National MHSPF Mental Health Service Planning Framework

Service Element and Activity Descriptions

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Population based planning for Mental Health service development

national mental health strategy

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NMHSPF Project Products

Draft Framework
Draft Service Element and Activity Descriptions
Draft Care Packages All Ages (0-4; 5-11; 12-17; 18-64; 65+; 65+ BPSD)
Draft Technical Manual
Draft Framework Estimator Tool (Beta Version) – LICENCE ONLY
Draft Framework Estimator Tool User Guide – LICENCE ONLY

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A. INTRODUCTION

As the building blocks for care packages, it is important to try and establish a 'standard' range of service elements that reasonably reflect the core service components of the mental health service system. Developing this service framework will not only summarise an agreed range of core service types, but will also result in the development of a consistent language across Australia when describing services.

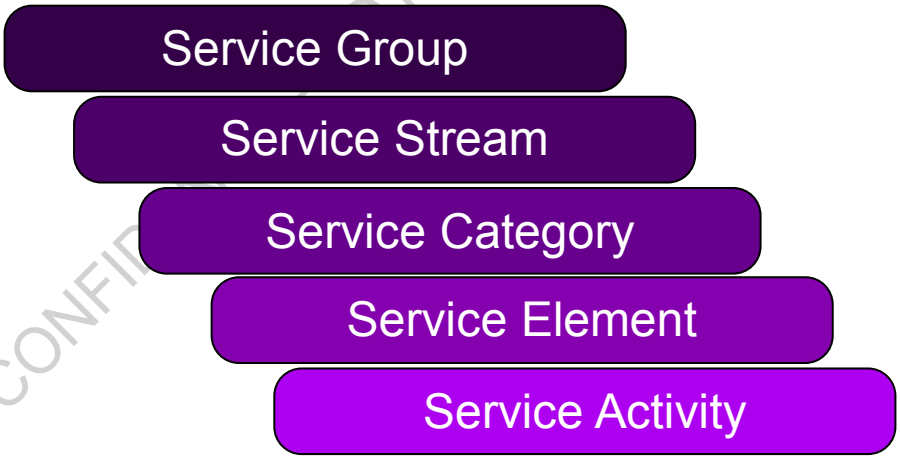
To inform the development of this service framework, the National Mental Health Service Planning Framework (NMHSPF) Project Team conducted a jurisdictional survey of service elements and key data indicators in late 2011. The purpose of the service mapping process was to firstly map the range of services currently provided by jurisdictions, including where possible, data measures of the services that will further help identify similarities or differences between services. The secondary purpose of the process was to develop a common language across all jurisdictions in relation to services provided.

Initial descriptions for each service element were sourced from the following key documents in use in Queensland and New South Wales:

- Siskind, D.,Harris, M., Buckingham, B., Pirkis, J. and Whiteford, H. (2011) *Planning Estimates for the Mental Health Community Support Sector*, Queensland Centre for Mental Health Research, Brisbane.
- NSW Health (2009) Service Element Definitions from the Appendices of the *MH-CCP Version 2.008c Discussion Document*, NSW Health, Sydney.
- Queensland Health (2010) Models of Service (various) for Queensland Public Mental Health Services, Brisbane.

Since that time, the content has been modified with more defined boundaries and relationships between elements. The current NMHSPF Taxonomy of mental health service elements is detailed in the following Section (B) and is structured as shown in Figure 1.

Figure 1: Overview of the NMHSPF Taxonomy structure



B. TAXONOMY OF SERVICE ELEMENTS

The NMHSPF Taxonomy, or classification, for mental health care describes the full range of services required in a comprehensive mental health system. The Taxonomy spans the care provision from promotion and prevention services through to primary and specialist mental health care. The Taxonomy is simply a classification system and although it is divided into 'Service Streams' for convenience, there is absolutely NO intention for this to be construed as to be supporting any particular sector or format for these services to be provided. The NMHSPF is very much limited to 'function' and 'resources' and not the provider or service environment in which function may be performed.

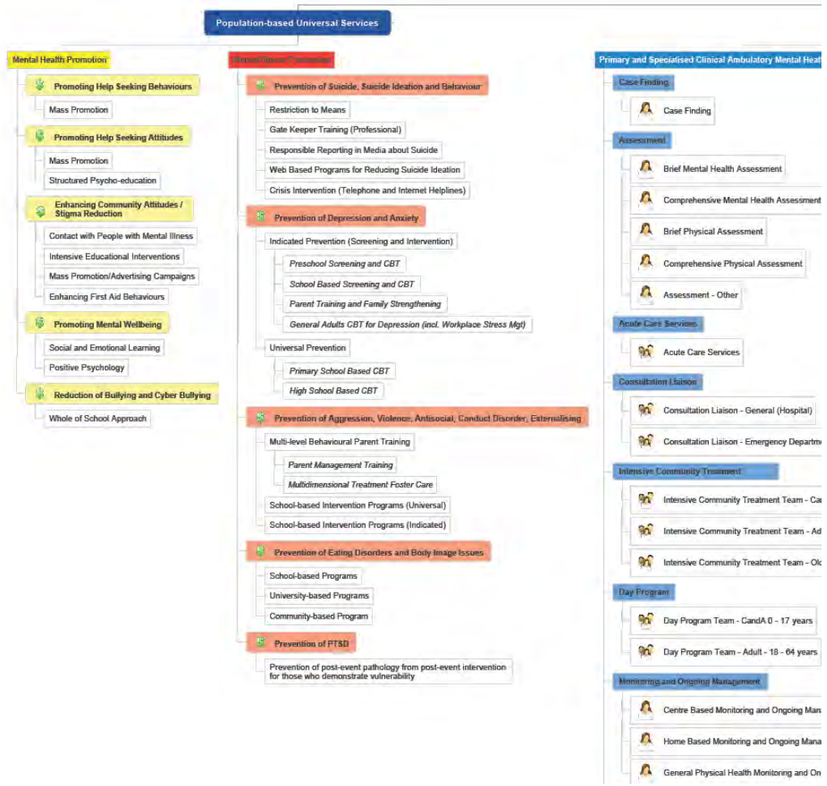
Flowing from the Taxonomy are descriptions of service elements and their activities to ensure clarity on the scope and function of each item in the Taxonomy. The descriptions are both quantitative and qualitative in nature and allow future users to understand the context of each element and activity and the resources estimated for those functions.

The current NMHSPF Taxonomy of mental health service elements is shown in Figure 2.

The following is example is used to provide explanation of the Taxonomy structure:

Taxonomy Structure	**Example**
Service Group	Services Tailored to Individual Needs
Service Stream	Specialised Mental Health Community Support Services
Service Category	Individual Support and Rehabilitation Services
Service Element	Individual Support and Rehabilitation
Service Activity	Individual Support and Rehab linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well

Figure 2: The NMHSPF Taxonomy



C. MODELLING SERVICE ELEMENTS USING INDIVIDUAL PROVIDERS

For ease of modelling, there are some Service Elements that are amenable to being described as a set of one-to-one encounters of various durations with peer workers, doctors, nurses, psychologists, social workers and other appropriately qualified staff. When care packages are developed in this way, all we need is a model of how many hours can be expected from each provider, to know how many providers need to be paid (by someone) to do the job.

Service Elements modelled as individual providers are identified in the Taxonomy with the image shown above.

D. MODELLING SERVICE ELEMENTS USING TEAMS

For ease of modelling, there are some Service Elements that are amenable to being described in groups or teams of providers. Providers may be grouped together to staff a particular type of facility or service (for example: Individual Support and Rehabilitation in a community setting; a Child acute inpatient unit in a hospital; a structured community-based team which provides ambulatory care). For each of these team based Service Elements the following have been determined wherever possible:

- Staffing profile
- FTE per place
- Average Case Load
- Average treatment days per quarter
- Hours.

Service Elements modelled as teams are identified in the Taxonomy with the images shown above, with blue referring to bed-based service teams and white to all other service teams.

E. MODELLING SERVICE ELEMENTS USING DOLLARS

For modelling purposes, there are some Service Elements that **are not** amenable to being easily and consistently described in terms of individual providers or teams, and quantification of these Service Elements in other terms (e.g. dosage of medicines) is too complex for this stage of the development of the NMHSPF. Therefore, to ensure that all Service Elements are included in the resource outputs of the model, the Modelling Group has decided to express these Service Elements in terms of a dollar ($) price.

Service Elements modelled in dollar terms are identified in the Taxonomy with the image shown above.

F. MODELLING SERVICE ELEMENTS THAT ARE NOT PART OF THE MENTAL HEALTH SERVICE SYSTEM

The Scope of the NMHSPF Project was limited to the Mental Health Service System. There are some Service Elements that are not part of the Mental Health Service System that are considered critical for the operation of the System, and therefore should be acknowledged for modelling purposes. Whilst these Service Elements are modelled, they do not contribute to the total Mental Health Service System resource outputs of the model.

Service Elements modelled that are not part of the Mental Health Service System are identified in the Taxonomy with the image shown above.

G. WORKFORCE CATEGORIES

In the early stages of the NMHSPF Project, workforce categories were established to inform the Care Package development. The area of greatest contention included the classification of non-clinical staff, as this workforce area is experiencing a period of dynamic change currently. In consideration of stakeholder feedback and review of current workforce development activity, the following workforce categories and Staff Types were agreed[1]:

Table 1 below shows the workforce categories and Staff Types within the NMHSPF model.

Table 1: Workforce Categories and Staff Types

Workforce Categories	Staff Types
Peer Worker	Consumer Peer Worker
	Carer Peer Worker
Vocationally Qualified	MH Worker
	Enrolled Nurse
	Other Vocationally Qualified
Tertiary Qualified	Nurse Practitioner
	Nurse
	Social Worker
	Psychologist
	Occupational Therapist
	Other (e.g. Pharmacist)
Medical	GP
	Psychiatrist
	Specialist Other (e.g. geriatricians and paediatricians)
	Registrar
	Junior Medical Officer

The order of workforce categories emphasises the primary importance of peer work, and the increasing broader role of consumers and carers as outlined in the Fourth National Mental Health Plan.[2] The overall

[1] Expert Working Group meeting 12 November 2013.

[2] Australian Health Ministers (2009) *Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009-2014,* Commonwealth of Australia, Canberra.

approach to modelling the workforce in each Care Package item was to identify the particular Staff Type wherever possible. However, where there was no consensus of expert opinion on Staff Type, the higher level Workforce Category was used.

Peer Workers

Consumer and carer roles in the mental health sector are still a rapidly evolving workforce. The NMHSPF has conceptualised consumer and carer roles into two areas: roles that can be performed by consumers and carers; and those that must be performed by consumers and carers.

Roles that must be performed by consumers and carers have been modelled in the context of individual peer work, group based peer work and also included in the staffing profiles for bed based services and specialist ambulatory teams.

Outside of those roles, feedback from consumers, carers and community support service providers advised that all teams should have access to the experience of a peer worker and that it would be inappropriate to nominate one role within the team to a peer worker as it would depend on their qualifications and experience (as with any other mental health worker). Therefore, roles that can be performed by consumers and carers are modelled in the context of staffing profiles with a generic staff mix of tertiary and vocationally qualified staff, where an appropriately trained consumer or carer may fulfil any of those roles, alongside people with other skills, qualifications and experience.

The practical outcome of this approach is that the amount of peer work modelled only represents that which must be performed by peer workers. It is highly desirable for all service settings and teams to have access to and input from an experienced peer worker and so an overall higher ratio of peer work FTE to other FTE is recommended.

More details on the quantum of peer workers modelled can be found in the NMHSPF Technical Manual under Modelling Staff FTE.

Vocationally Qualified Workers

Vocationally Qualified Mental Health Workers are employed in a diversity of roles, with different levels of responsibility. In the current service environment, these workers are largely employed in community support services or as support officers in specialist public and private mental health services. This category also includes the work of Enrolled Nurses. Currently, these workers may or may not have a formal qualification (e.g. Certificate IV in Mental Health) and feedback from stakeholders recognised that experience is still highly regarded.

However, given that the model is based on what ‘should be’ and after considering the trend towards formal qualification in the workforce, it was agreed to define this workforce as being primarily a non-clinical workforce (that is, not a university trained service provider such as nurse, psychologist, occupational therapist or social worker) with a TAFE level qualification up to Advanced Diploma level in a mental health or related subject area. As per the discussion above, Peer workers with appropriate qualifications are included within the context of Vocationally Qualified Mental Health Workers.

Tertiary Qualified Workers

For the purposes of the NMHSPF, Tertiary Qualified workers are those that are university trained (or equivalent) with a minimum 3 year Bachelor degree in a discipline related to mental health care. This category largely performs a specialist function. The most common professions modelled include nurses, psychologists, social workers and occupational therapists.

‘Tertiary Qualified – Other’ includes other professional care such as physiotherapy, speech therapy, pharmacy and professionals assisting with communication issues (not related to cultural background). In the community support sector, there are also tertiary qualified workers who act in the roles of program manager or supervisor who may have a community services related degree that would also be included in the ‘Other’ category.

The Nurse Practitioner was modelled separately to other nursing roles, as although the numbers are quite low, they have a different cost. Similarly, in keeping with the level of qualification between vocationally qualified and tertiary qualified workers, Enrolled Nurses fit in the category of Vocationally Qualified workers.

Medical Workforce

The NMHSPF models two professionals in the medical workforce: General Practitioner (GP) and Psychiatrist. Significant discussion was conducted around the costs between trainee psychiatrists, junior medical officers and registrars. Because of the impact of supervision and workforce development issues, these other medical workers are included only in the context of team based staffing profiles in both the specialist ambulatory and the bed based services. All other interventions that orient towards a single medical practitioner have been allocated to either a GP or Psychiatrist.

Medical students are not included anywhere in the modelling as they are not paid, are supernumerary to the modelled workforce and their supervision requirements are incorporated in the context of overhead costs for the service.

H. CLASSIFICATION OF LEVEL OF EVIDENCE

The approach to the classification of evidence was drawn from the research by Mihalopoulos et al (2011) and was modified for the purposes of the NMHSPF Project. The approach will be applied to all service elements. Members noted that international evidence may not be easily generalised to the Australian service environment and to consider this in attributing the rating for level of evidence.

Members noted that the levels of evidence were not hierarchical in nature, but were rather just ways of categorising the strength of the evidence. Evidence often exists in the context of efficacy of interventions, but not necessarily on the prevalence or population to which it applies.

Table 2: **National Mental Health Service Planning Framework (NMHSPF) – Classifying the level of evidence in support of service elements and care package development (adapted from Mihalopoulos et al (2011)[3])**

Level	Description	Detail
1.*	**"Sufficient evidence of Effectiveness"**	Effectiveness is demonstrated by sufficient evidence from well designed research: a) The effect is unlikely to be due to chance (e.g. P<0.05), and b) The effect is unlikely to be due to bias, e.g. evidence from[4]: - a level I study design; - several good-quality level II studies; or - several high quality level III-1 or III-2 studies from which effects of bias and confounding can be reasonably excluded on the basis of the design and analysis.

[3] Mihalopoulos, C., Vos, T;, Pirkis, J and Carter, R. (2011) "The Economic Analysis of Prevention in Mental Health Programs", *Annual Review of Clinical Psychology 2011*. 7:169–201

[4] The evidence classifications below are based on those of the Natl. Med. Res. Counc. (2000).
I: evidence obtained from a systematic review of all relevant randomized controlled trials..
II: evidence obtained from at least one properly designed randomized controlled trial.
III-I: evidence obtained from well-designed pseudo-randomized controlled trials (alternate allocation or some other method).
III-2: evidence obtained from comparative studied with concurrent controls and allocation not randomized (cohort studies), case-control studies, or interrupted time series with a control group.
III-3: evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel Control group.
IV: evidence obtained from either pretest or posttest case series.
Source: Table is based on Habyt et al.(2006).

Level	Description	Detail
2.*	**"Limited evidence of effectiveness"**	Effectiveness is demonstrated by limited evidence from studies of varying quality. The effect is probably not due to change e.g. P< 0.10, but bias – although not certainly an explanation for the effect – cannot be excluded as a possible explanation; e.g. evidence from: a) one level II study of uncertain or indifferent quality; b) evidence from one level III-1 or III-2 study of high quality; c) evidence from several level III-1 or III-2 studies of insufficiently high quality to rule out bias as a possible explanation; or d) evidence from a sizeable number of level III-3 studies that are of good quality and consistent in suggesting an effect.
3.*	**"Inconclusive evidence of effectiveness"**	Inadequate evidence due to insufficient research or research of inadequate quality. No position could be reached on the presence or absence of an effect of the intervention (e.g. no evidence from level I or level II studies; level III studies are available, but they are few and of poor quality).
4.#	**"Likely to be effective"**	Effectiveness results are based on: a) Sound theoretical rationale and program logic; and b) Level IV studies, indirect evidence[5] or parallel evidence[6] for outcomes; or c) Epidemiological modelling to the desired outcome using a mix of evidence types or levels. The effect is unlikely to be due to chance (the final uncertainty interval does not include zero and there is no evidence of systematic bias in the supporting studies). Implementation of this intervention should be accompanied by an appropriate evaluation budget.
5. #	**"May be effective"**	Effectiveness results are based on: a) Sound theoretical rationale and program logic; or b) Level IV studies, indirect or parallel evidence for outcomes; or c) Epidemiological modelling to the desired outcome using a mix of evidence types or levels. The effect is probably not due to chance, but bias – although not certainly an explanation for the effect – cannot be excluded as a possible explanation. The intervention would benefit from further research and /or pilot studies before implementation.
6. ^	**"Consensus of expertise"**	Agreement by individuals with expertise in the mental health sector (including consumers, carers, community support workers and clinical workers) sourced from both within and/or external to the Project.
7. #	**"No evidence of effectiveness"**	No position could be reached on the likely credentials of this intervention. Further research may be warranted.

***** Conventional approach based on epidemiological study design: Evidence from Level I-II study designs.
# Additional categories utilized in the ACE-Prevention study: evidence from Level IV studies, indirect[5] or parallel evidence[6], and/or from epidemiological modelling using a mixture of study designs.
^ Added for purposes of the NMHSPF Project.

[5] Indirect evidence: information that strongly suggests that the evidence exists (eg. A high and continued investment in food advertising is indirect evidence
that there is positive (but proprietary) evidence that food advertisement increases sales of those products (Swinburn et al. 2005).
[6] Parallel evidence: evidence of intervention effectiveness for another public health issue using similar strategies (eg., the role of social marketing,
regulation, or behavioural change initiatives in tobacco control, sun exposure, speeding , etc) (Swinburn et al. 2005).

1 Service Group – Population-based universal services

1.1 SERVICE STREAM – MENTAL HEALTH PROMOTION

Service Stream		Mental Health Promotion
Service Category	**PHB**	**Promoting Help Seeking Behaviours**
Service Element	PHB1	Mass Promotion
Service Category	**PHA**	**Promoting Help Seeking Attitudes**
Service Element	PHA1	Mass Promotion
Service Element	PHA2	Structured Psycho-Education
Service Category	**SR**	**Enhancing Community Attitudes/Stigma Reduction**
Service Element	SR1	Contact with People with Mental Illness
Service Element	SR2	Intensive Educational Interventions
Service Element	SR3	Mass Promotion/Advertising Campaigns
Service Element	SR4	Enhancing First Aid Behaviours
Service Category	**PMW**	**Promoting Mental Wellbeing**
Service Element	PMW1	Social and Emotional Learning
Service Element	PMW2	Positive Psychology
Service Category	**RB**	**Reduction of Bullying and Cyber Bullying**
Service Element	RB1	Whole of School Approach

Promotion has been modelled at Service Category level, and Service Elements and Service Activities have been identified and described where possible.

1.1.1 Service Category – Promoting Help Seeking Behaviours

1.1.1.1 Service Element – Mass Promotion

Attribute	Details
Description	Promoting Help Seeking Behaviours - Mass Promotion
Fundamental Attributes	• Media campaigns, websites, books, brochures, videos, TV ads, billboards, personalities, telephone information services) • Depression or 'mental illness' more broadly • Psychosis
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	Adults: any affective disorder: 6.2% (16-85yrs) [Slade, T., et al., *2007 National Survey of Mental Health and Wellbeing: methods and key findings.* Aust N Z J Psychiatry, 2009. **43**(7): p. 594-605.] Professional help-seeking: 58.6% of those with affective disorder [Burgess, P.M., et al., *Service use for mental health problems: findings from the 2007 National Survey of Mental Health and Wellbeing.* Aust N Z J Psychiatry, 2009. **43**(7): p. 615-23] Psychosis: 12-month treated prevalence 0.45% [Morgan, V.A., et al., *People living with psychotic illness in 2010: the second Australian national survey of psychosis.* Australian and New Zealand Journal of Psychiatry, 2012. **46**(8): p. 735-52.]
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	• From one week to several years
Workforce	
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	3 • < 10% increase in calls to suicide prevention centres and number of admissions to hospital [Dyck, R., Suicide awareness weeks: the outcomes, in Proceedings of the 16th Congress of the International Association for Suicide Prevention1993: Regensburg, Germany.] • Treatment seeking in high exposure states (beyondblue) increase by 14.6% vs 6.0% in low exposure states) [Jorm, A.F., H. Christensen, and K.M. Griffiths, The impact of beyondblue: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments. Aust N Z J Psychiatry, 2005. 39(4): p. 248-54.] • Increases in help seeking but not in those with depression [Wright, A., et al., Development and evaluation of a youth mental health community awareness campaign - The Compass Strategy. BMC Public Health, 2006. 6: p. 215.] • Duration of untreated psychosis (DUP) reduced from 16 to 5 weeks in intervention area [Joa, I., et al., The key to reducing duration of untreated first psychosis: information campaigns. Schizophr Bull, 2008. 34(3): p. 466-72.]
Key Reference:	Dumesnil, H. and P. Verger, *Public awareness campaigns about depression and suicide: a review.* Psychiatr Serv, 2009. **60**(9): p. 1203-13.
Limitations of Evidence:	• Small effects on help seeking behaviour • Longer term (beyond 6 months) effects unclear
Recommendations for future research:	

1.1.2 Service Category – Promoting Help Seeking Attitudes

1.1.2.1 Service Element – Mass Promotion

Attribute	Details
Description	Promoting Help Seeking Attitudes - Mass Promotion
Fundamental Attributes	• Short media campaigns (TV, booklets) • Long national or community programs (Media campaigns, websites, books, brochures, videos, TV ads, billboards, personalities, telephone information services) • Depression or 'mental illness' more broadly
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	Adults: any affective disorder: 6.2% (16-85yrs) [Slade, T., et al., 2007 National Survey of Mental Health and Wellbeing: methods and key findings. Aust N Z J Psychiatry, 2009. 43(7): p. 594-605.] Professional help-seeking: 58.6% of those with affective disorder (34.9% of those with any disorder) [Burgess, P.M., et al., Service use for mental health problems: findings from the 2007 National Survey of Mental Health and Wellbeing. Aust N Z J Psychiatry, 2009. 43(7): p. 615-23]
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	• Short-term: One TV program, information booklets • Long-term: from one week to several years
Workforce	Government or NGOs (e.g. beyondblue, Royal College of Psychiatrists)
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	5 - Short-term 3 - Long-term • Short term: Intentions to seek care for depression increased by < 10% [Sogaard, A. and V. Fonnebo, Norwegian Mental Health Campaign in 1992: part II: changes in knowledge and attitudes. Health Education Research, 1995. 10: p. 267-278.] • Long term: 5-25% increases in willingness to seek professional help (depending on source) [Jorm, A.F., H. Christensen, and K.M. Griffiths, The impact of beyondblue: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments. Aust N Z J Psychiatry, 2005. 39(4): p. 248-54.]; [Wright, A., et al., Development and evaluation of a youth mental health community awareness campaign - The Compass Strategy. BMC Public Health, 2006. 6: p. 215.]; [Paykel, E.S., D. Hart, and R.G. Priest, Changes in public attitudes to depression during the Defeat Depression Campaign. Br J Psychiatry, 1998. 173: p. 519-22.]; [Health, I.o.M., Post-Project Community Survey on the Public Awareness of Depression in New Territories West District of Hong Kong. Hong Kong, , 2002, 2002, Lingnan University: Hong Kong.].
Key Reference:	Dumesnil, H. and P. Verger, *Public awareness campaigns about depression and suicide: a review.* Psychiatr Serv, 2009. **60**(9): p. 1203-13.
Limitations of Evidence:	• Short term campaigns have limited effects on intentions • Long term campaigns may improve attitudes to professional treatments

Recommendations for future research:	

1.1.1.2 Service Element – Structured Psycho Education

Service Activity – Structured Psycho Education – In person

Attribute	Details
Description	Promoting Help Seeking Attitudes - Structured Psycho Education – in person
Fundamental Attributes	In-person (videos, interview, seminar, written material)
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	Adults: any affective disorder: 6.2% (16-85yrs) [Slade, T., et al., 2007 National Survey of Mental Health and Wellbeing: methods and key findings. Aust N Z J Psychiatry, 2009. 43(7): p. 594-605.] Professional help-seeking: 58.6% of those with affective disorder (34.9% of those with any disorder) [Burgess, P.M., et al., Service use for mental health problems: findings from the 2007 National Survey of Mental Health and Wellbeing. Aust N Z J Psychiatry, 2009. 43(7): p. 615-23]
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	• One x 30-minute video [Buckley, G.I. and J.M. Malouff, *Using modeling and vicarious reinforcement to produce more positive attitudes toward mental health treatment.* Journal of Psychology, 2005. **139**(3): p. 197-209] • 1 interview (10-15 mins) []Donohue, B., et al., *Improving athletes' perspectives of sport psychology consultation: a controlled evaluation of two interview methods.* Behavior Modification, 2004. **28**(2): p. 182-93. • 5 -10 mins written material [Han, D.Y., et al., *Effects of psychoeducation for depression on help-seeking willingness: biological attribution versus destigmatization.* Psychiatry and Clinical Neurosciences, 2006. **60**(6): p. 662-8.] • Seminar plus written [Sharp, W., et al., *Mental health education: An evaluation of a classroom-based strategy to modify helpseeking for mental health problems.* J Coll Stud Dev, 2006. **47**(4): p. 419-438.]
Workforce	Research Assistant
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	1 • Post-test range - d=0.12 (general interview) to d=0.34 (video) • FU range - d=0.26 (seminar (4 weeks)) to d=0.56 (video (2 weeks))
Key Reference:	Gulliver, A., et al., *A systematic review of help-seeking interventions for depression, anxiety and general psychological distress.* BMC Psychiatry, 2012. **12**: p. 81.
Limitations of Evidence:	
Recommendations for future research:	

Service Activity – Structured Psycho Education – Online

Attribute	Details
Description	Structured Psycho Education – online
Fundamental Attributes	• Online (incl. email and websites plus phone)
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	Adults: any affective disorder: 6.2% (16-85yrs) [Slade, T., et al., 2007 National Survey of Mental Health and Wellbeing: methods and key findings. Aust N Z J Psychiatry, 2009. 43(7): p. 594-605.] Professional help-seeking: 58.6% of those with affective disorder (34.9% of those with any disorder) [Burgess, P.M., et al., Service use for mental health problems: findings from the 2007 National Survey of Mental Health and Wellbeing. Aust N Z J Psychiatry, 2009. 43(7): p. 615-23]
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	• Two e-cards with basic or enhanced MHL/help seeking info
Workforce	Research Assistant, MH Professional
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	3 • Beliefs at 6 weeks (rating any formal source as helpful) d=0.53 vs control (general health information) [Costin, D.L., et al., *Health e-cards as a means of encouraging help seeking for depression among young adults: randomized controlled trial.* Journal of Medical Internet Research, 2009. **11**(4): p. e42.] • Emails may change attitudes
Key Reference:	Gulliver, A., et al., *A systematic review of help-seeking interventions for depression, anxiety and general psychological distress.* BMC Psychiatry, 2012. **12**: p. 81.
Limitations of Evidence:	
Recommendations for future research:	

1.1.3 Service Category – Enhancing Community Attitudes and Stigma Reduction

1.1.3.1 Service Element – Contact with People with Mental Illness

Attribute	Details	
Description	Contact with people with a mental illness	
Fundamental Attributes	• Presentation by/interaction with person (in person or by video) with a history of mental illness (almost always accompanied by education) • Depression, depression and schizophrenia or mental illness generally	
Service specifications and suggested modelling attributes		
Target Age:	**0-17yrs**	**18-64 yrs**
Target Pop'n Profile	Depressive disorder: 3.7% (6-17yrs) (CAC-NSMHW [Sawyer, M.G., et al., The mental health of young people in Australia: key findings from the child and adolescent component of the national survey of mental health and well-being. The Australian and New Zealand Journal of Psychiatry, 2001. 35(6): p. 806-14.] Any anxiety disorder: 31.9% (13-18yrs) (USA NCS-A;[Merikangas, K.R., et al., Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). Journal of the American Academy of Child and Adolescent Psychiatry, 2010. 49(10): p. 980-9.])	Adults: any mental disorder: 20% (16-85yrs) [Slade, T., et al., *2007 National Survey of Mental Health and Wellbeing: methods and key findings.* Aust N Z J Psychiatry, 2009. **43**(7): p. 594-605.]
% Target Pop'n		
Avg contact hours and timeframe per activity (if applic)	From one 20 min session to several hours pw for several weeks	
Workforce	MH consumer, Research Assistant, MH Professional	
Evidence Base		
Level of Evidence:	1 • mean d=0.24 overall (mean d=0.24, attitudes, mean d=0.30 behavioural intentions) • contact in person- mean d=0.40 overall (mean d=0.37 attitudes, mean d=0.46 behavioural intentions) • contact in video- mean d=0.17 overall (mean d=0.18 attitudes, mean d=0.17 behavioural intentions) Education more effective than contact in changing attitudes in adolescents. In-person contact more effective than by video	1 • mean d=0.28 overall (mean d=0.41 attitudes, mean d=0.19 behavioural intentions) • contact in person- mean d=0.52 overall (mean d=0.66 attitudes, mean d=0.40 behavioural intentions) • contact in video- mean d=0.16 overall (mean d=0.30 attitudes, mean d=0.20 behavioural intentions) Contact more effective than education in adults. In person contact more effective than by video

Key Reference:	Corrigan, P.W., et al., Challenging the public stigma of mental illness: a meta-analysis of outcome studies. Psychiatric Services, 2012. 63(10): p. 963-73.	
Limitations of Evidence:		
Recommendations for future research:		

1.1.3.2 Service Element – Intensive Educational Interventions

Attribute	Details	
Description	Intensive educational interventions	
Fundamental Attributes	**Adolescents:** Mostly school-based interventions Videos, written information, creation of artwork, writing, role plays, group exercises Depression, depression and schizophrenia or mental illness generally **Adults:** Lectures, websites, written material	
Service specifications and suggested modelling attributes		
Target Age:	**0-17yrs**	**18-64 yrs**
Target Pop'n Profile	Depressive disorder: 3.7% (6-17yrs) (CAC-NSMHW [Sawyer, M.G., et al., The mental health of young people in Australia: key findings from the child and adolescent component of the national survey of mental health and well-being. The Australian and New Zealand Journal of Psychiatry, 2001. 35(6): p. 806-14.] Any anxiety disorder: 31.9% (13-18yrs) (USA NCS-A;[Merikangas, K.R., et al., Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). Journal of the American Academy of Child and Adolescent Psychiatry, 2010. 49(10): p. 980-9.])	Adults: any mental disorder: 20% (16-85yrs) [Slade, T., et al., *2007 National Survey of Mental Health and Wellbeing: methods and key findings.* Aust N Z J Psychiatry, 2009. **43**(7): p. 594-605.]
% Target Pop'n		
Avg contact hours and timeframe per activity (if applic)	From one 20 min session to several hours pw for several weeks	
Workforce	Research Assistant, MH Professional, Teacher	Research Assistant, MH Professional
Gross Cost per activity (If applic)		
Evidence Base		
Level of Evidence:	1 • d=0.39 overall (d=0.45 attitudes, d=0.30 behavioural intentions)	1 • d=0.29 overall (d=0.31 attitudes, d=0.25 behavioural intentions)
Key Reference:	Corrigan, P.W., et al., *Challenging the public stigma of mental illness: a meta-analysis of outcome studies.* Psychiatric Services, 2012. **63**(10): p. 963-73.	
Limitations of Evidence:		
Recommendations for future research:		

1.1.3.3 Service Element – Mass Promotion/Advertising Campaigns

Attribute	Details
Description	Mass promotion/advertising campaigns
Fundamental Attributes	• Media campaigns, events, websites, books, brochures, videos, TV ads, billboards, personalities, telephone information services) • Depression, depression and schizophrenia or mental illness generally
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	Adults: any affective disorder: 6.2% (16-85yrs) [Slade, T., et al., *2007 National Survey of Mental Health and Wellbeing: methods and key findings.* Aust N Z J Psychiatry, 2009. **43**(7): p. 594-605.]
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	• Varies from TV series to longer more intensive multifaceted campaigns
Workforce	Government or NGOs
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	4 • Changes between 5 - 20% depending on attitudes
Key Reference:	Corrigan, P.W., et al., *Challenging the public stigma of mental illness: a meta-analysis of outcome studies.* Psychiatric Services, 2012. **63**(10): p. 963-73.
Limitations of Evidence:	• Longer term campaigns generally considered to work (although not in all cases [Corrigan, P.W., et al., *Challenging the public stigma of mental illness: a meta-analysis of outcome studies.* Psychiatric Services, 2012. **63**(10): p. 963-73.] but study designs have limitations [Crisp, A., et al., *Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists.* World Psychiatry, 2005. **4**(2): p. 106-13] ; [Gaebel, W., et al., *Evaluation of the German WPA "program against stigma and discrimination because of schizophrenia--Open the Doors": results from representative telephone surveys before and after three years of antistigma interventions.* Schizophrenia Research, 2008. **98**(1-3): p. 184-93.] ;[Dietrich, S., et al., *Impact of a campaign on the public's attitudes towards depression.* Health Educ Res, 2009. **25**(1): p. 135-50.]; [Henderson, C., et al., *England's time to change antistigma campaign: one-year outcomes of service user-rated experiences of discrimination.* Psychiatric Services, 2012. **63**(5): p. 451-7.]. • Short term (3-week) campaigns not likely to be effective [Evans-Lacko, S., et al., Evaluation of a brief anti-stigma campaign in Cambridge: do short-term campaigns work? BMC Public Health, 2010. 10: p. 339.
Recommendations for future research:	

1.1.3.4 Service Element – Enhancing First Aid Behaviours

Attribute	Details
Description	Enhancing first Aid Behaviours
Fundamental Attributes	
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	• Adults: any mental disorder: 20% (16-85yrs), • Adolescents: any mental disorder: 25% (16-85yrs) [Slade, T., et al., 2007 National Survey of Mental Health and Wellbeing: methods and key findings. Aust N Z J Psychiatry, 2009. 43(7): p. 594-605.]
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	12-14 hour course
Workforce	MH Professional
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	1 • 12 studies showed increased confidence in providing help. • 6 studies showed increased help provided to others • MHFA effective in enhancing confidence and first-aid behaviours
Key Reference:	Jorm, A.F. and B.A. Kitchener, *Noting a landmark achievement: Mental Health First Aid training reaches 1% of Australian adults.* Aust N Z J Psychiatry, 2011.
Limitations of Evidence:	
Recommendations for future research:	

1.1.4 Service Category – Promoting Mental Wellbeing

1.1.4.1 Service Element – Social and Emotional Learning

Attribute	Details
Description	Social and Emotional Learning
Fundamental Attributes	• Classroom-based interventions, interventions for parents, whole of school policy development • Most have explicit goals and focus on active learning and skills development
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	• Adolescents: depressive disorder: 3.7% (6-17yrs) (CAC-NSMHW [Sawyer, M.G., et al., *The mental health of young people in Australia: key findings from the child and adolescent component of the national survey of mental health and well-being.* The Australian and New Zealand Journal of Psychiatry, 2001. **35**(6): p. 806-14.])
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	Mean no. of sessions 41, median 24
Workforce	Teachers, non-school personnel (Research Assistants, consultants)
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	1 • Social and emotional skills g=0.57 (95% CI 0.48-0.67) • Attitudes towards self and others g=0.23 (95% CI 0.16-0.30) • Positive social behaviours g=0.24 (95% CI 0.16-0.29) • Conduct problems g=0.22 (0.16-0.29) • Emotional distress g=0.24 (95% CI 0.14-0.35) • Academic performance g=0.27 (95% CI 0.15-0.39) • At 6 mth follow-up ESs of reduced magnitude but significant for all outcomes
Key Reference:	Durlak, J.A., et al., *The impact of enhancing students' social and emotional learning: a meta-analysis of school-based universal interventions.* Child Development, 2011. **82**(1): p. 405-32.
Limitations of Evidence:	• SEL programs have positive effects. • Programs delivered by teachers more effective.
Recommendations for future research:	

1.1.4.2 Service Element – Positive Psychology

Attribute	Details
Description	Positive Psychology
Fundamental Attributes	Mindfulness, positive writing, hope therapy, positive reminiscence, gratitude, happiness programs, wellbeing therapy, positive psychotherapy, CBT
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	• Adults: any mental disorder: 20% (16-85yrs) [Slade, T., et al., 2007 National Survey of Mental Health and Wellbeing: methods and key findings. Aust N Z J Psychiatry, 2009. 43(7): p. 594-605.]
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	• ≤ 4 weeks to > 12 weeks
Workforce	
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	1 • Wellbeing mean r=0.29 • Depression mean r=0.31 (In non-depressed people: wellbeing mean r=0.26 Depression mean r=0.21) • Positive psychology interventions improve wellbeing and ameliorate depression
Key Reference:	Sin, N.L. and S. Lyubomirsky, *Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: a practice-friendly meta-analysis.* Journal of Clinical Psychology, 2009. **65**(5): p. 467-87.
Limitations of Evidence:	
Recommendations for future research:	

1.1.5 Service Category – Reduction of Bullying and Cyber Bullying

1.1.5.1 Service Element – Whole of School Approach

Attribute	Details
Description	Whole of School Approach
Fundamental Attributes	Training for school personnel, material for parents, videos, school-wide rules, individual counselling
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	• 27% bullied every few weeks or more [Cross, D., et al., Australian Covert Bullying Prevalence Study (ACBPS), 2009, Child Health Promotion Research Centre, Edith Cowan University: Perth]
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	Weeks to years
Workforce	Teacher, Research Assistant, MH Professional
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	1 • Whole of school approach generally effective in reducing bullying • 8 out of 10 studies showed reduction in bullying
Key Reference:	Vreeman, R.C. and A.E. Carroll, *A systematic review of school-based interventions to prevent bullying*. Archives of Pediatrics and Adolescent Medicine, 2007. **161**(1): p. 78-88.
Limitations of Evidence:	
Recommendations for future research:	

1.1.6 Other Service Elements reviewed but not included in this Service Stream due to evidence level

Category - Element: Promoting Help Seeking Behaviours - Structured Psycho Education

Attribute	Details
Description	Structured psycho-education
Fundamental Attributes	Online (incl. email and websites plus phone calls from interviewer)
Service specifications and suggested modelling attributes	
Target Pop'n Profile	Adults: any affective disorder: 6.2% (16-85yrs) [Slade, T., et al., 2007 National Survey of Mental Health and Wellbeing: methods and key findings. Aust N Z J Psychiatry, 2009. 43(7): p. 594-605.] Professional help-seeking: 58.6% of those with affective disorder (34.9% of those with any disorder) [Burgess, P.M., et al., Service use for mental health problems: findings from the 2007 National Survey of Mental Health and Wellbeing. Aust N Z J Psychiatry, 2009. 43(7): p. 615-23]
Avg contact hours and timeframe per activity (if applic)	• 3-6 weeks website (MoodGym or Bluepages) plus weekly phone calls • Christensen, H., et al., The effect of web based depression interventions on self reported help seeking: randomised controlled trial [ISRCTN77824516]. BMC Psychiatry, 2006. 6: p. 13. • Two e-cards with MHL/help seeking info • [Costin, D.L., et al., *Health e-cards as a means of encouraging help seeking for depression among young adults: randomized controlled trial.* Journal of Medical Internet Research, 2009. **11**(4): p. e42.]
Evidence Base	
Level of Evidence:	3 Moodgym at 6 wks d=0.24, 6mths d=0.13 Online intervention with support more effective than emails alone in increasing professional treatment seeking
Key Reference:	Gulliver, A., et al., *A systematic review of help-seeking interventions for depression, anxiety and general psychological distress.* BMC Psychiatry, 2012. **12**: p. 81.
Limitations of Evidence:	
Recommendations for future research:	

Category - Element: Promoting Help Seeking Attitudes - Provision of online mental health information

Attribute	Details
Description	Provision of online mental health information
Fundamental Attributes	Websites
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	Adults: any mental disorder: 20% (16-85yrs) Adolescents: any mental disorder: 25% (16-85yrs)

	[Slade, T., et al., 2007 National Survey of Mental Health and Wellbeing: methods and key findings. Aust N Z J Psychiatry, 2009. 43(7): p. 594-605.]
Evidence Base	
Level of Evidence:	6
Key Reference:	Reavley, N.J. and A.F. Jorm, *The quality of mental disorder information websites: A review.* Patient Educ Couns, 2010. **85**(2): p. e16-25.
Limitations of Evidence:	• Quality of information generally poor, although quality of info on affective disorders may be improving • Very little understanding of the influence of website quality on user behaviour.
Recommendations for future research:	

Category - Element: Promoting Mental Wellbeing - Relaxation

There was concern around whether this is the realm of health or other government. The Service Element – Relaxation was removed.

Category - Element: Promoting Mental Wellbeing – Physical Activity
There was concern around whether this is the realm of health or other government. The Service Element – Physical Activity was removed.

Attribute	**Details**
Description	Physical Activity
Fundamental Attributes	Increase levels of physical activity
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	Adults: any mental disorder: 20% (16-85yrs) [Slade, T., et al., *2007 National Survey of Mental Health and Wellbeing: methods and key findings.* Aust N Z J Psychiatry, 2009. **43**(7): p. 594-605.]
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	
Workforce	
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	6 Evidence suggests an association between higher levels of physical activity and reduced risk of depression but no general population intervention-level evidence available (refer to universal and indicated prevention sections for specific subgroups)
Key Reference:	Jacka, F.N. and M. Berk, *Depression, diet and exercise.* MJA Open, 2012. **1**(Suppl 4): p. 21-23.
Limitations of Evidence:	

Recommendations for future research:	

Category - Element: Promoting Mental Wellbeing – Lifestyle Promotion

There was concern around whether this is the realm of health or other government. The Service Element – Lifestyle Promotion was removed.

Category - Element: Systemic Promotion – Legislation and Policy

No evidence for impact of policy on reducing prevalence of disorders or suicide rates (Burgess 2004 [3]). Promotion and prevention working group members agreed not to include this category or service element in the Taxonomy. The Service Category – Systemic Promotion and Service Element – Legislation and Policy were removed.

Category - Element: Reduction of Bullying and Cyber Bullying – Curriculum Interventions

Promotion and prevention working group members agreed not to include this service element in the Taxonomy. The Service Element – Curriculum Interventions was removed.

Attribute	**Details**
Description	Videos, lectures, classroom discussions
Fundamental Attributes	
Service specifications and suggested modelling attributes	
% Target Pop'n	27% bullied every few weeks or more Cross, D., et al., Australian Covert Bullying Prevalence Study (ACBPS), 2009, Child Health Promotion Research Centre, Edith Cowan University: Perth
Avg contact hours and timeframe per activity (if applic)	1 session to 15 weeks of classroom modules
Workforce	Teachers, RA, MHP
Evidence Base	
Level of Evidence:	3
Key Reference:	Vreeman, R.C. and A.E. Carroll, *A systematic review of school-based interventions to prevent bullying.* Archives of Pediatrics and Adolescent Medicine, 2007. **161**(1): p. 78-88.
Limitations of Evidence:	**No effect on bullying** 6 out of 10 studies found no effect on bullying. 4 studies found some decreases but increases in some subgroups
Recommendations for future research:	

Category - Element: Reduction of Bullying and Cyber Bullying – Cyber Bullying

Attribute	Details
Description	Cyber-bullying
Fundamental Attributes	Decrease level of cyber-bullying
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	
% Target Pop'n	10% of primary and secondary students Cross, D., et al., Australian Covert Bullying Prevalence Study (ACBPS), 2009, Child Health Promotion Research Centre, Edith Cowan University: Perth
Avg contact hours and timeframe per activity (if applic)	
Workforce	
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	3
Key Reference:	ang, J., T.R. Nansel, and R.J. Iannotti, *Cyber and traditional bullying: differential association with depression.* Journal of Adolescent Health, 2011. **48**(4): p. 415-7..
Limitations of Evidence:	**Evidence suggests an association between cyber-bullying and risk of mental disorders but no intervention-level evidence available**
Recommendations for future research:	

Category - Element: Reduction of Bullying and Cyber Bullying – Workplace

Attribute	Details
Description	Workplace bullying
Fundamental Attributes	Organisation level interventions (work climate, leadership and job design interventions, code of conduct, policy and legislation, formal investigations/grievance procedures, monitoring, employee selection, teambuilding/team training, conflict management training, mediation, multisource feedback, bystander interventions) Individual level interventions (training, mentoring, informal support, counselling
Service specifications and suggested modelling attributes	
% Target Pop'n	6.8% of workers in a 6-month period Commonwealth of Australia, Workplace Bullying: We just want it to stop, 2012, House of representatives, Standing Committee on Education and Employment: Canberra.
Avg contact hours and timeframe per activity (if applic)	Varies very widely
Workforce	Researchers, MHPs, consultants
Evidence Base	

Level of Evidence:	4 Evidence suggests an association between poor work climate, managers with poor interpersonal skills and bullying. Organisation level interventions with leadership commitment and a proactive approach more likely to be successful.
Key Reference:	ling, J.C., et al., Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS. Final report., 2013, NIHR Service Delivery and Organisation programme.
Limitations of Evidence:	mostly case studies and small sample sizes
Recommendations for future research:	

1.1.7 References used for this Service Stream

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8. Iling, J.C., et al., *Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS. Final report.*, 2013, NIHR Service Delivery and Organisation programme.
9. Sawyer, M.G., et al., *The mental health of young people in Australia: key findings from the child and adolescent component of the national survey of mental health and well-being.* The Australian and New Zealand Journal of Psychiatry, 2001. **35**(6): p. 806-14.
10. Merikangas, K.R., et al., *Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A).* Journal of the American Academy of Child and Adolescent Psychiatry, 2010. **49**(10): p. 980-9.
11. Corrigan, P.W., et al., *Challenging the public stigma of mental illness: a meta-analysis of outcome studies.* Psychiatric Services, 2012. **63**(10): p. 963-73.
12. Grausgruber, A., et al., *["Schizophrenia has many faces" - evaluation of the Austrian Anti-Stigma-Campaign 2000-2002].* Psychiatrische Praxis, 2009. **36**(7): p. 327-33.
13. Crisp, A., et al., *Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists.* World Psychiatry, 2005. **4**(2): p. 106-13.
14. Gaebel, W., et al., *Evaluation of the German WPA "program against stigma and discrimination because of schizophrenia--Open the Doors": results from representative telephone surveys before and after three years of antistigma interventions.* Schizophrenia Research, 2008. **98**(1-3): p. 184-93.
15. Dietrich, S., et al., *Impact of a campaign on the public's attitudes towards depression.* Health Educ Res, 2009. **25**(1): p. 135-50.
16. Henderson, C., et al., *England's time to change antistigma campaign: one-year outcomes of service user-rated experiences of discrimination.* Psychiatric Services, 2012. **63**(5): p. 451-7.
17. Evans-Lacko, S., et al., *Evaluation of a brief anti-stigma campaign in Cambridge: do short-term campaigns work?* BMC Public Health, 2010. **10**: p. 339.
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19. Reavley, N.J. and A.F. Jorm, *The quality of mental disorder information websites: A review.* Patient Educ Couns, 2010. **85**(2): p. e16-25.
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1.2 SERVICE STREAM – MENTAL HEALTH PREVENTION

Service Stream		Mental Health Prevention
Service Category	**PS**	**Prevention of Suicide, Suicide Ideation and Behaviour**
Service Element	PS1	Restriction to Means
Service Element	PS2	Gate Keeper Training (Professional)
Service Element	PS3	Responsible Reporting in Media about Suicide
Service Element	PS4	Web Based Programs for Reducing Suicide Ideation
Service Element	PS6	Crisis Intervention (Telephone and Internet Helplines)
Service Category	**PDA**	**Prevention of Depression and Anxiety**
Service Element	PDAS	Indicated Prevention (Screening and Intervention)
Service Activity	PDAS1	Preschool Screening and CBT
Service Activity	PDAS2	School Based Screening and CBT
Service Activity	PDAS3	Parent Training and Family Strengthening
Service Activity	PDAS4	General Adults CBT for Depression (incl.Workplace Stress Mgt)
Service Element	UP	Universal Prevention
Service Activity	UP1	Primary School Based CBT
Service Activity	UP2	High School Based CBT
Service Category	**PA**	**Prevention of Aggression, Violence, Antisocial, Conduct Disorder, Externalising**
Service Element	PA1	Multi-Level Behavioural Parent Training
Service Activity	PA2	Parent Management Training
Service Activity	PA3	Multidimensional Treatment Foster Care
Service Element	PA4	School-Based Intervention Programs (Universal)
Service Element	PA5	School-Based Intervention Programs (Indicated)
Service Category	**PE**	**Prevention of Eating Disorders And Body Image Problems**
Service Element	PE1	School-Based Programs
Service Element	PE2	University-Based Programs
Service Element	PE3	Community-Based Programs
Service Category	**PP**	**Prevention of PTSD**
Service Element	PP1	Prevention of Post-Event Pathology From Post-Event Intervention For Those Who Demonstrate Vulnerability

Prevention has been modelled at Service Category level, and Service Elements and Service Activities have been identified and described where possible.

1.2.1 Service Category – Prevention of Suicide, Suicide Ideation and Behaviour

1.2.1.1 Service Element – Restriction to Means

Attribute	Details		
Description	Broad population-based. Community-level and community-supported strategy. Effective when the method to be restricted is: 1) highly lethal and commonly used, accounting for significant proportion of deaths. 2) specific to regional context, culturally acceptable and well-recognised 3) suitable for elimination or restriction through broad policy action 4) implementation and effects can be monitored. e.g. fire arm control legislation (US); mandatory catalytic converters in car exhaust systems (UK)		
Fundamental Attributes	Success depends on cohesive community action by individuals, social leadership and means restriction (MR) being embedded into changes in the environment.		
Service specifications and suggested modelling attributes			
Target Age:	**12-17yrs**	**18-64 yrs**	**65+ yrs**
Target Pop'n Profile			
% Target Pop'n		12 month prevalence: suicidal acts (SA) 0.4%* (16-85yrs); #10; NMHS; 2007	
Avg contact hours and timeframe per activity (if applic)	Not applicable	Not applicable	Not applicable
Workforce	Community-level and community-supported strategy.		
Gross Cost per activity (If applic)			
Evidence Base			
Level of Evidence:	Evidence of effectiveness only when method is highly lethal. Does not inevitably lead to means substitution, and when it does, means chosen are less lethal, have lower risk of fatality and associated with fewer deaths. Only effective upon lower fatality rate of alternative methods should means substitution occur. LEVEL OF EVIDENCE: Level of evidence 2: % decline annual suicide rate: 1.5-9.5% (guns), 19-33% (domestic gas), 23% (barbiturates) #59 (Mann et al.,2005) all level III-3 (interrupted time series without control) – large number of III-3 studies of relatively good quality, but more so consistent in indicating effect > ecological observational BUT all systematic reviews (Mann; Van der Feltz) suggest this is important and likely to be highly effective, when part of national multilevel strategy.		
Key Reference:	Yip et al (2012); Mann et al (2005)		
Limitations of Evidence:			
Recommendations for future research:			

1.2.1.2 Service Element – Gate Keeper Training (Professional)

Service Activity – Gatekeeper Training (Non-medical professionals)

RATIONALE FOR CATEGORY:

- These are non-medical community gatekeepers (not general public)
- Most consistency in effect, grouped together in such a way by Mann and van der Feltz.
- Greater exposure than general public to high risk groups, and greater ability to identify , intervene and refer

Attribute	Details
Description	Variable, often tailored for each community and local MH services e.g.: Australian Aboriginal community gatekeeper training included myths and facts about suicide, warning signs and referral strategies. Community members play critical facilitatory role in dissemination of knowledge and in early detection of depression and suicide risk. Mann et al (2005) suggests Gate Keeper training is most likely to be effective where gatekeeper roles are formalised within organisations, and pathways to treatment are readily available. More research needed on intermediate outcomes.
Fundamental Attributes	*LINK Program (US Air Force):* 1) Look for possible concerns (suicide risk factor identification) 2) Inquire about concerns/risk (intervention skills) 3) Note level of risk 4) Know referral strategies/resources (implement referral procedures to relevant MH services).
Service specifications and suggested modelling attributes	
Target Pop'n Profile	12 month prevalence: SI: 2.3%; SP: 0.6%; SA: 0.4%* (16-85yrs); NSMHW; 2007
Avg contact hours and timeframe per activity (if applic)	2 days (3 hrs – 5 days)
Workforce	**Non-medical professionals** Delivery: MHP/ Trained volunteers deliver the training. Audience: only for first responders, public service and defence services.
Evidence Base	
Level of Evidence:	3 (knowledge, skills, attitude) 4 (SA, SI, SR) • RRR = 33% (airforce *LINK program*: Knox et al, 2003) • LINK program delivered in > 5 million personnel in multilevel approach, content also shown for this LINK program - Knox KL, Litts DA, Talcott GW, et al. Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study. Br Med J. 2003;327:1376–1378. • Need clear fast track to available treatment in order for preventive effect to occur / be maximised • RRR = 33% (airforce LINK program: large cohort: Knox et al, 2003) • Promising positive effects on knowledge, attitudes, skills in identification and intervention in short-term, some positive effects on self-efficacy. Mixed results as to sustainability of these effects, and on referral practices. Limited evidence of efficacy in reducing suicidal behaviour in short-term. Preventive potential depends on clear fast track to treatment being available.
Key Reference:	Isaac et al (2009) – only non medical gatekeepers , Mann et al (2005), van der Feltz et al (2012) – only non medical gatekeepers
Limitations of Evidence:	
Recommendations for future research:	Need more research into long-term effects and suicide outcomes.

