Greater Shepparton, Mitchell, Strathbogie (Goulburn Valley), Albury, Benalla, Indigo, Wodonga (North East), and Buloke (North West) than Victoria.
- The rate of new cancer cases in 2007-11 was higher than the Victorian average in all Murray PHN regions. The highest rate was in Central Victoria and North West regions. The rate of new cancer cases is notably higher for males than females. This rate is likely to have been influenced by age structure of the population as it has not been age standardised.

Heart related conditions

Key issues

- Hospital admissions for heart attack are higher in many parts of
- the catchment than the Victorian average, and very high in some areas.
- Bendigo Health report that 60% of patients who have been previously admitted for heart-related activity will be readmitted within a three-year period.
- Lifestyle risk factors, including smoking and obesity, can be more systematically managed with primary care providers, through the use of clinical audit tools and improvement to practice workflows and systems, recognising that:
    - Smoking is higher in 12 of our local government areas than the Victorian average
    - Obesity is higher in 17 of our local government areas than the Victorian average.

Description of evidence

- Congestive cardiac failure rates are on par with national rates, however by SA3 levels within Murray PHN, Loddon-Elmore is 40% higher than the national average, and to a lesser extent, Shepparton, Wodonga-Alpine, Murray River-Swan Hill, Moira, Albury and Campaspe.
- Gannawarra LGA has the highest rate of potentially avoidable hospitalisations for hypertension in the Murray PHN catchment (approximately double the Victorian rate).
- Rates of potentially avoidable hospitalisations for angina are significantly high in many of Murray PHN's LGAs compared with the Victorian average, especially in Loddon (247 compared with 86 per 100,000) and Towong - followed by Gannawarra, Strathbogie and Wangaratta.
- Strathbogie LGA, within the Murray PHN catchment, has the highest rate of potentially avoidable hospitalisations for rheumatic heart disease in Victoria.
- Patients at risk of poor heart health can be better managed within primary and community health settings.

After hours

Key issues

- Difficulties in recruiting to isolated GP practices with younger graduates preferring a different lifestyle to that offered by small towns.
- There is still a number of GP practices not in collaborative after hours arrangements.
- Increasing community expectations of care on-demand for non-urgent conditions.
- Opportunity to expand the use of Rural and Isolated Practice Endorsed Registered Nurses (RIPERN) for after-hours support at urgent care centres.
- The average number of after-hours GP attendances per person in Shepparton SA3 is above the national average.
- Poor 'in hours access' and patients disengaged from GPs are presenting 'out of hours' to urgent care centres or emergency departments.
- New models of care and service delivery to support specific populations e.g. peri-urban or dormitory towns and palliative care and support through after hours.
- Need for new models to include after-hours support for carers.
- Availability of video conferencing technology to support remote consultation in after hours - improved support for rural communities with limited GP access.
- Demands and pressures of significant seasonal changes and/or major events to population numbers during peak tourist seasons (Yarrawonga, Mount Beauty, Mount Hotham, Echuca) puts significant strain on local practices and there is need for additional locum staffing and rosters to meet demand during peak seasons and events.
- Access to psychological services, particularly for populations unable to access in business hours.
- Access to pharmacies after hours for dispensing of medication in smaller towns and rural areas – a super pharmacy strategy is underway but not in small communities.

Description of evidence

- Difficulties in recruiting to isolated GP practices with younger graduates seeking a different lifestyle to that offered by small towns: Mallee Track Health in Ouyen persevered for 12 months to recruit a permanent doctor.
- Meetings with some practices where collaborative after hours arrangements across small towns became unsustainable.
- Kyneton District Health Service reports that for 2015/16, 82% of presentations were categorised a 'seen by nurse only' compared with an average of 40% for Victorian rural hospital emergency departments.
- Data provided by Ambulance Victoria for the 2015 calendar year for ambulance callouts to residential aged care facilities in Bendigo indicates that only 53% of the 1247 cases were classified as an emergency.
- Based on a recent review of six small rural hospitals in which four of the six were not using their RIPERN staff effectively or wanted to recruit or train more (four of the six were in the Murray PHN catchment area).
- Five-month Heathcote RIPERN trial which targeted frequent presenters to improved supports and access to in hours services and thereby diverted 31 potential urgent care centre presentations, saved an estimated 86 bed days and 14 ambulance transfers and the hospital board has agreed to continue the approach within its existing resources.
- Evidence from Cobaw Community Health that 46% of Kyneton and Woodend residents work outside the shire increasing the demand for extended hours and after-hours services.

- Evidence from Sunraysia Community Health Services is that 70% of clients die in hospital despite many stating preference to die at home. New after-hours palliative care models are currently being trialled across the Murray PHN catchment.
- A recent report prepared for the Loddon Mallee Regional Palliative Care Consortium indicated that just under 60% of carers that responded to their survey were 65 years or older.
- St Anthony's Medical Group telehealth trial has commenced at Boort.

Potentially avoidable hospitalisations

Key issues

- Relationship to lack of access to after-hours GP services and supportfor isolated GPs.
- Relationship to absolute GP shortages in some localities (e.g. Buloke/Mildura LGAs).
- Lack of communication regarding discharge planning and return to community services
- Link to electronic compatibility issues for information transfer/ communication between primary care and acute services.
- Further work for the North East region regarding discharge planning processes, admission process and acute length of stay period to understand patient admissions to emergency departments and/or acute.
- Need to increase development and review of care plans for chronic diseases.
- Need to increase use of condition specific patient action plans for chronic disease management.
- Lack of public dental services in Buloke and Gannawarra result in admissions for dental conditions/ extractions (especially for children).
- Health literacy levels relate to potentially avoidable hospitalisations. (e.g. smoking remains the key risk factor for respiratory related hospitalisations).
- Link to transport issues.
- Link to ageing population and comorbidities, with ageing population rates in regional areas above state average.
- Reduced access to endocrinology services has a relationship to admissions for diabetes complications.
- Relationship between reduced access to high risk foot services and diabetes complications, cellulitis and gangrene admissions.

Description of evidence

- The overall rate of all categories of potentially avoidable hospitalisations for Murray PHN (2826) is slightly higher than the national PHN rate (2643)
- By SA3 region, Murray River-Swan Hill, Campaspe, Shepparton, Moira, Mildura, Wodonga-Alpine, Loddon-Elmore and Wangaratta-Benalla have higher rates of potentially avoidable hospitalisations compared with the national average.
- The rate of potentially avoidable hospitalisations for chronic conditions is significantly higher than national comparisons, especially in Campaspe, Murray River-Swan Hill and Shepparton and a lesser extent to Loddon – Elmore, Moira, Wodonga-Alpine, Bendigo, Wangaratta-Benalla and the Upper Goulburn Valley areas.
- Cellulitis potentially avoidable hospitalisation rates are similar to national averages. However rates by SA3 level are significantly higher than the national average in Murray River-Swan Hill, Wodonga-Alpine and Moira regions.
- The rate of potentially avoidable hospitalisations for COPD is significantly higher in the Murray PHN region than national averages (321 compared with 260 per 100,000), with 11 of the 12 SA3 regions within the Murray PHN catchment being higher than the national rate.
- Rates for COPD admissions in the Campaspe area are more than double the national average (530 compared with 260 per 100,000).
- The rate of potentially avoidable hospitalisations for diabetes complications is slightly higher overall for the Murray PHN region with 210, compared with 183 per 100,000.

- However, the potentially avoidable hospitalisation rate for diabetes complications by SA3s is 40% higher than national rates in Murray River-Swan Hill and 30% higher than national rates in Wodonga- Alpine, Upper Goulburn Valley and Campaspe. Albury, Moira and Wangaratta-Benalla are slightly higher than national averages. This is a significant change from the previous year.
- The rate of potentially avoidable hospitalisations for acute and vaccine-preventable conditions is overall on par with the national average, however by SA3 regions, Murray-River-Swan Hill, Mildura and Moira are higher than the national rate.
- Congestive cardiac failure rates are on par with national rates, however by SA3 levels within Murray PHN, Loddon-Elmore is 40% higher than the national average, and to a lesser extent, Shepparton, Wodonga-Alpine, Murray River-Swan Hill, Moira, Albury and Campaspe are higher than the national average for congestive cardiac failure admissions.
- Rates of potentially avoidable hospitalisations for kidney and urinary tract infections are lower in the Murray PHN region, compared with the national average. The exception to this, by SA3 region within Murray PHN's catchment, is Loddon-Elmore (30% higher) and to a lesser extent, Bendigo, Wangaratta-Benalla and Mildura.
- The Murray PHN region's rates of potentially avoidable deaths (per 100,000) 2011-13 were higher than national averages, significantly in the Loddon-Elmore SA3 region, moderately higher in Moira, Murray River-Swan Hill, Albury, Shepparton, Mildura, Wangaratta-Benalla and slightly higher in Upper Goulburn Valley, Campaspe and Bendigo areas.
- 15% of adults within the Murray PHN catchment reported needing to see a GP, but did not. This is a 5% reduction from the previous needs assessment.
- 37% of adults stated they could not access their preferred GP in the preceding 12 months (2013-14).
- In 2013–14, the percentage of adults who felt they waited longer than acceptable to get an appointment with a GP was higher in Murray PHN than national averages.
- In 2015–16, the overall percentage of adults who were admitted to any hospital in the preceding 12 months was slightly less than the national average. This is a reduction from previous years.
- In 2015–16, the percentage of adults who went to a hospital emergency department for their own health in the preceding 12 months was significantly higher than the national average (19% compared with 13.5%). Murray is ranked the third-highest PHN nationally for visit to a hospital emergency department.
- In 2015–16, the percentage of adults who delayed or avoided filling a prescription due to cost in the preceding 12 months was higher than the national average.
- In 2015–16, the number of specialist attendances per person, age-standardised, was lower for the Murray PHN region than national averages.
- In 2015–16, the percentage of adults who reported having a long-term health condition was 57.8%, compared with 50.2% nationally.

eHealth

Key issues

eHealth is also referred to as digital health.

- Murray PHN's strategic planning balances its contractual obligations to the Commonwealth with the realities of evolving technologies, limited resources and an increased expectation from the public and providers for what digital health can deliver. The many stakeholders and universal presence of digital health necessitates consideration of multiple perspectives.
- A general lack of education, understanding and uptake of eHealth, including by private allied health practitioners.
- A belief among some health practitioners that eHealth is problematic and that they won't use it until there is an effective system that communicates with the hospital, GP and pharmacy systems.
- A knowledge gap between what the consumer expectations are around the My Health Record and the reality of how some GPs and specialists are using the record. Patients think consent has been given and that their information is automatically uploaded and available (misperception).
- My Health Record will be opt-out from 2018.
- Lack of interoperable secure messaging.
- Variable infrastructure (internet connections aren't great in many rural areas).
- Confusion and variability regarding video conferencing platforms for telehealth.
- Under-use of telehealth for patients subject to regional and rural disadvantage.
- Inconsistent awareness of basic general practice IT requirements for both general practices and their IT providers.
- Towns located on borders face the additional challenges of working across them where state-based eHealth systems and initiatives may vary.

Description of evidence

- Almost all general practices (97%) have clinical and business software systems in place that support safe and efficient information exchange between health services and analysis of population health needs and patterns.
- Currently 178 general practices (96% of all practices) within the Murray PHN catchment receive the e-Health Practice Incentives Payment (ePIP). These are the essential building blocks that will support improvements in patient care.
- While 72% of all general practices were receiving ePIP payments in 2013-2014, only 16% were uploading clinical information to the system.
- Opportunity to scale up supporting implementation and improvement in quality of care across the Murray PHN catchment area and strengthen GP integration with pharmacy and allied health services.

Health workforce

Key issues

Key issues raised elsewhere in this needs assessment include:

- Existing labour shortages across a range of professions and disciplines.
- Skills shortages for emerging and growing needs such as aged care, dual diagnoses, patient and consumer engagement, digital health care, information management systems and evidence-led practice.
- Provider capabilities to attract and retain a skilled workforce and to establish and maintain strong collaborations with peer service providers and others in the broader health and social services sectors.
- Access needs are outlined and future models of care need to be considered with the quantum, availability and capacity of specialists to meet demand.
- Specific challenges for rural communities in attracting, training and retaining skilled workforce, especially for residential aged care, women's health and allied health.
- Training opportunities in rural and regional settings and analytics about workforce supply and demand issues at a regional level.
- Workforce sustainability issues continue to present challenges for remote Aboriginal and Torres Strait Islander communities.

Description of evidence

- There is limited regional health workforce data collection and analytics. It is more often historically reported and not as informative about demand and supply issues, with the focus more often being on general practitioners and not the whole health workforce.
- A focus on strategic engagement of key players is planned to collaborate on workforce strategies that redevelop and support an accessible and sustainable primary health system.
- In 2011 data, the catchment had 13% of its workforce employed in the health care and social assistance industries. For the Aboriginal and Torres Strait Islander population, the percentage was higher at almost 19%.
- Need for significantly more nurses and personal care workers with enhanced skills
- Distinct districts of General Practice Workforce Shortage Mildura, Ouyen, Murrayville, Boort, Wedderburn, Rushworth, Yea, Numurkah, Moyhu, Corryong, Wangaratta and Bethanga.
- The movement toward larger practices continued, with decreased proportions of GP participants working in solo practice (13% to 9%), and in practices of two to four individual GPs (35% to 21%) The proportion of practices with 10 or more GPs more than doubled, from 13% to 29%.
- The proportion of practices using medical deputising services for some or all their after-hours patient care increased from 51% to 57%.

References

Australian Bureau of Statistics (2015) *Australian Demographic Statistics – June 2015*, Canberra.

Australian Bureau of Statistics (2016) *Patient Experiences in Australia 2015-16,* Canberra.

Australian Bureau of Statistics (2017) *Census of Population and Housing 2016,* Canberra.

Australian Government (2011) *Relative Risk Report,* Department of Health and Ageing, Canberra.

Australian Government (2013) *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*, Department of Health and Ageing, Canberra.

Australian Government (2015) *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2015-2024,* COAG Health Council, Adelaide.

Australian Government Department of Health (2016) *2016 Historical PHN immunisation coverage data,* [Online], Available: http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/2016-historical-phn-immunisation-coverage-data

Australian Government Department of Health (2017) *Access to Allied Psychological Services (ATAPS) Data,* [Online], Available: http://www.health.gov.au/internet/main/publishing.nsf/Content/C66677BB7EB7084ECA257F15000413F9/$File/ATAPS%20tables_Public%20Release%20series_V2a%20%202015-16%20update%2020%20October%202017.xlsx

Australian Government Department of Health (2017) *Annual Medicare Statistics,* [Online], Available: http://www.health.gov.au/internet/main/publishing.nsf/content/annual-medicare-statistics

Australian Government Department of Health (2017), *Doctor Connect: Modified Monash Model* [Online], Available: http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/MMM_locator

Australian Government Department of Health (2017), *General Practice Statistics,* [Online], Available: http://www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Australian Government Department of Health (2017) *Medicare Benefits Schedule Data,* [Online], Available: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-MBS_Data

Australian Government Department of Health (2017) *Mental Health Nurse Incentive Program (MHNIP) Data,* [Online], Available: http://www.health.gov.au/internet/main/publishing.nsf/Content/C66677BB7EB7084ECA257F15000413F9/$File/MHNIP%20tables_Public%20Release%20series_V2a%201%20Sep%202017%20PPS.xlsx

Australian Healthcare and Hospitals Association (2015) *Health Workforce: AHHA Primary Health Network Discussion Paper Series, Paper Five,* Canberra.

Australian Institute of Health and Welfare (2011-13) *National Mortality Database,* [Online], Available: https://www.aihw.gov.au/about-our-data/our-data-collections/national-mortality-database

Australian Institute of Health and Welfare (2015) *Web update: Australians' experiences with access to health care in 2013-14*, [Online], Available: https://www.myhealthycommunities.gov.au/our-reports/australians-experiences-with-primary-health-care-updates/october-2015/media-resources/media-release

Australian Institute of Health and Welfare (2017) *My Healthy Communities: Primary Health area Murray*, [Online], Available: http://www.myhealthycommunities.gov.au/primary-health-network/phn205

Australian Institute of Health and Welfare (2017) *Web update: potentially preventable hospitalisations in 2015-15,* [Online], Available: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017

Cancer Council Victoria (2015-17) *Victorian Cancer Registry,* [Online], Available: http://www.cancervic.org.au/research/registry-statistics/vcr

Conway, M. & Voros, J. *Foresight: Learning from the future,* Swinburne University of Technology, Melbourne.

Coroners Court of Victoria (2016) *Suicide frequency by Primary Health Network and local government area, Victoria 2013-15,* Melbourne.

Crime Statistics Agency Victoria (2017) *Explore crime by location,* [Online], Available: https://www.crimestatistics.vic.gov.au/explore-crime-by-location

Duckett, S. & Griffiths, K. (2016) *Perils of Place: Identifying hotspots of health inequality,* Grattan Institute, Melbourne.

headspace (2016) *Annual Report 2015-16*. Melbourne.

Kenny, A., Dickson Swift, V., McKinstry, C., Kidd, S., Spong, J., Pearce, N., McGlashan, A. & Christian, R. (2015) *Where do I start? Mental health service access in small rural communities in the Southern Mallee catchment.* La Trobe University Rural Health School, Bendigo.

Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J. & Zubrick, S.R. (2015) *The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. Department of Health, Canberra.

Lloyd, B., Gao, C.X., Heilbronn, C. & Lubman, D.I. (2013) *Self harm and mental health-related ambulance attendances in Australia,* Turning Point, Melbourne.

Loddon Mallee Regional Palliative Care Consortium (2016) *Project Scoping Report,* Castlemaine.

Monash University (2016) *Methamphetamine in the Murray Primary Health Network,* Melbourne.

Murray Exchange (2015) *Victorian Injury Surveillance Unit Dataset,* Murray PHN, Bendigo.

Murray Exchange (2017) *North West Cancer – average total new cases per year – by sex (2007-2011),* [Online], Available: http://exchange.murrayphn.org.au/north-west-victoria/85-general-health-and-wellbeing/646-cv-lifetime-prevalence-of-self-reported-doctor-diagnosed-strole-2011-12-9

Murray Exchange (2017) *Victorian Admitted Episodes Dataset 2011-2012, 2013-2014,* Murray PHN, Bendigo.

Murray Exchange (2017) *Victorian Emergency Minimum Dataset 2011-2012, 2013-2014,* Murray PHN, Bendigo.

Murray, K.E., Davidson, G.R. & Schweizer, R.D. (2008) *Psychological Wellbeing of Refugees Resettling in Australia,* Australian Psychological Society, Melbourne.

Murray PHN (2016) *Partners in Recovery – modelling on expected transition of PIR clients to the NDIS,* Bendigo.

Public Health and Information Development Unit (2015), *Social Health Atlas of Australia 2015,* Torrens University, Adelaide.

Public Health and Information Development Unit (2016), *Aboriginal and Torres Strait Islander Social Health Atlas of Australia,* Torrens University, Adelaide.

Public Health and Information Development Unit (2017) *Social Health Atlas, Primary Health Networks (incl. Local Government Areas),* [Online], Available: http://phidu.torrens.edu.au/current/maps/sha-aust/phn-lga-single-map/atlas.html

Royal Flying Doctor Service (2017) *Mobile Dental Care,* [Online], Available: https://www.flyingdoctor.org.au/vic/our-services/mobile-dental-care/

Rural Health Workforce Australia (2016) *Medical practice in rural and remote Australia: Combined Rural Workforce Agencies National Minimum Data Set report as at 30th November 2015,* Melbourne.

Testa, C. (2015) 'Ouyen battles to find doctor', *Sunraysia Daily,* [Online], Available: http://www.sunraysiadaily.com.au/story/2944134/ouyen-battles-to-find-doctor/

Turning Point (2015-2017), *AODstats,* [Online], Available: http://www.aodstats.org.au/#overview

VicHealth (2016) *Indicators Survey 2015 LGA profiles,* [Online], Available: https://www.vichealth.vic.gov.au/media-and-resources/publications/vichealth-indicators-lga-profiles-2015

Victoria State Government (2013) *2013 LGA profiles data,* [Online], Available: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/2013-LGA-profiles-data

Victoria State Government (2013-14) *Victorian Health Information Surveillance System,* [Online], Available: https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/interactive-data-on-the-health-of-victorians/victorian-health-information-surveillance-system

Victoria State Government (2014) *Victorian Population Health Survey 2011-12,* Department of Health, Melbourne.

Victoria State Government (2016) *Victorian Population Health Survey 2014,* Department of Health and Human Services, Melbourne.

Victoria State Government (2015) *Ambulance Victoria Annual Report 2014-15 – Incidents,* [Online], Available: https://www.data.vic.gov.au/data/dataset/annual-report-2014-15-final-1011-to-1415-incidents

Victoria State Government (2017) *Health status of Victorians,* [Online], Available: https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians

Victoria State Government (2017) *HOSdata – Victorian hospital data reports,* [Online], Available: https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/hosdata

Victoria State Government (2017) *Registration of mental health clients* [Online], Available: https://www2.health.vic.gov.au/mental-health/research-and-reporting/reporting-requirements-for-clinical-mental-health-services/registration-of-mental-health-clients

Victoria State Government (2017) *Victorian Child and Adolescent Monitoring System (VCAMS),* [Online], Available: http://www.education.vic.gov.au/about/research/Pages/vcams.aspx

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RB-4

This is the attachment marked '**RB-4**' referred to in the witness statement of Dr Ravi Subramanya Bhat dated 4 July 2019.

Australian Early Development Census
An Australian Government Initiative

Our Children
Our Communities
Our Future

Australian Early Development Census

Community Profile 2018

Greater Shepparton,
VIC

Since 2002, the Australian Government has worked in partnership with eminent child health research institutes, the Centre for Community Child Health, Royal Children's Hospital, Melbourne, and the Telethon Kids Institute, Perth to deliver the Australian Early Development Census program to communities. The Australian Government continues to work with its partners, and with state and territory governments to implement the AEDC nationwide.

Contents

Note on presentation conventions: the hyphen (-) is used throughout the tables in this Community Profile where Australian Early Development Census data was not collected or not reported for any given year. All percentages presented in this Community Profile have been rounded to one decimal place. Figures may not add up to 100% due to rounding.

Note on links: the symbol is used in this document to highlight links to the Australian Early Development Census website: **www.aedc.gov.au**. These links will connect you with further information and resources.

Note on children with special needs status: domain indicator information about children with special needs is not included in the Australian Early Development Census results because of the already identified substantial developmental needs of this group.

Note on accessibility: an accessible text version of the Australian Early Development Census Community Profile is available for download from the data explorer on the Australian Early Development Census website. If you use assistive technology and need further assistance, please email **support@aedc.gov.au**. Please tell us what format you need. It will also help if you let us know what assistive technology you use.

Note on per cent calculation: unless otherwise specified the per cent is based on the valid n value.

AEDC publication rules have been applied and for more information visit the AEDC website **(https://www.aedc.gov.au/data-users/data-user-responsibilities/publishing-requirements).**

AEDC-1903-002-1 ISSN: 2206-1614

About the Australian Early Development Census

In 2009, Australia became the first country in the world to collect national data on the developmental health and wellbeing of all children starting school. The success of the 2009 data collection laid the foundation for the Australian Government's commitment to ongoing Australian Early Development Census (AEDC) data collections every three years, with the most recent in 2018.

The AEDC measures the development of children in Australia in their first year of full-time school. AEDC data is collected using an adapted version of the Early Development Instrument, which was developed in Canada.

The Australian version of the Early Development Instrument consists of approximately 100 questions across five key domains, which are closely linked to child health, education and social outcomes. Figure 1 provides a description of each of the AEDC domains.

Figure 1 – AEDC domain descriptions.

Physical health and wellbeing

Children's physical readiness for the school day, physical independence and gross and fine motor skills.

Social competence

Children's overall social competence, responsibility and respect, approach to learning and readiness to explore new things.

Emotional maturity

Children's pro-social and helping behaviours and absence of anxious and fearful behaviour, aggressive behaviour and hyperactivity and inattention.

Language and cognitive skills (school-based)

Children's basic literacy, advanced literacy, basic numeracy, and interest in literacy, numeracy and memory.

Communication skills and general knowledge

Children's communication skills and general knowledge based on broad developmental competencies and skills measured in the school context.

For each of the five AEDC domains, children receive a score between zero and ten, where zero is most developmentally vulnerable.

In 2009, when the AEDC was first completed nationally, a series of cut-off scores was established for each of the five domains:

- Children falling below the 10th percentile were categorised as 'developmentally vulnerable'
- Children falling between the 10th and 25th percentile were categorised as 'developmentally at risk'
- All other children were categorised as 'developmentally on track'.

The cut-off scores set in 2009 provide a reference point against which later AEDC results can be compared. These have remained the same for all data collections. For example, nationally in the 2018 AEDC, only 6.6 per cent of children were considered developmentally vulnerable on the language and cognitive skills (school-based) domain, using the cut-off scores established in 2009.

For further information about the domains and domain characteristics (developmentally on track, at risk and vulnerable) please refer to the fact sheet About the AEDC domains (**www.aedc.gov.au/abtdom**). Links to additional AEDC resources can be found at Appendix 2.

How to use this AEDC data

The AEDC provides important information for communities, governments and schools to support their planning and service provision. The early environments and experiences children are exposed to shape their development. The AEDC is considered to be a measure of how well children and families are supported from conception through to school age.

Research shows that investing time, effort and resources in children's early years, when their brains are developing rapidly, benefits children and the whole community. Early developmental gains support children through their school years and beyond.

The AEDC helps communities understand how children are developing before they start their first year of full-time school, what is being done well and what can be improved. Communities can use the AEDC to help identify services, resources and support to meet the needs of their community.

The AEDC data is a powerful tool for initiating conversations and partnerships across education, health and community services. By providing a common ground from which key stakeholders can work together, the AEDC can enable communities to form partnerships to plan and implement activities, programs and services to help shape the future and wellbeing of children in Australia. Connecting with key stakeholders, particularly early childhood education and care services, can give communities the opportunity to reach families in ways that are not resource intensive.

When reviewing the information in this profile consider:

- what are the strengths and vulnerabilities of children in the community?
- how does this community compare to other similar communities, the state or territory or the Australian average?
- what factors may be contributing to the percentage and number of children who are developmentally vulnerable in the community?
- what other demographic and community data would be useful to add context to the AEDC data?

When exploring this community's AEDC results you may wish to consider how well connected the network of community stakeholders are and who provides services to children and families. Ask:

- are families well informed about what is available in the community?
- does the community have well established referral pathways for connecting families to services and supports?
- does the community have well-connected services that work collaboratively to deliver programs across systems and sectors?

Also consider how stakeholders can connect strategically with the community and families to:

- be informed about what is happening for children in the community
- discuss what could be done to better support children's development in the early years
- collaborate in the development and implementation of a community plan that strategically provides a vision and direction for early years' service provision within the community.

Refer to the AEDC User Guides (**www.aedc.gov.au/resources/user-guides**) for ideas and strategies on how to respond to AEDC data and connecting with this community.

About this community

AEDC communities are a geographic area, usually equivalent to a Local Government Area, made up of AEDC local communities.

Local communities are a small area locality, usually representing a suburb or town.

This AEDC Community Profile presents AEDC results for children living in this community regardless of where they attend school.

Location

Greater Shepparton is in the Goulburn region of VIC.

For more information on community boundaries refer to the AEDC fact sheet Understanding AEDC community boundaries (**www.aedc.gov.au/ucb**).

AEDC local communities

The AEDC local communities that make up the Greater Shepparton community are: Shepparton Rural North West, Shepparton South East, Shepparton surrounds South, Shepparton surrounds East, Shepparton Central, Shepparton North East, Shepparton North West, Shepparton surrounds North, Mooroopna, Kialla, Shepparton Rural South, Tatura, Shepparton Rural East, Shepparton Rural North.

Across the 2009, 2012, 2015 and 2018 AEDC data collections some local communities may not have always been included in a Community Profile due to there being insufficient AEDC data available for reporting purposes in any particular year.

For the purposes of the AEDC, data for the following local communities, which are part of Greater Shepparton have either never, or only sometimes, been reported in a Community Profile:

Local communities reported in some but not all years:
Shepparton surrounds North, Shepparton Rural East

Local communities not reported in any years to date:
Nil

Information about children in this community

The following tables show trends for this community, including important information on demographics, early education experiences, special needs and transition to school.

Background information

Table 4.1 – Demographic information about this community.

Demographics	2012	2015	2018
Total number of children measured	976	963	904
Number of schools contributing to the results	40	38	41
Number of teachers contributing to the results	75	69	71
Mean age of children at completion	5 years 9 months	5 years 9 months	5 years 10 months

Table 4.2 – Further demographic information about this community.

Demographics	2012		2015		2018	
	n	%	n	%	n	%
Sex - Male	497	50.9	490	50.9	470	52.0
Sex - Female	479	49.1	473	49.1	434	48.0
Aboriginal and Torres Strait Islander children	74	7.6	75	7.8	78	8.6
Children born in another country	52	5.3	48	5.0	58	6.4
Children with English as a second language	122	12.5	144	15.0	135	14.9
Children with a language background other than English (LBOTE[1]) and who ARE proficient in English	118	12.2	131	13.7	127	14.1
Children with a language background other than English (LBOTE) and who ARE NOT proficient in English	28	2.9	37	3.9	45	5.0
Children with a primary caregiver who reported they completed some form of post-school qualification[2]	-		622	69.4	597	69.0

[1] For the AEDC, children are considered LBOTE if they speak a language other than English at home or if they have English as a second language status. More information on AEDC terms and definitions is available in the fact sheet Definition of AEDC terms (**www.aedc.gov.au/defterm**).

[2] This data was not collected for the 2009 and 2012 AEDC

Non-parental early childhood education

Table 4.3 – Non-parental early childhood education and/or care.[3]

Types of non-parental early childhood education and/or care	2012			2015			2018		
	n (valid)	n (yes)	%	n (valid)	n (yes)	%	n (valid)	n (yes)	%
Playgroup	472	281	59.5	509	280	55.0	474	270	57.0
Day care	585	243	41.5	669	217	32.4	627	210	33.5
Preschool or kindergarten	894	860	96.2	907	856	94.4	866	836	96.5
Family day care	531	31	5.8	657	57	8.7	602	23	3.8
Grandparent	476	103	21.6	650	148	22.8	605	137	22.6
Other relative	452	29	6.4	630	52	8.3	595	56	9.4
Nanny	558	5	0.9	717	7	1.0	642	≤3	≤0.5
Other	463	14	3.0	623	36	5.8	594	40	6.7

Special needs

Table 4.4 – Support.[4]

Types of support required or identified	2012		2015		2018	
	n	%	n	%	n	%
Children with special needs status	48	4.9	35	3.6	59	6.5
Children identified by teachers as requiring further assessment (e.g. medical and physical, behaviour management, emotional and cognitive development)	76	8.0	113	12.1	110	12.5

[3] Although teachers are well placed to report on the development of children, the extent to which teachers know about children's early education and care experiences varies. Nevertheless, early education and care data is collected in the AEDC to support communities, governments and researchers better reflect on and respond to the experiences of children and families. In cases where teachers don't know they indicate this, and these cases are excluded from Table 4.3. When reviewing data, consider how many children in the community this represents and how reliably this might reflect the experience of children in the community as a whole. Playgroup attendance refers to any time prior to entering full-time school, whereas all the other types of care arrangements listed above refer to the year before entering full-time school.

[4] For the AEDC, this means children identified already as requiring special assistance in the classroom with high needs due to chronic medical, physical, or intellectually disabling conditions. Teachers were asked to base their response on medical diagnosis. More information on AEDC terms and definitions is available in the fact sheet Definition of AEDC terms **(www.aedc.gov.au/defterm)**.

Transition to school

Table 4.5 – Teachers' response to the question: Would you say that this child is making good progress in adapting to the structure and learning environment of the school.

Child is making good progress in adapting to the structure and learning environment of the school	2012		2015		2018	
	n	%	n	%	n	%
True	941	96.6	927	96.9	847	94.0
Not true	29	3.0	29	3.0	54	6.0
Don't know	4	0.4	≤3	≤0.3	0	0.0

Table 4.6 – Teachers' response to the question: Would you say that this child has parent(s)/caregiver(s) who are actively engaged with the school in supporting their child's learning.

Child has parent(s)/caregiver(s) who are actively engaged with the school in supporting their child's learning	2012		2015		2018	
	n	%	n	%	n	%
True	902	92.6	865	90.4	800	88.8
Not true	60	6.2	91	9.5	101	11.2
Don't know	12	1.2	≤3	≤0.3	0	0.0

Table 4.7 – Teachers' response to the question: Would you say that this child is regularly read to/encouraged in his/her reading at home.

Child is regularly read to/encouraged in his/her reading at home	2012		2015		2018	
	n	%	n	%	n	%
True	900	92.4	858	89.7	780	86.6
Not true	58	6.0	95	9.9	118	13.1
Don't know	16	1.6	4	0.4	≤3	≤0.3

AEDC domain results

This section presents an overview of this community's AEDC results across all collections including the percentage of children who are:

- developmentally on track, at risk, or vulnerable, by domain
- vulnerable on one or more domain(s)
- vulnerable on two or more domains.

Results for this community for each of the AEDC domains are then presented in more detail and compared to the state or territory and national results for the three most recent collections.

How to interpret the domain results

Developmentally on track children are considered to be developing well. As such, it is desirable to see the percentage of children who are 'on track' increase with each new wave of the AEDC collection.

Developmentally at risk children should be considered alongside changes in the percentage of children developmentally on track and developmentally vulnerable. Ideally more children will be on track as communities work to ensure all children are supported in their development. For example, in a community where children and families face many complex challenges, a reduction in those who are developmentally vulnerable could coincide with an increase in those at risk which would signal an overall improvement. As such, any changes in the 'at risk' group cannot be interpreted without also looking at the percentage of children who are vulnerable and on track.

Developmentally vulnerable children are facing some significant challenges in their development. As such, it is desirable to see the percentage of children who are 'vulnerable' decrease with each new wave of the AEDC collection.

How to compare your results

Most communities will see some change in the percentage of children who are developmentally on track, at risk or vulnerable in 2018 compared to previous collections. In some cases, this difference will be small and in others, it will be more substantial.

To assist communities to make informed decisions, a method described as the 'critical difference' has been developed which calculates whether the change in percentage of children considered developmentally on track, at risk or vulnerable over time is large enough to be considered significant.

The critical difference is the minimum percentage point change required between collections for the results to represent a 'significant change' in children's development. Table 5.1 indicates whether the change in each developmental domain category represents a significant change.

Appendix 1 provides detailed information on the critical difference required by domain and community size to represent a significant change for children who are developmentally on track, at risk or vulnerable.

Trends in child development in this community

Figures 5.1 to 5.5 show broad trends for each domain from 2009 to 2018. Results are also presented in tabular format in Table 5.1.

Figure 5.1 – Trends in the physical health and wellbeing domain for this community.

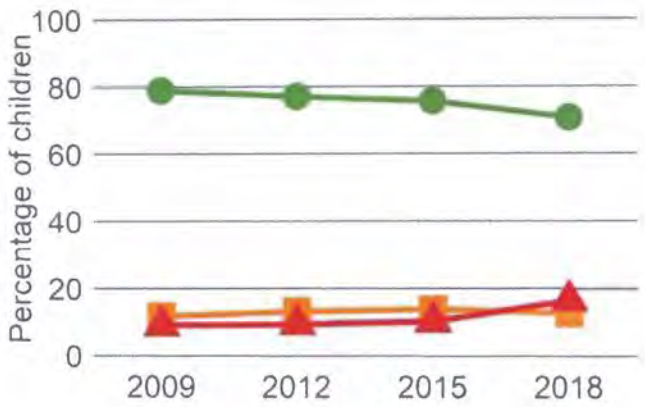


Figure 5.2 – Trends in the social competence domain for this community.

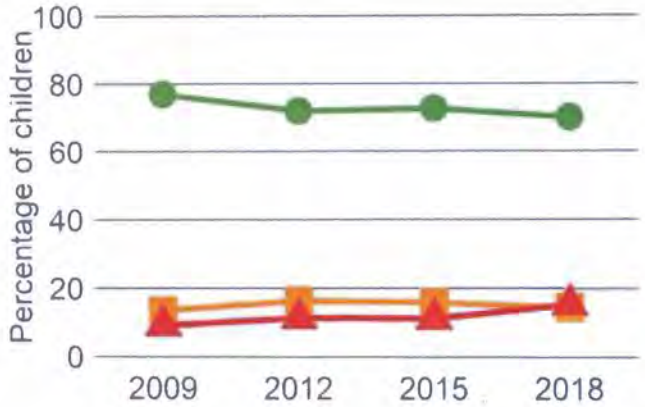


Figure 5.3 – Trends in the emotional maturity domain for this community.

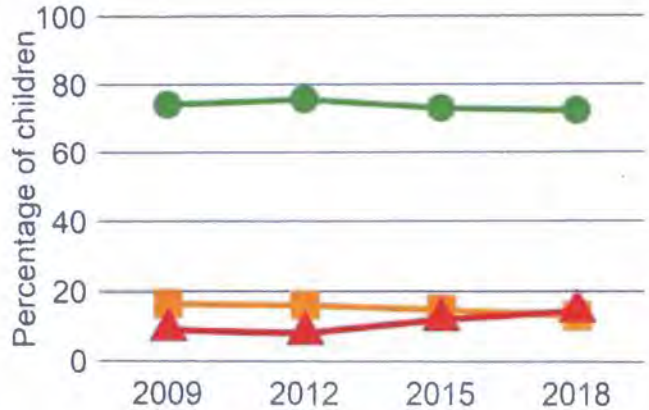


Figure 5.4 – Trends in the language and cognitive skills (school-based) domain for this community.

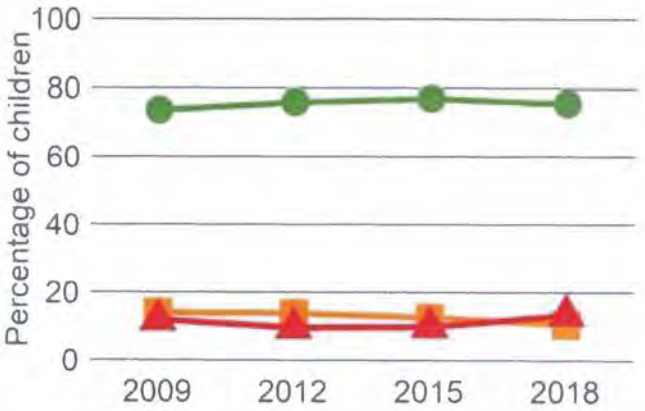


Figure 5.5 – Trends in the communication skills and general knowledge domain for this community.

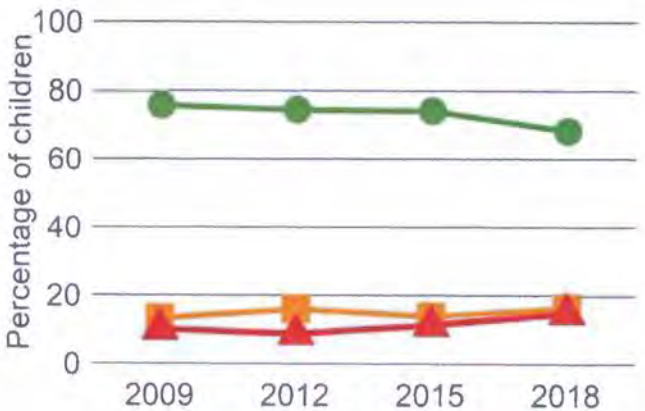


Table 5.1 – AEDC domain results over time for this community.

		2009		2012		2015		2018		S
		n	%	n	%	n	%	n	%	2009 vs 2018
Physical health and wellbeing	On track	603	78.9	707	77.1	698	75.7	595	70.7	Significant decreas
	At risk	91	11.9	123	13.4	129	14.0	108	12.8	No significant change
	Vulnerable	70	9.2	87	9.5	95	10.3	139	16.5	Significant increase
Social competence	On track	588	77.0	666	72.0	670	72.7	590	70.1	Significant decrease
	At risk	105	13.7	153	16.5	147	16.0	122	14.5	No significant change
	Vulnerable	71	9.3	106	11.5	104	11.3	130	15.4	Significant increase
Emotional maturity	On track	562	74.2	693	75.7	673	73.1	609	72.3	No significant change
	At risk	126	16.6	148	16.2	137	14.9	111	13.2	Significant decrease
	Vulnerable	69	9.1	74	8.1	111	12.1	122	14.5	Significant increase
Language and cognitive skills (school-based)	On track	563	73.8	703	76.1	711	77.2	637	75.7	No significant change
	At risk	108	14.2	130	14.1	118	12.8	91	10.8	Significant decrease
	Vulnerable	92	12.1	91	9.8	92	10.0	114	13.5	No significant change
Communication skills and general knowledge	On track	581	76.0	689	74.7	685	74.4	577	68.5	Significant decrease
	At risk	104	13.6	150	16.3	130	14.1	139	16.5	Significant increase
	Vulnerable	79	10.3	83	9.0	106	11.5	126	15.0	Significant increase

Physical health and wellbeing	Significant decrease
	No significant change
	Significant increase
Social competence	Significant decrease
	No significant change
	Significant increase
Emotional maturity	No significant change
	No significant change
	Significant increase
Language and cognitive skills (school-based)	No significant change
	No significant change
	Significant increase
Communication skills and general knowledge	Significant decrease
	No significant change
	Significant increase

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Significant change has been colour coded: green text represents a positive change, red text represents a negative change. At risk has not been colour coded as any changes should be interpreted in context with changes in the percentage of children who are vulnerable and on track.

Table 5.2 and Figure 5.6 present trends in the summary indicators (the percentage of children who are developmentally vulnerable on one or more domain(s) and developmentally vulnerable on two or more domains) from 2009 to 2018.

Table 5.2 – Number and percentage of children for this community who are vulnerable on one or more developmental domain(s) or two or more developmental domains.