1.2.1.3 Service Element – Responsible Reporting in Media

Service Activity – Responsible Reporting in the Media about Suicide – Effect on Media Reporting

Attribute	Details
Description	Implementation of media guidelines around responsible reporting of suicide (e.g.: Mindframe guidelines; Aust)
Fundamental Attributes	• Moratorium (media blackout) on suicides e.g. in subway. • Avoid sensationalism and glorification; • avoid detailed description of method; • focus on treatability of mental illness and preventability of suicide • Include crisis and information service contact details in media reporting
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	
% Target Pop'n	National consumers of media.
Avg contact hours and timeframe per activity (if applic)	
Workforce	MHP and media professionals (TV, radio, print)
Gross Cost per activity (If applic)	Training of journalists (unknown amount of sessions and minutes)
Evidence Base	
Level of Evidence:	Three different levels of evidence • 5 - All pre-post case series IV • 4 - likely to be effective (short-term); • 7 - No evidence of effectiveness (long-term) EFFECTIVENESS STATISTICS: Australia: • rates for Mindframe (Mindframe and Mental Health guidelines, Commonwealth of Australia, 2002); • Mindframe: developed in partnership with media; nationally funded dissemination; ongoing training "By combining the nine dimensions of quality, it was possible to generate a total quality score for each item across both years of the Media Monitoring Project. " • "A *total quality score* could be calculated for 415 suicide items from 2000/01 and 388 from 2006/07. The total quality scores ranged from 0 to 100 in both years, but the median score increased from 57.1% in 2000/01 to 75.0% in 2006/07. Figure 1 *(sic)* shows the distribution of total quality scores for each year, demonstrating graphically that the overall quality of suicide reporting improved significantly during the life of the Media Monitoring Project (Chi² = 189.88, df = 9, p < .000). Figure 1. Distribution of total quality scores for suicide items, by year (2000/2001, n = 415; 2006/2007, n = 388). (pg. 30)" - Pirkis J, Dare A, Blood RW, Rankin B, Williamson M, Burgess P, Jolley D. "Changes in media reporting of suicide in Australia between 2000/01 and 2006/07". *Crisis*. 2009;30(1):25-33. doi: 10.1027/0227-5910.30.1.25\ Austria: • Significant improvement in report quality. Collaborative development; active dissemination; targeted training to local journalists; monitoring • Niederkrotenthaler, T., and Sonneck, G. (2007). "Assessing the impact of media guidelines for reporting on suicides in Austria: Interrupted time series analysis." *Australasian Psychiatry*, 41, 419–428.
Key Reference:	Bohanna and Wang (2012); Pirkis et al (2009) and Niederkrotenthaler and Sonneck

	(2007). Bohanna and Wang (2012): Review of quantitative (outcomes of suicide rates (2), quality and quantity of media reports) and qualitative research (interviews with media professionals)
Limitations of Evidence:	Implementation of media guidelines may be effective in improving media reporting of suicide over the short term only when certain conditions met (e.g. media consultation when developing; active dissemination strategy, ongoing targeted journalist training). Insufficient evidence to support long-term positive effect on media reporting. • 7 no evidence of effectiveness (long-term) • In fact, negative evidence exists if conditions not met: - likely to revert to sensational reporting over time if no ongoing training (Jamison et al , 2003) - qualitative evidence suggests journalists likely to resist when insufficient collaboration or consultation occurred in development and training (Collings and Kemp, 2010)
Recommendations for future research:	

Service Activity – Responsible Reporting in the Media about Suicide – Effect on Imitative Suicide Rates

Attribute	**Details**
Description	Responsible (appropriate and sensitive) professional media coverage of suicide.
Fundamental Attributes	Media guidelines (as above) can have positive effect only when: 1) developed collaboratively with media and mental health organisations 2) active dissemination strategy 3) includes ongoing, targeted journalist training, education and maintenance of knowledge 4) ongoing monitoring of implementation.
Service specifications and suggested modelling attributes	
% Target Pop'n	12 month prevalence: SI: 2.3%; SP: 0.6%; SA: 0.4%* (16-85yrs); #10; NMHS; 2007
Workforce	Media professionals (TV, radio, print)
Gross Cost per activity (If applic)	Training of journalists (unspecified amount of sessions and minutes)
Evidence Base	
Level of Evidence:	Level of evidence 5 may be effective : limited evidence, only 2 studies assessing suicide rates (both level III-3) EFFECTIVENESS STATISTICS: • significant national decrease of 81 suicides annually since guideline introduction – • ONLY significant in areas in which complaint newspapers reached more than 67% of population (Niederkrotenthaler and Sonneck, 2007) in a review of Austrian suicide rates from 1982-2005. Level of evidence III-3 (ecological) - Niederkrotenthaler, T., and Sonneck, G. (2007). Assessing the impact of media guidelines for reporting on suicides in Austria: Interrupted time series analysis. *Australasian Psychiatry, 41*, 419–428. • 75% decrease in subway suicides in 1987 following implementation of guidelines (moratorium on subway suicide reporting); rates remained low over 5 yrs; overall decrease suicide rate of 19.5% (1986-1990) (Sonneck et al , 1998) Level of evidence III-3 (ecological) - Sonneck, G., Etzersdorfer, E., and Nagel-Kuess, S. (1994). Imitative suicide

	on the Viennese subway. *Social Science and Medicine, 38*, 453–457. No randomized controlled trials (RCT);
Key Reference:	Bohanna and Wang (2012)
Limitations of Evidence:	• No data available for media blackouts (#59: Mann et al 2005). Decrease of 75% in subway suicides in 1987 post implementation of guidelines; rates remained low over 5 yrs; overall decrease suicide rate of 19.5% (1986-1990) (#62: Sonneck et al , 1998). Signficant decrease of 81 suicides annually (1982-2005) only in areas with high coverage of compliant newspapers (>67% pop. coverage) (#61: Niederkrotenthaler and Sonneck, 2007). • CONCLUSION: Implementation of media guidelines may be effective in improving media reporting over the short term only when certain conditions met. Maximal effectiveness in short -term most likely when accompanied by key features (Austalian and Austrian studies proof of concept). However, significant international variability exists and journalist awareness, use and opinion of guidelines is generally low; insufficient evidence to support long-term positive effect on media reporting. • Promising evidence, however inadequate empirical evaluation to support a preventive effect on suicide due to low methodological quality of existing studies (no RCTs; 2-3 quantitative; majority qualitative).
Recommendations for future research:	

1.2.1.4 Service Element – Web Based Programs for Preventing Suicide Ideation

Service Activity –CBT – all ages

Attribute	Details		
Description	Cognitive Behavioural Therapy (CBT) including components of Dialectical behaviour therapy (DBT) / Problem solving therapy (PST) / Mindfulness-based cognitive therapy (MBCT) CBT + Prolonged exposure therapy (PE) (MoodGYM)		
Fundamental Attributes			
Service specifications and suggested modelling attributes			
Target Age:	**12-17yrs**	**18-64 yrs**	**65+ yrs**
Target Pop'n Profile			
% Target Pop'n	12 month prevalence: SI: 2.3% (16-85yrs); NSMHW; 2007, any affective illness: 6.2% (16-85yrs) (Slade et al, 2007)		
Avg contact hours and timeframe per activity (if applic)	Online; 6 weekly modules; 10.5 self-help hrs over 6 weeks; 6 mins researcher email response pp. Intervention offered to participants within national telephone crisis helpline.		
Workforce	Unguided self-help; researcher (via email response to queries regarding intervention),		
Gross Cost per activity (If applic)			
Evidence Base			
Level of Evidence:	3 - Inconclusive evidence of effectiveness d= 0.28, [95% CI: 0.03-0.54] (mean change in SI baseline-posttest; interv. Vs. TAU control) (van Spijker et al, in press) - van Spijker, BAJ, van Straten, A and Kerkhof, AJFM (submitted). Effectiveness of online self-help for suicidal thoughts: Results of a randomised controlled trial. EFFECTIVENESS STATISTICS - ES statistic for SI program**:** ES is 0.28, (Cohens d=0.28) with 95%CI ranging from 0.03 to 0.54 = significant mean decrease in SI. This is based on the mean change from baseline to post-test (i.e. 6 weeks after BL), comparing the intervention = TAU, with the control group (TAU only and 15 minutes information page online about suicide) on suicidal thoughts. **Van Spijker et al (2012)** - van Spijker, BAJ, PhD,[1] M. Cristina Majo, PhD,[2] Filip Smit, PhD,[2,3] Annemieke van Straten, PhD,[1] and Ad J.F.M Kerkhof, PhD[1]. Reducing Suicidal Ideation: Cost-Effectiveness Analysis of a Randomized Controlled Trial of Unguided Web-Based Self-help. *J Med Internet Res. 2012* Sep-Oct; 14(5): e141. Published online 2012 October 26. doi: 10.2196/jmir.1966 PMCID: PMC3517339 • NB: Intervention offered to participants within national telephone crisis helpline. • Data for delivery are averages per participant across 6 week intervention period. • RESULTS: "The proportion of participants that showed clinically significant change in suicidal ideation was significantly higher in the intervention group: 35% compared with 21% in the control group. For each treatment response,		

	€34,727 (US $41,325) of societal costs were saved relative to TAU indicating the intervention on top of TAU produces better health at lower costs, compared with CAU alone." ** Quote from paper • Suicidal Ideation results (** Quotes from paper) • *IE = incremental effectiveness was given for a treatment response :* defined as a clinically significant decrease in suicidal ideation on the BSS (Beck Suicide Ideation Scale). ** Quote from paper • "The proportion of participants that showed clinically significant change in suicidal ideation was significantly higher in the intervention group: 35% compared with 21% in the control group. " • "In the intervention group, 35.3% (41/116) met the criteria for clinically significant change in SI , compared with 20.8% (25/120) in the control group. *The difference in effectiveness was 0.353 − 0.208 = IE = 0.15 (SE 0.06)*. " Cost Effectiveness results (** Quotes from paper) • "Total per-participant costs encompassed costs of health service uptake, participants' out-of-pocket expenses, costs stemming from production losses, and intervention costs. " These were expressed in Euros (€) for the reference year 2009. • *"For each significantly improved participant, €34,727 (US $41,325) of societal costs were saved relative to CAU."* • "The annualized incremental costs were −€5039 per participant. Therefore, the mean incremental cost-effectiveness ratio (ICER) was estimated to be −€5039/0.15 = −€34,727 after rounding *(US −$41,325) for an additional treatment response,* indicating annual cost savings per treatment responder." • "With no willingness to pay for one significantly improved participant, there is a 93% probability that the intervention would be regarded as more cost-effective than CAU" • "Different willingness to pay ceilings only minimally affects cost-effectiveness probability estimates. Sensitivity analyses confirmed the robustness of these findings." Control group results (** Quotes from paper) • "Effectiveness further indicated by especially given that all participants were encouraged to engage in CAU. Moreover, the control group made more use of this CAU than the intervention group and called more often for exceeding cut-off SI score. " **Christensen, Farrer et al (in preparation).** o Christensen H, Farrer L, Batterham P, Mackinnon KM, Griffiths K, Donker T. The effect of a web based depression intervention on suicide ideation: Secondary outcome from a randomised controlled trial. *(in prep.)* NB: Data presented for web-based only condition. EFFECTIVENESS STATISTICS: Small ES at post and medium ES at 6 month for web based, but no consistent effects for online conditions. Regardless of intervention, SI significantly declined over 12 months. Those with higher baseline SI were significantly more likely to continue SI following completion of online modules. However, those with greater improvement in depression symptoms were less likely to experience SI after the program.
Key Reference:	**Van Spijker et al (in press)** o van Spijker, BAJ, van Straten, A and Kerkhof, AJFM (submitted). Effectiveness of online self-help for suicidal thoughts: Results of a randomised controlled trial. **Van Spijker et al (2012)** o van Spijker, BAJ, PhD,[1] M. Cristina Majo, PhD,[2] Filip Smit,

	PhD,[2,3] Annemieke van Straten, PhD,[1] and Ad J.F.M Kerkhof, PhD[1]. Reducing Suicidal Ideation: Cost-Effectiveness Analysis of a Randomized Controlled Trial of Unguided Web-Based Self-help. *J Med Internet Res. 2012* Sep-Oct; 14(5): e141. Published online 2012 October 26. doi: 10.2196/jmir.1966 PMCID: PMC3517339 **Christensen, Farrer et al (in preparation).** o Christensen H, Farrer L, Batterham P, Mackinnon KM, Griffiths K, Donker T. The effect of a web based depression intervention on suicide ideation: Secondary outcome from a randomised controlled trial. *(in prep.)*
Limitations of Evidence:	Suggests potential for SI to resolve spontaneously over time, and significantly more so in those with resolving depression. Suggests interventions treating depression may beneficially affect SI, however mechanisms by which this occurs is unknown. Significant reductions in suicidality, intent to die (p<.001) during call, but not at follow-up. Initial tentative suggestion of a promising online self-help intervention for SI that is feasible, cost-saving and effective. It increases likelihood of a favourable clinical outcome (sig. mean change in SI) when offered on top of TAU at lower cost, in the short-term; with sig. However, long-term effects, and effect on SA and completed suicides, are as yet unknown. Online CBT programs are no more successful than current call centre practice in resolving suicidal ideation. Insufficient evidence at this stage to recommend online CBT strategies for depression to be implemented for those experiencing SI. Substantial evidence exists however, to support utility of online CBT for depression only.
Recommendations for future research:	

1.2.1.5 Service Element – Crisis Intervention (Telephone and Internet Helplines)

Service Activity – Community Crisis Intervention Telephone Helplines

Research supports intervention for immediate reduction of caller distress, but then issues with the follow through with mental health services was identified. Members noted that telephone helplines are often used as a stop gap for after-hours mental health services and not particularly as a suicide prevention tool. ASIST is a mandated part of lifeline training and there are other modules to address grief and postvention etc.

There was significant discussion on whether this activity should be included in the Taxonomy due to the evidence currently available (see table below). Members noted the potential for it to be effective in immediate reduction of caller distress, with acceptable referral and action planning. On this basis and in consideration of existing funding for these services, Members agreed for this Service Element and Activity to be included, but with a strong recommendation for further research.

Attribute	Details		
Description	**Telephone Crisis Lines** 24 hour free call telephone hotline. Description of content and recommendations for service improvement taken from Kalafat et al (2007) A six step problem-solving intervention model is followed during the call, consisting of 1) establishing rapport 2) defining the problem(s) and assessment of suicide risk 3) exploring affect (incl. reduction of anxiety and other negative emotional states) 4) exploring callers coping responses 5) development of alternative problem solving methods 6) development of specific plan of action and/or referral to informal or formal support resources. If caller is suicidal: a) caller with suicidal ideation (SI) or planning: 1) identify precipant of suicidal state 2) generate alternative coping strategies 3) mobilise supports. OR b) caller at acute imminent suicide risk: action may include 1) obtain caller location (via direct request, tracing calls, use of caller ID) 2) dispatch emergency personnel if direct intervention is indicated. **Web-Based Programs** Online CBT programs are no more successful than current call centre practice in resolving suicidal ideation. Insufficient evidence at this stage to recommend online CBT strategies for depression be implemented for those experiencing SI. Substantial evidence exists however, to support utility of online CBT for depression only. **Real-time online chat rooms.** Suggestion chat rooms may replace telephone helplines in future, yet no research or evidence exists as to best-practice features, implementation or effect.		
Fundamental Attributes			
Service specifications and suggested modelling attributes			
Target Age:	12-17yrs	18-64 yrs	65+ yrs

Target Pop'n Profile	Unknown population profile, Approx. 483,000 calls per annum (2011-2012; Lifeline, 2012)		
% Target Pop'n	12% (1.9mill) Austs. accessed MH services; 35% (1.12mill) of MI accessed MH services (16-85yrs); #12 (ABS, 2008); NMHS, 2007		
Avg contact hours and timeframe per activity (if applic)	24 hrs Time limited one-off calls; 21 mins (average duration; Lifeline, 2005); On call 24 hrs rapid response to acute MH crisis in community Real-time online chat rooms.		
Workforce	Trained volunteers/ trained MHP		
Gross Cost per activity (If applic)			
Evidence Base			
Level of Evidence:	Level of evidence 5 may be effective : Single level IV study: Pre-post case series Sig reductions in suicidality, intent to die (p<.001) during call, but not at follow-up. Potential to be effective in immediate reduction of caller distress, with acceptable referral and action plan rates but inadequate follow-through of such referrals. Need for improvement in outreach strategies to increase follow-up of referrals and reduce re-attempt, particularly with callers displaying high intent to die at end of call. Suicide risk assessment with validated instrument is critical for prevention, as is improvement of referral database and outreach strategies.		
Key Reference:	Kalafat J, Gould MS, Munfakh JL, Kleinman M. An evaluation of crisis hotline outcomes. Part 1: Nonsuicidal crisis callers. An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. [Suicide Life Threat Behav. 2007] Hawton and van Heeringen (2009) (web based programs)		
Limitations of Evidence:	- Results shown for suicidal callers only (Gould et al, 2007) - N = 1, 085 baseline suicidal callers. N = 380 follow-up callers (drop out rate = 64.7%) (those followed up 3 weeks later). - Average time between baseline and follow-up = 13.5 days - Overall referral rate provided was for those who were in baseline only, comprising referral to existing therapists/services and to new services. - Data provided for Rescue procedure rate, - Overall referral rate and action plan rate was for baseline sample, whilst referral follow-through rate was for those participating in follow up no control, no randomisation, very small sample, large loss to follow-up		
Recommendations for future research:			

1.2.2 Service Category – Prevention of Depression and Anxiety

1.2.2.1 Service Element: Indicated Prevention (Screening and Intervention)

Service Activity – School-Based- Anxiety (7-17 yrs)

Service Activity – School-based-Depression (5-18 yrs)

Service Activity – Parent Training and Family Strengthening (pre-school)

Attribute	**Details**		
Description	CBT – Children		
Fundamental Attributes	Cognitive behavioural therapy		
Service specifications and suggested modelling attributes			
Activity:	**School-Based- Anxiety (7-17 yrs)**	**School-based-Depression**	**Parent Training and Family Strengthening (pre-school)**
Target Age:	**5-18 yrs**	**5-18 yrs**	**18-64 yrs**
Target Pop'n Profile	any anxiety illness: 31.9% (13-18yrs) (USA NCS-A; Merikangas et al, 2010)	depressive illness: 3.7% (6-17yrs) (CAC-NSMHW; Sawyer et al, 2001)	
% Target Pop'n	31.9% (13-18yrs)	3.7% (6-17yrs)	
Avg contact hours and timeframe per activity (if applic)	F2F CBT: 9 (8-15) sessions, 50-70 mts per session. Web-based CBT (MoodGYM): 5 modules, 20-40 mts per module.	10 (4-15) sessions, 70-90 mts per session	Social Learning and CBT (e.g. Positive Parenting Program (Triple P) , Parental Education Program [PEP]) Triple P: weekly (30-90 min) se delivered over 1-4 months for children with behaviour problems; PEP: 3 weekly 2 h group sessions and a booster se 1 month later, 2 month in total
Workforce	GRAD / Teacher / MHP	GRAD / Teacher / MHP	Triple P: MHP / nurses with accredited training; PEP: MHP
Gross Cost per activity (If applic)			
Evidence Base			
Level of Evidence:	1 sufficient evidence of effectiveness Literature references are based on adolescents	1 sufficient evidence of effectiveness FRIENDS: d= 0.31 (post-test); d= 0.19 (12 mo FU).	1 sufficient evidence of effectiveness Triple P: 5 RCTs with 6 mo-3 yrs FU vs. waitlist controls. FU`s effectiveness

	FRIENDS: d= -0.20 (post-test); d= 0.10 (12 mo FU). MoodGYM: d= 0.15 (post-test); d = 0.25 (6 mo FU). (ES are compared to control condition- waitlist) 53% of indicated CBT-based trials for teenagers reported positive effects in reducing anxiety symptoms	MoodGYM: d (males)= 0.41 (post-test) ; d (males)= 0.27 (6 mo FU); d (females)= 0.06 (post-test); d (females)= 0.05 (6 mo FU). (ES are compared to control-waitlist) 60% of indicated CBT-based trials for teenagers reported positive effects in reducing depressive symptoms	is uncertain. Effective for child anxiety and stress, ; PEP: 2 RCTs (6 mo and 1 yr FU) in Australia. Effective in prevention of child anxiety illnesss. (no specific statistics reported)
Key Reference:	#, (Christensen 2011)	#, (Christensen 2011)	# (Bayer et al 2009
Limitations of Evidence:	School-Based- Anxiety **(7-17 yrs)**		Most programs focus on behaviour problems. There are some programs effective for reducing emotional problems (anxiety and stress), such as PEP and Triple P in pre-school aged Australian children. However, risk of bias in these studies were high
Recommendations for future research:			

Service Activity – General Adults – CBT (Group, individual) - Depression

Service Activity – General Adults – CBT (web-based) – Depression

Attribute	**Details**	
Description	General Adults – CBT (Group, individual)- Depression	
Fundamental Attributes	Cognitive behavioural therapy	
Service specifications and suggested modelling attributes		
Activity:	**General Adults – CBT (Group, individual)- Depression**	**General Adults – CBT (web-based) – Depression**
Target Age:	**18-64 yrs**	**18-64 yrs**
Target Pop'n Profile	any affective illness: (16-85yrs) (Slade et al, 2007)	any affective illness: (16-85yrs) (Slade et al, 2007)
% Target Pop'n	6.2%*	6.2%
Avg contact hours and timeframe per activity (if applic)	Group: 8 (6-12), 2 hrs per session. Ind: 1 f2f contact, 6 telephone contacts, self-help book	8 (4-12), mts=?
Workforce	MHP/ GRAD	GRAD
Gross Cost per activity (If applic)		

Evidence Base		
Level of Evidence:	1 sufficient evidence of effectiveness Grp: RR=0.65; Ind: RR=0.74. RR is at FU, compared to TAU The typical Indicated preventive intervention is an 8 se group-based using CBT as content (e.g. Coping With Depression CWD) with a reduced risk of developing major depression of 35%.	1 sufficient evidence of effectiveness d=0.56 (-0.71--0.41) at post-test vs control group/ TAU Web-based CBT can significantly reduce depressive symptoms with an effect size of .56 at post-test. The typical intervention includes 8 modules. Supported web-based CBT is significantly more effective with greater retention.
Key Reference:	#, (Munoz et al. 2010)	# (Richard, 2012)
Limitations of Evidence:		
Recommendations for future research:		

1.2.2.2 Service Element: Universal Prevention

Service Activity – School-Based (primary) CBT- Anxiety (7-13 yrs)

Service Activity – School-based (Primary) – CBT Depression (5-19 yrs)

Service Activity – School-based (Teenage) – CBT Anxiety (12-17 yrs)

Service Activity – School-based (Teenage) – CBT Depression (5-19 yrs)

Service Activity – School-based (Primary) – CBT Anxiety (12-17 yrs)

Attribute	**Details**				
Description	CBT – school based				
Fundamental Attributes	Cognitive behavioural therapy				
Service specifications and suggested modelling attributes					
Activity:	**School-Based (primary) CBT- Anxiety (7-13 yrs)**	**School-based (Primary) – CBT Depression (5-19 yrs)**	**School-based (Teenage) – CBT Anxiety (12-17 yrs)**	**School-based (Teenage) – CBT Depression (5-19 yrs)**	**School-based (Primary) – CBT Anxiety (12-17 yrs)**
Target Age:	**7-13 yrs**	**5-19 yrs**	**12-17 yrs**	**5-19 yrs**	**12-17 yrs**
Target Pop'n Profile		depressive illness: 3.7% (6-17yrs) (CAC-NSMHW; Sawyer et al, 2001)			
% Target Pop'n	31.9% (13-18yrs)	4.8% males, 4.9% females (13-17yrs)	31.9% (13-18yrs)	4.8% males, 4.9% females (13-17yrs)	31.9% (13-18yrs)
Avg contact hours and timeframe per activity (if applic)	9 (8-10) + 2 booster (50-70 minutes/ session)	8-12 sessions	9 (5-10) sessions,50-70 mts	CBT, psychoeducation 8-12 sessions	9 (5-10) sessions,50-70 mts
Workforce	GRAD / Teacher / MHP	GRAD / Teacher / MHP	MHP, GRAD/ teachers	MHP, GRAD/ teachers	GRAD / Teacher / MHP
Gross Cost per activity (If applic)					
Evidence Base					
Level of Evidence:	1 sufficient evidence of	1 sufficient evidence of effectiveness	1 sufficient evidence of effectiveness	1 sufficient evidence of effectiveness	1 sufficient evidence of effectiveness

	effectiveness FRIENDS (grade 6): d=0.55 (12 mo FU, compared to control condition) 60% of universal CBT-based trials for teenagers reported positive effects in reducing anxiety symptoms	RD -0.09 (95% CI -0.14- -0.05), p=0.0003 at post-test. Effect are up significant to 12 mo, but not at 24 mo FU. (compared to no intervention) The typical universal preventive intervention is an 8-12 se school-based using CBT as content with a reduced risk of developing a depressive illness of RD -0.09 at post-test.	SIT: d=1.61 (post-test, within group; d=1.19 sy FU, within group) 60% of universal primary school CBT-based trials reported positive effects in reducing anxiety symptoms	RD: -0.09 (95% CI -0.14- -0.05), p=0.0003 at post-test. Effect are up to 12 mo, but not to 24 mo The typical universal preventive intervention is an 8-12 se school-based using CBT as content with a reduced risk of developing a depressive illness of RD -0.09 at post-test.	FRIENDS (grade 9): d=0.17 (12 mo FU, compared to control condition) 60% of universal primary school CBT-based trials reported positive effects in reducing anxiety symptoms
Key Reference:	#, (Christensen 2011)	# (Merry et al 2012)	#, (Christensen 2011)	# (Merry et al 2012)	#, (Christensen 2011)
Limitations of Evidence:		Effect are up to 12 mo, but not to 24 mo.		Effect are up to 12 mo, but not to 24 mo.	
Recommendations for future research:					

1.2.3 Other Service Elements reviewed but not included in the Suicide/ Depression/ Anxiety Prevention Categories due to evidence level

Category - Element - Activity: Prevention of Suicide, Suicide Ideation and Behaviour - Gatekeeper Training (professional) - Gatekeeper Training (General Practitioners)

This service activity is a combination of training for GPs and joint telephone hotline with mental health professionals. Promotion and prevention working group members agreed that the training for GPs belongs in the prevention stream and the subsequent interventions with the person with mental illness belongs to the primary care part of the Taxonomy. Members agreed for inclusion in that part of the Taxonomy. Given there is already mental health training given to GPs in Australia, members agreed not to model training for 100% GPs but rather try embedding into the continuing education program for GPs. The Service Activity – Gatekeeper Training (General Practitioners) was removed.

Attribute	Details
Description	*For General Practitioners in Primary Care:* 1) Connecting with own attitudes and their impact on intervention 2) Knowledge and skills in risk factors, identification and assessment of risk, development of intervention plan 3) Present model for effective intervention with at risk person, simulate and observe process in role plays 4) Provide information on local referral resources and referral practices. RATIONALE FOR only medical CATEGORY: - Justification for delineation from other professionals > specific content and delivery features for GP that are not relevant for non-medical professionals (van der Feltz et al 2011) Neither van der Feltz or Mann use a general heading for “Professionals” – they always split into GP and other community based professional gatekeepers
Fundamental Attributes	1) use of screening tools for depression and suicide risk e.g. Patient Health Questionnaire (PHQ-9) 2) information on treatment of depression and suicidality (based on existing national guidelines) 3) information on pharmacological treatments and relation to suicide risk 4) information on high risk populations. Most likely to be effective when supplemented by tools to facilitate GPs: 5) telephone helpline providing psychiatric consultation 6) guidelines outlining referral options for at risk people to local MH services 7) information pamphlets/posters for vulnerable populations in waiting rooms.
Service specifications and suggested modelling attributes	
Target Age:	16-85yrs
Target Pop’n Profile	mentally ill accessing Community based providers
% Target Pop’n	7.9% (of 3.2 mill with MI) (16-85yrs), #12 (ABS, 2008) #13 Burgess et al 2009); NMHS; 2007: 34.6%; GP: 24.7%; Psychologist: 13.2%; Psychiatrist:
Avg contact hours and timeframe per activity (if applic)	2 days (3 hrs – 5 days) (Isaac et al, 2009). Booster sessions recommended, teleconferencing and videoconferencing when local experts not available (Mann et al 2005) 3 – 4 sessions x > 3 hrs, group format (role plays), embed within continuing medical education or professional supervision. . Periodic delivery.
Workforce	Delivery: Members of GP primary care organisations. Psychiatric consultation for

	GPs via telephone hotline recommended. Audience: NA
Evidence Base	
Level of Evidence:	- Level of evidence: 2 – all cohort, some consistent effects > however, strongly endorsed as most promising by van der Feltz and Mann = likely to be effective in short term when part of multi-component strategy - Unique effect of gatekeeper programs difficult to accurately assess, as GP gatekeeper always delivered as part of multilevel strategy – indeed, Mann and van der Feltz suggests most effective when instituted as part of multipronged attack – ensures downstream care and referral pathways remain open, and complemented by awareness in other professional roles EFFECTIVENESS STATISTICS: - EAAD Sweden, Hungary, Germany: cohort studies of primary care physician education – o some significant, other non significant effects on suicidal acts (suicide attempts and completed suicides), suicide rate – some not maintained over long term. - Quote statistic for "Nuremberg Alliance against Depression" (NAAD) study in Germany: o multilevel approach incl. professional gatekeeper (Hergerl et al) – sig decrease in suicidal acts (suicide attempts and completed suicides), and deaths by 24% compared with control region. - Hegerl U, Althaus D, Schmidtke A, et al. The alliance against depression:2-year evaluation of a community-based intervention to reduce suicidality. Psychol Med. 2006;36:1225–1233 24% sig reduction in suicidal acts (SA) and suicide rate (SR) (Hegeral et al, 2006) Likely to be effective in short-term improvement in knowledge, identification, and referral of suicidal people, and in short-term reduction in suicide rate. However, effect often diminishes or lost over time, with booster training sessions suggested to ensure long-term maintenance of preventive effect (Mann et al, 2005). Facilitatory tools may augment effect. Preventive potential depends on clear fast track to treatment being available. Furthermore, often implemented within multilevel interventions, so unique effect of gatekeeper programs remains unclear. Effect may occur mainly through improved identification and treatment of underlying mental illness (particularly depression via prescription of anti-depressants) (Mann et al, 2005). Embedding within primary care institutions and educational activities essential to facilitate implementation and ensure sustainability (van der Feltz, 2011). Likely to be effective only when part of chain of care where effective treatments are available. Institutional settings may be particularly suited to program implementation. (Isaac et al, 2009).
Key Reference:	Isaac et al (2009) – only GP, van der Feltz and Mann, NAAD study in Germany,
Limitations of Evidence:	- Van der Feltz (2011) suggests training alone may not be enough > other facilitatory measures may augment effect. - Need clear fast track to available treatment in order for preventive effect to occur / be maximised Likely to be effective in short-term improvement in knowledge, identification, and referral of suicidal people, and in short-term reduction in suicide rate. However, effect often diminishes or lost over time, with booster training sessions suggested to ensure long-term maintenance of preventive effect (Mann et al, 2005).
Recommendations for future research:	

Category - Element - Activity: Prevention of Suicide, Suicide Ideation and Behaviour - Gatekeeper Training (professional) - Gatekeeper Training (Community)

This service element was also removed for the reasons outlined above.

Category - Element - Activity: Prevention of Suicide, Suicide Ideation and Behaviour - Gatekeeper Training (professional) - Gatekeeper Training (Schools)

Evidence is also less robust in preventing suicide behaviour, but it could be argued that it is having a positive effect on the cultural environment, skills and awareness of students in schools which could have subsequent effects against suicide. Recommended for further research. The Service Activity School-based Prevention Programs – Gatekeeper Training (Schools) was removed.

Attribute	Details
Description	Gatekeeper training (school staff specific)
Fundamental Attributes	
Service specifications and suggested modelling attributes	
Target Age:	
Target Pop'n Profile	Audience: teachers/school counsellors/peer leaders.
% Target Pop'n	12 month prevalence: SI: 3.4%; SP: 1.0%; SA: 1.1%* (16-24yrs); #8, Johnston et al 2009; NMHS; 2007
Avg contact hours and timeframe per activity (if applic)	1-1.5- 8 hrs; 1-2 sessions
Workforce	MHP/trained volunteers.
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	Data not available.
Key Reference:	#75 Robinson et al (2012)
Limitations of Evidence:	Limited evidence exists to support implementation of gatekeeper programs for school staff (increases in knowledge, attitudes, self-efficacy, some evidence for suicide prevention activities).
Recommendations for future research:	Controlled studies are necessary though to determine optimal content, frequency and confirm effect for suicide prevention, and long-term outcomes overall.

Category - Element - Activity: Prevention of Suicide, Suicide Ideation and Behaviour - Prevention of Online Contagion around Suicide - Online

No data available. Members agreed not to include this service element or activity in the Taxonomy but to recommend for further research. The Service Element Prevention of Online Contagion around Suicide and service activity Prevention of Online Contagion around Suicide were removed.

Attribute	Details		
Description	Prevention of Online Contagion around Suicide		
Fundamental Attributes			
Service specifications and suggested modelling attributes			
Target Age:	12-17yrs	18-64 yrs	65+ yrs
Target Pop'n Profile			
% Target Pop'n	1-5% of suicides are part of a cluster (Gould, Wallestsein and Kleinman, 1987). Clusters account for approximately 0.016-0.08% of suicide deaths in the Australian population		
Workforce	Real-time online chat rooms.		
Evidence Base			
Level of Evidence:	7 no evidence of effectiveness No research exists on how, why or what occurs in online contagion No understanding of underlying mechanisms, real-time spread, how young people are affected by online suicides New media may have harmful iatrogenic effects (e.g pro-suicide) to which youth are particularly susceptible. However, online media also holds potential as information source and treatment, support of bereaved etc. To date, no research on prevention of online contagion exists.		
Key Reference:	Hawton and van Heeringen (2009); Hawton (2012); Cox et al (2012)		
Limitations of Evidence:			
Recommendations for future research:	- Calls for empirical research and development, piloting and testing of internet interventions to harness online for good, not harm - Cited references that call for more research and outline main challenges for field - Need better understanding of suicide and self harm clusters and social contagion. More research needed, as currently mechanisms underlying contagion remain unclear, as are best-practice guidelines in managing contagion (particularly for youth).		

Category - Element - Activity: Prevention of Suicide, Suicide Ideation and Behaviour - Prevention of Online Contagion around Suicide - Community

No data available. Members agreed not to include service element or activity in the Taxonomy but to recommend for further research. Members suggested there could be some interventions provided to Indigenous communities that has resulted in a reduction in the suicide rate. The service element Service Element – Prevention of Online Contagion around Suicide and service activity Methods Preventing Contagion around Suicide – Community were removed.

Attribute	Details		
Description			
Fundamental Attributes			
Service specifications and suggested modelling attributes			
Target Age:	12-17yrs	18-64 yrs	65+ yrs
Target Pop'n Profile			
% Target Pop'n	1-5% of suicides are part of a cluster; #85 (Gould et al 1987). Clusters account for approximately 0.016-0.08% of suicide deaths in the Australian population.		
Avg contact hours and timeframe per activity (if applic)			
Workforce			
Gross Cost per activity (If applic)			
Evidence Base			
Level of Evidence:	Literature largely explores possible underlying reasons for suicide clusters, or relates to identification of clusters Research mainly centres around youth – as thought to be most sensitive to peer suicide and susceptible to contagion Need better understanding of suicide and self harm clusters and social contagion.		
Key Reference:	#71 Hawton et al (2012)		
Limitations of Evidence:			
Recommendations for future research:	More research needed, as currently mechanisms underlying contagion remain unclear, as are best-practice guidelines in managing contagion (particularly for youth).		

Category - Element - Activity: Prevention of Suicide, Suicide Ideation and Behaviour - Crisis Intervention (Phone and Internet Help Lines) – 24 hr Crisis Teams

The 24 hr crisis teams service element and activity belongs in other parts of the Taxonomy. The Service Element Crisis Intervention (Phone and Internet Help Lines) and Service Activity – Community Crisis Intervention – 24 hr Crisis Teams were removed.

Attribute	Details		
Description	**Community Crisis Intervention – 24 hr Crisis Teams** Role of team: A single point of access for people in crisis; available 24 hours a day; provide prompt short-term response to mental health crisis in the community until other services available.		
Fundamental Attributes			
Service specifications and suggested modelling attributes			
Target Age:	12-17yrs	18-64 yrs	65+ yrs
Target Pop'n Profile		35% (16-85yrs)	
% Target Pop'n	12% (1.9mill) Austs. accessed MH services; 35% (1.12mill) of MI accessed MH services (16-85yrs); (ABS, 2008); NSMHW 2007		
Avg contact hours and timeframe per activity (if applic)	On call 24 hrs rapid response to acute MH crisis in community		
Workforce	MHP trained in acute MH in community based services		
Gross Cost per activity (If applic)			
Evidence Base			
Level of Evidence:	Level of evidence 5:may be effective only one Level III-3 study (sig results; interrupted time series without control) yet only one in UK so no consistent evidence of effect Pre-post: Sig. Reduction in suicide rates from 11.44 to 9.32 per 10 000 patient contacts (p<.0001)		
Key Reference:	While et al (2012)		
Limitations of Evidence:	Limited evidence from pre-post study in UK. Translation / replicability in Australian context unknown, as are long-term effects. No controlled studies . Insufficient evidence to recommend implementation.		
Recommendations for future research:			

Category - Element - Activity: Prevention of Suicide, Suicide Ideation and Behaviour - Crisis Intervention (Phone and Internet Help Lines) – Community Crisis Intervention Internet Helpline

Very limited evidence base however, despite the lack of serious empirical evaluation, there are services that have existed for several years and continue to attract funding from increase in utilisation, which could be construed as positive evidence. Members agreed not to include this service activity and recommend for future research. The Service Element Part of Service Element Crisis Intervention (Phone and Internet Help Lines) and Service Activity Community Crisis Intervention Internet Helplines were removed.

Category - Element - Activity: Prevention of Suicide, Suicide Ideation and Behaviour - School Based Prevention Programs – Targeted screening of at risk youth

Screening process is effective where there are referral pathways to effective and evidence based treatment. Screening can happen in school environments and then therapeutic interventions happen in clinical settings. Members concerned that the success is subject to the quality of the treatment, not the screening itself. Therefore, members agreed not to include the activity at this time, but recommend it for further research. The service element School Based Prevention Programs – Targeted Screening and service activity School Based Prevention Programs – Targeted Screening were removed.

Attribute	Details
Description	MH and suicide risk screening of at-risk youth Two stages: 1) brief screen to identify at-risk individuals. 2) In-depth f2f clinical assessment of those indicated individuals to determine who requires ongoing support
Fundamental Attributes	need to weigh up cost effectiveness whole school vs targeted, need appropriate culturally valid screening tool , high false negative and false positive rate when universal screening; often miss those at suicide risk , as suicidality is transient therefore, need regular screening.
Service specifications and suggested modelling attributes	
Target Age:	12-18yrs
Target Pop'n Profile	School staff (teachers, counsellors).
% Target Pop'n	12 month prevalence: SI: 3.4%; SP: 1.0%; SA: 1.1%* (16-24yrs); #8, Johnston et al 2009; NMHS; 2007
Avg contact hours and timeframe per activity (if applic)	
Workforce	Audience: School staff (teachers, consellors).
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	4 likely to be effective Mann et al (2005) = not recommended (may have negative results and trigger vulnerable people, need to weigh up cost effectiveness whole school vs targeted, need appropriate culturally valid screening tool , high false negative and false positive rate when universal screening; often miss those at suicide risk , as suicidality is transient therefore, need regular screening. 4-45% students identified as at risk; > 50% referral rate (average) Targeted screening of high risk individuals potential to be effective in identifying those with known risk factors when a sensitive and valid screening tool is used. Some indication of preventive suicide effect, but contingent upon clear referral pathways to available treatments. Strategy is problematic when identifies at risk individuals, but treatment is unavailable. Does not cause undue distress (Robinson et al, 2012). In the absence of appropriate school-based indicated interventions, individual therapeutic interventions should be delivered in clinical settings only.
Key Reference:	Mann et al (2005) Robinson et al (2012) = potential for effectiveness
Limitations of Evidence:	
Recommendations for future research:	

Category - Element - Activity: Prevention of Suicide, Suicide Ideation and Behaviour - School Based Prevention Programs – School-based Postvention – Other strategies

Attribute	Details
Description	DETAILS OF OTHER POSTVENTION STRATEGIES 6 main approaches: 1) Community response team [see below] 2) educational/psychological debriefings 3) individual and group counselling 4) screening of high-risk 5) responsible media reporting (particualrly social media) 6) promotion of healthy community recovery Only one strategy has been empirically evaluated, and only then in immediate effect, so only include this strategy : community response team and plan **(School-based Postvention – Crisis Response Plan and Teams)**
Fundamental Attributes	
Service specifications and suggested modelling attributes	
Target Age:	**12-18 yrs**
Evidence Base	
Level of Evidence:	(Level of evidence 4 for crisis teams: only 2 pre-post case studies – Level IV studies)
Key Reference:	
Limitations of Evidence:	
Recommendations for future research:	CONCLUSION: Literature is descriptive, no empirical evaluation of these strategies. In absence of evidence indicating otherwise, solid recommendations for the use of these strategies cannot be made. Furthermore, Cox et al (2012) suggests looking to broader interventions found to be effective in preventing suicide and identifying at risk youth, and general population, to inform future cluster postcention programs. Also recommends updating of guidelines to take into account social media, email and mobile phone technologies.

Category - Element - Activity: Prevention of Suicide, Suicide Ideation and Behaviour - School Based Prevention Programs – School-based Postvention – Crisis Response Plan and Team

Limited empirical evidence but supports some short term containment and identification of at-risk individuals. Some of the resources that perform this function currently exist as part of a larger role (e.g. crisis team or acute mental health services). However, the need for specialised expertise was noted and therefore the need for specialist team. Members agreed not to include the service element but recommend it for further research. The Service Element Reduce Stress and Contagion Following Suicide in Schools and the Service Activity – School Based Postvention were removed.

Attribute	Details
Description	**Crisis response plan and team** Role of team: 1) investigate the suicide event 2) provide immediate frontline support to distressed individuals 3) implement postvention strategies (e.g. liaise with media, police, school officials, deceased family; debrief peers and teachers; screen and assess high-risk peers; referral of high-risk peers to local MH services; offer gatekeeper training to key

	stakeholders [teachers, parents]). Timeframe of delivery: Development of plan: pre-existing. Roll-out of plan and team: immediate (day after suicide event). Format of delivery: Group psychoeducation and debriefing; f2f screening and referral; f2f and group meetings with stakeholders
Fundamental Attributes	Key elements critical to an effective crisis team response: - Adequate training (e.g. post-traumatic stress management; suicide intervention) of crisis team, - immediate set-up of team and timely implementation of plan, - collaborative approach using existing partnerships Success of team also contingent upon having plan in place before SA/SE, and effective treatment services being available to receive referrals.
Service specifications and suggested modelling attributes	
Target Age:	12-18 yrs
Target Pop'n Profile	High School Students who have been exposed to suicide in the school.
% Target Pop'n	1-5% of suicides are part of a cluster (Gould, Wallestsein and Kleinman, 1987); contagion estimated to be key factor in 60% suicides in youth (Davidson et al, 1989)
Avg contact hours and timeframe per activity (if applic)	Variable.
Workforce	Leaders: Community-based MH trauma teams (trained in PTSD). Collaborating agencies: law enforcement (police, coroner); school staff; local MH treatment services; local media and community liaison; parents.
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	4 likely to be effective 39 high-risk individuals identified and referred by team to MH services (Askland et al, 2003). Only one unrelated suicide recorded following crisis team operation, and steady decrease in hospitalisations for SA over folllowing 2 years (Hacker et al, 2008) Literature predominantly descriptive, very limited empirical evaluation (particularly of long-term). Initial tentative suggestion of some positive short-term effects on identification, referral of at-risk peers and containment of suicide contagion however controlled, long-term evaluation of crisis teams is lacking.
Key Reference:	Askland, K. D., Sonnenfeld, N., and Crosby, A. (2003). A public health response to a cluster of suicidal behaviors: Clinical psychiatry, prevention, and community health. Journal of Psychiatric Practice, 9, 219–227. doi 00131746-200305000-00005 Hacker, K., Collins, J., Gross-Young, L., Almeida, S., and Burke, N. (2008). Coping with youth suicide and overdose: One community's efforts to investigate, intervene, and prevent suicide contagion. Crisis, 29, 86–95 Cox et al (2012); Beautrais (2000)
Limitations of Evidence:	
Recommendations for future research:	

Category - Element - Activity: Prevention of Depression and Anxiety – Targeted Early Childhood Programs – Home Visiting Programs for Disadvantaged New Mothers and Babies

There is only limited evidence supporting the value of home visiting programs on anxiety and depression. One report did have evidence for the PPP program and so that could be recommended for anxiety. There are important outcomes for social and cognitive development and therefore, home visiting programs would only be included if social and cognitive development was an outcome measure. Members agreed to remove the service element and the service activities from the Taxonomy. **Note**: Programs such as PPP (Positive Parenting Program) and PEP (Parental Education Program) are also described in Parenting Training and Family Strengthening Service Element.

Attribute	Details
Description	Home Visiting Programs for Disadvantaged New Mothers and Babies
Fundamental Attributes	
Service specifications and suggested modelling attributes	
Target Age:	16-64yrs
Target Pop'n Profile	Mothers with new babies up to ?months.
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	1 to 3-13 visits per year (minutes per visit is unknown)
Workforce	MHP/ Specially trained lay providers
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	No evidence for improving maternal psychosocial health or outcomes for children (2007). 2012: Most studies reported some degree of effectiveness on child maltreatment, improvement in children`s cognitive and social development
Key Reference:	# (Bennet et al., 2007), # (WA, 2012)
Limitations of Evidence:	No statistically significant differences between intervention and control condition (TAU, or not described) for mothers on depression (SMD=-0.08 (95%CI -0.26,0.11, I(2)=63%) and anxiety (P=.85). (no data on child internalizing illnesses)
Recommendations for future research:	

References

Macdonald G, Bennett C, Dennis J, Coren E, Patterson J, Astin M, Abbott J.Home-based support for disadvantaged teenage mothers.*Cochrane Database Syst Rev*. 2007 Jul 18;(3):CD006723. Review. Update in: Cochrane Database Syst Rev. 2008;(1):CD006723. PMID:17636849

Bennett C, Macdonald GM, Dennis J, Coren E, Patterson J, Astin M, Abbott J.Home-based support for disadvantaged adult mothers.*Cochrane Database Syst Rev*. 2007 Jul 18;(3):CD003759. Review. Update in: Cochrane Database Syst Rev. 2008;(1):CD003759. PMID:17636732

Department for communities. Parenting WA home visiting Literature review (2012). Government of Western Australia, Department for communities Parenting WA

Category - Element - Activity: Prevention of Depression and Anxiety – Indicated Prevention (Screening and Intervention) - Diet Quality

Members agreed this service activity is not for inclusion now. The Service Activity was removed.

Attribute	Details
Description	**Diet Quality**
Fundamental Attributes	Note: Dietary improvement is: no processed food, no red meat, no take away. But: vegetables and fruit.
Service specifications and suggested modelling attributes	
Target Age:	All Ages
Target Pop'n Profile	any affective illness
% Target Pop'n	6.2% (16-85yrs) (Slade et al, 2007)
Avg contact hours and timeframe per activity (if applic)	N.A.
Workforce	N.A
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	6 no evidence of effectiveness Evidence suggests there is an association between diet quality and affective illnesses.
Key Reference:	# (Jacka et al 2012)
Limitations of Evidence:	There are no RCTs published yet, but several are currently in preparation.
Recommendations for future research:	

Category - Element - Activity: Prevention of Depression and Anxiety – Indicated Prevention (Screening and Intervention) - Exercise

Effectiveness shown in reducing symptoms of existing depression, not necessarily in preventing depression. Members agreed not to include exercise at this time. The Service Activity – Exercise was removed.

Attribute	Details
Description	**Exercise**
Fundamental Attributes	
Service specifications and suggested modelling attributes	
Target Age:	All Ages
Target Pop'n Profile	any affective illness: 6.2% (16-85yrs) (Slade et al, 2007)
% Target Pop'n	6.2% (16-85yrs)
Avg contact hours and timeframe per activity (if applic)	No data available (DIAGNOSIS) Structured, supervised exercise programmes 3 per week (45-60 mts) for 10-12 weeks Note:-amount of hours training is based on NICE guideline 2007 and is cited in

	Mead et al. 2010.
Workforce	Sport instructor
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	1 sufficient evidence of effectiveness Exercise seems to improve depressive symptoms in people with a diagnosis of depression, but when only methodologically robust trials are included, the effect sizes are only moderate and not statistically significant. SMD= -0.82 (95% CI: -1.12- -0.51) – high quality studies.SMD= -0.42 (95% CI: -0.88- 0.03)
Key Reference:	# (Mead et al., 2010)
Limitations of Evidence:	Note: Mead is based on diagnosis of depression. There is very limited evidence for prevention exercise interventions for depression (Dunn, 2008).
Recommendations for future research:	

Category - Element - Activity: Prevention of Depression and Anxiety – Indicated Prevention (Screening and Intervention) – Exercise (children and adolescents (<21 yrs))

Evidence not as strong as other interventions and assumption is that the exercise would be in addition to exercise programs conducted in school environments. Members discussed the various models but agreed this service activity is not for inclusion now in the Taxonomy and recommended for future research. The Service Activity – Exercise (children and adolescents (<21 yrs)) was removed.

Attribute	Details
Description	Exercise (children and adolescents (<21 yrs))
Fundamental Attributes	
Service specifications and suggested modelling attributes	
Target Age:	<21 years
Target Pop'n Profile	any affective illness
% Target Pop'n	6.2% (16-85yrs) (Slade et al, 2007)
Avg contact hours and timeframe per activity (if applic)	Vigorous exercise (aerobic exercise, weight lifting) 45 min (20-90), 3 times a week , min of 4 weeks
Workforce	Sport instructor
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	1 sufficient evidence of effectiveness Anxiety: SMD= -0.48 (95%CI: -0.97-0.01; ns). Depression: SMD= -0.66 (95% CI -1.25--0.08 sig) compared to no intervention at post-test
Key Reference:	# (Larun, 2009)

Limitations of Evidence:	Exercise has a small effect in reducing depression and anxiety scores in the general population of children and adolescents, but research is scarce and of low methodological quality.
Recommendations for future research:	

Category - Element - Activity: Prevention of Depression and Anxiety – Indicated Prevention (Screening and Intervention) – Workplace Screening and Care Management

Limited evidence showing effectiveness. However, issues of discrimination around disclosure prevents inclusion of this activity at this time. The Service Activity – Workplace Screening and Care Management was removed.

Attribute	Details
Description	Workplace Screening and Care Management
Fundamental Attributes	Screening + telephone support +care management
Service specifications and suggested modelling attributes	
Target Age:	18-64 yrs
Target Pop'n Profile	any affective illness: 6.2% (16-85yrs) (Slade et al, 2007)
% Target Pop'n	6.2% (16-85yrs)
Avg contact hours and timeframe per activity (if applic)	For patients reluctant for F2F treatment: 8 sessions CBT, 30-40 mts each by phone. For patients agreed to F2F treatment: not described.
Workforce	Care manager
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	3 inconclusive evidence of effectiveness b=-1.0, p=.01
Key Reference:	# (Harvey et al in prep)
Limitations of Evidence:	Screening [followed by care management] can reduce the impact of depression, but the possibility of false positives and the discrimination surrounding disclosure brings into question the usefulness of screening in this environment.
Recommendations for future research:	Further evidence is needed before wide scale screening can be recommended.

Category - Element - Activity: Prevention of Depression and Anxiety – Indicated Prevention (Screening and Intervention) – Workplace Stress Management Techniques

Evidence shows CBT effective and members noted the similarities to other service activities and agreed that this activity would be subsumed in General Adults Group and Web Based CBT. The Service Activity – Workplace Stress Management Techniques was removed.

Attribute	Details
Description	Workplace Stress Management Techniques
Fundamental	Cognitive behavioural therapy

Attributes	
Service specifications and suggested modelling attributes	
Target Age:	18-64 yrs
Target Pop'n Profile	any affective illness: 6.2% (16-85yrs) (Slade et al, 2007)
% Target Pop'n	6.2% (16-85yrs)
Avg contact hours and timeframe per activity (if applic)	CBT/PE/PS 7.4 (2-14), no data available for how many mts each session is.
Workforce	N.A.
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	5 may be effective CBT: pooled d=1.164 (95%CI: 0.46-1.87), p<.01 (post-test, vs control and treatment conditions); all interventions: pooled d=0.53). CBT had moderate levels of evidence for their effectiveness in reducing self-reported stress and symptoms of both depression and anxiety
Key Reference:	# (Harvey et al in prep)
Limitations of Evidence:	
Recommendations for future research:	

Category - Element - Activity: Prevention of Depression and Anxiety – Indicated Prevention (Screening and Intervention) – Pregnancy – Individual and Group CBT

Group based psychoeducation study claimed better results than CBT. There is some uncertainty on the reliability of results across different studies. Not for inclusion at this time, but recommended for further research. The Service Activity – Pregnancy – Individual Group CBT was removed.

Attribute	Details
Description	Pregnancy – Individual and Group CBT
Fundamental Attributes	Cognitive behavioural therapy
Service specifications and suggested modelling attributes	
Target Age:	18-64 yrs
Target Pop'n Profile	
% Target Pop'n	13% (munoz)
Avg contact hours and timeframe per activity (if applic)	GRP: PE: 8 se, 2 hrs / CBT: 12 se,? Hrs; IND: PS: 9 phone calls (min=4), 14 mts per call.
Workforce	MHP
Gross Cost per activity (If applic)	
Evidence Base	

Level of Evidence:	3 inconclusive evidence of effectiveness RR: PS:0.65; PE: 0.43; CBT:0.57 at FU compared to TAU Significant preventive effects were demonstrated only in the psycho-educational study. This is an 8 sessions, 2 hrs group-based psycho-educational study to prevent Major Depressive Disorder (MDD) in pregnant women with a relative risk reduction of 57%
Key Reference:	#, (Munoz et al. 2010)
Limitations of Evidence:	
Recommendations for future research:	

Category - Element - Activity: Prevention of Depression and Anxiety – Indicated Prevention (Screening and Intervention) – Child and Adolescent Web-based CBT

Attribute	**Details**
Description	Child and Adolescent Web-based CBT
Fundamental Attributes	
Service specifications and suggested modelling attributes	
Target Age:	All Ages
Target Pop'n Profile	
% Target Pop'n	
Avg contact hours and timeframe per activity (if applic)	CBT Self-guided 5 modules (20-40 mts)
Workforce	
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	3 inconclusive evidence of effectiveness Anxiety: d= 0.15 (post-test); d=0.25 (6 mo FU). Depression: d=0.43 (males only, post-test), d=0.27 (6 mo FU). All significant. ES is compared to wait-list. There is early support for the effectiveness of internet-based intervention programs for anxiety and depression in children and adolescents. The typical web-based intervention is CBT-based and can be delivered without support.
Key Reference:	# (Calear et al 2010)
Limitations of Evidence:	
Recommendations for future research:	

Category - Element - Activity: Prevention of Depression and Anxiety – Indicated Prevention (Screening and Intervention) – General Adults – CBT (Group, Individual) - Anxiety

Individual intervention was more effective than group based interventions and media based interventions were also more effective. Evidence indicates good effects in the short term, but not in the longer term. Therefore, members agreed not to include this activity. The Service Activity General Adults – CBT (Group, individual)- Anxiety was removed.