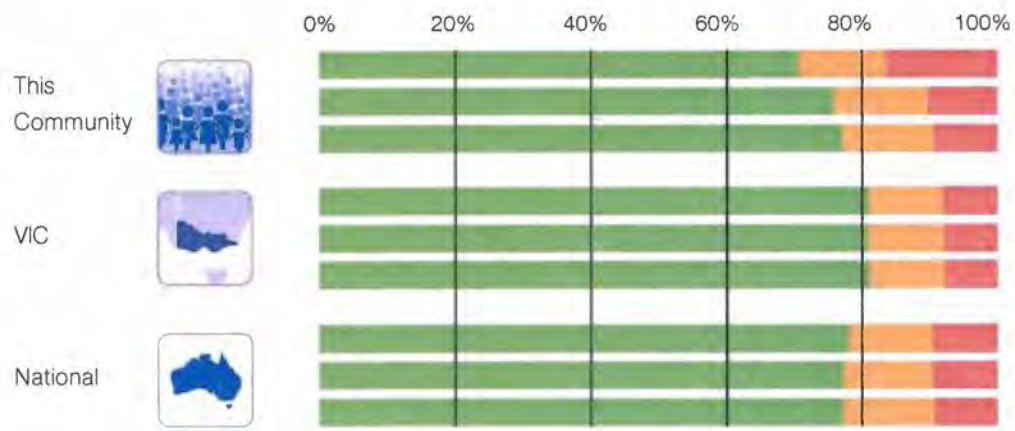
	2009		2012		2015		2018		Significant change	
	n	%	n	%	n	%	n	%	2009 vs 2018	2015 vs 2018
Vulnerable on one or more domain(s)	179	23.5	225	24.6	244	26.5	259	30.8	Significant increase	Significant increase
Vulnerable on two or more domains	96	12.6	107	11.6	136	14.8	163	19.4	Significant increase	Significant increase

Figure 5.6 – Community trends of vulnerability over time.

Physical health and wellbeing

This domain measures children's physical readiness for the school day, physical independence, and gross and fine motor skills

Physical health and wellbeing



		Developmentally on track		Developmentally at risk		Developmentally vulnerable	
		n	%	n	%	n	%
This Community	2018	595	70.7	108	12.8	139	16.5
	2015	698	75.7	129	14.0	95	10.3
	2012	707	77.1	123	13.4	87	9.5
VIC	2018	58,221	81.0	7,767	10.8	5,904	8.2
	2015	54,934	80.9	7,602	11.2	5,335	7.9
	2012	51,985	81.1	7,111	11.1	4,965	7.8
National	2018	229,542	78.1	36,105	12.3	28,247	9.6
	2015	221,855	77.3	37,347	13.0	27,711	9.7
	2012	211,806	77.3	36,637	13.4	25,479	9.3

Table 5.3 — Physical health and wellbeing domain category definitions.

Developmentally on track	Almost never have problems that interfere with their ability to physically cope with the school day. These children are generally independent, have excellent motor skills, and have energy levels that can get them through the school day.
Developmentally at risk	Experience some challenges that interfere with their ability to physically cope with the school day. This may include being dressed inappropriately, frequently late, hungry or tired. Children may also show poor coordination skills, have poor fine and gross motor skills, or show poor to average levels of energy during the school day.
Developmentally vulnerable	Experience a number of challenges that interfere with their ability to physically cope with the school day. This may include being dressed inappropriately, frequently late, hungry or tired. Children are usually clumsy and may have fading energy levels.

Physical health and wellbeing sub-domains

The physical health and wellbeing domain is the only AEDC domain that is reported with sub-domain analysis. Patterns of vulnerability vary across the physical health and wellbeing domain: for example, children might be coming to school hungry but still have developmentally appropriate fine and gross motor skills. As such, sub-domains are reported for the physical health and wellbeing domain below, enabling communities to make better sense of these results.

Table 5.4 – Children developmentally vulnerable on the physical health and wellbeing sub-domains.

Sub-domain	Description	2012		2015		2018	
		n	%	n	%	n	%
Physical readiness for school day	Children developmentally vulnerable on this sub-domain have at least sometimes experienced coming unprepared for school by being dressed inappropriately, coming to school late, hungry or tired.	111	12.1	140	15.2	168	20.0
Physical independence	Children developmentally vulnerable on this sub-domain range from those who have not developed independence or handedness or coordination, to those who have not developed any of these skills.	72	7.9	82	8.9	85	10.1
Gross and fine motor skills	Children developmentally vulnerable on this sub-domain could have poor fine and gross motor skills and/or poor overall energy levels during the school day.	71	7.8	87	9.4	127	15.1

Social competence

This domain measures children's overall social competence, responsibility and respect, approach to learning and readiness to explore new things

		Developmentally on track		Developmentally at risk		Developmentally vulnerable	
		n	%	n	%	n	%
This Community	2018	590	70.1	122	14.5	130	15.4
	2015	670	72.7	147	16.0	104	11.3
	2012	666	72.0	153	16.5	106	11.5
VIC	2018	55,597	77.3	9,974	13.9	6,331	8.8
	2015	52,378	77.2	9,548	14.1	5,934	8.7
	2012	50,226	78.6	8,519	13.3	5,151	8.1
National	2018	222,771	75.8	42,434	14.4	28,673	9.8
	2015	215,605	75.2	42,892	15.0	28,351	9.9
	2012	209,149	76.5	39,018	14.3	25,367	9.3

Table 5.5 — Social competence domain category definitions.

Developmentally on track	Almost never have problems getting along, working, or playing with other children; are respectful to adults, are self-confident, and are able to follow class routines; and are capable of helping others.
Developmentally at risk	Experience some challenges in the following areas: getting along with other children and teachers, playing with a variety of children in a cooperative manner, showing respect for others and for property, following instructions and class routines, taking responsibility for their actions, working independently, and exhibiting self-control and self-confidence.
Developmentally vulnerable	Experience a number of challenges with poor overall social skills. For example children who do not get along with other children on a regular basis, do not accept responsibility for their own actions and have difficulties following rules and class routines. Children may be disrespectful of adults, children, and others' property, have low self-confidence and self-control, do not adjust well to change; and are usually unable to work independently.

Emotional maturity

This domain measures children's pro-social and helping behaviours and absence of anxious and fearful behaviour, aggressive behaviour and hyperactivity and inattention

		Developmentally on track		Developmentally at risk		Developmentally vulnerable	
		n	%	n	%	n	%
This Community	2018	609	72.3	111	13.2	122	14.5
	2015	673	73.1	137	14.9	111	12.1
	2012	693	75.7	148	16.2	74	8.1
VIC	2018	55,651	77.7	10,167	14.2	5,791	8.1
	2015	52,392	77.5	9,817	14.5	5,408	8.0
	2012	50,605	79.3	8,604	13.5	4,566	7.2
National	2018	225,739	77.1	42,390	14.5	24,677	8.4
	2015	218,341	76.4	43,594	15.3	23,866	8.4
	2012	213,059	78.1	38,778	14.2	20,845	7.6

Table 5.6 — Emotional maturity domain category definitions.

Developmentally on track	Almost never show aggressive, anxious, or impulsive behaviour. Children will have good concentration and will often help other children.
Developmentally at risk	Experience some challenges in the following areas: helping other children who are hurt, sick or upset, inviting other children to join in activities, being kind to other children, and waiting their turn in activities. Children will sometimes experience problems with anxious behaviours, aggressive behaviour, temper tantrums, or problems with inattention or hyperactivity.
Developmentally vulnerable	Experience a number of challenges related to emotional regulation. For example, problems managing aggressive behaviour, being prone to disobedience and/or are easily distracted, inattentive, and impulsive. Children will usually not help others and are sometimes upset when left by their caregiver.

Language and cognitive skills (school-based)

This domain measures children's basic literacy, advanced literacy, basic numeracy, and interest in literacy, numeracy and memory

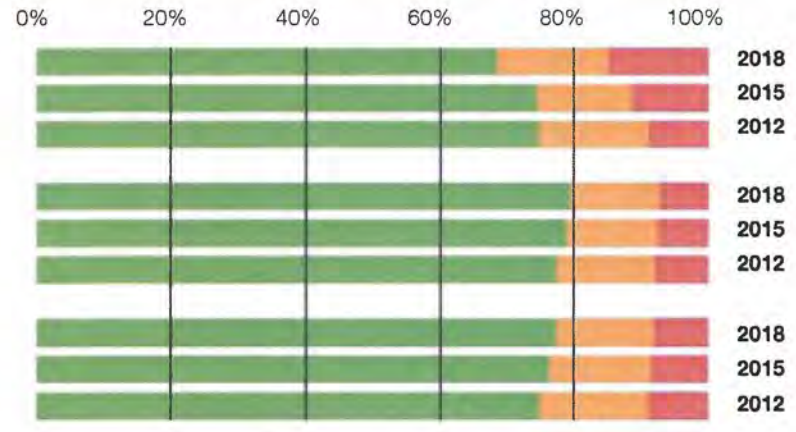
		Developmentally on track		Developmentally at risk		Developmentally vulnerable	
		n	%	n	%	n	%
This Community	2018	637	75.7	91	10.8	114	13.5
	2015	711	77.2	118	12.8	92	10.0
	2012	703	76.1	130	14.1	91	9.8
VIC	2018	60,779	84.6	6,461	9.0	4,608	6.4
	2015	57,474	84.7	6,062	8.9	4,292	6.3
	2012	53,929	84.0	6,351	9.9	3,915	6.1
National	2018	247,870	84.4	26,291	9.0	19,417	6.6
	2015	242,518	84.6	25,597	8.9	18,533	6.5
	2012	226,260	82.6	29,072	10.6	18,564	6.8

Table 5.7 — Language and cognitive skills (school-based) domain category definitions.

Developmentally on track	Children will be interested in books, reading and writing, and basic math; capable of reading and writing simple sentences and complex words. Will be able to count and recognise numbers and shapes.
Developmentally at risk	Have mastered some but not all of the following literacy and numeracy skills: being able to identify some letters and attach sounds to some letters, show awareness of rhyming words, know writing directions, being able to write their own name, count to 20, recognise shapes and numbers, compare numbers, sort and classify, and understand simple time concepts. Children may have difficultly remembering things, and show a lack of interest in books, reading, maths and numbers, and may not have mastered more advanced literacy skills such as reading and writing simple words or sentences.
Developmentally vulnerable	Experience a number of challenges in reading/writing and with numbers; unable to read and write simple words, will be uninterested in trying, and often unable to attach sounds to letters. Children will have difficulty remembering things, counting to 20, and recognising and comparing numbers; and usually not interested in numbers.

Communication skills and general knowledge

This domain measures children's communication skills and general knowledge based on broad developmental competencies and skills measured in the school context



		Developmentally on track		Developmentally at risk		Developmentally vulnerable	
		n	%	n	%	n	%
This Community	2018	577	68.5	139	16.5	126	15.0
	2015	685	74.4	130	14.1	106	11.5
	2012	689	74.7	150	16.3	83	9.0
VIC	2018	57,098	79.4	9,483	13.2	5,312	7.4
	2015	53,474	78.8	9,259	13.6	5,131	7.6
	2012	49,557	77.4	9,371	14.6	5,110	8.0
National	2018	227,163	77.3	42,473	14.5	24,232	8.2
	2015	219,023	76.3	43,415	15.1	24,475	8.5
	2012	204,702	74.7	44,633	16.3	24,520	9.0

Table 5.8 — Communication skills and general knowledge domain category definitions.

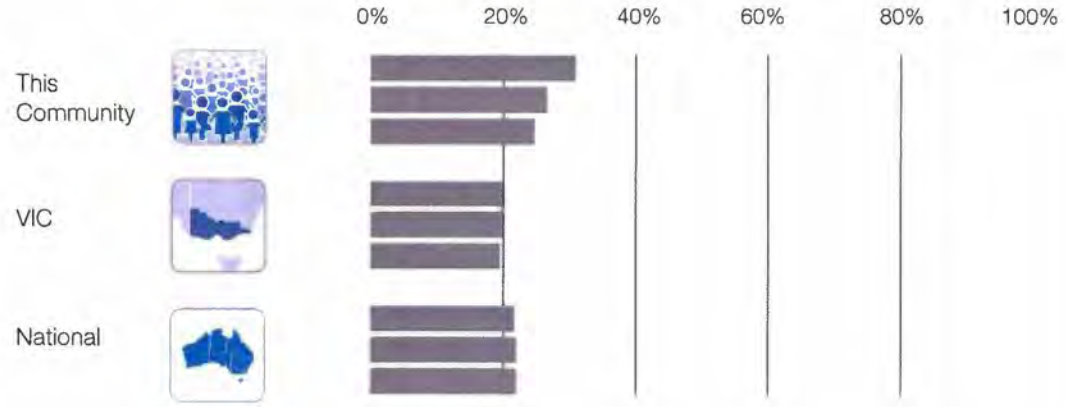
Developmentally on track	Children will have excellent communication skills, can tell a story and communicate easily with both children and adults, and have no problems with articulation.
Developmentally at risk	Have mastered some but not all of the following communication skills: listening, understanding and speaking effectively in English, being able to articulate clearly, being able to tell a story and to take part in imaginative play. Children may not know some basic general knowledge about the world such as knowing that leaves fall in autumn, apple is fruit, and dogs bark.
Developmentally vulnerable	Children will have poor communication skills and articulation; have limited command of English (or the language of instruction), have difficulties talking to others, understanding, and being understood; and have poor general knowledge.

Developmentally vulnerable on ≥1 and ≥2 domain(s)

Summary indicators of developmental vulnerability on 'one or more' and on 'two or more' domains

Developmentally vulnerable on one or more domain(s)

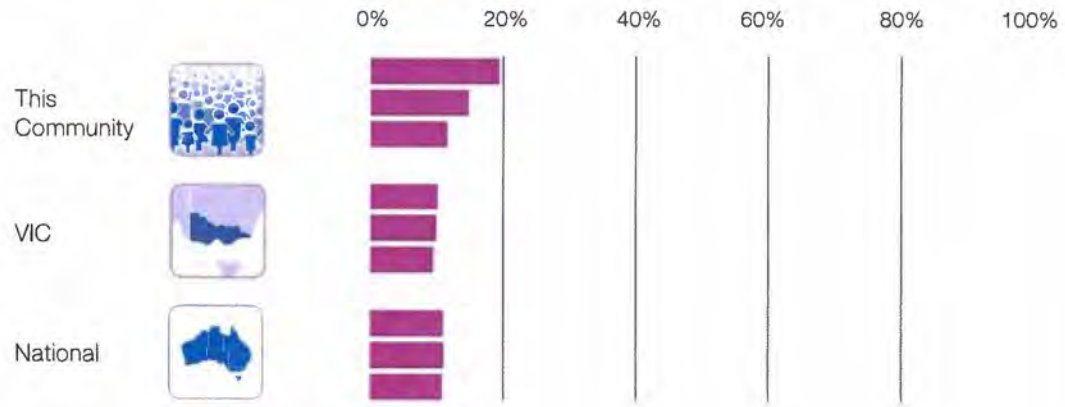
Vuln 1



	n	%
2018	259	30.8
2015	244	26.5
2012	225	24.6
2018	14,232	19.9
2015	13,465	19.9
2012	12,407	19.5
2018	63,448	21.7
2015	62,960	22.0
2012	59,933	22.0

Developmentally vulnerable on two or more domains

Vuln 2



	n	%
2018	163	19.4
2015	136	14.8
2012	107	11.6
2018	7,231	10.1
2015	6,707	9.9
2012	6,053	9.5
2018	32,434	11.0
2015	31,754	11.1
2012	29,543	10.8

AEDC results for local communities

This section presents national, state/territory, community and local community results for each of the five AEDC domains, as well as the two summary indicators (vulnerable on one or more domain(s) and vulnerable on two or more domains) for the last three collections.

AEDC geographic boundaries have been defined for the whole country to ensure that the data is reported in the most useful way that aligns with commonly understood geographies, such as suburbs. These boundaries enable AEDC results to be reported at the four different geographic levels.

AEDC local communities represent the smallest geographic areas. In most cases, AEDC local community boundaries are equivalent to suburbs.

To enable accurate comparisons with the Census of Population and Housing, and other socio-demographic data from the Australian Bureau of Statistics (ABS), 2018 AEDC boundaries align with the Statistical Area 1 (SA1) geography released by the ABS in 2016.

This has resulted in minor changes in boundaries, relative to boundaries used for reporting of community results for previous collections, which were based on 2011 ABS geographies.

In some cases, local communities from previous collections may have been combined to have sufficient numbers of children for reporting purposes in 2018. In other cases, local communities from previous collections may have been split to report 2018 data in a more useful way.

In all cases, 2018 boundaries have been applied to data from previous collections.

The following tables show the number and percentage of children developmentally on track, at risk and vulnerable for this community. The tables also provide data for each of the local communities included as part of the aggregate total. They also show community, state/territory and national data to provide context for:

- each of the 2012, 2015 and 2018 AEDC data collections
- the AEDC domains:
  - physical health and wellbeing
  - social competence
  - emotional maturity
  - language and cognitive skills (school-based)
  - communication skills and general knowledge.
- the two summary indicators:
  - developmentally vulnerable on one or more domain(s)
  - developmentally vulnerable on two or more domains.

The history of boundary change means that some local communities may not have data for all years in this section. For more information, refer to the AEDC factsheet Understanding community boundaries (**www.aedc.gov.au/ucb**).

Appendix 1 presents the critical difference estimates for communities of different sizes, which can be used to understand whether change over time is considered significant.

Physical health and wellbeing domain results

This domain measures children's physical readiness for the school day, physical independence, and gross and fine motor skills.

Table 6.1 – Communities in context: Physical health and wellbeing domain results at the national, state/territory, community and local community levels.

Region (including local communities)	Developmentally on track						Developmentally at risk						Developmentally vulnerable					
	2012		2015		2018		2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Australia	211,806	77.3	221,855	77.3	229,542	78.1	36,637	13.4	37,347	13.0	36,105	12.3	25,479	9.3	27,711	9.7	28,247	9.6
VIC	51,985	81.1	54,934	80.9	58,221	81.0	7,111	11.1	7,602	11.2	7,767	10.8	4,965	7.8	5,335	7.9	5,904	8.2
Greater Shepparton	707	77.1	698	75.7	595	70.7	123	13.4	129	14.0	108	12.8	87	9.5	95	10.3	139	16.5
Kialla	62	86.1	72	91.1	74	81.3	8	11.1	4	5.1	12	13.2	2	2.8	3	3.8	5	5.5
Mooroopna	56	46.3	69	64.5	61	54.5	33	27.3	19	17.8	18	16.1	32	26.4	19	17.8	33	29.5
Shepparton central	72	90.0	57	66.3	43	74.1	5	6.3	19	22.1	5	8.6	3	3.8	10	11.6	10	17.2
Shepparton north east	64	94.1	54	91.5	33	84.6	4	5.9	1	1.7	3	7.7	0	0.0	4	6.8	3	7.7
Shepparton north west	53	76.8	90	82.6	65	69.1	8	11.6	9	8.3	15	16.0	8	11.6	10	9.2	14	14.9
Shepparton Rural East	8	50.0	-		15	93.8	5	31.3	-		1	6.3	3	18.8	-		0	0.0
Shepparton Rural North	19	65.5	19	95.0	13	86.7	9	31.0	1	5.0	0	0.0	1	3.4	0	0.0	2	13.3
Shepparton Rural North West	39	81.3	31	77.5	27	87.1	4	8.3	6	15.0	3	9.7	5	10.4	3	7.5	1	3.2
Shepparton Rural South	37	90.2	26	61.9	15	50.0	3	7.3	13	31.0	10	33.3	1	2.4	3	7.1	5	16.7
Shepparton South East	180	78.6	151	64.5	145	63.0	30	13.1	50	21.4	32	13.9	19	8.3	33	14.1	53	23.0
Shepparton surrounds East	14	53.8	17	85.0	19	79.2	7	26.9	0	0.0	3	12.5	5	19.2	3	15.0	2	8.3
Shepparton surrounds North	18	78.3	17	85.0	20	76.9	1	4.3	2	10.0	2	7.7	4	17.4	1	5.0	4	15.4
Shepparton surrounds South	28	90.3	20	95.2	22	100.0	2	6.5	1	4.8	0	0.0	1	3.2	0	0.0	0	0.0
Tatura	57	89.1	66	90.4	43	79.6	4	6.3	3	4.1	4	7.4	3	4.7	4	5.5	7	13.0

Social competence domain results

This domain measures children's overall social competence, responsibility and respect, approaches to learning, and readiness to explore new things.

Table 6.2 – Communities in context: Social competence domain results at the national, state/territory, community and local community levels.

Region (including local communities)	Developmentally on track						Developmentally at risk						Developmentally vulnerable					
	2012		2015		2018		2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Australia	209,149	76.5	215,605	75.2	222,771	75.8	39,018	14.3	42,892	15.0	42,434	14.4	25,367	9.3	28,351	9.9	28,673	9.8
VIC	50,226	78.6	52,378	77.2	55,597	77.3	8,519	13.3	9,548	14.1	9,974	13.9	5,151	8.1	5,934	8.7	6,331	8.8
Greater Shepparton	666	72.0	670	72.7	590	70.1	153	16.5	147	16.0	122	14.5	106	11.5	104	11.3	130	15.4
Kialla	56	77.8	66	83.5	75	82.4	12	16.7	8	10.1	10	11.0	4	5.6	5	6.3	6	6.6
Mooroopna	60	49.6	68	63.6	59	52.7	29	24.0	25	23.4	22	19.6	32	26.4	14	13.1	31	27.7
Shepparton central	62	75.6	57	66.3	43	74.1	14	17.1	15	17.4	6	10.3	6	7.3	14	16.3	9	15.5
Shepparton north east	61	88.4	52	88.1	30	76.9	6	8.7	6	10.2	5	12.8	2	2.9	1	1.7	4	10.3
Shepparton north west	46	63.9	79	72.5	61	64.9	14	19.4	17	15.6	17	18.1	12	16.7	13	11.9	16	17.0
Shepparton Rural East	12	75.0	-		14	87.5	2	12.5	-		1	6.3	2	12.5	-		1	6.3
Shepparton Rural North	26	89.7	15	75.0	8	53.3	1	3.4	4	20.0	5	33.3	2	6.9	1	5.0	2	13.3
Shepparton Rural North West	35	72.9	29	74.4	27	87.1	11	22.9	9	23.1	3	9.7	2	4.2	1	2.6	1	3.2
Shepparton Rural South	37	90.2	38	90.5	25	83.3	4	9.8	4	9.5	3	10.0	0	0.0	0	0.0	2	6.7
Shepparton South East	153	66.2	149	63.7	141	61.3	46	19.9	42	17.9	42	18.3	32	13.9	43	18.4	47	20.4
Shepparton surrounds East	20	76.9	16	80.0	20	83.3	3	11.5	1	5.0	3	12.5	3	11.5	3	15.0	1	4.2
Shepparton surrounds North	16	69.6	13	65.0	19	73.1	4	17.4	3	15.0	1	3.8	3	13.0	4	20.0	6	23.1
Shepparton surrounds South	27	87.1	16	76.2	21	95.5	2	6.5	3	14.3	1	4.5	2	6.5	2	9.5	0	0.0
Tatura	55	85.9	64	87.7	47	87.0	5	7.8	6	8.2	3	5.6	4	6.3	3	4.1	4	7.4

Emotional maturity domain results

This domain measures children's pro-social and helping behaviour, anxious and fearful behaviour, aggressive behaviour and hyperactivity and inattention.

Table 6.3 – Communities in context: Emotional maturity domain results at the national, state/territory, community and local community levels.

Region (including local communities)	Developmentally on track						Developmentally at risk						Developmentally vulnerable					
	2012		2015		2018		2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Australia	213,059	78.1	218,341	76.4	225,739	77.1	38,778	14.2	43,594	15.3	42,390	14.5	20,845	7.6	23,866	8.4	24,677	8.4
VIC	50,605	79.3	52,392	77.5	55,651	77.7	8,604	13.5	9,817	14.5	10,167	14.2	4,566	7.2	5,408	8.0	5,791	8.1
Greater Shepparton	693	75.7	673	73.1	609	72.3	148	16.2	137	14.9	111	13.2	74	8.1	111	12.1	122	14.5
Kialla	55	76.4	64	81.0	78	85.7	12	16.7	9	11.4	5	5.5	5	6.9	6	7.6	8	8.8
Mooroopna	66	55.5	69	64.5	64	57.1	30	25.2	23	21.5	13	11.6	23	19.3	15	14.0	35	31.3
Shepparton central	63	78.8	61	70.9	42	72.4	11	13.8	18	20.9	7	12.1	6	7.5	7	8.1	9	15.5
Shepparton north east	58	82.9	48	81.4	31	79.5	9	12.9	7	11.9	7	17.9	3	4.3	4	6.8	1	2.6
Shepparton north west	57	79.2	79	72.5	65	69.1	10	13.9	14	12.8	10	10.6	5	6.9	16	14.7	19	20.2
Shepparton Rural East	14	87.5	-		13	81.3	0	0.0	-		1	6.3	2	12.5	-		2	12.5
Shepparton Rural North	27	93.1	15	75.0	12	80.0	2	6.9	3	15.0	1	6.7	0	0.0	2	10.0	2	13.3
Shepparton Rural North West	35	72.9	29	74.4	25	80.6	8	16.7	9	23.1	5	16.1	5	10.4	1	2.6	1	3.2
Shepparton Rural South	39	95.1	40	95.2	24	80.0	2	4.9	2	4.8	5	16.7	0	0.0	0	0.0	1	3.3
Shepparton South East	158	70.5	155	66.2	151	65.7	46	20.5	36	15.4	43	18.7	20	8.9	43	18.4	36	15.7
Shepparton surrounds East	21	80.8	13	65.0	19	79.2	4	15.4	4	20.0	3	12.5	1	3.8	3	15.0	2	8.3
Shepparton surrounds North	16	69.6	13	65.0	20	76.9	6	26.1	4	20.0	3	11.5	1	4.3	3	15.0	3	11.5
Shepparton surrounds South	27	87.1	15	71.4	20	90.9	4	12.9	1	4.8	2	9.1	0	0.0	5	23.8	0	0.0
Tatura	57	89.1	63	86.3	45	83.3	4	6.3	6	8.2	6	11.1	3	4.7	4	5.5	3	5.6

Language and cognitive skills (school-based) domain results

This domain measures children's basic literacy, advanced literacy, basic numeracy, and interest in literacy, numeracy and memory.

Table 6.4 – Communities in context: Language and cognitive skills (school-based) domain results at the national, state/territory, community and local community levels.

Region (including local communities)	Developmentally on track						Developmentally at risk						Developmentally vulnerable					
	2012		2015		2018		2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Australia	226,260	82.6	242,518	84.6	247,870	84.4	29,072	10.6	25,597	8.9	26,291	9.0	18,564	6.8	18,533	6.5	19,417	6.6
VIC	53,929	84.0	57,474	84.7	60,779	84.6	6,351	9.9	6,062	8.9	6,461	9.0	3,915	6.1	4,292	6.3	4,608	6.4
Greater Shepparton	703	76.1	711	77.2	637	75.7	130	14.1	118	12.8	91	10.8	91	9.8	92	10.0	114	13.5
Kialla	63	87.5	68	86.1	75	82.4	7	9.7	10	12.7	10	11.0	2	2.8	1	1.3	6	6.6
Mooroopna	60	49.6	77	72.0	75	67.0	34	28.1	10	9.3	19	17.0	27	22.3	20	18.7	18	16.1
Shepparton central	65	79.3	63	73.3	44	75.9	6	7.3	11	12.8	3	5.2	11	13.4	12	14.0	11	19.0
Shepparton north east	63	90.0	52	88.1	33	84.6	5	7.1	6	10.2	4	10.3	2	2.9	1	1.7	2	5.1
Shepparton north west	53	73.6	80	73.4	64	68.1	11	15.3	19	17.4	14	14.9	8	11.1	10	9.2	16	17.0
Shepparton Rural East	12	75.0	-		16	100.0	3	18.8	-		0	0.0	1	6.3	-		0	0.0
Shepparton Rural North	27	93.1	19	95.0	13	86.7	2	6.9	0	0.0	0	0.0	0	0.0	1	5.0	2	13.3
Shepparton Rural North West	35	72.9	31	79.5	30	96.8	12	25.0	6	15.4	0	0.0	1	2.1	2	5.1	1	3.2
Shepparton Rural South	40	97.6	38	90.5	25	83.3	1	2.4	4	9.5	3	10.0	0	0.0	0	0.0	2	6.7
Shepparton South East	166	72.5	166	70.9	152	66.1	34	14.8	32	13.7	27	11.7	29	12.7	36	15.4	51	22.2
Shepparton surrounds East	19	73.1	17	85.0	23	95.8	4	15.4	2	10.0	0	0.0	3	11.5	1	5.0	1	4.2
Shepparton surrounds North	18	78.3	16	80.0	19	73.1	2	8.7	4	20.0	5	19.2	3	13.0	0	0.0	2	7.7
Shepparton surrounds South	28	90.3	19	90.5	21	95.5	2	6.5	0	0.0	0	0.0	1	3.2	2	9.5	1	4.5
Tatura	54	84.4	57	78.1	47	87.0	7	10.9	11	15.1	6	11.1	3	4.7	5	6.8	1	1.9

Communication skills and general knowledge domain results

This domain measures children's communication skills and general knowledge based on broad developmental competencies and skills measured in the school context.

Table 6.5 – Communities in context: Communication skills and general knowledge domain results at the national, state/territory, community and local community levels.

Region (including local communities)	Developmentally on track						Developmentally at risk						Developmentally vulnerable					
	2012		2015		2018		2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Australia	204,702	74.7	219,023	76.3	227,163	77.3	44,633	16.3	43,415	15.1	42,473	14.5	24,520	9.0	24,475	8.5	24,232	8.2
VIC	49,557	77.4	53,474	78.8	57,098	79.4	9,371	14.6	9,259	13.6	9,483	13.2	5,110	8.0	5,131	7.6	5,312	7.4
Greater Shepparton	689	74.7	685	74.4	577	68.5	150	16.3	130	14.1	139	16.5	83	9.0	106	11.5	126	15.0
Kialla	62	86.1	70	88.6	65	71.4	7	9.7	4	5.1	14	15.4	3	4.2	5	6.3	12	13.2
Mooroopna	65	53.7	66	61.7	60	53.6	38	31.4	22	20.6	27	24.1	18	14.9	19	17.8	25	22.3
Shepparton central	64	78.0	62	72.1	43	74.1	13	15.9	11	12.8	8	13.8	5	6.1	13	15.1	7	12.1
Shepparton north east	58	84.1	53	89.8	31	79.5	7	10.1	3	5.1	4	10.3	4	5.8	3	5.1	4	10.3
Shepparton north west	51	73.9	90	82.6	65	69.1	9	13.0	10	9.2	18	19.1	9	13.0	9	8.3	11	11.7
Shepparton Rural East	10	62.5	-		16	100.0	6	37.5	-		0	0.0	0	0.0	-		0	0.0
Shepparton Rural North	22	75.9	19	95.0	11	73.3	5	17.2	1	5.0	3	20.0	2	6.9	0	0.0	1	6.7
Shepparton Rural North West	38	79.2	33	84.6	28	90.3	7	14.6	4	10.3	2	6.5	3	6.3	2	5.1	1	3.2
Shepparton Rural South	33	80.5	26	61.9	16	53.3	6	14.6	15	35.7	11	36.7	2	4.9	1	2.4	3	10.0
Shepparton South East	168	72.7	141	60.3	134	58.3	33	14.3	50	21.4	40	17.4	30	13.0	43	18.4	56	24.3
Shepparton surrounds East	18	69.2	16	80.0	23	95.8	6	23.1	2	10.0	0	0.0	2	7.7	2	10.0	1	4.2
Shepparton surrounds North	19	82.6	14	70.0	18	69.2	2	8.7	5	25.0	5	19.2	2	8.7	1	5.0	3	11.5
Shepparton surrounds South	28	90.3	20	95.2	21	95.5	3	9.7	0	0.0	1	4.5	0	0.0	1	4.8	0	0.0
Tatura	53	82.8	66	90.4	46	85.2	8	12.5	2	2.7	6	11.1	3	4.7	5	6.8	2	3.7

Vuln 1 | Vuln 2

Results for vulnerability summary indicators

Table 6.6 – Vulnerable on one or more domain(s) and two or more domains at the national, state/territory, community and local community levels.

Region (including local communities)	Vulnerable on one or more domain(s)						Vulnerable on two or more domains					
	2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%
Australia	59,933	22.0	62,960	22.0	63,448	21.7	29,543	10.8	31,754	11.1	32,434	11.0
VIC	12,407	19.5	13,465	19.9	14,232	19.9	6,053	9.5	6,707	9.9	7,231	10.1
Greater Shepparton	225	24.6	244	26.5	259	30.8	107	11.6	136	14.8	163	19.4
Kialla	9	12.5	11	13.9	19	20.9	3	4.2	6	7.6	9	9.9
Mooroopna	64	52.9	40	37.4	54	48.2	33	27.3	23	21.5	36	32.1
Shepparton central	18	22.5	24	27.9	19	32.8	7	8.6	17	19.8	12	20.7
Shepparton north east	8	11.8	7	11.9	9	23.1	2	2.9	3	5.1	4	10.3
Shepparton north west	21	30.0	28	25.7	30	31.9	13	18.6	16	14.7	18	19.1
Shepparton Rural East	5	31.3	-		2	12.5	2	12.5	-		1	6.3
Shepparton Rural North	4	13.8	2	10.0	3	20.0	1	3.4	1	5.0	2	13.3
Shepparton Rural North West	9	18.8	7	17.9	2	6.5	4	8.3	2	5.1	2	6.5
Shepparton Rural South	2	4.9	4	9.5	8	26.7	1	2.4	0	0.0	3	10.0
Shepparton South East	61	27.2	89	38.0	94	40.9	28	12.2	51	21.8	63	27.4
Shepparton surrounds East	8	30.8	5	25.0	3	12.5	4	15.4	4	20.0	2	8.3
Shepparton surrounds North	4	17.4	5	25.0	7	26.9	3	13.0	3	15.0	6	23.1
Shepparton surrounds South	2	6.5	6	28.6	1	4.5	2	6.5	2	9.5	0	0.0
Tatura	10	15.6	12	16.4	8	14.8	4	6.3	6	8.2	5	9.3

Appendix 1: Critical difference estimates

The critical difference method was developed to help communities understand if the change in the percentage of children considered developmentally on track, at risk or vulnerable over time is significant. The community may have a different number of children with valid scores on each of the AEDC domains and summary indicators from one collection to another. The smaller of the two numbers should be used in the critical difference table. The total number of valid instruments by each domain and summary indicator required to calculate the critical difference have been included in Tables A5 and A6.

For more information on the calculation of the critical difference, see the AEDC technical report Calculation of the critical difference **(www.aedc.gov.au/trcd).**

Worked example

If the community of Sometown had 56 children with a valid score in the social competence domain in 2015 and 81 children in 2018, then you should find the row in the correct category of developmentally on track, at risk or vulnerable, that is relevant for a community with 56 children (not 81 children), and look at the critical difference in that row (the 40-59 children row).

Table A1 shows that Sometown would need to see a change of at least 8.0 percentage points to represent a significant change between 2015 and 2018 in the percentage developmentally on track in the social competence domain.

The critical difference calculation takes into account the number of children included in the AEDC data collections and variation between teachers in the way they assess children.

Critical difference for developmentally on track children

This table provides information on the critical difference required to indicate a significant change for communities of different sizes for children who are developmentally on track on each of the five developmental domains.

Table A1 – On track critical difference percentage points for the five AEDC domains.

Community size (number of children)	Developmentally on track critical difference percentage points				
	Physical health and wellbeing (%)	Social competence (%)	Emotional maturity (%)	Language and cognitive skills (school-based) (%)	Communication skills and general knowledge (%)
15-19	17.3	12.9	13.5	13.9	15.6
20-24	15.0	11.2	11.7	12.0	13.5
25-29	13.4	10.1	10.5	10.8	12.1
30-39	12.3	9.2	9.6	9.9	11.1
40-59	10.6	8.0	8.4	8.6	9.6
60-79	8.7	6.6	6.9	7.0	7.8
80-99	7.6	5.7	6.0	6.1	6.8
100-199	6.8	5.1	5.4	5.5	6.1
200-299	4.8	3.7	3.8	3.9	4.3
300-699	3.9	3.0	3.1	3.2	3.5
700-1,499	2.6	2.0	2.1	2.1	2.3
1,500-2,499	1.8	1.4	1.4	1.5	1.6
2,500-3,499	1.4	1.1	1.1	1.1	1.2
3,500-6,000	1.2	0.9	1.0	1.0	1.0

Critical difference for developmentally at risk children

This table provides information on the critical difference required by domain to indicate a significant change for communities of different sizes for children who are developmentally at risk.

Table A2 – At risk critical difference percentage points for the five AEDC domains.

Community size (number of children)	Developmentally at risk critical difference percentage points				
	Physical health and wellbeing (%)	Social competence (%)	Emotional maturity (%)	Language and cognitive skills (school-based) (%)	Communication skills and general knowledge (%)
15-19	18.2	16.5	17.9	17.6	19.0
20-24	15.8	14.3	15.5	15.2	16.4
25-29	14.1	12.8	13.8	13.6	14.7
30-39	12.9	11.7	12.6	12.5	13.4
40-59	11.2	10.2	10.9	10.8	11.6
60-79	9.2	8.3	8.9	8.8	9.5
80-99	7.9	7.2	7.7	7.6	8.2
100-199	7.1	6.5	6.9	6.8	7.4
200-299	5.0	4.6	4.9	4.8	5.2
300-699	4.1	3.8	4.0	4.0	4.3
700-1,499	2.7	2.5	2.6	2.6	2.8
1,500-2,499	1.9	1.7	1.8	1.8	1.9
2,500-3,499	1.4	1.3	1.4	1.4	1.5
3,500-6,000	1.2	1.1	1.2	1.2	1.2

Critical difference for developmentally vulnerable children

This table provides information on the critical difference required by domain to indicate a significant change for communities of different sizes for children who are developmentally vulnerable.

Table A3 – Developmentally vulnerable critical difference percentage points for the five AEDC domains.

Community size (number of children)	Developmentally vulnerable critical difference percentage points				
	Physical health and wellbeing (%)	Social competence (%)	Emotional maturity (%)	Language and cognitive skills (school-based) (%)	Communication skills and general knowledge (%)
15-19	14.8	9.9	11.9	10.9	13.2
20-24	12.8	8.6	10.3	9.5	11.4
25-29	11.5	7.7	9.2	8.5	10.2
30-39	10.5	7.1	8.3	7.7	9.3
40-59	9.1	6.2	7.2	6.7	8.1
60-79	7.5	5.1	5.8	5.5	6.6
80-99	6.5	4.4	5.0	4.7	5.7
100-199	5.8	3.9	4.5	4.3	5.1
200-299	4.1	2.8	3.1	3.0	3.6
300-699	3.4	2.3	2.5	2.5	2.9
700-1,499	2.2	1.5	1.6	1.6	1.9
1,500-2,499	1.5	1.1	1.1	1.1	1.3
2,500-3,499	1.2	0.8	0.9	0.9	1.0
3,500-6,000	1.0	0.7	0.7	0.7	0.9

Table A4 – Developmentally vulnerable critical difference percentage points for summary indicators.

Community size (number of children)	Developmentally vulnerable critical difference percentage points	
	Vulnerable on one or more domain(s) (%)	Vulnerable on two or more domains (%)
15-19	17.4	12.5
20-24	15.1	10.8
25-29	13.5	9.7
30-39	12.3	8.8
40-59	10.7	7.7
60-79	8.7	6.3
80-99	7.5	5.4
100-199	6.7	4.9
200-299	4.7	3.5
300-699	3.9	2.8
700-1,499	2.5	1.9
1,500-2,499	1.7	1.3
2,500-3,499	1.3	1.0
3,500-6,000	1.1	0.8

Table A5 – Total number of valid instruments by domain (2012, 2015, 2018): Australia, state/territory, community and local community.

Region (including local communities)	Physical health and wellbeing			Social competence			Emotional maturity		
	2012	2015	2018	2012	2015	2018	2012	2015	2018
Australia	273,922	286,913	293,894	273,534	286,848	293,878	272,682	285,801	292,806
VIC	64,061	67,871	71,892	63,896	67,860	71,902	63,775	67,617	71,609
Greater Shepparton	917	922	842	925	921	842	915	921	842
Kialla	72	79	91	72	79	91	72	79	91
Mooroopna	121	107	112	121	107	112	119	107	112
Shepparton central	80	86	58	82	86	58	80	86	58
Shepparton north east	68	59	39	69	59	39	70	59	39
Shepparton north west	69	109	94	72	109	94	72	109	94
Shepparton Rural East	16	-	16	16	-	16	16	-	16
Shepparton Rural North	29	20	15	29	20	15	29	20	15
Shepparton Rural North West	48	40	31	48	39	31	48	39	31
Shepparton Rural South	41	42	30	41	42	30	41	42	30
Shepparton South East	229	234	230	231	234	230	224	234	230
Shepparton surrounds East	26	20	24	26	20	24	26	20	24
Shepparton surrounds North	23	20	26	23	20	26	23	20	26
Shepparton surrounds South	31	21	22	31	21	22	31	21	22
Tatura	64	73	54	64	73	54	64	73	54

Table A5 (continued) – Total number of valid instruments by domain (2012, 2015, 2018): Australia, state/territory, community and local community

Region (including local communities)	Language and cognitive skills (school-based)			Communication skills and general knowledge		
	2012	2015	2018	2012	2015	2018
Australia	273,896	286,648	293,578	273,855	286,913	293,868
VIC	64,195	67,828	71,848	64,038	67,864	71,893
Greater Shepparton	924	921	842	922	921	842
Kialla	72	79	91	72	79	91
Mooroopna	121	107	112	121	107	112
Shepparton central	82	86	58	82	86	58
Shepparton north east	70	59	39	69	59	39
Shepparton north west	72	109	94	69	109	94
Shepparton Rural East	16	-	16	16	-	16
Shepparton Rural North	29	20	15	29	20	15
Shepparton Rural North West	48	39	31	48	39	31
Shepparton Rural South	41	42	30	41	42	30
Shepparton South East	229	234	230	231	234	230
Shepparton surrounds East	26	20	24	26	20	24
Shepparton surrounds North	23	20	26	23	20	26
Shepparton surrounds South	31	21	22	31	21	22
Tatura	64	73	54	64	73	54

Table A6 – Total number of valid instruments for summary indicators (2012, 2015, 2018): Australia, state/territory, community and local community

Region (including local communities)	Number of children with valid scores (one or more domains)			Number of children with valid scores (two or more domains)		
	2012	2015	2018	2012	2015	2018
Australia	272,282	286,041	292,976	273,275	286,616	293,619
VIC	63,584	67,670	71,671	63,889	67,812	71,828
Greater Shepparton	913	921	842	920	921	842
Kialla	72	79	91	72	79	91
Mooroopna	121	107	112	121	107	112
Shepparton central	80	86	58	81	86	58
Shepparton north east	68	59	39	69	59	39
Shepparton north west	70	109	94	70	109	94
Shepparton Rural East	16	-	16	16	-	16
Shepparton Rural North	29	20	15	29	20	15
Shepparton Rural North West	48	39	31	48	39	31
Shepparton Rural South	41	42	30	41	42	30
Shepparton South East	224	234	230	229	234	230
Shepparton surrounds East	26	20	24	26	20	24
Shepparton surrounds North	23	20	26	23	20	26
Shepparton surrounds South	31	21	22	31	21	22
Tatura	64	73	54	64	73	54

Appendix 2: Additional resources

A variety of resources are available online to help you understand AEDC results and learn more about the scope and purpose of the program. The resources listed below are just some of those available. These can be accessed through the AEDC website (**www.aedc.gov.au**) or alternatively by clicking on the links provided.