Attribute	Details
Description	General Adults – CBT (Group, individual)- Depression/Anxiety
Fundamental Attributes	Cognitive behavioural therapy
Service specifications and suggested modelling attributes	
Target Age:	18-64 yrs
Target Pop'n Profile	any anxiety illness: 16-85yrs) (Slade et al, 2007)
% Target Pop'n	14.4% (
Avg contact hours and timeframe per activity (if applic)	1-10, total time range 30 mts-16 hrs).
Workforce	MHP
Gross Cost per activity (If applic)	
Evidence Base	
Level of Evidence:	1 sufficient evidence of effectiveness g= 0.25 for GAD, g=.24 for illness specific symptoms, compared to active control. Significant at post-test, but not at 6 and 12 mo FU. Individually administered media interventions are more effective than human-administered group interventions at preventing Generalized Anxiety Disorder (GAD).
Key Reference:	# (zalta 2011)
Limitations of Evidence:	Not Significant at 6 and 12 month follow up.
Recommendations for future research:	

Category - Element - Activity: Prevention of Depression and Anxiety – Indicated Prevention (Screening and Intervention) – General Adults – CBT (Web-Based) - Anxiety

No evidence to support it. Members agreed not to include it. The Service Activity – General Adults – CBT (web-based) – Anxiety was removed.

Category - Element - Activity: Prevention of Depression and Anxiety – Universal Prevention - Workplace – Training Managers

This service activity is not for inclusion. Level of evidence 7 no evidence of effectiveness , key reference # (Harvey et al in prep). The Service Activity – Workplace – Training Managers was removed.

Category - Element - Activity: Prevention of Depression and Anxiety – Universal Prevention - Workplace Mediation

One randomised control trial showed meditation was effective in reducing symptoms of depression and anxiety in full time workers (Author: Minoka, 2012). Members agreed not to include this activity. Level of evidence 3 inconclusive evidence of effectiveness, key reference # (Harvey et al in prep). The Service Activity – Workplace Meditation was removed.

Category - Element - Activity: Prevention of Depression and Anxiety – Universal Prevention - Workplace - CBT at Times of Transition

There was very little research. Level of evidence 3 inconclusive reference (Harvey et al in prep). The Service Activity – Workplace – CBT at Times of Transition was removed.

Category - Element - Activity: Prevention of Depression and Anxiety – Universal Prevention - Workplace - Resilience Training and Interventions for high-risk occupations

Stress Inoculation training (SIT) level of evidence 4 likely to be effective. Resilience training appears to be an intervention of great interest within certain high-risk groups (e.g. military and emergency services). There is, however, limited evidence that resilience training is effective amongst these groups. Reference # (Harvey et al in prep). Members agreed not to include this activity at this time. The Service Activity – Workplace – Resilience Training and Interventions for high-risk occupations was removed.

1.2.4 References used for Prevention of Suicide/Depression/Anxiety Categories

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1.2.5 Service Category – Prevention of Aggression, Violence, Antisocial, Conduct Disorder, Externalising

The content under this category has been adapted from: "Brief Analysis of the Effectiveness of Interventions for the Prevention of Aggression, Violence, Antisocial, Conduct Disorder, Externalising"; prepared by Professor Mark Dadds and Dr Caroline Moul (School of Psychology, University of NSW) for use by the NHMSPF Promotion and Prevention Working Group (October 2013).

1.2.5.1 Service Element - Multi-Level Behavioural Parent Training

Service Activity - Parent Management Training

The best researched intervention for the treatment of early onset externalising behaviour problems and disruptive behaviour disorders is training parents to better manage the child and family. There are a variety of well-developed and researched programs that share common core strategies.

- Programmes to prevent the persistence and development of disruptive behaviour disorders have proven efficacy at both secondary and tertiary levels of intervention. Interventions at the secondary level are effective in reducing the rate of onset of new cases and reducing subclinical symptoms in at-risk populations. Interventions at the tertiary level are effective at reducing diagnostic severity for children with a disruptive behaviour disorder.
- A variety of delivery modes are available, from receipt of written advice through to intense individual therapy. The Triple P model is a world leader in development and evaluation of such a multi-level public health approach to intervention.
- The biggest effects have been associated with group and individual parent training programmes delivered by specialist programme leaders, however, GPs, nurses and other care professionals can be effective program leaders given adequate training and supervision from mental health professionals - an encouraging outcome when considering real-world implementation.
- Effect sizes range from -0.97 to 2.19 and the size of the sample has been found to be a significant moderator of effect size with smaller samples (<100) having, on average, significantly greater effect sizes than larger samples. This may reflect the reduction in efficacy when moving from small research-based studies to larger real-world settings.

Summary

Effectiveness rating:	*1 – mean weighted effect size of 0.36 (range -0.97 to 2.19) (Piquero et al., 2009)*
Reason for effectiveness rating:	*Evidence of effectiveness from meta-analyses and randomised controlled trials.*
Level of intervention:	*Secondary or tertiary*
Most appropriate age range:	*3-12 years*
Key references:	(Brestan and Eyberg, 1998; Markie-Dadds and Sanders, 2006; Piquero, Farrington, Welsh, Tremblay, and Jennings, 2009; Webster-Stratton, Reid, and Hammond, 2004)

Examples of specific programs with demonstrated effectiveness

- Triple P – Positive Parenting Practices - Sanders
- The Incredible Years – Webster-Stratton
- Parent-Child Interaction Therapy - Eyberg
- Behavioural Parent Training – Dadds and Hawes

Service Activity - Multidimensional Treatment Foster Care[7]

Multidimensional Treatment Foster Care (MTFC) is one of twelve blueprints model programmes scientifically validated as effective by the Centre for Study and Prevention of Violence, USA. In MTFC, foster families are recruited and trained to provide a structured environment with clear and consistent rules and discipline. Multidimensional Treatment Foster Care has been found to be effective at reducing reoffending for delinquent youths at a one year follow-up.

Summary

Prevention level:	*Tertiary*
Effectiveness rating:	*1 (effect sizes between -0.14 to -0.40 in reduction in antisocial and delinquent behaviours)*
Reason for effectiveness rating:	*Three randomised-controlled trials demonstrating effectiveness in the USA (studies involving the program developers) and replicated in Sweden in 2011.*
Most appropriate age range:	*12-18*
References indicating effectiveness:	(Chamberlain, 2003; Eddy, Whaley, and Chamberlain, 2004; Westermark, Hansson, and Olsson, 2011)

[7] Multidimensional Treatment Foster Care is included so as to provide a behavioural "parent" training intervention that is applicable for looked-after children.

1.2.5.2 Service Element - School-Based Intervention Programs (Universal)

Universal school-based intervention programs may focus on one or more of a large range of topics, such as; education about antisocial behaviour and its prevention, emotional self-awareness, emotional control, self-esteem conflict resolution and social skills. Typically these programs utilise the classroom teacher to implement the intervention but may also use non-school personnel (university researcher) and may involve parental participation. These programs may not be solely focussed on reducing externalising behaviour problems and may also aim to improve social and emotional learning and academic performance.

- It should be noted that universal interventions are often targeted at schools in lower SES and/or high crime neighbourhoods so the children may be considered at higher than average risk for externalising behaviour problems.
- A meta-analysis demonstrated that, on average, children of lower SES and younger age show greater reductions in externalising behaviours following a universal school-based intervention than children of middle SES and older children (Wilson and Lipsey, 2007).
- A meta-analysis demonstrated that classroom teachers can successfully implement the program to produce significant change in behaviour (Durlak et al., 2011).
- There is no clear evidence to suggest that one component of universal school-based interventions (e.g. anger management, social problem solving or social skills training) is more successful than any other (Wilson and Lipsey, 2007).
- A systematic review of the effectiveness of universal school-based programs to prevent violent and aggressive behaviour found a mean effect of a 13.9% reduction in violent behaviour (effect size = 0.21) for students receiving a program compared with those not included in a program. The review also demonstrated that universal school-based interventions were effective across all age brackets; that is, kindergarten, elementary school, middle school and high school (Hahn et al., 2007).
- The long term effectiveness of school-based universal interventions is unclear – there is some evidence to suggest that the effectiveness reduces in accordance with length of time after the intervention finished (Hahn et al., 2007).
- It should be noted that results from universal school-based interventions cannot determine where change occurred. In other words, it is unclear whether these interventions are equally useful for children with disruptive behaviour disorders or externalising behaviour problems as for those without, or vice versa.

Summary

Prevention level:	*Primary*
Effectiveness rating:	*1*
Reason for effectiveness rating:	*Evidence from meta-analyses and a systematic review. Meta-analyses found the effect size for reducing externalising behaviour problems associated with universal school interventions to range from 0.15 to 0.30.*
Most appropriate target:	*NA*
Most appropriate age range:	*5-17 years*
Moderating or mediating factors:	*Age, SES, program setting*
References indicating effectiveness:	(Durlak, Weissberg, Dymnicki, Taylor, and Schellinger, 2011; Hahn et al., 2007; Wilson and Lipsey, 2007)

1.2.5.3 Service Element - School-Based Intervention Programs (Indicated)

Indicated school-based intervention programs are aimed at children identified as having a disruptive behaviour disorder or as having externalising behaviour problems. As with universal interventions, indicated school-based programs can comprise a range of modalities such as; cognitively oriented treatments such as anger management or social problem solving, social skills training, counselling and behaviour management.

- Meta-analyses demonstrate similar estimates of mean effect sizes of indicated intervention programs (effect size of 0.29; Wilson and Lipsey, 2007, effect size of 0.30 for individual school-based indicated intervention programs; Stoltz et al., 2009).
- Greater effect sizes associated with the following: individual as opposed to group interventions; behavioural strategies as opposed to other modalities; higher-risk children; higher quality implementation of the program, and smaller sample sizes.
- Comprehensive programs (those that combine indicated treatment elements with universally implemented programs) have been found to be non-significant at reducing violent and aggressive behaviours. It is not yet clear why this is the case.
- The positive relationship between risk-status and program effectiveness highlights the point that a program cannot have large effects unless there is sufficient problem behaviour, or risk for such behaviour to allow for significant improvement. Thus, the use of indicated programs may be most effectively utilised only for high-risk children – those who are already displaying significant externalising behaviour problems.
- It is important to note that not all programs included in meta-analyses had a significant effect with regards to reducing antisocial and aggressive behaviours; there was significant heterogeneity in the outcomes of programs. Some programs had a negative effect – children in the programs had greater levels of behaviour problems following treatment than children in comparison control groups. Thus, only specific school-based interventions that have a reliable evidence-base of effectiveness should be employed.

Summary

Prevention level:	*Secondary and tertiary*
Effectiveness rating:	*Level 1 for demonstration programs. Level 2 for programs in practice settings. See footnote*[8]
Reason for effectiveness rating:	*Meta-analyses demonstrating overall mean effectiveness for indicated programs (effect size = 0.29) consist predominantly of research conducted in demonstration settings. There is some evidence (Wilson et al., 2003) that programs in practice settings have smaller effects. In general, more research is required to determine the efficacy of indicated school-based programs in practice settings.*
Most appropriate target:	*Children at high risk of displaying externalising behaviour problems or already identified*
Most appropriate age range:	*5-17 years*
Moderating or mediating factors:	*Age of child, risk-level of child, program content, program setting*
References indicating effectiveness:	(Stoltz, Londen, Deković, Castro, and Prinzie, 2012; Wilson and Lipsey, 2007; Wilson, Lipsey, and Derzon, 2003)

[8] A problem of demonstration versus practice settings.

- The large majority of published research concerns that of interventions in demonstration settings; that is programs in which a researcher is involved with the design and application of the program. The effect size for programs conducted in demonstration settings is significantly higher than for programs conducted in practice settings in which the school is conducting the program independently from a research base (effect size = 0.10, Wilson et al., 2003).
- This problem reflects one of implementation quality and is a considerable concern as schools adopting these programs without the direct involvement of a researcher may have weak implementation. Thus, it is recommended that the best choice of a universal or indicated program for a school may be the one (evidence-based) they are most confident they can implement well.

1.2.5.4 References for this Category

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1.2.6 Service Category - Prevention of Eating Disorders and Body Image Problems

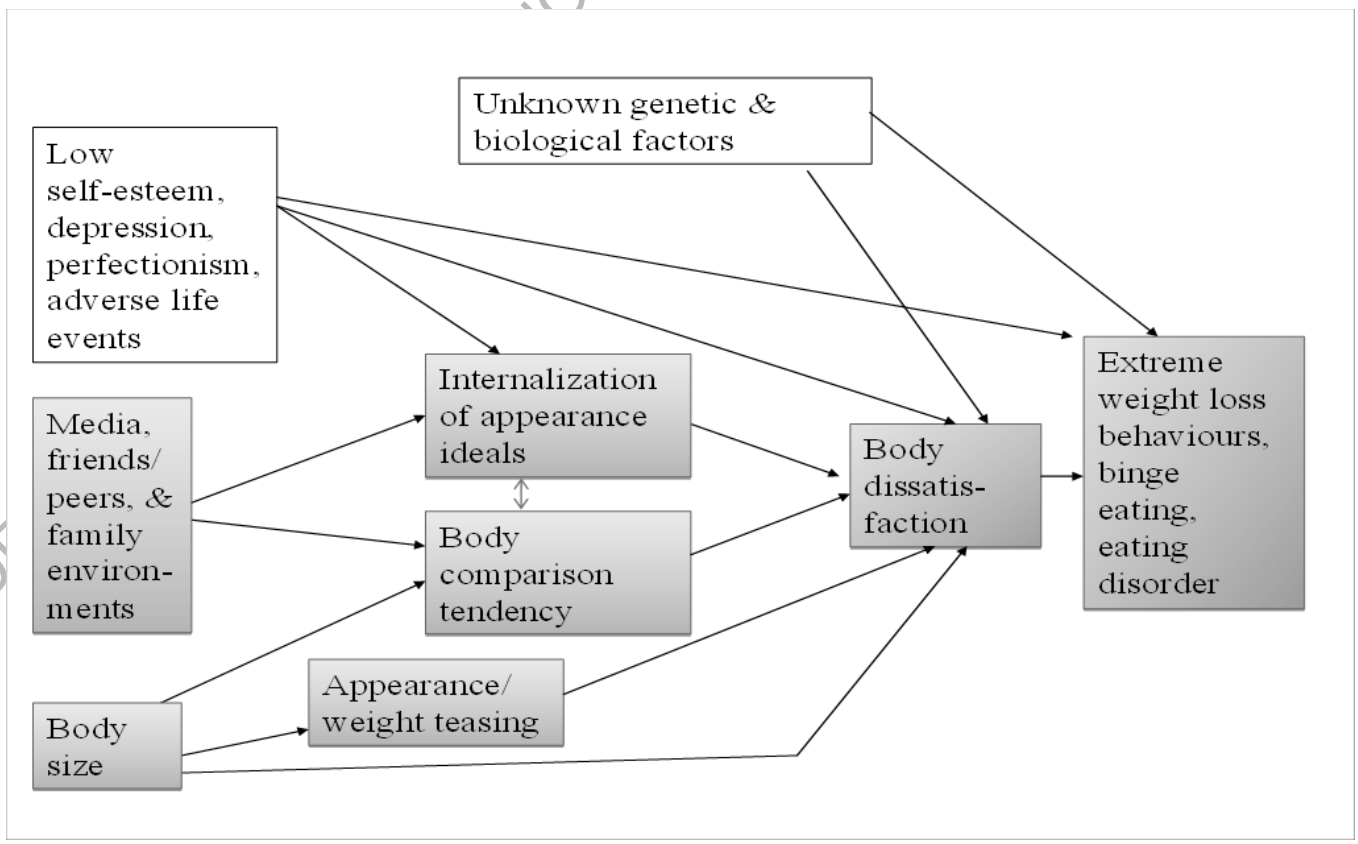
The content under this category has been adapted from: "Prevention of Body Image and Eating Disorders– Rapid Review"; prepared by Professor Susan J Paxton, Dr Laura Hart and Ms Siân McLean (School of Psychological Science, La Trobe University) for use by the NHMSPF Promotion and Prevention Working Group (October 2013).

1.2.6.1 Theoretical Framework – Risk Factor Approach

Most consistently identified risk factors for eating disorders are body dissatisfaction/weight and shape concerns, dieting and negative affect (Jacobi & Fittig, 2010; Stice, Marti, & Durant, 2011). These factors have been found to increase risk for bulimia nervosa and related disorders but risk factors for anorexia nervosa have been harder to specify and are likely to be more complex. Risk factors for the development of body dissatisfaction include exposure to environmental pressures to adhere to social appearance ideals, negative affect, higher body mass index (BMI) and undetermined genetic factors (Smolak, 2009). Two psychological processes have been shown to partially or fully mediate the impact of individual and environmental risk factors, and body dissatisfaction and eating disorders. These are: internalisation of appearance ideals (adoption of appearance ideals as a personal standard) and body comparison (comparing one's appearance to others). **The goal of prevention has been to reduce the presence or impact of upstream risk factors thereby reducing the likelihood of eating disorders or body dissatisfaction** (Levine & Smolak, 2009).

Assessment of prevention program outcomes has typically included assessment of the presence of risk factors as well as body image and eating disorder symptoms although a few studies have examined long term eating disorder outcomes (Austin et al., 2007; Berger, Sowa, Bormann, Brix, & Strauss, 2008; Stice, Shaw, Burton, & Wade, 2006; Taylor et al., 2006)

Figure 3: Biopsychosocial model of risk factors for the development of body dissatisfaction and eating disorders (Adapted from Wertheim & Paxton, 2012).



The body image and eating disorder prevention literature has typically been described in terms of **universal, selective and indicated prevention**. Universal and selective interventions have been delivered to groups unselected for risk status who are assumed to have low or non-clinical levels of body image and eating disorders. These interventions have been trialled in late primary and early high school children in school environments (See Levine & Smolak, 2009). Some have also been conducted in community settings such as in girl scout groups (e.g., Coller, Neumark-Sztainer, Bulfer, & Engebretson, 1999; Fiissel, 2006).

Indicated prevention programs have also been evaluated. In these studies, participants have been selected on the basis of elevated risk factors for eating disorders, particularly body dissatisfaction or disordered eating symptoms. These programs have typically been delivered to small groups of older adolescents or young adults in school, university or community settings (Stice, Marti, Spoor, Presnell & Shaw, 2008). Early intervention associated with early identification may also be considered prevention and university and community based interventions have been developed to facilitate this (e.g., Becker, Franko, Nussbaum, & Herzog, 2004; D'Souza, Forman, & Austin, 2005; Hart, Jorm, & Paxton, 2012).

A number of **systematic reviews and meta-analyses** have been conducted to identify prevention intervention effects and moderators of those effects. These analyses have usually included interventions across the universal – selective – indicated spectrum, and included all age groups rather than specifically identifying the setting as being school, university or community (Pratt & Woolfenden, 2002; Cororve Fingeret, Warren, Cepeda-Benito, & Gleaves, 2006; Stice & Shaw, 2004; Stice, Shaw, & Marti, 2007). The conclusions of these reviews will be outlined in this section. Conclusions reached can be interpreted with school, university and community settings in mind. However, two recent systematic reviews specifically review school-based (Yager, Diedrichs, Ricciardelli, & Halliwell, 2013) and university-based (Yager & O'Dea, 2008) interventions and these will be reviewed in the relevant section below.

It is notable that although boys and men do experience body dissatisfaction, disordered eating and eating disorders, **only a few studies have included males** and unless mentioned the results described below refer to findings for females.

An early Cochrane Review of eating disorder prevention randomised controlled trials (RCTs) for children and adolescents conducted in 2002 found that combined data from two eating disorder prevention programs based on a media literacy and advocacy indicated a reduction in internalisation or acceptance of societal appearance ideals at a 3- to 6-month follow-up (Pratt & Woolfenden, 2002).

More recently, **three meta-analyses** of controlled prevention interventions have been conducted (Cororve Fingeret, et al., 2006; Stice & Shaw, 2004; Stice, et al., 2007). Cororve Fingeret et al. (2006) reviewed 46 separate prevention studies and found that overall the programs had large effects on improving knowledge and small net effects on reducing maladaptive eating attitudes and behaviours. Effect sizes for general eating pathology, dieting, and thin-ideal internalization ranged from d = .17 to .21 at post-test and from d = .13 to .18 at follow- up. These effects were all positive and indicated improvements in symptoms of general eating pathology, dieting behaviours, and internalization of a thin-ideal body ideal following intervention. The effects for general eating pathology and dieting behaviours were the most consistent, as homogeneous distributions of effect size estimates were found for these variables at each time point. Body dissatisfaction was the most frequently evaluated outcome variable across the studies in this meta-analysis. While the overall effects for body dissatisfaction suggested positive improvements at post-test (d = .13) and follow-up (d = .07), follow-up effect sizes were not significantly different from zero. Importantly, studies targeting participants at relatively higher risk for developing an eating disorder, (indicated prevention usually including university students), produced greater benefits.

Stice and colleagues (Stice & Shaw, 2004; Stice, et al, 2007) have conducted two meta-analyses but the findings of the most recent will be described here as they report on overlapping data. Stice et al. (2007) found that 26 (51%) of the interventions reviewed resulted in significant reductions in at least one established risk-factor for eating pathology, such as body dissatisfaction and 15 (29%) of the prevention programs resulted in significant reductions in eating pathology. The average effect sizes (r) were all significant with the average effect size being: .14 for body dissatisfaction; ,12 for dieting; .18 for internalisation of the thin ideal; .12 for negative affect; and .13 for eating pathology.

However, there was wide variety in effect sizes indicating the importance of investigating **moderators of these effects.** As reported by Cororve Fingeret and colleagues (2006), the most notable moderator of effect sizes was **risk status** of participants. Studies in which participants were selected into the intervention on the

basis of an elevated risk factor score (indicated prevention[9]), usually high body dissatisfaction, produced greater prevention effects than those that did not. The authors propose that the distress that characterises high risk-individuals may motivate them to engage in the intervention to a greater extent than in groups unselected for risk. In addition, the lower levels of eating pathology in low risk samples may reduce observable outcomes as a result of floor effects (Stice et al., 2007).

Participant age was also a significant moderator of intervention effects such that intervention effects were significantly larger for samples in which participants were over rather than under 15 years old. Interventions were also significantly stronger when interactive rather than didactic, delivered by trained leaders rather than an endogenous provide (e.g., teacher), and contained dissonance content (which challenges internalisation of appearance ideals) rather than other content. Stice et al. (2007) also concluded that intervention effects for body dissatisfaction and dieting were significantly larger for programs that focused **solely on females** compared to those that also included males in the intervention.

[9] Stice and colleagues are unusual in the eating disorder field in describing interventions of this kind as 'selected' interventions rather than indicated so the more usual terminology is used here.

1.2.6.2 Service Element – School-based Programs

Universal and Selective Interventions

Despite the analyses described above finding greater effects for indicated prevention in older adolescent females and young women, there are a number of reasons researchers and practitioners have continued to explore universal and selected prevention in **early adolescents, mainly in school settings**. First, it would be ideal to prevent risk factors for eating disorder, in particular, body dissatisfaction and related disordered eating behaviours, becoming established in the first place, rather than waiting until they are present to intervene. Body dissatisfaction in adolescents predicts a number of negative health outcomes in addition to eating disorders, including reduced physical activity, smoking (Neumark-Sztainer, Paxton, Hannan, Haines, & Story, 2006), unsafe-sex (Schooler 2013), depressive symptoms and low self-esteem (Paxton, Neumark-Sztainer, Hannan, Eisenberg, 2006). Thus, waiting until the establishment of body dissatisfaction to be established before intervening is not desirable. Research suggests this requires intervention ideally no later than late primary or early high school (Wertheim, Koerner & Paxton, 2001). Second, school classrooms offer an opportunity in which to reach most young people in a learning environment (Yager et al., 2013). In addition, the peer environment is one which has a significant impact on the body image of young people (e.g., Helfert & Warschburger, 2011). Finally, it has been argued that interventions that are designed specifically for adolescents at high risk of an eating disorder potentially stigmatises participants (Franko, 2001). Taken together, these factors support the use of school-based prevention especially in early adolescence.

In the school setting, universal interventions are generally those that are provided to both girls and boys, whereas selective interventions are generally delivered to girls only, girls being at higher risk of body image and eating disorders. A recent systematic review of classroom-based programs used improvement of body image as the primary outcome, and psychological (i.e., self-esteem, negative affect, internalisation of appearance ideals) and sociocultural (i.e., pressure to be thin, appearance comparison and appearance teasing) risk factors as secondary outcomes (Yager et al., 2013). The impact on eating pathology (drive for thinness, body change strategies and disordered eating) was also examined. Of 16 studies that met inclusion criteria, nine were conducted with girls only, five included boys and girls, and two were conducted with boys only.

The two programs found to be most effective were multi-session **classroom-based interventions** that aimed to reduce internalisation of appearance ideals and body comparison, by increasing media literacy and reducing appearance-related peer pressure (Richardson & Paxton, 2010; Wilksch & Wade, 2009). In the Richardson and Paxton (2010) study conducted in Australia, grade 7 girls received three lessons from a trained researcher addressing peer and media pressures, and positive program effects on body image were observed at post-test and 3 month follow-up. In a recent study conducted in Britain, the program was adapted for 10-11 year old girls and boys and positive body image outcomes were observed in girls at three month follow-up (Bird, Halliwell, Diedrichs & Harcourt, 2013).

The study conducted by Wilksch and colleagues was also conducted in Australia (Wilksch, Durbridge & Wade, 2008; Wilksch & Wade, 2009). Participants were grade 7 and 8 girls and boys who received 8 lessons with a focus on media literacy in relation to body image but also containing lessons on peer influences and body image. In girls, no post-test or 6-month follow-up effects on body dissatisfaction or weight and shape concerns were observed, but at 30-month follow-up, weight and shape concerns were lower in the intervention than the control group. In boys, body dissatisfaction was lower than the control group at post-test and 6-month but not 30 month follow-up.

It is of interest to consider the findings of another recent universal intervention conducted in Spain in which 12-14 year old participants received either a media literacy unit (60-90 minute sessions), a media literacy unit plus a nutrition unit (one 90 minute session) or neither (Espinoza, Penelo & Raich, 2013). At 30-month follow-up, participants in both intervention groups had significantly more positive body image than the control group. These findings also provide support for media literacy intervention for body dissatisfaction.

In light of the focus on media literacy interventions, from a theoretical perspective it is relevant to note that although previous research has implicated media exposure (e.g., Schooler & Trinh, 2011) and peer environment factors as risk factors for body dissatisfaction, dieting and disordered eating (e.g., Sharpe, Naumann, Treasure, & Schmidt, 2013), there has until recently been no empirical evidence to support media literacy as a risk factor for body image and disordered eating outcomes. A recent cross-sectional investigation, however, suggests that in early adolescent girls, media literacy moderates body dissatisfaction,

its impact being mediated by internalisation of appearance ideals and body comparison tendency (McLean, Paxton & McLean, 2013), thus providing theoretical support for media literacy interventions.

An important area of prevention research examines programs that target the shared risk factors for both disordered eating and obesity (e.g., Austin, Field, Wiecha, Peterson, & Gortmaker, 2005; Austin, et al, 2007; Stock et al., 2007; Wilksch & Wade, 2013). Given the possible iatrogenic effects of anti-obesity programs on disordered eating, combined prevention programs are particularly valuable as they assess the impact of anti-obesity messages on eating pathology and body dissatisfaction. The healthy eating intervention, *Planet Health*, has been shown to reduce the odds of obesity in girls through prevention and remission during 2 school years, and also to protect against the use of purging and diet pills for weight control (Austin et al., 2007).

Taken together, there is growing evidence that supports the use of school-based curricula that address known risk factors for body dissatisfaction and disordered eating especially those interventions that address media and peer factors. The impact of these interventions appears to be on body image and associated risk factors such as internalisation of media ideals. Outcomes in relation to the prevention of clinical eating disorders have yet to be identified. **Thus, there is in relation to body image, Level 1 evidence in support of intervention package development (Mihalopoulos, Vos, Pirkis & Carter, 2011).**

Indicated Prevention Interventions

Indicated prevention interventions have also been examined in adolescent girls who are still at school. These are not strictly speaking school-based interventions but rather recruitment for participants may take place within a school but then the intervention is conducted by trained researchers or therapists away from the class-room setting.

As demonstrated in the meta-analyses described above indicated prevention has been shown to be effective, particularly in girls over 15 years old. The most notable example of an intervention of this kind is the **cognitive dissonance intervention** trialled by Stice and colleagues (Stice et al., 2008) and based on *The Body Project*, the original manual describing this approach (Stice & Presnell, 2007). Of relevance here is that about half the participants in the major study by Stice and colleagues describing this approach were recruited from high schools in the US using direct mailing and flyers. For inclusion, participants had to be 14-19 years old and answer in the affirmative to the question “Do you have body image concerns?” in a phone interview. This approach did indeed attract at-risk participants (mean age = 17.0 years). The dissonance intervention consisted of 3 weekly one hour small group (6-10 participants) sessions and homework tasks in which participants engaged in activities that critique the thin idea. This was compared to a healthy weight control program, an expressive writing control condition and assessment-only control condition. At 3-years follow-up, both the dissonance and healthy weight conditions resulted in significantly lower risk for onset of clinically significant eating pathology relative to assessment only controls.

A **cognitive behavioural therapy** (CBT) based approach, *My Body, My Life*, has also been shown to be effective in substantially reducing body image and eating disorder symptoms in girls who self-identified as having body image or eating problems recruited through Australian schools (mean age 14.4 years, SD=1.48) (Heinicke, Paxton, McLean, & Wertheim, 2007). In this study, a six session CBT based intervention delivered on-line using chat-room technology, resulted in substantial improvements in body image and eating related psychopathology that were maintained at 6 month follow-up.

Please note, screening for eating disorders in high school students as a means of promoting early identification and intervention has been evaluated (e.g., D’Souza et al., 2005) but is not reviewed here.

Taking into account meta-analysis findings and examination of specific examples, there is Level 1 evidence in support of intervention package development for indicated prevention of body image and eating disorders drawing at-risk participants from high school settings.

1.2.6.3 Service Element – University-based Programs

As indicated above, meta-analyses and systematic reviews consistently observe larger effects sizes for **indicated prevention** interventions than universal and selective interventions and these have frequently been offered to **college-students** (Stice et al., 2007). One systematic review has specifically examined prevention programs for body image and eating disorders delivered on university campuses (Yager and O'Dea, 2008). They identified 27 large randomised and controlled trials of programs to improve body image, dieting, and disordered eating and exercise behaviours of male and female college students. They concluded that many studies were limited by small samples sizes and exclusion of male participants. However, they observed that **dissonance-based approaches** have achieved consistent success in reducing internalisation of the thin ideal, body dissatisfaction, dieting and disordered eating among female college students (Yager and O'Dea, 2008), a finding supported by a meta-analysis of dissonance interventions compared to other control conditions (Stice, Shaw, Becker and Rohde, 2008). In addition, in a recent trial with college participants with elevated body dissatisfaction that compared outcomes following participation in the *Body Project* when delivered in a small group or alternatively by internet and two control conditions, positive outcomes were observed in both intervention conditions (Stice, Rohde, Durant and Shaw, 2012).

The *Body Project* (Stice and Presnell, 2007) was briefly described above and has been trialled as an indicated prevention intervention. However, it has also been adapted for use in college sororities in the USA to be delivered by trained sorority peer leaders as the *Reflections: Body Image Program* (Becker, Smith, and Ciao, 2005) and evaluated in a number of studies (e.g., Becker, Smith, and Ciao, 2006; Becker, Ciao, and Smith, 2008; Becker, et al., 2010). In these studies, the whole sorority group was expected to participate in the program (although not necessarily the research) and thus included both low and high risk participants. The intervention consisted of two 2-hour sessions administered by 3-4 trained peer leaders. Significant decreases in body image and eating disorder risk factors have been observed and generally high and low risk participants respond in a similar way. The difficulty with this approach within the Australian context is that we do not have university based structures like sororities. Some students do live in colleges on university campuses but these have no mandating power over the activities of the students.

A further program which has received extensive evaluation is the **CBT-based intervention,** *Student Bodies* (e.g., Low et al., 2006; Jacobi et al., 2007; Taylor et al., 2006). This is an 8 session (8 week) internet-based intervention with or without a moderated online discussion group. *Student Bodies* has been delivered in both selected and indicated formats and high school and college students, but effects have been strongest in indicated interventions in college students (e.g., Taylor et al., 2006). Taylor et al. (2006) recruited college-age women with high weight and shape concerns through campus emails, posters and advertising and they were randomised to either *Student Bodies* or a wait list contol. There was a significant reduction in weight and shape concerns in the intervention group at post-test, one-year and two-year follow-up. Although there was no difference in the number of participants who developed sub-clinical or clinical eating disorders during the follow-up period between the two groups, moderator analyses indicated significantly fewer of the overweight participants in the intervention than control group developed an eating disorder. In addition, at one site, significantly fewer participants with initially elevated compensatory behaviours in the intervention compared to the control group developed a clinical or sub-clinical eating disorder.

A range of other interventions have been trialled in different formats. Further supporting a web-based intervention for college women, the interactive psycho-educational program, Food, Mood and Attitude, reduced internalisation of the thin ideal in at-risk participants (Franko et al., 2005).

Please note, screening for eating disorders in a University population to promoting early identification and intervention has been evaluated (e.g., Becker et al., 2004) and supported by leaders in the field (Wilfley, Agras and Taylor, 2013) but is not reviewed here.

In conclusion, interventions for university women have been shown to reduce risk factors for body image and eating disorders, especially in high risk women. However, the Australian university context would need to be considered to ensure appropriate translation. In addition, a number of studies have used financial or course credit incentives to encourage participation and completion of assessment which would not be practical in many contexts.

However, there is Level 1 evidence in support of intervention package development for indicated prevention of body image and eating disorders for at risk female university students.

1.2.6.4 Service Element – Community-based Programs

There have been relatively few evaluations of community based prevention for body image and eating disorders and there are no meta-analyses that have attempted to group prevention interventions in this way. However, there are some examples of community-based interventions.

One early study evaluated a **selective** prevention intervention delivered to girl scouts with a mean age of 10 years (Neumark-Sztainer, Sherwood, Coller & Hannan, 2000). Body image and dieting outcomes were compared following a media literacy program compared to a stress management condition. There was significantly lower internalisation of the thin ideal following the media literacy compared to stress management condition, but no differences on a range of dieting behaviours.

Early intervention programs for young women have also been evaluated. One example of an **indicated intervention (or early intervention**) in which young adult female participants with body image and eating symptoms were recruited from the community was the evaluation of the 8 session, *Set Your Body Free* program (Paxton, McLean, Gollings, Faulkner & Wertheim, 2007). In this RCT, a therapist led, small group intervention has been shown to reduce body image and eating disorder symptoms in both internet and face-to-face delivery modes compared to a delayed treatment control. Although at this stage we have not identified a review of interventions of this kind, previous research supports early interventions of this kind (e.g., Cash, & Lavallee, 1997).

A final example of a community-based **early intervention** is Eating Disorder Mental Health First Aid. Mental health first aid (MHFA) has been defined as the help provided to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate professional help is received or until the crisis resolves (Kitchener, Jorm, & Kelly, 2010). Eating disorder MHFA resources have been developed and made available to the community on the internet and through MHFA training (Hart, Jorm & Paxton, 2012). A preliminary uncontrolled study suggested an Eating Disorder MHFA training session facilitated treatment seeking in individuals suspected of an eating disorder (Hart et al., 2012).

In conclusion, community based interventions have received less research attention. There is likely to be Level 1 support for community-based small group therapy approaches to early intervention for body image and eating disorders but this review has not examined this extensively. At this stage there is only Level 3 (inconclusive) evidence for other approaches described.

1.2.6.5 Additional notes for this Category

Possible Negative Effects of Interventions

Although the possibility of **iatrogenic effects** of including eating disorder related information has been raised (O'Dea & Abraham, 2000), the evidence does not support this contention. In their meta-analysis, Cororve Fingeret et al. (2006) summarised the between group effect sizes of interventions for body image and eating pathology that did or did not include descriptive information about eating disorders and generally found no significant differences between groups. Where there were significant differences, they were explained by higher mean effect sizes for interventions that did include eating disorder information.

Further Prevention Issues to be considered

Although there is sufficient evidence in a range of areas to support the development and dissemination of prevention approaches for body dissatisfaction and eating disorders, there are many areas which require attention a number of which are mentioned below.

- Research increasingly suggests that attitudes towards healthy eating, weight and shape and physical activity are formative in the pre-school years. Effective, evidence-based programs are needed for parents and in early childhood settings;
- Obesity and eating disorder prevention need to be better integrated to resolve the widespread belief that they are contradictory in message. Increasingly evidence suggests poor body image predicts poorer physical activity and eating outcomes;
- The role of social media, advertising and the internet, in the development of risk or protective factors for body dissatisfaction, are not well understood and prevention interventions have seldom addressed this important area;
- Although there is a range of generic mental health well-being programs being delivered in school settings, body image and eating disorder outcomes are seldom (perhaps never) assessed. Consequently, there is no evidence to suggest they are helpful in preventing body dissatisfaction or eating disorders;
- Although body image and eating problems are observed in males development of interventions that effectively engage males is difficult;
- Eating disorders occur across the life-span and are increasingly common in women as they experience pregnancy, childbirth and menopause. Prevention and early intervention programs across the lifespan require further development. In addition, children of parents with eating disorders are more likely to experience mental illness, disordered eating, clinical eating disorders and obesity. Prevention programs aimed at the pre-and post-natal period would therefore have secondary prevention benefits by protecting offspring;
- Further development and evaluation of screening and early identification would be especially beneficial in this area in which there is very low treatment seeking. Community interventions such as Eating Disorder MHFA training and up-skilling of the primary health care work-force could facilitate early identification and treatment seeking.
- Finally, public health interventions are likely to be required to counter the support given by industry for extreme and short-term diets, and to counter the stigma associated with eating disorders that reduces treatment seeking.

1.2.6.6 References for this Category

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1.2.7 Service Category - Prevention of PTSD

The content under this category has been adapted from: "Overview of the evidence supporting interventions for the prevention of PTSD"; prepared by Associate Professor Grant Devilly (School of Applied Psychology and Griffith Health Institute, Griffith University) for use by the NHMSPF Promotion and Prevention Working Group (October 2013).

1.2.7.1 Service Element - Prevention of Post-Event Pathology from Post-Event Intervention for Those Who Demonstrate Vulnerability.

For the small number of people who go on to demonstrate clinical symptomatology within the first month following trauma, we know that they are at a much greater risk of going on to develop longer term psychopathology such as posttraumatic stress disorder (approximately 80% of people with ASD from motor vehicle accidents or brain injuries in New South Wales have PTSD at 6 months; e.g., Harvey and Bryant, 1999; Bryant and Harvey, 1999). However, it should be kept in mind that the majority (60-70%) of people who have PTSD did *not*, at some point, meet criteria for ASD.

Nine RCTs have described four different types of interventions that were all started within the first month after a traumatic event. The effectiveness of interventions including TF-CBT (or using the cognitive restructuring, and prolonged exposure (PE) components), narrative exposure therapy, eye movement desensitization and reprocessing (EMDR), and providing a self-help booklet, were compared to no treatment, wait listed controls, usual care, or another psychological intervention. These nine RCTs were as follows:

- five studies (six publications) compared CBT with supportive counselling (Bryant et al, 1998; Bryant et al, 2005; Bryant et al, 2006; Bryant et al, 2003; Bryant et al, 1999; Foa et al, 2006)
- one study compared CBT with an assessment condition (Foa, Zoellner and Feeny 2006)
- one study compared CBT with prolonged exposure on its own (Bryant, et al. 1999)
- two studies compared the cognitive and exposure components of CBT with a waitlist (Bryant et al. 2008; Shalev et al. 2011)
- one study compared PE with supportive counselling (Bryant et al, 1999)
- one study compared narrative exposure therapy with relaxation-meditation therapy in children(Catani et al, 2009)
- one study compared an assessment condition with supportive counselling (Foa, Zoellner and Feeny 2006)
- one study compared eye movement desensitization and reprocessing with a wait listed control (Jarero, Artigas and Luber 2011)
- one study compared a self-help booklet with no information (Scholes, Turpin and Mason 2007)

Outcomes demonstrate that people who develop Acute Stress Disorder should be offered trauma Focussed CBT (which includes exposure and / or cognitive therapy). Of those treated with TF-CBT, less than 5% continued to have PTSD 4 years later, compared to 25% who received supportive counselling. This also leads most experts to recommend against general supportive counselling, while at the same time recommending CBT.

Summary – Acute Stress Disorder: **The provision of early intervention for these people is recommended. Studies have demonstrated that trauma focused cognitive behavioural therapy (TF-CBT), and in particular exposure therapy, are effective in preventing PTSD.**

1.2.7.2 Other Service Elements for this Category reviewed but not included due to evidence level

Prevention of post-event pathology from pre-event training

Pre-event training has been called 'resilience training', 'inoculation training' and also variants of 'psychological preparation'. It shall be referred to as resilience training here. Although the bulk of resilience research has been conducted in recent years, the term 'resilience' was first used in the 1950s to describe individuals who survived stressful environments (for review see Kaplan, 1999; Masten, Best, & Garmezy, 1990). The foundation of the concept of resilience was the possession of selective strengths or assets that help an individual survive adversity (Richardson, 2002). Over the last two decades, various models of resilience have been proposed, each emphasising various ecological and psychological contexts. Garmezy and colleagues defined resilience as a 'capacity' for successful adaptation in face of hardship (Garmezy, 1993; Masten et al., 1990) whilst Rutter (1987) described it as a positive response to stress and adversity.

As noted by Bonanno and colleagues (Bonanno, Rennicke, et al., 2005), there have been few attempts in the trauma literature to distinguish sub-groups within the broad category of individuals who are exposed to a traumatic incident yet do not go on to develop PTSD. Most studies of resilience have focused on children, with fewer studies examining resilience among adults. Many of these studies have been aimed at improving our understanding of how children growing up in adverse circumstances successfully avert later psychiatric disorder as opposed to halting posttraumatic disequilibrium (e.g., Elder, 1986; Smith, Smoll, & Ptacek, 1990; Werner, 1990; Zoccolillo, Pickles, Quinton, & Rutter, 1992).

In one of the very first studies to examine resilience in adults, Manhattan residents were randomly surveyed by phone following the September 11 terrorist attack (Bonanno, Galea, Bucciarelli, & Vlahov, 2006). With mild to moderate PTSD defined as two or more PTSD symptoms, and resilience defined as one or no PTSD symptoms in the first 6 months after the attack, over 65% of the residents were classified as being resilient. Resilient outcomes have also been documented in studies that utilised structured clinical interviews, and anonymous ratings from participants' friends or relatives (Bonanno, Moskowitz, Papa, & Folkman, 2005; Bonanno, Rennicke, et al., 2005).

To my knowledge, there are only three published randomised controlled trials, of which only two are field trials assessing the utility of resilience training with adults following traumatic life events. However, even one of these was not a randomly controlled study, was group delivered and retrospectively assessed participants who agreed to take part. This study (Sharpley, Fear, Greenberg, Jones & Wessely, 2008) referred to their intervention as pre-deployment stress briefing when provided to UK armed forces (Royal Navy and Royal Marines) before deployment to the 2003 Iraq War. This intervention consisted of education regarding the "role of the mental health team; an outline of the medical facilities in the Primary Casualty Receiving Facility; definition of stress, pressure and strain; types of stressors (physical, social, occupational and traumatic); effects of stress on individuals; advice on handling human remains; managing stressful thinking in a chemical or biological environment; simple advice on reducting stress; the importance of morale; levels of support available and when/where to seek this" (p. 31, Sharpley et al., 2007). On returning from Iraq all troops completed a questionnaire regarding their reactions. Those who had received the pre-briefings were allocated as the treatment group and those Naval and Marine personnel not registered as having received the pre-briefings were seen as a no-treatment control. As may be expected when using post-hoc and self-selected samples, the treatment group significantly differed to the control group on a number of variables - most notably experiencing more traumatic events and with a higher percentage having a combat role during deployment. Even considering these differences in groups, the results could be seen as generating some hope in the area. The results, whilst not significant, all pointed towards lowered pathology in the pre-briefing group. However, without a longitudinal study with an *a priori* experimental design, we could not be sure that the results are not due to participant biases and type III errors.

The other randomised controlled trial compared resilience training in Victorian police cadets (n=141) to 'training as usual' with additional psychologist's presence (n=140; Devilly & Varker, 2013). Program components had an evidence-base, drawing on findings from an extensive literature review and an experimental, analogue, study (described below; Varker & Devilly, 2012). Built upon the notion of serial approximation to the feared event and the provision of adaptive psychological resources, it was hypothesised that these would increase adaptive expectations and provide a sense of psychological and physical control. Cadet cohorts were randomly allocated to the study condition and these cadets were then followed-up at 6 and 12 month post-training. Results showed that, in general, recruits had low levels of stress. However, the treatment condition demonstrated a lack of correlation between number of traumatic events and symptomatology. The control condition continued to show the usual correlation between the

number of traumatic events and symptomatology, a relationship expected in all large samples from the research literature. We argue that this may have demonstrated a break between trauma exposure and symptomatology, which can only be properly demonstrated in the much longer term. The resilience training groups also rated their training with higher satisfaction than the control groups. Twelve month follow-up data displayed a trend for the resilience group to display higher relationship satisfaction, lower affective distress, lower trauma reactivity and lower workplace burnout. However, this 12 month follow-up only assessed half the sample in each condition, and hence why the differences between condition did not reach significance. A true test of resilience with emergency services personnel is in the longer term (i.e., > 5 years).

As noted above, we have also recently published a randomised controlled trial of inoculation (resilience) training using an analogue design (Varker & Devilly, 2012). Outcome was established from people's short term and long term (4 weeks) reactions to watching a stressful video of paramedics attending the scene of a road traffic accident. Built upon the premise that reducing shock and increasing a sense of control would directly interfere with known peri-traumatic predictors of pathology, the study provided serial approximation to a stressful event, psycho-education and coping strategies to deal with aversive physiological responses and high levels of stress in the experimental group. In this study community participants were either given this 'inoculation training' or 'pragmatic training' which we called 'accident management training'. This pragmatic training consisted of participants being given practical tips and strategies on what to do if they are involved in, or witness a traffic accident. Both sets of training were provided to participants one week before they were exposed to a video which had previously been used to investigate the effects of psychological debriefing (Devilly & Annab, 2008; Devilly, & Varker, 2008; Devilly, Varker, Hansen, & Gist, 2007). Considering that we had previously found prophylactic strategies to have possibly noxious outcomes using this stimulus (see below under 'debriefing'), we wished to make sure that any intervention was grounded in empirical data before progressing to a field trial. What we found was cause for cautious optimism. Those who received the inoculation training faired no worse than the control group on the main outcome measures – in other words there did not appear to be any deleterious effects on psychological distress measures or memory performance. However, participants who received the inoculation training displayed improvements in negative affect (with notable trends in depression and stress levels) suggesting a more general positive result from the intervention than normal 'pragmatic training'.

Summary – Resilience: The above comprise the only randomised controlled trials published in the research literature as of October 2013. The evidence points towards having a degree of cautious optimism in the utility of resilience training programmes for 'at risk' groups. All of the field trials also demonstrate the natural resilience of humans and the low base rates of pathological reactivity to trauma exposure (in the short term) for populations where exposure is expected. However, it should be stressed that two field trials does not make a body of evidence – just a correlation. For this reason one could argue for 'trialling' resilience training at a larger level, or one could argue for not providing this level of care until more research outcomes have become available.

Prevention of post-event pathology from post-event intervention for all exposed

This approach to prevent trauma reactions falls into the 'Debriefing' type intervention and the more recent 'Psychological Fist Aid (PFA)' approach. I will deal with the PFA first as the research literature is easy to summarise.

Psychological First Aid: Psychological First Aid (PFA) is an evidence-informed model used to assist those affected in the hours and early days following trauma (Uhernik & Husson, 2009). The Medical Reserve Corp Psychological First Aid Field Operations Training Manual (National Center for Child Traumatic Stress Network, 2006) emphasises that PFA is designed to reduce initial distress caused by traumatic events, and to foster short- and long-term adaptive functioning and coping. PFA comprises an assortment of processes and strategies that may be selected and used based upon a case formulated approach. As of today, there are no randomised controlled trials of the utility of PFA.

Debriefing: Debriefing is a generic term for the provision of services for targeted populations. This intervention is usually targeted towards people who have been exposed to traumatic events. They are provided with trauma education and ventilation opportunities, either in groups or individually. This generic term should be differentiated from the trademarked and specific term "Critical Incident Stress Debriefing (CISD)" (or the more recent "Critical Incident Stress Management (CISM)"). CISD and CISM have become ubiquitous terms in common parlance, but they represent a specific approach to debriefing – that of a private company called the International Critical Incident Stress Foundation (inc).

Debriefing "is best described as a generic term for a class of immediate interventions following trauma (usually within 3 days) that seeks to relieve stress with the goal of mediating or avoiding long term pathology. PD relies predominantly on ventilation/catharsis, normalisation of distress, and 'psycho-education' regarding presumed symptoms. CISD, on the other hand, is a proprietary PD variant originally articulated by Mitchell during the 1980's (Mitchell, 1983) through trade magazines, trade conferences, and proprietary seminars. It centers predominantly around group based interventions, though individual (or 'one-on-one') debriefings have always been advocated as an acceptable and expected variant, and relies heavily on reconstruction of the traumatic event, ventilation, and normalization. It also includes a structured "teaching" component." (p. 320, Devilly, Gist & Cotton, 2006).

Outcome from randomised controlled trials and meta-analyses of trials into CISD / CISM are quite consistent – there is either no psychological or economic benefit from this intervention, or it interferes with people's resolution following trauma. In other words, for an exposed population, at best it offers nothing – at worst it stops people from recovering from the shock of the event. This seems to be more prominent when the people debriefed are more distressed (Mayou, Ehlers & Hobbs, 2000) or where the stressor is greater (Devilly & Varker, 2008). One meta-analysis differentiated between generic debriefing and CISD (van Emmerik et al., 2001). They found CISD to harm improvement following exposure and generic debriefing to have no clear positive effect. Overall, meta-analyses have generally come to the conclusion that such interventions should not be part of routine practice. Meta-analyses which have come to this opinion include the Australian Guidelines for the Treatment of Acute Stress Disorder & Posttraumatic Stress Disorder (ACPMH, 2013), the UK's National Institute for Health and Care Excellence (NICE, 2005) and the UK and USA's Cochrane Collaboration (Rose, Wessely, & Bisson, 2004). Individual researchers have likewise come to such conclusions following quantitiative and qualitative reviews (e.g., Devilly, Gist & Cotton, 2006; McNally, Bryant & Ehlers, 2003).

Summary – Intervention for all: At this stage the evidence is a). new methods of 'intervention for all' are unproven and b). old methods are not recommended. Current recommendations centre around the provision of practical and emotional support where requested and that victims are made aware of the availability of this support.

"Although immediate debriefing has yielded null or paradoxical outcomes, the value of contemporaneous instrumental assistance and support—those kinds of practical help often learned better from grandmothers than from graduate training—has increasingly been found to be useful in disaster response. Structured interventions, however, may be better embedded in models of stepped care, where the nature and level of intervention is conservatively tailored to the needs, context, and course of individual resolution." (p. 741, Devilly & Gist, 2002).

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2 Service Group – Services Tailored to Individual Needs

2.1 SERVICE STREAM – PRIMARY AND SPECIALISED CLINICAL AMBULATORY MENTAL HEALTH CARE SERVICES

Primary and Specialised Clinical Ambulatory Mental Health Care Services refers to services tailored to individuals and provided by clinical staff with recognised health qualifications.

For the purpose of this Project, the operational definition of **Primary Mental Health Care Services** as developed by the Queensland Centre for Mental Health Research is: "health care services aimed at the early detection and treatment of mental health problems and the maintenance of mental health, that are delivered to individuals, usually in community settings, within a service model where mental health problems are identified and managed as part of a broader range of health care to a population". Primary mental health care services are often the first point of contact and may be delivered via a range of modalities, including face-to-face contact, internet and telephone, and may be provided on an individual or group basis. They are usually focussed on the high prevalence illnesses of anxiety and depression.

The NMHSPF makes a distinction between mild illnesses that are treatable within the primary mental health sector; moderate illnesses that are treatable in the primary mental health sector with specialist mental health assistance; and severe illnesses that require specialist mental health care delivered via multidisciplinary teams in the community and/or in a hospital setting. Individuals with a severe illness require support, rehabilitation and recovery services.

For the purpose of this Project, **Specialised Clinical Ambulatory Mental Health Care Services** are defined as services specifically designed for the treatment of mental health problems and include services delivered in both hospital and community settings. Specialised Clinical Ambulatory Mental Health Care Services are delivered by mental health clinicians – psychiatrists, mental health nurses, psychologists and other specialist allied health practitioners usually operating as multidisciplinary teams across community ambulatory, inpatient and bed based care settings. Most people who need these services have severe mental illness and significant functional difficulties that requires coordination of care and support across multiple agencies, family, friends, support people, carers and providers.