Refer to the AEDC User Guides (**www.aedc.gov.au/resources/user-guides**) for ideas and strategies on how to respond to AEDC data and connecting with this community.

Key resources to help you get the most from this Community Profile

For detailed information on AEDC results reporting, refer to the fact sheet Understanding the results (**www.aedc.gov.au/unders**).

The fact sheet Definition of AEDC terms (**www.aedc.gov.au/defterm**) is a valuable guide that describes terminology used throughout the program.

The AEDC Data Explorer (**www.aedc.gov.au/tables**) is a searchable resource that allows comparisons across years and communities. 2018 AEDC community data is available from March 2019.

AEDC resources at a glance

AEDC publications

Important AEDC resources include:

- AEDC National report 2018 (**www.aedc.gov.au/natrep18**)
- Schools sector messages (**www.aedc.gov.au/schsect**)
- Calculation of the critical difference (**www.aedc.gov.au/trcd**)
- Fact sheet library (**www.aedc.gov.au/factsheets**)
  - About the AEDC data collection (**www.aedc.gov.au/abtdata**)
  - About the AEDC domains (**www.aedc.gov.au/abtdom**)
  - Definition of AEDC terms (**www.aedc.gov.au/defterm**)
  - Understanding community boundaries (**www.aedc.gov.au/ucb**)
  - Understanding the results (**www.aedc.gov.au/unders**).

AEDC videos

- Introduction to the AEDC (**www.aedc.gov.au/vi1**)
- Informing your planning (**www.aedc.gov.au/vi2**)
- Understanding the data (**www.aedc.gov.au/vi3**).

Key AEDC web pages

- Resources for communities (**www.aedc.gov.au/communities/resources-for-communities**)
- Communities FAQs (**www.aedc.gov.au/communities/faq-for-communities**)
- AEDC community results tables (**www.aedc.gov.au/tables**)
- Validation and trial of the AEDC (**www.aedc.gov.au/valid**).

28/05/2019- 1300hrs. Meeting with Matthew at SRRP.

- Matthew is happy with his current medication levels but still wanting to reduce them if possible. – Matthew reports he experiences sever hunger cravings that last all day. He finds this distressing and hard to manage. He is currently using will power to resist eating but finds this hard to do all day long. **Appearance-** Dressed in clean casual clothes; No personal hygiene concerns; Good skin color; Eyes clear. **Behavior-** Good eye contact; No abnormal movements or gestures. **Speech-** Good articulation; normal rate, volume and quantity. **Mood/Affect-** Matthew and stated he was feeling good. Affect was congruent with this. **Thought Stream-**Normal speed of thought; Minimal pressured or hesitant thinking. **Thought Content-**No delusions observed; no compulsion or obsessions were prominent at this time. **Thought Form-** Normal amount of thought and production; No disturbance in language. **Perception-** No hallucination of any form reported. **Cognition-** Normal level of alertness and consciousness; orientated to person, time and place. **Insight-** Good capacity to organize and understand problems; Good understanding of illness, triggers and treatment options. **Risk-** No current self-harm urges; No current suicidal thoughts. No urges to harm others. **Plan-** Continue with current medication and treatment. Try drinking water and snacking on raw vegetables to satisfy hunger cravings.

Raelene North. Case Manager. SW 2.4

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RB-5

This is the attachment marked '**RB-5**' referred to in the witness statement of Dr Ravi Subramanya Bhat dated 4 July 2019.

Australian Early Development Census
An Australian Government Initiative

Our Children
Our Communities
Our Future

Australian Early Development Census

Community Profile 2018

Mitchell,
VIC

Since 2002, the Australian Government has worked in partnership with eminent child health research institutes, the Centre for Community Child Health, Royal Children's Hospital, Melbourne, and the Telethon Kids Institute, Perth to deliver the Australian Early Development Census program to communities. The Australian Government continues to work with its partners, and with state and territory governments to implement the AEDC nationwide.

Contents

Note on presentation conventions: the hyphen (-) is used throughout the tables in this Community Profile where Australian Early Development Census data was not collected or not reported for any given year. All percentages presented in this Community Profile have been rounded to one decimal place. Figures may not add up to 100% due to rounding.

Note on links: the symbol is used in this document to highlight links to the Australian Early Development Census website: **www.aedc.gov.au**. These links will connect you with further information and resources.

Note on children with special needs status: domain indicator information about children with special needs is not included in the Australian Early Development Census results because of the already identified substantial developmental needs of this group.

Note on accessibility: an accessible text version of the Australian Early Development Census Community Profile is available for download from the data explorer on the Australian Early Development Census website. If you use assistive technology and need further assistance, please email **support@aedc.gov.au**. Please tell us what format you need. It will also help if you let us know what assistive technology you use.

Note on per cent calculation: unless otherwise specified the per cent is based on the valid n value.

AEDC publication rules have been applied and for more information visit the AEDC website **(https://www.aedc.gov.au/data-users/data-user-responsibilities/publishing-requirements).**

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AEDC-1903-002-1

About the Australian Early Development Census

In 2009, Australia became the first country in the world to collect national data on the developmental health and wellbeing of all children starting school. The success of the 2009 data collection laid the foundation for the Australian Government's commitment to ongoing Australian Early Development Census (AEDC) data collections every three years, with the most recent in 2018.

The AEDC measures the development of children in Australia in their first year of full-time school. AEDC data is collected using an adapted version of the Early Development Instrument, which was developed in Canada.

The Australian version of the Early Development Instrument consists of approximately 100 questions across five key domains, which are closely linked to child health, education and social outcomes. Figure 1 provides a description of each of the AEDC domains.

Figure 1 – AEDC domain descriptions.

Physical health and wellbeing

Children's physical readiness for the school day, physical independence and gross and fine motor skills.

Social competence

Children's overall social competence, responsibility and respect, approach to learning and readiness to explore new things.

Emotional maturity

Children's pro-social and helping behaviours and absence of anxious and fearful behaviour, aggressive behaviour and hyperactivity and inattention.

Language and cognitive skills (school-based)

Children's basic literacy, advanced literacy, basic numeracy, and interest in literacy, numeracy and memory.

Communication skills and general knowledge

Children's communication skills and general knowledge based on broad developmental competencies and skills measured in the school context.

For each of the five AEDC domains, children receive a score between zero and ten, where zero is most developmentally vulnerable.

In 2009, when the AEDC was first completed nationally, a series of cut-off scores was established for each of the five domains:

- Children falling below the 10th percentile were categorised as 'developmentally vulnerable'
- Children falling between the 10th and 25th percentile were categorised as 'developmentally at risk'
- All other children were categorised as 'developmentally on track'.

The cut-off scores set in 2009 provide a reference point against which later AEDC results can be compared. These have remained the same for all data collections. For example, nationally in the 2018 AEDC, only 6.6 per cent of children were considered developmentally vulnerable on the language and cognitive skills (school-based) domain, using the cut-off scores established in 2009.

For further information about the domains and domain characteristics (developmentally on track, at risk and vulnerable) please refer to the fact sheet About the AEDC domains **(www.aedc.gov.au/abtdom)**. Links to additional AEDC resources can be found at Appendix 2.

How to use this AEDC data

The AEDC provides important information for communities, governments and schools to support their planning and service provision. The early environments and experiences children are exposed to shape their development. The AEDC is considered to be a measure of how well children and families are supported from conception through to school age.

Research shows that investing time, effort and resources in children's early years, when their brains are developing rapidly, benefits children and the whole community. Early developmental gains support children through their school years and beyond.

The AEDC helps communities understand how children are developing before they start their first year of full-time school, what is being done well and what can be improved. Communities can use the AEDC to help identify services, resources and support to meet the needs of their community.

The AEDC data is a powerful tool for initiating conversations and partnerships across education, health and community services. By providing a common ground from which key stakeholders can work together, the AEDC can enable communities to form partnerships to plan and implement activities, programs and services to help shape the future and wellbeing of children in Australia. Connecting with key stakeholders, particularly early childhood education and care services, can give communities the opportunity to reach families in ways that are not resource intensive.

When reviewing the information in this profile consider:

- what are the strengths and vulnerabilities of children in the community?
- how does this community compare to other similar communities, the state or territory or the Australian average?
- what factors may be contributing to the percentage and number of children who are developmentally vulnerable in the community?
- what other demographic and community data would be useful to add context to the AEDC data?

When exploring this community's AEDC results you may wish to consider how well connected the network of community stakeholders are and who provides services to children and families. Ask:

- are families well informed about what is available in the community?
- does the community have well established referral pathways for connecting families to services and supports?
- does the community have well-connected services that work collaboratively to deliver programs across systems and sectors?

Also consider how stakeholders can connect strategically with the community and families to:

- be informed about what is happening for children in the community
- discuss what could be done to better support children's development in the early years
- collaborate in the development and implementation of a community plan that strategically provides a vision and direction for early years' service provision within the community.

Refer to the AEDC User Guides (**www.aedc.gov.au/resources/user-guides**) for ideas and strategies on how to respond to AEDC data and connecting with this community.

About this community

AEDC communities are a geographic area, usually equivalent to a Local Government Area, made up of AEDC local communities.

Local communities are a small area locality, usually representing a suburb or town.

This AEDC Community Profile presents AEDC results for children living in this community regardless of where they attend school.

Location

Mitchell is in the Goulburn region of VIC.

For more information on community boundaries refer to the AEDC fact sheet Understanding AEDC community boundaries (**www.aedc.gov.au/ucb**).

AEDC local communities

The AEDC local communities that make up the Mitchell community are: Seymour, Pyalong/Sugarloaf Creek/Tooborac, Puckapunyal, Kilmore/Willowmavin, Wallan/Upper Plenty, Broadford/Clonbinane, Wandong/Heathcote Junction.

Across the 2009, 2012, 2015 and 2018 AEDC data collections some local communities may not have always been included in a Community Profile due to there being insufficient AEDC data available for reporting purposes in any particular year.

For the purposes of the AEDC, data for the following local communities, which are part of Mitchell have either never, or only sometimes, been reported in a Community Profile:

Local communities reported in some but not all years:
Nil

Local communities not reported in any years to date:
Nil

Information about children in this community

The following tables show trends for this community, including important information on demographics, early education experiences, special needs and transition to school.

Background information

Table 4.1 – Demographic information about this community.

Demographics	2012	2015	2018
Total number of children measured	521	525	515
Number of schools contributing to the results	32	33	35
Number of teachers contributing to the results	51	54	59
Mean age of children at completion	5 years 10 months	5 years 9 months	5 years 10 months

Table 4.2 – Further demographic information about this community.

Demographics	2012		2015		2018	
	n	%	n	%	n	%
Sex - Male	289	55.5	278	53.0	262	50.9
Sex - Female	232	44.5	247	47.0	253	49.1
Aboriginal and Torres Strait Islander children	13	2.5	16	3.0	13	2.5
Children born in another country	12	2.3	9	1.7	10	1.9
Children with English as a second language	17	3.3	22	4.2	20	3.9
Children with a language background other than English (LBOTE[1]) and who ARE proficient in English	15	2.9	27	5.1	26	5.1
Children with a language background other than English (LBOTE) and who ARE NOT proficient in English	4	0.8	≤3	≤0.6	≤3	≤0.6
Children with a primary caregiver who reported they completed some form of post-school qualification[2]	-		363	71.7	395	80.1

[1] For the AEDC, children are considered LBOTE if they speak a language other than English at home or if they have English as a second language status. More information on AEDC terms and definitions is available in the fact sheet Definition of AEDC terms **(www.aedc.gov.au/defterm)**.

[2] This data was not collected for the 2009 and 2012 AEDC

Non-parental early childhood education

Table 4.3 – Non-parental early childhood education and/or care.[3]

Types of non-parental early childhood education and/or care	2012			2015			2018		
	n (valid)	n (yes)	%	n (valid)	n (yes)	%	n (valid)	n (yes)	%
Playgroup	136	37	27.2	79	52	65.8	152	55	36.2
Day care	280	74	26.4	238	56	23.5	264	44	16.7
Preschool or kindergarten	474	459	96.8	479	461	96.2	489	468	95.7
Family day care	226	12	5.3	225	5	2.2	259	6	2.3
Grandparent	209	43	20.6	223	36	16.1	265	45	17.0
Other relative	193	8	4.1	224	24	10.7	263	19	7.2
Nanny	234	≤3	≤1.3	236	4	1.7	287	4	1.4
Other	202	7	3.5	221	5	2.3	265	8	3.0

Special needs

Table 4.4 – Support.[4]

Types of support required or identified	2012		2015		2018	
	n	%	n	%	n	%
Children with special needs status	22	4.2	21	4.0	35	6.8
Children identified by teachers as requiring further assessment (e.g. medical and physical, behaviour management, emotional and cognitive development)	56	11.1	65	12.7	68	13.6

[3] Although teachers are well placed to report on the development of children, the extent to which teachers know about children's early education and care experiences varies. Nevertheless, early education and care data is collected in the AEDC to support communities, governments and researchers better reflect on and respond to the experiences of children and families. In cases where teachers don't know they indicate this, and these cases are excluded from Table 4.3. When reviewing data, consider how many children in the community this represents and how reliably this might reflect the experience of children in the community as a whole. Playgroup attendance refers to any time prior to entering full-time school, whereas all the other types of care arrangements listed above refer to the year before entering full-time school.

[4] For the AEDC, this means children identified already as requiring special assistance in the classroom with high needs due to chronic medical, physical, or intellectually disabling conditions. Teachers were asked to base their response on medical diagnosis. More information on AEDC terms and definitions is available in the fact sheet Definition of AEDC terms **(www.aedc.gov.au/defterm)**.

Transition to school

Table 4.5 – Teachers' response to the question: Would you say that this child is making good progress in adapting to the structure and learning environment of the school.

Child is making good progress in adapting to the structure and learning environment of the school	2012		2015		2018	
	n	%	n	%	n	%
True	513	98.5	510	97.1	492	95.7
Not true	7	1.3	15	2.9	22	4.3
Don't know	≤3	≤0.6	0	0.0	0	0.0

Table 4.6 – Teachers' response to the question: Would you say that this child has parent(s)/caregiver(s) who are actively engaged with the school in supporting their child's learning.

Child has parent(s)/caregiver(s) who are actively engaged with the school in supporting their child's learning	2012		2015		2018	
	n	%	n	%	n	%
True	484	92.9	491	93.5	481	93.6
Not true	35	6.7	30	5.7	33	6.4
Don't know	≤3	≤0.6	4	0.8	0	0.0

Table 4.7 – Teachers' response to the question: Would you say that this child is regularly read to/encouraged in his/her reading at home.

Child is regularly read to/encouraged in his/her reading at home	2012		2015		2018	
	n	%	n	%	n	%
True	480	92.1	487	92.8	476	92.6
Not true	38	7.3	34	6.5	37	7.2
Don't know	≤3	≤0.6	4	0.8	≤3	≤0.6

AEDC domain results

This section presents an overview of this community's AEDC results across all collections including the percentage of children who are:

- developmentally on track, at risk, or vulnerable, by domain
- vulnerable on one or more domain(s)
- vulnerable on two or more domains.

Results for this community for each of the AEDC domains are then presented in more detail and compared to the state or territory and national results for the three most recent collections.

How to interpret the domain results

Developmentally on track children are considered to be developing well. As such, it is desirable to see the percentage of children who are 'on track' increase with each new wave of the AEDC collection.

Developmentally at risk children should be considered alongside changes in the percentage of children developmentally on track and developmentally vulnerable. Ideally more children will be on track as communities work to ensure all children are supported in their development. For example, in a community where children and families face many complex challenges, a reduction in those who are developmentally vulnerable could coincide with an increase in those at risk which would signal an overall improvement. As such, any changes in the 'at risk' group cannot be interpreted without also looking at the percentage of children who are vulnerable and on track.

Developmentally vulnerable children are facing some significant challenges in their development. As such, it is desirable to see the percentage of children who are 'vulnerable' decrease with each new wave of the AEDC collection.

How to compare your results

Most communities will see some change in the percentage of children who are developmentally on track, at risk or vulnerable in 2018 compared to previous collections. In some cases, this difference will be small and in others, it will be more substantial.

To assist communities to make informed decisions, a method described as the 'critical difference' has been developed which calculates whether the change in percentage of children considered developmentally on track, at risk or vulnerable over time is large enough to be considered significant.

The critical difference is the minimum percentage point change required between collections for the results to represent a 'significant change' in children's development. Table 5.1 indicates whether the change in each developmental domain category represents a significant change.

Appendix 1 provides detailed information on the critical difference required by domain and community size to represent a significant change for children who are developmentally on track, at risk or vulnerable.

Trends in child development in this community

Figures 5.1 to 5.5 show broad trends for each domain from 2009 to 2018. Results are also presented in tabular format in Table 5.1.

Figure 5.1 – Trends in the physical health and wellbeing domain for this community.

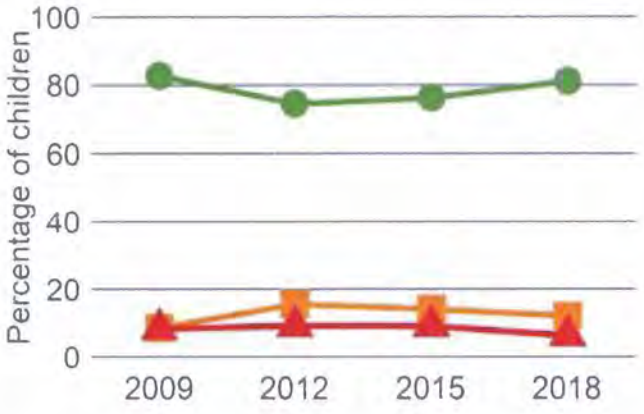


Figure 5.2 – Trends in the social competence domain for this community.

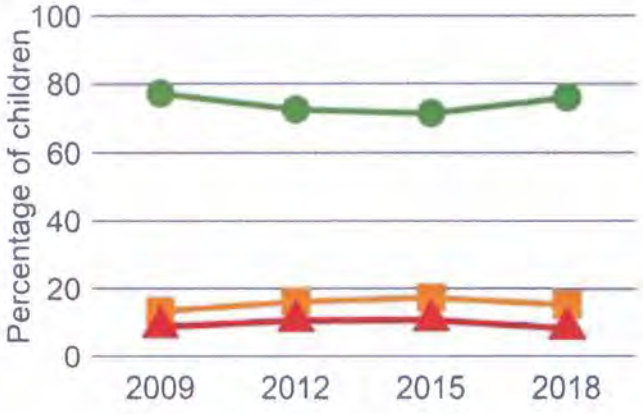


Figure 5.3 – Trends in the emotional maturity domain for this community.

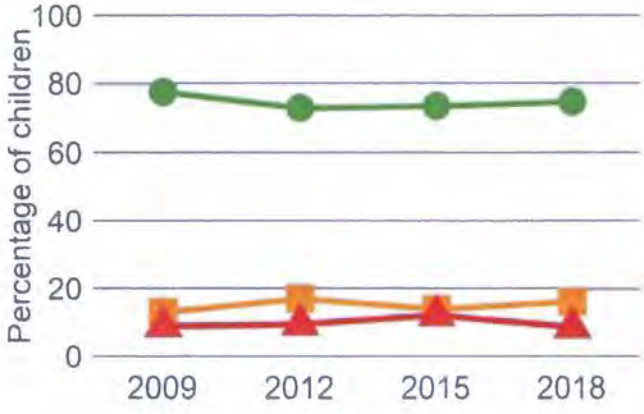


Figure 5.4 – Trends in the language and cognitive skills (school-based) domain for this community.

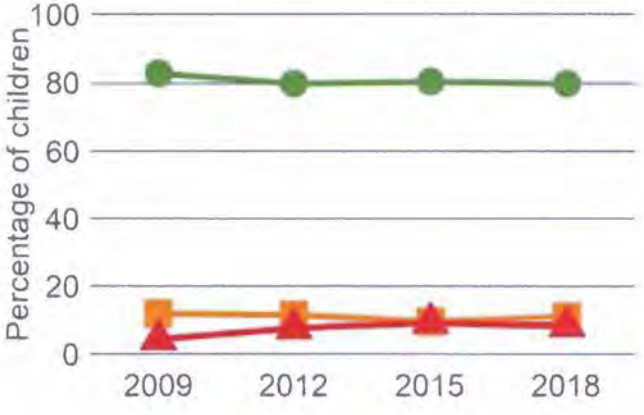


Figure 5.5 – Trends in the communication skills and general knowledge domain for this community.

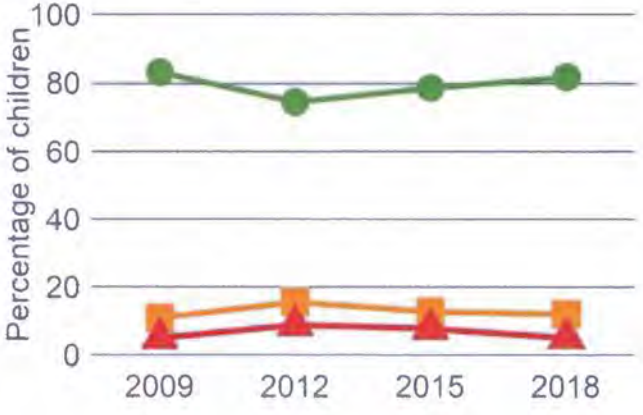


Table 5.1 – AEDC domain results over time for this community.

		2009		2012		2015		2018		Significant change	
		n	%	n	%	n	%	n	%	2009 vs 2018	2015 vs 2018
Physical health and wellbeing	On track	389	82.8	373	74.7	385	76.4	389	81.2	No significant change	Significant increase
	At risk	41	8.7	79	15.8	72	14.3	59	12.3	Significant increase	No significant change
	Vulnerable	40	8.5	47	9.4	47	9.3	31	6.5	No significant change	Significant decrease
Social competence	On track	364	77.4	363	72.7	361	71.6	365	76.2	No significant change	Significant increase
	At risk	64	13.6	82	16.4	88	17.5	74	15.4	No significant change	No significant change
	Vulnerable	42	8.9	54	10.8	55	10.9	40	8.4	No significant change	Significant decrease
Emotional maturity	On track	365	77.7	365	73.1	371	73.6	357	74.8	Significant decrease	No significant change
	At risk	62	13.2	86	17.2	71	14.1	78	16.4	No significant change	No significant change
	Vulnerable	43	9.1	48	9.6	62	12.3	42	8.8	No significant change	Significant decrease
Language and cognitive skills (school-based)	On track	391	83.0	399	80.0	406	80.6	383	80.0	Significant decrease	No significant change
	At risk	58	12.3	60	12.0	50	9.9	55	11.5	No significant change	No significant change
	Vulnerable	22	4.7	40	8.0	48	9.5	41	8.6	Significant increase	No significant change
Communication skills and general knowledge	On track	393	83.4	373	74.7	397	78.8	393	82.0	No significant change	Significant increase
	At risk	53	11.3	80	16.0	66	13.1	60	12.5	No significant change	No significant change
	Vulnerable	25	5.3	46	9.2	41	8.1	26	5.4	No significant change	Significant decrease

Significant change has been colour coded: green text represents a positive change, red text represents a negative change. At risk has not been colour coded as any changes should be interpreted in context with changes in the percentage of children who are vulnerable and on track.

Table 5.2 and Figure 5.6 present trends in the summary indicators (the percentage of children who are developmentally vulnerable on one or more domain(s) and developmentally vulnerable on two or more domains) from 2009 to 2018.

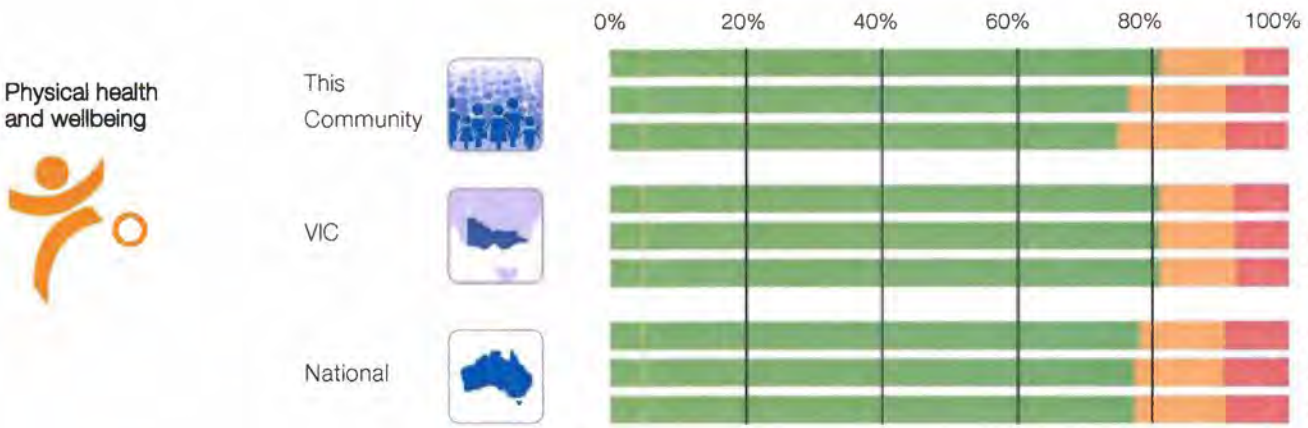
Table 5.2 – Number and percentage of children for this community who are vulnerable on one or more developmental domain(s) or two or more developmental domains.

	2009		2012		2015		2018		Significant change	
	n	%	n	%	n	%	n	%	2009 vs 2018	2015 vs 2018
Vulnerable on one or more domain(s)	93	19.8	127	25.5	126	25.0	96	20.1	No significant change	
Vulnerable on two or more domains	43	9.1	62	12.4	64	12.7	50	10.4	No significant change	

Figure 5.6 – Community trends of vulnerability over time.

Physical health and wellbeing

This domain measures children's physical readiness for the school day, physical independence, and gross and fine motor skills



		Developmentally on track		Developmentally at risk		Developmentally vulnerable	
		n	%	n	%	n	%
This Community	2018	389	81.2	59	12.3	31	6.5
	2015	385	76.4	72	14.3	47	9.3
	2012	373	74.7	79	15.8	47	9.4
VIC	2018	58,221	81.0	7,767	10.8	5,904	8.2
	2015	54,934	80.9	7,602	11.2	5,335	7.9
	2012	51,985	81.1	7,111	11.1	4,965	7.8
National	2018	229,542	78.1	36,105	12.3	28,247	9.6
	2015	221,855	77.3	37,347	13.0	27,711	9.7
	2012	211,806	77.3	36,637	13.4	25,479	9.3

Table 5.3 — Physical health and wellbeing domain category definitions.

Developmentally on track	Almost never have problems that interfere with their ability to physically cope with the school day. These children are generally independent, have excellent motor skills, and have energy levels that can get them through the school day.
Developmentally at risk	Experience some challenges that interfere with their ability to physically cope with the school day. This may include being dressed inappropriately, frequently late, hungry or tired. Children may also show poor coordination skills, have poor fine and gross motor skills, or show poor to average levels of energy during the school day.
Developmentally vulnerable	Experience a number of challenges that interfere with their ability to physically cope with the school day. This may include being dressed inappropriately, frequently late, hungry or tired. Children are usually clumsy and may have fading energy levels.

Physical health and wellbeing sub-domains

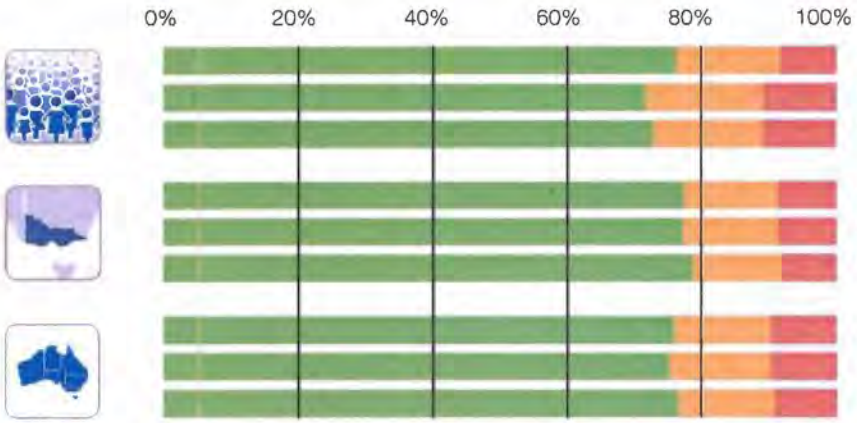
The physical health and wellbeing domain is the only AEDC domain that is reported with sub-domain analysis. Patterns of vulnerability vary across the physical health and wellbeing domain: for example, children might be coming to school hungry but still have developmentally appropriate fine and gross motor skills. As such, sub-domains are reported for the physical health and wellbeing domain below, enabling communities to make better sense of these results.

Table 5.4 – Children developmentally vulnerable on the physical health and wellbeing sub-domains.

Sub-domain	Description	2012		2015		2018	
		n	%	n	%	n	%
Physical readiness for school day	Children developmentally vulnerable on this sub-domain have at least sometimes experienced coming unprepared for school by being dressed inappropriately, coming to school late, hungry or tired.	61	12.2	39	7.7	48	10.0
Physical independence	Children developmentally vulnerable on this sub-domain range from those who have not developed independence or handedness or coordination, to those who have not developed any of these skills.	37	7.4	33	6.5	38	7.9
Gross and fine motor skills	Children developmentally vulnerable on this sub-domain could have poor fine and gross motor skills and/or poor overall energy levels during the school day.	43	8.6	46	9.1	29	6.1

Social competence

This domain measures children's overall social competence, responsibility and respect, approach to learning and readiness to explore new things



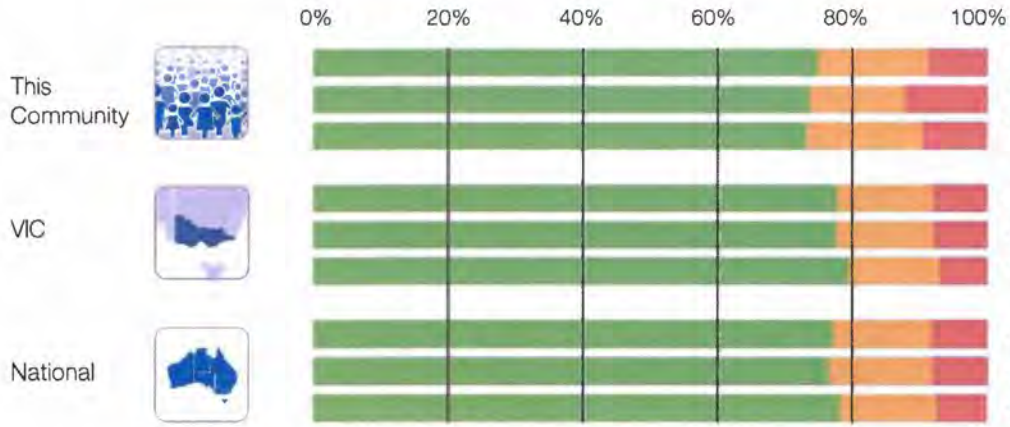
		Developmentally on track		Developmentally at risk		Developmentally vulnerable	
		n	%	n	%	n	%
This Community	2018	365	76.2	74	15.4	40	8.4
	2015	361	71.6	88	17.5	55	10.9
	2012	363	72.7	82	16.4	54	10.8
VIC	2018	55,597	77.3	9,974	13.9	6,331	8.8
	2015	52,378	77.2	9,548	14.1	5,934	8.7
	2012	50,226	78.6	8,519	13.3	5,151	8.1
National	2018	222,771	75.8	42,434	14.4	28,673	9.8
	2015	215,605	75.2	42,892	15.0	28,351	9.9
	2012	209,149	76.5	39,018	14.3	25,367	9.3

Table 5.5 — Social competence domain category definitions.

Developmentally on track	Almost never have problems getting along, working, or playing with other children; are respectful to adults, are self-confident, and are able to follow class routines; and are capable of helping others.
Developmentally at risk	Experience some challenges in the following areas: getting along with other children and teachers, playing with a variety of children in a cooperative manner, showing respect for others and for property, following instructions and class routines, taking responsibility for their actions, working independently, and exhibiting self-control and self-confidence.
Developmentally vulnerable	Experience a number of challenges with poor overall social skills. For example children who do not get along with other children on a regular basis, do not accept responsibility for their own actions and have difficulties following rules and class routines. Children may be disrespectful of adults, children, and others' property, have low self-confidence and self-control, do not adjust well to change; and are usually unable to work independently.

Emotional maturity

This domain measures children's pro-social and helping behaviours and absence of anxious and fearful behaviour, aggressive behaviour and hyperactivity and inattention



		Developmentally on track		Developmentally at risk		Developmentally vulnerable	
		n	%	n	%	n	%
This Community	2018	357	74.8	78	16.4	42	8.8
	2015	371	73.6	71	14.1	62	12.3
	2012	365	73.1	86	17.2	48	9.6
VIC	2018	55,651	77.7	10,167	14.2	5,791	8.1
	2015	52,392	77.5	9,817	14.5	5,408	8.0
	2012	50,605	79.3	8,604	13.5	4,566	7.2
National	2018	225,739	77.1	42,390	14.5	24,677	8.4
	2015	218,341	76.4	43,594	15.3	23,866	8.4
	2012	213,059	78.1	38,778	14.2	20,845	7.6

Table 5.6 — Emotional maturity domain category definitions.

Developmentally on track	Almost never show aggressive, anxious, or impulsive behaviour. Children will have good concentration and will often help other children.
Developmentally at risk	Experience some challenges in the following areas: helping other children who are hurt, sick or upset, inviting other children to join in activities, being kind to other children, and waiting their turn in activities. Children will sometimes experience problems with anxious behaviours, aggressive behaviour, temper tantrums, or problems with inattention or hyperactivity.
Developmentally vulnerable	Experience a number of challenges related to emotional regulation. For example, problems managing aggressive behaviour, being prone to disobedience and/or are easily distracted, inattentive, and impulsive. Children will usually not help others and are sometimes upset when left by their caregiver.

Language and cognitive skills (school-based)

This domain measures children's basic literacy, advanced literacy, basic numeracy, and interest in literacy, numeracy and memory

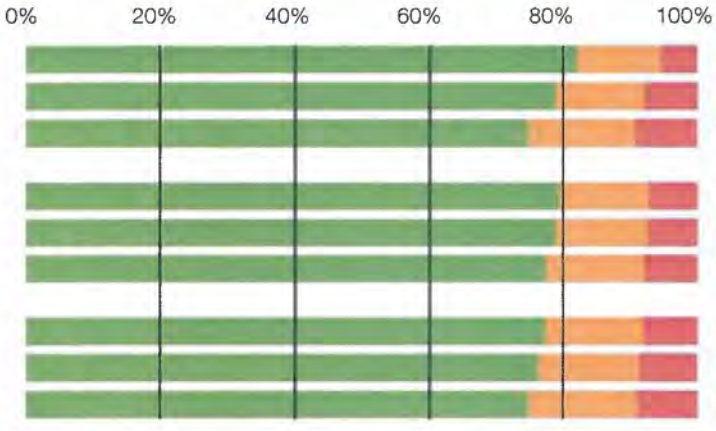
		Developmentally on track		Developmentally at risk		Developmentally vulnerable	
		n	%	n	%	n	%
This Community	2018	383	80.0	55	11.5	41	8.6
	2015	406	80.6	50	9.9	48	9.5
	2012	399	80.0	60	12.0	40	8.0
VIC	2018	60,779	84.6	6,461	9.0	4,608	6.4
	2015	57,474	84.7	6,062	8.9	4,292	6.3
	2012	53,929	84.0	6,351	9.9	3,915	6.1
National	2018	247,870	84.4	26,291	9.0	19,417	6.6
	2015	242,518	84.6	25,597	8.9	18,533	6.5
	2012	226,260	82.6	29,072	10.6	18,564	6.8

Table 5.7 — Language and cognitive skills (school-based) domain category definitions.

Developmentally on track	Children will be interested in books, reading and writing, and basic math; capable of reading and writing simple sentences and complex words. Will be able to count and recognise numbers and shapes.
Developmentally at risk	Have mastered some but not all of the following literacy and numeracy skills: being able to identify some letters and attach sounds to some letters, show awareness of rhyming words, know writing directions, being able to write their own name, count to 20, recognise shapes and numbers, compare numbers, sort and classify, and understand simple time concepts. Children may have difficultly remembering things, and show a lack of interest in books, reading, maths and numbers, and may not have mastered more advanced literacy skills such as reading and writing simple words or sentences.
Developmentally vulnerable	Experience a number of challenges in reading/writing and with numbers; unable to read and write simple words, will be uninterested in trying, and often unable to attach sounds to letters. Children will have difficulty remembering things, counting to 20, and recognising and comparing numbers; and usually not interested in numbers.

Communication skills and general knowledge

This domain measures children's communication skills and general knowledge based on broad developmental competencies and skills measured in the school context



		Developmentally on track		Developmentally at risk		Developmentally vulnerable	
		n	%	n	%	n	%
This Community	2018	393	82.0	60	12.5	26	5.4
	2015	397	78.8	66	13.1	41	8.1
	2012	373	74.7	80	16.0	46	9.2
VIC	2018	57,098	79.4	9,483	13.2	5,312	7.4
	2015	53,474	78.8	9,259	13.6	5,131	7.6
	2012	49,557	77.4	9,371	14.6	5,110	8.0
National	2018	227,163	77.3	42,473	14.5	24,232	8.2
	2015	219,023	76.3	43,415	15.1	24,475	8.5
	2012	204,702	74.7	44,633	16.3	24,520	9.0

Table 5.8 — Communication skills and general knowledge domain category definitions.

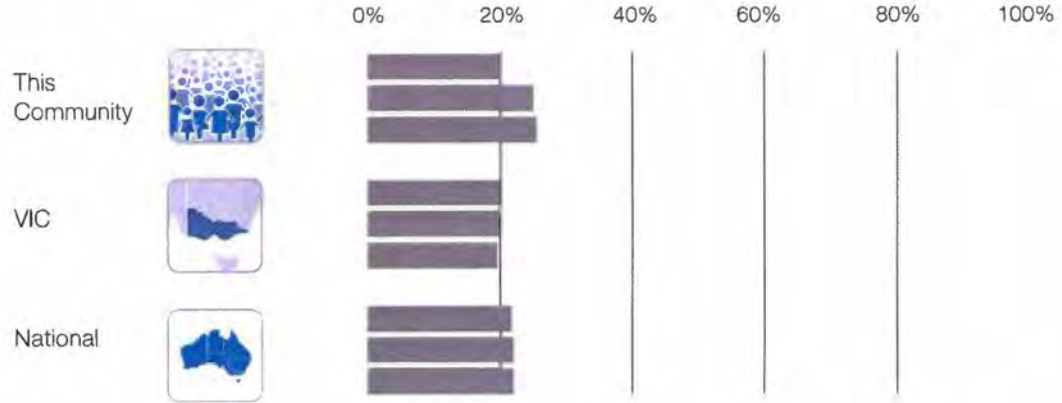
Developmentally on track	Children will have excellent communication skills, can tell a story and communicate easily with both children and adults, and have no problems with articulation.
Developmentally at risk	Have mastered some but not all of the following communication skills: listening, understanding and speaking effectively in English, being able to articulate clearly, being able to tell a story and to take part in imaginative play. Children may not know some basic general knowledge about the world such as knowing that leaves fall in autumn, apple is fruit, and dogs bark.
Developmentally vulnerable	Children will have poor communication skills and articulation; have limited command of English (or the language of instruction), have difficulties talking to others, understanding, and being understood; and have poor general knowledge.

Developmentally vulnerable on ≥1 and ≥2 domain(s)

Summary indicators of developmental vulnerability on 'one or more' and on 'two or more' domains

Developmentally vulnerable on one or more domain(s)

Vuln 1



	n	%
2018	96	20.1
2015	126	25.0
2012	127	25.5
2018	14,232	19.9
2015	13,465	19.9
2012	12,407	19.5
2018	63,448	21.7
2015	62,960	22.0
2012	59,933	22.0

Developmentally vulnerable on two or more domains

Vuln 2

	n	%
2018	50	10.4
2015	64	12.7
2012	62	12.4
2018	7,231	10.1
2015	6,707	9.9
2012	6,053	9.5
2018	32,434	11.0
2015	31,754	11.1
2012	29,543	10.8

AEDC results for local communities

This section presents national, state/territory, community and local community results for each of the five AEDC domains, as well as the two summary indicators (vulnerable on one or more domain(s) and vulnerable on two or more domains) for the last three collections.

AEDC geographic boundaries have been defined for the whole country to ensure that the data is reported in the most useful way that aligns with commonly understood geographies, such as suburbs. These boundaries enable AEDC results to be reported at the four different geographic levels.

AEDC local communities represent the smallest geographic areas. In most cases, AEDC local community boundaries are equivalent to suburbs.

To enable accurate comparisons with the Census of Population and Housing, and other socio-demographic data from the Australian Bureau of Statistics (ABS), 2018 AEDC boundaries align with the Statistical Area 1 (SA1) geography released by the ABS in 2016.

This has resulted in minor changes in boundaries, relative to boundaries used for reporting of community results for previous collections, which were based on 2011 ABS geographies.

In some cases, local communities from previous collections may have been combined to have sufficient numbers of children for reporting purposes in 2018. In other cases, local communities from previous collections may have been split to report 2018 data in a more useful way.

In all cases, 2018 boundaries have been applied to data from previous collections.

The following tables show the number and percentage of children developmentally on track, at risk and vulnerable for this community. The tables also provide data for each of the local communities included as part of the aggregate total. They also show community, state/territory and national data to provide context for:

- each of the 2012, 2015 and 2018 AEDC data collections
- the AEDC domains:
  - physical health and wellbeing
  - social competence
  - emotional maturity
  - language and cognitive skills (school-based)
  - communication skills and general knowledge.
- the two summary indicators:
  - developmentally vulnerable on one or more domain(s)
  - developmentally vulnerable on two or more domains.

The history of boundary change means that some local communities may not have data for all years in this section. For more information, refer to the AEDC factsheet Understanding community boundaries (**www.aedc.gov.au/ucb**).

Appendix 1 presents the critical difference estimates for communities of different sizes, which can be used to understand whether change over time is considered significant.

Physical health and wellbeing domain results

This domain measures children's physical readiness for the school day, physical independence, and gross and fine motor skills.

Table 6.1 – Communities in context: Physical health and wellbeing domain results at the national, state/territory, community and local community levels.

Region (including local communities)	Developmentally on track						Developmentally at risk						Developmentally vulnerable					
	2012		2015		2018		2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Australia	211,806	77.3	221,855	77.3	229,542	78.1	36,637	13.4	37,347	13.0	36,105	12.3	25,479	9.3	27,711	9.7	28,247	9.6
VIC	51,985	81.1	54,934	80.9	58,221	81.0	7,111	11.1	7,602	11.2	7,767	10.8	4,965	7.8	5,335	7.9	5,904	8.2
Mitchell	373	74.7	385	76.4	389	81.2	79	15.8	72	14.3	59	12.3	47	9.4	47	9.3	31	6.5
Broadford-Clonbinane	45	63.4	60	70.6	57	85.1	19	26.8	17	20.0	6	9.0	7	9.9	8	9.4	4	6.0
Kilmore-Willowmavin	92	73.6	91	81.3	94	83.2	17	13.6	12	10.7	15	13.3	16	12.8	9	8.0	4	3.5
Puckapunyal	18	69.2	22	66.7	15	51.7	4	15.4	6	18.2	10	34.5	4	15.4	5	15.2	4	13.8
Pyalong-Sugarloaf Creek-Tooborac	32	78.0	22	68.8	21	80.8	5	12.2	6	18.8	3	11.5	4	9.8	4	12.5	2	7.7
Seymour	49	75.4	32	59.3	57	73.1	9	13.8	11	20.4	12	15.4	7	10.8	11	20.4	9	11.5
Wallan-Upper Plenty	113	80.7	131	84.5	118	87.4	20	14.3	15	9.7	10	7.4	7	5.0	9	5.8	7	5.2
Wandong-Heathcote Junction	24	77.4	27	81.8	27	87.1	5	16.1	5	15.2	3	9.7	2	6.5	1	3.0	1	3.2

Social competence domain results

This domain measures children's overall social competence, responsibility and respect, approaches to learning, and readiness to explore new things.

Table 6.2 – Communities in context: Social competence domain results at the national, state/territory, community and local community levels.

Region (including local communities)	Developmentally on track						Developmentally at risk						Developmentally vulnerable					
	2012		2015		2018		2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Australia	209,149	76.5	215,605	75.2	222,771	75.8	39,018	14.3	42,892	15.0	42,434	14.4	25,367	9.3	28,351	9.9	28,673	9.8
VIC	50,226	78.6	52,378	77.2	55,597	77.3	8,519	13.3	9,548	14.1	9,974	13.9	5,151	8.1	5,934	8.7	6,331	8.8
Mitchell	363	72.7	361	71.6	365	76.2	82	16.4	88	17.5	74	15.4	54	10.8	55	10.9	40	8.4
Broadford-Clonbinane	49	69.0	65	76.5	49	73.1	13	18.3	9	10.6	17	25.4	9	12.7	11	12.9	1	1.5
Kilmore-Willowmavin	80	64.0	80	71.4	83	73.5	31	24.8	24	21.4	19	16.8	14	11.2	8	7.1	11	9.7
Puckapunyal	16	61.5	21	63.6	20	69.0	6	23.1	5	15.2	4	13.8	4	15.4	7	21.2	5	17.2
Pyalong-Sugarloaf Creek-Tooborac	30	73.2	23	71.9	21	80.8	5	12.2	5	15.6	3	11.5	6	14.6	4	12.5	2	7.7
Seymour	45	69.2	31	57.4	59	75.6	9	13.8	10	18.5	10	12.8	11	16.9	13	24.1	9	11.5
Wallan-Upper Plenty	121	86.4	117	75.5	107	79.3	14	10.0	29	18.7	16	11.9	5	3.6	9	5.8	12	8.9
Wandong-Heathcote Junction	22	71.0	24	72.7	26	83.9	4	12.9	6	18.2	5	16.1	5	16.1	3	9.1	0	0.0

Emotional maturity domain results

This domain measures children's pro-social and helping behaviour, anxious and fearful behaviour, aggressive behaviour and hyperactivity and inattention.

Table 6.3 – Communities in context: Emotional maturity domain results at the national, state/territory, community and local community levels.

Region (including local communities)	Developmentally on track						Developmentally at risk						Developmentally vulnerable					
	2012		2015		2018		2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Australia	213,059	78.1	218,341	76.4	225,739	77.1	38,778	14.2	43,594	15.3	42,390	14.5	20,845	7.6	23,866	8.4	24,677	8.4
VIC	50,605	79.3	52,392	77.5	55,651	77.7	8,604	13.5	9,817	14.5	10,167	14.2	4,566	7.2	5,408	8.0	5,791	8.1
Mitchell	365	73.1	371	73.6	357	74.8	86	17.2	71	14.1	78	16.4	48	9.6	62	12.3	42	8.8
Broadford-Clonbinane	52	73.2	66	77.6	53	79.1	14	19.7	8	9.4	11	16.4	5	7.0	11	12.9	3	4.5
Kilmore-Willowmavin	94	75.2	84	75.0	91	80.5	20	16.0	16	14.3	11	9.7	11	8.8	12	10.7	11	9.7
Puckapunyal	13	50.0	19	57.6	19	65.5	7	26.9	6	18.2	5	17.2	6	23.1	8	24.2	5	17.2
Pyalong-Sugarloaf Creek-Tooborac	29	70.7	19	59.4	16	61.5	8	19.5	8	25.0	7	26.9	4	9.8	5	15.6	3	11.5
Seymour	47	72.3	35	64.8	48	61.5	11	16.9	10	18.5	20	25.6	7	10.8	9	16.7	10	12.8
Wallan-Upper Plenty	110	78.6	123	79.4	102	76.7	20	14.3	18	11.6	21	15.8	10	7.1	14	9.0	10	7.5
Wandong-Heathcote Junction	20	64.5	25	75.8	28	90.3	6	19.4	5	15.2	3	9.7	5	16.1	3	9.1	0	0.0

Language and cognitive skills (school-based) domain results

This domain measures children's basic literacy, advanced literacy, basic numeracy, and interest in literacy, numeracy and memory.

Table 6.4 – Communities in context: Language and cognitive skills (school-based) domain results at the national, state/territory, community and local community levels.

Region (including local communities)	Developmentally on track						Developmentally at risk						Developmentally vulnerable					
	2012		2015		2018		2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Australia	226,260	82.6	242,518	84.6	247,870	84.4	29,072	10.6	25,597	8.9	26,291	9.0	18,564	6.8	18,533	6.5	19,417	6.6
VIC	53,929	84.0	57,474	84.7	60,779	84.6	6,351	9.9	6,062	8.9	6,461	9.0	3,915	6.1	4,292	6.3	4,608	6.4
Mitchell	399	80.0	406	80.6	383	80.0	60	12.0	50	9.9	55	11.5	40	8.0	48	9.5	41	8.6
Broadford-Clonbinane	58	81.7	64	75.3	48	71.6	8	11.3	13	15.3	10	14.9	5	7.0	8	9.4	9	13.4
Kilmore-Willowmavin	105	84.0	93	83.0	99	87.6	13	10.4	9	8.0	10	8.8	7	5.6	10	8.9	4	3.5
Puckapunyal	23	88.5	27	81.8	22	75.9	2	7.7	5	15.2	6	20.7	1	3.8	1	3.0	1	3.4
Pyalong-Sugarloaf Creek-Tooborac	32	78.0	24	75.0	22	84.6	3	7.3	1	3.1	2	7.7	6	14.6	7	21.9	2	7.7
Seymour	40	61.5	39	72.2	52	66.7	16	24.6	8	14.8	13	16.7	9	13.8	7	13.0	13	16.7
Wallan-Upper Plenty	117	83.6	128	82.6	112	83.0	16	11.4	13	8.4	13	9.6	7	5.0	14	9.0	10	7.4
Wandong-Heathcote Junction	24	77.4	31	93.9	28	90.3	2	6.5	1	3.0	1	3.2	5	16.1	1	3.0	2	6.5

Communication skills and general knowledge domain results

This domain measures children's communication skills and general knowledge based on broad developmental competencies and skills measured in the school context.

Table 6.5 – Communities in context: Communication skills and general knowledge domain results at the national, state/territory, community and local community levels.

Region (including local communities)	Developmentally on track						Developmentally at risk						Developmentally vulnerable					
	2012		2015		2018		2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Australia	204,702	74.7	219,023	76.3	227,163	77.3	44,633	16.3	43,415	15.1	42,473	14.5	24,520	9.0	24,475	8.5	24,232	8.2
VIC	49,557	77.4	53,474	78.8	57,098	79.4	9,371	14.6	9,259	13.6	9,483	13.2	5,110	8.0	5,131	7.6	5,312	7.4
Mitchell	373	74.7	397	78.8	393	82.0	80	16.0	66	13.1	60	12.5	46	9.2	41	8.1	26	5.4
Broadford-Clonbinane	46	64.8	62	72.9	54	80.6	14	19.7	15	17.6	11	16.4	11	15.5	8	9.4	2	3.0
Kilmore-Willowmavin	90	72.0	96	85.7	94	83.2	24	19.2	10	8.9	17	15.0	11	8.8	6	5.4	2	1.8
Puckapunyal	17	65.4	25	75.8	21	72.4	4	15.4	5	15.2	6	20.7	5	19.2	3	9.1	2	6.9
Pyalong-Sugarloaf Creek-Tooborac	30	73.2	20	62.5	21	80.8	7	17.1	5	15.6	3	11.5	4	9.8	7	21.9	2	7.7
Seymour	43	66.2	28	51.9	58	74.4	10	15.4	16	29.6	11	14.1	12	18.5	10	18.5	9	11.5
Wallan-Upper Plenty	119	85.0	134	86.5	114	84.4	20	14.3	14	9.0	12	8.9	1	0.7	7	4.5	9	6.7
Wandong-Heathcote Junction	28	90.3	32	97.0	31	100.0	1	3.2	1	3.0	0	0.0	2	6.5	0	0.0	0	0.0

Vuln 1 | Vuln 2

Results for vulnerability summary indicators

Table 6.6 – Vulnerable on one or more domain(s) and two or more domains at the national, state/territory, community and local community levels.

Region (including local communities)	Vulnerable on one or more domain(s)						Vulnerable on two or more domains					
	2012		2015		2018		2012		2015		2018	
	n	%	n	%	n	%	n	%	n	%	n	%
Australia	59,933	22.0	62,960	22.0	63,448	21.7	29,543	10.8	31,754	11.1	32,434	11.0
VIC	12,407	19.5	13,465	19.9	14,232	19.9	6,053	9.5	6,707	9.9	7,231	10.1
Mitchell	127	25.5	126	25.0	96	20.1	62	12.4	64	12.7	50	10.4
Broadford-Clonbinane	21	29.6	19	22.4	13	19.4	11	15.5	12	14.1	5	7.5
Kilmore-Willowmavin	35	28.0	22	19.6	21	18.6	18	14.4	12	10.7	8	7.1
Puckapunyal	8	30.8	13	39.4	9	31.0	5	19.2	7	21.2	5	17.2
Pyalong-Sugarloaf Creek-Tooborac	9	22.0	12	37.5	4	15.4	6	14.6	6	18.8	2	7.7
Seymour	21	32.3	20	37.0	21	26.9	11	16.9	13	24.1	14	17.9
Wallan-Upper Plenty	24	17.1	35	22.6	26	19.5	6	4.3	11	7.1	15	11.1
Wandong-Heathcote Junction	9	29.0	5	15.2	2	6.5	5	16.1	3	9.1	1	3.2

Appendix 1: Critical difference estimates

The critical difference method was developed to help communities understand if the change in the percentage of children considered developmentally on track, at risk or vulnerable over time is significant. The community may have a different number of children with valid scores on each of the AEDC domains and summary indicators from one collection to another. The smaller of the two numbers should be used in the critical difference table. The total number of valid instruments by each domain and summary indicator required to calculate the critical difference have been included in Tables A5 and A6.

For more information on the calculation of the critical difference, see the AEDC technical report Calculation of the critical difference **(www.aedc.gov.au/trcd).**

Worked example

If the community of Sometown had 56 children with a valid score in the social competence domain in 2015 and 81 children in 2018, then you should find the row in the correct category of developmentally on track, at risk or vulnerable, that is relevant for a community with 56 children (not 81 children), and look at the critical difference in that row (the 40-59 children row).

Table A1 shows that Sometown would need to see a change of at least 8.0 percentage points to represent a significant change between 2015 and 2018 in the percentage developmentally on track in the social competence domain.

The critical difference calculation takes into account the number of children included in the AEDC data collections and variation between teachers in the way they assess children.

Critical difference for developmentally on track children

This table provides information on the critical difference required to indicate a significant change for communities of different sizes for children who are developmentally on track on each of the five developmental domains.

Table A1 – On track critical difference percentage points for the five AEDC domains.

Community size (number of children)	Developmentally on track critical difference percentage points				
	Physical health and wellbeing (%)	Social competence (%)	Emotional maturity (%)	Language and cognitive skills (school-based) (%)	Communication skills and general knowledge (%)
15-19	17.3	12.9	13.5	13.9	15.6
20-24	15.0	11.2	11.7	12.0	13.5
25-29	13.4	10.1	10.5	10.8	12.1
30-39	12.3	9.2	9.6	9.9	11.1
40-59	10.6	8.0	8.4	8.6	9.6
60-79	8.7	6.6	6.9	7.0	7.8
80-99	7.6	5.7	6.0	6.1	6.8
100-199	6.8	5.1	5.4	5.5	6.1
200-299	4.8	3.7	3.8	3.9	4.3
300-699	3.9	3.0	3.1	3.2	3.5
700-1,499	2.6	2.0	2.1	2.1	2.3
1,500-2,499	1.8	1.4	1.4	1.5	1.6
2,500-3,499	1.4	1.1	1.1	1.1	1.2
3,500-6,000	1.2	0.9	1.0	1.0	1.0

Critical difference for developmentally at risk children

This table provides information on the critical difference required by domain to indicate a significant change for communities of different sizes for children who are developmentally at risk.

Table A2 – At risk critical difference percentage points for the five AEDC domains.

Community size (number of children)	Developmentally at risk critical difference percentage points				
	Physical health and wellbeing (%)	Social competence (%)	Emotional maturity (%)	Language and cognitive skills (school-based) (%)	Communication skills and general knowledge (%)
15-19	18.2	16.5	17.9	17.6	19.0
20-24	15.8	14.3	15.5	15.2	16.4
25-29	14.1	12.8	13.8	13.6	14.7
30-39	12.9	11.7	12.6	12.5	13.4
40-59	11.2	10.2	10.9	10.8	11.6
60-79	9.2	8.3	8.9	8.8	9.5
80-99	7.9	7.2	7.7	7.6	8.2
100-199	7.1	6.5	6.9	6.8	7.4
200-299	5.0	4.6	4.9	4.8	5.2
300-699	4.1	3.8	4.0	4.0	4.3
700-1,499	2.7	2.5	2.6	2.6	2.8
1,500-2,499	1.9	1.7	1.8	1.8	1.9
2,500-3,499	1.4	1.3	1.4	1.4	1.5
3,500-6,000	1.2	1.1	1.2	1.2	1.2

Critical difference for developmentally vulnerable children

This table provides information on the critical difference required by domain to indicate a significant change for communities of different sizes for children who are developmentally vulnerable.

Table A3 – Developmentally vulnerable critical difference percentage points for the five AEDC domains.

Community size (number of children)	Developmentally vulnerable critical difference percentage points				
	Physical health and wellbeing (%)	Social competence (%)	Emotional maturity (%)	Language and cognitive skills (school-based) (%)	Communication skills and general knowledge (%)
15-19	14.8	9.9	11.9	10.9	13.2
20-24	12.8	8.6	10.3	9.5	11.4
25-29	11.5	7.7	9.2	8.5	10.2
30-39	10.5	7.1	8.3	7.7	9.3
40-59	9.1	6.2	7.2	6.7	8.1
60-79	7.5	5.1	5.8	5.5	6.6
80-99	6.5	4.4	5.0	4.7	5.7
100-199	5.8	3.9	4.5	4.3	5.1
200-299	4.1	2.8	3.1	3.0	3.6
300-699	3.4	2.3	2.5	2.5	2.9
700-1,499	2.2	1.5	1.6	1.6	1.9
1,500-2,499	1.5	1.1	1.1	1.1	1.3
2,500-3,499	1.2	0.8	0.9	0.9	1.0
3,500-6,000	1.0	0.7	0.7	0.7	0.9

Table A4 – Developmentally vulnerable critical difference percentage points for summary indicators.

Community size (number of children)	Developmentally vulnerable critical difference percentage points	
	Vulnerable on one or more domain(s) (%)	Vulnerable on two or more domains (%)
15-19	17.4	12.5
20-24	15.1	10.8
25-29	13.5	9.7
30-39	12.3	8.8
40-59	10.7	7.7
60-79	8.7	6.3
80-99	7.5	5.4
100-199	6.7	4.9
200-299	4.7	3.5
300-699	3.9	2.8
700-1,499	2.5	1.9
1,500-2,499	1.7	1.3
2,500-3,499	1.3	1.0
3,500-6,000	1.1	0.8

Table A5 – Total number of valid instruments by domain (2012, 2015, 2018): Australia, state/territory, community and local community.

Region (including local communities)	Physical health and wellbeing			Social competence			Emotional maturity		
	2012	2015	2018	2012	2015	2018	2012	2015	2018
Australia	273,922	286,913	293,894	273,534	286,848	293,878	272,682	285,801	292,806
VIC	64,061	67,871	71,892	63,896	67,860	71,902	63,775	67,617	71,609
Mitchell	499	504	479	499	504	479	499	504	477
Broadford-Clonbinane	71	85	67	71	85	67	71	85	67
Kilmore-Willowmavin	125	112	113	125	112	113	125	112	113
Puckapunyal	26	33	29	26	33	29	26	33	29
Pyalong-Sugarloaf Creek-Tooborac	41	32	26	41	32	26	41	32	26
Seymour	65	54	78	65	54	78	65	54	78
Wallan-Upper Plenty	140	155	135	140	155	135	140	155	133
Wandong-Heathcote Junction	31	33	31	31	33	31	31	33	31

Table A5 (continued) – Total number of valid instruments by domain (2012, 2015, 2018): Australia, state/territory, community and local community

Region (including local communities)	Language and cognitive skills (school-based)			Communication skills and general knowledge		
	2012	2015	2018	2012	2015	2018
Australia	273,896	286,648	293,578	273,855	286,913	293,868
VIC	64,195	67,828	71,848	64,038	67,864	71,893
Mitchell	499	504	479	499	504	479
Broadford-Clonbinane	71	85	67	71	85	67
Kilmore-Willowmavin	125	112	113	125	112	113
Puckapunyal	26	33	29	26	33	29
Pyalong-Sugarloaf Creek-Tooborac	41	32	26	41	32	26
Seymour	65	54	78	65	54	78
Wallan-Upper Plenty	140	155	135	140	155	135
Wandong-Heathcote Junction	31	33	31	31	33	31

Table A6 – Total number of valid instruments for summary indicators (2012, 2015, 2018): Australia, state/territory, community and local community

Region (including local communities)	Number of children with valid scores (one or more domains)			Number of children with valid scores (two or more domains)		
	2012	2015	2018	2012	2015	2018
Australia	272,282	286,041	292,976	273,275	286,616	293,619
VIC	63,584	67,670	71,671	63,889	67,812	71,828
Mitchell	499	504	477	499	504	479
Broadford-Clonbinane	71	85	67	71	85	67
Kilmore-Willowmavin	125	112	113	125	112	113
Puckapunyal	26	33	29	26	33	29
Pyalong-Sugarloaf Creek-Tooborac	41	32	26	41	32	26
Seymour	65	54	78	65	54	78
Wallan-Upper Plenty	140	155	133	140	155	135
Wandong-Heathcote Junction	31	33	31	31	33	31

Appendix 2: Additional resources

A variety of resources are available online to help you understand AEDC results and learn more about the scope and purpose of the program. The resources listed below are just some of those available. These can be accessed through the AEDC website (**www.aedc.gov.au**) or alternatively by clicking on the links provided.

Refer to the AEDC User Guides (**www.aedc.gov.au/resources/user-guides**) for ideas and strategies on how to respond to AEDC data and connecting with this community.

Key resources to help you get the most from this Community Profile

For detailed information on AEDC results reporting, refer to the fact sheet Understanding the results (**www.aedc.gov.au/unders**).

The fact sheet Definition of AEDC terms (**www.aedc.gov.au/defterm**) is a valuable guide that describes terminology used throughout the program.

The AEDC Data Explorer (**www.aedc.gov.au/tables**) is a searchable resource that allows comparisons across years and communities. 2018 AEDC community data is available from March 2019.

AEDC resources at a glance

AEDC publications

Important AEDC resources include:

- AEDC National report 2018 (**www.aedc.gov.au/natrep18**)
- Schools sector messages (**www.aedc.gov.au/schsect**)
- Calculation of the critical difference (**www.aedc.gov.au/trcd**)
- Fact sheet library (**www.aedc.gov.au/factsheets**)
  - About the AEDC data collection (**www.aedc.gov.au/abtdata**)
  - About the AEDC domains (**www.aedc.gov.au/abtdom**)
  - Definition of AEDC terms (**www.aedc.gov.au/defterm**)
  - Understanding community boundaries (**www.aedc.gov.au/ucb**)
  - Understanding the results (**www.aedc.gov.au/unders**).

AEDC videos

- Introduction to the AEDC (**www.aedc.gov.au/vi1**)
- Informing your planning (**www.aedc.gov.au/vi2**)
- Understanding the data (**www.aedc.gov.au/vi3**).

Key AEDC web pages

- Resources for communities (**www.aedc.gov.au/communities/resources-for-communities**)
- Communities FAQs (**www.aedc.gov.au/communities/faq-for-communities**)
- AEDC community results tables (**www.aedc.gov.au/tables**)
- Validation and trial of the AEDC (**www.aedc.gov.au/valid**).

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RB-6

This is the attachment marked '**RB-6**' referred to in the witness statement of Dr Ravi Subramanya Bhat dated 4 July 2019.

AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE

GUIDELINES

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GUIDELINES ON THE IMPLEMENTATION OF THE AUSTRALASIAN TRIAGE SCALE IN EMERGENCY DEPARTMENTS

Contents

1. GENERAL PRINCIPLES

1.1 Function of Triage

Triage is an essential function in Emergency Departments (EDs), where many patients may present simultaneously. It aims to ensure that patients are treated in the order of their clinical urgency which refers to the need for time-critical intervention. Clinical urgency is not synonymous with complexity or severity. Triage also allows for the allocation of the patient to the most appropriate assessment and treatment area, and contributes information that helps to describe the departmental case-mix. Changing models of care in some EDs (for example streaming, clinical initiatives nurses, triage liaison physicians) do not preclude the need for triage.

1.2 The Triage Assessment

Triage is the first point of public contact with the ED. The triage assessment generally should take no more than two to five minutes with a balanced aim of speed and thoroughness being the essence. The triage assessment involves a combination of the presenting problem and general appearance of the patient, and may be combined with pertinent physiological observations. Vital signs should only be measured at triage if required to estimate urgency, or if time permits. Any patient identified as ATS Category 1 or 2 should be taken immediately into an appropriate assessment and treatment area. A more complete nursing assessment should be done by the treatment nurse receiving the patient. The triage assessment is not intended to make a diagnosis. The initiation of investigations or referrals from triage is not precluded if time permits.

In Australasia, triage is carried out by staff members who are both specifically trained and experienced.

1.3 Safety at Triage

It is essential that all EDs plan for the potential risk of aggressive behaviour of patients or their relatives at triage. There must be a safe and non-threatening physical environment, which is as private as possible whilst not exposing staff to risk. Front line staff should have minimisation-of-aggression training and protocols and procedures for dealing with challenging behaviour. Where the safety of staff and/or other patients is under threat, staff and patient safety should take priority and an appropriate security response should take place prior to clinical assessment and treatment.

1.4 Time to Treatment

The time to treatment described for each ATS Category refers to the maximum time a patient in that category should wait for assessment and treatment. In the more urgent categories, assessment and treatment should occur simultaneously. Ideally, patients should be seen well within the recommended maximum times. Implicit in the descriptors of Categories 1 to 4 is the assumption that the clinical outcome may be affected by delays to assessment and treatment beyond the recommended times.

The maximum waiting time for Category 5 represents a standard for service provision.

Where a patient has a waiting time less than or equal to the maximum waiting time defined by their ATS Category, the ED is deemed to have achieved the performance indicator for that presentation. Achievement of indicators should be recorded and compared between large numbers of presentations.

1.5 Re-triage

If a patient's condition changes while one is waiting for the treatment, or if additional relevant information becomes available that impacts on the patient's urgency, the patient should be re-triaged. Both the initial triage and any subsequent categorisations should be recorded, and the reason for the re-triage documented.

1.6 Triage Colours

Emergency Departments throughout Australia and New Zealand utilise a range of ED Information Systems (EDIS) in order to provide key functions, such as triage management and assessment. Using these systems, EDs can choose to identify each ATS Category using a specific colour.

Red (Category 1), Orange (Category 2), Green (Category 3), Blue (Category 4) and White (Category 5), are commonly utilised by EDs in order to identify each ATS Category, and are recommended to be the standard colours used throughout Australia and New Zealand. However, colour designations should only be used as an adjunct to the numerical designations identifying each triage category.

2. EXTENDED DEFINITIONS AND EXPLANATORY NOTES

2.1 Arrival Time

The arrival time is the first recorded time of contact between the patient and ED staff. Triage assessment should occur at this point.

2.2 Time of Medical Assessment and Treatment

Although important assessment and treatment may occur during the triage process, this time represents the start of the care for which the patient is presented.

- Usually it is the time of first contact between the patient and the doctor initially responsible for their care. This is often recorded as 'Time seen by doctor'.
- Where a patient in the ED has contact exclusively with nursing staff acting under the clinical supervision of a doctor, it is the time of first nursing contact. This is often recorded as 'Time seen by nurse'.
- Where a patient is treated according to a documented, problem specific clinical pathway, protocol or guideline approved by the Director of Emergency Medicine, it is the earliest time of contact between the patient and staff implementing this protocol. This is often recorded as the earlier of 'Time seen by nurse', "Time seen by nurse practitioner" or Time see by doctor'.

2.3 Waiting Time

This is the difference between the time of arrival and the time of initial medical assessment and treatment. A recording accuracy to within the nearest minute is appropriate.

2.4 Documentation Standards

The documentation of the triage assessment should include at least the following essential details:

- Date and time of assessment
- Name of triage officer
- Chief presenting problem(s)
- Limited, relevant history
- Relevant assessment findings
- Initial triage category allocated

- Re-triage category with time and reason
- Assessment and treatment area allocated
- Any diagnostic, first aid or treatment measures initiated

3. SPECIFIC CONVENTIONS

3.1 Paediatrics

The same standards for triage categorisation should apply to all ED settings where children are seen – whether purely Paediatric or mixed departments. All five triage categories should be used in all settings. Children should be triaged according to objective clinical urgency. Individual departmental policies such as 'fast-tracking' of specific patient populations should be separated from the objective allocation of a triage category.

3.2 Trauma

Individual departments may have policies that provide for immediate team responses to patients meeting certain criteria. However, the triage category should be allocated according to their objective clinical urgency.

3.3 Behavioural Disturbance

Patients presenting with mental health or behavioural problems should be triaged according to their clinical and situational urgency. Where physical and behavioural problems co-exist, the highest appropriate triage category should be applied based on the combined presentation.

While some acutely-disturbed patients may require an immediate clinical response (perhaps combined with a security response) to ensure their safety, it is recognised that some individuals entering an ED and posing an immediate threat to staff (e.g. brandishing a dangerous weapon) should not receive a clinical response until the safety of staff can be ensured. In this situation, staff should act so as to protect themselves and other ED patients and obtain immediate intervention from security staff and/or the police service. Once the situation is stabilised, a clinical response can take place as (and if) required, and triage should reflect clinical and situational urgency.

Individual departments may have procedures and assessment tools to assist with identifying at risk mental health patients. These are considered as supportive to initial triage and may be applied following formal triage assessment.

4. CLINICAL DESCRIPTORS

4.1 Source

The listed clinical descriptors for each category are based on available research data where possible, as well as expert consensus. However, the list is not intended to be exhaustive nor absolute and must be regarded as indicative only. Absolute physiological measurements must be taken as the sole criterion for allocation to an ATS category. Senior clinicians should exercise their judgement, and where there is doubt, err on the side of caution.

4.2 Most Urgent Features Determine Category

The most urgent clinical feature identified, determines the ATS category. Once a high-risk feature is identified, a response commensurate with the urgency of that feature should be initiated.

5. AUSTRALASIAN TRIAGE SCALE: DESCRIPTORS FOR CATEGORIES

ATS Category	Response	Description of Category	Clinical Descriptors (indicative only)
Category 1	Immediate simultaneous assessment and treatment	**Immediately Life-Threatening** Conditions that are threats to life (or imminent risk of deterioration) and require immediate aggressive intervention.	Cardiac arrest Respiratory arrest Immediate risk to airway – impending arrest Respiratory rate <10/min Extreme respiratory distress BP< 80 (adult) or severely shocked child/infant Unresponsive or responds to pain only (GCS < 9) Ongoing/prolonged seizure IV overdose and unresponsive or hypoventilation Severe behavioural disorder with immediate threat of dangerous violence
Category 2	Assessment and treatment within 10 minutes (assessment and treatment often simultaneous)	**Imminently life-threatening** The patient's condition is serious enough or deteriorating so rapidly that there is the potential of threat to life, or organ system failure, if not treated within ten minutes of arrival **or** **Important time-critical treatment** The potential for time-critical treatment (e.g. thrombolysis, antidote) to make a significant effect on clinical outcome depends on treatment commencing within a few minutes of the patient's arrival in the ED **or** **Very severe pain** Humane practice mandates the relief of very severe pain or distress within 10 minutes	Airway risk – severe stridor or drooling with distress Severe respiratory distress Circulatory compromise - Clammy or mottled skin, poor perfusion - HR<50 or >150 (adult) - Hypotension with haemodynamic effects - Severe blood loss Chest pain of likely cardiac nature Very severe pain - any cause Suspected sepsis (physiologically unstable) Febrile neutropenia BSL < 3 mmol/l Drowsy, decreased responsiveness any cause (GCS< 13) Acute stroke Fever with signs of lethargy (any age) Acid or alkali splash to eye – requiring irrigation Suspected endophthalmitis post-eye procedure (post-cataract, post-intravitreal injection), sudden onset pain, blurred vision and red eye. Major multi trauma (requiring rapid organised team response)

			Severe localised trauma – major fracture, amputation Suspected testicular torsion High-risk history: - Significant sedative or other toxic ingestion - Significant/dangerous envenomation - Severe pain or other feature suggesting PE, aortic dissection/AAA or ectopic pregnancy Behavioural/Psychiatric: - violent or aggressive - immediate threat to self or others - requires or has required restraint - severe agitation or aggression
ATS Category	**Response**	**Description of Category**	**Clinical Descriptors (indicative only)**
Category 3	Assessment and treatment start within 30 mins	**Potentially Life-Threatening** The patient's condition may progress to life or limb threatening, or may lead to significant morbidity, if assessment and treatment are not commenced within thirty minutes of arrival **or** **Situational Urgency** There is potential for adverse outcome if time-critical treatment is not commenced within thirty minutes **or** Humane practice mandates the relief of severe discomfort or distress within thirty minutes	Severe hypertension Moderately severe blood loss – any cause Moderate shortness of breath Seizure (now alert) Persistent vomiting Dehydration Head injury with short LOC- now alert Suspected sepsis (physiologically stable) Moderately severe pain – any cause – requiring analgesia Chest pain likely non-cardiac and mod severity Abdominal pain without high risk features – mod severe or patient age >65 years Moderate limb injury – deformity, severe laceration, crush Limb – altered sensation, acutely absent pulse Trauma - high-risk history with no other high-risk features Stable neonate

			Child at risk of abuse/suspected non-accidental injury Behavioural/Psychiatric: - very distressed, risk of self-harm - acutely psychotic or thought disordered - situational crisis, deliberate self-harm - agitated / withdrawn - potentially aggressive
Category 4	Assessment and treatment start within 60 mins	**Potentially serious** The patient's condition may deteriorate, or adverse outcome may result, if assessment and treatment is not commenced within one hour of arrival in ED. Symptoms moderate or prolonged **or** **Situational Urgency** There is potential for adverse outcome if time-critical treatment is not commenced within hour **or** **Significant complexity or Severity** Likely to require complex work-up and consultation and/or inpatient management **or** Humane practice mandates the relief of discomfort or distress within one hour	Mild haemorrhage Foreign body aspiration, no respiratory distress Chest injury without rib pain or respiratory distress Difficulty swallowing, no respiratory distress Minor head injury, no loss of consciousness Moderate pain, some risk features Vomiting or diarrhoea without dehydration Eye inflammation or foreign body – normal vision Minor limb trauma – sprained ankle, possible fracture, uncomplicated laceration requiring investigation or intervention – Normal vital signs, low/moderate pain Tight cast, no neurovascular impairment Swollen "hot" joint Non-specific abdominal pain Behavioural/Psychiatric: - Semi-urgent mental health problem - Under observation and/or no immediate risk to self or others
Category 5	Assessment and treatment start within 120 minutes	**Less Urgent** The patient's condition is chronic or minor enough that symptoms or clinical outcome will not be significantly affected if assessment and treatment are delayed up to two hours from arrival **or**	Minimal pain with no high risk features Low-risk history and now asymptomatic Minor symptoms of existing stable illness Minor symptoms of low-risk conditions Minor wounds - small abrasions, minor lacerations (not requiring sutures) Scheduled revisit e.g. wound review, complex dressings

		Clinico-administrative problems Results review, medical certificates, prescriptions only	Immunisation only Behavioural/Psychiatric: - Known patient with chronic symptoms - Social crisis, clinically well patient

6. DOCUMENT REVIEW

Timeframe for review: every five (5) years, or earlier if required.

6.1 Responsibilities

Document authorisation: Council of Advocacy Practice and Partnerships
Document implementation: Standards Committee
Document maintenance: Policy and Research Department

6.2 Revision History

Version	Date of Version	Pages revised / Brief Explanation of Revision
V1	Nov 00	Approved by Council
V2	Nov 05	Approved by Council
V4	Nov 13	Approved by Council
V5	Jul 16	**Section 1.6:** addition of recommended triage colours. **Section 5:** Additional clinical descriptors added to Category 2: - Suspected sepsis (physiologically unstable) - Febrile neutropenia - Suspected endophthalmitis post-eye procedure - Suspected testicular torsion **Section 5:** Additional clinical descriptors added to Category 3: - Suspected sepsis (physiologically stable) - Suspected stroke

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RB-7

This is the attachment marked '**RB-7**' referred to in the witness statement of Dr Ravi Subramanya Bhat dated 4 July 2019.

Goulburn Valley Area Mental Health Service - Community Liaison Psychiatry

Evaluation Report

An evaluation of the Goulburn Valley Area Mental Health Service Community Liaison Psychiatry initiative has been undertaken by researchers at The University of Melbourne Department of Rural Health. The aim of this evaluation was to identify how the Goulburn Valley Area Mental Health Service Community Liaison Psychiatry (CLP) initiative has operated and how it has been received by key participants including general practitioners (GPs), other practice staff and patients. It addition, within the limits of the evaluation, it aimed to identify indications of clinical impact of the initiative.

Background

Liaison psychiatry is an established special interest or sub-speciality of psychiatry. It originated, and is most commonly viewed as the engagement of psychiatry with general medical patients, typically inpatients, experiencing psychiatric problems in addition to, or as a part of, their broader medical or surgical issues and is based on a desire to provide comprehensive medical care.[1,2] The potential benefit of a community psychiatry liaison model has been long identified.[3] The concept of shared care has been widely promoted as a model for mental health care, typically including the patient's GP and a psychologist, psychiatrist or mental health nurse.[4] There has been debate about the distinction between mental health shared care and community consultation liaison psychiatry.[5,6] The Consultation Liaison in Primary Care Psychiatry (CLIPP) project in Melbourne has been described as an example of a successful community liaison psychiatry and shared care project undertaken in a large city setting.[7] Providing psychiatric care in limited population rural areas has been recognised as a significant challenge.[8]

The CLP initiative in the Goulburn Valley has been informed by the existing published literature. It aimed to achieve something that is relatively unusual - to provide a single psychiatric assessment consultation at the patient's usual general practice, supporting early specialist informed diagnostic and management approaches, that may reduce progression to more severe mental–ill health requiring higher intensity interventions. The provision of such consultations, in the patient's usual rural located general practice, may include either face to face consultation or video-conference consultation. The initiative did not aim to provide shared care but support for community mental health care through liaison between psychiatrists and GPs.

Evaluation Method and Participant Demographics

Six general practices that had participated in the initiative were identified by Goulburn Valley Area Mental Health Service. These practices were contacted by the researchers and requested to participate in the evaluation project; all agreed to participate. Five of the practices were located in smaller rural towns in the region (population < 7500) and one in a larger regional centre. Participating practices identified 230 patients who had participated in the CLP initiative during 2013-2015. Data were collected during the second half of 2015. Limited additional data from patients were collected during 2016. The evaluation was informed by an earlier limited pilot project undertaken at one of the six practices.

This evaluation included three data sources:

- Participating general practice staff, both GPs and practice managers.
- Patients who had participated in the initiative
- Clinical records of patients who had participated in the initiative

Data were collected from GPs and practice managers using one on one semi-structured interviews. Data were collected from participating patients initially using one on one semi-structured interviews. Due to limited recruitment of patients for these interviews, additional anonymous survey data were collected from participating patients. Clinical records of patients who had participated in the initiative were identified, anonymised by the general practice staff and reviewed by the researchers.

Staff Interviews

Interviews were undertaken with medical and administrative staff from five of the participating practices; staff interview data were not collected from the pilot practice. Interviewees were volunteers and included GPs (n=12) and practice managers (n=5). In some practices the practice manager was also the practice nurse. These interviews aimed to understand practice staff members' expectations and experience of the project. To help identify any impact resulting from the CLP initiative, staff were encouraged to talk about the support for their practice patients who were experiencing mental health problems both before and after the introduction of the initiative. Staff were also asked about any suggestions they may have for future directions of the initiative.

Clinical record audit

Clinical records for audit were available from five practices; similarly to the staff interviews, data were not collected from the pilot practice. Practices were asked to identify patients who had participated in the CLP initiative during 2013-2015 and randomly select 25 records for audit by the research team. The final number of clinical records available for audit (n=80) was less than anticipated. One practice was only able to identify three relevant clinical records with the other practices each identifying between 15 and 25 patients. Patients whose clinical records were included in the audit ranged in age from 18 -80 years (median 46) with 58% being female and 42% male. The employment status of 52% of participants was unavailable; 24% of the total were recorded as being employed part or full time, 11 % as unemployed, 5% as students and 8% as a pensioner or retiree. Data were analysed descriptively.

Patient interviews and survey

Each practice was asked to randomly select 20 patients identified as participating in the CLP initiative and send them a letter on behalf of the researchers, inviting them to participate in an interview about their experience of the initiative. Practices were asked to send out five

letters each week with the researchers notifying the practice to stop when the proposed number of interviewees (n=5) had been recruited. To maintain patient confidentiality this was done independently of the researchers, who did not know which patients had been contacted by letter. Similarly the practice staff did not know which patients had responded as patients were invited to respond directly to the researchers using one of a range of pathways including phone call, text message, email or reply paid postcard.

It was anticipated that recruitment of patients for interview would be difficult. After some months of effort only four (n=4) patients were recruited for interview. These patients, two males and two females, each participated in a 45-60 minute semi-structured interview with a member of the research team, exploring their expectations, experience and impact from their single CLP consultation. Interviews were undertaken at a location of the patient's choice, typically at their usual general practice clinic and were audio recorded for later thematic analysis.

Following the very limited recruitment of patients to participate in an interview, it was decided to seek further patient data through a structured survey. A similar recruitment mechanism to that used for patient interviews was adopted, with practices identifying patients who had participated in the CLP initiative mailing to them a survey on behalf of the research team. To promote participation the survey was limited to 11 questions, eight with fixed response options and three with free response. Three of the six practices agreed to participate in this additional data collection, identifying 165 eligible patients. A total of 16 surveys were returned (response rate of 10%), with a further nine returned as not known at this address (5%). Three responders were unable to recall the details of the CLP psychiatrist consultation; completed data addressing expectations and experience were available from the remaining 13 respondents.

Ethics

Ethics approval for this research was obtained from The University of Melbourne. Reflecting the diverse nature of the data collection this was done in two parts, an initial minimal risk application covering practice staff interviews and a standard risk application covering

patient interviews, patient surveys and clinical record audit. Respective ethics approval numbers were 1545054 and 1545153

Findings

Analysis of all data streams has been completed. Findings from interview, survey and audit data are presented using headings that emerged as themes from interview data.

General comments

As a broad general comment the project has been well received by practice staff, GPs and Practice Managers. Interviewed practice staff recommended continuation of the program. The small number of patients interviewed expressed mixed comments about the project. However, nine patients (69%) responding to the survey rated the psychiatrist consultation as worthwhile or excellent with only three (31%) rating it as disappointing. No patients selected the option that the consultation with the psychiatrist was a waste of time.

The availability of specialist mental health advice without the barrier of travel (time, cost and inconvenience) was viewed positively. Service arrangements before the introduction of this initiative were mixed but typically required patient travel to a regional centre or Melbourne. GPs expressed the view that this locally available service diminished the risk of patients giving up on help-seeking for mental health concerns that may previously have resulted from both time delays and inconvenience associated with seeing a specialist in Shepparton or Melbourne.

Expectations

Both practice managers and GPs reported feeling positive about the service when it was initially proposed, regarding any approach that diminished barriers to care as potentially desirable. Their expectations were less well formulated. Many had previous positive experience of video-linked specialist services to their patients in areas other than psychiatry

but were unsure how this approach would work for those experiencing mental–ill health. Most commented favourably about the possibility of obtaining early diagnostic and management advice.

More than half of the patients reported that the consultation was initiated to provide them and their GP with more information about their mental health concerns. A similar number expected that the consultation would result in greater understanding of their mental health. Others reported exacerbation of their problems as the trigger for the consultation being arranged, perhaps with an implied expectation that the precipitating issue might be resolved.

When asked about what they were expecting would happen during the psychiatrist consultation more than half of the patients selected the option 'I wasn't sure what would happen'.

Experience of the CLP consultations

GPs and practice managers largely reported positive experience of the consultations. Whilst both diagnostic and management issues were considered, GPs reported progression of an existing management approach or initiation of a new approach as the most common outcome of a CLP consultation. Waiting times for CLP consultations that had been referred by GPs were described by most as being reasonable.