Service Stream		Primary and Specialised Clinical Ambulatory MH Care Services
Service Category	**AC**	**Case Finding**
Service Element	AC1	Case Finding
Service Category	**AA**	**Assessment**
Service Element	AA1	Brief Mental Health Assessment
Service Element	AA2	Comprehensive Mental Health Assessment
Service Element	AA3	Brief Physical Assessment
Service Element	AA4	Comprehensive Physical Assessment
Service Element	AA5	Assessment - Other
Service Category	**AB**	**Acute Care Services**
Service Element	AB1	Acute Care Services
Service Category	**CL**	**Consultation Liaison**
Service Element	BG	Consultation Liaison - General (Hospital)
Service Element	BL	Consultation Liaison - Emergency Department (Hospital)
Service Category	**AR**	**Intensive Community Treatment Service**
Service Element	AR1	Intensive Community Treatment Team - C&A 0 - 17 years
Service Element	AR2	Intensive Community Treatment Team- Adult - 18 - 64 years
Service Element	AR3	Intensive Community Treatment Team - Older Adult 65+ years
Service Category	**AD**	**Day Program**

Service Element	AD1	Day Program Team - C&A 0 - 17 years
Service Element	AD2	Day Program Team - Adult - 18 - 64 years
Service Category	**AM**	**Monitoring & Ongoing Management**
Service Element	AM1	Centre Based Monitoring & Ongoing Management
Service Element	AM2	Home Based Monitoring & Ongoing Management
Service Element	AM3	General Physical Health Monitoring & Ongoing Management
Service Category	**AL**	**Care Coordination and Liaison**
Service Element	AL1	Care Coordination and Liaison
Service Element	AL2	Medico Legal Coordination and Liaison
Service Category	**AT**	**Structured Psychological Therapies (SPT)**
Service Element	AT1	SPT Ultra Brief Intervention- Individual
Service Element	AT2	SPT Brief Intervention- Individual
Service Element	AT3	SPT Brief Intervention- Family
Service Element	AT4	SPT Brief intervention - Group
Service Element	AT5	SPT Extended Intervention- Individual
Service Element	AT6	SPT Extended Intervention- Family
Service Element	AT7	SPT Extended Intervention- Group
Service Category	**AW**	**Clinician Led Web-based Psychological Interventions**
Service Element	AW1	Clinician Led Web-based Psychological Interventions
Service Category	**AS**	**Specialist Clinical Interventions - Other**
Service Element	AS1	Specialist Clinical Interventions - Other
Service Category	**AP**	**Physical Therapies**
Service Element	AP2	Transcranial Magnetic Stimulation (TMS)
Service Element	AP3	Other Evidence Based Physical Therapies
Service Category	**AY**	**Pharmacotherapy**
Service Element	AY1	Pharmacotherapy Prescription
Service Element	AY2	Pharmacotherapy Review

2.1.1 Service Category – Case Finding

Case-finding occurs when screening is offered when indicated to an individual during attendances for care.

2.1.1.1 Service Element – Case Finding

Attribute	Details
Description	Case-finding to detect the presence of a MH illness/ illness - occurs when screening is offered when indicated to an individual during attendances for care.
Service specifications and suggested modelling attributes	
Target Pop'n Profile	Individuals presenting to primary care with risk factors for mental illness
Avg timeframe per activity (if applic)	1 x 15 minute once only
Workforce	GP or Practice Nurse
Evidence Base	
Level of Evidence:	1
Key Reference:	• US preventive task force; • Cochrane review of screening; • NICE guidelines from the UK

2.1.2 Service Category – Assessment

A mental health assessment is a determination of a person's mental health status and need for mental health services, made by a suitably trained mental health professional or mental health team (which may consist of a psychiatrist, psychologist, mental health nurse and/or allied health professional), based on the collection and evaluation of data obtained through interview and observation, of a person's mental history and presenting problem(s). The assessment may include consultation with the person's family and concludes with formation of problems/issues, documentation of a preliminary diagnosis or diagnosis, and a written treatment plan supported by the assessment and interview data.

Description Source: Modified from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2013 Canberra.

The AIHW document provides a detailed view of the various sub-categories within the MHIC 1.0 and associated codes.

Service specifications and suggested modelling attributes					
Element:	**Brief Mental Health Assessment**	**Comprehensive Mental Health Assessment**	**Brief Physical Health Assessment**	**Comprehensive Physical Health Assessment**	**Assessment – Other**
Average timeframe per activity (if applicable)	Up to 30 mins per assessment. Average 15 mins	Up to 60 minutes per assessment. Average 45 mins	Up to 30 mins per assessment. Average 15mins	Up to 60 minutes per assessment. Average 45 mins	Up to 60 mins per assessment
Evidence Base					
Level of Evidence:	1				
Key Reference:	• NHMRC Guidelines and • RANZCP clinical practice guidelines • NICE guidelines from the UK • MBS guidelines - Primary Care Items Medicare Health Assessments Resource Kit • Development of a prototype Australian mental health intervention classification: a working paper. Working papers and data briefings. Cat. no. HSE 130. Canberra: AIHW. <http://www.aihw.gov.au/publication-detail/?id=60129542689>.				

2.1.2.1 Service Element – Brief Mental Health Assessment

Up to 30 mins per assessment. (average 15 minutes)

The assessment will be tailored and developmentally appropriate to the age of the person. This includes at least two elements of comprehensive assessment, which may include triage. It involves the gathering, evaluation and recording of information by suitably trained health or mental health professional relative to the person's problem(s), strengths, functional status or situation and must include (but is not limited to) at least two of the following assessment components:

- Mental status assessment
- Mental health history assessment
- Triage/emergency assessment
- Risk assessment
- Medication assessment
- Social assessment
- Environmental assessment
- Assessment summary and clinical formulation
- Review of care plan
- Developmental or observational assessment
- Functional assessment
- Cognitive assessment
- Psychological assessment
- Rehabilitation assessment
- Administer an outcome measurement tool

Description Source: Modified from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2013 Canberra.

2.1.2.2 Service Element – Comprehensive Mental Health Assessment

Up to 60 mins per assessment. (average 45 minutes)

The assessment will be tailored and developmentally appropriate to the age of the person. This involves the gathering, evaluation and recording of information by suitably trained health or mental health professional relative to the person's problem(s), strengths, functional status or situation and must include (but is not limited to) at least four of the following assessment components:

- Mental status assessment;
- Mental health history assessment;
- Risk assessment;
- Medication assessment
- Social assessment
- Environmental assessment
- Assessment summary and clinical formulation
- Development of a further care plan (even if the plan includes provision of no further services);
- Review of care plan
- Developmental or observational assessment
- Functional assessment
- Cognitive assessment
- Psychological assessment
- Rehabilitation assessment
- Administer an outcome measurement tool
- Assessment summary and clinical formulation
- Development and Review of a Recovery Plan.

Description Source: Modified from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2013 Canberra.

2.1.2.3 Service Element – Brief Physical Assessment

Up to 30 minutes per assessment (average 15 mins)

This involves the collection and assessment of information relating to physical health. A physical assessment is usually conducted as part of the general mental health assessment to determine appropriate interventions. The assessment will be tailored and developmentally appropriate to the age of the person.
This is a targeted assessment that includes at least 1 of the components of a comprehensive physical assessment. This may include but is not limited to:

- Monitoring of medication side effects
- Preventative health review
- Monitor metabolic syndrome risk factors
- Monitor abnormal involuntary movements
- Monitor basic physical observations (pulse, BP, temperature, respiratory rate)
- Physical examination
    - Cardiovascular
    - Respiratory
    - Gastrointestinal
    - Neurological (brief and comprehensive)
    - Other

Description Source: Brief physical assessment is a term developed by the PCCNH EWG. We have applied the definition from "Physical assessment MHIC code 1041.00" AIHW MH intervention classification definition in italics - plus some other additional descriptors.

Comments re Child and Adolescent population – no changes recommended to that of a brief physical assessment for the general population.

2.1.2.4 Service Element – Comprehensive Physical Assessment

Up to 60 minutes per assessment (average 45 minutes)

This involves the collection and assessment of information relating to the physical state of a person with a mental health condition. A physical assessment is usually conducted as part of the general mental health assessment because it is important to assess both the physical and mental health status of the person to determine appropriate interventions, especially those involving medications. Some physical conditions may create the appearance of mental health conditions.

The health assessment must include:

- information collection, including taking a patient history and undertaking examinations and investigations as clinically required;
- making an overall assessment of the patient's health, including the patient's readiness to make lifestyle changes;
- initiating interventions and referrals as clinically indicated;
- providing advice and information about lifestyle modification programs to the patient including strategies to achieve lifestyle and behaviour changes;
- keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
- offering the patient's family, friends, support people and carers (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

Comments re health assessment for a person aged 75 years and older

The health assessment must include:

- information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;
- making an overall assessment of the patient;
- recommending appropriate interventions;
- providing advice and information to the patient;
- keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
- offering the patient's family, friends, support people and carers (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to them.

Specific components of the health assessment for older people include:

- measurement of the patient's blood pressure, pulse rate and rhythm;
- an assessment of the patient's medication;
- an assessment of the patient's continence;
- an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;
- an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months;
- an assessment of the patient's psychological function, including the patient's cognition and mood; and
- an assessment of the patient's social function, including the availability and adequacy of paid and unpaid help, and whether the patient is responsible for caring for another person.

The health professional undertaking the health assessment may also consider:

- any need the patient may have for community services;
- whether the patient is socially isolated;
- the patient's oral health and dentition; and
- the patient's nutrition status.

Description Source: Comprehensive physical assessment is a term developed by the PCCNH EWG. We have applied the definition from "Physical assessment MHIC code 1041.00" AIHW MH intervention classification definition in italics - plus some other additional descriptors.

2.1.2.5 Service Element – Assessment - Other

Up to 60 minutes per assessment

This activity includes all *other* assessments that may be required by an individual other than the assessment activities described above. This may include assessments for exercise based or occupational therapy. An example of an *Assessment – Other* is a rehabilitation assessment. This involves a mental health professional undertaking an assessment of the impact of mental illness on a person's ability to fulfil their roles and responsibilities. This may have a focus on activities such as employment, parenting etc or specific abilities/tasks within an activity.

Description Source: Modified from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2013 Canberra.

2.1.3 Service Category – Acute Care Services

2.1.3.1 Service Element – Acute Care Services

Attribute	Details		
Description	Acute Care Services (ACS) provide a mental health service to all persons with acute care needs in a community setting. ACS are delivered by multidisciplinary teams that function as the first point of contact to mental health services 24/7. ACS are aimed at persons aged 18-64 but also provide after-hours crisis response to all age groups. The key functions of the ACS are to: • Provide a centralised, co-ordinated mental health triage 24/7. • Ensure timely responses to mental health crises in the community. • Ensure a timely assessment and provide short term mental health care for people in the acute phase of a mental illness as an alternative to an admission to an inpatient or bed based service • Facilitate onward referral to the most appropriate services. Acute Care Services for persons aged 0-17yrs and over 65 years are usually provided as Access components of age specific community mental health teams. These services operate in business hours. They are delivered by multidisciplinary teams that provide specialist expertise in the initial intake (advice, information and screening/triage), specialist clinical assessment and treatment, social and functional assessment, forward referral and assessment of family, friends, support people and carers, ensuring timely access to specialist mental health services.		
Fundamental Attributes	Facilitate community access 24/7 to mental health triage, crisis assessment and intervention across all age groups. Acute Care Services provide short term home based acute treatment. Services are provided by multidisciplinary teams with defined clinical governance structures and clear pathways of care. ACS are integrated with local mental health services, emergency departments and primary care supports.		
Service specifications and suggested modelling attributes			
Target Age:	**0-17years**	**18-64 years**	**65+ years**
Target Population Profile	Infants, children and adolescents up to the age of 18 years predominantly, will have diagnoses such as depression, anxiety illnesses, adjustment illnesses, attachment illnesses, developmental illnesses and behavioural illnesses including complex attention deficit hyperactivity illness and conduct illness. Many people will also present with peer and family problems, which can exacerbate mental health problems and illnesses.	All persons with serious mental illness or mental illness who have associated significant levels of disturbance and psychosocial disability due to their illness. This includes some people diagnosed with conditions such as severe personality illness, severe anxiety illness, or those who present in situational crisis that may lead to self-harm or inappropriate behaviour towards others, the distinguishing factor being the level of severity of the disturbance and problem.	Individuals over the age of 65 who have complex presentations including: serious mental illness or mental illness who have associated significant levels of disturbance and psychosocial disability due to their illness and/or exacerbation of underlying personality traits, drug and alcohol problems and physical health care needs; serious mental illness complicated by functional difficulties associated with ageing; or severe mental illness as a complication of the behavioural and psychological symptoms associated with dementia (BPSD) or other age-

			related illnesses.
Workforce	Multidisciplinary	Multidisciplinary	Multidisciplinary
Hours of Operation	Business Hours with capacity for some After Hours programs.	24/7	Business Hours
Evidence Base			
Level of Evidence:	2		
Key Reference Source:	▪ Acute Care Team Model of Service, Queensland Public Mental Health Services (Endorsed Executive Director Mental Health, Queensland 02/07/2010) ▪ Community Child and Youth Model of Service, QLD Public Mental Health Services (Endorsed Executive Director Mental Health, Queensland 02/07/2010) ▪ Crisis Assessment and Treatment Teams (CAT Services) (Victoria 2007) ▪ BMJ. 2005 September 17; 331(7517): 599. Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. Sonia Johnson, senior lecturer in social and community psychiatry,[1] Fiona Nolan, research fellow in mental health nursing,[2] Stephen Pilling, Director,[3] Andrew Sandor, consultant psychiatrist,[4] John Hoult, consultant psychiatrist,[2] Nigel McKenzie, consultant psychiatrist,[2] Ian R White, senior scientist,[5] Marie Thompson, trainee clinical psychologist,[6] and Paul Bebbington, professor of social and community psychiatry[1]		
Limitations of Evidence:	Nil		
Recommendations for future research:	N/A		

Service Element – Acute Care Services – Staffing Profile

Acute Care Services

Acute Care Service (Team modelled for approx 250,000 people @ 11 Fte/100k)

SCHEME	STAFF CATEGORY	FTE	Other time %	Gross available daily hours (wkly/7)	Net consumer service available daily delivery hours	Net consumer service annual delivery hours	Available hours per annum per FTE	Weighted average salary **	Cost	FTE % share	Over heads
NMHSPF	TOTAL	28.95		180.99	86.62	31,615	1,092	103,197	2,988,005	100%	23%
NMHSPF	Vocationally Qualified	-	0.33	-	-	-	-	$0	$0	0%	23%
NMSPF	Peer Worker	1.45	0.33	6.79	4.55	1,661	1,149	$57,070	$82,487	5%	23%
NMHSPF	Tertiary Qualified	24.32	0.33	107.06	71.73	26,181	1,077	$97,499	$2,371,157	84%	23%
NMHSPF	Medical	3.19	0.33	15.43	10.34	3,773	1,183	$167,545	$534,361	11%	23%

Information from Care Package	
Hours Per Annum for an individual	220
Total Target Population for care pa	2,250
Total Hours Req per Annum	495,000

NMHR	TOTAL	Total FTE (Includes Leave)	Other time %	Gross available daily hours (wkly/7)	Consumer service delivery hours daily	Consumer Service delivery hours annual	Available hours/annum/FTE	Salary **	Cost		
NMHR	**Total Medical**	3.19		15.43	10.34	3,773	1,183		$534,361	11%	23%
NMHR	Psychiatrist	1.54	33%	7.43	4.98	1,817	1,183	$200,564	$307,989	5%	23%
NMHR	Registrar	1.65	33%	8.00	5.36	1,956	1,183	$136,885	$226,372	6%	23%
NMHR	Junior Medical Officer	-	33%	-	-	-	-	$150,783	$0	0%	23%
NMHR	Other Medical Specialis	-	33%	-	-	-	-	$200,564	$0	0%	23%
NMHR	**Total Nursing**	20.51		89.14	59.73	21,800	1,063		$2,007,015	71%	23%
NMHR	Registered Nurse	17.96	33%	77.71	52.07	19,005	1,058	$92,550	$1,662,526	62%	23%
NMHR	Nurse Practitioner	2.54	33%	11.43	7.66	2,795	1,098	$135,388	$344,489	9%	23%
NMHR	Enrolled Nurse	-	33%	-	-	-	-	$67,197	$0	0%	23%
NMHR	**Total Allied Health**	3.81		17.91	12.00	4,381	1,149		$364,142	13%	23%
NMHR	Psychologist	0.58	33%	2.71	1.82	664	1,149	$95,532	$55,173	2%	23%
NMHR	Social Worker	1.62	33%	7.60	5.09	1,859	1,149	$95,532	$154,485	6%	23%
NMHR	Occupational Therapist	1.62	33%	7.60	5.09	1,859	1,149	$95,532	$154,485	6%	23%
NMHR	Other TQ (eg pharmacis	-	33%	-	-	-	-	$67,381	$0	0%	23%
NMHR	**VQ and Peer Workers**	1.45		6.79	4.55	1,661	1,149		$82,487	5%	23%
NMHR	Consumer Peer Worker	0.81	33%	3.79	2.54	928	1,149	$58,831	$47,478	3%	23%
NMHR	Carer Peer Worker	0.64	33%	3.00	2.01	734	1,149	$54,844	$35,008	2%	23%
NMHR	VQMH Worker	-	33%	-	-	-	-	$45,724	$0	0%	23%
NMHR	VQ Other	-	33%	-	-	-	-	$51,717	$0	0%	23%
	Total Available Hours					31615.07					
Annual Cost Salaries		$2,988,005									
*** Including Overheads**	22.5%	$3,660,306									

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	59,075	49.94		$8,366,533
NMHR	Psychiatrist	28,444	24.04	$200,564	$4,822,212
NMHR	Registrar	30,632	25.89	$136,885	$3,544,321
NMHR	Junior Medical Officer	-	-	$150,783	$0
NMHR	Other Specialist	-	-	$200,564	$0
NMHR	**Total Nursing**	341,323	321.10		$31,424,010
NMHR	Registered Nurse	297,563	281.26	$92,550	$26,030,308
NMHR	Nurse Practitioner	43,759	39.84	$135,388	$5,393,702
NMHR	Enrolled Nurse	-	-	$67,197	$0
NMHR	**Total Allied Health**	68,593	59.68		$5,701,406
NMHR	Psychologists	10,393	9.04	$95,532	$863,849
NMHR	Social Workers	29,100	25.32	$95,532	$2,418,778
NMHR	Occupational Therapists	29,100	25.32	$95,532	$2,418,778
NMHR	Other	-	-	$67,381	$0
NMHR	**VQ and Peer Workers**	26,009	22.63		$1,291,500
NMHR	Consumer Peer Worker	14,523	12.64	$58,831	$743,370
NMHR	Carer Peer Worker	11,487	9.99	$54,844	$548,130
NMHR	VQMH Worker	-	-	$45,724	$0
NMHR	VQ Other	-	-	$51,717	$0

Total FTE	453.34
FTE/Client	0.20
Case load..clients/FTE	5
Annual Cost Salaries	$46,783,450
*** Including Overheads** 22.5%	$57,309,727

4380.94

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38.0	38.0	38.0	38.0	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs							
Monday	Day		8	8	16		8	16	56	12	8			20	3.8	7.6	7.6		19.0	3.8	3.0			6.8	102
	Evening	-		8	24		8		40					-					-					-	40
	Night	-							-					-					-					-	-
Tuesday	Day		8	8	16		8	16	56	8	8			16	3.8	7.6	7.6		19.0	3.8	3.0			6.8	98
	Evening	-		8	24		8		40					-					-					-	40
	Night	-							-					-					-					-	-
Wednesday	Day		8	8	16		8	16	56	12	8			20	3.8	7.6	7.6		19.0	3.8	3.0			6.8	102
	Evening	-		8	24		8		40					-					-					-	40
	Night	-							-					-					-					-	-
Thursday	Day		8	8	16		8	16	56	8	8			16	3.8	7.6	7.6		19.0	3.8	3.0			6.8	98
	Evening	-		8	24		8		40					-					-					-	40
	Night	-							-					-					-					-	-
Friday	Day	-	8	8	16		8	16	56	12	8			20	3.8	7.6	7.6		19.0	3.8	3.0			6.8	102
	Evening	-		8	24		8		40					-					-					-	40
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-	16	40	-	16		72		8			8		7.6	7.6		15.2	3.8	3.0			6.8	102
Sunday	All shifts	-	-	16	40	-	16		72		8			8		7.6	7.6		15	3.8	3.0			7	102
Total Hours per week		-	40	112	280	-	112	80	624	52	56	-	-	108	19.0	53.2	53.2	-	125	26.6	21.0	-	-	47.6	905
Annual & Other Leave Relief wee		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	40	40	80	-	40	80	280	52	40	-	-	92	19	38	38	-	95	19	15	-	-	34	501
Evening Hours (Mon-Fri)		-	-	40	120	-	40	-	200	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	200
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	16	40	-	16	-	72	-	8	-	-	8	-	8	8	-	15	4	3	-	-	7	102
Sunday Hours		-	-	16	40	-	16	-	72	-	8	-	-	8	-	8	8	-	15	4	3	-	-	7	102
Total Hours		-	40	112	280	-	112	80	624	52	56	-	-	108	19	53	53	-	125	27	21	-	-	48	905
Weekly FTE's		-	1.1	2.9	7.4	-	2.9	2.1	16.4	1.3	1.4	-	-	2.7	0.5	1.4	1.4	-	3.3	0.7	0.6	-	-	1.3	22.4
Relief FTE's		-	0.2	0.6	1.5	-	1.3	0.4	4.1	0.2	0.3	-	-	0.5	0.1	0.2	0.2	-	0.5	0.1	0.1	-	-	0.2	5.1
Annual FTE's		-	1.2	3.6	8.9	-	4.3	2.5	20.5	1.5	1.7	-	-	3.2	0.6	1.6	1.6	-	3.8	0.8	0.6	-	-	1.4	29.0

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, cleaning other non-labour costs including communicatio, transport, utilities and maintenace etc. It is expressed as a proportion of labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:

Drawn from RMH and AH Vic & Qld PMH Modelling
Does not include ED acute care. Consumer Peer Workers modelled at a ratio of 2.5% (1:40) of the ambulatory workforce, based on a ratio of 1FTE peer work per 100K to an overall ambulatory rate of 40FTE per 100K population. Carer Peer work is modelled at 1.8% (0.75:40) of the ambulatory workforce.

2.1.4 Service Category – Consultation Liaison

2.1.4.1 Service Element – Consultation Liaison – General (Hospital)

Attribute	Details
Status	Delivered in non-mental health general hospital beds
Services Delivered	Provides specialist mental health services to patients within the general hospital setting. Conducts mental health assessments and provides advice on clinical management and early recognition of symptoms relating to mental health to the general health treating team. Facilitate linkages between the general hospital, primary care and other health services for patients whose physical health care is complicated by their mental health problems. Also provides teaching, training and mental health promotion support for general hospital staff.
Key Distinguishing Features	Consultation liaison (CL) teams are multidisciplinary and while operating as part of the local area or district mental health service are embedded in the work of the general hospital. As well as local services CL teams may use telemedicine services to support smaller 'satellite' hospitals. CL teams have an important role in maintaining continuity of care between general hospital and mental health services and are actively involved in teaching and research programs within the hospital.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	All
Diagnostic Profile	Patients of the general hospital (including obstetric units) who may have significant mental health problems or have clinically significant distress associated with their medical illness.
Hours	Mon-Fri – Business hours with after hours on call emergency service provided by local mental health or in larger services by the CL team.
Suggested Modelling Attributes	
Indicative staffing FTE/Bed	Multidisciplinary – 50% consultation role and 50% liaison role. 12.78 FTE – modelled as service for a large General Hospital (600 beds).
Sources	• Consultation Liaison Psychiatry Model of Service, QPMHS, Queensland, 2011. • Mental Health Responses in Emergency Departments, Program Management circular, Victorian Government, 2008. • Delivering the Governments Mental Health Policies, Services, Staffing and Costs, Boardman and Parsonage, the Sainsbury Centre for Mental Health, UK, 2007. • Royal Melbourne and Alfred Hospitals, Melbourne, Victoria. • NMHSPF Expert Working Group

Service Element – Consultation Liaison – General (Hospital) – Staffing Profile

Consultation Liaison - General (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	TOTAL	12.78	0.02	59.43	0.10	21,691	1,698	#DIV/0!	$1,564,097	0.11	30%
NMHSPF	Vocationally Qualified	0.00	0.00	0.00	0.00	-	-	#DIV/0!	$0	-	30%
NMSPF	Peer Worker	0.00	0.00	0.00	0.00	-	-	#DIV/0!	$0	-	30%
NMHSPF	Tertiary Qualified	8.76	0.01	40.00	0.07	14,600	1,666	$101,014	$884,992	0.08	30%
NMHSPF	Medical	4.02	0.01	19.43	0.03	7,091	1,766	$169,090	$679,105	0.04	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	4.02	0.01	19.43	0.03	7,091	1,766		$679,105	0.04	30%
NMHR	Psychiatrist	1.18	0.00	5.71	0.01	2,086	1,766	$212,167	$250,620	0.01	30%
NMHR	Registrar	1.65	0.00	8.00	0.01	2,920	1,766	$136,885	$226,372	0.02	30%
NMHR	Junior Medical Officer	1.18	0.00	5.71	0.01	2,086	1,766	$171,102	$202,113	0.01	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$212,167	$0	-	30%
NMHR	**Total Nursing**	6.45	0.01	29.14	0.05	10,637	1,649		$651,533	0.06	30%
NMHR	Registered Nurse	5.18	0.01	23.43	0.04	8,551	1,651	$92,550	$479,288	0.04	30%
NMHR	Nurse Practitioner	1.27	0.00	5.71	0.01	2,086	1,639	$135,388	$172,245	0.01	30%
NMHR	Enrolled Nurse	0.00	0.00	0.00	0.00	-	-	$67,197	$0	-	30%
NMHR	**Total Allied Health**	2.31	0.00	10.86	0.02	3,963	1,715		$233,460	0.02	30%
NMHR	Psychologist	2.31	0.00	10.86	0.02	3,963	1,715	$101,058	$233,460	0.02	30%
NMHR	Social Worker	0.00	0.00	0.00	0.00	-	-	$101,058	$0	-	30%
NMHR	Occupational Therapist	0.00	0.00	0.00	0.00	-	-	$101,058	$0	-	30%
NMHR	Other TQ (eg pharmacis	0.00	0.00	0.00	0.00	-	-	$71,279	$0	-	30%
NMHR	**VQ and Peer Workers**	0.00	0.00	0.00	0.00	-	-	$0	$0	-	30%
NMHR	Consumer Peer Worker	0.00	0.00	0.00	0.00	-	-	$62,234	$0	-	30%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$62,234	$0	-	30%
NMHR	VQMH Worker	0.00	0.00	0.00	0.00	-	-	$48,370	$0	-	30%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$58,686	$0	-	30%

Annual Cost Salaries	$1,564,097
*** Including Overheads** 30%	$2,033,326
Average Daily Available Bed Day C	$9
Average Cost per Patient per annu	$141

Bed Based Service Parameters	
Beds	600
Availability	100%
Average Available Beds	600
ABD/Bed/Year	365
Occupancy	87%
OBD/Bed Year	317.6
ALOS (days)	12
Admissions/Bed/Year	26.46
Annual Readmit Rate	10%
Patients/Bed/Year	24.06

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Required		198
Cost		$671,692
Staffing		
NMHR	**Total Medical**	1.3
NMHR	Psychiatrist	0.4
NMHR	Registrar	0.5
NMHR	Junior Medical Officer	0.4
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	2.1
NMHR	Registered Nurse	1.7
NMHR	Nurse Practitioner	0.4
NMHR	Enrolled Nurse	0.0
NMHR	**Total Allied Health**	0.8
NMHR	Psychologists	0.8
NMHR	Social Workers	0.0
NMHR	Occupational Therapists	0.0
NMHR	Other	0.0
NMHR	**VQ and Peer Workers**	0.0
NMHR	Consumer Peer Worker	0.0
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		4.2

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	4	8	8				8	28	8	8	8		24	15.2				15.2					-	67
	Evening	-	-	8				-	8					-					-					-	8
	Night	-	-					-	-					-					-					-	-
Tuesday	Day		8	8				8	24	8	8	8		24	15.2				15.2					-	63
	Evening	-	-	8				-	8					-					-					-	8
	Night	-	-					-	-					-					-					-	-
Wednesday	Day	4	8	8				8	28	8	8	8		24	15.2				15.2					-	67
	Evening	-	-	8				-	8					-					-					-	8
	Night	-	-					-	-					-					-					-	-
Thursday	Day		8	8				8	24	8	8	8		24	15.2				15.2					-	63
	Evening	-	-	8				-	8					-					-					-	8
	Night	-	-					-	-					-					-					-	-
Friday	Day	4	8	8				8	28	8	8	8		24	15.2				15.2					-	67
	Evening	-	-	8				-	8					-					-					-	8
	Night	-	-					-	-					-					-					-	-
Saturday	All shifts	-	-	16					16		8			8					-					-	24
Sunday	All shifts	-	-	16					16		8			8					-					-	24
Total Hours per week		12	40	112	-	-	-	40	204	40	56	40	-	136	76.0	-	-	-	76	-	-	-	-	-	416
Annual & Other Leave Relief wks		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		8	8	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		12	40	40	-	-	-	40	132	40	40	40	-	120	76	-	-	-	76	-	-	-	-	-	328
Evening Hours (Mon-Fri)		-	-	40	-	-	-	-	40	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	40
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	16	-	-	-	-	16	-	8	-	-	8	-	-	-	-	-	-	-	-	-	-	24
Sunday Hours		-	-	16	-	-	-	-	16	-	8	-	-	8	-	-	-	-	-	-	-	-	-	-	24
Total Hours		12	40	112	-	-	-	40	204	40	56	40	-	136	76	-	-	-	76	-	-	-	-	-	416
Weekly FTE's		0.5	1.1	2.0	-	-	-	1.1	5.4	1.0	1.4	1.0	-	3.4	2.0	-	-	-	2.0	-	-	-	-	-	10.8
Relief FTE's		0.1	0.2	0.6	-	-	-	0.2	1.1	0.2	0.3	0.2	-	0.6	0.3	-	-	-	0.3	-	-	-	-	-	2.0
Annual FTE's		0.4	1.2	3.6	-	-	-	1.3	6.5	1.2	1.7	1.2	-	4.0	2.3	-	-	-	2.3	-	-	-	-	-	12.8

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from Boardman & Parsonage UK, 2007 and QLD profiles.
Team structure for 600 bed hospital
For ED and General. Need to split if needed
Need to describe service parameters.
Validation B Kotze

2.1.4.2 Service Element – Consultation Liaison – Emergency Department (Hospital)

Attribute	Details
Status	Delivered in general hospital emergency department
Services Delivered	Consultation/liaison in the emergency department is provided by specialist mental health staff. These staff may be a component of the mental health acute care service co-located in the emergency department or employed as emergency department staff or in smaller services on-call recall services may be in place. The key functions in the provision of emergency department consultation/liaison are facilitation of: • specialist mental health intake, assessment , treatment (if indicated) to enable prompt referral and access to appropriate mental health care and/or support 24 hrs, 7 days a week. • linkage to appropriate services for follow up and/or facilitation of transfers to inpatient units if indicated. • advice on clinical management and early recognition of symptoms relating to mental health to the emergency department treating team • linkages between the emergency department, emergency response services, primary care and other health services Specialist mental health staff may also be collocated with emergency response services (e.g. Police, Ambulance and Clinical Early Response) • teaching, training in mental health specialty for emergency department staff. CL-ED teams have an important role in maintaining continuity of care between emergency department and mental health services and are actively involved in teaching and research programs with emergency department staff.
Key Distinguishing Features	Operate 24 hour, 7 days a week in an emergency department setting. Consultation liaison teams are multidisciplinary and while operating as part of the local area or district mental health service, are embedded in the work of the emergency department and located in the emergency department. As well as provision of service to local emergency departments CL teams may use telemedicine services to support staff in smaller 'satellite' emergency departments. Effective, collaborative partnerships with local mental health services/teams, Emergency Department services/teams external service providers and agencies, specifically general practitioners, the Police Service, the Ambulance Service, alcohol and other drugs services.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	All
Diagnostic Profile	All persons, any age, presenting to Emergency Departments requiring a mental health response. This may include children and young people, adults and older persons with psychosis, depression and other mood illnesses, anxiety conditions, attempted suicide and other acts of deliberate self-harm, behavioural disturbances that may be associated with substance use, and reactions to personal crises. People may also present with associated or unrelated physical problems.
Hours	24 hours / 7 days
Suggested Modelling Attributes	
Indicative staffing FTE/Bed	14.4 FTE – modelled as service for a large General Hospital (600 beds)
Sources	• Acute Care Team MOS Consultation Liaison Psychiatry Model of Service, QPMHS, Queensland, 2011. • Police, Ambulance and Clinical Early Response Evaluation Final Report April 2012 Victoria • Mental Health Responses in Emergency Departments, Victorian Government, 2008. • Delivering the Governments Mental Health Policies, Services, Staffing and Costs, Boardman and Parsonage, the Sainsbury Centre for Mental Health, UK,

	2007. • Royal Melbourne and Alfred Hospitals, Melbourne, Victoria. • NMHSPF Expert Working Groups.

Service Element – Consultation Liaison – Emergency Department (Hospital) – Staffing Profile

Consultation Liaison - Emergency Department (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	TOTAL	14.44	0.02	61.14	0.10	22,317	1,545	#DIV/0!	$1,672,352	0.1	30%
NMHSPF	Vocationally Qualified	0.00	0.00	0.00	0.00	-	-	#DIV/0!	$0	-	30%
NMSPF	Peer Worker	0.00	0.00	0.00	0.00	-	-	#DIV/0!	$0	-	30%
NMHSPF	Tertiary Qualified	10.54	0.02	42.29	0.07	15,434	1,464	$99,584	$1,049,835	0.1	30%
NMHSPF	Medical	3.90	0.01	18.86	0.03	6,883	1,766	$159,698	$622,517	0.0	30%
NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	3.90	0.01	18.86	0.03	6,883	1,766		$622,517	0.0	30%
NMHR	Psychiatrist	1.18	0.00	5.71	0.01	2,086	1,766	$212,167	$250,620	0.0	30%
NMHR	Registrar	2.72	0.00	13.14	0.02	4,797	1,766	$136,885	$371,896	0.0	30%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$171,102	$0	-	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$212,167	$0	-	30%
NMHR	**Total Nursing**	8.23	0.01	31.43	0.05	11,471	1,394		$816,376	0.1	30%
NMHR	Registered Nurse	6.96	0.01	25.71	0.04	9,386	1,349	$92,550	$644,131	0.0	30%
NMHR	Nurse Practitioner	1.27	0.00	5.71	0.01	2,086	1,639	$135,388	$172,245	0.0	30%
NMHR	Enrolled Nurse	0.00	0.00	0.00	0.00	-	-	$67,197	$0	-	30%
NMHR	**Total Allied Health**	2.31	0.00	10.86	0.02	3,963	1,715		$233,460	0.0	30%
NMHR	Psychologist	2.31	0.00	10.86	0.02	3,963	1,715	$101,058	$233,460	0.0	30%
NMHR	Social Worker	0.00	0.00	0.00	0.00	-	-	$101,058	$0	-	30%
NMHR	Occupational Therapist	0.00	0.00	0.00	0.00	-	-	$101,058	$0	-	30%
NMHR	Other TQ (eg pharmaci	0.00	0.00	0.00	0.00	-	-	$71,279	$0	-	30%
NMHR	**VQ and Peer Workers**	0.00	0.00	0.00	0.00	-	-	$0	$0	-	30%
NMHR	Consumer Peer Worker	0.00	0.00	0.00	0.00	-	-	$62,234	$0	-	30%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$62,234	$0	-	30%
NMHR	VQMH Worker	0.00	0.00	0.00	0.00	-	-	$48,370	$0	-	30%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$58,686	$0	-	30%

Annual Cost Salaries	$1,672,352
* Including Overheads 30%	$2,174,058
Average Daily Available Bed Day C	$10
Average Cost per Patient per annu	$151

Bed Based Service Parameters	
Beds	600
Availability	100%
Average Available Beds	600
ABD/Bed/Year	365
Occupancy	87%
OBD/Bed Year	317.6
ALOS (days)	12
Admissions/Bed/Year	26.46
Annual Readmit Rate	10%
Patients/Bed/Year	24.06

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Required		198
Cost		$718,182
Staffing		
NMHR	**Total Medical**	1.3
NMHR	Psychiatrist	0.4
NMHR	Registrar	0.9
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	2.7
NMHR	Registered Nurse	2.3
NMHR	Nurse Practitioner	0.4
NMHR	Enrolled Nurse	0.0
NMHR	**Total Allied Health**	0.8
NMHR	Psychologists	0.8
NMHR	Social Workers	0.0
NMHR	Occupational Therapists	0.0
NMHR	Other	0.0
NMHR	**VQ and Peer Workers**	0.0
NMHR	Consumer Peer Worker	0.0
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		4.8

		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
Description		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38	Worked	
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	4		8				8	20	8	8			16	15.2				15.2					-	51
	Evening	-		8					8		4			4					-					-	12
	Night	-		8					8					-					-					-	8
Tuesday	Day			8				8	16	8	8			16	15.2				15.2					-	47
	Evening	-		8					8		4			4					-					-	12
	Night	-		8					8					-					-					-	8
Wednesday	Day	4		8				8	20	8	8			16	15.2				15.2					-	51
	Evening	-		8					8		4			4					-					-	12
	Night	-		8					8					-					-					-	8
Thursday	Day			8				8	16	8	8			16	15.2				15.2					-	47
	Evening	-		8					8		4			4					-					-	12
	Night	-		8					8					-					-					-	8
Friday	Day	4		8				8	20	8	8			16	15.2				15.2					-	51
	Evening	-		8					8		4			4					-					-	12
	Night	-		8					8					-					-					-	8
Saturday	All shifts	-	-	24					24		16			16					-					-	40
Sunday	All shifts	-	-	24					24		16			16					-					-	40
Total Hours per week		12	-	168	-	-	-	40	220	40	92	-	-	132	76.0	-	-	-	76	-	-	-	-	-	428
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		12	40	40	-	-	-	40	92	40	40	-	-	80	76	-	-	-	76	-	-	-	-	-	248
Evening Hours (Mon-Fri)		-	-	40	-	-	-	-	40	-	20	-	-	20	-	-	-	-	-	-	-	-	-	-	60
Night Hours (Mon-Fri)		-	-	40	-	-	-	-	40	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	40
Saturday Hours		-	-	24	-	-	-	-	24	-	16	-	-	16	-	-	-	-	-	-	-	-	-	-	40
Sunday Hours		-	-	24	-	-	-	-	24	-	16	-	-	16	-	-	-	-	-	-	-	-	-	-	40
Total Hours		12	40	168	-	-	-	40	220	40	92	-	-	132	76	-	-	-	76	-	-	-	-	-	428
Weekly FTEs		0.3	1.1	4.4	-	-	-	1.1	6.8	1.0	2.3	-	-	3.3	2.0	-	-	-	2.0	-	-	-	-	-	12.1
Relief FTEs		0.1	0.2	0.9	-	-	-	0.2	1.4	0.2	0.4	-	-	0.6	0.3	-	-	-	0.3	-	-	-	-	-	2.3
Annual FTEs		0.4	1.2	5.3	-	-	-	1.3	8.2	1.2	2.7	-	-	3.9	2.3	-	-	-	2.3	-	-	-	-	-	14.4

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from Boardman & Parsonage UK, 2007 and QLD profiles.
Team structure for 600 bed hospital.
Note may operate as part of ACT.
Need to describe service parameters.
Validation B Kotze

2.1.5 Service Category– Intensive Community Treatment Service

2.1.5.1 Service Element – Intensive Community Treatment Team – C and A - 0 - 17 years

2.1.5.2 Service Element – Intensive Community Treatment Team- Adult - 18 - 64 years

2.1.5.3 Service Element – Intensive Community Treatment Team - Older Adult 65+ years

Attribute	Details
Description	Intensive Community Treatment Services (ICTS) are delivered by multidisciplinary teams who provide ongoing recovery oriented assessment and assertive treatment and care, aimed at improving the quality of life for persons with complex mental health needs requiring intensive intervention in a community or residential setting. The key functions of Intensive Community Treatment Services are to: • provide intensive, developmentally appropriate, specialist mental health interventions and ongoing assessment for those persons who require the higher intensity (level of contact, range of interventions/services) treatment, rehabilitation and support to recover from mental illness • minimise the impact of mental illness on people, their family, friends, support people and carers, who are living in the community • facilitate access to a broad range of clinical and non-clinical services to enable people to establish, re-establish or reclaim a meaningful life • work with the person and their network to develop their sense of self efficacy, personal support systems and live independently to participate fully in their community. • ensure engagement with primary care and other specialist service providers to enable access to early intervention and timely treatment. Age specific adult (18-64) Intensive Community Treatment Services are provided on an extended hours basis and delivered via mobile outreach. Child and Adolescent (0-17) and Older Persons (65+) Intensive Community Treatment Services are primarily provided in business hours and may be provided over extended hours to meet particular needs. All age services have an early intervention and prevention focus to assist people to manage crisis situations and reduce the need for inpatient care or the length of an inpatient stay. The approach places a strong emphasis on psycho education, vocational rehabilitation, and consultation, collaboration and co-ordination with other key services and health care providers. Services work with other key services to facilitate joint care planning and case management with general practitioners (GPs) and other health care providers. Services work to build partnerships and support the development and access to a comprehensive range of services and supports.
Fundamental Attributes	Intensive Community Treatment (ICT) services are mobile and delivered by multidisciplinary teams in home and/or community settings. The team treatment approach has an emphasis on recovery, rehabilitation and community integration and may be provided over months and/or years.

Service specifications and suggested modelling attributes			
Target Age:	**0-17years**	**18-64 years**	**65+ years**
Target Population Profile	Infants, children and adolescents up to the age of 18 years (who are experiencing psychological distress and/or a mental illness) and their family, friends,	Adults with serious and/or persistent mental illness or personality illnesses, that have a significant impact on their functioning. Individuals	Individuals over the age of 65 who have severe impairment and/or distress related to serious mental illness or mental illness, most commonly initial or recurrent affective or

	support people and carers. They may present with a range of mental health problems and/or illnesses, but predominantly, they will have diagnoses such as depression, anxiety illnesses, adjustment illnesses, attachment illnesses, developmental illnesses and behavioural illnesses including complex attention deficit hyperactivity illness and conduct illness.	engaged with ICT services may have diagnoses such as schizophrenia, psychosis, severe personality illness and affective illnesses complicated by co morbidities including substance misuse and personality illnesses.	psychotic illness. Older people accessing ICT services may commonly present with associated significant levels of disturbance and psychosocial disability due to their illness and/or exacerbation of underlying personality traits, drug and alcohol problems and physical health care needs; or serious mental illness complicated by functional problems associated with ageing; or severe mental illness and complications of behavioural and psychological symptoms associated with dementia (BPSD) or other age-related illnesses.
Hours of Operation	Extended Hours	Extended Hours	Business Hours
Workforce	Multidisciplinary As per Staffing Profile	Multidisciplinary As per Staffing Profile	Multidisciplinary As per Staffing Profile emphasis on physiotherapy and occupational therapy
Evidence Base			
Level of Evidence:	1		
Key Reference Source:	• Queensland Public Mental Health Services Models of Service– Community Care Team and Mobile Intensive Rehabilitation Team Child and Youth MHS , Older Persons Community Models of Service 2011(Endorsed Executive Director Mental Health, Queensland 02/07/2010) • Framework of recovery oriented practice (Victoria) http://docs.health.vic.gov.au/docs/doc/0D4B06DF135B90E0CA2578E900256566/$FILE/framework-recovery-oriented-practice.pdf • Mobile Support and Treatment Teams Victoria, http://docs.health.vic.gov.au/docs/doc/5163B638988176D1CA257A2C001319E3/$FILE/aged_mh_ict_pstatement.pdf • Issakidis C et al. Intensive case management in Australia: A randomized controlled trial. *Acta Psychiatry Scand* 1999 May 99 360-367. • Adaobi Udechuku James Olver Karen Hallam, Frances Blyth, Melissa Leslie, Marina Nasso, Paul Schlesinger, Lorraine Warren, Miles Turner, Graham Burrows[1] *Assertive community treatment of the mentally ill: service model and effectiveness* Article first published online: Australasian Psychiatry 11 JUN 2005		
Limitations of Evidence:	Nil		
Recommendations for future research:	N/A		

Service Element – Intensive Community Treatment Team – C and A - Staffing Profile

Intensive Community Treatment Team - C&A 0 - 17 years

Intensive Community Treatment Service Youth (Team modelled for approx 250K people @ 14/100k)

SCHEME	STAFF CATEGORY	FTE	Other time %	Gross available daily hours (wkly/7)	Net consumer service available daily delivery hours	Net consumer service annual delivery hours	Available hours per annum per FTE	Weighted average salary **	Cost	FTE % share	Over heads
NMHSPF	TOTAL	33.58		218.54	104.59	38,174	1,137	94,017	3,157,502	100%	23%
NMHSPF	Vocationally Qualified	3.00	0.33	14.11	9.46	3,452	1,149	47,107	141,473	9%	23%
NMSPF	Peer Worker	1.59	0.33	7.47	5.01	1,827	1,149	58,831	93,526	5%	23%
NMHSPF	Tertiary Qualified	24.38	0.33	112.23	75.19	27,445	1,126	90,922	2,217,101	73%	23%
NMHSPF	Medical	4.61	0.33	22.29	14.93	5,450	1,183	153,121	705,403	14%	23%

Information from Care Package	
Hours Per Annum for an individual	220
Total Target Population for care pa	2,250
Total Hours Req per Annum	495,000

NMHR	TOTAL	Total FTE (Includes Leave)	Other time %	Hours available/ 7 days	Consumer service delivery hours daily	Consumer Service delivery hours annual	Available hours/annum/FTE	Salary **	Cost		0.23
NMHR	**Total Medical**	4.61		22.29	14.93	5,450	1,183		$705,403	14%	23%
NMHR	Psychiatrist	1.54	33%	7.43	4.98	1,817	1,183	$200,564	$307,989	5%	23%
NMHR	Registrar	3.07	33%	14.86	9.95	3,633	1,183	$129,399	$397,414	9%	23%
NMHR	Junior Medical Officer	-	33%	-	-	-	-	$161,745	$0	0%	23%
NMHR	Other Medical Specialis	-	33%	-	-	-	-	$200,564	$0	0%	23%
NMHR	**Total Nursing**	6.83		29.71	19.91	7,267	1,064		$604,872	20%	23%
NMHR	Registered Nurse	5.56	33%	24.00	16.08	5,869	1,057	$81,560	$453,082	17%	23%
NMHR	Nurse Practitioner	1.27	33%	5.71	3.83	1,397	1,098	$119,310	$151,791	4%	23%
NMHR	Enrolled Nurse	-	33%	-	-	-	-	$59,218	$0	0%	23%
NMHR	**Total Allied Health**	17.56		82.51	55.28	20,179	1,149		$1,612,229	52%	23%
NMHR	Psychologist	5.08	33%	23.89	16.00	5,841	1,149	$95,532	$485,523	15%	23%
NMHR	Social Worker	5.08	33%	23.89	16.00	5,841	1,149	$95,532	$485,523	15%	23%
NMHR	Occupational Therapist	5.08	33%	23.89	16.00	5,841	1,149	$95,532	$485,523	15%	23%
NMHR	Other TQ (eg pharmacis	2.31	33%	10.86	7.27	2,655	1,149	$67,381	$155,660	7%	23%
NMHR	**VQ and Peer Workers**	4.59		21.59	14.46	5,279	1,149		$234,998	14%	23%
NMHR	Consumer Peer Worker	0.92	33%	4.34	2.91	1,062	1,149	$58,831	$54,363	3%	23%
NMHR	Carer Peer Worker	0.67	33%	3.13	2.10	765	1,149	$58,831	$39,163	2%	23%
NMHR	VQMH Worker	2.31	33%	10.86	7.27	2,655	1,149	$45,724	$105,630	7%	23%
NMHR	VQ Other	0.69	33%	3.26	2.18	797	1,149	$51,717	$35,842	2%	23%
	Total Available Hours					38174.26					
Annual Cost Salaries		$3,157,502									
*** Including Overheads**	22.5%	$3,867,940									

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	70,669	59.74		$9,146,855
NMHR	Psychiatrist	23,556	19.91	$200,564	$3,993,650
NMHR	Registrar	47,113	39.82	$129,399	$5,153,205
NMHR	Junior Medical Officer	-	-	$161,745	$0
NMHR	Other Specialist	-	-	$200,564	$0
NMHR	**Total Nursing**	94,225	88.53		$7,843,292
NMHR	Registered Nurse	76,105	72.03	$81,560	$5,875,045
NMHR	Nurse Practitioner	18,120	16.50	$119,310	$1,968,248
NMHR	Enrolled Nurse	-	-	$59,218	$0
NMHR	**Total Allied Health**	261,656	227.66		$20,905,536
NMHR	Psychologists	75,743	65.90	$95,532	$6,295,705
NMHR	Social Workers	75,743	65.90	$95,532	$6,295,705
NMHR	Occupational Therapist	75,743	65.90	$95,532	$6,295,705
NMHR	Other	34,428	29.96	$67,381	$2,018,421
NMHR	**VQ and Peer Workers**	68,449	59.56		$3,047,189
NMHR	Consumer Peer Worker	13,771	11.98	$58,831	$704,917
NMHR	Carer Peer Worker	9,921	8.63	$58,831	$507,818
NMHR	VQMH Worker	34,428	29.96	$45,724	$1,369,690
NMHR	VQ Other	10,329	8.99	$51,717	$464,764

Total FTE	435.48
FTE/Client	0.19
Case load..clients/FTE	5
Annual Cost Salaries	#########
*** Including Overheads** 22.5%	#########

20178.87

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours	All Total Hours
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38	Worked	Worked
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	8	8	8	8		8	8	48	12	16			28	22.8	22.8	22.8	15.2	83.6	4.3	3.1	7.6		15.0	175
	Evening	-							-					-	7.6	7.6	7.6		22.8			7.6	7.6	15.2	38
	Night	-							-					-					-					-	-
Tuesday	Day		8	8	8		8	8	40	8	24			32	22.8	22.8	22.8	15.2	83.6	4.4	3.1	7.6		15.1	171
	Evening	-							-					-	7.6	7.6	7.6		22.8			7.6		7.6	30
	Night	-							-					-					-					-	-
Wednesday	Day		8	8	8		8	8	40	12	16			28	22.8	22.8	22.8	15.2	83.6	4.3	3.2	7.6	7.6	22.7	174
	Evening	-							-					-	7.6	7.6	7.6		22.8			7.6		7.6	30
	Night	-							-					-					-					-	-
Thursday	Day		8	8	8		8	8	40	8	24			32	22.8	22.8	22.8	15.2	83.6	4.4	3.1	7.6		15.1	171
	Evening	-							-					-	7.6	7.6	7.6		22.8			7.6		7.6	30
	Night	-							-					-					-					-	-
Friday	Day	-	8	8	8		8	8	40	12	24			36	22.8	22.8	22.8	15.2	83.6	4.3	3.2	7.6	7.6	22.7	182
	Evening	-							-					-	7.6	7.6	7.6		22.8			7.6		7.6	30
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-	7.6	7.6	7.6		22.8	4.4	3.1			7.5	30
Sunday	All shifts	-	-			-			-					-	7.6	7.6	7.6		23	4.3	3.1			7	30
Total Hours per week		8	40	40	40	-	40	40	208	52	104	-	-	156	167.2	167.2	167.2	76.0	578	30.4	21.9	76.0	22.8	151.1	1,093
Annual & Other Leave Relief weeks		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11				11	11	11											
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		8	40	40	40	-	40	40	208	52	104	-	-	156	114	114	114	76	418	22	16	38	15	91	873
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	38	38	38	-	114	-	-	38	8	46	160
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	8	8	8	-	23	4	3	-	-	8	30
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	8	8	8	-	23	4	3	-	-	7	30
Total Hours		8	40	40	40	-	40	40	208	52	104	-	-	156	167	167	167	76	578	30	22	76	23	151	1,093
Weekly FTE's		0.2	1.1	1.1	1.1	-	1.1	1.1	5.5	1.3	2.6	-	-	3.9	4.4	4.4	4.4	2.0	15.2	0.8	0.6	2.0	0.6	4.0	24.6
Relief FTE's		0.0	0.2	0.2	0.2	-	0.5	0.2	1.4	0.2	0.5	-	-	0.7	0.7	0.7	0.7	0.3	2.4	0.1	0.1	0.3	0.1	0.6	4.4
Annual FTE's		0.2	1.2	1.3	1.3	-	1.5	1.3	6.8	1.5	3.1	-	-	4.6	5.1	5.1	5.1	2.3	17.6	0.9	0.7	2.3	0.7	4.6	33.6

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, cleaning other non-labour costs including communicatio, transport, utilities and maintenace etc. It is expressed as a proportion of labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Drawn from QLD, NSW and Victorian models
Validated B Kotze
Check Med time across hosp and comm
Consumer Peer Workers modelled at a ratio of 2.5% (1:40) of the ambulatory based on a ratio of 1FTE peer work per 100K to an overall ambulatory rate of 40FTE per 100K population.
Carer Peer work is modelled at 1.8% (0.75:40) of the ambulatory workforce.