Post consultation follow up letters were, at times, received by the GP after their follow-up consultation with the patient had occurred. The mechanism that was most favourably commented upon involved the GP scheduling a time slot coinciding with the final ten minutes of the CLP consultation. The GP joined the consultation allowing direct interaction with the psychiatrist. Some GPs, whilst identifying the merit of this approach felt it was logistically difficult in terms of time allocation and was limited to those GPs who worked on the day of the consultation (i.e. it was seen as a significant difficulty for those working part time).

Patients were asked about their view of the outcome of the consultation; 70% reported that it was either as they had expected, or better than expected. Only 30% felt it was less positive than expected.

Video conferencing

Most of the consultations discussed by the GPs and practice staff were undertaken by videoconference. This varied between some high fidelity video links and simpler "Skype' type connections. Regardless of the type of connection the video-consultations were regarded positively without significant negative intrusion due to technical difficulties. Generally the limitations of video-consultations, including dealing with a 'head on a small screen' and limitations in observing non-verbal cues, were seen as being more than outweighed by the convenience and easier access to specialist advice.

Most patients responding to the survey had previously experienced a face to face consultation. The most common response from those who had experienced a video-conference consultation was that it didn't make any difference to the communication compared to a direct face to face consultation.

Patient Diagnosis

Based on the clinical audit data and supported by the GP interviews, most patients referred for a CLP consultation were designated as experiencing a high prevalence disorder, typically depression or (non-specific) anxiety. Smaller numbers of patients were designated as experiencing PTSD or Borderline Personality Disorder. Only a few patients were designated with a specific low prevalence disorder; three patients were recorded as experiencing Schizophrenia and three with Bipolar Affective Disorder.

A clearly identifiable post-consultation diagnosis was not identified in all records. However, a changed primary diagnosis and/or an additional diagnosis was identified in 18% of the clinical records. The most common additional diagnosis was of substance abuse and/or drug induced psychosis. For two patients, what might be regarded as a more serious diagnosis

was the outcome, with PTSD and Bipolar being identified rather than anxiety or depression. By contrast five patients were designated with might be regarded as a less serious diagnosis after the consultation, including PTSD and Bipolar being re-designated as Adjustment Disorder or Personality Disorder.

Management following Psychiatrist assessment

Clinical audit data indicates that the specialist psychiatrists' management suggestions were generally implemented completely by the referring GP. This included both medication changes and non-pharmacological (typically psychological) interventions. Broadly, GPs reported during interview that therapeutic rather than diagnostic changes resulted from the psychiatrist assessment, most commonly an increase in medication dose. The majority of patients responding to the survey reported a small change in their treatment following the psychiatrist consultation.

None of the interviewed GPs felt the project had in any way deskilled them. On the contrary, a number reported feeling empowered and skilled by their engagement with the initiative, feeling a greater level of skill and confidence addressing common mental health problems. There was insufficient data to identify changes in GPs referral and management patterns that could be attributed to change in GPs' skill levels.

Reporting and feedback to referring GPs

GPs and practice staff reported receipt of a written report by the psychiatrist, typically within two weeks. Some commented it included more detail than they required and on occasions they saw their patient before the report was received. As noted above the reporting mechanism that was described most positively was when the GP spoke briefly to the psychiatrist at the end of the video-consultation.

Follow-up consultations

A concern frequently expressed by GPs related to patient follow-up. Whilst the initiative was understood by most GPs to provide a single initial assessment, many expressed the view that a more formalised follow-up mechanism, typically after a few months, would be helpful. The researchers noted that a small number of GPs reported that a routine follow-up format was operating in their setting. This was however the exception.

Clinical benefit from the project

Pre and post consultation outcome measures such as DASS21 or K10 were not available for most patients. As noted above, clarification of diagnosis was identified for a number of patients and patients reported treatment change. The number of consultations that could be identified as being mental health specific in the 12 months before and the 12 months after the psychiatrist assessment showed wide variation without a statistically significant degree of change when patient pre-post matched paired data were compared. The respective pre and post means were 3.3 and 3.9 mental health specific consultations in each 12 month period. These data however were limited by being incomplete, especially during the year following the psychiatrist consultation.

Measurement of clinical benefit associated with the project presents a number of challenges, not least of which is that this project could be seen as being primarily about addressing access issues. There does not appear to be any reason to assume that clinical benefit from this initiative, other than that achieved by addressing access barriers, would be any different from routine GP referral for psychiatrist assessment and subsequent informed management. Perhaps the important clinical outcomes may relate to more patients obtaining specialist diagnostic and management advice than occurred before this initiative commenced.

Conclusions and Recommendations

This review of the CLP initiative suggests it is a worthwhile approach, providing an additional service to support mental health care in rural areas. Participating clinicians (GPs) and practice managers commented favourably on the initiative noting it addressed significant barriers to access of specialist mental health care in rural areas. Clinical record audit suggests that GPs adopted the management advice offered by the psychiatrist. Patients' comments about the initiative were more restrained, perhaps reflecting unfulfilled expectations. However it is worth noting that few patients felt their engagement with the visiting psychiatrist was disappointing. Based on this limited evaluation, that did not consider economic factors, the following recommendations are made:

1. The CLP initiative should continue to provide initial specialist psychiatric diagnostic and management consultations to rural patients in their usual general practice.

2. Consultations continue to use video-link technology if in-person attendance at the clinic by the psychiatrist is not possible (typically for travel distance reasons)

3. Referring GPs be encouraged to ensure patients are well informed of the nature of the assessment consultations and have appropriate expectations of the potential outcomes of the consultations

4. Reporting to the referring GP be undertaken in a timely manner. Direct communication between the psychiatrist and the GP at the end of the consultation should be seen, when possible, as the ideal model. This discussion will be followed by a more formal report.

5. Specialist psychiatrist follow-up consultations be considered as part of the initiative; it is suggested this be done after 2 - 3 months.

6. The current model of operation be reviewed to assess the possibility of increasing flexibility including assessments not being limited to specific sessions each 2-3 weeks. Whilst it is recognised that the potential for greater flexibility will be

resource dependent, especially psychiatrist staff, unused consultation time slots from one clinic could be made available to patients from others clinics if more urgent assessment is required.

7. Measurement of clinical benefit of the initial psychiatrist assessment and subsequent GP management should be untaken as routine – in view of the common diagnostic categories identified the DASS21 tool is recommended, with alternative measurers being considered in specific cases.

Additional Information

Following the data collection during 2015 one participating practice withdrew from the CLP initiative and instituted similar video-conference consultations with a private psychiatrist. A key driver for this change was the high level of patient 'non-show' consultations, typically >50%. This was felt by the practice to be due to significant time delay between the initial decision by the GPs to seek a specialist psychiatrist consultation, often at a time of crisis for the patient, and the consultation occurring. In place of the CLP initiative model of allocated sessions each few weeks, the model the practice has now adopted allows patients to be seen, by video-link, at any time. In addition, much more opportunity for patient follow-up is available in this recently adopted model. The patient's GPs or practice nurse typically liaises with the psychiatrist online at the end of the initial consultation.

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15th December 2016

References

1. Lloyd G, Mayou R. Liaison psychiatry or psychological medicine. Br J Psych, 2003;183(4):366
2. Royal Australian and New Zealand College of Psychiatrists. Faculty of Consultation-Liaison Psychiatry 2016. Available at: https://www.ranzcp.org/Membership/Faculties-sections/Consultation-Liaison.aspx [Accessed 15 Dec 2016]
3. Siedel U. Clinical practice and community medicine. BMJ 1979; 2(6202): 1441
4. Horner D., Asher K. General Practitioners and mental health staff sharing patient care: working model. Australas Psychiatry 2005;13(2):176-80
5. Carr V., Lewin T. Consultation-liaison psychiatry in general practice. Aust N Z J Psychiatry 1997;31(1):85-94.
6. Gribble R. Shared care but not consultation-liaison psychiatry. Aust NZJ Psychiatry 1998;32(2)311-3
7. Meadows G. Establishing a collaborative service model for primary mental health care. Med J Aust 1998;168(4):162-5
8. Hood E., Malcolmson S., Young L., Abbey S. Psychiatric consultation in the eastern Canadian Artic: Development and evolution of the Baffin Psychiatric Consultation Service. Can J Psychiatry 1993;38(1):23-7

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ATTACHMENT RB-8

This is the attachment marked '**RB-8**' referred to in the witness statement of Dr Ravi Subramanya Bhat dated 4 July 2019.

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Original Research

Understanding drivers of rural and remote health outcomes: A conceptual framework in action

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Abstract

Objective: *To demonstrate the usefulness of a conceptual framework to increase the understanding of rural and remote health by applying it to specific rural and remote health scenarios.*

Design: *A conceptual framework was applied to two case studies illustrative of key issues in rural health to reflect different contexts, issues and responses.*

Results: *Application of the framework to both case studies highlighted that changes in rural and remote health are diverse. While power was a key element of the framework, the interaction of all framework components underpinned changes.*

Conclusion: *The framework facilitated understanding of change in these rural scenarios and demonstrated that improvement in rural health requires change at both the local and structural levels.*

KEY WORDS: *case study, conceptual framework, isolation, power, rural health.*

Introduction

Understanding the many needs, local changes and policy impacts in rural and remote health is difficult given the diversity of rural and remote contexts, structural and local influences, and the variety of policies aimed to improve rural and remote health.[1,2] For this reason, a framework to understand specific rural health and remote health situations would be useful to analyse the impacts of policy, identify points of change and explain the elements of rural health 'on the ground'.[1,2] The goal is to provide rural and remote health practitioners, students, managers, policy-makers, researchers and others with a framework to better understand the context in which they work.[1,3]

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A framework for understanding rural health situations

Based on extensive consultation and a comprehensive review of relevant literature, a conceptual framework of rural and remote health has been developed to address the need for more theoretical and comprehensive understanding of rural and remote health. This framework is based on the interaction of six key concepts, namely: (i) geographic isolation; (ii) the rural locale; (iii) local health responses; (iv) broader health systems; (v) broader social structures; and (vi) power[3] (Fig. 1). Viewing these concepts through Giddens'[4] theory of structuration connects individual actions with broader social structures and provides a perspective of power. Each of the six concepts vary for each rural/remote health situation and aims to take account of the diversity of rural/remote contexts, Aboriginal and Torres Strait Islander cultures, health services and actions.[3]

1. Geographic isolation and distance from other population centres and services characteristically distinguish rural and remote health from urban health and determine patterns of accessibility.
2. The rural locale is a particular 'setting in which social relations are constituted'[5] and where rural health outcomes occur.[6–9] Rural locales incorporate all types of social relations, including conversations between health consumers, individual behaviours, the actions of community groups (such as fundraising for their hospital), relationships with the natural environment (through farming, mining, bushwalking), networks between individuals and power rela-

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What is already known on this subject:

- *Explanation of health circumstances in diverse rural and remote contexts is difficult and often inadequate.*
- *Previous papers have identified the need for a more theoretical and comprehensive understanding of rural and remote health.*
- *A comprehensive conceptual framework of rural and remote health has been developed and peer reviewed.*

What this study adds:

- *This paper presents a conceptual framework for understanding specific situations and health issues in rural and remote Australia.*
- *The paper demonstrates the usefulness of a conceptual framework for improved and holistic understanding of specific rural health responses.*
- *The results highlight that changes are needed in community and health responses in rural and remote contexts as well as changes in broader health systems, social structures and power relations to improve rural health outcomes.*

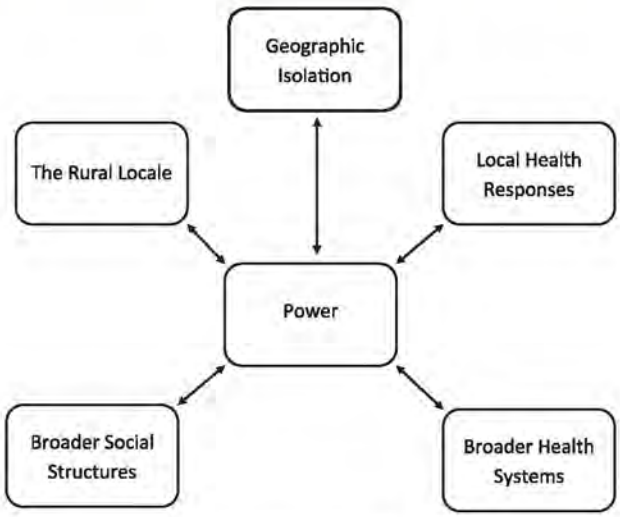


FIGURE 1: *A Conceptual framework of rural and remote health.*

tions within the community (who are the decision-makers). While the focus is essentially 'local', the 'local' is also shaped by connections with non-local people.

3. Health responses in rural locales – health services, programs and actions, whether formal or informal, are developed in specific rural locales to meet the needs of local communities. They include the local health clinic, general practice or hospital, the local community health centre, Aboriginal Community Controlled Health Organisations and allied health services. Other activities might include community services (meals-on-wheels), maternal and child health, consumer groups and health promotion projects.
4. Broader health systems – a range of health stakeholders impact upon an understanding of health in a given rural or remote place, including government, professional organisations (such as the Australian Medical Association) and pharmaceutical companies. Hence, broad health systems comprising 'organizations, institutions, resources and people' aiming to improve health[10] shape the ways in which local health care services are designed, delivered, managed, monitored and funded.
5. Broader social structures are existing rules, resources, relations and social organisations that are maintained to reproduce particular political, social, cultural and economic behaviours and understandings.[4] The historical, social and economic arrangements of society have significant impact on the lives of rural people and result in their unequal health status.[11,12]
6. Power is understood as 'the capacity to make a difference, to transform something from one state to another', either as individual action or as an outcome of a larger system.[13] In this way, power constrains what one is able to do, but also, by prescribing protocols for what is expected and providing opportunities for individuals and groups to act, enables action to be initiated.[4,14]

Structuration theory overarches these six key concepts and suggests that it is the actions of individuals which create, maintain or change existing structures, just as structures shape what individuals do, how they act and with whom they act. At times, structures become constraining by not allowing individuals to challenge or change them (as with racism), but it is still individual action that reinforces these structures (those perpetuating racist systems).[4] This means that all aspects of rural and remote health are both structural and individual.

Application of the framework

This framework can be used by educators, practitioners, researchers and policy-makers to better understand the

interplay of factors shaping rural and remote health outcomes. To illustrate this, the framework is applied to two specific scenarios. Application of the framework identifies where and why action occurred and how connections between different components resulted in change.

Development of a rural community model of service delivery

Scenario

There are more than 1500 rural and remote communities across Australia.[15] Many of these have health services that struggle to sustain their workforce, maintain appropriate infrastructure, meet the health needs of the local population and maintain a sustainable and quality model of care.

Setting

Corryong is a small farming town in the mountainous country of south-eastern Australia. It has an ageing population, a below-average income and is 1.5 hours drive from the nearest regional centre.

Past response

Like other rural communities, Corryong struggled to meet the health needs of its residents with traditional GP/hospital-based model of health care.

Current response

In the 1990s, the Commonwealth developed the multipurpose service (MPS) program, a flexible model that allows rural health services to pool health funding from Commonwealth, state and local governments, integrate services and develop a local model of health care.[16] The health service in Corryong became an MPS in 1995 and undertook significant community consultation. Responding to consumer needs and preferences, the board and a new CEO developed a unique model of care. As the model was implemented, the resident GPs moved elsewhere, creating community concern. Against a background of significant media attention, some staff resisted the change in model of care and styles of practice. The MPS recruited salaried GPs prior to the departure of the original GPs. One integrated service was developed that provided a small hospital, an aged care facility, community health services, a bulk-billing GP clinic and an array of health prevention/promotion programs. Where necessary, staff were retrained to increase some services and decrease others. Ongoing community consultation is conducted.[17–19]

Outcomes

The MPS model allowed for fund pooling to create an integrated health service in Corryong based on community-driven planning. The health service also operates a gym for community use, a bus to transport individuals to specialists at the nearest regional centre, and every inpatient has an assessment undertaken to offer the full range of services.[19]

Application of the framework

This scenario has resulted from a combination of the geographic isolation of this small town, the local health needs associated with an ageing local population characterised by low incomes (broader social structures which result in low-income residents having poorer health outcomes) and an unsustainable local model of care (local health response) based on traditional models of health services (broader health systems). Change began at the policy level through the development of the MPS program (broader health systems level), involving a shift in power at the structural level. This was followed by actions of the health service to become an MPS and to implement a new model (local health response) based on consumer consultation (agency within the rural locale). But resistance by the outgoing GPs was an alternative local health response. As highlighted in Table 1, it was the combination of power/action in both government and local health service levels that led to the development of the new model.

A community-driven Aboriginal health promotion initiative

Scenario

Aboriginal and Torres Strait Islander health in Australia is characterised by particularly poor health outcomes, resulting in a significantly shorter life expectancy of more than 10 years.[20]

Setting

Shepparton is a regional centre in northern Victoria. Most local mainstream health services have not provided culturally secure health services for local Aboriginal communities and other areas of community life have also been exclusive. In response, the local Aboriginal communities have developed the Rumbalara Aboriginal Cooperative with an Aboriginal Medical Service.

TABLE 1: *Application of the framework to particular scenarios to understand changes in rural and remote health policy*

	Policy development and health service change	Community-initiated health promotion
Scenario	A new policy enables rural health services to change to a community-based model of service delivery through the multipurpose service (MPS) model.	A group of local leaders develop an innovative health promotion program through the establishment of Rumbalara Football Netball Club.
Geographical isolation	An isolated rural community with limited access to larger centres and health services. Located 130 km east of Wodonga in Snowy Mountains.	Large rural centre, 200 km from Melbourne
Rural locale	High health needs among the ageing, low-income, farming community. Some community members resisted change, particularly those aware of recruitment difficulties and fearing GP departure. Some welcomed aspects of the new model that suited their own needs (e.g. bulk-billing, expanded community health). Wide community consultation resulted in many local consumers participating in development of new model of health service.	Large population of both Aboriginal and non-Aboriginal residents. Aboriginal residents have poorer health and are socially marginalised from mainstream services and community activities. Strong football culture in the region. Other clubs/players resistant to the inclusion of Rumbalara in a mainstream league and few local sponsors. Sporting structures of the league enabled inclusion of Rumbalara into the mainstream league, despite resistance.
Local health responses	The health service, under board direction, enabled change to an MPS. In order to meet local needs, engage disadvantaged community residents and develop a sustainable service, the new CEO of the health service developed a new integrated model of health care based on community consultation. With some community support and media attention, existing GPs were opposed and then left. New GPs were recruited with no gap in GP service. Model has continued to develop since initial implementation with further community consultation.	A team of Aboriginal leaders developed an Aboriginal community-controlled club that participated in a mainstream football league. These leaders were supported by the local Aboriginal cooperative and health service, and integrated healthy lifestyles into the philosophy of the club. They developed a model of community-led primary prevention and health promotion.
Broader health systems	A Commonwealth MPS policy supports sustainable rural services by enabling pooling of funds and designing an integrated service to meet the needs of the local community.	Despite lack of systematic and financial support for health promotion activities, funding was secured.
Broader social structures	The new model of care focused on increasing access to health care, particularly for elderly and low-income residents who have lower health status due to broader social structures. Model addressed transport, income and other barriers to consumer engagement and use of services.	Social determinants of health were linked with health promotion activities within the sporting club by addressing issues of income disadvantage and institutional racism present in the league and social settings.
Power	Power characterised all levels in this case study. The actions of the board and new CEO reflected power as did the actions of GPs deciding to leave. Power was also reflected in consumers participating in consultation and some community resistance. Power was embedded in Commonwealth structures to offer a new model of care and social structures with disadvantaged rural and low-income residents on a range of indicators.	Power relations were reflected in mainstream resistance to the club's development and struggle for financial support. However, the actions of a group of Aboriginal leaders, a form of power, enabled the club to challenge to a mainstream sporting league. Use of the networks by these leaders secured funding at the state level, which was also a form of power.

Healthy lifestyles have been promoted, but there are few avenues for participation in sport.

Past response

Health promotion through mainstream services has failed to resonate with the local Aboriginal community. As a result, there were few culturally appropriate avenues for fitness. Further, only very good Aboriginal football players were recruited by mainstream football clubs. Appropriate avenues for sport, fitness and social participation for members of the Aboriginal community were scarce.

Current response

A group of Aboriginal leaders in the region used networks to secure funding from non-local sources to develop Rumbalara Football and Netball Club (RFNC). The same leaders engaged local community members to participate in and operate the club with a specific health vision. Members' desire to participate, their love of sport and support from the club enabled the club to thrive. RFNC participates in a mainstream league, but its central philosophy is to improve the health and well-being of its community. The club addresses disadvantage by providing its players with transport to games and training, uniforms and boots/shoes when needed, breakfast to all junior teams before the games and dinner after Thursday night training. Attached to the club is a Healthy Lifestyles Program (HLP), a series of health promotion, prevention and early intervention programs. The HLP works with the local Aboriginal cooperative and medical service as well as other Aboriginal organisations to provide these programs. RFNC has also played a vital role in fostering strong relationships between the Aboriginal and mainstream communities who meet on the field every Saturday during the season.

Outcome

This health response culminated in an innovative primary health care model, addressing determinants of health in culturally appropriate and complementary ways to other local health services. Evaluation of the HLP indicated that the biggest health outcome is the very existence of the club that increases the fitness, social participation and community connectedness of its members, and particularly the self-esteem of younger members.[21] Development of the club was not straightforward, as is implied here, but a complex and tenacious process of Aboriginal leaders participating in and challenging league rules, government requirements and working across Aboriginal and mainstream structures.

Application of the framework

This scenario reflects the interplay of structural constraints (power) that created the appalling conditions of Aboriginal health and social exclusion of Aboriginal people (broader social structures). Change was initiated within the rural locale, where a group of local Aboriginal leaders acted to secure funding by using their networks at the state level (broader health systems) to develop a health initiative in partnership with other health services (local health response) within the local mainstream sporting league (rural locale) to address the social determinants of Aboriginal health (broader social structures) (Table 1). The agency (power) of these actors within their own communities, mainstream sporting leagues and state government, enabled the development of a club with a specific health vision.

Conclusion

Application of this framework suggested that while geographic location cannot be physically changed, integration between structural level changes and action within rural/remote places and health services can lead to improvements in rural and remote health. The framework emphasises the importance of power at all levels, including in community action, recognition of rural and remote in policy arenas, and in the many decisions made about rural and remote health. Furthermore, it calls for the simultaneous actions of rural residents and health professionals, communities and health services as well as changes in broader health systems and social structures to redress rural and remote health inequities.

Furthermore, the analysis demonstrated how this framework can be used to explain the specific circumstances of rural health scenarios. Application of this framework to a new place, policy or case study can provide a clear explanation of the situation. Now practitioners, communities, policy-makers, educators, advocates and researchers can use this framework to understand a new rural or remote health situation – as a guide to expediently compile relevant information so as to understand the context one is working in or for.

References

1 Bourke L, Humphreys J, Taylor J, Wakerman J. Charting the future course of rural health and remote health – why we need theory. *Australian Journal of Rural Health* 2010a; **18** (2): 54–58.
2 Farmer J, Clark A, Munoz S. Is a global rural and remote health research agenda desirable or is context supreme? *Australian Journal of Rural Health* 2010; **18** (3): 96–101.
3 Bourke L, Humphreys JS, Wakerman J, Taylor J. Understanding rural and remote health: a framework for analysis in Australia. *Health and Place* 2012; **18** (3): 496–503.

4 Giddens A. *The Constitution of Society*. Berkeley: University of California Press, 1986.
5 Curtis S, Rees-Jones I. Is there a place for geography in the analysis of health inequality? *Sociology of Health and Illness* 1998; **20**: 646–672. quote p: 645.
6 Bernard P, Charafeddine R, Frohlich K, Daniel M, Kestens Y, Potvin L. Health inequalities and place: a theoretical conception of neighbourhood. *Social Science & Medicine* 2007; **65** (9): 1839–1852.
7 Breslow L. From disease prevention to health promotion. *JAMA: the Journal of the American Medical Association* 1999; **281** (11): 1030–1033.
8 Popay J, Williams G, Thomas C, Gatrell T. Theorising inequalities in health: the place of lay knowledge. *Sociology of Health & Illness* 1998; **20** (5): 619–644.
9 Wilkinson KP. *The Community in Rural America*. New York: Greenwood Press, 1991.
10 World Health Organization. About health systems. [Cited 31 Jan 2011]. Available from URL: http://www.who.int/healthsystems/about/en/, quote p: 1.
11 Marmot MG, Wilkinson RG. *Social Determinants of Health*, 2nd edn. Oxford, UK: Oxford University Press, 2006.
12 World Health Organization. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: WHO, 2008.
13 Miller S. A structurationist interpretation of land use conflict in Lancaster County, Pennsylvania. PhD Thesis. State College, PA, USA: The Pennsylvania State University, 1992, quote p: 90.
14 Giddens A. *Central Problems in Social Theory Action, Structure, and Contradiction in Social Analysis*. London: The MacMillan Press Limited, 1979.
15 Humphreys J, Wakerman J, Wells R, Kuipers P, Entwistle P, Jones J. 'Beyond workforce': a systematic solution for primary health service provision in small rural and remote communities. *Medical Journal of Australia* 2008; **188** (8): 77–80.
16 NSW Health. Multipurpose services – policy and operational guidelines. [Cited 17 Nov 2011]. Available from URL: http://www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_049.pdf
17 Evans F, Hoodless M. Using evidence based needs assessment to lead change in a small rural community. 5th National Rural Health Conference Proceedings, Adelaide, South Australia, 14–17th March 1999. Available from URL: http://nrha.ruralhealth.org.au/conferences/docs/PAPERS/5_eba.pdf.
18 Hoodless M, Evans F. The multipurpose service program: the best health service option for rural Australia. *Australian Journal of Primary Health* 2001; **7** (1): 99–97.
19 Evans F, Han GS, Madison J. *Healthcare Reform and Interest Groups: The Case of Rural Australia*. Lanham, MD: University Press of America, 2006.
20 Carson B, Dunbar T, Chenhall RD, Bailie R, eds. *Social Determinants of Indigenous Health*. Sydney: Allen & Unwin, 2007.
21 Rumbalara Football Netball Club & Department of Rural Health. *Evaluation of the Healthy Lifestyles Program, Rumbalara Football Netball Club*. Shepparton: Rumbalara Football Netball Club & Department of Rural Health. The University of Melbourne, 2001.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RB-9

This is the attachment marked '**RB-9**' referred to in the witness statement of Dr Ravi Subramanya Bhat dated 4 July 2019.

Human
Services

Peoplefirst

Victoria's Mental Health Service

The Framework for Service Delivery

93/0255 March 1994

Mental Health Branch

Minister's Foreword

'The improvement of facilities, treatment and care for our mentally ill will be one of the highest priorities of a Coalition Government.' (Coalition Health Policy, September 1992, p. 20)

Reform of mental health services in Victoria remains a high priority for this Government. While it is easy to recognise examples of efficient and effective mental health services in the State, it remains important to ensure that the same high quality services are available to all Victorians.

In July 1993, the discussion paper, *Victoria's Health Reform: Psychiatric Services*, was released. This paper opened up discussion about the future of mental health services and a large number of responses were received. Comments came from industry and professional groups, hospitals and non-government agencies, carers, as well as from individuals who have directly used the services.

This document, *Victoria's Mental Health Service, The Framework for Service Delivery*, builds on the Discussion Paper and the responses to it, and provides a detailed framework upon which a comprehensive network of mental health services can be established. This framework provides a clear vision for the service system which will guide service redevelopment over the next five years. It will allow redevelopment and redistribution of services to take place in a uniform and consistent manner in all regions.

Most importantly, the document makes quite explicit, in a way that has not occurred previously, the Government's expectations about how the mental health service system is to operate and be managed. This will allow new mainstreaming arrangements to be developed in an informed way where all parties can expect the same high standards in our mental health system as are expected in our general health system.

I am confident that this framework will provide a sound guide for the coming years. There is much to be done to reform and reshape the mental health service and I look forward to working closely with those who will contribute to building on this framework across the State.

The Hon. Marie Tehan, MP
MINISTER FOR HEALTH

Contents

Introduction

Services for people with mental illness have had a troubled history. Like many human services, they have often been too few in number, slow to respond to changes in knowledge and approach to service provision, and they have often responded more to the needs of staff and the apprehensions or misapprehensions of the community than to the needs of their clients. These circumstances may be found in many countries including Britain and the United States of America.

Victoria has its own legacy of mistakes reflected in the reports of abuses within psychiatric hospitals, past attempts at deinstitutionalisation, the slow rate of service system change and the acknowledged deficiencies and gaps in current services. Manifestations of these shortcomings have most recently been described in the 1993 report of the Human Rights and Equal Opportunity Commission. Despite the legacy of past failures, and the global commonality of characteristic service provision problems, the onus for resolving them rests squarely with those now responsible for the administration of the inherited service systems.

It is recognised that many people will experience some type of mental health problem in their lives and that they will gain help from a variety of personal and professional networks.

In Australia, the need for reform of services for those who have a mental illness has been recognised as a national priority by the Ministers for Health of the states and territories, and acknowledged by the Commonwealth. Cooperative effort at ministerial and departmental level has resulted in the establishment of a national mental health policy and plan, and agreement on a reform agenda to span the 1993–1997 period. Victoria's participation in this process is acknowledged and confirmed in the Medicare Agreement with the Commonwealth which was signed by the Minister for Health, The Hon. Marie Tehan, in 1993.

In July 1993, Mrs Tehan released the discussion paper *Victoria's Health Reforms: Psychiatric Services* which confirmed the Government's commitment to improving services for people with a mental illness and described the broad directions that reform would take in Victoria. During three months of public consultation, a wide range of views were provided about the directions outlined in the paper. These views came from consumers, carers, clinicians and other staff, academia, professional associations, hospitals and other service providers and contributed significantly to the refinement of those ideas.

This report builds on that material and describes the means by which services for people with mental illness will be provided in Victoria over the next few years, and a progressive agenda for expansion and enhancement of those services.

Like other Australian states, Victoria has some services at the leading edge of modern service provision and others which lag behind. Our change agenda recognises the merit of the leading elements of Victorian services and sets them as benchmarks for others to match. The key change in Victoria must be to match in practice the long held aim of shifting the focus from a reliance on separate psychiatric hospitals as the preferred place of treatment. An expansion of general hospital psychiatric units for the treatment of acute patients in less stigmatising settings is required, along with the development of treatment and other services from community-based settings.

Innovative services which provide assessment and treatment in community settings both on a crisis and long-term basis, have demonstrated that for many people help is less disruptive and more effective when it is provided in their regular locality. More people can receive services in community settings than would ever be possible when only hospitals are used.

Hospital care should only be used when it is the most appropriate form of treatment. We need a much better balance between modern inpatient hospital services and expanded community services. Over the past decade there has been insufficient action on this. That balance will now be reversed.

Victoria will not repeat the mistakes of the recent past which saw many people discharged from psychiatric hospitals without adequate clinical or support services available in the community. Adequate hospital and community services will be maintained throughout the State. The expanded range of new community services will also mean that many of those discharged in the past who still need services will now be better able to receive them. The housing needs of people with mental illness are also recognised and the State has a strong commitment to providing more public housing stock.

Emphasis will be given to services which focus on prevention and early intervention to limit the effects of illness to the greatest degree possible. In addition, specific work will be undertaken to improve the level of awareness about mental illness in the community aided by Commonwealth funding of $2.1 million.

This document describes the framework on which the future delivery of mental health services in Victoria will be based. It describes the way services will be organised and managed across the State and an improved method of providing funds for services. This will ensure the best value from the mental health budget. It will also outline the range of services that will be provided and describe the principles under which they will operate to ensure that the most severely mentally ill and the most disabled will have improved access to community and hospital base care. Finally, it will detail the specific service enhancements that will be achieved in Victoria over the next few years.

The Basis for Mental Health Services in Victoria

Key Principles for Service Provision

Provision of mental health services in Victoria follows from the overlapping but distinct policies of the State and Federal Governments. The Victorian Minister for Health, The Hon. Marie Tehan, has emphasised four principles on which health, aged and community services are to be based in Victoria. They are:

- To put people first, rather than institutions or systems. To ensure a fairer distribution of limited resources.
- To obtain value for taxpayer's funds.
- To provide a better health status and outcome for all Victorians.

These priorities underpin the framework described in this document and have radical implications relative to those prior to 1993 when institutional and industrial interests were allowed to retard widely supported reforms.

The Legislative Framework

Currently the *Mental Health Act 1986* provides the legislative framework which guides and regulates the provision of services to persons with a mental illness. The Act clearly indicates that services operate so that:

- persons who are mentally ill receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given; and
- in providing for the care and treatment of persons who are mentally ill and the protection of members of the public, any restriction upon the liberty of patients and other persons who are mentally ill and any interference with their rights, dignity and self-respect is kept to the minimum necessary in the circumstances.

Clear directions are provided for the Victorian Department of Health and Community Services (H&CS) about the way services are to be delivered. Services must:

- provide standards and conditions of care and treatment for persons who are mentally ill which are, in all possible respects, at least equal to those provided for persons suffering from other forms of illness;
- take into account the religious, cultural and language needs of persons who are mentally ill;
- minimise the adverse effects of mental illness in the community;
- be comprehensive, accessible and acceptable;
- be designed to reduce the incidence of mental illness in the community;
- provide for intervention at an early stage of mental illness; and
- support the patient in the community and coordinate with other community services.

Most importantly, the Act also defines the rules and safeguards which must apply when care is provided to any person on an involuntary basis. Victoria is currently participating in a national project which is examining the potential for greater uniformity in mental health legislation across the States and Territories.

The effect of implementing the service delivery framework detailed here will be to give these principles practical, rather than merely rhetorical, force.

The National Agenda for Mental Health Reform

The National Mental Health Policy and Plan has been agreed to by all Australian Health Ministers and sets broad directions for service reform for the next five years. This was confirmed with the signing of the Medicare Agreement. Priorities for reform have included:

- The mainstreaming of mental health services within the wider health system.
- Delivery of a seamless, integrated and balanced range of services.
- An increase in the provision of acute inpatient care within general hospital settings.

- A redirection of funds into community treatment and support services.

In particular, the targeting of services towards those with a serious mental illness has been stressed together with a focus on continuity of care and recognition of the specific needs of some groups in the planning and delivery of services. A particular goal identified by Minister Tehan is to achieve an even split of funds between community and hospital based services by the end of the coming five-year period. This stands in contrast with past times, when the community-based elements of spending reached about 25% after many years of pious intentions coupled with official inertia and industrial resistance.

Priority for Serious Mental Illness

About 30% of people attending general practitioners suffer identifiable psychiatric disorders, most commonly depression and/or anxiety. A decision to refer the person to a specialist mental health service is made in a minority of cases.

Approximately three to four per cent of Victorians at any given time will require treatment and/or support due to the impact of a serious mental illness. Many will have only one episode and, with appropriate treatment, will make a successful recovery. Others will have repeated episodes and some will suffer significant levels of disability. They will require access to specialist treatment and support services as well as general community services. In some cases, services may be required for many years or for lifetime duration.

Figure 1: Community Contacts

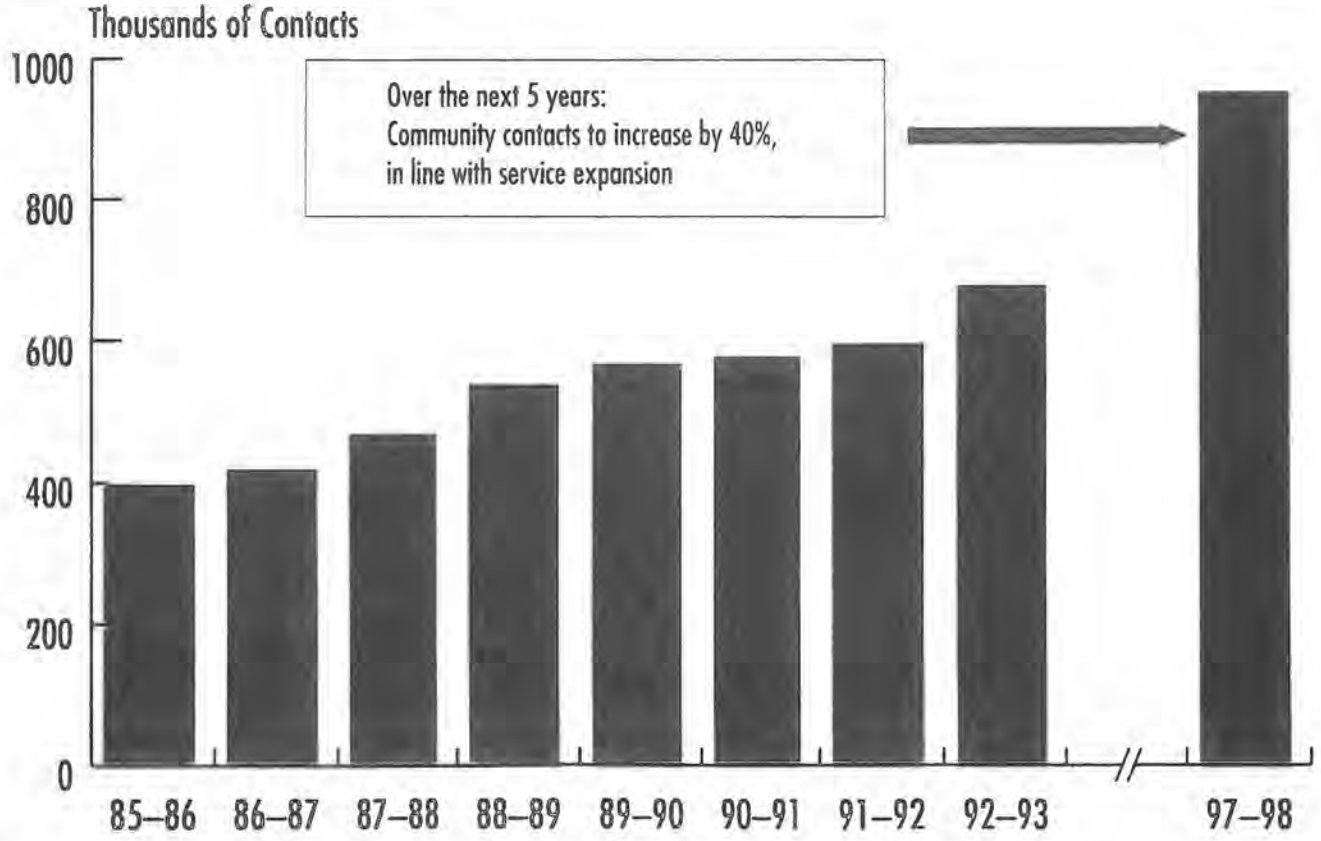
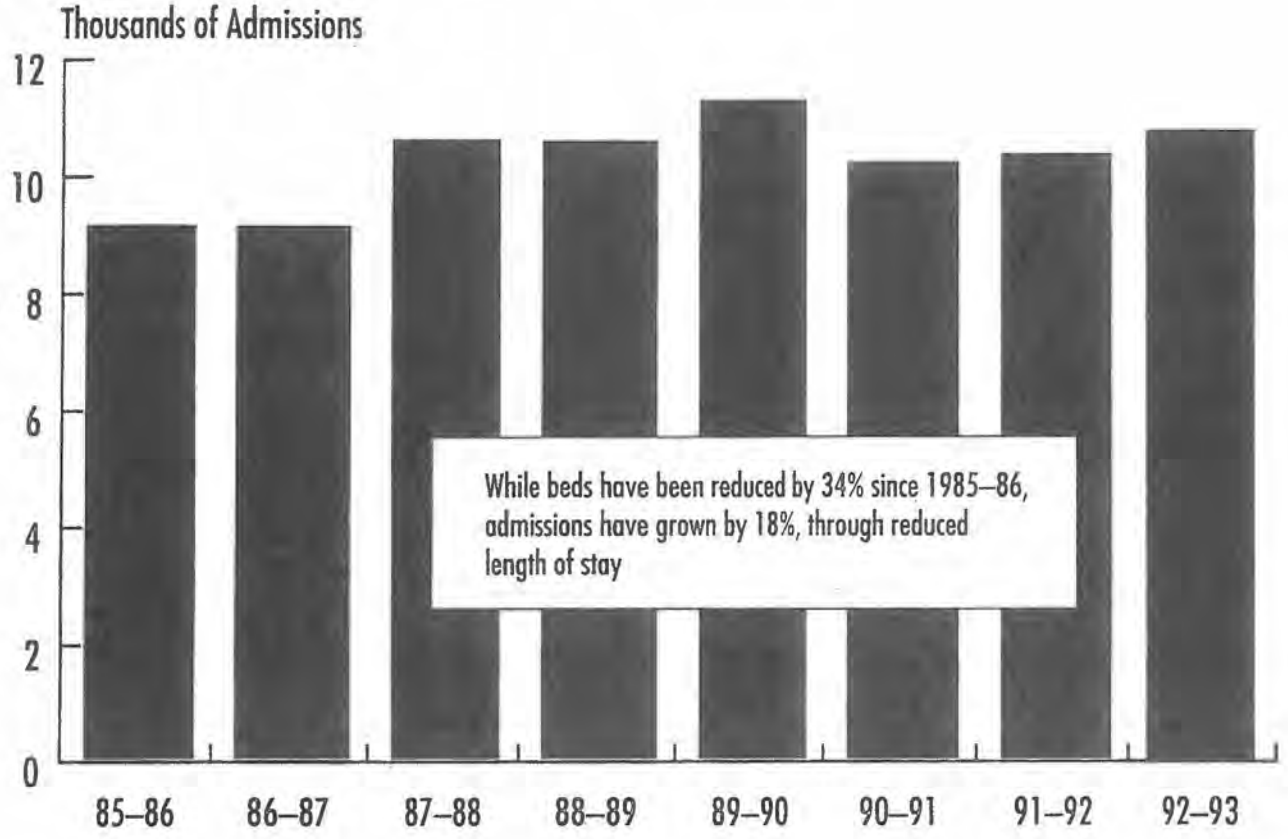


Figure 2: Trend in Admissions



ome people will also have other disabilities or disorders which can result in complex clinical presentations. Effective care and treatment will require assistance from a range of professionals operating within and across a range of public and private, hospital and community based settings. At present, this care is rarely available outside the public mental health system and so the focus on the most seriously mentally ill in adult, child and adolescent and aged service areas remains critical. This direction is consistent with the National Mental Health Policy.

Mainstreaming and Co-Location

The concept of mainstreaming encapsulates the desire to reduce the relative isolation of mental health services and thereby reduce consequential stigma and neglect which applied to those services and the people using them. The assumption has been made that common management of mental health services and general health services would automatically result in an increase in the quality of service provision and consumer outcomes. Arrangements for the management of hospitals differ between states and the practical application of mainstreaming meant quite different things in different parts of the country. In Victoria in the early nineties, this was translated into placing both community and hospital mental health services under the management of certain acute hospitals without any real direction on how the services were to be provided, what service elements were required or how the service elements would work together. This process was halted in 1993 in recognition that ideology on its own provided an insufficient base for service provision and redevelopment.

Since October 1992, significant steps have been taken to bring the overall management of mental health services into the same framework as the rest of the general health and welfare system. Some general hospitals have taken over the management and delivery of comprehensive psychiatric services with considerable success. Psychiatric Services managers now work alongside other elements of management of the health and welfare system in H&CS regional offices. This ended a long history of bureaucratic segregation of the Office of Psychiatric Services and its predecessors. Psychiatric Services managers share common reporting lines to a single Regional Director who will be responsible for configuring services according to this framework. Mental health service provision is now a mixture of contracted and directly managed services, in common with many other services provided by and through H&CS. Mental health services will no longer be isolated as in the years prior to October 1992.

The National Mental Health Policy also acknowledges the need to co-locate acute inpatient services with general hospital acute inpatient services to provide many of the benefits sought from the mainstreaming concept as identified above. Co-location is already being achieved in Victoria as new acute services are constructed and this, as a preferred model, will now continue. It must, however, be recognised in Victoria, as in some other states, that co-location does not require, nor necessarily imply, common management of all service elements in order to achieve those benefits.

Delivering an Integrated Service

A comprehensive mental health service must encompass services which cater for both acute episodes and long-term care. It should include inpatient, community, and home based care options. Integration of service

Figure 3: Proportion of Total Psychiatric Beds in Large Stand Alone Psychiatric Facilities, as at June 1993

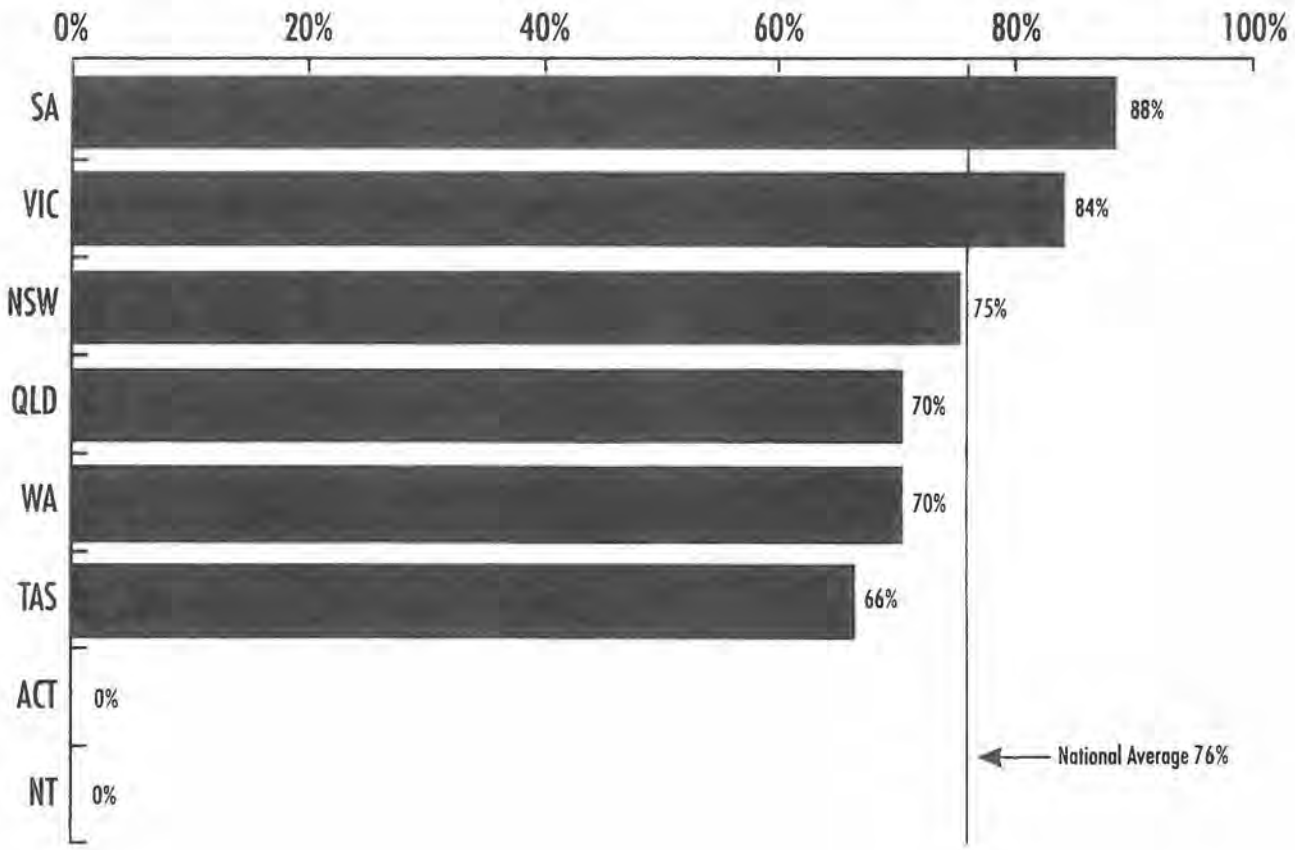
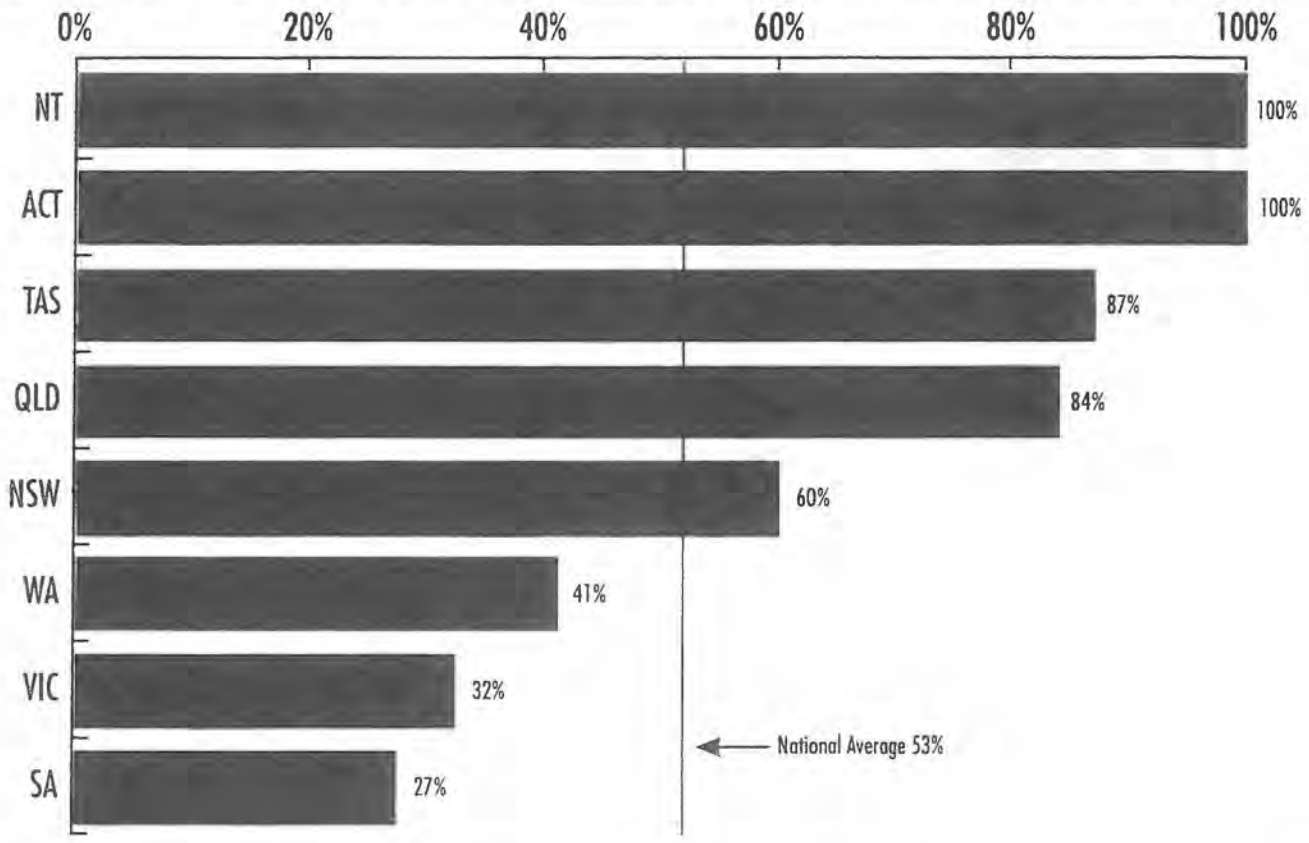


Figure 4: Percentage of Total Acute Beds Located in General Hospitals, by State and Territory, as at June 1993.



delivery is required to ensure continuity of care so that clients can move between service elements as their needs change and receive the most appropriate service response at any time. This requires coordination at two levels:

- From a service system perspective, it relates to the deployment of a region's mental health budget in such a way as to ensure that the appropriate range of service options are available to meet the needs of the community it serves.
- From a client perspective, it reflects the need for case management so that each person is able to access the services they need, when they need them, and with one clinician accountable for ensuring, but not necessarily providing, their proper treatment and support.

In Victoria, services are available through a range of providers including:

- general hospitals;
- non-government organisations;
- private providers, including general practitioners and private psychiatrists; and
- directly through government agencies.

Effective case management processes will be critical to achieving and maintaining continuity of care for clients, including cases where clients have linkages with other services such as accommodation, child welfare, disability or drug and alcohol services. This approach recognises the critical role that carers play in the provision of support for people with mental illness. Services must be sensitive to this and support the involvement of carers wherever possible. Victoria will introduce standard approaches to case management through a common framework for client services delivery.

Together with an appropriate mix of services in each region, this should achieve integrated service delivery across the State.

Putting It All Together

There is a high level of consistency through the various legislative and policy directions outlined above. Unfortunately, Victoria has lacked a consistent approach to the creation, redevelopment, and, indeed, the operation of its mental health services. The framework for the provision of services outlined in the following chapters will lead to greater consistency and quality in the type, range and operation of services across the State.

Through this framework, H&CS will ensure that:

- Mental health services will be responsive to the needs of clients.
- Choices for treatment and care are available.
- Services are delivered in a timely manner and in the least restrictive environment.
- The rights of the clients of mental health services are respected, protected and promoted.
- The providers of services are accountable.
- Services do not stigmatise patients.
- The best possible standards of care are used.
- Value for money is achieved.

The Organisation of Services

Organisation Through Regions and Local Areas

H&CS is organised through nine regions which span Victoria. Health and welfare services are delivered, either directly or indirectly on a contractual basis, through these nine regions. While the regional offices primarily serve an administrative function, the delivery and organisation of mental health services through a common administrative framework enables maximum use of generic services and skills. This facilitates coordination and liaison with other human services and will be particularly helpful when dealing with clients who also use services other then mental health. It provides a common base for planning and developing practical operational protocols and linkages to other services. Regional structures currently allow the provision of services on a statewide, regional or local area basis and this will continue to apply to the delivery of mental health services.

Within regions, psychiatric services will continue to be organised on a local area basis although the previous, formally defined sub-regional sectors may not all be maintained. Instead, each region will be responsible for identifying the most appropriate local areas around which to base the delivery of services. It is expected that these will be influenced by a range of features including:

- population characteristics such as age, ethnicity, family structures, socioeconomic status and other indicators;
- geographic features including transport and mobility factors;
- special needs such as recent and expected population growth, level of homelessness in the area, number of people with serious mental illness;
- service demand and utilisation data from both community-based and hospital services;
- the spread of mental health and other human services including government and non-government agencies; and
- the most effective deployment of resources.

Above all, local service areas should be established to support the most effective and efficient delivery of services. Accordingly, it is expected that local areas may vary significantly in size.

Working within a consistent regional structure will still enable the recognition of natural service catchment areas that may sit across regional boundaries. In these circumstances, the affected regions must agree on service delivery arrangements which will work with the least inconvenience to clients and in such a way that H&CS regional boundaries are invisible to users. Such arrangements will need to be formalised and may require the transfer of resources between regions on a purchase of service basis. The regional organisation of services must not arbitrarily restrict the choice of service available to consumers.

Distribution of Resources to Regions and Areas

Historical concentrations of spending on mental health services in Victoria have focused around the large psychiatric hospitals and have matched neither the location nor the needs of the community. Redistribution of available funds is urgently required to rectify this. Allocation of funds to services based on individual client entitlements is preferred, but there is no mechanism currently available in the service system which can achieve this. In the interim, the budget will be redistributed to regions on the basis of a weighted population formula that combines both population and proxy measures of service need. It will also take into account the additional costs of delivering services in rural areas. Statewide services will be separately funded. See 'Resourcing Mental Health Services' for details of this approach to service funding.

The allocation of funds to local areas and service providers will be determined within each region to

obtain the best mix of service type and quantity for each area. This will proceed as quickly as the funds can be freed up from the state psychiatric hospitals and will have a significant impact on the provision of services, particularly in the traditionally under-served Eastern and Southern Metropolitan Regions.

The regional mental health budget will include all funds directed by H&CS into public mental health services, including funds directed to the non-government and acute hospital sectors. Regions must ensure that funds are deployed to obtain the best mix of services through the most effective service provider arrangements. All funding agreements will be time-limited and relate to specific service delivery targets. Historic distortions in the inter-regional allocation of funds will rapidly lose importance as a factor in future funding.

Management of Services at a Regional Level

A key objective of the National Mental Health Policy is the establishment of an identifiable mental health program at central and area or regional levels. Such a regional mental health service should be part of the regional mainstream or general health administration and be responsible for planning all specialised mental health services. It should also manage the allocation of resources between the components of the local mental health service system. The area or regional mental health service should be the 'budget holder' for all specialised state-funded mental health services, whether delivered in separate or mainstreamed health settings. This approach is critical to achieving an adequate range of services which are balanced according to the needs of an area's population.

Requirements for integrated regional and area service delivery are assisted through regional managers having responsibility for:

- distributing the mental health budget equitably throughout the region;
- improving integrated service delivery by implementing policies which relate to the design, style and operation of mental health services;
- ensuring the planning and provision of a balanced range of services to reflect local needs; and
- negotiating funding and service arrangements with agencies and monitoring standards of service delivery.

Local service planning and management will ensure the development of formal links with other components of the mental health and related service systems. Integration of public mental health with the activities of general practitioners and private psychiatrists offers particular promise and can best be approached on a local basis.

Planning the distribution of services and arrangements for service management must be completed so that agency responsibilities are clear and unequivocal and a prompt response can be made to any person in the region who requires treatment and/or support for a serious mental illness.

Management of Service Elements

Each regional service system will consist of three mental health programs:

- child and adolescent;
- general adult; and
- aged persons.

Each of these programs will operate through a number of service elements, provided locally, regionally, or on a supra-regional or statewide basis.

Comprehensive mental health services are very different from the style of most services provided currently by general hospitals.

In implementing this framework, each H&CS regional office will identify the strengths, weaknesses and gaps in their present service delivery systems. Strong and effective service elements will become the base around which future redevelopment takes place. Redirection of service arrangements must lead to improved service outcomes.

The preferred approach is for comprehensive and integrated area based services to be managed by a single hospital which has the interest and skill to provide a community-led mental health service. However, in some areas, acute inpatient services may be provided through a general hospital, with the community assessment and treatment services operated directly through the H&CS regional office. Rehabilitation and support services are provided through non-government agencies. Where there is no suitable auspice agency in an area, it might be necessary for H&CS to continue to directly provide some services. This, however, is not the preferred option and every effort will be made to identify suitable auspice agencies. It may also be the case that some existing general hospitals will not wish to deliver existing mainstreamed services in a community-led manner. Alternatives will be pursued where this is so.

There are major differences in the needs and opportunities in the nine regions. Each H&CS region will determine the most appropriate approach to management of mental health services. We will encourage stronger networks with general practitioners and the development and reliance on other agencies, including non-government managed disability support services and private providers. The development of networks and protocols will clearly be required. Protocols will also be developed to govern the interrelationship between child and adolescent, adult and aged mental health services.

The choice of providers by H&CS will be purely pragmatic—the arrangement which will lead to a better level of service delivery and improved consumer outcomes will be selected. Confidence that the auspice agency will deliver the type of service with the right outcomes at the agreed price is paramount. In most cases that will involve agreement on the following issues:

- Focus on providing treatment for persons who are seriously mentally ill and/or have a severe level of associated disability.
- Commitment to maximise the amount of psychiatric treatment support provided through the community mental health services.
- Agreement that all publicly funded hospital beds be gazetted under s. 94 of the Mental Health Act to ensure the ability to treat clients admitted on an involuntary basis.
- Coverage of the catchment area defined by the Regional Office.
- A high level of confidence by the region that delivery of the service by the proposed agency would enhance service effectiveness.
- Ability to guarantee protection of funds provided for the psychiatric service and management of the service as a discrete program.
- Agreement that the service will operate at or below the prevailing state benchmark cost for that type of service and recognise the need for further reduction in future years.

Effective management arrangements are not to be confused with issues of continuity of individual patient care, which will be further addressed in the next chapter.

The Provision of Services

The Delivery of Services

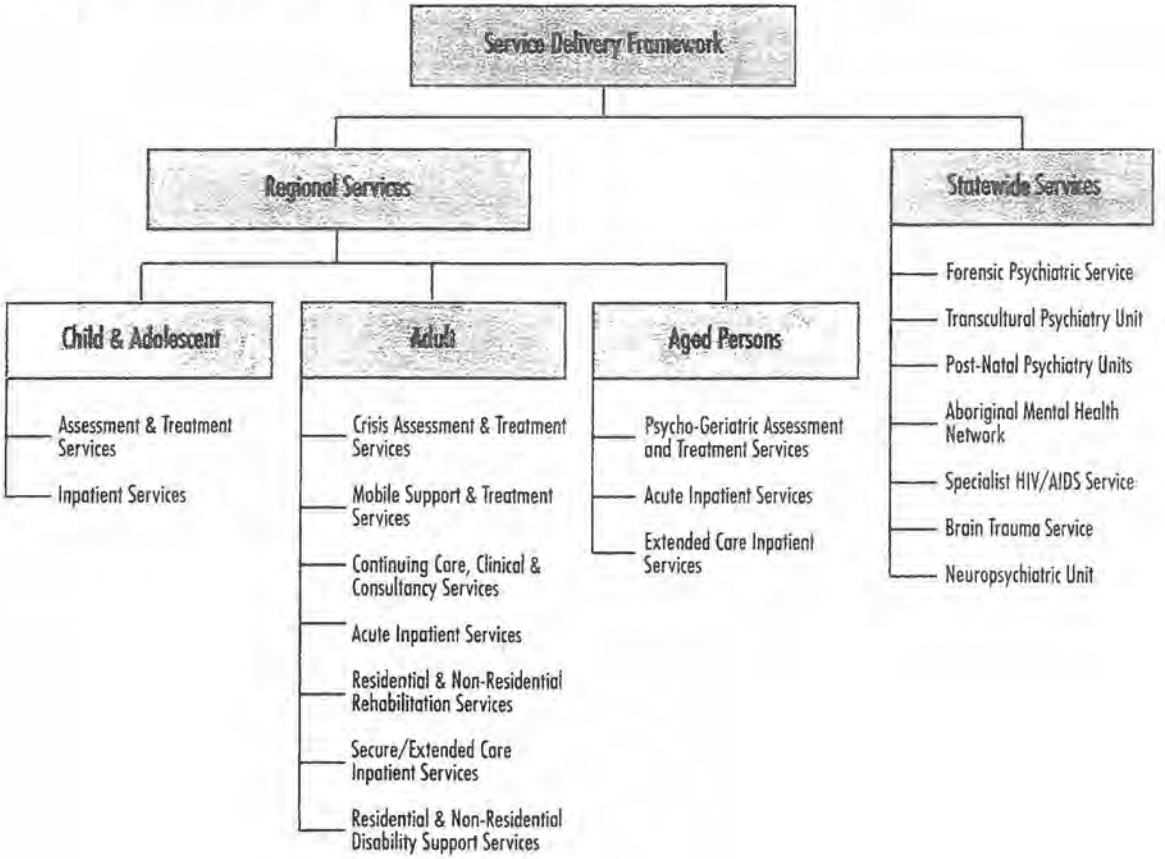
The mental health service system will focus on three client groups within each region—children and adolescents, adults, and aged persons (see 'Program Descriptions'). Common general principles and directions will apply to all three client groups, however, although programs are broadly organised around age levels and the needs of clients in those groups, they will not be segmented within the rigid age criteria that currently apply.

Matching of patients to services must be based on clinical criteria. For example, adolescents suffering early onset psychoses ought to receive services through the adult program since they will have ongoing service needs and clinically form part of a group generally aged between 14 and 30 years. Persons who have been in receipt of services from the adult service ought not be automatically excluded when they reach age 65 unless their service needs would be better met through the aged persons program. Similarly, persons who have not reached 65 but who suffer from age-related conditions may get a better service response from the aged persons program. Individual case management will assist the matching of individual client needs and service provision within and across the three program areas.

Child, Adolescent and Family Mental Health Services

These are services for children and adolescents up to the age of 16 years with serious emotional disturbance. This includes young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to their growth and development and/or

Figure 5: Victoria's Mental Health Services—The Framework for Service Delivery



where there are serious difficulties in the person's social or family environment.

It is recognised that many children and adolescents with an emotional disturbance do not require specialist mental health services and are well supported by primary care and other health, educational and community services. It is therefore vital that specialist mental health services have strong linkages with the broader network of services for children and young people and, accordingly, specific protocols are being developed to support this direction.

Service Elements

- Child and adolescent assessment and treatment services
- Inpatient services

General Adult Mental Health Services

These are services for adults with serious mental illness, primarily between the ages of 16 and 64 years. The adult program is, and will probably remain, the largest of the three programs and includes a range of more specialist statewide services. The mental health service will provide specialist treatment and support but is not able to meet all the needs of a person who has a serious mental illness and will often need to work cooperatively with other community support services. In some cases, such as in forensic psychiatry, a self-contained service will be provided. Generally, however, strong formal linkages with other human services will be required. Liaison Psychiatry Services provide a consultation and treatment service to a range of medical and surgical units within general hospital.

Service Elements

- Crisis assessment and treatment services
- Mobile treatment and support services
- Continuing care, clinical and consultancy services
- Acute inpatient services
- Residential and non-residential rehabilitation services
- Residential and non-residential disability support services
- Secure/extended care inpatient services

Aged Persons Mental Health Services

These services are primarily for people aged 65 years and over, including those with:

- a long-standing mental illness who have grown older;
- functional illnesses such as depression and psychoses which have developed in later life; and
- psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

People whose mental illness is of late onset or is characteristic of older patients should be treated as far as possible as part of the aged care service system, rather than as part of general adult or aged person psychiatry. Aged persons' mental health services, therefore, should operate with strong linkages with the broader network of health and community services for older persons.

Service Elements

- Psycho-geriatric assessment and treatment services
- Acute inpatient services
- Extended care inpatient services

Community Oriented Service Delivery

This framework is based on the principle that the majority of people with mental illness can be effectively treated in community settings and that this practice will lead to improved consumer outcomes. The regional mental health service system must provide services which will ensure that consumers are treated, supported and rehabilitated in or near their usual place of residence and, as much as possible, in a community-based, or non-hospital setting. For this to occur, specific service delivery targets must minimise

Figure 6: Episodes of Service Use

the extent and use of inpatient services and maximise the ability of community-based services to respond quickly and effectively.

Service delivery will be driven through community-led mental health services and will recognise the interdependence of the public and private sectors for service provision and, most importantly, place the focus clearly on the needs of clients. In particular:

- Services will be provided on a local basis to allow improved access, clinical continuity and case management.
- Community-based service networks will become the nucleus of the service system, with hospital inpatient services providing appropriate support and back-up.
- The decision to admit to hospital will be based on a comprehensive assessment and formulation of a management plan which should consider a number of treatment options, including treatment in the community, if at all possible. Hospital admissions will be minimised and will only occur in the context of a community-based treatment and service delivery strategy, when community-based alternatives are either inappropriate or unavailable. Within this service system, inpatient admission must not be seen as a failure either by the patient or the community-based staff but as a valid treatment option.

To maximise community treatment, the management and clinical leadership of services is expected, for the most part, to be community-based. It is expected that each area will have a senior psychiatric position of Director of Clinical Services. This will be a joint appointment and will provide clinical leadership across hospital and community settings. Community services will be equipped with the ability and authority to purchase inpatient services as required. Services will be planned and/or delivered by multidisciplinary teams with a client's progress being supported by case management arrangements.

Access to Mental Health Services

The public mental health service must be accessible to all Victorians. While the service system is targeted at people with serious mental illness, some consumers will pose particular difficulties for service providers. Regional service systems must be designed to ensure that all people living within the region have access to appropriate mental health services, and ensure that treatment and/or support is actually provided.

All mental health services will operate within clearly defined catchments and will be responsible for providing or arranging provision of services to all clients living within, or in the case of clients who are transient, originating from that area. Catchment areas will be defined within each region and will take into account urban/rural differences, population density, population dispersion, location of existing services, accessibility to services, and service utilisation patterns. The region of origin refers to a client's place of residence at the time the client is initially registered with the public mental health service system and regional responsibilities will continue until such a time as the person is:

- formally discharged from the mental health service system; or
- formally transferred to another region or local area service.

Protocols for the transfer of a client's treatment and care will be established to guide this process. These arrangements are necessary to ensure that responsibility for even the most demanding consumers is always clear and that services will not be able to assist their clients to move to other regions without making adequate arrangements for continued care. In some instances, these arrangements may involve a transfer of resources.

Entry to the Service System

Public mental health services are targeted at people with a serious mental illness and services must remain focused on this group of persons. Loss of this focus would quickly result in service capacity being swamped by people with less serious mental disturbance and a consequential inability to respond to those most in need.

Initial assessment and treatment will be provided routinely through community mental health services with hospital inpatient admissions occurring only when required by the severity of the illness and the degree of risk. People may present at a crisis assessment and treatment (CAT) service, a community mental health service, or an intensive mobile treatment service. Each of these services performs an assessment function and may admit clients or make a more appropriate referral within or outside the service system.

All referrals for admission to acute inpatient mental health services will involve assessment by the CAT service. This includes referrals from within the inpatient services of a co-located facility (such as an acute general hospital), from accident and emergency (A&E) departments, outpatient departments, and from the community (including mental health services, other agencies, private practitioners and clients themselves).

Wherever possible, the community psychiatrist will be appointed to work across inpatient and community-based services. The community-based psychiatrist will have the responsibility for the clinical decisions of the CAT service and the decision to admit or not admit. A decision to admit is in fact a decision that appropriate treatment cannot be provided effectively within the community.

In situations where a referral to the inpatient service is generated from a hospital A&E department or from within the inpatient service of a co-located facility

(such as a general hospital), the CAT service will work with the referring medical officer to determine the most appropriate treatment options, with particular emphasis on community treatment. This arrangement is already working effectively in several general hospitals.

To ensure that the CAT operates as effectively as possible, protocols will be established to ensure efficient operation between community-based services and co-located facilities. Collaborative and explicit working arrangements will be an operational priority.

Continuity of Care

The *National Health Strategy Issues Paper* identifies the common features of mental health services promoting continuity of care as:

- case management;
- a multidisciplinary approach;
- an assessment program that offers single point of entry into an integrated service; and
- an information system to support continuity and integration concepts.

In Victoria, a consistent approach to case management will provide the framework for individualised care, provided and actively managed for the duration of the person's illness. The primary objectives of this form of care are to:

- Enable a client's service needs to be met effectively and efficiently through the use of a common set of processes and functions.
- Enable planned and coordinated service provision to individual clients.
- Provide staff with a common practice framework.
- Strengthen links between service delivery and service planning.
- Establish a single point of responsibility for the delivery of services to a particular client.

Within this context, case management will be used to facilitate co-ordination, accountability and continuity of service delivery, and ensure the provision of the appropriate services in a timely and efficient manner. The case manager will guide the client through the system, ensuring that client needs are assessed, planned for and met in a timely and effective manner. The level of intensity of case management support will vary according to the needs of the individual client. Clients with complex, multiple needs, requiring a range of services will need more intensive support from a case manager than will clients with less complex needs. Intensity of case management support will also vary as a client's needs change.

The Key Features of a Good Regional Mental Health Service

- Services are organised around identified catchment areas which between them cover all localities within the region.
- Arrangements are in place for the delivery of a crisis mental health and mobile treatment and support service in all parts of the region.
- Maximum provision of treatment and support occurs in the community, with inpatient services being used only when necessary in the interests of the client.
- Acute inpatient services are provided by a general hospital and are co-located on the hospital campus.
- Services are targeted to people who are seriously mentally ill, with priority given to those most in need of intervention.
- The service monitors—and assists where necessary—the progress of all clients to ensure that service provision is targeted, coordinated and provided in the most effective way.
- Professional, service and community linkages and networks are developed, maintained and formalised with written protocols where appropriate.
- The service is available and accessible and is actively promoted across the region.

- Community education activities aimed at increasing the acceptance of people with mental illness in the community are undertaken.
- Services are provided to clients and carers by appropriately skilled medical, nursing and allied health staff.
- The use and demand for services is monitored and the budget applied to secure a balanced range of acute, long-term and support services across the region.
- The qualitative and quantitative performance of service providers is regularly reviewed and service agreements accurately and specifically define the expectations of funded agencies.

Monitoring, Evaluation and Quality Assurance

The operation of an effective and efficient mental health service requires the development, maintenance and review of systems for monitoring and evaluating the effects of service delivery.

This framework for service delivery identifies a range of key service requirements for the overall regional service system, individual service networks and individual service components. The Psychiatric Services Branch, through the regions, will monitor standards that will apply uniformly to all service providers. Key performance indicators will be developed that will allow comparative evaluation and monitoring of service performance against identified targets within and across regions.

Funding and service agreements will be substantially developed to reflect these requirements and will form the basis for service monitoring. Existing agreements will need to be renegotiated to ensure that the funds provided deliver the type of service required. Service evaluation will include consumer and carer involvement in its design and implementation and is seen as a priority for the State.

In order to undertake effective service monitoring and evaluation, a relevant database and information system must be available. At present, there is a system-wide database and information system available to mental health services which reflects the current utilisation of most inpatient and community-based services. The Australian Health Ministers, through the Australian Health Ministers Advisory Committee (AHMAC), have made a commitment to establish a National Minimum Data Set for mental health services, covering both hospital and community-based services. H&CS is currently reviewing its data requirements in the context of this framework and the national project. It is expected that this review will determine the extent to which local systems can be developed to suit local regional and facility needs in a reliable and timely manner, while ensuring that H&CS has access to the necessary information to be confident that mental health services are being delivered appropriately.

Outcome orientated service delivery evaluation will increasingly become the focus of evaluation. The 1991 *Report of the Mental Health Task Force to the Australian Health Ministers Advisory Committee* identified three areas in which mental health outcome indicators should be developed:

- indicators related to agreed national resource priorities;
- indicators for establishing mechanisms to monitor and enforce service standards, and consumer rights and satisfaction; and
- indicators of progress towards nationally consistent mental health legislation.

The Australian Council of Health Care Standards accreditation will be the standard for all inpatient facilities but further development is required for the accreditation of community-based mental health

services. Clinical indicators which measure the clinical management and outcome of care for mental health services are being developed for inclusion in the Australian Council of Health Care Standards survey process for accreditation.

Quality assurance systems will be expected to form a routine part of clinical service activity. Such systems should be open to scrutiny and involve the participation of consumers and carers. The development of quality assurance processes will be required from each service provider.

Program Descriptions

Child, Adolescent and Family Mental Health Services

Child, Adolescent and Family Mental Health Services at a Glance

Objectives

1. To alleviate serious emotional disturbance through the provision of a mental health assessment and treatment service which responds effectively and efficiently to the needs of children, adolescents and their families.
2. To provide direct services to children and adolescents where effective help is unable to be provided through other service systems.
3. To provide active support and consultancy to, and work in conjunction with, other services for children and adolescents.

Target Group

Services are targeted at children and adolescents up to the age of 16 years with serious emotional disturbance. That is, young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to psychosocial development and/or where it leads to serious difficulties in the person's social or family environment.

Service Elements

- Child and Adolescent Assessment and Treatment Services.
- Inpatient Services.

Key Service Linkages

- Child and family services (including protective services, child care services, kindergartens, maternal and child health nurses).
- Services for people with intellectual, physical or sensory disabilities.
- Health services including general practitioners, paediatricians, drug and alcohol services and private child psychiatrists.
- Education services.
- Other community services including juvenile justice, housing, police, emergency accommodation services and disaster/emergency management services.
- General adult psychiatric services.

Objectives

1. To alleviate serious emotional disturbance through the provision of a mental health assessment and treatment service which responds effectively and efficiently to the needs of children, adolescents and their families.

2. To provide direct services to children and adolescents where effective help is unable to be provided through other service systems.

3. To provide active support and consultancy to other services who are working with children and adolescents and to work in conjunction with those services wherever possible.

Specialist public mental health services for children and adolescents must focus on service provision for those who are most disturbed and whose needs cannot be met through other avenues.

Many children and adolescents with emotional problems will not require specialist mental health services. Some will be helped by their families and available social support networks and others will receive assistance from services available in the community. When a young person does not respond to these interventions and there is a likelihood of more serious disturbance emerging, specialist mental health services may be required. Recent reductions in general support systems are resulting in an increased demand for services from specialist mental health services.

In order to ensure access to comprehensive services, cooperative relationships and innovative service options will need to be developed by each region to ensure the provision of a network of core services for children, adolescents and their families. Some services will be provided on a local area basis whereas others will be provided on a regional or super-regional basis. Rural areas will continue to develop service arrangements with metropolitan areas so that their clients have access to a full range of service options.

It is particularly important that child, adolescent and family mental health services are responsive to their client group. Available funding for child, adolescent and family mental health services must therefore be carefully targeted and the type of service which is provided, continuously reviewed to ensure maximum effectiveness and value from these funds. The best use of funds should be achieved through:

- early intervention;
- maximum provision of services in community settings;
- minimising the use of hospitalisation; and
- use of the shortest term interventions possible to resolve the situation.

The challenge for child and adolescent services is to actively adapt these strategies to ensure that they provide effective services to the greatest number of clients.

Target Group

Child, adolescent and family mental health services provide services to children and adolescents with serious emotional disturbance. That is, young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to psychosocial development and/or where there are serious 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 and suicidal behaviour, more often emotional disturbance in childhood and adolescence presents in other ways—hyperactivity, nightmares, depression, fearfulness, bed wetting, soiling, temper tantrums, stealing, poor impulse control, anti-social behaviour, obsessional behaviour, relationships problems, language problems, learning difficulties, refusal to go to school, unusual eating patterns and physical illness.

While many young people at some time in childhood will present with one or more of these behaviours or difficulties, usually children and adolescents are not considered to be emotionally disturbed unless a pattern of symptoms emerge which are inappropriate for that young person's age, stage of development or circumstances.

The highest priority for child, adolescent and family mental health services are those young people with the most severe symptoms or who are in a high risk group. Some disorders more commonly emerge at particular developmental stages.

Children and adolescents in the following circumstances are more likely to be at risk of a serious emotional disturbance:

- Victims of physical, sexual or emotional abuse.
- Those within the welfare and juvenile justice systems.

- Homeless youth.
- Those from severely disruptive homes.
- Those whose parents suffer from a mental illness or a dependence on drugs or alcohol.
- Infants with attachment difficulties and where there are serious problems in parent/infant relationships.
- Those with developmental difficulties, learning difficulties and/or an intellectual disability.
- Those with chronic health problems and disabilities.
- Post trauma and post disaster victims.

It is recognised that many children and adolescents with emotional disturbance do not require specialist mental health services and are supported by primary care and other health, educational and support services available in the community. Specialist mental health services operate as part of a broader network of services for children and young people and must develop and maintain linkages with these services.

Work undertaken by the Early Psychosis Prevention and Intervention Centre (EPPIC) indicates that adolescents suffering early onset psychoses are best provided with services through a specialised stream of the adult program as they are likely to have ongoing service needs. The model of practice developed by EPPIC will form the future development of services for adolescents. This must be supported by the development of a statewide consultative role for EPPIC.

Service Elements

There are two types of public mental health services provided for young people and their families which ought be available in, or able to be accessed from, each region:

- Child and adolescent assessment and treatment services
- Inpatient services

The current arrangements, whereby metropolitan child and adolescent services provide active support to service provision in rural regions, will continue until such time as appropriately trained professional staff can be recruited to work in those areas. This provides some child psychiatric clinical support in those areas and formalises access to metropolitan inpatient services.

Child and adolescent forensic services are provided through the Child, Adolescent and Family Welfare Division of H&CS. Despite this, child and adolescent assessment and treatment service staff must still provide services to young people involved in the juvenile justice system on the same basis as would be done for other clients. Assessment with a view to treatment or support ought be undertaken while that for the purpose of a court report is more properly the function of the forensic service.

Child and Adolescent Assessment and Treatment Services

These are community-based services which will offer a range of services including family therapy, parent counselling, individual therapy and group therapy and medication-based treatments. Services will be organised to enable a timely response to referrals, including crises, and be delivered on an outreach basis where appropriate. They should be present in each region.

Key service requirements for child and adolescent assessment and treatment services are:

- To intervene as early as possible to enhance healthy development and reduce the incidence of mental illness in children and adolescents.
- To routinely commence all treatment with brief interventions. The use of longer-term interventions will require careful consideration and justification.
- To minimise their contact with the young person and focus on enhancing and providing support to the young person's wider support system as many children and adolescents with emotional problems will not require specialist mental health services.

- To plan and deliver services in a manner appropriate to the different needs of children and adolescents, including consideration of the different developmental stages of the young person, the wishes of the individual and their family. They should be organised in a way that ensures a timely and mobile response.
- To assess and treat children and adolescents in the context of their families, other carers and their wider social support system.
- To provide services in the least restrictive environment and in a manner which is least intrusive to the child or adolescent. Periods of hospitalisation should be minimised.
- To allow children and adolescents access to services even if they are involved in child protection, juvenile justice or disability service systems. Similarly, young people must not be denied service because they are not suited to a particular style of intervention. Service provision must adapt to the circumstances of these young people.

Inpatient Services

Inpatient services are provided for children and adolescents who have severe emotional disturbance which cannot be treated in a less restrictive setting. Inpatient services will normally be co-located with hospitals. Regional service systems must include provision for access to inpatient care for young people even if it is provided out of their region. They must also organise service delivery in ways that minimise the young person's period of hospitalisation.

Key service requirements for child and adolescent inpatient services are:

- To ensure that all admissions to the service have the involvement of the community-based child and adolescent assessment and treatment service, periods in hospital are kept to a minimum, and appropriate follow-up arrangements are made through the assessment and treatment service following discharge.
- To provide service in the least restrictive environment and in a manner which is least intrusive to the child or adolescent.
- To ensure all beds are gazetted under s. 94 of the Mental Health Act and are accordingly able to admit involuntary patients.
- To manage young people who require a short-term secure environment and intensive support.

Linkages with Other Service Providers

The provision of specialised mental health services must occur in collaboration with other services to provide responsive service options. Child and adolescent mental health services staff will consult with and provide advice to other human service systems to assist their work with individual clients as well as improve their ability to support the emotional wellbeing of children and young people through their services and programs.

Formal links will be established with:

- Child and family services (including protective services, child care services, kindergartens, maternal and child health nurses).
- Services for people with intellectual, physical or sensory disabilities.
- Health services including general practitioners, paediatricians, drug and alcohol services and private child psychiatrists.
- Education services.
- Other community services including juvenile justice, police, emergency accommodation services and disaster/emergency management services.

Continued attention will be given to cross-program linkages both internal and external to H&CS. Protocols have recently been established with the Child, Adolescent and Family Welfare Division in relation to child and adolescents involved in the child welfare system. It is intended that clear protocols be developed at both a central and regional level to ensure the necessary

coordination of service provision to children and adolescents. This will include formalising the relationship with adult mental health services in relation to service delivery for adolescents with early onset psychoses based on work done by EPPIC.

General Adult Mental Health Services

General Adult Mental Health Services at a Glance

Objectives

1. To assess and treat adults with a serious mental illness in a timely and effective way.
2. To monitor and coordinate the provision of services to clients to ensure continuity of care in the least restrictive environment.
3. To deliver a range of community and residential treatment and care programs on a continuous or intermittent basis.
4. To undertake prevention activities and community education to increase public awareness and understanding of mental illness.

Target Group

Adults with a serious mental illness aged between 15 and 64 years including those suffering from a severe personality disorder where the person's behaviour places themselves or others at risk of harm.

Service Elements

- Crisis assessment and treatment services.
- Mobile treatment and support services.
- Continuing care, clinical and consultancy services.
- Acute inpatient services.
- Residential and non-residential rehabilitation services.
- Residential and non-residential disability support services.
- Secure/extended care inpatient services.

Key Service Linkages

- Primary health care services including GPs, private psychiatrists, community health centres and general hospitals.
- Child and adolescent and aged persons' mental health services.
- Disability, drug and alcohol and child welfare services.
- Housing and accommodation, domiciliary care, social support and employment and training services.

Objectives

General adult mental health services will incorporate a network of community focused adult mental health services providing assessment, treatment, and psychosocial rehabilitation services to people with serious mental illness and associated psychosocial disability. In summary the objectives of these services are:

1. To assess and treat persons with a serious mental illness in a timely and effective way.

2. To monitor and coordinate the provision of services to clients to ensure continuity of care in the least restrictive environment.

3. To deliver a range of community and residential treatment and care programs on a continuous or intermittent basis.

4. To undertake prevention activities and community education to increase public awareness and understanding of mental illness.

Each adult mental health service will be responsible for providing services to people residing in its catchment area. Services will be provided in a way which causes minimum intrusion and disruption into the person's life. This means that services should be available to consumers as close as possible to their local communities and their usual and familiar surrounds. It should also minimise the size and use of inpatient services and ensure that the maximum amount of service is provided through community service outlets.

Initial assessment and treatment will be provided routinely through community mental health services with hospital inpatient admissions occurring only when required by the severity of the illness and the degree of risk. People may present at a crisis assessment and treatment service, a community mental health service or an intensive mobile treatment service. Each of these elements performs an assessment function and may admit consumers to the service or make a more appropriate referral either within or outside the service system.

Exceptions to these arrangements relate to hospital orders made under s. 15 of the Mental Health Act in relation to persons convicted of criminal offences. The provisions of this section allow the court to make a hospital order instead of passing sentence. Persons convicted of criminal offences may therefore be admitted to a psychiatric hospital following assessment by the authorised psychiatrist of that hospital and on the order of the court. People on court admissions enter the service system directly through the hospital system rather than through the community mental health services component.