Service Element – Intensive Community Treatment Team- Adult -Staffing Profile

Intensive Community Treatment Team- Adult - 18 - 64 years

Intensive Community Treatment Service Adult (Team modelled for approx 250K people 20.5/100k)

SCHEME	STAFF CATEGORY	FTE	Other time %	Gross available daily hours (wkly/7)	Net consumer service available daily delivery hours	Net consumer service annual delivery hours	Available hours per annum per FTE	Weighted average salary **	Cost	FTE % share	Over heads
NMHSPF	**TOTAL**	**52.82**		338.56	162.03	59,139	1,120	96,943	5,120,045	100%	23%
NMHSPF	Vocationally Qualified	3.47	0.33	16.29	10.91	3,983	1,149	47,722	165,367	7%	23%
NMSPF	Peer Worker	2.52	0.33	11.83	7.93	2,893	1,149	58,831	148,068	5%	23%
NMHSPF	Tertiary Qualified	42.11	0.33	190.86	127.87	46,674	1,108	96,289	4,054,525	80%	23%
NMHSPF	Medical	4.72	0.33	22.86	15.31	5,590	1,183	159,173	752,085	9%	23%

Information from Care Package	
Hours Per Annum for an individual	220
Total Target Population for care pa	2,250
Total Hours Req per Annum	495,000

NMHR	TOTAL	Total FTE (Includes Leave)	Other time %	Hours available/ 7 days	Consumer service delivery hours daily	Consumer Service delivery hours annual	Available hours/annum/FTE	Salary **	Cost		0.23
NMHR	**Total Medical**	4.72		22.86	15.31	5,590	1,183		$752,085	9%	23%
NMHR	Psychiatrist	1.65	33%	8.00	5.36	1,956	1,183	$200,564	$331,681	3%	23%
NMHR	Registrar	3.07	33%	14.86	9.95	3,633	1,183	$136,885	$420,405	6%	23%
NMHR	Junior Medical Officer	-	33%	-	-	-	-	$161,745	$0	0%	23%
NMHR	Other Medical Specialis	-	33%	-	-	-	-	$200,564	$0	0%	23%
NMHR	**Total Nursing**	21.92		96.00	64.32	23,477	1,071		$2,083,620	42%	23%
NMHR	Registered Nurse	20.65	33%	90.29	60.49	22,079	1,069	$92,550	$1,911,376	39%	23%
NMHR	Nurse Practitioner	1.27	33%	5.71	3.83	1,397	1,098	$135,388	$172,245	2%	23%
NMHR	Enrolled Nurse	-	33%	-	-	-	-	$67,197	$0	0%	23%
NMHR	**Total Allied Health**	20.18		94.86	63.55	23,197	1,149		$1,970,905	38%	23%
NMHR	Psychologist	4.47	33%	21.03	14.09	5,143	1,149	$101,058	$452,174	8%	23%
NMHR	Social Worker	6.01	33%	28.23	18.91	6,903	1,149	$101,058	$606,995	11%	23%
NMHR	Occupational Therapist	7.39	33%	34.74	23.28	8,496	1,149	$101,058	$747,071	14%	23%
NMHR	Other TQ (eg pharmacis	2.31	33%	10.86	7.27	2,655	1,149	$71,279	$164,665	4%	23%
NMHR	**VQ and Peer Workers**	5.98		28.11	18.84	6,875	1,149		$313,435	11%	23%
NMHR	Consumer Peer Worker	1.45	33%	6.83	4.58	1,670	1,149	$58,831	$85,479	3%	23%
NMHR	Carer Peer Worker	1.06	33%	5.00	3.35	1,223	1,149	$58,831	$62,589	2%	23%
NMHR	VQMH Worker	2.31	33%	10.86	7.27	2,655	1,149	$45,724	$105,630	4%	23%
NMHR	VQ Other	1.16	33%	5.43	3.64	1,328	1,149	$51,717	$59,737	2%	23%
	Total Available Hours					59139.18					

Annual Cost Salaries		$5,120,045
*** Including Overheads**	22.5%	$6,272,056

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	46,786	39.55		$6,295,017
NMHR	Psychiatrist	16,375	13.84	$200,564	$2,776,195
NMHR	Registrar	30,411	25.71	$136,885	$3,518,822
NMHR	Junior Medical Officer	-	-	$161,745	$0
NMHR	Other Specialist	-	-	$200,564	$0
NMHR	**Total Nursing**	196,503	183.51		$17,440,082
NMHR	Registered Nurse	184,806	172.86	$92,550	$15,998,378
NMHR	Nurse Practitioner	11,697	10.65	$135,388	$1,441,703
NMHR	Enrolled Nurse	-	-	$67,197	$0
NMHR	**Total Allied Health**	194,164	168.94		$16,496,643
NMHR	Psychologists	43,043	37.45	$101,058	$3,784,738
NMHR	Social Workers	57,781	50.27	$101,058	$5,080,599
NMHR	Occupational Therapists	71,115	61.88	$101,058	$6,253,045
NMHR	Other	22,224	19.34	$71,279	$1,378,261
NMHR	**VQ and Peer Workers**	57,547	50.07		$2,623,478
NMHR	Consumer Peer Worker	13,977	12.16	$58,831	$715,464
NMHR	Carer Peer Worker	10,235	8.90	$58,831	$523,875
NMHR	VQMH Worker	22,224	19.34	$45,724	$884,133
NMHR	VQ Other	11,112	9.67	$51,717	$500,007

Total FTE		442.07
FTE/Client		0.20
Case load..clients/FTE		5
Annual Cost Salaries		$42,855,220
*** Including Overheads**	22.5%	$52,497,645

23197.31

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	8	8	24	24		8	8	80	8	20			28	22.8	22.8	38.0	15.2	98.8	6.8	5.0	7.6	7.6	27.0	234
	Evening	-		24	8		8		40					-	7.6	7.6	7.6		22.8			7.6		7.6	70
	Night	-							-					-					-					-	-
Tuesday	Day		8	24	24		8	8	72	12	16			28	22.8	38.0	38.0	15.2	114.0	6.8	5.0	7.6	7.6	27.0	241
	Evening	-		24	8		8		40					-	7.6	7.6	7.6		22.8			7.6		7.6	70
	Night	-							-					-					-					-	-
Wednesday	Day		8	24	24		8	8	72	8	16			24	22.8	22.8	38.0	15.2	98.8	6.9	5.0	7.6	7.6	27.1	222
	Evening	-		24	8		8		40					-	7.6	7.6	7.6		22.8			7.6		7.6	70
	Night	-							-					-					-					-	-
Thursday	Day	8	8	24	24		8	8	80	12	16			28	2.8	38.0	38.0	15.2	94.0	6.8	5.0	7.6	7.6	27.0	229
	Evening	-		24	8		8		40					-	7.6	7.6	7.6		22.8			7.6		7.6	70
	Night	-							-					-					-					-	-
Friday	Day	-	8	24	24		8	8	72	8	20			28	22.8	22.8	38.0	15.2	98.8	6.8	5.0	7.6	7.6	27.0	226
	Evening	-		24	8		8		40					-	7.6	7.6	7.6		22.8			7.6		7.6	70
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-	24	16	-	8		48	4	8			12	7.6	7.6	7.6		22.8	6.9	5.0			11.9	95
Sunday	All shifts	-	-	24	16	-	8		48	4	8			12	7.6	7.6	7.6		23	6.8	5.0			12	95
Total Hours per week		**16**	**40**	**288**	**192**	**-**	**96**	**40**	**672**	**56**	**104**	**-**	**-**	**160**	**147.2**	**197.6**	**243.2**	**76.0**	**664**	**47.8**	**35.0**	**76.0**	**38.0**	**196.8**	**1,693**
Annual & Other Leave Relief week		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		16	40	120	120	-	40	40	376	48	88	-	-	136	94	144	190	76	504	34	25	38	38	135	1,152
Evening Hours (Mon-Fri)		-	-	120	40	-	40	-	200	-	-	-	-	-	38	38	38	-	114	-	-	38	-	38	352
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	24	16	-	8	-	48	4	8	-	-	12	8	8	8	-	23	7	5	-	-	12	95
Sunday Hours		-	-	24	16	-	8	-	48	4	8	-	-	12	8	8	8	-	23	7	5	-	-	12	95
Total Hours		16	40	288	192	-	96	40	672	56	104	-	-	160	147	198	243	76	664	48	35	76	38	197	1,693
Weekly FTE's		0.4	1.1	7.6	5.1	-	2.5	1.1	17.7	1.4	2.8	-	-	4.0	3.9	5.2	6.4	2.0	17.5	1.3	0.9	2.0	1.0	5.2	39.2
Relief FTE's		0.1	0.2	1.6	1.1	-	1.1	0.2	4.2	0.3	0.5	-	-	0.7	0.6	0.8	1.0	0.3	2.7	0.2	0.1	0.3	0.2	0.8	7.7
Annual FTE's		**0.5**	**1.2**	**9.2**	**6.1**	**-**	**3.6**	**1.3**	**21.9**	**1.7**	**3.1**	**-**	**-**	**4.7**	**4.5**	**6.0**	**7.4**	**2.3**	**20.2**	**1.5**	**1.1**	**2.3**	**1.2**	**6.0**	**52.8**

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, cleaning other non-labour costs including communicatio, transport, utilities and maintenace etc. It is expressed as a proportion of labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Drawn from QLD, and Victorian models
Consumer Peer Workers modelled at a ratio of 2.5% (1:40) of the ambulatory based on a ratio of 1FTE peer work per 100K to an overall ambulatory rate of 40FTE per 100K population.
Carer Peer work is modelled at 1.8% (0.75:40) of the ambulatory workforce.

Service Element – Intensive Community Treatment Team - Older Adult - Staffing Profile

Intensive Community Treatment Team - Older Adult 65+ years

Intensive Community Treatment Service Older Persons (Team modelled for approx 250K people @ 4.5/100k)

SCHEME	STAFF CATEGORY	FTE	Other time %	Gross available daily hours (wkly/7)	Net consumer service available daily delivery hours	Net consumer service annual delivery hours	Available hours per annum per FTE	Weighted average salary **	Cost	FTE % share	Over heads
NMHSPF	**TOTAL**	**12.76**		82.82	39.64	14,467	1,134	101,531	1,295,195	100%	23%
NMHSPF	Vocationally Qualified	-	0.33	-	-	-	-	-	-	0%	23%
NMSPF	Peer Worker	0.61	0.33	2.87	1.92	702	1,149	54,844	33,508	5%	23%
NMHSPF	Tertiary Qualified	9.78	0.33	44.86	30.05	10,970	1,121	89,125	871,921	77%	23%
NMHSPF	Medical	2.36	0.33	11.43	7.66	2,795	1,183	164,982	389,766	19%	23%

Information from Care Package	
Hours Per Annum for an individual	220
Total Target Population for care pa	2,250
Total Hours Req per Annum	495,000

NMHR	TOTAL	Total FTE (Includes Leave)	Other time %	Hours available/ 7 days	Consumer service delivery hours daily	Consumer Service delivery hours annual	Available hours/annum/FTE	Salary **	Cost		0.23
NMHR	**Total Medical**	2.36		11.43	7.66	2,795	1,183		$389,766	19%	23%
NMHR	Psychiatrist	1.18	33%	5.71	3.83	1,397	1,183	$200,564	$236,915	9%	23%
NMHR	Registrar	1.18	33%	5.71	3.83	1,397	1,183	$129,399	$152,851	9%	23%
NMHR	Junior Medical Officer	-	33%	-	-	-	-	$150,783	$0	0%	23%
NMHR	Other Medical Specialis	-	33%	-	-	-	-	$200,564	$0	0%	23%
NMHR	**Total Nursing**	6.32		28.57	19.14	6,987	1,106		$563,317	50%	23%
NMHR	Registered Nurse	5.05	33%	22.86	15.31	5,590	1,108	$81,560	$411,526	40%	23%
NMHR	Nurse Practitioner	1.27	33%	5.71	3.83	1,397	1,098	$119,310	$151,791	10%	23%
NMHR	Enrolled Nurse	-	33%	-	-	-	-	$59,218	$0	0%	23%
NMHR	**Total Allied Health**	3.47		16.29	10.91	3,983	1,149		$308,604	27%	23%
NMHR	Psychologist	1.16	33%	5.43	3.64	1,328	1,149	$89,058	$102,868	9%	23%
NMHR	Social Worker	1.16	33%	5.43	3.64	1,328	1,149	$89,058	$102,868	9%	23%
NMHR	Occupational Therapist	1.16	33%	5.43	3.64	1,328	1,149	$89,058	$102,868	9%	23%
NMHR	Other TQ (eg pharmacis	-	33%	-	-	-	-	$62,815	$0	0%	23%
NMHR	**VQ and Peer Workers**	0.61		2.87	1.92	702	1,149		$33,508	5%	23%
NMHR	Consumer Peer Worker	0.35	33%	1.64	1.10	402	1,149	$54,844	$19,171	3%	23%
NMHR	Carer Peer Worker	0.26	33%	1.23	0.82	300	1,149	$54,844	$14,337	2%	23%
NMHR	VQMH Worker	-	33%	-	-	-	-	$42,626	$0	0%	23%
NMHR	VQ Other	-	33%	-	-	-	-	$51,717	$0	0%	23%
	Total Available Hours					14466.88					

Annual Cost Salaries	$1,295,195
*** Including Overheads** 22.5%	$1,586,614

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	95,629	80.83		$13,336,271
NMHR	Psychiatrist	47,815	40.42	$200,564	$8,106,294
NMHR	Registrar	47,815	40.42	$129,399	$5,229,977
NMHR	Junior Medical Officer	-	-	$150,783	$0
NMHR	Other Specialist	-	-	$200,564	$0
NMHR	**Total Nursing**	239,073	216.18		$19,274,489
NMHR	Registered Nurse	191,258	172.64	$81,560	$14,080,806
NMHR	Nurse Practitioner	47,815	43.53	$119,310	$5,193,683
NMHR	Enrolled Nurse	-	-	$59,218	$0
NMHR	**Total Allied Health**	136,271	118.57		$10,559,233
NMHR	Psychologists	45,424	39.52	$89,058	$3,519,744
NMHR	Social Workers	45,424	39.52	$89,058	$3,519,744
NMHR	Occupational Therapists	45,424	39.52	$89,058	$3,519,744
NMHR	Other	-	-	$62,815	$0
NMHR	**VQ and Peer Workers**	24,027	20.91		$1,146,515
NMHR	Consumer Peer Worker	13,747	11.96	$54,844	$655,966
NMHR	Carer Peer Worker	10,280	8.94	$54,844	$490,549
NMHR	VQMH Worker	-	-	$42,626	$0
NMHR	VQ Other	-	-	$51,717	$0

Total FTE	436.48
FTE/Client	0.19
Case load..clients/FTE	5
Annual Cost Salaries	$44,316,509
*** Including Overheads** 22.5%	$54,287,723

3982.67

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day		12	12	8			8	40	8	8			16	7.6	7.6	7.6		22.8	1.6	1.2			2.8	82
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Tuesday	Day		12	12	8			8	40	8	8			16	7.6	7.6	7.6		22.8	3.4	2.4			5.8	85
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Wednesday	Day		12	12	8			8	40	8	8			16	7.6	7.6	7.6		22.8	1.6	1.3			2.9	82
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Thursday	Day		12	12	8			8	40	8	8			16	7.6	7.6	7.6		22.8	1.7	2.5			4.2	83
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Friday	Day	-	12	12	8			8	40	8	8			16	7.6	7.6	7.6		22.8	3.2	1.2			4.4	83
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-					-	-
Sunday	All shifts	-	-			-			-					-					-					-	-
Total Hours per week		-	60	60	40	-	-	40	200	40	40	-	-	80	38.0	38.0	38.0	-	114	11.5	8.6	-	-	20.1	414
Annual & Other Leave Relief weeks		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11				11	11	11											
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	60	60	40	-	-	40	200	40	40	-	-	80	38	38	38	-	114	12	9	-	-	20	414
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Hours		-	60	60	40	-	-	40	200	40	40	-	-	80	38	38	38	-	114	12	9	-	-	20	414
Weekly FTE's		-	1.6	1.6	1.1	-	-	1.1	5.3	1.0	1.0	-	-	2.0	1.0	1.0	1.0	-	3.0	0.3	0.2	-	-	0.5	10.3
Relief FTE's		-	0.3	0.3	0.2	-	-	0.2	1.1	0.2	0.2	-	-	0.4	0.2	0.2	0.2	-	0.5	0.0	0.0	-	-	0.1	1.9
Annual FTE's		-	1.9	1.9	1.3	-	-	1.3	6.3	1.2	1.2	-	-	2.4	1.2	1.2	1.2	-	3.5	0.3	0.3	-	-	0.6	12.8

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, cleaning other non-labour costs including communicatio, transport, utilities and maintenace etc. It is expressed as a proportion of labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowance:

Variable inputs

Variable Inputs

Comments:

Drawn from Victorian models and Qld PMH models and St George OPMH, NSW. Validated R McKay. Consumer Peer Workers modelled at a ratio of 2.5% (1:40) of the ambulatory based on a ratio of 1FTE peer work per 100K to an overall ambulatory rate of 40FTE per 100K population. Carer Peer work is modelled at 1.8% (0.75:40) of the ambulatory workforce.

2.1.6 Service Category – Day Program

2.1.6.1 Service Element – Day Program Team – C and A 0 - 17 years

2.1.6.2 Service Element – Day Program Team - Adult - 18 - 64 years

Attribute	**Details**	
Description	Mental Health Day Programs may be used as a part of an overall treatment strategy and/or an alternative to inpatient care. Day programs are usually time limited and targeted to treat specific age groups, illnesses, symptoms or address developmental difficulties, or needs (e.g. children and adolescents, anxiety symptoms, eating disorders, functional problems) The goal is to reduce the severity of mental health symptoms and to promote effective participation in the areas such as schooling, social functioning, symptom management and other life skills. Day programs aim to support the person to achieve their recovery goals utilising a flexible approach that enables work with family, friends, support people and carers and other agencies. (e.g. education, social services) Day Programs are usually integrated with both Mental Health Inpatient Units and Community Mental Health Services to enhance continuity in service provision, provide a flexible range of intensive therapy, treatment and rehabilitation options to maximise recovery within a therapeutic milieu. The key functions of Day Programs are to: • It provides multidisciplinary and collaborative consultation, diagnostic assessment, treatment and a range of evidence based interventions including recovery and discharge planning • It provides alternatives to a hospital admission for people with severe and complex mental health issues who need additional support or intensive outreach due to difficulties engaging in mainstream services. • Arrange, coordinate and support access to a range of integrated services to ensure seamless service provision.	
Fundamental Attributes	Day programs are usually time limited; provide targeted treatment interventions in the least restrictive environment possible while recognising the need for safety, with the minimum possible disruption to the family, friends, support people and carers, educational, social and community networks. Day programs for children and adolescents differ significantly from adult day with a focus on the developmental context and specific requirements for family involvement, integration with education programs and a multifaceted/multi modal approach.	
Service specifications and suggested modelling attributes		
Target Age:	**0-17years**	**18-64 years**
Target Population Profile	Pre-school and school age children with complex needs and/or developmental illnesses. E.g. autism with speech and language illness, disruptive behavioural illnesses, Eating disorders. The aetiology of their symptoms may be rooted in sexual abuse, physical abuse, neglect, parental separation, chaotic family environments, inappropriate discipline and/or a genetic predisposition. They may also have a history of criminal activity, periods in “care”, learning	Persons with severe and complex mental health issues such as emerging personality illness, eating disorder, chronic depression and extreme anxiety. Individuals with serious and/or persistent mental illness who may have diagnoses such as schizophrenia, psychosis, severe personality illness and affective illnesses complicated by co morbidities who experience social isolation and severe functional problems.

	difficulties, emotional and behavioural difficulties, abuse, chronic physical illness / disability; sensory problems; parental mental illness or substance abuse ; trauma or refugee status. Day programs aim to provide intensive treatment interventions with whole families aimed at improving parenting skills, promoting healthy child development, preventing placement and facilitating family stability.	
Frequency of activity	Sessions (may be up to 5 days a week)	Sessions (may be up to 5 days a week)
Hours of Operation	Usually Business Hours but increasing emphasis on flexibility	
Workforce	As per Staffing Profile	
Evidence Base		
Level of Evidence:	2	
Key Reference Sources :	• Evaluating the outcomes of adolescent day programs in an Australian child and adolescent mental health service. Nicola Kennair, David Mellor and Peter Brann. http://ccp.sagepub.com/content/16/1/21.abstract • *The Evidence Base to Guide Development of Tier 4 CAMHS,* Zarrina Kurtz, April 2009 National CAMHS Support Service, Department of Health. http://www.nmhdu.org.uk/silo/files/the-evidence-base-to-guide-dvt-of-tier-4-camhs-apr-09.pdf • Modified from Queensland Public Mental Health Services Models of Service Child and Adolescent Day Programs 2011 • *Review of the PDRSS Day Program, Adult Residential Rehabilitation and Youth Residential Rehabilitation Services for the Victorian Department of Health* State of Victoria, Department of Health, 2012	
Limitations of Evidence:	Nil	
Recommendations for future research:		

Service Element – Day Program Team – C and A – Staffing Profile

5 Day program

Day Program Team - C&A 0 - 17 years

SCHEME	STAFF CATEGORY	FTE	Other time %	Gross available daily hours (wkly/7)	Net consumer service available daily delivery hours	Net consumer service annual delivery hours	Available hours per annum per FTE	Weighted average salary **	Cost	FTE % share	Over heads
NMHSPF	TOTAL	5.96		39.04	26.16	6,800.77	1,141	93,573	557,889	100%	23%
NMHSPF	Vocationally Qualified	-	0.33	-	-	-	-	-	-	0%	23%
NMSPF	Peer Worker	0.28	0.33	1.84	1.23	320.53	1,146	54,844	15,337	5%	23%
NMHSPF	Tertiary Qualified	4.74	0.33	30.80	20.64	5,365.36	1,133	83,845	397,211	79%	23%
NMHSPF	Medical	0.94	0.33	6.40	4.29	1,114.88	1,180	153,801	145,341	16%	23%

NMHR	TOTAL	Total FTE (Includes Leave)	Other time %	Hours available/ 5 days	Consumer service delivery hours daily	Consumer Service delivery hours annual	Available hours/annum/FTE	Salary **	Cost		0.23
NMHR	**Total Medical**	0.94		6.40	4.29	1,115	1,180		$145,341	16%	23%
NMHR	Psychiatrist	0.47	0.33	3.20	2.14	557	1,180	$186,972	$88,344	8%	23%
NMHR	Registrar	0.47	0.33	3.20	2.14	557	1,180	$120,630	$56,997	8%	23%
NMHR	Junior Medical Officer	-	0.33	-	-	-	-	$150,783	$0	0%	23%
NMHR	Other Medical Specialis	-	0.33	-	-	-	-	$186,972	$0	0%	23%
NMHR	**Total Nursing**	1.27		8.00	5.36	1,394	1,095		$103,763	21%	23%
NMHR	Registered Nurse	1.27	0.33	8.00	5.36	1,394	1,095	$81,560	$103,763	21%	23%
NMHR	Nurse Practitioner	-	0.33	-	-	-	-	$119,310	$0	0%	23%
NMHR	Enrolled Nurse	-	0.33	-	-	-	-	$59,218	$0	0%	23%
NMHR	**Total Allied Health**	3.47		22.80	15.28	3,972	1,146		$293,448	58%	23%
NMHR	Psychologist	1.16	0.33	7.60	5.09	1,324	1,146	$89,058	$102,868	19%	23%
NMHR	Social Worker	1.16	0.33	7.60	5.09	1,324	1,146	$89,058	$102,868	19%	23%
NMHR	Occupational Therapist	0.58	0.33	3.80	2.55	662	1,146	$89,058	$51,434	10%	23%
NMHR	Other TQ (eg pharmacis	0.58	0.33	3.80	2.55	662	1,146	$62,815	$36,278	10%	23%
NMHR	**VQ and Peer Workers**	0.28		1.84	1.23	321	1,146		$15,337	5%	23%
NMHR	Consumer Peer Worker	0.15	0.33	0.98	0.66	171	1,146	$54,844	$8,169	2%	23%
NMHR	Carer Peer Worker	0.13	0.33	0.86	0.58	150	1,146	$54,844	$7,168	2%	23%
NMHR	VQMH Worker	-	0.33	-	-	-	-	$42,626	$0	0%	23%
NMHR	VQ Other	-	0.33	-	-	-	-	$51,717	$0	0%	23%
	Total Available Hours					6800.77					

Annual Cost Salaries		$557,889
*** Including Overheads**	22.5%	$683,414

Information from Care Package	
Hours Per Annum for an individual	220
Total Target Population for care pa	2,250
Total Direct Hrs Req per Annum	257,400

*Assumes efficiency for Day program

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	42,197	35.77		$5,500,958
NMHR	Psychiatrist	21,098	17.88	$186,972	$3,343,692
NMHR	Registrar	21,098	17.88	$120,630	$2,157,266
NMHR	Junior Medical Officer	-	-	$150,783	$0
NMHR	Other Specialist	-	-	$186,972	$0
NMHR	**Total Nursing**	52,746	48.15		$3,927,292
NMHR	Registered Nurse	52,746	48.15	$81,560	$3,927,292
NMHR	Nurse Practitioner	-	-	$119,310	$0
NMHR	Enrolled Nurse	-	-	$59,218	$0
NMHR	**Total Allied Health**	150,326	131.15		$11,106,619
NMHR	Psychologists	50,109	43.72	$89,058	$3,893,421
NMHR	Social Workers	50,109	43.72	$89,058	$3,893,421
NMHR	Occupational Therapists	25,054	21.86	$89,058	$1,946,711
NMHR	Other	25,054	21.86	$62,815	$1,373,066
NMHR	**VQ and Peer Workers**	12,132	10.58		$580,486
NMHR	Consumer Peer Worker	6,461	5.64	$54,844	$309,172
NMHR	Carer Peer Worker	5,670	4.95	$54,844	$271,314
NMHR	VQMH Worker	-	-	$42,626	$0
NMHR	VQ Other	-	-	$51,717	$0

Total FTE		225.66
FTE/Client		0.10
Case load..clients/FTE		10
Annual Cost Salaries		$21,115,355
*** Including Overheads**	22.5%	$25,866,310

Model for Day program
Avg attendance 10 for 5 hours (25 hours per week per client)
5 hour supervised attendance per day
of these 2 hours Indiv
and 3 hours group (1 staff per 5 clients in group)
So the 10 clients require per day
50 direct client hrs including 20 indiv and 30 group hrs
converts to 26 direct staff hours per day.
or 2.6 hours direct time per client per day
0r prescribing a 5 hour day of day program costs
2.6hours of direct staff time
so divide total requirred by 5/2.6.

3971.76

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day			8					8					-	7.6	7.6	7.6	3.8	26.6	0.7	0.8			1.5	35
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Tuesday	Day			8					8	8				8	7.6	7.6		3.8	19.0	1.4	1.0			2.4	37
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Wednesday	Day			8					8		8			8	7.6	7.6	3.8	3.8	22.8	0.7	0.8			1.5	40
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Thursday	Day			8					8	8				8	7.6	7.6		3.8	19.0	1.4	1.0			2.4	37
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Friday	Day	-		8					8		8			8	7.6	7.6	7.6	3.8	26.6	0.7	0.8			1.5	44
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-					-	-
Sunday	All shifts	-	-			-			-					-					-					-	-
Total Hours per week		-	-	40	-	-	-	-	40	16	16	-	-	32	38.0	38.0	19.0	19.0	114	4.9	4.3	-	-	9.2	195
Annual & Other Leave Relief weeks		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0		11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	40	-	-	-	-	40	16	16	-	-	32	38	38	19	19	114	5	4	-	-	9	195
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Hours		-	-	40	-	-	-	-	40	16	16	-	-	32	38	38	19	19	114	5	4	-	-	9	195
Weekly FTE's		-	-	1.1	-	-	-	-	1.1	0.4	0.4	-	-	0.8	1.0	1.0	0.5	0.5	3.0	0.1	0.1	-	-	0.2	4.9
Relief FTE's		-	-	0.2	-	-	-	-	0.2	0.1	0.1	-	-	0.1	0.2	0.2	0.1	0.1	0.5	0.0	0.0	-	-	0.0	0.8
Annual FTE's		-	-	1.3	-	-	-	-	1.3	0.5	0.5	-	-	0.9	1.2	1.2	0.6	0.6	3.5	0.1	0.1	-	-	0.3	6.0

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, cleaning other non-labour costs including communicatio, transport, utilities and maintenace etc. It is expressed as a proportion of labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Drawn from NSW Shoalhaven/Rivendell services.
Validated B kotze
Daily Places available (5 days) 8 to 12
Occupancy 90%
Avg hours of attendance/ week 20
Hrs of Operation Mon to Fri 8.30 to 5.00
After Hours Prog Hours/wk 2 4pm to 6 pm
Includes educational services paid for by educ
Ages 12 to 18
Day programs delivered during holidays ...but closed for 4 to 5 weeks.
Consumer Peer Workers modelled at a ratio of
2.5% (1:40) of the ambulatory based on a ratio
of 1FTE peer work per 100K to an overall
ambulatory rate of 40FTE per 100K population.
Carer Peer work is modelled at 1.8% (0.75:40)
of the ambulatory workforce.

Service Element – Day Program Team - Adult – Staffing Profile

5 Day program

Day Program Team - Adult - 18 - 64 years

SCHEME	STAFF CATEGORY	FTE	Other time %	Gross available daily hours (wkly/7)	Net consumer service available daily delivery hours	Net consumer service annual delivery hours	Available hours per annum per FTE	Weighted average salary **	Cost	FTE % share	Over heads
NMHSPF	**TOTAL**	**5.93**		38.86	26.04	6,769.41	1,141	93,751	556,389	100%	23%
NMHSPF	Vocationally Qualified	-	0.33	-	-	-	-	-	-	0%	23%
NMSPF	Peer Worker	0.25	0.33	1.66	1.11	289.17	1,146	54,844	13,837	4%	23%
NMHSPF	Tertiary Qualified	4.74	0.33	30.80	20.64	5,365.36	1,133	83,845	397,211	80%	23%
NMHSPF	Medical	0.94	0.33	6.40	4.29	1,114.88	1,180	153,801	145,341	16%	23%

NMHR	TOTAL	Total FTE (Includes Leave)	Other time %	Hours available/ 5 days	Consumer service delivery hours daily	Consumer Service delivery hours annual	Available hours/annum/FTE	Salary **	Cost		0.23
NMHR	**Total Medical**	0.94		6.40	4.29	1,115	1,180		$145,341	16%	23%
NMHR	Psychiatrist	0.47	0.33	3.20	2.14	557	1,180	$186,972	$88,344	8%	23%
NMHR	Registrar	0.47	0.33	3.20	2.14	557	1,180	$120,630	$56,997	8%	23%
NMHR	Junior Medical Officer	-	0.33	-	-	-	-	$150,783	$0	0%	23%
NMHR	Other Medical Specialist	-	0.33	-	-	-	-	$186,972	$0	0%	23%
NMHR	**Total Nursing**	1.27		8.00	5.36	1,394	1,095		$103,763	21%	23%
NMHR	Registered Nurse	1.27	0.33	8.00	5.36	1,394	1,095	$81,560	$103,763	21%	23%
NMHR	Nurse Practitioner	-	0.33	-	-	-	-	$119,310	$0	0%	23%
NMHR	Enrolled Nurse	-	0.33	-	-	-	-	$59,218	$0	0%	23%
NMHR	**Total Allied Health**	3.47		22.80	15.28	3,972	1,146		$293,448	58%	23%
NMHR	Psychologist	1.16	0.33	7.60	5.09	1,324	1,146	$89,058	$102,868	19%	23%
NMHR	Social Worker	1.16	0.33	7.60	5.09	1,324	1,146	$89,058	$102,868	19%	23%
NMHR	Occupational Therapist	0.58	0.33	3.80	2.55	662	1,146	$89,058	$51,434	10%	23%
NMHR	Other TO (eg pharmacis	0.58	0.33	3.80	2.55	662	1,146	$62,815	$36,278	10%	23%
NMHR	**VQ and Peer Workers**	0.25		1.66	1.11	289	1,146		$13,837	4%	23%
NMHR	Consumer Peer Worker	0.15	0.33	1.00	0.67	174	1,146	$54,844	$8,335	3%	23%
NMHR	Carer Peer Worker	0.10	0.33	0.66	0.44	115	1,146	$54,844	$5,501	2%	23%
NMHR	VQMH Worker	-	0.33	-	-	-	-	$42,626	$0	0%	23%
NMHR	VQ Other	-	0.33	-	-	-	-	$51,717	$0	0%	23%
	Total Available Hours					6769.41					

Annual Cost Salaries	$556,389
*** Including Overheads** 22.5%	$681,576

Information from Care Package

Hours Per Annum for an individual	220
Total Target Population for care pa	2,250
Total Direct Hrs Req per Annum	**257,400** *Assumes efficiency for Day program

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	42,392	35.93		$5,526,439
NMHR	Psychiatrist	21,196	17.97	$186,972	$3,359,180
NMHR	Registrar	21,196	17.97	$120,630	$2,167,259
NMHR	Junior Medical Officer	-	-	$150,783	$0
NMHR	Other Specialist	-	-	$186,972	$0
NMHR	**Total Nursing**	52,990	48.38		$3,945,483
NMHR	Registered Nurse	52,990	48.38	$81,560	$3,945,483
NMHR	Nurse Practitioner	-	-	$119,310	$0
NMHR	Enrolled Nurse	-	-	$59,218	$0
NMHR	**Total Allied Health**	151,022	131.76		$11,158,065
NMHR	Psychologists	50,341	43.92	$89,058	$3,911,455
NMHR	Social Workers	50,341	43.92	$89,058	$3,911,455
NMHR	Occupational Therapists	25,170	21.96	$89,058	$1,955,728
NMHR	Other	25,170	21.96	$62,815	$1,379,426
NMHR	**VQ and Peer Workers**	10,995	9.59		$526,125
NMHR	Consumer Peer Worker	6,624	5.78	$54,844	$316,943
NMHR	Carer Peer Worker	4,372	3.81	$54,844	$209,182
NMHR	VQMH Worker	-	-	$42,626	$0
NMHR	VQ Other	-	-	$51,717	$0

Total FTE	225.66
FTE/Client	0.10
Case load..clients/FTE	10
Annual Cost Salaries	$21,156,112
*** Including Overheads** 22.5%	$25,916,237

Model for Day program
Avg attendance 10 for 5 hours (25 hours per week per client)
5 hour supervised attendance per day
of these 2 hours Indiv
and 3 hours group (1 staff per 5 clients in group)
So the 10 clients require per day
50 direct client hrs including 20 indiv and 30 group hrs
converts to 26 direct staff hours per day.
or 2.6 hours direct time per client per day
0r prescribing a 5 hour day of day program costs
2.6hours of direct staff time
so divide total requirred by 5/2.6.

3971.76

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours	All Total Hours
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38	Worked	Worked
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day			8					8					-	7.6	7.6	7.6	3.8	26.6	1.0	0.7			1.7	36
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Tuesday	Day			8					8	8				8	7.6	7.6		3.8	19.0	1.0	0.6			1.6	37
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Wednesday	Day			8					8		8			8	7.6	7.6	3.8	3.8	22.8	1.0	0.7			1.7	41
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Thursday	Day			8					8	8				8	7.6	7.6		3.8	19.0	1.0	0.6			1.6	37
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Friday	Day	-		8					8		8			8	7.6	7.6	7.6	3.8	26.6	1.0	0.7			1.7	44
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-		-				-					-					-					-	-
Sunday	All shifts	-	-		-				-					-					-					-	-
Total Hours per week		-	-	40	-	-	-	-	40	16	16	-	-	32	38.0	38.0	19.0	19.0	114	5.0	3.3	-	-	8.3	194
Annual & Other Leave Relief weeks		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0		11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	40	-	-	-	-	40	16	16	-	-	32	38	38	19	19	114	5	3	-	-	8	194
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Hours		-	-	40	-	-	-	-	40	16	16	-	-	32	38	38	19	19	114	5	3	-	-	8	194
Weekly FTE's		-	-	1.1	-	-	-	-	1.1	0.4	0.4	-	-	0.8	1.0	1.0	0.5	0.5	3.0	0.1	0.1	-	-	0.2	4.9
Relief FTE's		-	-	0.2	-	-	-	-	0.2	0.1	0.1	-	-	0.1	0.2	0.2	0.1	0.1	0.5	0.0	0.0	-	-	0.0	0.8
Annual FTE's		-	-	1.3	-	-	-	-	1.3	0.5	0.5	-	-	0.9	1.2	1.2	0.6	0.6	3.5	0.2	0.1	-	-	0.3	5.9

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, cleaning other non-labour costs including communicatio, transport, utilities and maintenace etc. It is expressed as a proportion of labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowance:

Variable inputs

Variable Inputs

Comments:

Consumer Peer Workers modelled at a ratio of 2.5% (1:40) of the ambulatory based on a ratio of 1FTE peer work per 100K to an overall ambulatory rate of 40FTE per 100K population. Carer Peer work is modelled at 1.8% (0.75:40) of the ambulatory workforce.

2.1.7 Service Category – Monitoring and Ongoing Management

Monitoring and ongoing management involves the ongoing systematic collection, analysis, interpretation of information for the ongoing management of a person's health status and/or ongoing need for specialist mental health services. This is performed by specialist trained mental health professionals. (E.g. psychiatrists, psychologists, mental health nurses and/or allied health professionals) Monitoring involves the collection and evaluation of data obtained through interview and observation, including taking a comprehensive history and exploration of presenting problem(s). Monitoring and ongoing assessment will include consultation with the person's family and concludes with a formulation of problems/issues, a preliminary diagnosis or diagnosis, and an updated treatment plan supported by the assessment and interview data.

2.1.7.1 Service Element – Centre Based Monitoring and Ongoing Management

The nature of the centre based support will depend on the person's needs. Services provided by clinicians will include:

- Mental health status monitoring;
- Risk assessment;
- Risk management plan;
- Physical health review;
- Family, friends, support people and carers needs assessment;
- Social and environmental assessment;
- Individualised Care Plan and Review.

2.1.7.2 Service Element – Home Based Monitoring and Ongoing Management

The nature of the home/outreach will depend on the person's needs. Services provided by clinicians will include:

- Mental health status monitoring;
- Risk assessment;
- Risk management plan;
- Physical health review;
- Family, friends, support people and carers other needs assessment;
- Social and environmental assessment;
- Individualised Care Plan and Review.

2.1.7.3 Service Element – General Physical Health Monitoring and Ongoing Management

Monitoring required as part of good mental health treatment, including metabolic screening (Body Mass Index (BMI), waist circumference, weight, BP, blood tests etc.) and screening to comply with treatment guidelines (e.g. mandatory monitoring criteria - clozapine). The assessment will be tailored and developmentally appropriate to the age of the person.

2.1.8 Service Category – Care Coordination and Liaison

2.1.8.1 Service Element – Care Coordination and Liaison

Care coordination and liaison includes working in partnership and liaison with primary care providers, acute health and emergency services, rehabilitation and support services, family, friends, support people and carers and other agencies that occur outside of the clinical encounter. Care Coordination and Liaison includes:

- Person centred interagency planning meeting (Case Conferences)
- Liaison and/or consultation with family, friends, support people and carers
- Liaison with other services/agencies including schools – verbal and written
- Transition Planning / Handover / Referral / Discharge Planning
- Multi-Disciplinary Team Reviews
- Medical records if outside of the clinical encounter.

For some people, an effective treatment plan includes coordinating services rather than the coordination of care of people at the individual level.

Care co-ordination and liaison is considered at two levels. The care coordination and liaison work undertaken as core business to effectively manage planning and service delivery is measured as part of the core hours assigned to particular clinical and non-clinical service providers and teams. Additional hours for care coordination and liaison are only identified where it is believed that the level of complexity is such that additional effort is required to supplement the coordination and liaison effort which would ordinarily be able to be provided as part of standard practice.

Average timeframe per activity (if applicable)

Average minimum time of 15 minutes
Average time:
- Preparation of report – 60minutes
- Tribunal attendance – 30 minutes

Forensic report writing - excluded

Description Source: Modified from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2013 Canberra (see Text Box excerpt).

Service coordination interventions

For some consumers, the progression of an effective treatment plan includes interventions involving consultation with others, for example, case conferencing, liaison with other professionals, and secondary consultations. It is planned that this category will also include those consultative processes involving the new 'care facilitator' role which was specified in the national mental health reform budget statement. MHIC code 8011.xx

Definition

This involves consultation with others, for example, case conferencing, liaison with other professionals, and secondary consultations. This category will also include those consultative processes involving the new care facilitator' role which was specified in the national mental health reform budget statement.

The following components:

- Case conferencing (MHIC code 8011.01)
- Liaison with other professionals (MHIC code 8011.02)
- Secondary consultations (MHIC code 8011.03)
- Service coordination for consumers with severe, persistent mental illness and complex care needs involving care facilitator (MHIC code 8011.04)
- Other service coordination (MHIC code 8011.05).

2.1.8.2 Service Element– Medico Legal Coordination and Liaison

- **Medico-Legal Activity related to the Mental Health Act**

Used to record ALL activities related to the administration of the Mental Health Act (the Act) - specific to each State - including the enactment or enforcement of the Act, or any other activity associated with the Act. All Mental Health Act related activities undertaken should be recorded under this code rather than using a more specific code.

- **Other Medico-Legal Activity Not related to the Mental Health Act**

Any activity associated with a legal act (excluding the Mental Health Act) pertaining to a person, including the enactment or enforcement of the Act, or any other activity associated with the Act.

Medico-legal activity may include*:

- Applications from the person with mental illness
- Applications from third parties (i.e. solicitors, teachers, family members)
- Court related requests (i.e. subpoenas, summons)
- Police Service requests (statements, search warrants, coronial investigations)
- Child Safety requests for reports and documents
- Other Third Parties (Insurance companies, non-party to the proceedings)
- Other Health Professionals (GP's, private agencies or professionals, and requests that are not required for the ongoing care or treatment of the person)

*N.B. This is not an exhaustive list

2.1.9 Service Category – Structured Psychological Therapies

Attribute	Details
Description	Those interventions which include a structured interaction between a participant and a qualified mental health professional(s) using a recognised, psychological method, for example, cognitive behavioural techniques, family therapy or psycho education counselling. These are recognised, structured or published techniques for the treatment of mental and emotional illnesses. Structured psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental health. The interventions embrace the following three approaches: Psychosocial therapy, Education and/or Counselling. Structured psychological therapies can be delivered on either an individual or group basis, typically in an office or community setting. **Structured Psychological Therapies include but are not limited to:** • Cognitive Behaviour Therapy • Dialectical Behaviour therapy (DBT). • Acceptance and Commitment Therapy (ACT) • Insight-oriented therapy • Psycho education • Cognitive Skills Training/Remediation • Couple therapy • Supportive psychotherapy • Play therapy • Interpersonal psychotherapy • Narrative therapy • Family, friends, support people and carers -focussed therapy and interventions **Techniques often used within cognitive and/or behavioural therapies include:** • Cognitive restructuring • Cognitive remediation • Desensitisation (graded exposure or exposure therapy) • Relapse-prevention • Relaxation • Response-prevention • Rational emotive therapy • Role play/rehearsal • Structured problem solving • Treatment adherence
Evidence Base	
Key Reference:	*Description Source: Modified from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2013 Canberra.*

2.1.9.1 Service Element – SPT Ultra Brief Intervention – Individual

These may be face to face; telephone; video conferencing and/or Skype. This structured interaction, less than 5 minutes, between a mental health participant and a qualified mental health professional using a recognised, psychological intervention - e.g., CBT, family therapy or psycho-education counselling. Psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental wellbeing.

Description Source: Modified from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2013 Canberra.

2.1.9.2 Service Element – SPT Therapy: Brief Intervention - Individual

This structured interaction, less than 15 minutes, between the person and a qualified mental health professional using a recognised, psychological method - e.g., CBT, family therapy or psycho-education counselling. Psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental wellbeing. It may be face to face; telephone; video conferencing and/or Skype (as a substitute for face to face consultation).

Description Source: expert advice.

2.1.9.3 Service Element – SPT Brief Intervention - Family

This is a structured interaction, less than 15 minutes, between the person's family and a qualified mental health professional using a recognised, psychological method - e.g., CBT, family therapy or psycho-education counselling. Psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental health. Family interventions focus on building personal capacity, resilience, coping skills and mutual support for family, friends, support people and carers. Includes services such as access to education and information, individual advocacy, intensive support to assist in navigating the mental wellbeing and community care systems. These may be face to face; telephone; video conferencing and/or Skype, dyadic work

Description Source: expert advice

2.1.9.4 Service Element – SPT Extended Intervention - Individual

This structured interaction, lasting 45 minutes, between the person and a qualified mental health professional using a recognised, psychological method - e.g., CBT, family therapy or psycho-education counselling. Psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental wellbeing. These may be face to face; telephone; video conferencing and/or Skype.

Description Source: expert advice

2.1.9.5 Service Element – SPT Extended Intervention - Family

This is a structured interaction, lasting 45 minutes, between the person's family and a qualified mental health professional using a recognised, psychological method - e.g., CBT, family therapy or psycho-education counselling. The scope of interventions is limited to family, friends, support people and carers. It should be noted that in this context, family, friends, support people and carers includes people who have a significant emotional connection to the person, such as friends and partners support person, and those who have a formal role as the person's carer. These may be face to face; telephone; video conferencing and/or Skype.

Description Source: expert advice

2.1.9.6 Service Element – SPT Extended Intervention - Group

This is a structured interaction, lasting 60 minutes, between people (on average 8) in a group setting (other than of a multiple-family group) facilitated by mental health clinicians (2) using a recognised, psychological method - e.g., CBT or psycho-education.

Description Source: expert advice

2.1.10 Service Category – Clinician Led Web-based Psychological Interventions

2.1.10.1 Service Element – Clinician Led Web-based Psychological Interventions

Clinician mediated e-Interventions include:

- Sole use of e-Interventions (computer based interventions) through establishment of an online clinic providing online counselling and/or prescription of e-Interventions and communication via email/skype. Offering an e-Intervention as the 'low intensity' treatment modality alternative.
- Offering the e-intervention component of a mixed service delivery model integrating other treatment modalities (e.g., provide a person with six face-to-face sessions and six e-Intervention sessions).
- Use of e-Interventions as adjuncts to supplement traditional face-to-face care.
- Another approach involves employing a stepped care model whereby e-Interventions may become the first major port of call for those with low level or mild mental health symptoms (Christensen, in press).

Description Source: http://www.psychology.org.au/publications/inpsych/2010/feb/klein/
e-Interventions and Psychology, by Associate Professor Britt Klein MAPS, Co-Director, National eTherapy Centre Faculty of Life and Social Sciences, Swinburne University

2.1.11 Service Category – Specialist Clinical Interventions – Other

2.1.11.1 Service Element – Specialist Clinical Interventions – Other

Specialist Clinical Interventions – Other - describes interventions carried out by specialist trained mental health clinicians during a service contact to improve, maintain or assess the health of a person that are not defined elsewhere. If not therapeutic or diagnostic, an intervention will nevertheless contribute materially to the improvement of a client's health, alter the course of a health condition or promote wellness. Interventions include invasive and non-invasive procedures, cognitive interventions and other interventions (including psychosocial interventions)

Description Source: Modified from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2013 Canberra.

2.1.12 Service Category – Physical Therapies

2.1.12.1 Service Element – Transcranial Magnetic Stimulation (TMS)

Transcranial Magnetic Stimulation (TMS) is a new treatment for depression and other psychiatric illnesses. There is an emerging consensus that TMS does have antidepressant effect and may play a useful role in the treatment of people diagnosed with depression.

TMS uses a very focused magnetic field to activate specific areas of the brain. Repeated TMS stimulation progressively alters brain activity improving depression in some people. TMS requires no anaesthesia or medication and generally you may go about normal activities immediately following the treatment.

Description Source: http://www.thevictoriaclinic.com.au/index.php/our-services/innovative-treatments-for-depression-tms/

2.1.12.2 Service Activity – Other Evidence Based Physical Therapies

Such as:

- Light therapy as a treatment for Seasonal Affective Disorder.

Description Source: Expert opinion - Dr Helen McGowan, NMHAS-Mental Health, Older Adult Program, Western Australia.

- Exercise for Older Adults

  Evidence- systematic review and meta-analysis of randomised controlled trials Access the most recent version at DOI: 10.1192/bjp.bp.111.095174 *BJP 2012, 201:180-185.*

- Sensory Modulation

Sensory modulation techniques include the use of sensory rooms (especially in hospital based settings) as well as strategies that can be implemented in the person's environment (e.g. home, work etc) that assist people to self-sooth, manage agitation, arousal, symptoms and distress, support emotional regulation techniques (such as mindfulness) and offer another strategy to assist in coping with the challenges of daily life and support occupational performance. Sensory profiling, sensory modulation techniques, sensory rooms, sensory diets, environments and interventions, have increasing recognition in trauma sensitive approaches and are becoming common tools to assist in the reduction of seclusion and restraint in acute settings. Research shows individuals with a trauma history, mental illness, addictions, or those who have developed problematic behavioural patterns, are sometimes unaware of their particular sensory needs or stress responses.

References:

Miller LJ, Reisman JE, McIntosh DN, et al. An ecological model of sensory modulation: Performance of children with fragile X syndrome, autistic disorder, attention-deficit/ hyperactivity disorder, and sensory modulation dysfunction. In: Smith-Roley S, Blanche EI and Schaaf RC (eds). *Understanding the nature of sensory integration with diverse populations*. San Antonio, TX: Therapy Skill Builders, (2001), pp.57–88.

Champagne T and Stromberg N. Sensory approaches in inpatient psychiatric settings: Innovative alternatives to seclusion and restraint. *J Psychosoc Nurs* (2004) 42: 1–8.;

Chalmers, A., Harrison, S., Mollison, K., Molloy, N.,and Gray, K., Establishing sensory-based approaches in mental health inpatient care: a multidisciplinary approach *Australasian Psychiatry* (2012) 20: 35

Novak, T., Scanlan, J., McCaul, D., MacDonald N,.and Clarke, T., Pilot study of a sensory room in an acute inpatient psychiatric unit *Australasian Psychiatry* (2012) 20: 401

Te Pou o te Whakaaro Nui *Sensory modulation in mental health clinical settings: A review of the literature*, Auckland , Te Pou o te Whakaaro Nui, (2011)

Note that Electro-Convulsive Therapy (ECT) is shown under Bed Based Services

2.1.13 Service Category– Pharmacotherapy

2.1.13.1 Service Element – Pharmacotherapy Prescription

Pharmacotherapy prescription encompasses the clinical assessment and subsequent judgement that pharmacotherapy is appropriate and indicated for the person. It typically will also involve the prescribing of an appropriate pharmacological agent and may include the preparation and administration of oral or depot intramuscular injection (IMI). As well as details of the medication prescribed, the administration route and whether the prescription is new or a repeat, is collected.

Description Source: AIHW 2013. Development of a prototype Australian mental health intervention classification: a working paper. Working papers and data briefings. Cat. no. HSE 130. Canberra: AIHW. <http://www.aihw.gov.au/publication-detail/?id=60129542689>.Further details at Annex B: Psychopharmacotherapeutic Drug for the MHIC

2.1.13.2 Service Element – Pharmacotherapy Review

This incorporates a review of a person's current medication regime to determine appropriateness of the regime and an assessment of the person's ability to manage medication safely. It may be further disaggregated to:

- Pharmacotherapy Review A - No additional monitoring/imaging
- Pharmacotherapy Review B - Medium Monitoring
- Pharmacotherapy Review C - High Monitoring

Description Source: Expert Working Group advice combined with the AIHW 2013. Development of a prototype Australian mental health intervention classification: a working paper.