The Mental Health Act also makes provision for the use of community treatment orders (CTOs) whereby involuntary patients receive treatment for their mental illness in the community. CTOs are used as an alternative to admission to a psychiatric inpatient service or where the patient's condition is such that continued hospitalisation is no longer the least restrictive environment in which the person can receive treatment.

Target Group

Adult public mental health services will provide assessment, treatment and support services to people with serious mental illness and/or an associated significant level of psychosocial disability. This includes clients suffering from functional psychoses, both acute and persistent, severe mood or eating disorders, or with severe anxiety disorders, as well as those who present with situational crises which may lead to self-harm or inappropriate behaviour directed towards others. People with a severe personality disorder whose behaviour places themselves or others at risk of harm are included in the target group.

Services will be organised to address the needs of persons primarily between the ages of 15 and 64 years, although age alone will not be a sufficient criterion to exclude a person from service provision or to transfer them to other services such as aged care services. Similarly, the decision about which program will provide services to a young person will be based on established criteria that reflect client need. Protocols will be developed to enable orderly and responsible transfer of case management services between program areas and to outline the clinical grounds on which a decision to transfer can be made.

Individuals whose primary diagnosis and service requirements relate to drug or alcohol dependence, developmental disability, brain damage or senile dementia, will, from time to time, be referred. It is, therefore, important that protocols are made between the Mental Health Service and other health and welfare services and agencies. Mental health services have neither the skills or services to manage or treat these people in isolation. For example, provision of care for those with senile dementia are primarily provided through the aged care service system. People who need forensic mental health services will receive specialist service input.

Service Elements

Each regional service system will consist of a number of service elements which must operate to ensure that a coordinated system of care is provided. The service elements are:

- Psychiatric crisis assessment and treatment services.
- Mobile treatment and support services.
- Continuing care, clinical and consultancy services.
- Acute inpatient services.
- Residential and non-residential rehabilitation services.
- Residential and non-residential disability support services.
- Secure/extended care inpatient services.

Each service must fulfil its responsibility as an element or component of the local service network. Service elements might be organised in different ways in different areas according to rural and metropolitan population differences, varying auspice arrangements, and geographic and socio-demographic features within defined catchment areas. It will, however, be necessary for each local service network to organise entry to the mental health system via its community-based services. A number of specialist mental health services, such as adult forensic services, will be available on a statewide basis.

Each service element, and in particular the crisis and mobile treatment service, is expected to be functionally separate to ensure the integrity of service delivery. For example, the same staff cannot respond both to acute crises and also guarantee regular mobile treatment. Each service element is expected to have a single point of management responsibility. In addition to operating in accordance with the overall framework for service delivery, individual components of the general adult psychiatric service system will be expected to achieve and maintain specific service requirements as outlined below. Details are now provided for each of the service elements of the general adult mental health program.

The Crisis Assessment and Treatment Service (CAT)

This must be available on a 24-hour, seven-days-a-week basis and be a mobile service to provide effective intervention throughout the community. The service will assess all persons who are deemed appropriate for hospital admission and will determine whether the person can be managed effectively in a less restrictive setting. The service will provide support to, and liaison with, other mental health and general health workers and other service agencies as well as the client's family and carer network. The service will have the responsibility for screening of all inpatient bed admissions

(gatekeeping), urgent assessment where hospitalisation is considered an option, and crisis resolution and treatment of acutely ill clients referred to the service. These services may be structured differently in metropolitan and rural locations.

The CAT service will develop and work within the context of an overall treatment plan and may extend through a client's brief admission to hospital. The role of the CAT service will be to minimise unnecessary hospitalisation and facilitate the appropriate admission and early discharge where appropriate. Protocols must be established by regions and auspice agencies to ensure the necessary involvement of the CAT service prior to hospitalisation. In situations where the management of the CAT service is separate from that of the inpatient facility, joint assessment may be necessary where the initial contact has been with the inpatient service.

Key service requirements for CAT services are:

- To provide 24-hour crisis assessment and mental health treatment in a timely and client oriented manner to resolve mental health crises as effectively and efficiently as possible.
- To monitor all persons referred to, or presenting for admission to, hospital thus preventing unnecessary hospitalisation where services can be provided adequately in the community. All hospital admissions will involve the CAT service.
- To minimise a client's length of stay in acute inpatient facilities through expediting the earliest possible discharge with CAT or other service referral or follow-up.
- To ensure all referred clients are linked into appropriate follow-up care whether provided through the CAT service or not.
- To provide primary, secondary and tertiary consultation to other service providers in the community in

relation to psychiatric crisis management and treatment.

The Mobile Support and Treatment Service

The Mobile Support and Treatment (MST) Service provides intensive long-term community support to clients with substantial and prolonged severe mental illness and associated disability. In many cases this service will avoid or minimise the need for repeated and lengthy hospital admissions. Most commonly the client will have a diagnosis of schizophrenia, however the specific focus of the MST service is the client group that:

- is especially prone to the relapse of their symptomatology and has a wide range of psychosocial rehabilitation needs that would typically result in the client's admission to hospital;
- is commonly not compliant with treatment regimes;
- typically requires intensive treatment from other community based services; and
- is typically lacking in motivation, ability to function independently and has a poor understanding of their mental illness despite repeated attempts at education.

The service will provide mobile and assertive treatment and care which is continuous and accessible on an extended hours basis with support from the CAT service as required. The service will assist many people living in special residential services and boarding houses.

Key service requirements for MST services are:

- To provide assertive outreach, intensive long-term support, treatment and rehabilitation to the most severely disabled clients in their own environment.
- To provide an extended hours service over seven days every week.
- To provide intensive community support and preventative interventions to reduce the likelihood of a client's need for hospitalisation.
- To provide or arrange rehabilitation to develop the client's daily living skills and enhance their capacity for independent community living.
- To provide support to reduce the client's length of stay in hospital when appropriate.
- To support the client in maintaining safe, secure and affordable accommodation.
- To educate the client, family and carers about mental illness and provide support as required.

Continuing Care, Clinical and Consultancy Services

A range of community-based services will be available to provide assessment, treatment and consultancy services in addition to continuing care and case management. These services will provide an initial assessment service for people requesting assistance where a CAT service response is not required. Ongoing case management will generally be provided by staff from these services, focusing on the seriously mentally ill who require treatment, monitoring and continuing support as well as more specialist individual, group and family therapy programs. Services will be closely linked with the bed based and other community-based services. Strong links will be required with local non-government agencies to enable clients to receive regular day program support as well as appropriate assistance in the development of a range of community living skills.

Key service requirements for continuing care, clinical and consultancy services are:

- To ensure that all clients of the service receive case management monitoring and support.
- To provide ongoing treatment, support and psychosocial rehabilitation programs.
- To provide clinical consultation to other primary health service providers in relation to mental illness management and treatment.
- To undertake community development and education activities to increase community awareness and

understanding of psychiatric disorders and develop community resources.

- To provide liaison and consultation to other service providers in the community in relation to psychiatric treatment and service delivery models.

Acute Inpatient Services

Acute inpatient units provide short-term inpatient management of seriously mentally ill clients referred generally by the community mental health service. They will be co-located with acute general hospitals wherever possible. The principal role of the acute inpatient units will be the provision of acute assessment and management of individuals who require inpatient treatment and intervention. Services will provide voluntary and involuntary short-term inpatient management during an acute phase of mental illness until sufficient recovery allows that treatment to be effectively provided in a community-based setting.

There are many occasions when a person suffering from a serious mental illness is unwilling, or unable, to seek or receive treatment. Recent analysis of the legal status of those admitted to psychiatric service inpatient facilities demonstrates that almost half of the admissions are involuntary. In order to avoid administrative barriers to treatment, all publicly funded acute inpatient services must be gazetted in accordance with s. 94 of the Mental Health Act and accordingly able to admit involuntary patients. Acute inpatient units must have a 'high dependency' area where clients who require secure and intensive management can be accommodated.

Key service requirements for acute inpatient services are:

- To provide a short-term, voluntary and involuntary assessment and treatment service during an acute phase of a client's mental illness until this can be managed in the community.

- To ensure all beds are gazetted in accordance with s. 94 of the Mental Health Act and accordingly are able to admit involuntary patients.
- To ensure all admissions to the unit have had involvement of the CAT service.
- To ensure all clients are considered by the crisis assessment and treatment service for management in the community subsequent to the person's inpatient stay and that a discharge plan is prepared.
- To ensure that clients who require a short-term secure environment and intensive support can be managed.

Residential and Non-Residential Rehabilitation Services

A key requirement in the management of severely mentally ill people who present with major psychosocial disabilities is the provision of a range of rehabilitation services. These services comprise bed and community-based components. An important function of services is to assist seriously disabled people to learn or re-learn everyday living skills necessary for their adjustment to successfully living in the community.

The purpose of this service is to enhance the functioning, self-esteem and independence of individuals with a serious mental illness to ensure their maximum involvement in community life. These services should, wherever possible, be provided in the client's own environment and have links with employment and recreational services provided by other agencies.

Residential rehabilitation services will be primarily provided through community care units (CCU). These are designed to accommodate people with serious mental illness and severe psychosocial disability who have been traditionally managed in the long stay wards of psychiatric hospitals. CCUs are purpose-built units providing a home-like environment that have access to 24-hour clinical support. The CCU represents a shift in the focus of service delivery that provides an opportunity for community living that will enhance the client's quality of life. The appropriate design of a CCU has been modified based on experience with those already operational.

Key service requirements for rehabilitation services are:

- To provide a range of rehabilitation services to assist clients with significant disabilities to learn or re-learn everyday living skills necessary for their adjustment to successfully living in the community.
- To provide residential based rehabilitation services with access to 24-hour clinical support.
- To provide psychosocial rehabilitation programs designed to enhance the client's personal skills and facilitate community integration.
- To ensure all beds are gazetted in accordance with s. 94 of the Mental Health Act.

Residential and Non-Residential Disability Support Services

These services provide psychosocial rehabilitation and support in a variety of ways to people with seriously disabling mental health conditions to minimise stress, promote and maintain recovery and improve quality of life. These services complement the assessment and treatment functions of clinical services.

Residential services include staffed respite care, short-term residential services with on-site staff providing transitional rehabilitation, and longer-term residential services often with 24-hour staffing.

The link between stable housing and improved mental health and individual functioning is well established. Residential and accommodation support services provide a range of housing options for people with different levels of psychiatric disability. These range from intensively supported residential care through to housing in the community with support and assistance to improve daily living skills. The preferred approach is

to provide long-term accommodation with the level of support being adjusted according to the resident's actual need for assistance.

Non-residential disability support services provide independent living skills, training, using both centre-based and outreach approaches, information and support to carers and consumers based on mutual aid principles, and community education.

Some services, such as information and self-help services for consumers and carers, operate on a statewide basis while other services are more localised and form an integral part of local area service networks. Apart from those services clearly based around statewide coverage, disability support services are expected to meet the service needs of their local area or sector and to form effective linkages with local clinical services. These support services are expected to be present in all regions and will continue to be managed through the community-managed non-government sector wherever possible.

Services are predominantly provided through non-government agencies that receive funding from government and this area of service is expected to continue to increase. Some leisure activity programs for people with mental health disabilities are also provided through funds from the Victorian Department of Arts, Sport and Tourism.

Key service requirements for disability support services are:

- To provide services to people with serious psychiatric disabilities.
- To undertake community development and education within the local community to facilitate community acceptance of service participants as local community citizens.
- To provide psychosocial rehabilitation programs designed to enhance the participant's personal skills and social relationships.
- To provide programs which provide environmental change in order to reduce social handicaps.

Secure/Extended Care Inpatient Services

Secure/extended care inpatient services provide intensive treatment and support for clients who have unremitting and severe symptomatology together with an associated significant disturbance in behaviour that inhibits the client's capacity to live in the community. These services will generally be provided on a regional basis due to the low prevalence of client need. Each region will define the relationship between regional and local area services to ensure equitable access, continuity of care, and the return of clients to their local community as soon as they are able to live in a less restrictive setting. Facilities will have to be able to manage clients on an involuntary basis and therefore must be gazetted in accordance with s. 94 of the Mental Health Act.

Key service requirements for secure/extended care inpatient services are:

- To provide secure extended mental health treatment and care on an involuntary basis where necessary.
- To provide appropriate psychosocial rehabilitation and behaviour management programs to help modify disruptive behaviours and maximise social and personal functioning.
- To maintain active individualised care planning to monitor the changing needs of clients and their suitability for less restrictive treatment and care.
- To provide family support and educational programs to foster continued links between clients, their relatives and the community.
- To facilitate client access to other services appropriate to their health and welfare needs.
- To develop and maintain links with referring agencies, other service system elements, and service

providers to ensure effective admission, discharge and follow-up planning.
- To provide liaison and consultation services to other agencies on the treatment and management of clients with treatment resistant illnesses and difficult behaviours.

Linkages with Other Service Providers

General practitioners, general hospitals and private psychiatrists are significant providers of health services to mentally ill people. Each mental health service must develop strong linkages with these services so that support, guidance and early responses can be provided to clients who require specialist assessment, treatment and care. This will also help to ensure provision of ongoing, follow-up, support services. Shared care arrangements are to be encouraged and supported wherever possible.

Because of the varied needs of people with psychiatric disability, linkages need to be developed with other services. This will include housing and accommodation services, social support services, community health services, domiciliary care, and employment and training services. The linkages may take the form of providing cooperative care arrangements for clients of these services, advice and support to staff of the other service systems on mental health issues, or joint planning for the development of programs to more appropriately meet the needs of people with a psychiatric disability.

Adult mental health services will need to develop cooperative arrangements with child and adolescent mental health services and aged persons mental health services to assist with the client's transition through the mental health services network where this is necessary. Effective inter-program linkages will assist in the development of appropriate and more effective treatment options for service users.

Aged Persons Mental Health Services

Aged Persons Mental Health Services at a Glance

Objectives

1. To provide effective and efficient assessment, treatment and support to care for clients within their familiar surroundings in the community as long as possible.
2. To ensure care is monitored and coordinated in conjunction with general health and community support services.
3. To provide health education and health promotion programs for older people with a psychiatric disorder and their carers which incorporate information on ageing, mental illness and strategies for healthy adjustment to these processes.

Target Group

Services are provided primarily to people aged 65 years and over including:

- people with a long-standing mental illness who have grown older;
- people with functional illnesses such as depression and psychoses which have developed in later life; and
- people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

Service Elements

- Psychogeriatric assessment and treatment services.
- Acute inpatient services.
- Extended care inpatient services.

Key Service Linkages

- Extended care centres, nursing homes and hospice care services.
- Aged care assessment teams.
- District nursing services and community health services.
- Home and Community Care services and other local government services for older people.
- General practitioners.
- Public and private hospitals with particular reference to discharge planning.
- Non-government operated nursing homes, hostels and supported residential services.

Objectives

Older people represent a growing proportion of the Victorian population, as a result of the combined impact of increased longevity and the higher proportion of the population over 60 years of age. These two changes result in a significant increase in older people's use of public, private and voluntary health services. Not only are there more older people requiring these services, but increased longevity is changing the nature of service needs. Mental health services have to respond to increased demand and the changing nature of this demand.

Over the next 20 years there will be:

- A significant increase in the incidence of dementia, including Alzheimers disease, as the 'older old' are the fastest growing population group in the community.
- An increase in the numbers and life span of people with pre-existing psychiatric disorders.
- Increased prevalence of physical disorders and disabilities which give rise to social and psychological problems.

Historically, aged persons mental health services were largely inpatient services for people who grew old with a pre-existing psychiatric disorder. Older people who experience a psychiatric disorder in later life may or may not receive a specialist aged persons mental health service.

Those patterns have now changed. Aged persons mental health services must take into account the complex mix of physical, neurological and psychosocial issues relating to the older person with a long-standing or late life disorder. Specific characteristics of age related mental illness must be considered including:

- medical and psychological issues;
- cultural and social issues for the client such as family supports, social networks, community supports and financial circumstances; and
- life history including preferred coping mechanisms, work history and personal hobbies and interests.

Older people with a psychiatric disorder receive services in a wide range of health and community support agencies. These agencies can be considered at three different levels.

Geriatric Health and Community Care Services

Geriatric services play an important role in the continuing care of older people with a mental illness. These services may be inpatient or community-based.

Most geriatric inpatient services are provided in extended care centres that have established services for psychogeriatric assessment and psychogeriatric care alongside other specialised geriatric health services such as rehabilitation, palliative care and some acute medical services.

There are other services within geriatric health, residential care and community care services which make a particular contribution to older people with a psychiatric illness. Dementia units in residential facilities are an important part of the services to frail older people with severe dementia or Alzheimers disease. Some intensive community support services which have a case management function are responsible for assisting older people with varying degrees of dementia or other forms of psychiatric disorder live within their own homes. Some of these services are funded either through the Linkages Projects which are part of the Victorian Home and Community Care Program, or through the Commonwealth National Action Plan on Dementia. The variety and diversity of these services means that a wide number of geriatric health and aged care services have direct involvement in the provision of services to older people with a psychiatric illness.

Other Aged Residential and Community Care Services

A significant number of home and community care services, private and voluntary hostels and nursing homes, and community-based aged care agencies have a major role in the care and support of older people with psychiatric disorders, particularly dementia. Some of these services have established programs to provide

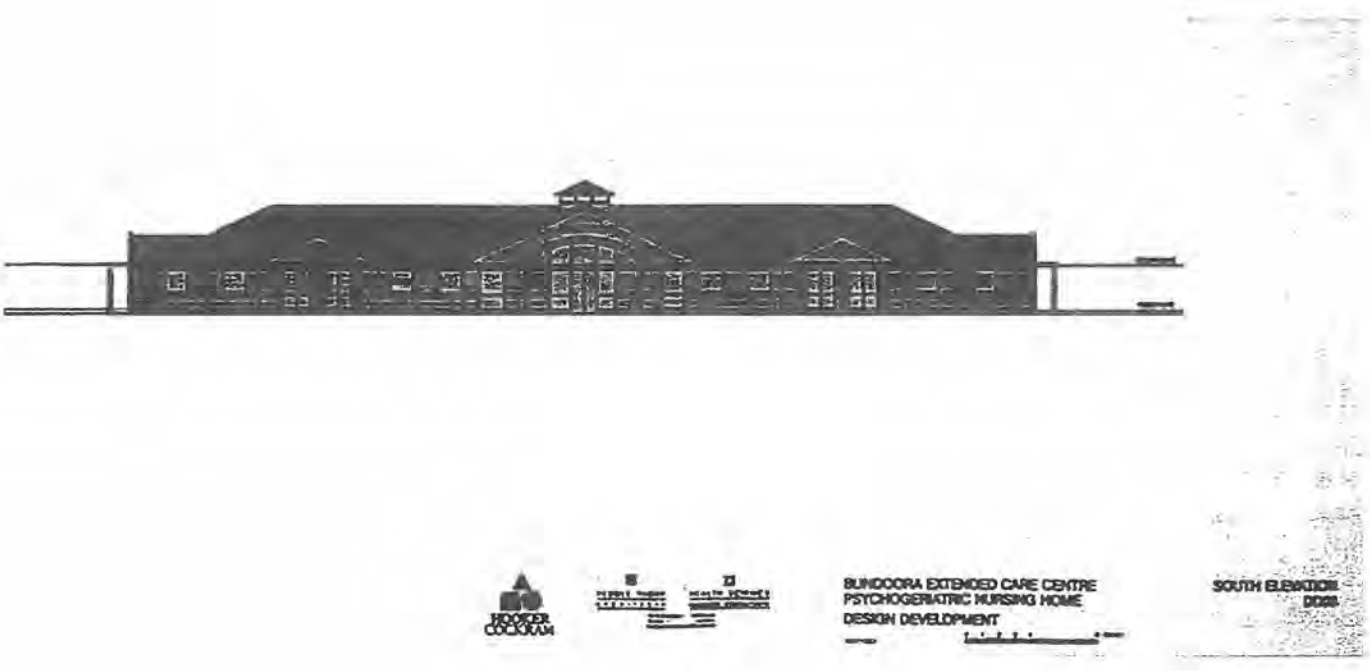
appropriate and relevant services. Many are able to adapt their services to provide not only good quality care to older people with psychiatric illness, but also to enable their clients to maintain maximum feasible levels of independence. The majority of older people with dementia are cared for by these services and will not require the dedicated aged persons mental health services discussed in detail below.

Dedicated Aged Persons Mental Health Services

These are the psychogeriatric assessment, treatment, acute inpatient and extended care inpatient services of the Psychiatric Services Program. The objectives of these services are:

1. To provide effective and efficient assessment, treatment and support to care for clients within their familiar surroundings in the community as long as possible.
2. To ensure care is monitored and coordinated in conjunction with general health and community support services.
3. To provide health education and health promotion programs for older people with a psychiatric disorder and their carers which incorporate information on ageing, mental illness and strategies for healthy adjustment to these processes.

Dedicated aged mental health services are critical to the overall mental health system as they have specific expertise to provide interventions that do not rely on chemical and physical restraint and promote care in the least restrictive environment. An increasing number of clients enter these services because their level of behavioural disturbance cannot be managed by other health and community care service providers.



Target Group

Aged persons mental health services provide services primarily to people aged 65 years and over. The client group includes:

- people with a long-standing mental illness who have grown older;
- people with functional illnesses such as depression and psychoses which have developed in later life; and
- people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

People whose mental illness is of late onset or is characteristic of older patients should be treated as far as possible as part of the aged care system rather than as part of general adult psychiatry which extends from 15 years of age. Aged persons mental health services, therefore, should operate with strong linkages with the broader network of health and community services for older persons.

Service provision to people who are mentally ill and who are over the age of 65 years becomes more complex as the effects of the ageing process become more prominent and clinical approaches differ according to the cause of the condition. Detection of age-related conditions is more likely to occur in a service which specialises in aged persons rather than in one which deals with people from 15 years of age. This also allows transition to the aged care service to be managed in a manner that is sensitive and orientated to the client's need at a time when the client can best adapt to that change, that is, in the absence of changing clinical needs. The use of age as a guideline acknowledges that people over the age of 65 years with mental illness often have co-existing physical problems which need attention from aged care services. This is particularly pertinent to the 'very old', that is those over 85 years who are more likely to suffer chronic illness, progressive disability, poorer recovery rates and physical frailty.

Functional Disorders

A small but significant proportion of people over the age of 65 years will suffer a functional disorder and require treatment and care for the first time. The most prevalent disorders that develop in this age group are depression, paranoid psychosis and heightened anxiety states. People who have a long-standing mental illness continuing past 65 years of age, may also have complicating issues related to ageing. These may be in the form of physical frailty, psychological stress and/or significant changes in their social circumstances.

Organic Disorders

Organic disorders are characterised by physiological changes in the brain with the person experiencing a deterioration in their intellect, judgement and memory, and significant personality changes. The most prevalent organic disorder in the elderly is dementia, with Alzheimer's disease and Multi-Infarct dementia being the most common. Severe dementia affects four to five per cent of the population over 65 years. There is a relatively small number of people who develop dementia before the age of 65. Between 65 and 75 years the proportion increases up to six per cent and over 75 years there is a very marked increase in the incidence of a person developing dementia.

Aged persons mental health services will be available to clients with dementia with a significant level of behavioural disturbance that presents considerable difficulties for the aged health and community care system. Mental health services will be able to provide a secure environment with intensive treatment, care and support.

In addition, aged mental health services will provide assessment and care to the small number of people under 65 years of age who develop organic disorders

related to the ageing process and other conditions. The Psychiatric Services Branch will establish formal links between the statewide Organic Brain Disorders Unit and regional services with regard to the management of the early onset of organic disorders where it may not be appropriate to manage the younger person in the aged care system.

Service Elements

Each region will provide services through a number of elements including:

- Psychogeriatric assessment and treatment services.
- Acute inpatient services.
- Extended care inpatient services.

Services provided through these elements will include early intervention, prevention and education, assessment and diagnosis, case management, acute inpatient services, continuing care, respite care, carer support and education, and liaison and consultation with other service providers.

The service system will ensure that services are delivered in a flexible manner to meet client's individual needs. Some services will need to be locally-based promoting easy access for the person living at home. Other services should be offered on a regional basis. The manner in which each of the component functions is delivered will reflect regional and area differences, however, a number of specific services will be required as detailed below.

Psychogeriatric Assessment and Treatment Services

Initial assessment and treatment will routinely be provided through the Psychogeriatric Assessment and Treatment Service (PGATS). The PGATS are a focal point in the aged persons mental health service providing, in most cases, the first point of contact with clients and their families. In addition to the assessment role, they provide a treatment, rehabilitation and case management service. All admissions to acute beds should occur with involvement of the PGATS in order to ensure that clients are managed in the least restrictive setting. There will be an increasing focus on achieving a more coordinated assessment service with the geriatric assessment teams.

Services will be delivered through multidisciplinary teams able to provide clinical expertise in medical assessment and treatment, psychological, behavioural, social and functional assessments and a corresponding range of therapeutic interventions. The services will be community-focused in the assessment and treatment of the older person and incorporate case management, access to acute or extended care inpatient facilities, education for the consumer and carer, and consultation and advice to other agencies.

The number and pattern of admissions to inpatient care is insufficient to justify provision of PGATS on a 24-hour basis. Accordingly, the after hours crisis response will usually be provided by the adult service CAT services with later transfer to the aged persons mental health service where appropriate.

Key service requirements for PGATS are:

- To provide assessment, treatment and rehabilitation in a timely and client orientated manner in community settings.
- To monitor all persons referred to or presenting for admission to hospital, thus preventing unnecessary hospitalisation where services can be provided adequately in the community. All admissions to the aged care acute or extended care units will involve the PGATS.
- To minimise a client's length of stay in acute inpatient facilities through the earliest possible discharge with appropriate referrals and service follow-up.

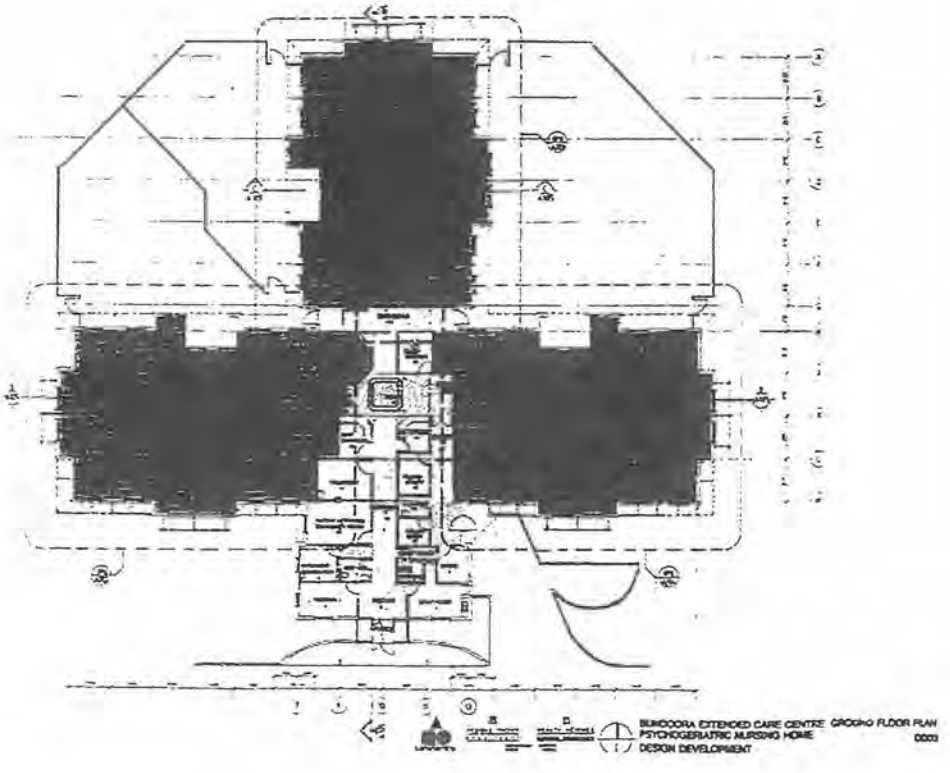
- To ensure all consumers are linked into appropriate follow-up care, including those referred to but not accepted for PGAT services.
- To provide primary, secondary and tertiary consultation to other service providers in the community in relation to psychogeriatric management and treatment.
- To provide ongoing case management services.

Acute Inpatient Services

These hospital units provide assessment and treatment for older people with acute symptoms who cannot safely be cared for or supported within the community by the PGATS or the generic aged care system. The assessment function enables the accurate diagnosis of the older person when their presentation is more complex or when their symptoms are creating acute distress or jeopardising their safety. Where possible, all aged mental health inpatient facilities will be co-located with general aged care services.

Key service requirements for acute inpatient services are:

- To provide an inpatient service that enables the assessment and treatment of a clients mental, physical and social state.
- To provide a short-term, voluntary and involuntary treatment service during an acute phase of a client's mental illness where this cannot be managed in the community.
- To ensure all beds are gazetted in accordance with s. 94 of the Mental Health Act and accordingly able to admit involuntary patients.
- To ensure all admissions to the unit have had involvement of the PGATS.
- To ensure that clients who require a short-term secure environment and intensive support can be managed.



Extended Care Inpatient Services

Extended care inpatient services are provided in psychogeriatric nursing homes situated in community settings. These services will provide a range of inpatient services for aged clients who cannot be managed in the general aged care system due to their level of persistent cognitive, emotional or behavioural disturbance. They must be sufficiently flexible to enable long-term accommodation, ongoing assessment, treatment and care of residents, rehabilitation, and respite care.

A generic brief for the development of these units has been designed that will be applied in future developments. The design of these units will enable the necessary flexibility of care to be provided.

Respite care should be available to meet the needs of both carers and consumers. Although each element of the service system will play a significant role in the support and education of carers, linkages with relevant carer support services need to occur.

Key service requirements for extended care inpatient services are:

- To provide extended mental health inpatient treatment and rehabilitation to all clients who are unable to be managed in generic aged care facilities.
- To provide respite care to clients (and for relatives) who cannot be managed in aged health and community care facilities.
- To transfer clients to generic aged care services in the least disruptive manner as soon as their condition permits.

Linkages with Other Service Providers

Aged persons mental health services operate within the context of the general aged care system. Collaborative working relationships must be developed to complement the elements in each service system in assessing and/or treating the client. A significant number of people assessed by aged persons mental health services have either progressed from or will go onto receive services provided by generic aged care services.

Provision must be made for the development of collaborative care arrangements for the older person, or the provision of specialist input from aged persons mental health services to services for older people. In particular, linkages need to be developed with:

- Extended care centres, nursing homes and hospice care services.
- Aged care assessment teams.
- District nursing services and community health services.
- Home and Community Care services and other local government services for older people.
- General practitioners.
- Public and private hospitals with particular reference to discharge planning.
- Non-government operated nursing homes, hostels and supported residential services.

It is essential that when an older person is able to receive continuing care and treatment in a general aged care service that this should occur. In the main, it is the level of behavioural disturbance associated with mental illness in the elderly that requires specialist aged mental health involvement. Usually, the person's level of behavioural disturbance will reduce in severity over time making a referral to a nursing home or other geriatric facility possible and more appropriate in order to ensure the least restrictive setting for care.

As with general aged care services, collaborative working relationships need to be developed and maintained with general adult mental health services as both service systems will at times need to complement each other in assessing and/or treating the client.

The Psychiatric Services Division and the Aged Care Division of H&CS will continue to work cooperatively to develop and manage the delivery of mental health services to the Victorian aged population. While future service development will occur in the context of mental health services being based within generic aged care services rather than psychiatric or general health services, the Psychiatric Services Division will maintain program and budget responsibility. This level of cooperation must similarly occur at a regional level.

Services for People with Specific Needs

Protocols for Multi-Agency Involvement

The complex needs of some clients requires a coordinated and cooperative approach to service provision between specialist mental health services and other agencies. This is particularly so for people with intellectual, sensory or physical disabilities, head injuries or those requiring drug and alcohol services. Protocols are called for which identify the roles and responsibilities of services and detail the way in which coordination and cooperation will occur.

To date, formal protocols have been developed in relation to disability services and child protection services. The Psychiatric Services Branch will continue to develop and refine specific approaches and protocols with other service providers in relation to responding to a severe mental illness for the following groups of people:

- Families and other carers.
- Aboriginal people.
- People with a disability or sensory impairment.
- People with drug and alcohol problems.
- People with HIV/AIDS.
- People who are homeless.
- People from Non–English-speaking backgrounds.
- Women.

The provision of specialist mental health services must take into account the specific needs of these groups of clients so that access is facilitated and services provided in ways that are most effective. Too often they have been victims of endless buck-passing. Service provision should be integrated, as far as possible, within existing mental health service networks. It is essential, therefore, that mental health service staff are trained to respond to the needs of such people, both through direct service delivery and by liaison and involvement with other agencies.

Support Services for Families and Other Carers

Families and other carers have an important role in the care of people with a mental illness. Funds have been provided to organisations which provide information, support and advocacy for carers. A program to train clinical staff in working with families is currently being piloted by North Eastern Metropolitan Psychiatric Services in conjunction with the Schizophrenia Fellowship and Bouverie Family Therapy Centre. This project will aid the development of statewide staff training, and will assist with the establishment of statewide guidelines on family and care support.

Respite care is another area of particular significance for carers, especially with more targeted use of inpatient services. Each Region must consider options for access to respite care services, including residential as well as in-home services. A pilot respite care service in the Eastern Region using a staffed residential facility has been established through the Schizophrenia Fellowship. The evaluation of this service will provide direction for service development in other regions.

Services for Aboriginal People

Aboriginal people with a serious mental illness have specific needs determined by a number of factors which may include loss of culture and identity, loss of control of destiny, poor physical health, inadequate education, family dislocation, unemployment and alcohol and substance abuse. These factors can be further compounded by the considerable disadvantage experienced by the Aboriginal community and the deprivation they may suffer as a result.

The statewide Aboriginal Mental Health Network was established in recognition of the special needs of Aboriginal people with serious mental illness and associated disabilities, and the importance of effective linkages with other Aboriginal services, especially

health services. Inpatient services are currently provided through North Eastern Metropolitan Psychiatric Services with outpatient services and community liaison through the Aboriginal Health Service. Establishment of community-based services must be examined including the establishment of a staffed community residential service to provide transitional rehabilitation as an alternative to inpatient admission. Development of satellite services in rural areas with well-established Aboriginal communities will also be explored.

Services for People with a Disability or a Sensory Impairment

In order to provide satisfactory services for clients who also have a physical and/or intellectual disability or a sensory impairment, specialist mental health service providers will need specific skills and knowledge. Access to appropriate training for mental health workers will be required and services need to maintain appropriate liaison with disability services to obtain information and advice where necessary.

A number of people with an intellectual disability and a serious mental illness are presently receiving services from community mental health services or are inpatients in hospital services. Access to specialist assessment and treatment services by this client group must be an integral part of a comprehensive mental health service system, with collaboration between services from different program areas to ensure that service provision is coordinated and effective.

Guidelines for joint service provision are the focus of the formal protocol developed between the Psychiatric Services Branch and the H&CS Disability Services Branch. Implementation of the protocol will be accompanied by targeted staff training. Liaison will continue with the Disabilities Services Branch and regular consultation with consumer and disability organisations should be an integral part of service planning.

Services for People with Drug and Alcohol Problems

Substance abuse amongst people with serious mental illness is increasingly common, and raises complex issues of assessment and treatment. The complexity and social costs of dual disorders mean that these clients are often in contact with an array of services including general health services, accident and emergency services in general hospitals, the police, social welfare agencies, agencies for homeless persons, drug and alcohol services, and mental health services.

Mental health services have a responsibility to provide assessment services in situations of differential diagnosis, dual diagnosis of mental illness and drug/alcohol dependency. Mental health services will be provided for clients with dual diagnosis of mental illness and a substance abuse disorder, in collaboration with other services such as drug and alcohol agencies. Assessment and consultation services will continue to be made available for people with severe alcohol-related brain damage.

Mental health services on their own have neither the skills nor the facilities to treat, manage or rehabilitate people with drug or alcohol dependence. Intervention for serious mental illness cannot reasonable commence until the dependence is being suitably managed.

Services for People with HIV/AIDS

The number of people with serious mental illness and HIV/AIDS infection is not known and includes those with a pre-existing mental illness as well as others whose mental illness is a consequence of the HIV/AIDS infection. The individual client's primary need for care will determine which agency is responsible for coordination of service provision across different program areas, including access to specialist assessment and treatment services as appropriate. Mental health services will take responsibility for service

provision to clients from their respective catchment areas who require specialist clinical services. The exception is those persons with AIDS-related dementia and associated behavioural problems who require inpatient care in a secure facility. Specialist inpatient treatment will continue to be provided for these people on the North Eastern Metropolitan Psychiatric Services campus.

Services for Homeless Persons

The inner city areas of metropolitan Melbourne have a higher proportion of people who are homeless or at risk of homelessness, and staff of night shelters and other services for homeless people consistently report a significant number of people with a psychiatric disability seeking services. A survey of homeless people in inner Melbourne undertaken in 1987 found that around 18% had current symptoms of a psychotic disorder.

Shelters, refuges, boarding houses and special residential services play an important part in meeting the needs of homeless people. The mentally ill who are homeless have a right to access these services. Given the choice, many of these homeless people would choose to be in the community rather than be contained in psychiatric hospitals. Treatment provided in community settings does not lead to the negative consequences of institutionalisation.

Psychiatric support is and will continue to be provided to people in the community and will be responsive to the service needs of homeless people with serious mental illness and associated disabilities. Effective service responses include assessment and treatment provided on an outreach basis as well as services aimed at stabilising the person's housing and improving their quality of life. Regions characterised by high levels of homelessness will also have special services targeting the homeless mentally ill.

The outreach assessment and treatment service provided by the Homeless Persons' Service of the Inner North Mental Health Service has proved effective in making clinical services accessible to residents of night shelters. Based on the success of this service it will be extended during 1994 by increasing the number of clinical staff working on an outreach basis in the localities of St. Kilda and Collingwood, Fitzroy and Richmond where there are also known to be concentrations of homeless people. In addition, a number of non-government disability support services have been established which work directly with homeless people. These include individual support services, day activity programs and accommodation support.

Access to stable low-cost housing is another essential component of services for homeless people. Through inter-departmental housing and support projects, new housing places with associated accommodation support have already been established, and other projects are being planned. A number of these projects target homeless people in the inner city. Victoria has a strong commitment to providing public housing stock to people who are mentally ill.

Accommodation support is also provided to people with psychiatric disabilities living in shared housing allocated through the Victorian Department of Planning and Development's Group Home Program. An important innovation has been the funding by the Department of non-government organisations to provide accommodation support for people with psychiatric disabilities, as part of Housing and Support Projects. These projects are based on low-cost long-term housing being provided by the Victorian Department of Planning and Development in conjunction with the provision of funded accommodation support from a non-government service.

Services for Persons from Non–English-Speaking Backgrounds

Language and cultural barriers can present a significant obstacle to people from non–English-speaking backgrounds (NESB) in gaining access to mental health services and receiving optimum treatment. Improving access requires:

- the availability and appropriate use of trained interpreters;
- staff who incorporate sensitivity to cultural differences into their practice; and
- services which cater for the needs of people from varied ethnic backgrounds.

Effective provision of community treatment and care often requires liaison and consultation with relevant ethnic agencies and bilingual health service practitioners as well as the provision of information and support for families and other carers. The Mental Health Interpreter Service provides access to trained interpreters for clinical services.

The Victorian Transcultural Psychiatry Unit was established to improve understanding of psychiatric problems experienced by different ethnic groups and to provide training and consultation on transcultural psychiatric issues for clinical staff. It also provides a limited outpatient service. In addition, particular clinical services are undertaking service development projects to improve the responsiveness of their services to people from non–English-speaking backgrounds. This is particularly important in areas with significant numbers of recent or newly arrived migrants as well as those with more established ethnic communities.

A number of psychiatric disability support services actively support access from NESB people with psychiatric disabilities. Services already operating include independent living skills programs, accommodation support, and information provision.

Services for Women

Planning and delivery of mental health services must be sensitive to the needs of women according to their age, cultural background and social circumstances. Specific programs for women may also be developed. Services will need to address particular issues faced by women with a serious mental illness including the risk of sexual assault and abuse, and their responsibility for infants, children and older family members. Planning should include liaison with women's services such as information and health services and sexual assault centres.

There are a number of service developments and projects which address these objectives. For instance, in 1992, a women's advisory group was established by North Eastern Metropolitan Psychiatric Services to improve service responsiveness to the needs of women clients. Initiatives include health screening for women inpatients in extended care and psychogeriatric wards, development of health assessment protocols for women in acute care, staff training in sexuality education, and sexuality education for clients. Psychiatric services in other regions have also introduced sexuality education programs for clients, and particular hospitals have redesigned their acute units to ensure greater safety for women inpatients.

A resource and training kit is being published by Healthsharing Women aimed at improving the knowledge and skills of staff working with women with psychiatric disabilities. Based on consultation with clients and staff, the kit will provide a valuable tool for staff training in psychiatric services and the non-government disability support sector. Disability support services in several regions have already established independent living skills programs specifically designed for women clients with one service publishing a guide to program development for use by other services.

Housing for women with psychiatric disabilities is also receiving attention in a number of metropolitan regions, with homeless women being given priority. For example, a housing and support project in the inner city has resulted in the provision of six units for homeless women with psychiatric disabilities together with the employment of an accommodation support worker.

The particular needs of women with dependent children are being addressed through different types of services. Two psychiatric inpatient services and a general maternity hospital have made special provision for the treatment of women with postnatal disorders accompanied by their babies. In addition, a non-government residential service is providing short-term accommodation and support to women with acute psychiatric problems who have dependent children. Funding is also provided to a family support agency to employ staff able to assist parents with psychiatric disabilities in undertaking their parental roles.

Resourcing Mental Health Services

Source of Funds

Public expenditure must target the provision of appropriate services to the seriously mentally ill. It is vital that scarce public dollars should be spent in the most efficient and effective way possible.

Public funding for mental health services in Victoria is available from a number of sources.