2.1.14 Individual Practitioner Staffing Profiles for this Service Stream

2.1.14.1 Mild and Moderate Care Packages

Individual Practitioners - Mild and Moderate

SCHEME	STAFF CATEGORY	FTE	Other time %	Gross available daily hours (wkly/5)	Net consumer service available daily delivery hours	Net consumer service annual delivery hours	Available hours per annum per FTE	Weighted average salary **	Cost	FTE % share	Over heads
NMHSPF	TOTAL	10.00		78.96	67.12	15,436.68	1,544	$98,338	1,080,379	100%	0%
NMHSPF	Vocationally Qualified	2.00	0.15	15.20	12.92	2,972	1,486	$45,724		100%	23%
NMSPF	Peer Worker	2.00	0.15	15.20	12.92	2,972	1,486	$58,831		100%	23%
NMHSPF	Tertiary Qualified	4.00	0.15	31.04	26.38	6,068	1,517	$128,648		100%	0%
NMHSPF	Medical	2.00	0.15	17.53	14.89	3,425	1,650	$179,837		100%	0%

Mild and Moderate

NMHR	TOTAL	Total FTE (includes Leave)	Other time %	Hours available/5 days	Consumer service delivery hours daily	Consumer Service delivery hours annual	Available hours/annum/FTE	Salary **	Cost			
NMHR					14.89	3,425.16						
NMHR	General Practitioner	1.00	0.15	8.44	7.17	1,650	1,650	$179,837	$179,837	100%	0%	P is not regular penalty column
NMHR	Psychiatrist	1.00	0.15	9.06	7.72	1,775	1,775	$255,686	$255,686	100%	0%	
NMHR	Registrar											
NMHR	Junior Medical Officer											
NMHR	Other Medical Specialist											
NMHR												
NMHR	Registered Nurse											
NMHR	Nurse Practitioner											
NMHR	Enrolled Nurse											
NMHR					26.38	6,068.32						
NMHR	Psychologist	1.00	0.15	7.76	6.60	1,517	1,517	$128,648	$128,648	100%	0%	
NMHR	Social Worker	1.00	0.15	7.76	6.60	1,517	1,517	$128,648	$128,648	100%	0%	
NMHR	Occupational Therapist	1.00	0.15	7.76	6.60	1,517	1,517	$128,648	$128,648	100%	0%	
NMHR	Other TQ (eg pharmacist)	1.00	0.15	7.76	6.60	1,517	1,517	$128,648	$128,648	100%	0%	
NMHR					25.84	5,943.20						
NMHR	Consumer Peer Worker	1.00	0.15	7.60	6.46	1,486	1,486	$58,831	$58,831	100%	23%	Regular penalty
NMHR	Carer Peer Worker	1.00	0.15	7.60	6.46	1,486	1,486	$58,831	$58,831	100%	23%	
NMHR	VQMH Worker	1.00	0.15	7.60	6.46	1,486	1,486	$45,724	$45,724	100%	23%	
NMHR	VQ Other	1.00	0.15	7.60	6.46	1,486	1,486	$55,477	$55,477	100%	23%	

Description		Nursing								Medical						Allied Health					Peer Workers		Voc Qual			ACMHP
		Director	DNG/MJMNC	CN	RN	Enrolled Nurse	Graduate Nurse Trainee	Nurse Practitioner	Nursing Total	General Practitioner	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	42.2	45.4	45	45		Worked	38.6	38.0	38.0	38.0		38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs			Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day				7.6			0	15	6.4	9.1				18	7.6	7.6	7.6	7.6	31.0	7.6	7.6	7.6	7.6	30.4	94
	Evening	-							-						-					-					-	-
	Night	-							-						-					-					-	-
Tuesday	Day				7.6			0	15	6.4	9.1				18	7.6	7.6	7.6	7.6	31.0	7.6	7.6	7.6	7.6	30.4	94
	Evening	-							-						-					-					-	-
	Night	-							-						-					-					-	-
Wednesday	Day				7.6			0	15	6.4	9.1				18	7.6	7.6	7.6	7.6	31.0	7.6	7.6	7.6	7.6	30.4	94
	Evening	-							-						-					-					-	-
	Night	-							-						-					-					-	-
Thursday	Day				7.6			0	15	6.4	9.1				18	7.6	7.6	7.6	7.6	31.0	7.6	7.6	7.6	7.6	30.4	94
	Evening	-							-						-					-					-	-
	Night	-							-						-					-					-	-
Friday	Day				7.6			0	15	6.4	9.1				18	7.6	7.6	7.6	7.6	31.0	7.6	7.6	7.6	7.6	30.4	94
	Evening	-							-						-					-					-	-
	Night	-							-						-					-					-	-
Saturday	All shifts	-	-			-			-						-					-					-	-
Sunday	All shifts	-	-			-			-						-					-					-	-
Total Hours per week		-	-	-	38	-	-	38	76	42	45	-	-	-	88	38.0	38.0	38.0	38.0	155	38.0	38.0	38.0	38.0	152.0	471
Annual & Other Leave Relief weeks		0	0	0		0		10					0	0												
On Call Episodes (weighted)																										
Public Holidays Worked		0	0		11	11		11	11				11	11												
Productive Weeks per FTE		44.14	44.14	43.14	44.03	43.14		35.14	44.00			44.00	44.14	44.14	46.00					46.00					46.00	46.00
Day Shift Hours (Mon-Fri)		-	-	-	38	-	-	38	76	42.2	45.4	-	-	-	88	38	38	38	38	155	38	38	38	38	152	471
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Hours		-	-	-	38	-	-	38	76	42.2	45.4	-	-	-	88	38	38	38	38	155	38	38	38	38	152	471
Weekly FTE's		-	-	-	1.0	-	-	1.0	2.0	1.0	1.0	-	-	-	2.0	1.0	1.0	1.0	1.0	4.0	1.0	1.0	1.0	1.0	4.0	12.0
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Annual FTE's		-	-	-	1.0	-	-	1.0	2.0	1.0	1.0	-	-	-	2.0	1.0	1.0	1.0	1.0	4.0	1.0	1.0	1.0	1.0	4.0	12.0

*Overheads is an estimate of costs associated with other services including corporate overheads, security services, cleaning other non-labour costs including communicatio, transport, utilities and maintenace etc. It is expressed as a proportion of labour costs.
** Average annual salary escalated to include overtime, on call and other penalty rate allowances

2.1.14.2 Severe Care Packages

Individual Practitioners - Severe

SCHEME	STAFF CATEGORY	FTE	Other time %	Gross available daily hours (wkly/5)	Net consumer service available daily delivery hours	Net consumer service annual delivery hours	Available hours per annum per FTE	Weighted average salary **	Cost	FTE % share	Over heads
NMHSPF	TOTAL	12.00		92.84	58.63	13,210.04	1,101	91,452	1,097,425	100%	0%
NMHSPF	Vocationally Qualified	2.00	0.33	15.20	10.18	2,299	1,149	$45,724		100%	23%
NMHSPF	Peer Worker	2.00	0.33	15.20	10.18	2,299	1,149	$58,831		100%	23%
NMHSPF	Tertiary Qualified	5.00	0.33	38.00	25.46	5,695	1,149	$95,532		100%	23%
NMHSPF	Medical	3.00	0.27	24.44	17.89	4,016	1,183	$136,885		100%	23%

Inter- Severe

NMHR	TOTAL	Total FTE (includes Leave)	Other time %	Hours available/5 days	Consumer service delivery hours daily	Consumer Service delivery hours annual	Available hours/annum/FTE	Salary **	Cost		
NMHR					17.89	4,015.92					
NMHR	General Practitioner	1.00	0.15	8.44	7.17	1,650	1,650	$179,837	$179,837	100%	0%
NMHR	Psychiatrist	1.00	0.33	8.00	5.36	1,183	1,183	$200,564	$200,564	100%	23%
NMHR	Registrar	1.00	0.33	8.00	5.36	1,183	1,183	$136,885	$136,885	100%	23%
NMHR	Junior Medical Officer										
NMHR	Other Medical Specialist										
NMHR											
NMHR	Registered Nurse										
NMHR	Nurse Practitioner	1.00	0.33	7.60	5.09	1,098	1,098	$135,388	$135,388	100%	23%
NMHR	Enrolled Nurse										
NMHR					20.37	4,597.06					
NMHR	Psychologist	1.00	0.33	7.60	5.09	1,149	1,149	$95,532	$95,532	100%	23%
NMHR	Social Worker	1.00	0.33	7.60	5.09	1,149	1,149	$95,532	$95,532	100%	23%
NMHR	Occupational Therapist	1.00	0.33	7.60	5.09	1,149	1,149	$95,532	$95,532	100%	23%
NMHR	Other TQ (eg pharmacist)	1.00	0.33	7.60	5.09	1,149	1,149	$95,532	$95,532	100%	23%
NMHR					20.37	4,597.06					
NMHR	Consumer Peer Worker	1.00	0.33	7.60	5.09	1,149	1,149	$58,831	$58,831	100%	23%
NMHR	Carer Peer Worker	1.00	0.33	7.60	5.09	1,149	1,149	$58,831	$58,831	100%	23%
NMHR	VQMH Worker	1.00	0.33	7.60	5.09	1,149	1,149	$45,724	$45,724	100%	23%
NMHR	VQ Other	1.00	0.33	7.60	5.09	1,149	1,149	$55,477	$55,477	100%	23%

Description		Nursing: Director	Nursing: CNC/NUM/NC	Nursing: CN	Nursing: RN	Nursing: Enrolled Nurse	Nursing: Graduate Nurse Training	Nursing: Nurse Practitioner	Nursing Total Worked	Medical: General Practitioner	Medical: Psychiatrist	Medical: Registrar	Medical: Jun Med Off	Medical: Other Specialist	Medical Total Worked	Allied Health: Psychologist	Allied Health: Social Worker	Allied Health: Occupational Therapist	Allied Health: Other	Allied Health Total Worked	Peer Workers: Consumer Peer Worker	Peer Workers: Carer peer Worker	Voc Qual: VQ MH Worker	Voc Qual: VQ Other	VQ Total Hours Worked	AOMHP: All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38		42.2	40	40	40			38	38	38	38		38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs			Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day				7.6			8	15	8.4	8.0	8			24	7.6	7.6	7.6	7.6	30.4	7.6	7.6	7.6	7.6	30.4	100
	Evening	-							-						-					-					-	-
	Night	-							-						-					-					-	-
Tuesday	Day				7.6			8	15	8.4	8.0	8			24	7.6	7.6	7.6	7.6	30.4	7.6	7.6	7.6	7.6	30.4	100
	Evening	-							-						-					-					-	-
	Night	-							-						-					-					-	-
Wednesday	Day				7.6			8	15	8.4	8.0	8			24	7.6	7.6	7.6	7.6	30.4	7.6	7.6	7.6	7.6	30.4	100
	Evening	-							-						-					-					-	-
	Night	-							-						-					-					-	-
Thursday	Day				7.6			8	15	8.4	8.0	8			24	7.6	7.6	7.6	7.6	30.4	7.6	7.6	7.6	7.6	30.4	100
	Evening	-							-						-					-					-	-
	Night	-							-						-					-					-	-
Friday	Day	-			7.6			8	15	8.4	8.0	8			24	7.6	7.6	7.6	7.6	30.4	7.6	7.6	7.6	7.6	30.4	100
	Evening	-							-						-					-					-	-
	Night	-							-						-					-					-	-
Saturday	All shifts	-	-			-			-						-					-					-	-
Sunday	All shifts	-	-			-			-						-					-					-	-
Total Hours per week		-	-	-	38	-	-	38	76	42	40	40	-	-	122	38.0	38.0	38.0	38.0	152	38.0	38.0	38.0	38.0	152.0	582
Annual & Other Leave/Relief weeks		6	6	6		6	6	6					6													
On Call Episodes (weighted)																										
Public Holidays Worked		0	0		11	11	11	11					11													
Productive Weeks per FTE		44.14	44.14	43.14	44.68	42.14	38.14	43.14		46.00	44.14	44.14	44.14	46.00		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	38	-	-	38	76	42.2	40.0	40	-	-	122	38	38	38	38	152	38	38	38	38	152	582
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Hours		-	-	-	38	-	-	38	76	42.2	40.0	40	-	-	122	38	38	38	38	152	38	38	38	38	152	582
Weekly FTEs		-	-	-	1.0	-	-	1.0	2.0	1.0	1.0	1.0	-	-	3.0	1.0	1.0	1.0	1.0	4.0	1.0	1.0	1.0	1.0	4.0	13.0
Relief FTEs		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Annual FTEs		-	-	-	1.0	-	-	1.0	2.0	1.0	1.0	1.0	-	-	3.0	1.0	1.0	1.0	1.0	4.0	1.0	1.0	1.0	1.0	4.0	13.0

*Overheads is an estimate of costs associated with other services including corporate overheads, security services, cleaning other non-labour costs including communicatio, transport, utilities and maintenance etc. It is expressed as a proportion of labour costs.
** Average annual salary escalated to include overtime, on call and other penalty rate allowances

2.1.15 Service Category and Element removed from this Service Stream

Service Stream – Primary and Specialised Clinical Ambulatory Mental Health Care Services
Service Category – Early Psychosis Services 15-24 years
Service Element – Early Psychosis Services 15-24 years

Initially when developing the Taxonomy and the Early Psychosis Services Care Packages, it was expected that this care would be modelled via this Service Element and a staffing team profile. As the Care Packages were developed, it was found that existing service elements could be used instead. The Service Element – Early Psychosis Services 15-24 years and Service Category – Early Psychosis Services 15-24 years were removed from the Taxonomy.

Attribute	Details
Description	Early Psychosis (EP) services aim to facilitate early identification and treatment of psychosis and therefore reduce the disruption to the young person's functioning and psychosocial development. The key functions of an EP service are to: ▪ improve early identification and treatment for young people at risk of psychotic illness ▪ facilitate access to age-appropriate assessment ▪ explore the possible causes of psychotic symptoms and treat them ▪ reduce delays in initial treatment to reduce disruption in a young person's restoring the normal developmental trajectory and psychosocial functioning ▪ provide meaningful interventions that are based on assertive outreach principles that promote functional recovery, reduce frequency and severity of relapse, and prevent or delay the first relapse ▪ involve families, carers, significant others and peers in care reducing the burden for carers and reducing the disruption ▪ educate the young person and their family members ▪ reduce the stigma associated with psychosis and improve professional and community awareness of the symptoms of psychosis and the need for early intervention ▪ develop meaningful engagement, provide evidence-based interventions, promote recovery during each phase of illness, and promote positive social, occupational and educational outcomes ▪ provide a seamless service for young people experiencing EP that effectively integrates child , and adult mental health service (MHS) streams, and works in partnership with primary care, education, social services, youth services and other sectors ▪ at the end of the treatment period, ensure that care is transferred thoughtfully and in a timely manner Predominantly, Early Psychosis (EP) services are based in the community and the majority of EP service provision will occur in the home, a community clinic, a general practice or other nominated place within the community. In some circumstances, service provision may be delivered as part of an inpatient admission and the EP service will ensure continuity of care during this time.
Fundamental Attributes	Early Psychosis services provide early detection and treatment for young people aged 15 – 24 years (inclusive) who are at risk of or are experiencing Early Psychosis. The service unites the child and adolescent (0 – 18 years) and adult (18 years and over) mental health service streams in the provision of care to young people (15-24 years) There is a developmental focus of care, with an emphasis on assertive therapeutic outreach and holistic care involving family, friends, support people and carers and organisations across the child and adolescent (youth) sector.
Service specifications and suggested modelling attributes	
Target Age:	15-24 years

Target Population Profile	15-24 years with emerging psychotic illnesses
Workforce	Nursing, Allied Health, Medical, Psychiatry
Hours of Operation	Extended hours
Gross Cost per activity (If applic)	N/A
Evidence Base	
Level of Evidence:	1
Key Reference Sources:	• Primary Source: Early Psychosis Prevention and Intervention Centre http://eppic.org.au/eppic-clinical-guidelines • Modified from Queensland Public Mental Health Services Models of Service Early Psychosis 2011 (Endorsed Executive Director Mental Health, Queensland 02/07/2010) • Amminger, G.P., et al., Outcome in early-onset schizophrenia revisited: findings from the • Early Psychosis Prevention and Intervention Centre long-term follow-up study. Schizophrenia Research, 2011. 131(1-3): p. 112-9. • Killackey, E., Review: early intervention services can be clinically beneficial for people with early psychosis. Evidence Based Mental Health, 2011. 14(2): p. 50. • McGorry, P., Early Intervention in Psychiatry: the critical period. Early Intervention in Psychiatry, 2011. 5(1): p. 1-2. • 70. McGorry, P., The mental health of young people: a new frontier in the health and social policy of the 21st century. Early Intervention in Psychiatry, 2011. 5: p. 1-3. • Alvarez-Jimenez, M., et al., Preventing the second episode: a systematic review and meta-analysis of psychosocial and pharmacological trials in first-episode psychosis. Schizophrenia Bullettin, 2011. 37(3): p. 619-630.
Limitations of Evidence:	Nil
Recommendations for future research:	

2.2 SERVICE STREAM – SPECIALISED MENTAL HEALTH COMMUNITY SUPPORT SERVICES

Service Stream		Specialised MH Community Support Services
Service Category	**G**	**Group Support and Rehabilitation Services**
Service Element	GR	Group Support and Rehabilitation
Service Activity	GR1	Group Support and Rehab linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well
Service Activity	GR2	Group Support and Rehab linked to early childhood, education and/or employment
Service Activity	GR3	Group Support and Rehab linked to enhanced relationships and social participation
Service Activity	GR4	Group Support and Rehab linked to navigating the primary and mental health care systems
Service Element	GP	Group Based Peer Work
Service Activity	GP1	Group Based Peer Work - Moderate
Service Activity	GP2	Group Based Peer Work - Severe
Service Activity	GP3	Group Based Carer Peer Work - Moderate
Service Activity	GP4	Group Based Carer Peer Work - Severe
Service Category	**I**	**Individual Support and Rehabilitation Services**
Service Element	IR	Individual Support and Rehabilitation
Service Activity	IR1	Individual Support and Rehab linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well
Service Activity	IR2	Individual Support and Rehab linked to early childhood, education and/or employment
Service Activity	IR3	Individual Support and Rehab linked to enhanced relationships and social participation
Service Activity	IR5	Individual Support and Rehab linked to health management services
Service Activity	IR6	Individual support and Rehab linked to Community Aged Care
Service Activity	IR7	Flexible Funding Pool - Consumer
Service Element	IP	Individual Peer Work
Service Activity	IP1	Individual Peer Work
Service Activity	IP2	Individual Carer Peer Work
Service Category	**O**	**Other Residential Services**
Service Element	OC	Residential Crisis and Respite Services
Service Category	**F**	**Family and Carer Support**
Service Element	FR	Flexible Respite
Service Element	FD	Day Respite
Service Element	FS	Family Support Services
Service Element	FG	Group Carer Support Services
Service Activity	FG1	Group Carer Support linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well
Service Activity	FG2	Group Carer Support linked to education and/or employment
Service Activity	FG3	Group Carer Support linked to enhanced relationships and social participation
Service Activity	FG4	Group Carer Support linked to health management
Service Element	FI	Individual Carer Support Services
Service Activity	FI1	Individual Carer Support linked to accessing and maintaining safe and secure

		housing including practical skills for maintaining a home and living well
Service Activity	FI2	Individual Carer Support linked to education and employment
Service Activity	FI3	Individual Carer Support linked to enhanced relationships and social participation
Service Activity	FI4	Individual Carer Support linked to health management
Service Activity	FI5	Flexible Funding Pool - Carer

2.2.1 Service Category – Group Support and Rehabilitation Services

Descriptor

Group support and rehabilitation activities are services that aim to improve the quality of life and psychosocial functioning of people using mental health services, through the provision of group-based social, recreational or prevocational activities. With the exception of peer support services, group support activities are led by a member of the community managed organisation.

Distinguishing Features

- Delivered to groups of people simultaneously
- Primarily engage people in one or more social, recreational, prevocational or physical activities
- Centre-based or conducted in community environments
- Led by an employee or representative of a community managed organisation that may or may not be a peer worker.
- Structured or unstructured group support and activities

Inclusions

- Neighbourhood, community and drop-in centres
- Structured community day programs
- Leisure and recreation activities
- Psychological educational programs
- Clubhouses
- Support for day-to-day living

Exclusions

- Self-help and mutual support activities delivered on a group basis.

Example Services

- Helping Hands
- Pananga Clubhouse

Taxonomy

- Group Based Support and Rehabilitation
- Group Based Peer Support

Description Source: AIHW Non-Government Organisation Establishment (NGOE) National Minimum Dataset (NMDS) Service Taxonomy (draft January 2013)

2.2.1.1 Service Element – Group Support and Rehabilitation

Attribute	Details
Description	Group based services that aim to improve the quality of life and psychosocial functioning of people using mental health services. Included in this element are psychosocial group programs, recovery oriented groups (eg. Exercise/Sport/Recreational, Community Access, life skills, health management, volunteering, opportunity programs, individual/ family/ friend/ carer education, arts based therapeutic services, leadership programs, relaxation/mindfulness and groups for specialised populations). Groups may be centre based (eg day program) or Sessional (eg 2hrs per week) in nature and may or may not be structured, time limited or ongoing. Note that these groups may or may not be run by peer workers, but exclude groups that are specifically delivered by peer workers, as this is covered under Group Based Peer Work
Fundamental Attributes	Key distinguishing attributes would be services that may or may not require a specific facility but could be hosted in a number of environments. Note that dedicated peer support services are included in the Group Based Peer Work Element and are out of scope for this element.

Service specifications and suggested modelling attributes	
Activities:	• **Group Support and Rehab linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well** • **Group Support and Rehabilitation linked to education and employment.** • **Group Support and Rehabilitation linked to enhancing relationships and social participation** • **Group Support and Rehabilitation linked to health management.**
Target Age:	16-64 yrs
Target Pop'n Profile	People with moderate to severe mental illness.
Avg timeframe and frequency per activity	Low Support (eg. Drop in Centres) 2 hrs per day, 1.5 days per week, 15 weeks per year Medium Support (eg. Structured Part Day Programs) – 3hrs per day, 3x days per week x 25 weeks per year High Support (Full Day Program)– 6 hrs per day, 5 days per week, x 46 wks per year
Hours of Operation and Proportion BH and AH	Day Program: Business Hours Flexible Hours – Drop in Centre

Workforce

Workforce Type	SCHADS Award Level	Hours worked	Proportion of Business hours and After Hours	Estimated % of Direct Care
Tertiary Qualified	Level 6	1.0 FTE	Business hours only	30% Direct Care
Vocational Qual	Level 5	1.0 FTE	75% BH and 25% AH	70% Direct Care
Vocational Qual	Level 3-4	3.5 FTE	75% BH and 25% AH	80% Direct Care

Average 6x participants per facilitator/staff member.

Evidence Base

Level of Evidence:	
Key Reference:	
Limitations of Evidence:	
Recommendations for future research:	

Service Activity – Group Support and Rehab linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well

Group support and rehabilitation services are provided specifically towards an individual's personal goals of the establishment and maintenance of safe and secure housing and living well. The concept of safe and secure housing encompasses:

- Sustainability (security) of tenure or ownership of a dwelling suitable to the needs of the individual/ family/ friend/ support person or carer
- Financial security through affordable rental or mortgage repayments, budgeting and ongoing ability to pay household bills, including during periods of being unwell
- Physical safety and security through well-maintained property and access to support for managing crises
- Environmental safety and security through social and cultural acceptance and access to neighbourhood facilities.

The services are provided on a group basis, and may be provided for individuals stepping down from residential care, assist an individual to maintain or change their housing circumstances (e.g. Individuals living with family members or in group accommodation, homeless individuals or for those living independently and are at risk of homeless).

Critical factors to succeed in housing includes the availability of affordable housing, effectively engaging the housing market, maintaining personal wellness, adequate income, housekeeping and budget management skills, the provision of adequate transport and being able to successfully navigate the individual's neighbourhood and access services as required.

Information Gathering

Group based assessment of psychosocial needs and functional assessment identifying housing needs, support available, personal strengths and areas for development; including the provision of information that identifies different housing options and outlines access issues.

Planning

Development of a person centred recovery plan inclusive of support networks driven by the individual that identifies housing goals, referral pathways, housing providers, resource options and advocates as appropriate and associated skill development and action required.

Action

As per the recovery plan, support the individual in establishing and maintaining housing arrangements including:

- Resources: Establish financial resources, legal and tenancy support, practical support (both personally and in relation to property maintenance) and processes to support skill development. Engaging assertively with the housing market is critical to establishing safe and secure housing. Particularly in the context of liaising/networking and following up on commitments made, supporting accommodation hunting and development of the housing application. Also support the individual to

access public housing tenancy support officers and rental assistance schemes, or assist with the installation of security devices, advancing or assisting with bond money and removal costs.
- Skill Development: with a focus on Rehabilitation to improve competence and confidence in community living, particularly in relation to managing tenancy matters.
- Social/Cultural Context: Ensure housing allocation is safe and appropriate to personal and cultural circumstances. Address stigma, provide flexible support tailored to individual need to promote the likelihood of successful housing arrangements.
- Health and Wellbeing: Improve independence and resilience and ensure appropriate support is provided to maintain a healthy home environment.

Outcomes

Stability of housing and individual housing goals are met along with critical success factors for maintaining that housing.

Collaboration

Individual and their family/ friends / support people or carers, housing providers, income support or management, mental and general health clinical and community support services, financial brokers, tribunals and other social, health and community opportunities.
There is a need to establish mental health support positions dedicated to housing issues to enhance secure housing outcomes and enhance intersectoral links, particularly between mental health, generic and dedicated housing and other social support services.

Service Activity – Group Support and Rehab linked to early childhood, education and/or employment

General description

Group support and rehabilitation services provided specifically towards an individual's personal goals towards education and or employment. The services are provided on a group basis, and generally target the functions of accessing and supporting education and employment opportunities rather than providing the education and employment services themselves.

Information Gathering

Group based exploration of psychosocial needs and functional assessment identifying education and employment targets, motivation to work and/or study, self-identified support needs, support available, personal strengths and areas for development. Also includes the provision of information that identifies different education/employment options and outlines access issues.

Planning

Development of a person centred recovery plan inclusive of support networks driven by the individual that identifies education and/or employment goals, referral pathways, service providers, resource options and advocates as appropriate and associated skill development and action required. Particularly need to consider the long term of positive effects of supporting individuals back into school, which further supports post-secondary study and subsequent employment opportunities *(McLaren, K (2004) Work in Practice – Best practice employment support services for people with mental illness, NZ)*.

Action

As per the recovery plan, support the person in accessing and maintaining education and employment through the following activity:

- Resources: Provide career counselling and assistance in course selection and enrolment procedures, linking to disability liaison or counselling services as required. (VETE) Establish financial counselling and access to financial support, transport services and employment/education

practical support. Engage assertively with the employment and education providers to ensure a flexible and supportive environment is established. Ensure mental health staff respond flexibly to the needs and availability of the individual around their work/education commitments and pressures. Regular review meetings with the individual and both mental health and employment and/or education services. Where appropriate, family/ friends/ support people and carers should be involved in the review process.

- Skill Development (including Rehabilitation Focus): Preventing relapse and coping with work/education pressures. Establishing effective employment or study strategies early in the illness trajectory may have life-long impact on employment outcomes, preventing secondary disability and associated economic and social costs. Providing a specialist VETE service ensures employment and education remain a high priority when other issues required addressing by the care coordinator (eg decline in mental or physical health). (VETE)
- Social/Cultural Context: Address stigma in the work/education environment. Provide flexible support tailored to individual need, tutoring and flexible delivery of education courses or employment arrangements promotes the likelihood of success. (VETE)
- Health and Wellbeing: Close links and integration with care coordination services, primary care, crisis intervention and accommodation issues will support the stability of health without detracting from progressing the vocational and educational goals of the individual. (VETE)

Outcomes

Completion of studies or vocational training. Participation in supported or open employment, independent income, sustained or stable involvement in employment and education.

Collaboration

Foster a close working relationship with income support services and Job Capacity Assessors to ensure referrals to employment services are processed appropriately. Need to establish mental health clinical and support positions dedicated to vocational and educational issues to enhance employment and educational outcomes. Enhanced intersectoral links, particularly between mental health, generic employment and education services (e.g. Resume production, course content information), Disability Employment Services, TAFE, Universities and other social support services.

Description Source:

Frost, B., Morris, A., Sherring, J. and Robson, E. (2008) Vocational Education, Training and Employment (VETE) Pilot Project Report – Psychiatric Rehabilitation Services 2006-2007, NSW Health, Sydney.

Service Activity – Group Support and Rehab linked to enhanced relationships and social participation

General description

Group based interventions working with the individual to identify and develop interests. Work with the person to access activities within the community to participate in. Working with the individual to identify relationships which are important to them, and work on developing, maintaining and growing those relationships.

Information Gathering

Identify with the person what their interests are and identify what is available in the community. Identifying support people who may be available to assist with accessing and participating in community activities.

Planning

Working with the person to develop a person centred recovery plan inclusive of support networks, which involves developing the skills to find, access and participate in community activities. Assisting the person to plan every aspect of participation in social activities, this will involve identifying the resources and skill development required.

Action:

As per the person centred recovery plan inclusive of support networks:

- Resources: Establish financial resources in order to assist with funding community activities or access to community activities. Identify and establish support to access and engage in community activities eg transport, travel skill development etc. Identify support people to assist with community integration and participation (may include workers).
- Skill Development (including Rehabilitation Focus): identify and develop skills required to access and participate in community activities e.g. ability to catch the bus, social presentation and skills,
- Social/Cultural Context: ensure activities planned are socially and culturally appropriate and safe for the person.
- Health and Wellbeing: ensure that activities planned will assist with the development of improved health and well being.

Outcomes

Increasing social participation and community engagement in order to meet goals connected to social inclusion.

Collaboration

Individual/ family / friends/ support people and carers, organisations providing courses and activities, educational and vocational providers, community organisations, non government organisations

Description Source: Expert Working Group input

Service Activity – Group Support and Rehab linked to navigating the primary and mental health care systems

General description

Group based programs assisting a person to improve or maintain his or her health or wellness. People with serious mental illness experience a life expectancy 25 years less than the general population – this is mainly due to physical health issues related to smoking, obesity and lack of physical activity. (J.Parks “25 years too late” http://www.abc.net.au/rampup/articles/2012/09/10/3586516.htm). It needs to be noted that not all people with a serious mental illness experience issues related to smoking, lack of physical exercise or obesity and therefore not all people will require support and / or skills building in these areas. Actively seeking or establishing strategies and activities that promote good health and wellbeing. Examples might include regular physical health assessment and treatment as appropriate, massage and other forms of relaxation activities, counselling and peer support, recreational activities, skill development in health practices (e.g. Cooking, cleaning, fitness).

Information Gathering

Engage the participant in a relationship of trust to develop a plan for health management. Assess health status (including physical and mental health) identifying barriers and enablers for good health. Include a review of physical and mental health needs, thorough history and review of medication (both physical and otherwise). Provide a collation of physical and dental health contacts and connect to these services. Assess readiness for change and skills connected with coping, health management, menu planning, shopping, cooking and fitness. Assessing readiness to engage in quit smoking initiatives (where applicable).

Planning

Prioritise and set health and wellness goals by formulating a health and wellness plan, that is driven by the person with support in the planning process.

Action

In the context of a group format, support the person in developing healthy behaviours and support access and use of resources as appropriate:

- Resources: Nicotine replacement therapy, brokerage funds (e.g. to assist in accessing gym memberships or exercise clothes), respite and/or personal support services,
- Skill Development (including Rehabilitation Focus): Support the person in developing skills in healthy practices and overall health management and to engage or disengage in activities which assist in improving health
- Social/Cultural Context: Utilising support and respite services as required to maintain and promote social relationships in work, education and social/cultural environments.
- Health and Wellbeing: As above.

Outcomes

Better life expectancy stats – people with serious mental illness having decreased rates of smoking, obesity and increased rates of physical exercise – lower rates of cardiovascular disease, respiratory disease etc, lower rates of hospitalisation, presentation to EDs for physical health issues etc.

Collaboration

General Practice and other health services, community health management organisations (Eg. gyms, swimming pools, weight management services, smoking cessation services), other recreational, educational and vocational services and mental health care and related support services.

Description Source: Expert Working Group input

Service Activity – Group Support and Rehab – Staffing Profile

Summary of Staffing Profile for Group Support and Rehabilitation

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Overheads %
NMHSPF	TOTAL	6.35		41.80	20.63	7,530	1,185	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	5.20	0.25	24.43	19.00	6,936	1,334	39,186	203,704	82%	20%
NMSPF	Peer Worker	-	0.25	-	-	-		#DIV/0!	-	0%	20%
NMHSPF	Tertiary Qualified	1.16	0.35	5.43	1.63	594	515	-	-	18%	20%
NMHSPF	Medical	-	0.25	-	-	-		-	-	0%	20%

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost		O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	1.16		5.43	1.63	594	515		$65,275	18%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmacis	1.16	0.70	5.43	1.63	594	515	$56,511	$65,275	18%	20%
NMHR	**VQ and Peer Workers**	5.20		24.43	19.00	6,936	1,334		$248,966	82%	20%
NMHR	Consumer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Carer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	VQMH Worker	4.04	0.20	19.00	15.20	5,548	1,372	$45,724	$184,853	64%	20%
NMHR	VQ Other	1.16	0.30	5.43	3.80	1,388	1,201	$55,477	$64,114	18%	20%
	Total Available Hours					7530.16					

Annual Cost Salaries	$314,241
*** Including Overheads 20.0%**	$377,089

Information from Care Package	
Hours Per Annum for an individual	220
Particpitants per service Provider	6
Total Target Population for care pa	2,250
Total Hours Req per Annum	82,500

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	1,085	2.11		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	1,085	2.11	$56,511	$119,191
NMHR	**VQ and Peer Workers**	12,665	9.49		#DIV/0!
NMHR	Consumer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	Carer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQMH Worker	10,131	7.38	$45,724	$337,539
NMHR	VQ Other	2,534	2.11	$55,477	$117,071

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

594.43

Description		Nursing								Medical					Allied Health						Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other SCHADS L6 1.0 FTE 100%BH	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker SCHADSL3 3.5FTE 70%BH	VQ Other SCHADS L5 1.0FTE 70%BH	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-				7.6	7.6			18.7	5.4	24.1	32
	Evening	-							-					-					-			4.7	1.4	6.1	8
	Night	-							-					-					-					-	-
Tuesday	Day								-					-				7.6	7.6			18.7	5.3	24.0	32
	Evening	-							-					-					-			4.8	1.3	6.1	8
	Night	-							-					-					-					-	-
Wednesday	Day								-					-				7.6	7.6			18.6	5.4	24.0	32
	Evening	-							-					-					-			4.7	1.4	6.1	8
	Night	-							-					-					-					-	-
Thursday	Day								-					-				7.6	7.6			18.7	5.3	24.0	32
	Evening	-							-					-					-			4.7	1.3	6.0	8
	Night	-							-					-					-					-	-
Friday	Day	-							-					-				7.6	7.6			18.7	5.3	24.0	32
	Evening	-							-					-					-			4.7	1.4	6.1	8
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-		-				-					-					-			8.0	2.3	10.3	10
Sunday	All shifts	-	-		-				-					-					-			8.0	2.3	10	10
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	38.0	38	-	-	133.0	38.0	171.0	209
Annual & Other Leave Relief weeks		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	38.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	38	38	-	-	93	27	120	158
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	24	7	30	30
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	8	2	10	10
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	8	2	10	10
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	38	38	-	-	133	39	171	209
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.0	1.0	-	-	3.5	1.0	4.5	1.0
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.2	0.2	-	-	0.5	0.2	0.7	0.2
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.2	1.2	-	-	4.0	1.2	5.2	6.4

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:

Support from sector indicated. Feedback indicated model would generally include M-F BH with 2x evenings per week until 8pm & Sat PM. Have allowed for some Sunday time for drop in centres. Feedback also that program manager/team leader role should be limited to SCHADS Level 6 as per roles defined in the NSW SACS/SCHADS document.

Respite data indicates 24% of respite services are provided in a day centre setting, with a demand of 17% weekday, 10% Weeknight and and 73% weekend across all types of respite.

The assumption applied here however, is that the majority of day respite services are provided on weekdays to avoid gross distortion of other group based programs. However, the AH workforce was increased to 30% instead of 25%.

2.2.1.2 Service Element – Group Based Peer Work

Attribute	Details	
Description	Group based services that share a common interest and are led and self managed by peer workers. Includes services that aim to empower and support the individual, family, friends or support person by working through group processes and sharing life experiences with people who have similar experiences and to help develop support networks for crisis situations. Have a mental health promotion and prevention and psychological education function through 'wellbeing' benefit. Include Voice Hearing Group, Symptom Management Group, arts based/recreation based programs and Grow.	
Fundamental Attributes	Key distinguishing attribute is that the groups are facilitated specifically by peer workers. The services may or may not require a specific facility but could be hosted in a number of environments and would generally be of short duration (eg. Group program of 2 hours). The group programs may or may not be structured (eg two hour session for 6 weeks) and might be time limited or ongoing.	
Service specifications and suggested modelling attributes		
Activities:	• **Group Based Peer Work – Moderate** • **Group Based Peer Work – Severe**	• **Group Based Carer Peer Work – Moderate** • **Group Based Carer Peer Work – Severe**
Target Age:	16-64yrs	18-64yrs
Target Pop'n Profile	People with a diagnosis of mental illness experiencing moderate to severe levels of psychosocial disability.	Family/ friends/ support people or carers may need social emotional support coupled with education, knowledge and friendships due to the ongoing demands placed on their own health and wellbeing. Groups should be *"founded on the key principles of respect, shared responsibility and mutual agreement of what is helpful"* (Mead, Hilton and Curtis, 2001, p.135)
Avg timeframe per activity (if applic)	2 hours per week, 46 weeks	Services should be flexible to suit the demand. Group Supported Services provide opportunity for involvement activities in the general community and should be peer delivered.
Frequency of activity	Weekly	Weekly
Hours of Operation and Proportion BH and AH	70% business hours and 30% after hours estimated across all forms of group peer work.	70% business hours and 30% after hours estimated across all forms of group peer work.
Workforce	**Group Based Peer Work – Moderate**: 2x Facilitators per 12 participants. 50% BH, 50% AH **Group Based Peer Work – Severe**: 2x Facilitators per 6 participants, 90% BH, 10%AH	**Group Based Carer Peer Work – Moderate**: 2x Facilitators per 12 participants. 50% BH, 50% AH **Group Based Carer Peer Work – Severe**: 2x Facilitators per 6 participants 70% BH, 30% AH
Evidence Base		
Level of Evidence:		
Key Reference:	Catelein, S., Bruggeman, R., van Busschbach, M., van der Gaag, M., Stant, A. D., Knegtering, H., Wiersma, D. (2008). The effectiveness of peer support groups in psychosis: a	Recognition and Respect – Mental Health Carers Report , Mental Health Council of Australia 2012 (2012) Mental health peer support for hospital

	randomized controlled trial. *Acta Psychiatr Scand 118,* 64-72	avoidance and early discharge: An Australian example of consumer driven and operated service, Dr Sharon Lawn, BA, DipEd, MSW, PhD[1,2†], Ann Smith[1] and Kelly Hunter[1] 2008, Vol. 17, No. 5 , Pages 498-508 (doi:10.1080/09638230701530242)
Limitations of Evidence:	There is limited Australian Research on group peer support.	
Recommendations for future research:	Most studies are based on the efficacy of peer support with a few randomised controlled trails in USA and Europe. Further research within the Australian context is required.	

Description Source: Consumer and Carer Reference Group input

Service Activity – Group Based Peer Work (Moderate and Severe)

General description

Peer groups can offer shared understanding and normalisation of the experience of mental illness, and a space free of stigmatising views. By sharing the experiential knowledge about what enables recovery, peers offer hope and optimism. The authentic experience of 'those who've been there' provides expert knowledge, enabling a greater likelihood to motivate empowerment and self efficacy.

Access

Voluntary participation for people with mental illness and/or a psychosocial disability in which the group addresses a common issue by working on recovery.

Outcomes

> *"Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again. The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution."* Patricia E. Deegan, 1988

Improved symptoms, increased participants' social networks and quality of life, reduction in hospitalisations and shorter hospitalisations when a person is hospitalised. Improved daily functioning and improved illness management (Solomon 2004).

Collaboration

Community managed mental health services, community health services, other community services that promote social inclusion as well as, housing, vocational, education, drug and alcohol services.

Service Activity – Group Based Carer Peer Work (Moderate and Severe)

General description

Peer groups can offer shared understanding and normalisation of the experience of caring for someone with mental illness, and a space free of stigmatising views. By sharing the experiential knowledge about what enables self care for the family/friends/support person or carer and early intervention and recovery for the person they care for, peers offer hope and optimism towards wellbeing and a better future. The authentic experience of 'those who've been there' is credible and influential expert knowledge. It allows for social connection and understanding.

Access

Participation for the family/friends/support people or carer of people with a psychiatric disability offers hope in which the group addresses a common issue experienced by all.

Outcomes

Improved wellbeing of the family/friends/support people or carers, by increased knowledge and understanding of mental illness, confidence and ability to develop supportive social networks, better understanding of respite, recovery, early intervention and relapse planning.

Collaboration

Community managed mental health services, community health services, other community services (housing, vocational, drug and alcohol) and carer organisations.

Service Activity – Group Based Peer Work - Staffing Profiles

Group Based Peer Work – Moderate

Summary of Staffing Profile for Group Based Peer Work - Moderate

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Overheads %
NMHSPF	TOTAL	1.85		12.16	6.51	2,378	1,287	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	-	0.25	-	-	-		-	-	0%	20%
NMSPF	Peer Worker	1.85	0.25	8.69	6.51	2,378	1,287	62,234	115,016	100%	20%
NMHSPF	Tertiary Qualified	-	0.35	-	-	-		#DIV/0!	-	0%	20%
NMHSPF	Medical	-	0.25	-	-	-		-	-	0%	20%

Information from Care Package	
Hours Per Annum for an individual	220
Particpitants per service Provider	6
Total Target Population for care pa	2,250
Total Hours Req per Annum	82,500

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost		O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	-		-	-	-	-		$0	0%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmacis	-	0.70	-	-	-	-		$0	0%	20%
NMHR	**VQ and Peer Workers**	1.85		8.69	6.51	2,378	1,287		$115,016	100%	20%
NMHR	Consumer Peer Worker	1.85	0.25	8.69	6.51	2,378	1,287	$62,234	$115,016	100%	20%
NMHR	Carer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	VQMH Worker	-	0.20	-	-	-	-		$0	0%	20%
NMHR	VQ Other	-	0.30	-	-	-	-		$0	0%	20%
	Total Available Hours					2377.71					
Annual Cost Salaries		$115,016									
*** Including Overheads**	**20.0%**	$138,019									

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	-	#DIV/0!		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	-	#DIV/0!	$0	#DIV/0!
NMHR	**VQ and Peer Workers**	13,750	10.69		#DIV/0!
NMHR	Consumer Peer Worker	13,750	10.69	$62,234	$665,121
NMHR	Carer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQMH Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQ Other	-	#DIV/0!	$0	#DIV/0!

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

0.00

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MHWorker	VQ Other	VQ Total Hours	All Total Hours
																				SCHADS L4					
																				2x 0.8FTE 50%BH					
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38	Worked	Worked
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-					-	6.0				6.0	6
	Evening	-							-					-					-	4.2				4.2	4
	Night	-							-					-					-					-	-
Tuesday	Day								-					-					-	6.0				6.0	6
	Evening	-							-					-					-	4.1				4.1	4
	Night	-							-					-					-					-	-
Wednesday	Day								-					-					-	6.0				6.0	6
	Evening	-							-					-					-	4.2				4.2	4
	Night	-							-					-					-					-	-
Thursday	Day								-					-					-	6.0				6.0	6
	Evening	-							-					-					-	4.1				4.1	4
	Night	-							-					-					-					-	-
Friday	Day	-							-					-					-	6.0				6.0	6
	Evening	-							-					-					-	4.2				4.2	4
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-	5.0				5.0	5
Sunday	All shifts	-	-			-			-					-					-	5.0				5	5
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	60.8	-	-	-	60.8	61
Annual & Other Leave Relief weeks		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	30	-	-	-	30	30
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	21	-	-	-	21	21
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5	-	-	-	5	5
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5	-	-	-	5	5
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	61	-	-	-	61	61
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.6	-	-	-	1.6	-
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.2	-	-	-	0.2	-
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.8	-	-	-	1.8	1.8

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Profile developed by the Consumer and Carer Reference Group at their meeting on 10/04/13

Group Based Peer Work – Severe

Summary of Staffing Profile for Group Based Peer Work - Severe

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Overheads %
NMHSPF	**TOTAL**	**2.31**		15.20	8.14	2,972	1,287	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	-	0.25	-	-	-		-	-	0%	20%
NMSPF	Peer Worker	2.31	0.25	10.86	8.14	2,972	1,287	58,831	135,907	100%	20%
NMHSPF	Tertiary Qualified	-	0.35	-	-	-		#DIV/0!	-	0%	20%
NMHSPF	Medical	-	0.25	-	-	-		-	-	0%	20%

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost		O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	-		-	-	-	-		$0	0%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmacis	-	0.70	-	-	-	-		$0	0%	20%
NMHR	**VQ and Peer Workers**	2.31		10.86	8.14	2,972	1,287		$135,907	100%	20%
NMHR	Consumer Peer Worker	2.31	0.25	10.86	8.14	2,972	1,287	$58,831	$135,907	100%	20%
NMHR	Carer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	VQMH Worker	-	0.20	-	-	-	-		$0	0%	20%
NMHR	VQ Other	-	0.30	-	-	-	-		$0	0%	20%
	Total Available Hours					2972.14					

Annual Cost Salaries	$135,907
*** Including Overheads 20.0%**	$163,089

Information from Care Package

Hours Per Annum for an individual	**220**
Particpitants per service Provider	**3**
Total Target Population for care pa	**2,250**
Total Hours Req per Annum	**165,000**

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	-	#DIV/0!		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	-	#DIV/0!	$0	#DIV/0!
NMHR	**VQ and Peer Workers**	55,000	42.75		#DIV/0!
NMHR	Consumer Peer Worker	55,000	42.75	$58,831	$2,514,990
NMHR	Carer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQMH Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQ Other	-	#DIV/0!	$0	#DIV/0!

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

0.00

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
																				SCHADS L4 2x 1.0FTE 90%BH					
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-					-	13.7				13.7	14
	Evening	-							-					-					-	1.0				1.0	1
	Night	-							-					-					-					-	-
Tuesday	Day								-					-					-	13.6				13.6	14
	Evening	-							-					-					-	1.0				1.0	1
	Night	-							-					-					-					-	-
Wednesday	Day								-					-					-	13.7				13.7	14
	Evening	-							-					-					-	1.0				1.0	1
	Night	-							-					-					-					-	-
Thursday	Day								-					-					-	13.7				13.7	14
	Evening	-							-					-					-	1.0				1.0	1
	Night	-							-					-					-					-	-
Friday	Day	-							-					-					-	13.7				13.7	14
	Evening	-							-					-					-	1.0				1.0	1
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-	1.3				1.3	1
Sunday	All shifts	-	-			-			-					-					-	1.3				1	1
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	76.0	-	-	-	76.0	76
Annual & Other Leave Relief weeks		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	68	-	-	-	68	68
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5	-	-	-	5	5
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	1
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	1
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	76	-	-	-	76	76
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2.0	-	-	-	2.0	-
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.3	-	-	-	0.3	-
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2.3	-	-	-	2.3	2.3

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

++ Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Profile developed by the Consumer and Carer Reference Group at their meeting on 10/04/13

Group Based Carer Peer Work – Moderate

Summary of Staffing Profile for Group Based Carer Peer Work - Moderate

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Overheads %
NMHSPF	**TOTAL**	**1.85**		12.16	6.51	2,378	1,287	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	-	0.25	-	-	-		-	-	0%	20%
NMSPF	Peer Worker	1.85	0.25	8.69	6.51	2,378	1,287	62,234	115,016	100%	20%
NMHSPF	Tertiary Qualified	-	0.35	-	-	-		#DIV/0!	-	0%	20%
NMHSPF	Medical	-	0.25	-	-	-		-	-	0%	20%

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost		O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	-		-	-	-	-		$0	0%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmacis	-	0.70	-	-	-	-		$0	0%	20%
NMHR	**VQ and Peer Workers**	1.85		8.69	6.51	2,378	1,287		$115,016	100%	20%
NMHR	Consumer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Carer Peer Worker	1.85	0.25	8.69	6.51	2,378	1,287	$62,234	$115,016	100%	20%
NMHR	VQMH Worker	-	0.20	-	-	-	-		$0	0%	20%
NMHR	VQ Other	-	0.30	-	-	-	-		$0	0%	20%
	Total Available Hours					2377.71					

Annual Cost Salaries	$115,016
*** Including Overheads 20.0%**	$138,019

Information from Care Package

Hours Per Annum for an individual	220
Particpitants per service Provider	6
Total Target Population for care pa	2,250
Total Hours Req per Annum	82,500

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	-	#DIV/0!		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	-	#DIV/0!	$0	#DIV/0!
NMHR	**VQ and Peer Workers**	13,750	10.69		#DIV/0!
NMHR	Consumer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	Carer Peer Worker	13,750	10.69	$62,234	$665,121
NMHR	VQMH Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQ Other	-	#DIV/0!	$0	#DIV/0!

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

0.00

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MHWorker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
																					SCHADS L4				
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-					-		6.0			6.0	6
	Evening	-							-					-					-		4.2			4.2	4
	Night	-							-					-					-					-	-
Tuesday	Day								-					-					-		6.0			6.0	6
	Evening	-							-					-					-		4.1			4.1	4
	Night	-							-					-					-					-	-
Wednesday	Day								-					-					-		6.0			6.0	6
	Evening	-							-					-					-		4.2			4.2	4
	Night	-							-					-					-					-	-
Thursday	Day								-					-					-		6.0			6.0	6
	Evening	-							-					-					-		4.1			4.1	4
	Night	-							-					-					-					-	-
Friday	Day	-							-					-					-		6.0			6.0	6
	Evening	-							-					-					-		4.2			4.2	4
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-		5.0			5.0	5
Sunday	All shifts	-	-			-			-					-					-		5.0			5	5
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	60.8	-	-	60.8	61
Annual & Other Leave Relief weeks		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	30	-	-	30	30
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	21	-	-	21	21
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5	-	-	5	5
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5	-	-	5	5
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	61	-	-	61	61
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.6	-	-	1.6	-
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.2	-	-	0.2	-
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.8	-	-	1.8	1.8

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Profile developed by the Consumer and Carer Reference Group at their meeting on 10/04/13

Group Based Carer Peer Work – Severe

Summary of Staffing Profile for Group Based Carer Peer Work - Severe

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Over heads %
NMHSPF	TOTAL	2.31		15.20	8.14	2,972	1,287	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	-	0.25	-	-	-	-	-	-	0%	20%
NMSPF	Peer Worker	2.31	0.25	10.86	8.14	2,972	1,287	58,831	135,907	100%	20%
NMHSPF	Tertiary Qualified	-	0.35	-	-	-	-	#DIV/0!	-	0%	20%
NMHSPF	Medical	-	0.25	-	-	-	-	-	-	0%	20%

Information from Care Package	
Hours Per Annum for an individual	220
Particpitants per service Provider	3
Total Target Population for care pa	2,250
Total Hours Req per Annum	165,000

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost		O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	-		-	-	-	-		$0	0%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmaci	-	0.70	-	-	-	-		$0	0%	20%
NMHR	**VQ and Peer Workers**	2.31		10.86	8.14	2,972	1,287		$135,907	100%	20%
NMHR	Consumer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Carer Peer Worker	2.31	0.25	10.86	8.14	2,972	1,287	$58,831	$135,907	100%	20%
NMHR	VQMH Worker	-	0.20	-	-	-	-		$0	0%	20%
NMHR	VQ Other	-	0.30	-	-	-	-		$0	0%	20%
	Total Available Hours					2972.14					

Annual Cost Salaries	$135,907
*** Including Overheads 20.0%**	$163,089

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	-	#DIV/0!		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	-	#DIV/0!	$0	#DIV/0!
NMHR	**VQ and Peer Workers**	55,000	42.75		#DIV/0!
NMHR	Consumer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	Carer Peer Worker	55,000	42.75	$58,831	$2,514,990
NMHR	VQMH Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQ Other	-	#DIV/0!	$0	#DIV/0!

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

0.00

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
																					SCHADS L4				
																					2x 1.0FTE 70%BH				
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-					-		10.6			10.6	11
	Evening	-							-					-					-		3.3			3.3	3
	Night	-							-					-					-					-	-
Tuesday	Day								-					-					-		10.7			10.7	11
	Evening	-							-					-					-		3.2			3.2	3
	Night	-							-					-					-					-	-
Wednesday	Day								-					-					-		10.6			10.6	11
	Evening	-							-					-					-		3.3			3.3	3
	Night	-							-					-					-					-	-
Thursday	Day								-					-					-		10.7			10.7	11
	Evening	-							-					-					-		3.2			3.2	3
	Night	-							-					-					-					-	-
Friday	Day	-							-					-					-		10.6			10.6	11
	Evening	-							-					-					-		3.3			3.3	3
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-		3.2			3.2	3
Sunday	All shifts	-	-			-			-					-					-		3.3			3	3
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	76.0	-	-	76.0	76
Annual & Other Leave Relief wee		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	53	-	-	53	53
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16	-	-	16	16
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	-	-	3	3
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	-	-	3	3
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	76	-	-	76	76
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2.0	-	-	2.0	-
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.3	-	-	0.3	-
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2.3	-	-	2.3	2.3

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:

Profile developed by the Consumer and Carer Reference Group at their meeting on 10/04/13

2.2.2 Service Category – Individual Support and Rehabilitation Services

Descriptor

> *"Recovery ...is best described as a process, sometimes lifelong, defined and led by the person with a mental illness or disorder, through which they achieve independence, self-esteem and a meaningful life in the community.' Recovery and rehabilitation are different concepts although rehabilitation approaches can be seen to increasingly incorporate a recovery philosophy"* (Martin, 2008; 10).

Includes personalised support and psychosocial rehabilitation provided on an individual basis. Functions might include:

- Assessment (priorities, values, strengths, needs)
- Goal setting and planning,
- Strategies such as skill development, coaching/supporting, counselling, co-ordination of services, building personal and community resources (e.g. maintaining and developing relationships, access to opportunities).
- Support to access community transport, domestic support services, vocational, recreational and health management activities

The service provided occurs in the context of outreach to the appropriate setting (e.g home, work, school, shopping centre) and may or may not be linked to an individuals' accommodation.

Personalised Support and rehabilitation is fundamentally a non-clinical service that is performed by appropriately qualified workers (which may include having lived experience) generally working in the community environment.

Distinguishing Features

Key distinguishing attributes would be services that are:

- Tailored to the individual in their focus of care and intensity of support;
- Provided by suitably qualified service providers
- Services provided are generally outside the scope of the specialised clinical ambulatory services; and
- May or may not be linked to the provision of accommodation.

Inclusions

Services included in this element are summarised as follows (Siskind et al, 2012):

- Living Skills – aim to improve the day to day functioning of individuals through side by side instruction, role-modelling, corrective feedback and positive reinforcement (Eg. Shopping, cooking, budgeting, personal hygiene, public transport)
- Therapeutic Services – includes psychological education, family therapy, grief therapy, mediation, well-being and relapse prevention programs.
- Social Inclusion – includes support in engaging in communities of meaning and choice, such as engaging in community activities and events, peer based activities, study, work, recreation, music, art, physical activities and accessing health management/GP care.
- Early Intervention – intensive outreach and assertive psychosocial support to people in crisis with an aim to avoid hospitalisation. Aims to provide extra support to resolve psychosocial stressors and promote resilience and symptom management through appropriate use of medication and other strategies .
- Psychosocial rehabilitation – range of support and skill development activities oriented towards empowerment, recovery and individual capacity.
- Emotional support – aims to assist people in addressing acute and ongoing psychosocial challenges through activities including befriending, listening, providing practical problem solving and management of stressors.
- Advocacy – is to build capacity in a person to advocate on their own behalf or speaking, acting or writing on behalf of a person to improve their welfare.

Note: These services exclude carer support and brokerage (Flexible Funding Pool) as these services are incorporated under other elements, for example Group Based Carer Peer Work, Individual Carer Peer Work, Family and Carer Support, Individual Carer Support Services.