Table 1: Funding for Mental Health Services in Victoria 1993–94

	$ Million	Per Cent of Total Current Funding
Current		
Commonwealth Medical Benefits Scheme (1991–92 estimate) – private psychiatric services	51.0	15
Commonwealth-State Disability Agreement – Commonwealth and State funding	11.8	4
National Mental Health Reform and Incentive Grants – Commonwealth funding	4.2	1
Psychiatric Services Program – State funding	250.2	74
Hospital and Charities Fund – State funding	19.5	6
Total Current Funding	336.7	100
Capital		
Works & Services funding (including Commonwealth Building Better Cities funding)	9.7	–
Total Funding	346.4	–

Figure 7: Funding Sources

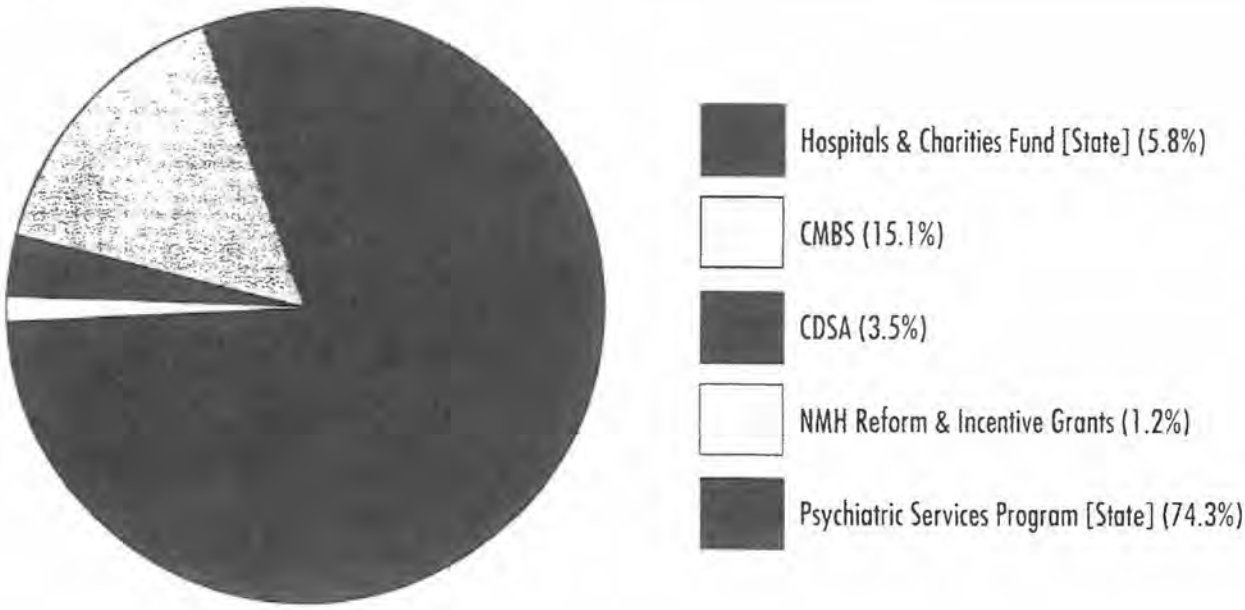
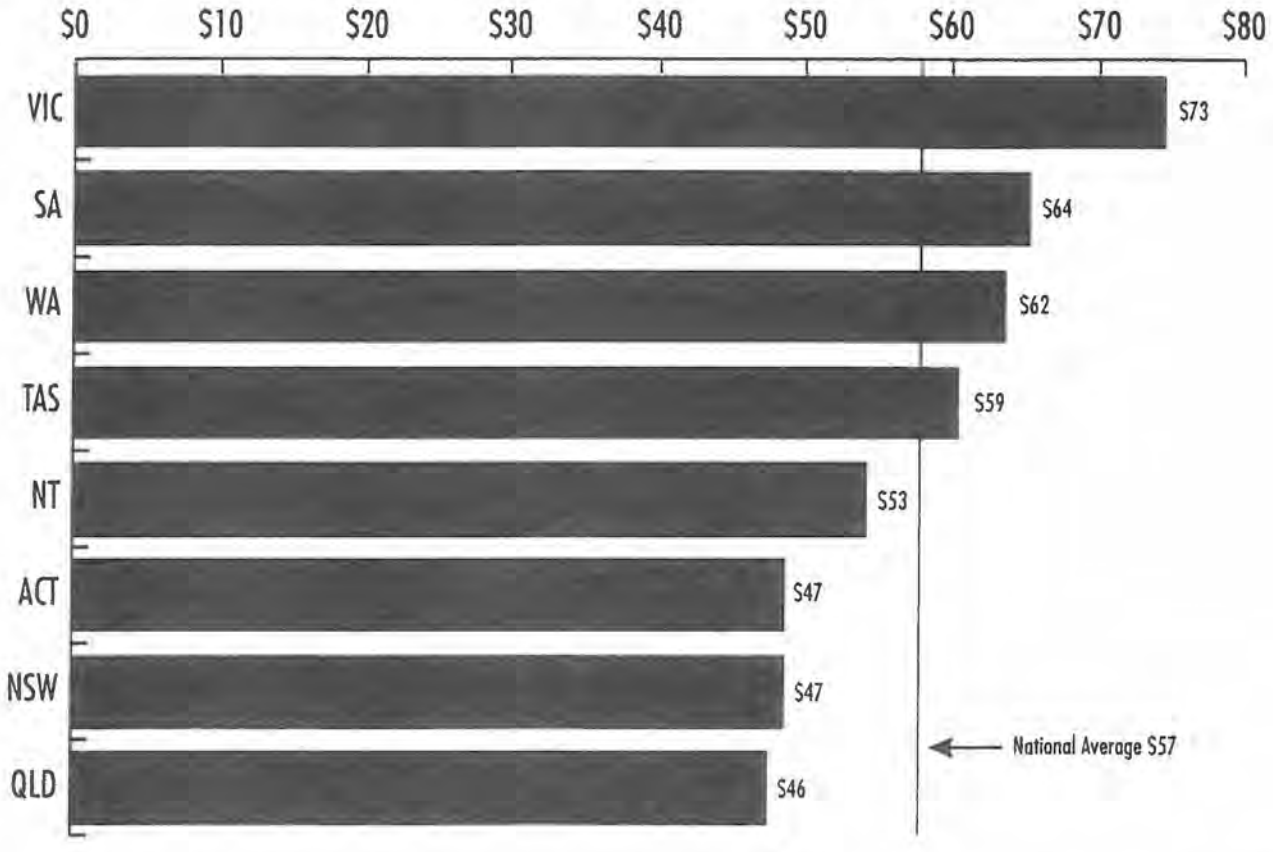


Figure 8: Estimated Per Capita Real Cost of Specialised Mental Health Services 1992–93.



Victoria already spends more on mental health services per head of population than any other Australian state or territory. Funds for the redevelopment of mental health services are being found from within the mental health budget through the introduction of more efficient work practices and the move to modern and more effective styles of service delivery. Funds made available to Victoria under the National Mental Health Strategy have facilitated the early introduction of some of these changes, which will continue over the next few years.

Principles of Resource Allocation

In allocating public resources for mental health services, the following objectives will be pursued by H&CS:

- Priority will be given to services for the seriously mentally ill.
- Resources will be redirected from hospital-based to community-based services wherever possible, with a target that 50% of resources are to be devoted to community-based services by 1997.
- Resources will be re-allocated to promote more equitable access to services across different geographic areas and needs-groups.
- Allocations will be targeted to meet the needs of the mentally ill and not to the support of existing institutions and infrastructure.
- Efficiency will be encouraged so that the available mental health funding will provide the maximum quantity of high-quality services—that is, value for money.

To achieve these objectives, a number of strategies will be applied, including:

- The introduction of unit-cost standards for services.

- Global budget allocations to regions rather than to individual institutions.
- A redistribution of resources between regions and services according to need.

Casemix and Unit Costs

Public hospital resourcing in Victoria is currently undergoing extensive reform through the introduction of 'casemix' funding. Under casemix, a significant part of a public hospital's funding is determined by its weighted throughput—that is, the number of episodes of care weighted by indices based on Diagnosis Related Groups (DRGs). This system provides incentives for hospitals to treat more cases and to reduce waiting lists.

The theory behind casemix is that individual episodes of care can be divided into clinically consistent DRGs on the basis that the total quantity of resources required to treat each care episode within the group is, on average, roughly equal. Unfortunately this is not currently possible in mental health services, because diagnosis is not a good predictor of the type or length of care a patient will require, and thus the resources required for that patient's care. Work is proceeding at a national level to develop a measure equivalent to the DRGs used in acute hospitals, but this may take several years. Nevertheless, incentives to achieve many of the same objectives as casemix are being incorporated into the new funding framework for mental health services in Victoria.

In the past, funding for mental health services was allocated according to historical precedent. Large psychiatric hospitals were allocated the same resources they received in former years without critical analysis of efficiency or appropriateness. From 1994–95, funding for inpatient services will be managed within a unit cost standard for occupied-bed-days in each type of service. These standard unit costs have been developed through the analysis of expenditure and outputs of existing services and on the assumption that inefficient work-practices will be phased out. Although it is not yet possible to assess the level of resources required to treat a particular patient, it is possible to set a target for the average cost of each day that a patient requires hospitalisation. Budget savings in 1994–95 will be achieved predominantly through application of the unit-cost standards as well as through reforms to work practices.

Average unit costs for inpatient mental health services are higher in Victoria than in other states. Over time, the unit cost targets for Victoria's services will be reduced, so that more resources can be devoted to community-based services.

Initially there will be no unit cost standards for community-based services, largely because an appropriate, measurable and comparable unit of output has not yet been defined. Although these services record 'contacts' with mentally ill patients, a contact can range from a five-minute phone call to a three-hour home visit, with considerably different resource implications. Data will be collected and guidelines will be developed during 1994–95 to enable unit cost targets to be established for community-based services in 1995–96.

On their own, unit cost standards for inpatient services might lead to incentives for hospitals to admit more patients for longer periods—this would work against the objective of only treating the mentally ill in hospital-based services where necessary. Moreover, limiting the cost of inpatient services does not ensure that those services are equitably distributed according to need. Accordingly, an overall funding framework, which incorporates the unit-cost standards but provides a more equitable statewide distribution with appropriate incentives, is being adopted.

The 'Planning Norms' Approach to Resource Allocation

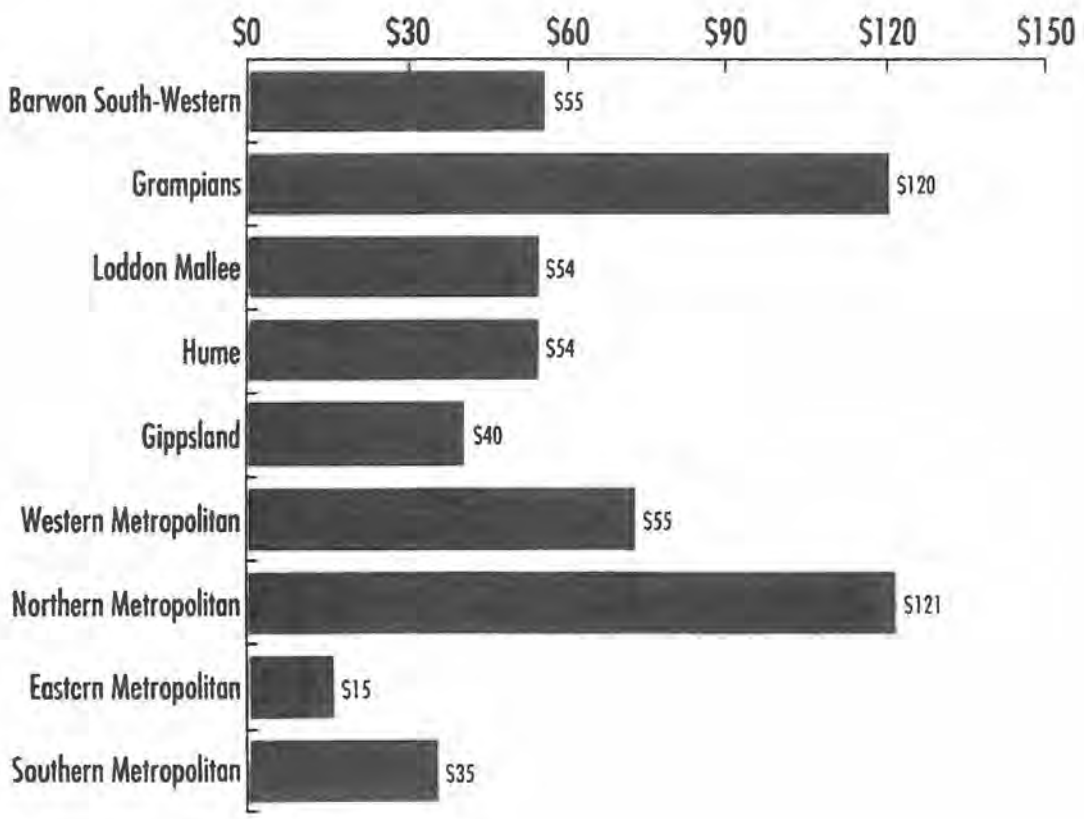
One way to allocate resources more equitably is to use standard ratios of service levels to population—for instance, 15 acute inpatient beds per 100,000 population as used in some other states. Using the unit cost standards for each bed day, an overall budget allocation could be generated for each region. However this 'planning norms' approach does not recognise the varying needs for some service types depending on the availability and effectiveness of other services types. For example, experience has shown that effective CAT services reduce the need for acute inpatient beds. This approach also fails to recognise that mental health services must be planned within a fixed overall budget. For these reasons, the 'planning norms' approach will not be pursued in Victoria.

The Needs-Based Purchaser-Provider Approach

There is a considerable body of evidence to suggest that an area's population, socioeconomic profile and population structure (in terms of age, marital status and gender) are good estimators of that area's need for and utilisation of mental health services. Measures of these factors will be used from 1994–95 to establish regional 'shares' of the mental health budget, which will act as a target for resource distribution over the next few years. Shifts in resources between regions to match these new targets will be phased in over a number of years.

Under this approach, global budget allocations for mental health services will be made to regions to enable flexibility within regions and an effective capacity for regional and area-based planning. Regional directors and psychiatric services managers will determine the most appropriate mix and structure of serv-

Figure 9: Location of 1992–93 Expenditure by Region in Victoria on Per Capita Basis



ices in each area, after considering the distribution of population and demand for services. Services will either be 'purchased' from a hospital or a non-government organisation, or where this is not possible, provided directly by H&CS. To enable the necessary changes to staffing and infrastructure, purchaser regions will need to give an agreed period of notice before shifting resources between different regions.

The average cost of inpatient services will be restricted to a unit cost standard. As community-based services become better established and more effective, there will be less need for relatively expensive inpatient services, and as inpatient services become more efficient, less resources will be required in inpatient settings. Redistribution of resources from the high cost services will permit expansion of the range and quantity of community-based mental health services, and consequently increase the overall number of people who can be treated. The approach provides appropriate incentives for efficiency and best use of inpatient services so that the total number of services delivered can thus be increased.

Incentives in the Private Health Sector

Despite a lack of agreement upon the definition of serious mental illness, a recent study revealed that approximately one-third of the clients seen by private psychiatrists have a serious mental illness compared with two-thirds of those seen by public psychiatrists. There are however, continued problems in the recruitment and retention of adequate numbers of psychiatrists in the public system and so greater incentives must be found for private psychiatrists to treat the seriously mentally ill. They must include recognition that:

- People with serious mental illness often require both psychiatric treatment and disability support services, but private psychiatrists have more difficulty in accessing these support services.
- People with serious mental illness can be unresponsive to treatment resulting in a need for support from other mental health and allied health staff, but this support is less likely to be available in the private sector.
- There is a lack of financial incentives for private psychiatrists to take on more difficult and complicated cases.
- There is relatively higher remuneration for private psychiatrists over (typically) salaried public sector psychiatrists.

The Commonwealth Medical Benefits Scheme (CMBS) provides significant funds for mental health services, with estimated rebates for consultant psychiatrist services in Victoria in 1991–92 totalling approximately $51 million. The CMBS essentially provides a time-based rebate rather than a rebate related to the complexity of the service offered. Accordingly, although treating the seriously mentally ill is much more difficult and complicated, the financial rewards from the CMBS are no higher. This can provide a disincentive to work with more seriously ill patients.

While the CMBS appears to over-reward private psychiatry provided by specialists, it also appears to discourage care for psychiatric patients by general practitioners, who do not have access to time-based payments. Severe distortions are hence imparted to the allocation of clinical effort by distortions within the CMBS.

It is somewhat incongruous that the significant level of funds which flow into Victoria from the medical benefits scheme are not more directly targeted towards people with serious mental illness at a time when the difficulties in providing services to that group are under such scrutiny in each state. Victoria is involved in a national working party which is providing advice on ways in which these barriers might be overcome and will continue to raise these matters with the

Commonwealth Government who carry the responsibility for the CMBS.

H&CS is also examining options for shared care arrangements with private practitioners so that people with serious mental illness can better access the range of resources available in the private sector.

A Strong and Skilled Workforce

The Mix of Skills

The quality of provision of mental health services is directly influenced by the clinical staff providing treatment, rehabilitation and support. Staff are required from different professional backgrounds and the service system will continue to utilise a multidisciplinary approach to mental health services. Clinical leadership will continue to be important as the service system becomes more focused around community settings. Particular attention must be given by managers to ensure that staff are able to work cooperatively and effectively with other professionals in other service areas and in the private sector as this will become increasingly important in the future. In addition, managers must ensure that appropriate arrangements for clinical supervision are in place and that lines of clinical accountability and decision making are clear and explicit in all settings.

The Role of Psychiatrists in Public Mental Health Services

Psychiatric care in community-based services, and some hospitals, is now delivered through the combined expertise of multidisciplinary teams that include nurses, psychiatrists, psychologists, and social workers, among others. This multidisciplinary approach supports the provision of comprehensive care. High levels of psychiatric disability amongst clients typically call for the establishment of a long-term relationship, treatment and a management plan for clients of the service.

As with a hospital-based service, a community-based service must provide appropriate medical and psychiatric services. There has been some confusion on this point in some of the more ideological driven elements of community mental health services. The responsibility for clinical standards in such a service must lie with a consultant psychiatrist who is fully trained and qualified to provide appropriate supervision and oversight with respect to the assessment, diagnosis, treatment planning and clinical services.

The psychiatrist's most significant role is clinical leadership. Such leadership is increasingly important given increased emphasis on accountability for the performance of mental health services. Supervision of other professionals in clinical matters is an important element of the role of the psychiatrist within both hospital and community-based services.

The Mental Health Act gives certain authority and responsibilities to psychiatrists with regard to the performance of their duties that no other professional group bears. Section 12(5)(b) of the Act provides the overall statutory responsibility and authority for the care of patients admitted under the Act. Such responsibilities include the ability to:

- detain, assess and review the need for involuntary hospitalisation;
- carry out the 24-hour examination;
- place persons on community treatment orders;
- consent to psychiatric and non-psychiatric treatment;
- grant leave and discharge persons under the Act;
- give authority to their transfer and accept transfers from other services;
- give reports to courts under the Sentencing Act; and produce the certificate of psychiatrists with regard to that Act.

As well, psychiatrists are qualified, on appointment, to sit on the Mental Health Review Board. Along with other more junior medical staff, they are responsible for:

- the prescription of medication;
- the recommendation of persons for involuntary hospitalisation;
- the ability to admit or refuse to admit persons presenting for voluntary admission;
- the production of doctor's certificates;
- giving intravenous medication;

- administering ECT; and
- directing non-medical staff in the medical management of their patients.

They perform a critical clinical role in mental health service delivery.

The role of psychiatrists will continue to remain central to treatment and clinical service delivery in the future although the emphasis will shift to one appropriate for a community-led service rather than one based on inpatient services. Psychiatrists who can provide strong clinical leadership in community settings and in fact champion a community-led service system, will quickly become Victoria's professional psychiatric leaders.

Recruitment and Retention of Psychiatrists

One of the issues which faces Victoria, along with other public mental health services in Australia, is that of maintaining adequate numbers of trained psychiatrists in the service. Despite the considerable numbers of psychiatrists who are trained in this State, there remains a continuing need to recruit from overseas to maintain adequate levels of service, particularly in rural areas. Significant factors contributing to this problem include:

- the ease with which psychiatrists can move into private practice once their training is completed;
- the functioning of the Commonwealth Medical Benefits Scheme (CMBS) which can easily ensure a relatively high income to the private psychiatrist;
- the perceived attractiveness of the autonomous working conditions of private practice to those of psychiatrists who continue to work in the public sector; and
- the less complex and less demanding characteristics of many private clients who are less likely to suffer from a serious mental illness.

H&CS has commenced a review of the issues impacting on recruitment and retention of public psychiatrists in Victoria. The review will:

- identify the trends and factors affecting recruitment and retention of psychiatrists in the public sector;
- explore the options which may resolve the problem; and
- make recommendations on viable strategies for change.

This review will also explore the viability of:

- extending sessional employment of private psychiatrists in public psychiatric services;
- contracting services out to private psychiatrists operating from public facilities;
- contracting all or some psychiatrist services through public hospitals; and
- encouraging public sector psychiatrists to take up a percentage of private practice.

The Public and Private Workforce

Public mental health services must find ways of working cooperatively with professionals in private practice. General practitioners provide services to a great many people who are mentally ill and this treatment would be far more effective with back-up from specialist mental health services. While the role of GPs is clearly recognised in the National Mental Health Policy, little work has yet been done to examine systematic ways of providing specialist back-up to GPs. Four new projects are being established in Victoria to explore the practical ways that effective shared-care working arrangements can be organised in both metropolitan and rural locations. Provisions in the Commonwealth Medical Benefits Scheme which place barriers in the way of this style of working will be examined. Close liaison is being established with the Australian and New Zealand College of General Practitioners on this and related issues.

Nursing and Allied Health Staff

While clinical leadership is the responsibility of the psychiatrist, other roles critical to the care and management of both inpatient and community-based clients are assumed by nursing and a range of allied health staff. Each service component will determine the appropriate mix of these staff to ensure the highest quality outcomes.

In community settings, nursing and allied health staff will have a lead role in the provision of case management. Individual professionals will, at the same time, offer specific expertise relevant to their discipline.

The major factor in the success of interdisciplinary teams is the appropriate application of the collective skills and knowledge of a range of disciplines to create the best outcomes for clients.

A Focus on Staff Development

There has been little systematic training provided to the department's mental health staff in relation to working within particular service settings. There has been a reliance on individual service units developing their own practices and procedures which has meant that staff roles and approaches are quite different across like services. Diversity has real value when it allows comparisons against benchmarks, and diffusion of innovations or superior standards. Unfortunately, the past framework allowed poor quality local practice standards in some state psychiatric hospitals to become entrenched only to be uncovered when a public disaster occurred. In future local innovation will be encouraged, but within a framework which guarantees acceptable basic standards of practice. Greater consistency in service delivery will be assisted through the development of statewide guidelines for the delivery of particular services and the provision of regular training opportunities for staff. In this way, there will be greater consistency in the skills staff develop and, therefore, in the way they provide services.

Taking Victoria Forward—Initiatives for 1994

This framework seeks to clarify many of the issues that have recently limited the further development of mental health services in Victoria. Many promising activities and redevelopment projects have been unable to progress without certainty about the type of services sought for this State. This period of waiting was unavoidable but is now over.

This document will provide the context in which future service redevelopment will occur over the next five years and will allow realistic time frames for change to be developed. These will, of course, be linked to the availability of funds for service redevelopment.

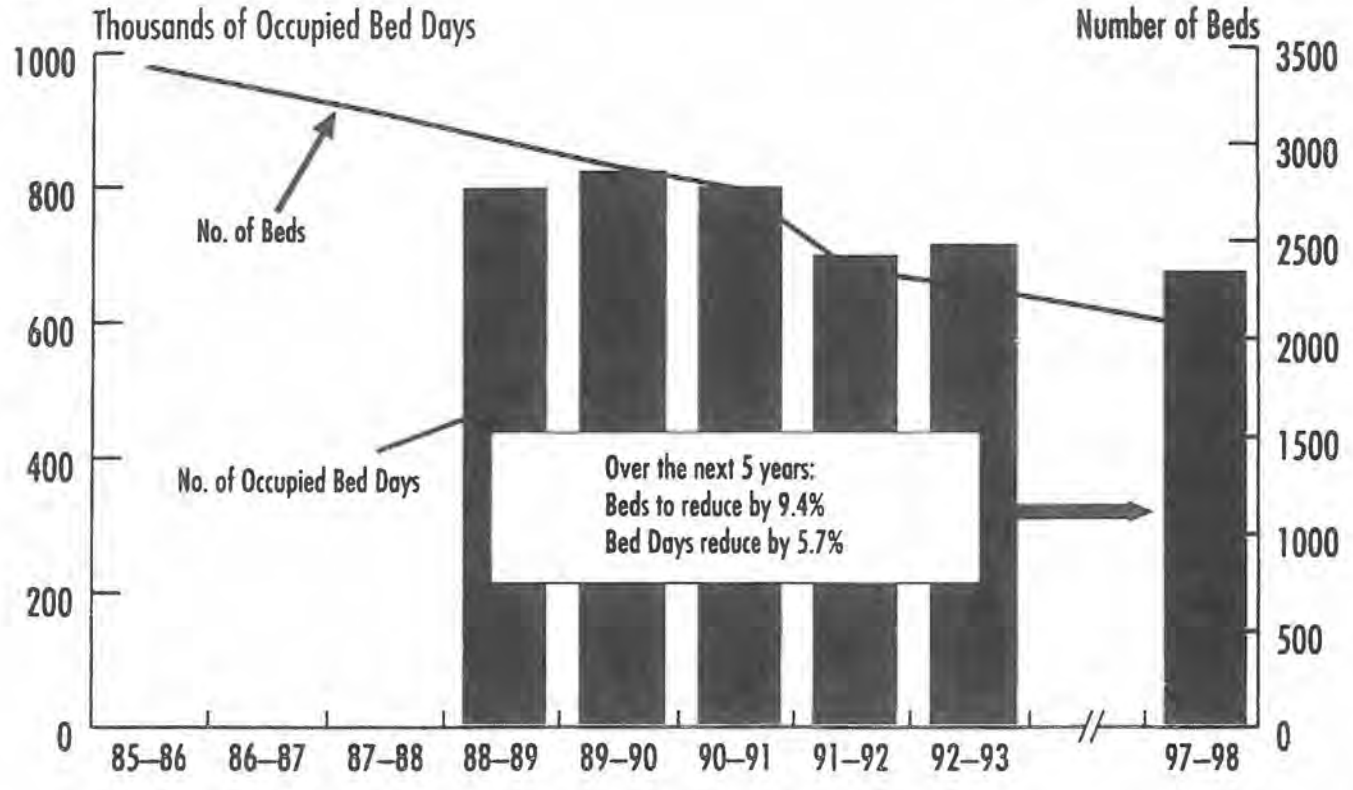
The following initiatives, which will be commenced in 1994, will fundamentally take the service system a major step forward. They provide for a dramatic increase in community-based services, as well as a significant redevelopment and relocation of services from stand alone psychiatric hospitals.

Expanded Community Crisis Assessment and Treatment Services

New or expanded crisis services will be put in place in Victoria prior to June 1994 in the areas where the current crisis teams either do not yet exist, or are unable to respond to the full demand. Coverage will be provided throughout the whole of metropolitan Melbourne and for all major population centres in country Victoria. Most Victorians, except those in sparsely populated rural areas, will then have access to community-based crisis response services. This will produce better quality services for clients at a reduced cost and will further reduce the demand for inpatient care in hospitals.

This initiative is based on the benchmark crisis services already operating in some parts of Melbourne and in rural locations such as Traralgon and Ballarat.

Figure 10: Trends in Inpatient Services



A total of 80 new treatment staff at an annual cost of $4.1 million will be appointed to new and expanded services throughout metropolitan Melbourne and in major rural centres. Included in this initiative are new services in the areas of Knox, Sherbrooke, Upper Yarra, the Mornington Peninsula (Frankston, Mornington, Hastings, Flinders), and selected areas in the Western metropolitan region. The inner Melbourne services focusing on Fitzroy, Carlton, Collingwood, Richmond, Kew, Camberwell and Hawthorn will be substantially extended. New country services will be established in Mildura and Shepparton and its environs. The service in the central sector of Gippsland will be expanded.

Expanded Community Mobile Treatment Services

Mobile treatment services already play a significant role in providing intensive treatment and support to those with chronic mental illness. These teams focus on prevention as well as treatment, working intensively with a small number of clients at risk of readmission due to recurrent crises and continuing disability. The teams also provide a range of social and vocational rehabilitation services in the client's own environment. These services operate on an extended hours basis and work to prevent treatment breakdown and possible readmission to hospital. The support they provide will help eliminate the 'revolving door syndrome' which has seen some clients constantly readmitted to hospital because of the absence of treatment and support in their community.

Four new services are proposed in both metropolitan and rural areas including eastern metropolitan Melbourne and the Barwon, Hume and Loddon Mallee Regions at an annual cost of $0.7 million to provide an additional 17.5 mobile treatment staff.

Expansion of Specialist Mental Health Services for Homeless Persons

The needs of homeless people who suffer from a mental illness are well recognised. For some time a specialised psychiatric team has operated out of the Inner North Community Mental Health Service in Carlton providing an outreach service to homeless persons in the North Melbourne, Flemington and Kensington municipalities. Based on the proven success of this service it will now be expanded to cover the St. Kilda and Collingwood, Fitzroy, Richmond localities where there are also known to be concentrations of homeless people. This initiative will result in a major improvement in service provision to this particularly disadvantaged group of Victorians.

The new services will be staffed at an annual cost of $0.3 million.

New Community Continuing Care Services

Community care units provide a supported residential service with clinical support and rehabilitation services. They provide a community alternative for the long-term rehabilitation wards in psychiatric hospitals offering new opportunities for clients who need that level of service. Built as 20 bed units, these are based on like services which are successfully operating in Canterbury and Geelong. Funded from the Building Better Cities Program and the State's Capital Works Budget, new units will be established in St Kilda, Ringwood, Brunswick and St Albans. These are at various stages of design and construction and are expected to become operational in the period 1994–1995.

Initially many of these units will provide alternative services for clients who are currently long-term patients in the large psychiatric hospitals but will increasingly be available for new clients from the community. The

average construction cost per unit is $1.2 million and they operate at an annual cost of approximately $1.3 million.

New Acute Units Co-Located in General Hospitals

The relocation of acute inpatient units out of stand-alone psychiatric hospital settings into general hospital settings is a key strategy of the National Mental Health Policy. A new 25 bed service located in the Box Hill Hospital will commence this year to replace part of the service currently provided through the North Eastern Metropolitan Psychiatric Service at Bundoora. The new service will operate from a modern facility in the locality that it will serve at an annual cost of approximately $2.5 million.

Planning and specification will continue in 1994 for the rebuilding and relocation of other services from the North Eastern Metropolitan Psychiatric Service's site. Further new inpatient services to replace those in other country psychiatric hospitals is also being planned. Construction is expected to proceed throughout 1995–1996.

Shared-Care Projects with General Practitioners

General practitioners are important providers of services to persons with mental illness however they have often operated without support from specialist community mental health services. Significant benefits will accrue from a better supported and more expert GP population. An increased number of mentally ill persons will receive treatment and support from their GP with back-up from the specialist mental health services, who will be able to focus on more intensive work with those who might otherwise be at risk of hospitalisation.

Four new projects, at a cost of $0.4 million, are being established in three metropolitan and one rural location and are designed to examine the most effective and efficient way to raise the level of support and integration of GP services into the community mental health network. Close liaison will be maintained with the Australian and New Zealand College of General Practitioners on this and related issues.

Expanded Child, Adolescent and Family Mental Health Services

The addition of new staff to the Grampians Region Community Child and Adolescent Psychiatric Service will enable the region to implement an integrated case management approach to service provision. Access to community-based treatment and support for geographically isolated young people will be improved through the linking of a range of specialist services. Emphasis will be given to early intervention and support for the client and the family. This initiative will cost $171,000.

The need to explore new ways of delivering psychiatric services to adolescents has prompted the need for the development of innovative projects in this field. These will focus on young people who are displaying symptoms of mental illness, complicated by factors associated either with social and/or economic disadvantage or other forms of illness. These projects have a full-year cost of approximately $250,000.

Redeveloped and Expanded Forensic Services

Services for adult forensic clients will be completely redeveloped and strengthened through the construction of a purpose-built security hospital in metropolitan Melbourne. This will allow consolidation of these specialist services on one site and will result in major service improvements and an expanded service capacity.

The new facility will offer enhanced community protection through more effective physical security and control as well as the provision of modern forensic treatment and rehabilitation programs. While the facility will predominantly cater for mentally ill offenders, it will also have capacity for the small number of intellectually disabled offenders who require a high security environment.

Expanded Mental Health Services for Aged Persons

Under the Building Better Cities Program, Victoria will commission new services for aged persons who have a serious mental illness including 32 hostel beds, 55 acute hospital beds and additional nursing home beds across the State. The hostel, at Jacana, will open in 1994–95 while the remaining beds will be commissioned in 1995–96. The first of the nursing home/acute unit developments will be commissioned at Caulfield Hospital in 1995–96.

The provision of two new staff to the Gippsland Region will allow a new approach to providing specialist service support to carers and generic nursing homes who have aged persons with a mental illness. This approach is expected to improve the accessibility of these services to mentally ill persons and ensure the continuity of linkages between consumers, carers, family and the community. This new support team will operate at an annual cost of $96,000.

Introduction of Teleconferencing Technology

The first pilot of teleconferencing in psychiatric service provision in Victoria will be established during 1994. This treatment mode uses video-conference technology and will increase access of more isolated, rural communities to specialist mental health services. The project will cost $85,000 and will link Swan Hill in northern Victoria to Bendigo.

Future Regional Planning for Optimal Service Delivery

The initiatives listed above will lead to a significant improvement in the mental health service system for Victoria. While the merits of community-based services have long been demonstrated both nationally and internationally, this represents the first time that a systematic and uniform approach has been taken to ensuring that the necessary services are available, integrated and linked in all parts of the State. This is the way that further service planning will take place.

Taking the framework described in this document, regions will now commence the task of planning a service system which aims for self-sufficiency in their locality. For the first time, they will know their share of the State's mental health budget and will be able to plan services which will get the best value from those funds. Victorians can be confident that funds will be equitably distributed across the State so that no one area gets services at the expense of others. The focus of expenditure of funds on institutions rather than clients will cease.

The typical planning stages will be:

- Identification of regional factors that will led to demand for mental health services such as population characteristics.
- Identification of current services and their current geographical coverage.
- Identification of gaps in service provision in each of the program areas against the framework in this document.
- Identification of funds required for desired mix of service elements.

- Examination of costs of existing services and identification of potential to redeploy existing funds into new services.
- Identification of priorities for regional service redevelopment.

Each region will establish service planning and coordination groups involving representation from major service providers in their region such as hospitals and non-government agencies, clients and carers as well as those with whom the mental health services share responsibility for client care such as disability, child welfare and drug and alcohol services. Consultation with these groups will help ensure that funds are distributed in the most effective way and that the best mix of services is provided within that locality. Regional plans will provide the base for further service redevelopment across the State. Plans should be completed by December 1994.

1995 onwards

Service change and development must continue to occur with the following directions being pursued over the next three to five years. In the context of this framework for service delivery, the Psychiatric Services Division has identified a range of gaps in the service system. The following priorities have been identified to address these.

- Accelerate the co-location of acute units with general acute hospital services. This will be achieved initially in areas where service provision will be most enhanced through this type of redevelopment.
- Building mobile support and treatment services up to an optimal level across the entire state. Along with recent developments in community based services (for example expansion of CAT services), these will form the core of community-based service provision.
- Relocation of services out of segregated psychiatric hospitals into new services in local communities that they serve.
- Review of the mental health legislative framework. This will take place in late 1994 following national work on the development of common legislative provisions for all states and territories which is due to be completed in August 1994.
- Development and implementation of minimal standards for service delivery and consistent measures of service performance and client outcomes. This will build upon national projects.
- Continued investigation of possible funding mechanisms for mental health services with a particular emphasis on the application of funds for individual client needs.
- Improvement of targets and configuration of child and adolescent mental health services.
- Development of service capacity and expertise for people with severe personality disorders.
- Extension of the skill, support and coordination of primary care services. This will build on the psychiatric shared care projects commencing in 1994 and spread across the State.
- Extension of teleconferencing technology to link services with rural and remote areas, with particular emphasis on child and adolescent services.
- Systematic development of secure extended care service capacity in all regions.
- Development and implementation of community education activities in Victoria to improve the perception and understanding of people with mental illness and their services. This will build upon planned national initiatives in this area.
- Review and expansion of professional education and training opportunities in Victoria. Staff skill levels are important and new methods of updating knowledge and skill must be formed. This will build upon the State's considerable investment in academic positions and specialist services.

- In conjunction with the Mental Health Research Institute, enhance the level of research undertaken in mental health in Victoria including that undertaken by universities and the major teaching hospitals. Options to be explored include the development of a state agenda for research (both applied and pure), encouragement of greater national funding and improving the coordination and targeting of research undertaken through state funded academic positions.

This framework provides the context for further service redevelopment for the next three to five years. The level of change that can be supported will always be dependent upon the level of funds available however much can be done by effective use of the current allocation. Commencing with the development of regional service plans, it will now be possible for firm plans and timelines to be defined and for targeted change to proceed.

Glossary

Assertive Care

Sustained, intensive contact and intervention with seriously (and usually) chronically mentally ill people who are likely to be non-compliant with treatment, often itinerant and frequently difficult to manage.

Carer

A person whose life is affected by virtue of his or her close relationship with a consumer, or who has a chosen and contracted caring role with a consumer.

Case Management

Involves the monitoring and tracking of a person's progress through the service system, including ensuring access to and coordination of the range of services necessary to meet the identified needs of a person within the integrated mental health service. This will vary in intensity according to client need and involve some delivery of clinical services.

Client/Patient

A person who makes use of, or is significantly affected by, a mental health service.

Comprehensive Service

Seriously mentally ill people often require a range of services which cover medical, psychological and social aspects. A comprehensive service is one that meets the clients' requirements for a diverse range of services which are coordinated, as far as possible, as one service system.

Continuity of Care

Integration and linkage of components of treatment and care across health service agencies according to individual need and that the client's contact with a designated service provider or case manager is, as far as possible, continued over time.

Disability

Any restriction or lack of ability to perform an activity within the expected range for a human being.

Gatekeeping

The process whereby all persons who are deemed appropriate for hospital admission are screened in order to determine whether the person can be managed in a less restrictive setting.

Integration of Services

This refers to the process whereby a mental health service functions as a coordinated specialist network which links assessment, treatment, rehabilitation and accommodation support services and their respective facilities to ensure continuity of care.

Interdisciplinary Clinical Team

The identifiable group of mental health personnel comprising a mix of professionals responsible for the treatment and care of persons with a mental disorder or a mental health problem.

Intersectoral Linkages

Collaboration between mental health services and other relevant Commonwealth, State/Territory and local government programs and the private and community sector to ensure the overall needs of people with mental disorders and mental health problems are effectively addressed.

Least Restrictive Environment

This recognises that all clients of the mental health service should be treated and cared for in an environment that respects their individual worth, dignity and privacy and which places upon them the least restriction of their rights and abilities to exercise informed choice in relation to their physical environment. The client has the right, also, to be treated in the most

facilitative environment with the least restrictive or intrusive effective treatment appropriate to the client's health needs and the need to protect the physical safety of others. It also implies that the treatment of clients shall be directed towards preserving and enhancing their personal autonomy.

Mainstreaming

This emphasises the importance of mental health services being an integral part of health, housing, social, welfare and recreational services, thereby helping to ensure that access to those services by people with mental disorders and mental health problems is equivalent to that received by the rest of the community. Administration of the mental health service system will occur in the same means as other health and welfare services.

Mental Health

The capacity of individuals and groups to interact with one another and the environment in ways that promote subjective wellbeing, optimal development and use of cognitive, affective and relational abilities, and the achievement of individual and collective goals consistent with justice.

Mental Health Problem

A disruption in the interactions between the individual, the group and the environment, producing a diminished state of mental health.

Mental Health Services

Specialised services designated to intervene in mental disorders and mental health problems.

Mental Health Service Network

Refers to a group of specialised mental health services, linked usually through responsibility for a specific geographical catchment area and which provide integrated and coordinated treatment options for persons with mental disorders. Such services are mainstreamed with general health services and have well developed relationships with all community groups able to assist people with mental disorders.

Multidisciplinary Service

A service delivery structure that ensures the specialist input of all the major health professions concerned with mental health problems. A multidisciplinary service structure ensures that a seriously mentally ill person is assessed, treated and cared for in a way that takes account of his/her medical, psychological and social needs.

National Mental Health Policy

A joint statement by Australian Health Ministers which is intended to set a clear direction for the future development of mental health services within Australia.

National Mental Health Plan

A plan agreed upon by all Australian Health Ministers, providing strategies to assist in the implementation of the National Mental Health Policy.

Performance Indicators

The collection of statistical data, and measures of social, economic and clinical outcomes.

Serious Mental Illness

Serious mental illness is understood as a set of diagnosable disorders that result in significant impairment of an individual's cognitive, affective and relational abilities.

Standards—Clinical and Service

Clinical practice standards are agreed and defined clinical procedures and practices for the optimal treatment and care of persons with mental disorders.

Service standards define what is required for a quality mental health service and are used to measure whether a service meets reasonable community expectations.

victoria ON THE MOVE

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RB-10

This is the attachment marked '**RB-10**' referred to in the witness statement of Dr Ravi Subramanya Bhat dated 4 July 2019.

BERRY STREET

We're for Childhood

SINCE 1877

Take Two

Take Two is an intensive therapeutic service for infants, children and young people who have suffered trauma, neglect and disrupted attachment. It provides high quality therapeutic services for families, as well as contributing to the service system that provides care, support and protection for these children. Take Two is a Victoria-wide service funded by the Department of Health and Human Services, and is also involved in partnership with therapeutic foster care, Aboriginal therapeutic home-based care, therapeutic residential care and the Stronger Families service.

We know that care alone is not sufficient to help children and young people recover from the trauma of family violence, abuse and neglect. Take Two works intensively with the distressed child or young person, and their carers, families and teachers, to help them understand their pain and learn to trust again.

Berry Street's Take Two Program is a partnership with:

- La Trobe University: Social Work and Social Policy, Department of Community and Allied Health
- Mindful Centre for Training and Research in Developmental Health
- Victorian Aboriginal Child Care Agency (VACCA)

Take Two also provides training, research and consultancy.

BERRY STREET
We're for Childhood
SINCE 1877

Bella is only three years old, but her short life has already been marked by family violence. Berry Street's trained counsellors worked with Bella and her mother to understand the effects of the trauma they had experienced
Find out how our staff helped Bella (/bellas-story)

Related services:

- Austin Health, Child & Adolescent Mental Health Services (http://www.austin.org.au/mentalhealth/CAMHS/)
- La Trobe University Faculty of Health Science (http://www.latrobe.edu.au/courses/feature/health)
- Mindful Centre (http://www.mindful.org.au/)
- Victorian Aboriginal Child Care Agency (VACCA) (https://www.vacca.org/)

Resources:

- Berry Street Service Charter (http://docs.berrystreet.org.au/berry-street-web-docs-service-charter/0345444001466640073)

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