Example Services

- Personal Helpers and Mentors Service (PHaMS)
- Home Based Outreach Support (HBOS) Victoria
- Individual Psychosocial Rehabilitation and Support Services (IPRSS) SA.
- Housing and Accommodation Support Initiative (HASI) NSW
- Housing and Support Program (HASP) Qld
- Housing and Accommodation Support Partnership (HASP) Program SA
- Individualised Community Living Strategy (ICLS) WA.
- Resource and Recovery Support Program, NSW
- Vocation, Education, Training, Employment (NSW)
- Individual Placement and Support/ Open Employment/Supported Employment Programs (Victoria, QLD, ACT)

Taxonomy

- Individual Support and Rehabilitation
- Individual Peer Work

References

Siskind, D., Harris, M., Pirkis, J., and Whiteford, H. (2012) “Personalised support delivered by support workers for people with severe and persistent mental illness: a systematic review of patient outcomes.” *Epidemiology and Psychiatric Sciences,* 21, 97-110

AIHW Non-Government Organisation Establishment (NGOE) National Minimum Dataset (NMDS) Service Taxonomy (draft April 2012)

2.2.2.1 Service Element – Individual Support and Rehabilitation

Attribute	Details
Services Delivered	Includes individual support services provided to the person wherever they are living, this can include people who are homeless. Examples of services delivered are: o assist people to self-manage their own recovery and build on their interests, aspirations and strengths to live full and active lives o develop skills to improve competence and confidence in community living o improve health and well-being o improve independence and resilience o prevent relapse and limit severity of any crisis o engage the person with desired community and social activities o reduce social and physical dislocation by assisting people to sustain suitable housing and to develop improved social relationships o increase opportunities to participate in the workforce o reduce demand on acute and emergency services. Rehabilitation at its most basic form refers to assisting a person to build or rebuild skills that enable them to engage in their lives more independently. Anthony and Farkas are quite specific about all workers having an understanding and knowledge of rehabilitation. *"Regardless of the discipline or background of the practitioner, the source of funding or the setting in which people are working, people who help people with severe mental illnesses improve their functioning and gain valued roles in the community should be aware of the essentials of the psychiatric rehabilitation process, its program models and the principles underlying its practice."* The services may be delivered in partnership between clinical and non clinical staff. Rehabilitation specialists with clinical training and experience provide individually tailored rehabilitation assessments, interventions and services. They are likely to have undergone post graduate study and training to develop their expertise. Some of the services that clinicians may deliver are summarised below: **OTs** o Functional assessment (independent living skills, functional cognition, social skills) o Assessment of motivation, routines, roles, skills and environment o Assessment of community support needs o Sensory processing / Modulation o Task analysis o Graded skills acquisition interventions **Clinical Psychology** o Provision of specialised evidence-based therapies for specific illnesses in individual and / or group based formats **Vocationally trained staff** o Provide practical rehabilitation interventions in their everyday work that aim to support the person to regain skills, independence and self-determination. They are likely to have undergone rehabilitation specific training and engage in supervision with a focus on rehabilitation. (Anthony W, Farkas M. (2012) *The Essential Guide to Psychiatric Rehabilitation Practice*. Boston: Boston University Center for Psychiatric Rehabilitation, Boston)
Key Distinguishing Features	Individual support is delivered to people wherever they are living. Rehabilitation needs to be distinguished from support. Both activities usually happen at the same time with a coordinated approach by workers, however rehabilitation is goal focussed and often time limited (ie once the person has built or rebuilt the skill/s required then either another skill or set of skills is targeted or rehabilitation is no longer required). Can occur in a wide variety of settings eg in the person's home, in the community, in

	residential facilities or in inpatient facilities.			
Service specifications and other useful descriptors to illustrate service elements.				
Intensity	**LOW**	**MEDIUM**	**HIGH**	**INTENSIVE**
Target Age:	16 +	16 +	16 +	16 +
Diagnostic Profile	Have a diagnosed mental illness and experience mild to moderate level of psychosocial disability. Require assistance in one domain	Have a diagnosed severe mental illness and experiencing moderate to severe level of psychosocial disability Require assistance in 1 – 2 domains	Have a diagnosed severe mental illness and experiencing moderate to severe level of psychosocial disability. Require assistance in more than 2 domains	Have a diagnosed severe mental illness and experiencing moderate to severe level of psychosocial disability. Require intensive assistance in more than 2 domains
Suggested Modelling Attributes				
Avg contact hours per individual support activity (timeframe)	Individual Support and rehabilitation – Low 1 hour/week (1 to 12 weeks) Individual Advocacy – Low-Medium 1-4 hours/week (1 to 12 weeks)	Individual support and rehabilitation – Medium 1-4 hours/day (2 weeks to lifetime) Emotional support – Medium 1-4 hours/day (2 weeks +) Social Inclusion– Medium 1- 4 hours/day (1 to 12 weeks)	Early intervention – High 4-24 hours/day (2 weeks to 3 months)	
Avg contact hours per rehabilitation activity	1.5 hours (one weekly session)	6 hours (1.5 X 4 times) per week	12 hours (1.5 X 8 times) per week	21 hours (1.5 session twice a day, 7 days)/week
Avg contact hours per activity re housing	2.5 hours per week (range is 1 – 4 hours/week)	8 hours per week (range is 5 – 12 hours per week)	16 hrs / week	28 hrs / week
Hours – individual support	Predominantly business hours, some weekend (<15%)	70% business hours 30 % after hours / weekend	75% business hours 25% after hours / weekend hours	50% business hours 50% after hours / weekend hours
Hours – Individual Rehabilitation	Business hours	75% business hours 25% after hours / weekend hours	75% business hours 25% after hours / weekend hours	50% business hours 50% after hours / weekend hours
Workforce				
Workforce Type	**SCHADS Award Level**	**Hours worked**	**Proportion of Business hours and After Hours**	**Estimated % of Direct Care**
Tertiary Qualified	Level 6	0.4 FTE	Business hours only	30% Direct Care
Vocational Qual	Level 5	2.0 FTE	60% BH and 40% AH	70% Direct Care
Vocational Qual	Level 3-4	6.0 FTE	60% BH and 40% AH	70% Direct Care
Evidence Base				
Level of				

Evidence:				
Key Reference:				
Limitations of Evidence:				
Recommendations for future research:				

Service Activity – Individual Support and Rehab linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well

General description

Individual support and rehabilitation services provided specifically towards a person's personal goals of the establishment and maintenance of safe, affordable and secure housing.

The concept of safe, affordable and secure housing encompasses

- Sustainability (security) of tenure or ownership of a dwelling suitable to the needs of the individual/ family/ friend/ support people or carers.
- Financial security through affordable rental or mortgage repayments, budgeting and ongoing ability to pay household bills, including during periods of unwellness
- Physical safety and security through well-maintained property and access to support for managing crises
- Environmental safety and security through social and cultural acceptance and access to neighbourhood facilities.

The services are provided on a one-to-one basis, and may be provided as in-reach for individuals stepping down from residential care, or as community outreach, assisting an individual to maintain or change their housing circumstances (eg. Individuals living with family members or group accommodation, homeless individuals or for those living independently and are at risk of becoming homeless). Mental health services may provide housing support services themselves or connect individuals with the services provided by others for accessing and maintaining housing.

Housing linked support may also include:

- Coordinated housing and support
- Cluster housing programs
- Long term supported housing

Critical factors to succeed in housing includes the availability of safe, affordable housing, effectively engaging the housing market, maintaining personal wellness, adequate income, housekeeping and budget management skills, the provision of adequate transport and being able to successfully navigate the individual's neighbourhood and access services as required.

Information Gathering

Psychosocial needs assessment and functional assessment identifying housing needs, support available, personal strengths and areas for development. Also includes the provision of information that identifies different housing options and outlines access issues.

Planning

Development of a person centred recovery plan inclusive of support networks driven by the person that identifies housing goals, referral pathways, housing providers, resource options and advocates as appropriate and associated skill development and action required.

Action

As per the recovery plan, support the individual in establishing and maintaining housing arrangements including:

- Resources: Establish financial resources, legal and tenancy support, practical support (both personally and in relation to property maintenance) and processes to support skill development. Engaging assertively with the housing market is critical to establishing safe, affordable and secure housing. Particularly in the context of liaising/networking and following up on commitments made, supporting accommodation hunting and development of the housing application. Also support the individual to access public housing tenancy support officers and rental assistance schemes, or assist with the installation of security devices, advancing or assisting with bond money and relocating costs.
- Skill Development (including Rehabilitation Focus): Develop skills to improve competence and confidence in community living, particularly in relation to managing tenancy matters.
- Social/Cultural Context: Ensure housing allocation is safe and appropriate to personal and cultural circumstances. Address stigma in the social environment. Provide flexible support tailored to individual need to promote the likelihood of successful housing arrangements.
- Health and Wellbeing: Improve independence and resilience and ensure appropriate support is provided to maintain a healthy home environment.

Outcomes

Stability of housing and individual housing goals are met along with critical success factors for maintaining that housing.

Collaboration

Individual/ family/ friends/ support people and carers, housing providers, income support or management, mental and general health clinical and community support services, financial brokers, tribunals and other social, health and community opportunities.

Need to establish mental health support positions dedicated to housing issues to enhance secure housing outcomes and enhance intersectoral links, particularly between mental health, generic and dedicated housing and other social support services.

Note: This service excludes carer support as it is incorporated under another service activity: Individual Carer Support linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well

Description Source: TBA.

Service Activity – Individual Support and Rehab linked to early childhood, education and/or employment

General description

Individual support and rehabilitation services provided specifically towards a person's personal goals towards education and or employment. The services are provided on a one-to-one basis, and generally target the functions of accessing and supporting education and employment opportunities rather than providing the education and employment services themselves.

Information Gathering

Psychosocial needs assessment and functional assessment identifying education and employment targets, motivation to work and/or study, self-identified support needs, support available, personal strengths and areas for development. Also includes the provision of information that identifies different education/employment options and outlines access issues.

Planning

"*Development of a person-centred recovery plan driven by the consumer that identifies education and/or employment goals, referral pathways, service providers, resource options and advocates as appropriate and associated skill development and action required. Particularly need to consider the long term of positive effects of supporting individuals back into school, which further supports post-secondary study and subsequent employment opportunities" (McLaren, K (2004) Work in Practice – Best practice employment support services for people with mental illness, NZ)*.

Action

As per the person centred recovery plan inclusive of support networks, support the person in accessing and maintaining education and employment through the following activity:

- Resources: Provide career counselling and assistance in course selection and enrolment procedures, linking to disability liaison or counselling services as required. (VETE)Establish financial counselling and access to financial support, transport services and employment/education practical support. Engage assertively with the employment and education providers to ensure a flexible and supportive environment is established. Ensure mental health staff respond flexibly to the needs and availability of the individual around their work/education commitments and pressures. Regular review meetings with the person and both mental health and employment and/or education services.
- Skill Development (including Rehabilitation Focus): Preventing relapse and coping with work/education pressures. Establishing effective employment or study strategies early in the illness trajectory may have life-long impact on employment outcomes, preventing secondary disability and associated economic and social costs. Providing a specialist VETE service ensures employment and education remain a high priority when other issues required addressing by the care coordinator (eg decline in mental or physical health). (VETE)
- Social/Cultural Context: Address stigma in the work/education environment. Provide flexible support tailored to individual need, tutoring and flexible delivery of education courses or employment arrangements promotes the likelihood of success. (VETE)
- Health and Wellbeing: Close links and integration with care coordination services, primary care, crisis intervention and accommodation issues will support the stability of health without detracting from progressing the vocational and educational goals of the individual. (VETE)

Outcomes

Completion of studies or vocational training. Participation in supported or open employment, independent income, sustained or stable involvement in employment and education.

Collaboration

Consider dedicating a combined caseload to 2-3 employment specialists to foster continuity to people. Foster a close working relationship with income support services and Job Capacity Assessors to ensure referrals to employment services are processed appropriately. Need to establish mental health clinical and support positions dedicated to vocational and educational issues to enhance employment and educational outcomes. Enhanced intersectoral links, particularly between mental health, generic employment and education services (eg. Resume production, course content information), Disability Employment Services, TAFE, Universities and other social support services.

A dedicated VETE specialist could carry a caseload of 25-30 individuals at any one time.

[VETE Report: Avg length of time to obtain employment was 14 weeks, Avg length of time in employment was 20 weeks, Avg hours worked per week was 22 hours and Avg rate of pay was $15.74 per hour]

Frost, B., Morris, A., Sherring, J. and Robson, E. (2008) Vocational Education, Training and Employment (VETE) Pilot Project Report – Psychiatric Rehabilitation Services 2006-2007, NSW Health, Sydney.

Note: This service excludes carer support as it is incorporated under another service activity: Individual Carer Support linked to education and employment

Service Activity – Individual Support and Rehab linked to enhanced relationships and social participation

General description

Working with the person to identify and develop interests. Work with the person to access activities within the community to participate in. Working with the person to identify relationships which are important to them and work on developing, maintaining and growing those relationships.

Information Gathering

Identify with the person what their interests are and identify what is available in the community. Identifying with the individual/ family/ friends/ support people or carers who may be available to assist with accessing and participating in community activities.

Planning

Working with the person to develop a person centred recovery plan Inclusive of support networks which involves developing the skills to find, access and participate in community activities. Assisting the person to plan every aspect of participation in social activities, this will involve identifying the resources and skill development required.

Action:

As per the person centred recovery plan inclusive of support networks

- Resources: establish financial resources in order to assist with funding community activities or access to community activities. Identify and establish support to access and engage in community activities eg transport, travel skill development etc. Identify support people to assist with community integration and participation (may include workers).
- Skill Development (including Rehabilitation Focus): identify and develop skills required to access and participate in community activities eg ability to catch the bus, social presentation and skills.
- Social/Cultural Context: ensure activities planned as socially and culturally appropriate and safe for person.

- Health and Wellbeing: ensure that activities planned will assist with development of improved health and well being.

Outcomes

Increasing social participation and community engagement in order to meet goals connected to social inclusion.

Collaboration

Individual/ family/ friend/ support people and carers, organisations providing courses and activities, educational and vocational providers, community organisations, non government organisations

Note: This service excludes carer support as it is incorporated under another service activity: Individual Carer Support linked to enhanced relationships and social participation

Service Activity – Individual Support and Rehab linked to health management services

General description

Assisting a person to improve or maintain his or her health or wellness. People with serious mental illness experience a life expectancy 25 years less than the general population – this is mainly due to physical health issues related to smoking, obesity and lack of physical activity. (Joe Parks research "25 years too late" http://www.abc.net.au/rampup/articles/2012/09/10/3586516.htm). It needs to be noted that not all people with a serious mental illness experience issues related to smoking, lack of physical exercise or obesity and therefore not all people will require support and / or skills building in these areas. Actively seeking or establishing strategies and activities that promote good health and wellbeing. Examples might include regular physical health assessment and treatment as appropriate, massage and other forms of relaxation activities, counselling and peer support, recreational activities, skill development in health practices (e.g. Cooking, cleaning, fitness).

Information Gathering

Engaging the participant in a relationship to develop a plan for health management. Assessing health status (including physical and mental health) and barriers and enablers for good health. Includes review of physical and mental health needs, thorough history and review of medication (both physical and otherwise). Collation of physical and dental health contacts and connection to these services. Assess readiness for change and skills connected with coping, health management, menu planning, shopping, cooking and fitness. Assessing readiness to engage in quit smoking initiatives (where applicable)

Planning

Prioritise and set health and wellness goals by formulating a health and wellness plan, that is driven by the participant with support in the planning process.

Action

Support the individual in developing healthy behaviours and support access and use of resources as appropriate:

- Resources: Nicotine replacement therapy, brokerage funds (Eg. to assist in accessing gym memberships or exercise clothes), respite and/or personal support services,
- Skill Development (including Rehabilitation Focus): Support the individual in building skills in healthy practices and overall health management and to engage or disengage in activities which assist in improving health. Development of insight to avoid neglecting personal health and to establish and maintain positive coping strategies.
- Social/Cultural Context: Utilising support and respite services as required to maintain and promote social relationships in work, education and social/cultural environments.

- Health and Wellbeing: As above.

Outcomes

Better life expectancy stats – people with serious mental illness having decreased rates of smoking, obesity and increased rates of physical exercise – lower rates of cardiovascular disease, respiratory disease etc, lower rates of hospitalisation, presentation to EDs for physical health issues etc.

Collaboration

General Practice and other health services, community health management organisations (Eg. Gyms, swimming pools, weight management services, smoking cessation services), other recreational, educational and vocational services and mental health care and related support services.

Note: This service excludes carer support as it is incorporated under another service activity: Individual Carer Support linked to health management

Service Activity – Individual support and Rehab linked to Community Aged Care

Includes individual support services provided to the aged person wherever they are living, this can include people who are homeless.

Service Activity – Flexible Funding Pool – Consumer

Goods and/or services which are procured on behalf of the person to purchase additional assistance that is not within the practice of the mental health sector. The goods and/or services are provided as part of the person's individual support plan and are related to a goal within the individual support plan. Examples are listed below. Brokerage funds may be part of or separate to the overall funding of the support "package".

Household – For example: buying cleaning equipment, replacing a fridge etc
Activities of Daily Living: For example: paying or helping to pay for a cleaner (either episodic or regularly), paying for driving lessons or bus tickets,
Membership / exercise: For example: entry to swimming pools, gym membership, exercise clothes (such as swimmers), club fees for sports club.
Recreational: For example: art lessons, books for a book club, supplies for a craft group.
Vocational / Training: For example: materials or transport to training/ vocational group, clothes for work opportunity.
Other: Expenses that don't fall into the preceding categories.

Note: This service excludes carer support as it is incorporated under another service activity:

Flexible Funding Pool – Carer

Service Activity – Individual support and Rehab – Staffing Profile

Summary of Staffing Profile for Individual Support and Rehabilitation

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Overheads %
NMHSPF	TOTAL	9.70		63.84	31.05	11,334	1,168	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	9.24	0.28	43.43	30.40	11,096	1,201	48,523	448,378	95%	20%
NMSPF	Peer Worker	-	0.25	-	-	-		#DIV/0!	-	0%	20%
NMHSPF	Tertiary Qualified	0.46	0.35	2.17	0.65	238	515	-	-	5%	20%
NMHSPF	Medical	-	0.25	-	-	-		-	-	0%	20%

Information from Care Package	
Hours Per Annum for an individual	1
Total Target Population for care pa	1
Total Hours Req per Annum	1

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost		O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	0.46		2.17	0.65	238	515		$26,110	5%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmaci	0.46	0.70	2.17	0.65	238	515	$56,511	$26,110	5%	20%
NMHR	**VQ and Peer Workers**	9.24		43.43	30.40	11,096	1,201		$470,797	95%	20%
NMHR	Consumer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Carer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	VQMH Worker	6.93	0.30	32.57	22.80	8,322	1,201	$48,370	$335,223	71%	20%
NMHR	VQ Other	2.31	0.30	10.86	7.60	2,774	1,201	$58,686	$135,574	24%	20%
	Total Available Hours					11333.77					

Annual Cost Salaries	$496,907
*** Including Overheads 20.0%**	$596,288

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	0	0.00		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	0	0.00	$56,511	$2
NMHR	**VQ and Peer Workers**	1	0.00		#DIV/0!
NMHR	Consumer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	Carer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQMH Worker	1	0.00	$48,370	$30
NMHR	VQ Other	0	0.00	$58,686	$12

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

237.77

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
																		SCHADSL6				SCHADSL3	SCHADS L5		
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-				3.0	3.0			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.1	4.8	17.9	18
	Night	-							-					-					-					-	-
Tuesday	Day								-					-				3.0	3.0			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.2	4.9	18.1	18
	Night	-							-					-					-					-	-
Wednesday	Day								-					-				3.0	3.0			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.1	4.8	17.9	18
	Night	-							-					-					-					-	-
Thursday	Day								-					-				3.1	3.1			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.2	4.9	18.1	18
	Night	-							-					-					-					-	-
Friday	Day	-							-					-				3.1	3.1			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.2	4.8	18.0	18
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-			14.0	1.4	15.4	15
Sunday	All shifts	-	-			-			-					-					-			13.2	4.9	18	18
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15.2	15	-	-	228.0	76.0	304.0	319
Annual & Other Leave Relief weeks																		7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked																									
Productive Weeks per FTE		52.14	52.14	52.14	52.14	52.14	52.14	52.14		52.14	52.14	52.14	52.14		52.14	52.14	52.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15	15	-	-	135	46	181	196
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	66	24	90	90
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	14	1	15	15
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	13	5	18	18
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15	15	-	-	228	76	304	319
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.4	0.4	-	-	6.0	2.0	8.0	0.4
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.1	0.1	-	-	0.9	0.3	1.2	0.1
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.5	0.5	-	-	6.9	2.3	9.2	9.7

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:

Support from sector indicated. Feedback indicated a need for more after hours time to include capacity for overnight care. Amended to 60% BH and 40% AH. Feedback also that program manager/team leader role should be limited to SCHADS Level 6 as per roles defined in the NSW SACS/SCHADS document.

2.2.2.2 Service Element – Individual Peer Work

Attribute	Details
Description	Individually oriented services that are led and self managed by peer workers, that share a common interest, share lived experiences with the participants. Includes services that aim to empower and support individuals/ family/ friends support people and carers by sharing life experiences with people who have similar experiences and to help develop support networks for crisis situations. These services have a mental health promotion and prevention function through 'wellbeing' benefit. Includes individual self help or individualised peer support services. The components of effective supporting programs includes: • The agency having structures and procedures to maintain the support program. Eg. Agency support for the coordinator, regular monitoring/reinforcing agency guidelines by coordinator for support person (being a role model for the person with mental illness by demonstrating consistency, reliability, interest, engagement, availability and responsiveness); • The person with mental illness and the support person are matched on the basis of shared experience. Eg. Caregiver status; gender and relationship to care recipient; language, culture and ethnicity; or characteristics of the person cared for; • The support person is selected for the program and paired with an person with mental illness based upon having more experience than the person with mental illness; • There are various group formats that can be used; where there are multiple support persons (business models), multiple people with mental illness (eg. Education) or where a group of person with mental illness – support person dyads meet regularly (eg. School context); • The act of supporting can be that of supporter, consultant, trainer, a reflective process, observing and giving feedback, buddy and tutor, listener; • Meetings between person with mental illness and support person can be face-to-face, telephone-based, in-home, involve structured activities, tailored to individual needs, and the person with mental illness following support person doing normal day-to-day activities; and • A resource library, website of person with mental illness/support person participants. A dedicated meeting place provided by the agency where they can feel safe, welcome and understood. Therefore, a carer peer support program should include: • Monitoring of program implementation and during the running of the program (keeping in touch with persons with mental illness – support persons); • Screening of prospective support persons (expectations, place in one's caring journey) • Matching of person with mental illness – support person pairs (gender, residential area, relationship to person with the mental illness and type of illness); • Support person training (initially and ongoing) in mental health issues and peer support training; • Offering peer support for carer support persons (support person peer support group, for debriefing, for training refresher/updates). *Cassar Bartolo, K and Sanders, F. (2008) Carer Involvement Project Gathering Lived Experience Phase 1, ARAFEMI, Victoria.*

Fundamental Attributes	Key distinguishing attributes are that the service must be delivered by a peer worker (Note that the organisation providing the service may or may not be a peer operated entity) and the service provided is predominantly focused on individual support.	
Service specifications and suggested modelling attributes		
Activities:	**Individual Consumer Peer Work**	**Individual Carer Peer Work**
Target Age:	18-64yrs	Carers may need social emotional support coupled with education, knowledge and friendships due to the ongoing demands placed on their own health and wellbeing. Groups should be*" founded on the key principles of respect, shared responsibility and mutual agreement of what is helpful"* (Mead, Hilton and Curtis, 2001, p.135)
Target Pop'n Profile		Services should be flexible to suit demand. Group Support Services provide opportunity for involvement activities in the general community and should be peer delivered.
Frequency of activity		
Hours of Operation and Proportion BH and AH		
Workforce	Consumer Peer Workers	Carer Peer Workers
Evidence Base		
Level of Evidence:		Recognition and Respect – Mental Health Carers Report (2012) Sharon Lawn, Anne Smith and Kelly Hunter (Journal of Mental Health October 2008; 17(5) 498-508 Peer support for hospital avoidance and early discharge Mead, Hilton and Curtis (2001)
Key Reference:		
Limitations of Evidence:		
Recommendations for future research:		

Service Activity – Individual Peer Work

General description

Individual peer work for the person with mental illness.

"People with lived experience of mental illness may work in the mental health sector in a variety of roles, both paid and voluntary. Their experience may be recognised by such titles as peer support worker, peer educator, consumer consultant and others which specifically highlight the peer to peer role and its significance to the recovery of a person experiencing mental illness".

"These roles should not to be confused with the work of people with lived experience of mental illness that work in the sector in a variety of positions, and bring the benefit of their experience to their work. Not all people with lived experience choose to share that experience with their employers and/or their clients." Comment from Mental Illness Fellowship Australia, 2012.

"Peer support now can mean a range of services: from the most basic form of peer support (the informal mutual support provided by individuals on a one-to-one basis) through to Peer Specialists (trained and employed to provide support to consumers within mental health or addiction services); through to totally peer run standalone services (e.g. peer run respite services, addiction services or alternatives to hospitalisation)". Peters, J. (2010) *Walk the walk and talk the talk – A summary of some peer support activities in IIMHL countries,* Te Pou, NZ

For the purposes of the NMHSPF Project, Peer Support work is directed at the intended/structured form of peer support, not the incidental/informal mutual support that might occur between individuals.

Information Gathering

Psychosocial and functional needs assessment to identify opportunities for peer support and supporting (mentoring).

Planning

As per the person's prioritised objectives, provide information and facilitate access to individual consumer peer support services where appropriate. Consider enablers and barriers to successful outcomes and assess motivation for change.

Action

- Resources: Telephone, online and face-to-face access to information and support to reduce emotional and geographical isolation. Resources can be an informal sharing and/or structured information/psycho-education program but all peer workers and support persons should be properly trained and provided with regular peer led supervision.
- Skill Development (including Rehabilitation Focus): Informal support developing coping strategies, and knowledge. Assistance in working through own healing process/counselling, dealing with underlying grief and loss issues. Develop skills in self and systemic advocacy. Emotional impact of mental illness and strategies for managing everyday life, reduce social isolation.
- Social/Cultural Context: Age appropriate education about mental illness and life skills to enhance coping in children. Peer networking is a key factor to reducing social isolation and promoting emotional support.
- Health and Wellbeing: Promote strategies for coping and regular focus on healthy behaviours.

Outcomes

Longer periods of community support between hospital admissions, less re-hospitalisation, increased discharge rates from inpatient and bed based services. Promotes choice and finds optimism, role models and motivation to drive personal recovery. Mental illness is not a life sentence and people can regain hope and confidence to achieve a better life.

Collaboration

It is Important to establish links with other services and opportunities.

Service Activity – Individual Carer Peer Work

General description

"In order to be effective, a carer peer support program needs to have built into its structure and philosophy, the dual purpose of learning and support. It is recommended that a carer peer support program be properly integrated in the organisational context, with well structured policies and procedures. That is, carer mentors are properly supported by peers and coordinating staff, so that they in turn can properly support the carer mentees. It is recommended that a carer peer support program includes structured peer worker selection

processes and sufficient peer support worker training. It is recommended that a carer peer mentoring program is based on national benchmarks for effective development of mentoring programs in order to coincide with existing programs. Further, that peer support/mutuality is built into the program framework". (Cassar Bartolo, K and Sanders, F. (2008) *Carer Involvement Project Gathering Lived Experience Phase 1,* ARAFEMI, Victoria.)

For the purposes of the NMHSPF Project, Peer Support work is directed at the intended/structured form of peer support, not the incidental/informal mutual support that might occur between individuals.

Information Gathering

Psychosocial and functional needs assessment to identify opportunities for peer support and supporting (mentoring).

Planning

As per the family/ friend/ support people or carer's prioritised objectives, provide information and facilitate access to carer peer support services where appropriate. Consider enablers and barriers to successful outcomes and assess motivation for change.

Action

- Resources: Telephone, online and face-to-face access to information and support to reduce emotional and geographical isolation. Resources can be an informal sharing and/or structured information/psycho-education program but all peer workers and support persons should be properly trained and supported through regular peer supervision.
- Skill Development (including Rehabilitation Focus): Informal support developing coping strategies, and knowledge. Assistance in working through own healing process/counselling, dealing with underlying grief and loss issues. Develop skills in self and systemic advocacy. Emotional impact of caring and strategies for managing everyday life, reduce social isolation.
- Social/Cultural Context: Age appropriate education about mental illness and life skills to enhance coping in children. Peer networking is a key factor to reducing social isolation and promoting emotional support.
- Health and Wellbeing: Promote strategies for coping and regular focus on family/ friend/ support people or carers' health and wellbeing practices.

Outcomes

Reduces stress through sharing experiences with people having similar experiences. This can increase family/ friend/ support people or carers' coping capacity, knowledge and satisfaction with support services. This in turn enhances the support person's existing skills and knowledge and encourages learning of new skills/knowledge for the person with mental illness. Opportunity to feel safe to vent emotions, validation of care giving experiences, affirmation of coping abilities, encouragement for continuing to provide care and cope with changing situations, exploration of alternative care giving arrangements, mutual support and sharing of information about community resources and coping strategies.
Toseland, Rossiter, Peak and Hill, (1990) in Cassar Bartolo, K and Sanders, F. (2008) *Carer Involvement Project Gathering Lived Experience Phase 1,* ARAFEMI, Victoria.

Collaboration

Important to establish links with other services and opportunities.

Cassar Bartolo, K and Sanders, F. (2008) *Carer Involvement Project Gathering Lived Experience Phase 1,* ARAFEMI, Victoria

2.2.3 Service Category – Other Residential Services

Descriptor

A residential mental health service is a service established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychosocial disability.

Distinguishing Features

The service also has the following characteristics:

- Has the workforce capacity to provide specialised mental health services; and
- Employs suitably trained mental health staff to provide rehabilitation, treatment or extended care on-site:
    - To people residing on an overnight basis;
    - In a domestic-like environment;
    - Encourages the person to take responsibility for their daily living activities; and
    - Staff are on –site for a minimum of 6 hours per day and at least 50 hours per week.

Inclusions

- These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing (but the trained staff must be on site for a minimum of 6 hours a day and at least 50 hours per week).
- Residential Respite
- Crisis residential services
- Supported Hostels

Exclusions

- Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as community based residential services;
- Services that are visited via in-reach services provided by Community Sector Organisation (CSO) staff, but where the residence is not regarded as the CSO worker's place of employment; and
- Clinical residential services.

Taxonomy

- Other Residential Services

Source

- National Health Data Dictionary V.15
- AIHW Non-Government Organisation Establishment (NGOE) National Minimum Dataset (NMDS) Service Taxonomy (draft April 2012)

2.2.3.1 Service Element – Residential Crisis and Respite Services

Attribute	Details
Description	Residential crisis and respite services are staffed home-like facilities in the community, providing short term accommodation where people in crisis can go to stabilise their illness or for the purposes of providing respite to the family/ friend/ support people or carers. Options can include crisis residential services where stays are limited to up to 48 hours through to planned respite of up to 14 days. Respite services are provided on a residential/overnight basis for short periods from several days to a few weeks. Respite services are generally non-clinical in nature, but may support some clinical services depending on the need of the person with mental health issues. Residential respite may also be planned or in response to a sudden need experienced by the person and their family/ friend/ support people or carers. Skill Development includes education (information about illness, recovery/ looking after yourself, household management help (shopping, cooking, budgeting, cleaning, personal hygiene), vocational advice (looking for work, resumé preparation, interview techniques), a focus on Indigenous and culturally and linguistically diverse needs, flexibility (such as utilising the whole of-family and/or kinship models), a focus on family/ friend/ support people or carers (personal wellbeing, relaxation techniques and local services available). Adapted from Psychiatric Disability Services of Victoria (VICSERV) (2008) Partners in Respite – Building Capacity in Community Mental Health Family Support and Carer Respite, VICSERV, Victoria. Outcomes include improved social networks, improved self-esteem, improved health and quality respite for family/ friend/ support people or carers.
Fundamental Attributes	Service provides staffed residential mental health care with length of stay less than 14 days. These services are may or may not be staffed by specialised clinicians. Services may include visits from clinicians.
Service specifications and suggested modelling attributes	
Activities:	**Residential Crisis and Respite Services**
Target Age:	16-64 years
Target Pop'n Profile	People with severe and persistent mental illness
Avg Length of Stay	10 days (based on an unpublished review of crisis residential services in Qld)
% Occupancy	90% +
Hours of Operation and Proportion BH and AH	24 hours – BH 9am to 5pm – 2 staff per 5 beds. AH 1 staff per 5 beds
Workforce	3.5FTE/100K as per staffing profile

Workforce Type	SCHADS Award Level	Hours worked	Proportion of Business hours and After Hours	Estimated % of Direct Care
Tertiary Qualified	Level 6	1.0 FTE	75% BH and 25% AH	N/A
Vocational Qual	Level 5	1.4 FTE	100% After hours	N/A
Vocational Qual	Level 3	3.0 FTE	33% BH and 67% AH	N/A

Average Unit Size and Bed rate/100K	5-10 beds per unit, 3 beds per 100K
Evidence Base	

Level of Evidence:	Level 1. – several high quality level III-1 or III-2 studies from which effects of bias and confounding can be reasonably excluded on the basis of the design and analysis.
Key Reference:	Lloyd-Evans B, Slade M, Jagielska D, Johnson S. Residential alternatives to acute psychiatric hospital admission: systematic review. Br J Psychiatry. 2009 Aug;195(2):109-17
Limitations of Evidence:	All evidence international. One evaluation of an Australian crisis residential service currently in submission to a peer reviewed journal
Recommendations for future research:	Australian randomised control trial of crisis residential services versus psychiatric hospitalisation.

Description Source:

Siskind D, Harris M, Pirkis J, Whiteford H. A domains-based Taxonomy of supported accommodation for people with severe and persistent mental illness. Soc Psychiatry Psychiatr Epidemiol. 2012a Oct 2. [Epub ahead of print]

Siskind D, Harris M, Buckingham B, Pirkis J, Whiteford H. Planning estimates for the mental health community support sector. Aust N Z J Psychiatry. 2012b Jun;46(6):569-80.

Service Element – Residential Crisis and Respite Services – Staffing Profile

Summary of Staffing Profile for Residential Crisis & Respite Services

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hours/ bed (avge avail)	Total hours per annum	Ttl Hrs/FTE	Weighted Salary **	Cost	Hours/day /person	Overheads %
NMHSPF	TOTAL	18.71	1.25	87.94	5.86	32,099	1,715	#DIV/0!	#DIV/0!	6.5	25%
NMHSPF	Vocationally Qualified	15.25	1.02	71.66	4.78	26,155	1,715	45,842	698,959	5.3	25%
NMSPF	Peer Worker	-	-	-	-	-		#DIV/0!	-	-	25%
NMHSPF	Tertiary Qualified	3.47	0.23	16.29	1.09	5,944	1,715	-	-	1.2	25%
NMHSPF	Medical	-	-	-	-	-		-	-	-	25%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Total hours	Available hours/annum/FTE	Salary **	Cost	#VALUE!	O'heads %
NMHR	**Total Medical**	-	0.00	0.00	0.00		-		$0	-	25%
NMHR	Psychiatrist	-	-	-	-		-		$0	-	25%
NMHR	Registrar	-	-	-	-		-		$0	-	25%
NMHR	Junior Medical Officer	-	-	-	-		-		$0	-	25%
NMHR	Other Medical Specialis	-	-	-	-		-		$0	-	25%
NMHR	**Total Nursing**	-	-	-	-		-		$210,060	-	25%
NMHR	Registered Nurse	-	-	-	-		-		$0	-	25%
NMHR	Nurse Practitioner	-	-	-	-		-		$0	-	25%
NMHR	Enrolled Nurse	-	-	-	-		-		$0	-	25%
NMHR	**Total Allied Health**	3.47	0.23	16.29	1.09		-		$210,060	1.2	25%
NMHR	Psychologist	-	-	-	-		-		$0	-	25%
NMHR	Social Worker	-	-	-	-		-		$0	-	25%
NMHR	Occupational Therapist	-	-	-	-		-		$0	-	25%
NMHR	Other TQ (eg pharmacis	3.47	0.23	16.29	1.09		-	$60,619	$210,060	1.2	25%
NMHR	**VQ and Peer Workers**	15.25	1.02	71.66	4.78		-		$857,813	5.3	25%
NMHR	Consumer Peer Worker	-	-	-	-		-		$0	-	25%
NMHR	Carer Peer Worker	-	-	-	-		-		$0	-	25%
NMHR	VQMH Worker	11.78	0.79	55.37	3.69		-	$53,660	$632,209	4.1	25%
NMHR	VQ Other	3.47	0.23	16.29	1.09		-	$65,105	$225,604	1.2	25%

Annual Cost Salaries	$1,277,933
* Including Overheads 25%	$1,597,416
Average Daily Available Bed Day C	$291.77
Average Cost per Patient per annu	$3,566.02

Bed Based Service Parameters	
Beds	15
Availability	100%
Average Available Beds	15
ABD/Bed per Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	10
Admissions/Bed per yea	32.85
Annual Readmit Rate	10%
Patients/Bed per year	29.86

Calculator	
Number of standardised admissions per annum multiplied by target population	90
Beds Required	3
Cost	$291,765

Staffing		
NMHR	**Total Medical**	0.0
NMHR	Psychiatrist	0.0
NMHR	Registrar	0.0
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	0.0
NMHR	Registered Nurse	0.0
NMHR	Nurse Practitioner	0.0
NMHR	Enrolled Nurse	0.0
NMHR	**Total Allied Health**	0.6
NMHR	Psychologists	0.0
NMHR	Social Workers	0.0
NMHR	Occupational Therapists	0.0
NMHR	Other	0.6
NMHR	**VQ and Peer Workers**	2.8
NMHR	Consumer Peer Worker	0.0
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	2.2
NMHR	VQ Other	0.6
Total		3.4

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other SCHADS L6 3.0 FTE	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker SCHADS L3 10.2 FTE	VQ Other SCHADS L5 3.0 FTE	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-				17.4	17.4			11.1	3.0	14.1	32
	Evening								-					-				1.2	1.2			10.5	2.7	13.2	14
	Night								-					-				0.0	-			6.6	2.7	9.3	9
Tuesday	Day								-					-				17.4	17.4			11.1	3.0	14.1	32
	Evening								-					-				1.2	1.2			10.5	2.7	13.2	14
	Night								-					-					-			6.6	2.7	9.3	9
Wednesday	Day								-					-				17.4	17.4			11.1	3.0	14.1	32
	Evening								-					-				1.2	1.2			10.5	2.7	13.2	14
	Night								-					-				0.0	-			6.6	2.7	9.3	9
Thursday	Day								-					-				17.4	17.4			11.1	3.0	14.1	32
	Evening								-					-				1.2	1.2			10.5	2.7	13.2	14
	Night								-					-					-			6.6	2.7	9.3	9
Friday	Day								-					-				17.4	17.4			11.1	3.0	14.1	32
	Evening								-					-				1.2	1.2			10.5	2.7	13.2	14
	Night								-					-				0.0	-			6.6	2.7	9.3	9
Saturday	All shifts								-					-				10.5	10.5			123.3	36.0	159.3	170
Sunday	All shifts								-					-				10.5	10.5			123.3	36.0	159	170
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	114.0	114	-	-	387.6	114.0	501.6	616
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7	5.6	7	7	7	7		
On Call Episodes (weighted)										9	9	9	9						5.6						
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	87	87	-	-	56	15	71	158
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6	6	-	-	53	14	66	72
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	33	14	47	47
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11	11	-	-	123	36	159	170
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11	11	-	-	123	36	159	170
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	114	114	-	-	388	114	502	616
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3.0	3.0	-	-	10.2	3.0	13.2	3.0
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.5	0.5	-	-	1.6	0.5	2.0	0.5
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3.5	3.5	-	-	11.8	3.5	15.2	18.7

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Service element descriptions provided by Dr D Siskind. References included.
Support from sector obtained.
Feedback from sector indicated need for a small amount of after hours for the TQ to attend to medication administration or functional programs.
Feedback also that program manager/team leader role should be limited to SCHADS Level 6 as per roles defined in the NSW SACS/SCHADS document.
Respite data indicates 63% of residential respite occurs on weekends. Demand per shift approximately one third each for day, evening and night with slightly higher for weekdays compared to weeknights and week evenings.

2.2.4 Service Category – Family and Carer Support

Descriptor

Family and carer support services are services that provide families, friends, support people and carers of people living with a mental illness the support, information, education and skill development opportunities to fulfil their caring role, while maintaining their own health and wellbeing (Mission Australia 2012). These services recognise that families, friends, support people and carers have their own life and experiences that are affected by the person's experience of mental illness and seeks to support them in both their personal goals and in the context of caring for the person with mental illness.

The Carer Recognition Act identifies the rights of carers to pursue their own goals and life outside of their caring responsibilities, noting that the goals of the person with mental illness may be in conflict with the Carer's goals. Carer support services should have a primary focus on the friends, support people and carer's needs whilst considering impact on the person with mental illness. Carer support services may also address succession issues, exploring security in care and accommodation for the person with mental illness as the friends, support people and carer's capacity to function decreases due to old age or infirmity.

Distinguishing Features

- Explicitly targeted at family, friends, support people and carers
- Includes all services focused on family and carer support except staffed residential respite services. Therefore, this includes services that, if they were not targeted at families and carers, would be reported in other service types

Inclusions

- Carer and family programs
- In-home and or day respite for family, friends, support people and carers
- Family-focused early intervention services

Exclusions

- Residential respite services

Example Services

- National Respite for Carers Program
- Young Carer Program
- Family Mental Health Support Services
- ARAFEMI

Taxonomy

- Flexible Respite
- Day Respite
- Family Support Services
- Individual Carer Support
- Group Based Carer Support

Source

- AIHW Non-Government Organisation Establishment (NGOE) National Minimum Dataset (NMDS) Service Taxonomy (draft April 2012)

2.2.4.1 Service Element – Flexible Respite

Attribute	Details
Description	Flexible respite *"should also have the capacity to directly respond to carer needs. This can be achieved through the provision of resources to the carer in order for them to continue in their caring role. The guiding principles underpinning this approach are flexibility and responsiveness". Cassar Bartolo, K and Sanders, F. (2008) Carer Involvement Project Gathering Lived Experience Phase 1, ARAFEMI, Victoria.* Flexible respite meets both the needs of the family, friends, support people and carers and the care recipient, matching staff with the care recipient in terms of personality, interest, age and gender. Adapted from Psychiatric Disability Services of Victoria (VICSERV) (2008) *Partners in Respite – Building Capacity in Community Mental Health Family Support and Carer Respite*, VICSERV, Victoria. Flexible respite care responsive to individual needs of the person, family, friends, support people and carer. Would include crisis respite, short term or regular respite services, young carers respite and working carers' respite. Two way flexibility of individual/carer respite (ie the person may be cared for within the home or taken out to an activity). Centre based respite care, (eg. Day to Day Living program) is excluded, but overnight care in the home is included.
Fundamental Attributes	Key distinguishing attributes would be that these services are specifically engaged to provide a respite function in the person's home or by taking the person receiving care out to another activity. Note that this excludes community based day respite as this is dealt with in other categories.
Service specifications and suggested modelling attributes	
Activities:	**In Home/Out of Home Respite**
Target Age:	18+ Years
Target Pop'n Profile	
Avg timeframe per activity (if applic)	
Frequency of activity	
Hours of Operation and Proportion BH and AH	60% Business Hours and 40% After Hours
Workforce	

Workforce Type	SCHADS Award Level	Hours worked	Proportion of Business hours and After Hours	Estimated % of Direct Care
Tertiary Qualified	Level 6	0.4 FTE	Business hours only	30% Direct Care
Vocational Qual	Level 5	2.0 FTE	40% BH and 60% AH	70% Direct Care
Vocational Qual	Level 3-4	6.0 FTE	40% BH and 60% AH	70% Direct Care

Evidence Base	
Level of Evidence:	
Key Reference:	

Limitations of Evidence:	
Recommendations for future research:	

Service Element – Flexible Respite – Staffing Profile

Summary of Staffing Profile for Flexible Respite

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Overheads %
NMHSPF	TOTAL	9.71		63.90	31.06	11,338	1,168	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	9.24	0.28	43.43	30.40	11,096	1,201	53,779	496,952	95%	20%
NMSPF	Peer Worker	-	0.25	-	-	-		#DIV/0!	-	0%	20%
NMHSPF	Tertiary Qualified	0.47	0.35	2.21	0.66	242	515	-	-	5%	20%
NMHSPF	Medical	-	0.25	-	-	-		-	-	0%	20%

Information from Care Package	
Hours Per Annum for an individual	1
Total Target Population for care pa	1
Total Hours Req per Annum	1

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost		O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	0.47		2.21	0.66	242	515		$26,625	5%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmacis	0.47	0.70	2.21	0.66	242	515	$56,511	$26,625	5%	20%
NMHR	**VQ and Peer Workers**	9.24		43.43	30.40	11,096	1,201		$522,290	95%	20%
NMHR	Consumer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Carer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	VQMH Worker	6.93	0.30	32.57	22.80	8,322	1,201	$53,660	$371,888	71%	20%
NMHR	VQ Other	2.31	0.30	10.86	7.60	2,774	1,201	$65,105	$150,403	24%	20%
	Total Available Hours					11,338					

Annual Cost Salaries	$548,916
*** Including Overheads 20.0%**	$658,699

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	0	0.00		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	0	0.00	$56,511	$2
NMHR	**VQ and Peer Workers**	1	0.00		#DIV/0!
NMHR	Consumer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	Carer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQMH Worker	1	0.00	$53,660	$33
NMHR	VQ Other	0	0.00	$65,105	$13

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

242.46

Description		Nursing								Medical					Allied Health						Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other SCHADSL6 0.4 FTE 100%BH	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker SCHADSL3 8.0FTE	VQ Other SCHADS L5 2.0FTE	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-				3.1	3.1			6.0	2.0	8.0	11
	Evening	-							-					-					-			5.4	1.8	7.2	7
	Night	-							-					-					-			5.4	1.8	7.2	7
Tuesday	Day								-					-				3.1	3.1			6.0	2.0	8.0	11
	Evening	-							-					-					-			5.4	1.8	7.2	7
	Night	-							-					-					-			5.4	1.8	7.2	7
Wednesday	Day								-					-				3.1	3.1			6.0	2.0	8.0	11
	Evening	-							-					-					-			5.4	1.8	7.2	7
	Night	-							-					-					-			5.4	1.8	7.2	7
Thursday	Day								-					-				3.1	3.1			6.0	2.0	8.0	11
	Evening	-							-					-					-			5.4	1.8	7.2	7
	Night	-							-					-					-			5.4	1.8	7.2	7
Friday	Day	-							-					-				3.1	3.1			6.0	2.0	8.0	11
	Evening	-							-					-					-			5.4	1.8	7.2	7
	Night	-							-					-					-			5.4	1.8	7.2	7
Saturday	All shifts	-	-			-			-					-					-			72.0	24.0	96.0	96
Sunday	All shifts	-	-			-			-					-					-			72.0	24.0	96	96
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15.5	15.5	-	-	228.0	76.0	304.0	320
Annual & Other Leave Relief week		8	8	9	9	9	18	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16	16	-	-	30	10	40	56
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	27	9	36	36
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	27	9	36	36
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	72	24	96	96
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	72	24	96	96
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16	16	-	-	228	76	304	320
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.4	0.4	-	-	6.0	2.0	8.0	0.4
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.1	0.1	-	-	0.9	0.3	1.2	0.1
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.5	0.5	-	-	6.9	2.3	9.2	9.7

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:

Respite data available (see technical manual). Data shows 63% for weekend shifts. Demand is spread approx one third for each shift, except weekday shifts being slightly higher than weeknights. Feedback also that program manager/team leader role should be limited to SCHADS Level 6 as per roles defined in the NSW SACS/SCHADS document.

2.2.4.2 Service Element – Day Respite

Attribute	Details			
Description	Day respite services are specifically engaged to provide a respite function in a centre based environment and do not involve any overnight care			
Fundamental Attributes	Key distinguishing attributes would be that these services are specifically engaged to provide a respite function in a centre based environment and does not involve any overnight care.			
Service specifications and suggested modelling attributes				
Activities:				
Target Age:	18+ Years			
Target Pop'n Profile				
Avg timeframe per activity (if applic)				
Frequency of activity				
Hours of Operation and Proportion BH and AH	100% Business Hours			
Workforce				
Workforce Type	**SCHADS Award Level**	**Hours worked**	**Proportion of Business hours and After Hours**	**Estimated % of Direct Care**
Tertiary Qualified	Level 6	0.4 FTE	Business hours only	30% Direct Care
Vocational Qual	Level 5	2.0 FTE	Business hours only	70% Direct Care
Vocational Qual	Level 3-4	6.0 FTE	Business hours only	70% Direct Care
Evidence Base				
Level of Evidence:				
Key Reference:				
Limitations of Evidence:				
Recommendations for future research:				

Service Element – Day Respite – Staffing Profile

Summary of Staffing Profile for Day Respite

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Overheads %
NMHSPF	**TOTAL**	**6.35**		41.80	20.63	7,529	1,185	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	5.20	0.25	24.43	19.00	6,935	1,334	36,529	189,870	82%	20%
NMSPF	Peer Worker	-	0.25	-	-	-		#DIV/0!	-	0%	20%
NMHSPF	Tertiary Qualified	1.16	0.35	5.43	1.63	594	515	-	-	18%	20%
NMHSPF	Medical	-	0.25	-	-	-		-	-	0%	20%

Information from Care Package	
Hours Per Annum for an individual	220
Particpitants per service Provider	6
Total Target Population for care pa	2,250
Total Hours Req per Annum	82,500

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost		O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	1.16		5.43	1.63	594	515		$65,275	18%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmaci	1.16	0.70	5.43	1.63	594	515	$56,511	$65,275	18%	20%
NMHR	**VQ and Peer Workers**	5.20		24.43	19.00	6,935	1,334		$232,063	82%	20%
NMHR	Consumer Peer Worke	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Carer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	VQMH Worker	4.04	0.20	19.00	15.20	5,548	1,372	$42,626	$172,325	64%	20%
NMHR	VQ Other	1.16	0.30	5.43	3.80	1,387	1,201	$51,717	$59,737	18%	20%
	Total Available Hours					7529.43					
	Annual Cost Salaries	$297,338									
	*** Including Overheads 20.0%**	$356,805									

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	1,086	2.11		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	1,086	2.11	$56,511	$119,203
NMHR	**VQ and Peer Workers**	12,664	9.49		#DIV/0!
NMHR	Consumer Peer Worke	-	#DIV/0!	$0	#DIV/0!
NMHR	Carer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQMH Worker	10,132	7.38	$42,626	$314,695
NMHR	VQ Other	2,533	2.11	$51,717	$109,091

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

594.43

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VO Total	All Total
																		SCHADS L6				SCHADS L3	SCHADS L5		Hours
																		1.0 FTE 100%BH				3.5FTE 100%BH	1.0FTE 100%BH		
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		Worked
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-				7.6	7.6			26.6	7.6	34.2	42
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Tuesday	Day								-					-				7.6	7.6			26.6	7.6	34.2	42
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Wednesday	Day								-					-				7.6	7.6			26.6	7.6	34.2	42
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Thursday	Day								-					-				7.6	7.6			26.6	7.6	34.2	42
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Friday	Day	-							-					-				7.6	7.6			26.6	7.6	34.2	42
	Evening	-							-					-					-					-	-
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-					-	-
Sunday	All shifts	-	-			-			-					-					-					-	-
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	38.0	38	-	-	133.0	38.0	171.0	209
Annual & Other Leave Relief wor		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11				11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	38	38	-	-	133	38	171	209
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	38	38	-	-	133	38	171	209
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.0	1.0	-	-	3.5	1.0	4.5	1.0
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.2	0.2	-	-	0.5	0.2	0.7	0.2
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.2	1.2	-	-	4.0	1.2	5.2	6.4

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:

Respite data available (see technical report) to determine demand for day respite services. Staffing profile based on the same ratio as used for Group support but without the AH component.

Feedback also that program manager/team leader role should be limited to SCHADS Level 6 as per roles defined in the NSW SACS/SCHADS document.

2.2.4.3 Service Element –Family Support Services

Attribute	Details			
Description	Services targeted at the family community in contrast to the individual and may be directed towards re-engagement of the individual with the family (ie family members currently not in a caring role because of disengagement). Would include information, family mediation and re-engagement, Child of Parents with Mental Illness (COPMI), and family oriented counselling.			
Fundamental Attributes	Key distinguishing attributes would be services that may or may not be provided by a peer worker and are specifically focused on the needs of the family (ie parents, siblings, other caregivers).			
Service specifications and suggested modelling attributes				
Target Age:	All ages (children require access as well as adults)			
Target Pop'n Profile	Child of Parents with Mental Illness (COPMI,) Family members of person with mental illness (PWM)I			
Avg timeframe per activity (if applic)	1 hr/week for 12 weeks			
Hours of Operation and Proportion BH and AH	100% BH			
Workforce				
Workforce Type	**SCHADS Award Level**	**Hours worked**	**Proportion of Business hours and After Hours**	**Estimated % of Direct Care**
Tertiary Qualified	Level 6	0.4 FTE	Business hours only	30% Direct Care
Vocational Qual	Level 5	2.0 FTE	60% BH and 40% AH	70% Direct Care
Vocational Qual	Level 3-4	6.0 FTE	60% BH and 40% AH	70% Direct Care
Evidence Base				
Level of Evidence:				
Key Reference:				
Limitations of Evidence:				
Recommendations for future research:				

Service Activity – Family Support

General description

"Mental health care that is provided in a way that recognises the unique role of personal and family relationships in promoting wellbeing, providing care, and fostering recovery across the lifespan and the needs of families and support givers themselves. Families are engaged and helped through e-counselling, education and support programs and services. Wherever possible, families become partners in care and

treatment and are integrated into decision-making in a way that respects a person's choice, consent and privacy". (Craze, L. (2012) *National Recovery-Oriented Mental Health Practice Framework – 2nd Consultation Draft,* on behalf of the Safety and Quality Partnership Subcommittee of the Australian Health Ministers' Advisory Council, Mental Health Standing Committee.)

Access

General aim is to reduce the impact of mental illness on all family members

Planning

Encourage and support people to develop advanced care directives and/or plans for the care of their children with their partners and families when they are well. Support people in sharing key elements of recovery goals and approaches with their partners/family members. (Craze, L. (2012) *National Recovery-Oriented Mental Health Practice Framework – 2nd Consultation Draft,* on behalf of the Safety and Quality Partnership Subcommittee of the Australian Health Ministers' Advisory Council, Mental Health Standing Committee.)

Action

- Resources: Practitioners working in the child protection, non-government welfare, housing and youth sectors do not necessarily have formal training or qualifications that include mental illness symptoms and treatment.
- Skill Development (including Rehabilitation Focus): Address age appropriate factors for risk and resilience, ensuring that the needs of all family members are addressed and included in the development of care planning and delivery. In particular, identify and maximise the strengths within the child and the family unit. Need to talk with children about their experience, worries and fears, parents should be active partners in the process of children receiving information about their illness. Parents may be ambivalent about their child receiving information, thinking that their child is protected by having little, or no, information or concerned that if they give the information they may be incorrect. Talking with children comprises of giving children age-appropriate information, but also gives them the opportunity to voice anxieties such as 'will I get it?', 'will Mum get better?', 'why did it happen to my dad?' Cowling, V., Edan, V., Cuff, R., Armitage, P., and Herszberg, D. *'Mental health consumer and carer participation in professional education: Getting There Together for children of parents with mental illness and their families',* Australian Social Work, Vol. 59, pp. 406-21, 2007.
  Work in partnership with families to support the recovery of a relative and to help them to identify and meet their own support needs. Eg. Support with own responses, information needs, education to use a recovery approach, family involvement in goal setting, recovery and wellness planning. (Craze, L. (2012) *National Recovery-Oriented Mental Health Practice Framework – 2nd Consultation Draft,* on behalf of the Safety and Quality Partnership Subcommittee of the Australian Health Ministers' Advisory Council, Mental Health Standing Committee.)
- Social/Cultural Context: Potential risk factors that may occur at different ages, such as a lack of attachment in infancy, social isolation, poverty, frequent and unplanned separations from the parent, insecure housing, irregular school attendance and lack of opportunity to participate in school-based, or extra curricular, activities. Similarly, the range of factors that may serve to foster resilience at each age and stage need to be considered, such as coordinated care at the ante and post-natal stages of birth, respite care and peer support groups for children and young people and awareness of developmental issues for adolescents by adults in the young person's family, extended family or school environment as well as identifying the strengths within the child and the family unit. Cowling, V., Edan, V., Cuff, R., Armitage, P., and Herszberg, D. *'Mental health consumer and carer participation in professional education: Getting There Together for children of parents with mental illness and their families',* Australian Social Work, Vol. 59, pp. 406-21, 2007.
  Support people to maintain, establish or re-establish relationships with family, partners, children, friends, cultural networks and significant others. Support people to fulfil their parenting roles and other important relationship roles. (Craze, L. (2012) *National Recovery-Oriented Mental Health Practice Framework – 2nd Consultation Draft,* on behalf of the Safety and Quality Partnership Subcommittee of the Australian Health Ministers' Advisory Council, Mental Health Standing Committee.)

Outcomes

- Increased resilience and social connectedness of children and young people with a parent with a mental illness, reduced stigma associated with mental illness, and enhanced community capacity to assist these families through partnerships between sectors and services, peer support programs, work force development and whole of community education.
- Parents who have a mental illness are able to access mental health services for treatment and rehabilitation that are also mindful of their parenting role.
- Dependent children and young people, whose parent has a mental illness, will have their needs recognised by their parent's mental health service and so have their own mental health optimised.
- Families where a parent has a mental illness will receive appropriate support to help them manage adverse circumstances and maximise each family member's resilience.
- Each family member, including dependent children and young people, can be involved in networks and service planning so that local policies and service development are relevant to the needs of families where a parent has a mental illness.
- Families where a parent has a mental illness have appropriate access to universal and targeted services that can support their needs.

Maybery, D., Reupert, A., Grove, C., Goodyear, M., Marston N. and Sutton K. (2012). *Targeted preliminary evaluation of Department of Health FaPMI strategy*. Report to Victorian Department of Health, Mental Health, Drugs and Regions Division.

Collaboration

There is a role in referring families and children to health, mental health or leisure and recreational services and activities

Service Element –Family Support Services – Staffing Profile

Summary of Staffing Profile for Family Support Services

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Overheads %
NMHSPF	**TOTAL**	**9.70**		63.84	31.05	11,334	1,168	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	9.24	0.28	43.43	30.40	11,096	1,201	48,523	448,378	95%	20%
NMSPF	Peer Worker	-	0.25	-	-	-		#DIV/0!	-	0%	20%
NMHSPF	Tertiary Qualified	0.46	0.35	2.17	0.65	238	515	-	-	5%	20%
NMHSPF	Medical	-	0.25	-	-	-		-	-	0%	20%

Information from Care Package	
Hours Per Annum for an individual	220
Total Target Population for care pa	2,250
Total Hours Req per Annum	495,000

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost		O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	0.46		2.17	0.65	238	515		$26,110	5%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmacis	0.46	0.70	2.17	0.65	238	515	$56,511	$26,110	5%	20%
NMHR	**VQ and Peer Workers**	9.24		43.43	30.40	11,096	1,201		$470,797	95%	20%
NMHR	Consumer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Carer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	VQMH Worker	6.93	0.30	32.57	22.80	8,322	1,201	$48,370	$335,223	71%	20%
NMHR	VQ Other	2.31	0.30	10.86	7.60	2,774	1,201	$58,686	$135,574	24%	20%
	Total Available Hours					11,334					
Annual Cost Salaries		$496,907									
*** Including Overheads**	**20.0%**	$596,288									

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	10,385	20.18		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	10,385	20.18	$56,511	$1,140,344
NMHR	**VQ and Peer Workers**	484,615	403.58		#DIV/0!
NMHR	Consumer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	Carer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQMH Worker	363,462	302.69	$48,370	#########
NMHR	VQ Other	121,154	100.90	$58,686	$5,921,177

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

237.77

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
																		SCHADS L6				SCHADS L3	SCHADS L5		
																		0.4 FTE 100%BH				8.0FTE 80%BH	2.0FTE 80%BH		
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-				3.0	3.0			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.1	4.8	17.9	18
	Night	-							-					-					-					-	-
Tuesday	Day								-					-				3.0	3.0			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.2	4.9	18.1	18
	Night	-							-					-					-					-	-
Wednesday	Day								-					-				3.0	3.0			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.1	4.8	17.9	18
	Night	-							-					-					-					-	-
Thursday	Day								-					-				3.1	3.1			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.2	4.9	18.1	18
	Night	-							-					-					-					-	-
Friday	Day	-							-					-				3.1	3.1			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.2	4.8	18.0	18
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-			14.0	1.4	15.4	15
Sunday	All shifts	-	-			-			-					-					-			13.2	4.9	18	18
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15.2	15	-	-	228.0	76.0	304.0	319
Annual & Other Leave Relief weeks		8	8	9	9	9	16	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15	15	-	-	135	46	181	196
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	66	24	90	90
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	14	1	15	15
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	13	5	18	18
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15	15	-	-	228	76	304	319
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.4	0.4	-	-	6.0	2.0	8.0	0.4
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.1	0.1	-	-	0.9	0.3	1.2	0.1
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.5	0.5	-	-	6.9	2.3	9.2	9.7

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:

Support from sector indicated. Feedback indicated a need for more after hours time as evidenced by long waiting lists for weekend and evening appointments. Recommended 60% BH and 40% AH. Feedback also that program manager/team leader role should be limited to SCHADS Level 6 as per roles defined in the NSW SACS/SCHADS document.

2.2.4.4 Service Element – Group Carer Support Services

Attribute	Details			
Description	Would include group based counselling or post suicide support, includes young carers and COPMI. Would include psychological education and training services, group based peer support, including young carers and COPMI.			
Fundamental Attributes	Key distinguishing attributes would be services that may or may not be provided by a peer worker, are specifically focused on the needs of the individual/ family/ friend/ support people or carers (in contrast to personalised support for the person with mental illness) and are provided in a group format.			
Service specifications and suggested modelling attributes				
Activities:	• **Group Carer Support linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well** • **Group Carer Support linked to education and employment.** • **Group Carer Support linked to enhancing relationships and social participation** • **Group Carer Support linked to health management.**			
Target Age:	All ages (children require access as well as adults)			
Avg timeframe per activity (if applic)	1hr/week for 12 weeks			
Hours of Operation and Proportion BH and AH	75% BH / 25% AH – Feedback suggested 2 evenings per week and Saturday PM			
Workforce				
Workforce Type	**SCHADS Award Level**	**Hours worked**	**Proportion of Business hours and After Hours**	**Estimated % of Direct Care**
Tertiary Qualified	Level 7	1.0 FTE	70% BH and 30% AH	80% Direct Care
Vocational Qual	Level 4	1.0 FTE	70% BH and 30% AH	80% Direct Care
Average 6x participants per staff member.				
Evidence Base				
Level of Evidence:				
Key Reference:				
Limitations of Evidence:				
Recommendations for future research:				

Service Activity – Group Carer Support linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well

General description

Group Support services provided specifically towards the family/ friend/ support people or carer's personal goals for the establishment and maintenance of safe and secure housing. The services are provided on a group basis, assisting an individual to maintain or change their housing circumstances (including succession planning for the care of the person with mental illness), remaining sensitive to cultural and multi-generational needs. (eg. Supporting the family/ friend/ support people or carers in the practical maintenance of their housing, accessing appropriate housing options as required, multi-generational living arrangements, homeless people or for those at risk of homelessness).

Information Gathering

In the context of a group program, identify psychosocial needs and functional assessment identifying housing needs, support available, personal strengths and areas for support and/or development. Also includes the provision of information that identifies different housing options and outlines access issues.

Planning

Development of a person centred recovery plan inclusive of support networks driven by the family/ friend/ support person or carer that identifies housing goals, referral pathways, housing providers, resource options and advocates as appropriate and associated skill development and action required.

Action

As per the recovery plan, support the family/ friend/ support person or carer in establishing and maintaining housing arrangements including:

- Resources: Establish financial resources, legal and tenancy support, practical support (both personally and in relation to property maintenance), processes to support skill development. Engaging assertively with the housing market is critical to establishing safe and secure housing. Particularly in the context of liaising/networking and following up on commitments made, supporting accommodation hunting and development of the housing application. Also support the family/friend/support person or carer to access public housing tenancy support officers and rental assistance schemes, or assist with the installation of security devices, advancing or assisting with bond money and removal costs as indicated in the support issues identified.
- Skill Development (including Rehabilitation Focus): Develop skills to improve competence and confidence in community living, particularly in relation to managing tenancy matters.
- Social/Cultural Context: Ensure housing allocation is safe and appropriate to personal and cultural circumstances.
- Health and Wellbeing: Improve independence and resilience and ensure appropriate support is provided to maintain a healthy home environment.

Issues for consideration relevant to particular family/friend/support person or carers include the following:

- Young Carers/Child of mentally ill parents (COPMI) – Is the young carer / COPMI safely and securely housed now?
  Do they need special housing support to attend school, do homework, maintain the house / garden, participate in social activities, pay the rent, manage finances, purchase and prepare food, etc. (Identify and quantify the additional actions required to provide the support needed.)
- Family/ friend/ support person or carer of 0 – 12 yrs. child with mental health problem – Housing location provides access to specialised and/or sympathetic schooling, therapeutic or social programs. Liaison with schools, childcare facilities. Financial support for repairs or additional safety and security features in housing.

- Family/ friend/ support person or carer of a young person (13 – 24 yrs.) with mental health problem – Supporting parent and families in setting personal and family boundaries to maintain safe and secure housing (skills development, practical support).
- Family/ friend/ support person or carer of an ageing person with mental health problems – Supporting them to find appropriate separate supported residential accommodation for an elderly frail person with a mental health problem. May include sale or division of property that the family/ friend/ support person or carer and ageing person have lived in for many years.
- Ageing family/ friend/ support person or carers > 65 yrs (and including those frail of any age) – Consider need for a ground floor dwelling, ease of access to local shops, transport, support for maintaining the house and yard, home modifications, tenancy / housing succession planning and increased respite services.

Outcomes

Stability of housing, individual housing goals are met and opportunity and right for community participation in accordance to personal goals. Reviews with family/friend/support person or carer to ascertain whether or not desired outcomes have been / are being achieved and how effectively; makes adjustments to or closes episode of support, accordingly. Returns to assessment, planning and implementation phases as indicated, to meet the same or another identified need for support.

Collaboration

Individuals/family/friend/support person or carers, housing providers, income support or management, mental and general health clinical and community support services, financial brokers, succession planning for secure housing for the person with mental illness, legal services, tribunals and other social, health and community opportunities. Supports and encourages the family/ friend/ support person or carer to participate in social and community activities.

Service Activity – Group Carer Support linked to education and/or employment

General description

Group support services provided specifically towards a family/ friend/ support person or carer's personal goals towards education and employment. The services are provided on a group basis, and generally target the functions of accessing and supporting education and employment opportunities rather than providing the education and employment services themselves.

Information Gathering

Psychosocial needs assessment and functional assessment identifying education and employment targets, motivation to work and/or study, self-identified support needs, support available, personal strengths and areas for development. Also includes the provision of information that identifies different education/employment options and outlines access issues.

Planning

Development of a person-centred plan driven by the family/ friend/ support person or carer that identifies education and/or employment goals, referral pathways, service providers, resource options and advocates as appropriate and associated skill development and action required. Particularly need to consider the long term of positive effects of supporting individuals back into school, which further supports post-secondary study and subsequent employment opportunities *(McLaren, K (2004) Work in Practice – Best practice employment support services for people with mental illness, NZ)*.

Action

As per the personal plan, support the family/ friend/ support person or carer in accessing and maintaining education and employment through the following activity:

- Resources: Provide career counselling and assistance in course selection and enrolment procedures, linking to other services as required. (VETE)Establish financial counselling and access to financial support, transport services and employment/education practical support. Engage assertively with the employment and education providers to ensure a flexible and supportive environment is established.
- Skill Development (including Rehabilitation Focus): Provide or provide access to, re-skilling, skills development or confidence building courses such as computer training, preparing curriculum vitae, preparing for job interviews, time management, assertiveness training. Establishing effective employment strategies early in the illness trajectory may have life-long impact on employment outcomes for the person with mental illness and family/ friend/ support person or carer, preventing secondary disability and associated economic and social costs. Providing a specialist VETE service ensures employment and education remain a high priority when other issues required addressing by the care coordinator (eg decline in mental or physical health). (VETE)
- Social/Cultural Context: Address stigma, encourage a sympathetic.
- Work/education environment able to accommodate circumstances such as unplanned absences to support the person they care for during fluctuating periods of episodic illness. Provide flexible support tailored to individual need, tutoring and flexible delivery of education courses or employment arrangements promotes the likelihood of success. (VETE)
- Health and Wellbeing: Close links and integration with care coordination services, primary care, crisis intervention and accommodation issues will support the stability of health of the person being cared for and support the family/ friend/ support person or carer's progress towards achieving their vocational and educational goals. (VETE)

Outcomes

Participation in employment, improved income, sustained or stable involvement in employment and education, greater personal independence / 'space'.

Collaboration

Establish agreements with the person being cared for and (as indicated) develop a backup plan with other services to provide or increase support during family/ friend/ support person or carer's absence at work. Foster a close working relationship with income support services and Job Capacity Assessors to ensure referrals to employment services are processed appropriately. Need to establish mental health carer support positions dedicated to vocational and educational issues to enhance employment and educational outcomes. Enhanced intersectoral links, particularly between mental health, generic employment and education services (eg. Resume production, course content information), Disability Employment Services, TAFE, Universities and other social support services.
Frost, B., Morris, A., Sherring, J. and Robson, E. (2008) Vocational Education, Training and Employment (VETE) Pilot Project Report – Psychiatric Rehabilitation Services 2006-2007, NSW Health, Sydney.

Service Activity – Group Carer Support linked to enhanced relationships and social participation

General description

In a group format, working with the family/ friend/ support person or carer to identify and develop social interests and to identify and manage any potential or actual negative impact from their caring role. Aim is to access activities within the local and broader community and to identify relationships which are important to them and work on developing, maintaining and growing those relationships. This may require working directly with the family/ friend/ support person or carer to develop their personal skills, or may be a matter of managing the logistics and responsibilities of their caring role (eg provision of respite).

Information Gathering

Identify what the person's social interests are and availability in the community. Work with the family/ friend/ support person or carer to identify support people who may be available to assist with accessing and participating in the desired activities. Consider issues such as isolation, previous relationships that have been neglected or otherwise negatively impacted by the caring role, and personal confidence and desire for increased socialisation.

Planning

Work with the family/ friend/ support person or carer to develop a personal plan that involves developing the skills to find, access and participate in community activities and develop social relationships. Consider the motivational status of the individual and assist them in planning each aspect of participation in social activities including identifying the resources and skill development required.

Action

As per the personal plan:

- Resources: Establish financial resources to assist with funding community activities or access to community activities. Identify and establish support to access and engage in community activities e.g. transport, respite etc. Identify support people to assist with community integration and participation (may include workers).
- Skill Development (including Rehabilitation Focus): Identify and develop skills required to access and participate in community activities e.g. Self-confidence, social presentation and communication skills.
- Social/Cultural Context: Ensure activities planned are socially and culturally appropriate and relevant to the priorities and desire of the individual.
- Health and Wellbeing: Promote activities that will assist in the development of improved health and well being.

Outcomes

Increasing social participation and community engagement in order to meet goals connected to social inclusion.

Collaboration

The person with mental illness, family, friends and support people, organisations providing courses and activities, educational and vocational providers, community organisations, non government organisations.

Service Activity – Group Carer Support linked to health management

General description

In a group format, assisting a person in a caring role to improve or maintain his or her health or wellness. In particular, avoiding self-neglect and actively seeking or establishing strategies and activities that promote good health and wellbeing. Examples might include regular physical health assessment and treatment as appropriate, massage and other forms of relaxation activities, counselling and peer support, recreational activities, skill development in health practices (eg. Cooking, cleaning, fitness) and use of personal support and respite services.

Information Gathering

Engaging the participant in a relationship to develop a plan for health management. Assessing health status (including physical and mental health) and barriers and enablers for good health. Includes review of physical and mental health needs, thorough history and review of medication (both physical and otherwise). Collation

of physical and dental health contacts and connection to these services. Assess readiness for change and skills connected with coping, health management, menu planning, shopping, cooking and fitness.

Planning

Prioritise and set health and wellness goals by formulating a health and wellness plan, that is driven by the participant with support in the planning process.

Action

Support the family/ friend/ support person or carer in developing healthy behaviours and support access and use of resources as appropriate:

- Resources: Nicotine replacement therapy, brokerage funds (e.g. to assist in accessing gym memberships or exercise clothes), respite and/or personal support services.
- Skill Development (including Rehabilitation Focus): Support the family/ friend/ support person or carer in building skills in healthy practices and overall health management and to engage or disengage in activities which assist in improving health. Development of insight to avoid neglecting personal health in favour of their caring role and to establish and maintain positive coping strategies.
- Social/Cultural Context: Utilising support and respite services as required to maintain and promote social relationships in work, education and social/cultural environments.
- Health and Wellbeing: As above.

Outcomes

Prevent deterioration of health status and increase coping and stability of caring role.

Collaboration

General Practice and other health services, community health management organisations (e.g. Gyms, swimming pools, weight management services), other recreational, educational and vocational services and mental health care and related support services.

Service Element – Group Carer Support Services – Staffing Profile

Summary of Staffing Profile for Group Carer Support Services

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Overheads %
NMHSPF	TOTAL	2.31		15.21	8.15	2,974	1,287	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	1.16	0.27	5.43	4.07	1,487	1,287	24,185	27,957	50%	20%
NMSPF	Peer Worker	-	0.25	-	-	-		#DIV/0!	-	0%	20%
NMHSPF	Tertiary Qualified	1.16	0.28	5.43	4.07	1,487	1,287	-	-	50%	20%
NMHSPF	Medical	-	0.25	-	-	-		-	-	0%	20%

Information from Care Package	
Hours Per Annum for an individual	220
Particpitants per service Provider	6
Total Target Population for care pa	2,250
Total Hours Req per Annum	82,500

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost	FTE share	O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	1.16		5.43	4.07	1,487	1,287		$74,129	50%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmacis	1.16	0.25	5.43	4.07	1,487	1,287	$64,126	$74,129	50%	20%
NMHR	**VQ and Peer Workers**	1.16		5.43	4.07	1,487	1,287		$55,915	50%	20%
NMHR	Consumer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Carer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	VQMH Worker	1.16	0.25	5.43	4.07	1,487	1,287	$48,370	$55,915	50%	20%
NMHR	VQ Other	-	0.30	-	-	-	-		$0	0%	20%
	Total Available Hours					2,974					
Annual Cost Salaries		$130,044									
*** Including Overheads**	**20.0%**	$156,052									

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	6,875	5.34		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	6,875	5.34	$64,126	$342,672
NMHR	**VQ and Peer Workers**	6,875	5.34		#DIV/0!
NMHR	Consumer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	Carer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQMH Worker	6,875	5.34	$48,370	$258,473
NMHR	VQ Other	-	#DIV/0!	$0	#DIV/0!

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

1487.24

Description		Nursing								Medical					Allied Health						Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other SCHADS L6 1.0 FTE 70% BH	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker SCHADS L4 1.0FTE 70%BH	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-				5.3	5.3			5.3		5.3	11
	Evening	-							-					-				1.8	1.8			1.8		1.8	3
	Night	-							-					-					-					-	-
Tuesday	Day								-					-				5.3	5.3			5.3		5.3	11
	Evening	-							-					-				1.7	1.7			1.7		1.7	3
	Night	-							-					-					-					-	-
Wednesday	Day								-					-				5.3	5.3			5.3		5.3	11
	Evening	-							-					-				1.8	1.8			1.8		1.8	3
	Night	-							-					-					-					-	-
Thursday	Day								-					-				5.3	5.3			5.3		5.3	11
	Evening	-							-					-				1.7	1.7			1.7		1.7	3
	Night	-							-					-					-					-	-
Friday	Day	-							-					-				5.3	5.3			5.3		5.3	11
	Evening	-							-					-				1.8	1.8			1.8		1.8	3
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-		-				-					-				1.7	1.7			1.7		1.7	3
Sunday	All shifts	-	-		-				-					-				1.6	2			1.6		2	3
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	38.0	38	-	-	38.0	-	38.0	76
Annual & Other Leave Relief week		9	9	9	9	9	18	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	36.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	27	27	-	-	27	-	27	53
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	8	8	-	-	8	-	8	16
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	2	-	-	2	-	2	3
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	2	-	-	2	-	2	3
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	38	38	-	-	38	-	38	76
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.0	1.0	-	-	1.0	-	1.0	1.0
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.2	0.2	-	-	0.2	-	0.2	0.2
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.2	1.2	-	-	1.2	-	1.2	2.3

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:

Support from sector indicated. Feedback indicated 80% Consumer Delivery Time was unrealistic. Modified to 75% which is still higher than other other community support services as there is no travel time lost per participant as occurs in outreach type services. AH time estimated based on advice of M-F & 2x PM sessions & 1x Sat PM Feedback also that program manager/team leader role should be limited to SCHADS Level 6 as per roles defined in the NSW SACS/SCHADS document.

2.2.4.5 Service Element – Individual Carer Support Services

Attribute	Details
Description	Needs identified by family/ friend/ support person or carer carers include: • Increased community awareness about the signs and symptoms of mental illness to facilitate detection, early intervention and support; • Increased recognition of the experiences and needs of family/friend/support person or carers and provision of information and referral for support; • Increased recognition and assistance to overcome the impact of living with a person with mental illness (relationships, family dynamics, reduced level of intimacy, social and emotional distancing, restricted social relationships); • Assistance with significant financial costs related to caring (accessing treatment, demands of specific aspects of the illness, time from work and ability to continue employment; • Increased access to effective treatment via better knowledge and awareness, availability of information, increased awareness and skills among health professionals and effective early intervention or crisis management. • Better inclusion of family/ friend/ support person or carer's needs and concerns – voice – and more inclusive approaches to treatment and management.
Fundamental Attributes	Key distinguishing attributes would be services that may or may not be provided by a peer worker, are specifically focused on the needs of the family/ friend/ support person or carer (in contrast to personalised support for the person with mental illness).
Service specifications and suggested modelling attributes	
Activities:	• **Individual Carer Support linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well** • **Individual Carer Support linked to education and employment.** • **Individual Carer Support linked to enhancing relationships and social participation** • **Individual Carer Support linked to health management.**
Target Age:	All ages (children require access as well as adults)
Target Pop'n Profile	COPMI, Family members of people with mental illness
Avg timeframe	1hr/week for 12 weeks
Hours of Operation and Proportion BH and AH	75% BH / 25% AH
Workforce	

Workforce Type	SCHADS Award Level	Hours worked	Proportion of Business hours and After Hours	Estimated % of Direct Care
Tertiary Qualified	Level 6	0.4 FTE	Business hours only	30% Direct Care
Vocational Qual	Level 5	2.0 FTE	60% BH and 40% AH	70% Direct Care
Vocational Qual	Level 3-4	6.0 FTE	60% BH and 40% AH	70% Direct Care

Evidence Base	
Level of Evidence:	
Key Reference:	*Victorian Mental Health Network (2004) in Cassar Bartolo, K and Sanders, F. (2008) Carer Involvement Project Gathering Lived Experience Phase 1, ARAFEMI,*

	Victoria.
Limitations of Evidence:	
Recommendations for future research:	

Service Activity – Individual Carer Support linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well

General description

Support services provided specifically towards a family/ friend/ support person or carer 's personal goals for the establishment and maintenance of safe and secure housing. The services are provided on a one-to-one basis, assisting a person to maintain or change their housing circumstances (including succession planning for the care of the person with mental illness), remaining sensitive to cultural and multi-generational needs. (eg. Supporting family/ friend/ support person or carers in the practical maintenance of their housing, accessing appropriate housing options as required, multi-generational living arrangements, homeless people or for those at risk of homelessness).

Information Gathering

Psychosocial needs assessment and functional assessment identifying housing needs, support available, personal strengths and areas for support and/or development. Also includes the provision of information that identifies different housing options and outlines access issues.

Planning

Development of a person centred recovery plan inclusive of support networks driven by the family/ friend/ support person or carer that identifies housing goals, referral pathways, housing providers, resource options and advocates as appropriate and associated skill development and action required.

Action

As per the recovery plan, support the family/ friend/ support person or carer in establishing and maintaining housing arrangements including:

- Resources: Establish financial resources, legal and tenancy support, practical support (both personally and in relation to property maintenance), processes to support skill development. Engaging assertively with the housing market is critical to establishing safe and secure housing. Particularly in the context of liaising/networking and following up on commitments made, supporting accommodation hunting and development of the housing application. Also support family/ friend/ support person or carer to access public housing tenancy support officers and rental assistance schemes, or assist with the installation of security devices, advancing or assisting with bond money and removal costs as indicated in the support issues identified.
- Skill Development (including Rehabilitation Focus): Develop skills to improve competence and confidence in community living, particularly in relation to managing tenancy matters.
- Social/Cultural Context: Ensure housing allocation is safe and appropriate to personal and cultural circumstances.
- Health and Wellbeing: Improve independence and resilience and ensure appropriate support is provided to maintain a healthy home environment.

Issues for consideration relevant to particular family/ friend/ support person or carers include the following:

- Young Carers/COPMI – Is the young carer / COPMI safely and securely housed now? Do they need special housing support to attend school, do homework, maintain the house / garden, participate in social activities, pay the rent, manage finances, purchase and prepare food, etc. (Identify and quantify the additional actions required to provide the support needed.)
- Family/ friend/ support person or carer of 0 – 12 yrs. child with mental health problem – Housing location provides access to specialised and/or sympathetic schooling, therapeutic or social programs. Liaison with schools, childcare facilities. Financial support for repairs or additional safety and security features in housing.
- Family/ friend/ support person or carer of a young person (13 – 24 yrs.) with mental health problem – Supporting them in setting personal and family boundaries to maintain safe and secure housing (skills development, practical support).
- Family/Friend/Support Person or Carer of an ageing person with mental health problems – Supporting the family/friend/support person or carer to find appropriate separate supported residential accommodation for an elderly frail person with a mental health problem. May include sale or division of property that the family/friend/support person or carer and ageing person have lived in for many years.
- Ageing family/ friend/ support person or carers > 65 yrs (including those frail of any age) – Consider need for a ground floor dwelling, ease of access to local shops, transport, support for maintaining the house and yard, home modifications, tenancy / housing succession planning and increased respite services.

Outcomes

Stability of housing, individual housing goals are met and opportunity and right for community participation in accordance to personal goals. Reviews to ascertain whether or not desired outcomes have been / are being achieved and how effectively; makes adjustments to or closes episode of support, accordingly. Returns to assessment, planning and implementation phases as indicated, to meet the same or another identified need for support.

Collaboration

Individuals, family, friends and support people, housing providers, income support or management, mental and general health clinical and community support services, financial brokers, succession planning for secure housing for the person with mental illness, legal services, tribunals and other social, health and community opportunities. Supports and encourages the family/friend/support person or carer to participate in social and community activities.

Service Activity – Individual Carer Support linked to education and/or employment

General description

Individual support services provided specifically towards a family/friend/support person or carer's personal goals towards education and employment. The services are provided on a one-to-one basis, and generally target the functions of accessing and supporting education and employment opportunities rather than providing the education and employment services themselves.

Information Gathering

Psychosocial needs assessment and functional assessment identifying education and employment targets, motivation to work and/or study, self-identified support needs, support available, personal strengths and areas for development. Also includes the provision of information that identifies different education/employment options and outlines access issues.

Planning

Development of a person-centred plan driven by the family/ friend/ support person or carer that identifies education and/or employment goals, referral pathways, service providers, resource options and advocates as appropriate and associated skill development and action required. Particularly need to consider the long term of positive effects of supporting people back into school, which further supports post-secondary study and subsequent employment opportunities *(McLaren, K (2004) Work in Practice – Best practice employment support services for people with mental illness, NZ)*.

Action

As per the personal plan, support the family/friend/support person or carer in accessing and maintaining education and employment through the following activity:

- Resources: Provide career counselling and assistance in course selection and enrolment procedures, linking to other services as required. (VETE)Establish financial counselling and access to financial support, transport services and employment/education practical support. Engage assertively with the employment and education providers to ensure a flexible and supportive environment is established.
- Skill Development (including Rehabilitation Focus): Provide or provide access to, re-skilling, skills development or confidence building courses such as computer training, preparing curriculum vitae, preparing for job interviews, time management, and assertiveness training. . Establishing effective employment strategies early in the illness trajectory may have life-long impact on employment outcomes for both the person with mental illness and family, friends, support people and carers, preventing secondary disability and associated economic and social costs. Providing a specialist VETE service ensures employment and education remain a high priority when other issues required addressing by the care coordinator (eg decline in mental or physical health). (VETE)
- Social/Cultural Context: Address stigma, encourage a sympathetic work/education environment able to accommodate circumstances such as unplanned absences to support the person they care for during fluctuating periods of episodic illness. Provide flexible support tailored to individual need, tutoring and flexible delivery of education courses or employment arrangements promotes the likelihood of success. (VETE)
- Health and Wellbeing: Close links and integration with care coordination services, primary care, crisis intervention and accommodation issues will support the stability of health of the person being cared for and support the family/friend/support person or carer's progress towards achieving their vocational and educational goals. (VETE)

Outcomes

Participation in employment, improved income, sustained or stable involvement in employment and education, greater personal independence / 'space'.

Collaboration

Establish agreements with the person being cared for and (as indicated) develop a backup plan with other services to provide or increase support during family/friend/support person or carer's absence at work. Foster a close working relationship with income support services and Job Capacity Assessors to ensure referrals to employment services are processed appropriately. There is a need to establish mental health carer support positions dedicated to vocational and educational issues to enhance employment and educational outcomes. Enhanced intersectoral links, particularly between mental health, generic employment and education services (e.g. Resume production, course content information), Disability Employment Services, TAFE, Universities and other social support services.
Frost, B., Morris, A., Sherring, J. and Robson, E. (2008) Vocational Education, Training and Employment (VETE) Pilot Project Report – Psychiatric Rehabilitation Services 2006-2007, NSW Health, Sydney.

Service Activity – Individual Carer Support linked to enhanced relationships and social participation

General description

Working with the family/friend/support person or carer to identify and develop social interests and to identify and manage any potential or actual negative impact from their caring role. Aim is to access activities within the local and broader community and to identify relationships which are important to the family/friend/support person or carer and work on developing, maintaining and growing those relationships. This may require working directly with the family/friend/support person or carer to develop their personal skills, or may be a matter of managing the logistics and responsibilities of their caring role (e.g. provision of respite).

Information Gathering

Identify what the person's social interests are and availability in the community. Work with the family/ friend/ support person or carer to identify support people who may be available to assist with accessing and participating in the desired activities. Consider issues such as isolation, previous relationships that have been neglected or otherwise negatively impacted by the caring role, and build personal confidence and desire for increased socialisation.

Planning

Work with the family/ friend/ support person or carer to develop a personal plan that involves developing the skills to find, access and participate in community activities and develop social relationships. Consider the motivational status of the individual and assist the family/ friend/ support person or carer in planning each aspect of participation in social activities including identifying the resources and skill development required.

Action

As per the personal plan:

- Resources: Establish financial resources to assist with funding community activities or access to community activities. Identify and establish support to access and engage in community activities Eg. transport, respite etc. Identify support people to assist with community integration and participation (may include workers).
- Skill Development (including Rehabilitation Focus): Identify and develop skills required to access and participate in community activities e.g. Self-confidence, social presentation and communication skills.
- Social/Cultural Context: Ensure activities planned are socially and culturally appropriate and relevant to the priorities and desire of the individual.
- Health and Wellbeing: Promote activities that will assist in the development of improved health and well being.

Outcomes

Increasing social participation and community engagement in order to meet goals connected to social inclusion.

Collaboration

The person with mental illness, family, friends, support people and carers, organisations providing courses and activities, educational and vocational providers, community organisations, non government organisations.

Service Activity – Individual Carer Support linked to health management

General description

Assisting a person in a caring role to improve or maintain his or her health or wellness. In particular, avoiding self-neglect and actively seeking or establishing strategies and activities that promote good health and wellbeing. Examples might include regular physical health assessment and treatment as appropriate, massage and other forms of relaxation activities, counselling and peer support, recreational activities, skill development in health practices (e.g. Cooking, cleaning, fitness) and use of personal support and respite services.

Information Gathering

Engage the participant in a relationship to develop a health management plan. Assessing health status (including physical and mental health) and barriers and enablers for good health. This includes review of physical and mental health needs, thorough history and review of medication (both physical and otherwise). The collation of physical and dental health contacts and connection to these services should be considered. Assess readiness for change and skills connected with coping, health management, menu planning, shopping, cooking and fitness.

Planning

Prioritise and set health and wellness goals by formulating a health and wellness plan, that is driven by the participant with support throughout the planning process.

Action

Support the family/friend/support person or carer in developing healthy behaviours and provide information about support access and use of resources as appropriate:

- Resources: Nicotine replacement therapy, brokerage funds (e.g. to assist in accessing gym memberships or exercise clothes), respite and/or personal support services.
- Skill Development (including Rehabilitation Focus): Support the family/ friend/ support person or carer in building skills in healthy practices and overall health management and to engage or disengage in activities which assist in improving health. Development of insight to avoid neglecting personal health in favour of their caring role and to establish and maintain positive coping strategies.
- Social/Cultural Context: Utilising support and respite services as required maintaining and promoting social relationships, in work, education and social/cultural environments.
- Health and Wellbeing: As above.

Outcomes

Prevent deterioration of health status and increase coping and stability of caring role.

Collaboration

General Practice and other health services, community health management organisations (e.g. Gyms, swimming pools, weight management services), other recreational, educational and vocational services and mental health care and related support services.

Service Activity – Flexible Funding Pool – Carer

Goods and/or services which are procured on behalf of the family/ friend/ support person or carer to purchase additional assistance that is not within the mental health sector. The goods and/or services are provided as part of the family/friend/support person or carer's support plan and are related to a goal within the plan. Examples are listed below. Brokerage funds may be part of or separate to the overall funding of the support "package".

Household – For example: buying cleaning equipment, replacing a fridge etc

Activities of Daily Living: For example: paying or helping to pay for a cleaner (either episodic or regularly), paying for driving lessons or bus tickets

Membership / exercise: For example: entry to swimming pools, gym membership, exercise clothes (such as swimmers), club fees for sports club.

Recreational: For example: art lessons, books for a book club, supplies for a craft group.

Vocational / Training: For example: materials or transport to training / vocational group, clothes for work opportunity.

Other: Expenses that don't fall into the preceding categories.

Note: This service excludes consumer support as it is incorporated under another service activity:

Flexible Funding Pool – Consumer

Service Activity – Individual Carer Support Services – Staffing Profile

Summary of Staffing Profile for Individual Carer Support Services

SCHEME	STAFF CATEGORY	FTE	Other Time%	Gross hours available per day (wkly/7)	Consumer Service Delivery hours available daily	Consumer Service Delivery hours available annual	Available hours/annum/FTE	Weighted Salary **	Cost	FTE share	Overheads %
NMHSPF	TOTAL	9.70		63.84	31.05	11,334	1,168	#DIV/0!	#DIV/0!	100%	20%
NMHSPF	Vocationally Qualified	9.24	0.28	43.43	30.40	11,096	1,201	48,523	448,378	95%	20%
NMSPF	Peer Worker	-	0.25	-	-	-		#DIV/0!	-	0%	20%
NMHSPF	Tertiary Qualified	0.46	0.35	2.17	0.65	238	515	-	-	5%	20%
NMHSPF	Medical	-	0.25	-	-	-		-	-	0%	20%

NMHR	TOTAL	Total FTE (Includes Leave)	Other Time %	Hours available/ 7 days	Consumer Service Delivery Time available daily	Consumer Service Delivery Time available annual	Available hours/annum/FTE	Salary **	Cost		O'heads %
NMHR	**Total Medical**	-		-	-	-	-		$0	0%	20%
NMHR	Psychiatrist	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Registrar	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Junior Medical Officer	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Other Medical Specialis	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Nursing**	-		-	-	-	-		$0	0%	20%
NMHR	Registered Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Nurse Practitioner	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Enrolled Nurse	-	0.25	-	-	-	-		$0	0%	20%
NMHR	**Total Allied Health**	0.46		2.17	0.65	238	515		$26,110	5%	20%
NMHR	Psychologist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Social Worker	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Occupational Therapist	-	0.30	-	-	-	-		$0	0%	20%
NMHR	Other TQ (eg pharmaci	0.46	0.70	2.17	0.65	238	515	$56,511	$26,110	5%	20%
NMHR	**VQ and Peer Workers**	9.24		43.43	30.40	11,096	1,201		$470,797	95%	20%
NMHR	Consumer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	Carer Peer Worker	-	0.25	-	-	-	-		$0	0%	20%
NMHR	VQMH Worker	6.93	0.30	32.57	22.80	8,322	1,201	$48,370	$335,223	71%	20%
NMHR	VQ Other	2.31	0.30	10.86	7.60	2,774	1,201	$58,686	$135,574	24%	20%
	Total Available Hours					11,334					

Annual Cost Salaries	$496,907
*** Including Overheads 20.0%**	$596,288

Information from Care Package	
Hours Per Annum for an individual	220
Total Target Population for care pa	2,250
Total Hours Req per Annum	495,000

NMHR		Hours needed (annual)	Annual FTE	Salary **	Cost
NMHR	**Total Medical**	-	#DIV/0!		#DIV/0!
NMHR	Psychiatrist	-	#DIV/0!	$0	#DIV/0!
NMHR	Registrar	-	#DIV/0!	$0	#DIV/0!
NMHR	Junior Medical Officer	-	#DIV/0!	$0	#DIV/0!
NMHR	Other Specialist	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Nursing**	-	#DIV/0!		#DIV/0!
NMHR	Registered Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	Nurse Practitioner	-	#DIV/0!	$0	#DIV/0!
NMHR	Enrolled Nurse	-	#DIV/0!	$0	#DIV/0!
NMHR	**Total Allied Health**	10,385	20.18		#DIV/0!
NMHR	Psychologists	-	#DIV/0!	$0	#DIV/0!
NMHR	Social Workers	-	#DIV/0!	$0	#DIV/0!
NMHR	Occupational Therapist	-	#DIV/0!	$0	#DIV/0!
NMHR	Other	10,385	20.18	$56,511	$1,140,344
NMHR	**VQ and Peer Workers**	484,615	403.58		#DIV/0!
NMHR	Consumer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	Carer Peer Worker	-	#DIV/0!	$0	#DIV/0!
NMHR	VQMH Worker	363,462	302.69	$48,370	#########
NMHR	VQ Other	121,154	100.90	$58,686	$5,921,177

Total FTE	#DIV/0!
FTE/Client	#DIV/0!
Case load..clients/FTE	#DIV/0!
Annual Cost Salaries	#DIV/0!
*** Including Overheads 20.0%**	#DIV/0!

237.77

Description		Nursing								Medical					Allied Health					Peer Workers		Vocat Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other SCHADSL6 0.4 FTE 100%BH	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker SCHADSL3 6.0FTE 60%BH	VQ Other SCHADS L5 2.0FTE 60%BH	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day								-					-				3.0	3.0			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.1	4.8	17.9	18
	Night	-							-					-					-					-	-
Tuesday	Day								-					-				3.0	3.0			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.2	4.9	18.1	18
	Night	-							-					-					-					-	-
Wednesday	Day								-					-				3.0	3.0			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.1	4.8	17.9	18
	Night	-							-					-					-					-	-
Thursday	Day								-					-				3.1	3.1			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.2	4.9	18.1	18
	Night	-							-					-					-					-	-
Friday	Day	-							-					-				3.1	3.1			27.0	9.1	36.1	39
	Evening	-							-					-					-			13.2	4.8	18.0	18
	Night	-							-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-			14.0	1.4	15.4	15
Sunday	All shifts	-	-			-			-					-					-			13.2	4.9	18	18
Total Hours per week		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15.2	15	-	-	228.0	76.0	304.0	319
Annual & Other Leave Relief weeks																		7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked																									
Productive Weeks per FTE		52.14	52.14	52.14	52.14	52.14	52.14	52.14		52.14	52.14	52.14	52.14		52.14	52.14	52.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15	15	-	-	135	46	181	195
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	66	24	90	90
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	14	1	15	15
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	13	5	18	18
Total Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	15	15	-	-	228	76	304	319
Weekly FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.4	0.4	-	-	6.0	2.0	8.0	0.4
Relief FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.1	0.1	-	-	0.9	0.3	1.2	0.1
Annual FTE's		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.5	0.5	-	-	6.9	2.3	9.2	9.7

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of labour costs. As per the MG meeting of 21 May 2013, an additional 2.0% has been added for education, training and program evaluation.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:

Support from sector indicated. Feedback indicated a need for more after hours time to work around carer activities. Recommended 60% BH and 40% AH. Feedback also that program manager/team leader role should be limited to SCHADS Level 6 as per roles defined in the NSW SACS/SCHADS document.

2.3 SERVICE STREAM – SPECIALISED BED-BASED MENTAL HEALTH CARE SERVICES

Service Stream		Specialised Bed-Based MH Care Services
Service Category	**B**	**Acute Inpatient Services (Hospital Based)**
Service Element	BP	Acute - Perinatal and Infant Mental Health (Hospital)
Service Element	BY	Acute - Child and Youth (0-17 years) (Hospital)
Service Element	BA	Acute - Adult (18-64 years) (Hospital)
Service Element	BB	Acute - Older Adult (65+ years BPSD) (Hospital)
Service Element	BO	Acute - Older Adult (65+ years) (Hospital)
Service Element	BD	Acute - Adult Eating Disorders (Hospital)
Service Element	BI	Acute - Intensive Care Unit (Hospital)
Service Element	BE	Acute - Psychiatric Emergency Care Unit (Hospital)
Service Element	BT	Same Day Admission for Administration of ECT (Hospital)
Service Category	**C**	**Sub-Acute Services (Residential and Hospital or Nursing Home Based)**
Service Element	CY	Step Up/ Step Down - Youth (Residential)
Service Element	CA	Step Up/Step Down - Adult_(Residential)
Service Element	CQ	Rehabilitation – Adult and Older Adult (Residential)
Service Element	CO	Sub-Acute Older Adult (65+ years)(Hospital)
Service Element	CI	Sub-Acute Intensive Care Service (Hospital)
Service Category	**D**	**Non-Acute Extended Treatment Services (Residential and Hospital or Nursing Home Based)**
Service Element	DI	Non-Acute - Intensive Care Service (Hospital)
Service Element	DC	Non-Acute -Intensive Care Service - Older Adult(65+) (Hospital Based)
Service Element	DT	Non-Acute - Adult and Older Adult (24 hour support) (Residential)
Service Element	DO	Non-Acute - Older Adult (Hospital/Nursing Home Based)
Service Element	DS	Non-Acute - Specialised Services (Hospital/Nursing Home Based)

2.3.1 Service Category – Acute Inpatient Services (Hospital Based)

Descriptor

Acute inpatient treatment is driven primarily by the need to respond to risk associated with a person's symptoms, behavioural disturbance and/or distress which are related to a recent onset or exacerbation of a mental illness.

Distinguishing Features

- The primary goal of care is reduction in severity of symptoms and/or distress associated with the recent onset or exacerbation of a mental illness.
- Services are delivered by a multidisciplinary team of health care professionals operating as part of a local integrated mental health service system.
- Acute care average lengths of stay are measured in days or weeks.
- Specialist stand alone units or sub-units of larger units may be provided for mothers and infants, children, young person, adults and for older adults.
- Units may be gazetted or declared to allow for involuntary detention.

Inclusions

- Acute mental health inpatient units co-located with acute general hospitals and private hospitals.
- In a small number of cases services are still provided by units located on psychiatric hospital campuses.
- Acute care provided in specialist acute units in prisons and/or forensic units (out of scope for this stage of the project).
- Acute or crisis care provided in specialist units described as psychiatric emergency care centres (PECCs) or psychiatric assessment and planning units (PAPUs) in emergency departments in general hospitals.
- Acute care provided in intensive or high dependency units operating as part of an acute mental health inpatient service. Between 10 and 20 percent of acute inpatient beds are usually provided as secure intensive care units.
- Acute care provided for mothers and infants in a designated perinatal and infant mental health unit.
- Acute care provided for adults with eating illnesses in a specialist mental health inpatient unit.
- Day only admission for the administration of Electro-convulsive therapy (ECT).

Exclusions

- Acute care provided in homes or other places in the community (considered as part of ambulatory services).
- Consultation-Liaison services provided to generic wards and emergency departments in general hospitals. (these are covered in service elements Consultation Liaison – General (Hospital), Consultation Liaison – Emergency Department (Hospital), which are part of Primary and Specialised Clinical Ambulatory MH Care Services

Example Services

- Inner West AMHS-Royal Melbourne Hospital Acute Inpatient Unit and Parkville Orygen Youth Health Acute Inpatient Unit. Victoria.
- WMIMHS – Ipswich General Hospital Acute Mental Health Unit and Older Persons Acute Unit. Queensland.
- RBH-PECC Unit. Queensland.
- Birunji Youth Unit (16-28) Campbelltown Hospital. New South Wales
- Bank House Infant and Child Mental Health Unit. New South Wales.
- The Mother Baby Unit – Austin Hospital, Victoria.
- The Perth Clinic – Western Australia.

2.3.1.1 Service Element – Acute – Perinatal and Infant Mental Health (Hospital)

Attribute	Details
Status	Gazetted
Services Delivered	Short to medium term, and intermittent voluntary and involuntary, inpatient care for mothers and their infants, where the mother exhibits signs and/or symptoms of severe mental illness that have not responded adequately to less intensive interventions in the community and/or the safety and treatment needs of the dyad/family warrant admission.
Key Distinguishing Features	Units are located on general hospital campuses and designed and operated to meet the special needs of mothers and babies. The inpatient unit works as part of an integrated model which includes specialist day centre, consultation liaison and ambulatory care services which may be delivered across a number of area or district services.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Mothers in the third trimester and mothers with infants up to 36 months.
Diagnostic Profile	Majority of mothers may present with a primary diagnosis of major depression. Mothers with a variety of other illnesses can also be treated. This may include schizophrenia and related illnesses; affective illnesses; anxiety illnesses, personality and behavioural illnesses and substance use illnesses.
Average unit size	6 beds
Hours	24hrs / 7 days.
Suggested Modelling Attributes	
% Occupancy	85% (specified within Bed Based Staffing profile, section: Bed Based Service Parameters.)
Average length of stay (LOS)	14 days (specified within the care packages, range from 5-14 days for this bed type)
Annual readmission rate	Within range 7 to 10 percent
Indicative staffing FTE/Bed	3.51 clinical Full Time Equivalent (FTE) per bed assuming co-location with other acute inpatient mental health services and access to paediatric and lactation services.
Sources	• Perinatal and Infant Acute Mental Health Services Model of Service Delivery, QPMHS, 2011 (Draft) – Primary Source. • Royal College of Psychiatrists, Standards for Mother and Baby Units, UK, 2008 • NMHSPF Expert Working Group

Service Element – Acute – Perinatal and Infant Mental Health – Staffing Profile

Acute - Perinatal and Infant Mental Health (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**20.80**	**3.47**	94.57	15.76	34,519	1,660	$106,001	$2,204,537	17.5	30%
NMHSPF	Vocationally Qualified	0.00	0.00	0.00	0.00	-	-	$0	$0	-	30%
NMSPF	Peer Worker	1.16	0.19	5.44	0.91	1,987	1,715	$54,844	$63,515	1.0	30%
NMHSPF	Tertiary Qualified	18.16	3.03	81.99	13.66	29,925	1,648	$105,047	$1,907,925	15.2	30%
NMHSPF	Medical	1.48	0.25	7.14	1.19	2,607	1,766	$157,865	$233,096	1.3	30%

NMHR	TOTAL	FTE	FTE/Bed	day	ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**1.48**	**0.25**	**7.14**	**1.19**	2,607	1,766		$233,096	1.3	30%
NMHR	Psychiatrist	0.59	0.10	2.86	0.48	1,043	1,766	$200,564	$118,457	0.5	30%
NMHR	Registrar	0.89	0.15	4.29	0.71	1,564	1,766	$129,399	$114,639	0.8	30%
NMHR	Junior Medical Officer	-	-	-	-	-	-	$161,745	$0	-	30%
NMHR	Other Medical Specialis	-	-	-	-	-	-	$200,564	$0	-	30%
NMHR	**Total Nursing**	**16.89**	**2.81**	**76.00**	12.67	27,740	1,642		$1,794,500	14.1	30%
NMHR	Registered Nurse	15.62	2.60	70.29	11.71	25,654	1,643	$102,673	$1,603,416	13.0	30%
NMHR	Nurse Practitioner	1.27	0.21	5.71	0.95	2,086	1,639	$150,196	$191,084	1.1	30%
NMHR	Enrolled Nurse	-	-	-	-	-	-	$74,547	$0	-	30%
NMHR	**Total Allied Health**	**1.27**	**0.21**	**5.99**	**1.00**	2,185	1,715		$113,426	1.1	30%
NMHR	Psychologist	0.12	0.02	0.54	0.09	198	1,715	$89,058	$10,287	0.1	30%
NMHR	Social Worker	0.58	0.10	2.73	0.45	996	1,715	$89,058	$51,705	0.5	30%
NMHR	Occupational Therapist	0.58	0.10	2.71	0.45	991	1,715	$89,058	$51,434	0.5	30%
NMHR	Other TQ (eg pharmaci	-	-	-	-	-	-	$56,511	$0	-	30%
NMHR	**VQ and Peer Workers**	**1.16**	**0.19**	**5.44**	**0.91**	1,987	1,715		$63,515	1.0	30%
NMHR	Consumer Peer Worker	0.58	0.10	2.73	0.45	996	1,715	$54,844	$31,841	0.5	30%
NMHR	Carer Peer Worker	0.58	0.10	2.71	0.45	991	1,715	$54,844	$31,674	0.5	30%
NMHR	VQMH Worker	-	-	-	-	-	-	$42,626	$0	-	30%
NMHR	VQ Other	-	-	-	-	-	-	$51,717	$0	-	30%

Annual Cost Salaries		$2,204,537
*** Including Overheads**	30%	$2,865,898
Average Daily Available Bed Day C		$1,309
Average Cost per Patient per annu		$19,193

Bed Based Service Parameters	
Beds	6
Availability	100%
Average Available Beds	6
ABD/Bed/Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	12
Admissions/Bed/Year	27.38
Annual Readmit Rate	10%
Patients/Bed/Year	24.89

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Required		192
Cost		$91,516,790
Staffing		
NMHR	**Total Medical**	47.2
NMHR	Psychiatrist	18.9
NMHR	Registrar	28.3
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	539.3
NMHR	Registered Nurse	498.7
NMHR	Nurse Practitioner	40.6
NMHR	Enrolled Nurse	0.0
NMHR	**Total Allied Health**	40.7
NMHR	Psychologists	3.7
NMHR	Social Workers	18.5
NMHR	Occupational Therapists	18.4
NMHR	Other	0.0
NMHR	**VQ and Peer Workers**	37.0
NMHR	Consumer Peer Worker	18.5
NMHR	Carer Peer Worker	18.4
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		664.1

		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
Description		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours	All Total Hours
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38	Worked	Worked
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	8	8		-	8	34	4	6			10	3.8	3.8	3.8		11.4	3.8	3.8			7.6	63
	Evening	-	-	8	16				24					-					-					-	24
	Night	-	-	8	16				24					-					-					-	24
Tuesday	Day	2	8	8	8		-	8	34	4	6			10		3.8	3.8		7.6	3.8	3.8			7.6	59
	Evening	-	-	8	8				16					-					-					-	16
	Night	-	-	8	16				24					-					-					-	24
Wednesday	Day		8	8	8		-	8	32	4	6			10		3.8	3.8		7.6	3.8	3.8			7.6	57
	Evening	-	-	8	8				16					-					-					-	16
	Night	-	-	8	16				24					-					-					-	24
Thursday	Day		8	8	8		-	8	32	4	6			10		3.9	3.8		7.7	3.9	3.8			7.7	57
	Evening	-	-	8	16				24					-					-					-	24
	Night	-	-	8	16				24					-					-					-	24
Friday	Day	-	8	8	8		-	8	32	4	6			10		3.8	3.8		7.6	3.8	3.8			7.6	57
	Evening	-	-	8	16				24					-					-					-	24
	Night	-	-	8	16				24					-					-					-	24
Saturday	All shifts	-	-	24	48	-			72					-					-					-	72
Sunday	All shifts	-	-	24	48	-			72					-					-					-	72
Total Hours per week		4	40	168	280	-	-	40	532	20	30	-	-	50	3.8	19.1	19.0	-	42	19.1	19.0	-	-	38.1	662
Annual & Other Leave Relief week		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		4	40	40	40	-	-	40	164	20	30	-	-	50	4	19	19	-	42	19	19	-	-	38	294
Evening Hours (Mon-Fri)		-	-	40	64	-	-	-	104	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	104
Night Hours (Mon-Fri)		-	-	40	80	-	-	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Saturday Hours		-	-	24	48	-	-	-	72	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	72
Sunday Hours		-	-	24	48	-	-	-	72	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	72
Total Hours		4	40	168	280	-	-	40	532	20	30	-	-	50	4	19	19	-	42	19	19	-	-	38	662
Weekly FTE's		0.1	1.1	4.4	7.4	-	-	1.1	14.0	0.5	0.8	-	-	1.3	0.1	0.5	0.5	-	1.1	0.5	0.5	-	-	1.0	16.4
Relief FTE's		0.0	0.2	0.9	1.5	-	-	0.2	2.9	0.1	0.1	-	-	0.2	0.0	0.1	0.1	-	0.2	0.1	0.1	-	-	0.2	3.3
Annual FTE's		0.1	1.2	5.3	8.9	-	-	1.3	16.9	0.6	0.9	-	-	1.5	0.1	0.6	0.6	-	1.3	0.6	0.6	-	-	1.2	20.8

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Drawn from RC Psych Standards and Recommendations for Planning - PIMH Qld MHPI. Validation BK. and review NSW, WA & Vic planning profiles ALOS, Occup & Readm rates drawn from adult rates. Assumes colocation and access to lactation and peadiatric servcies.

2.3.1.2 Service Element – Acute – Child and Youth (0-17 years) (Hospital)

2.3.1.3 Service Element – Acute – Adult (18-64 years) (Hospital)

2.3.1.4 Service Element – Acute – Older Adult (65+ years BPSD) (Hospital)

2.3.1.5 Service Element – Acute – Older Adult (65+ years) (Hospital)

These service elements are shown in the table below

Attribute	**Details**			
Status	Gazetted			
Services Delivered	Short to medium term 24 hour inpatient assessment and treatment services for people experiencing severe episodes of mental illness who cannot be adequately treated in a less restrictive environment. The core business is to provide multidisciplinary specialised assessment, best practice, evidence based and collaborative planning, interventions and preparation for discharge delivered through recovery oriented practices and procedures, in a safe, therapeutic and person friendly environment.			
Key Distinguishing Features	Programs primarily provide specialist psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential to result in prolonged difficulty or distress, or risk to self and/or others. The key characteristic of acute services is that the treatment effort is focused on decreasing acuity to a level that can be treated in less restrictive environments. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or people with a continuing mental illness for whom there has been an acute exacerbation of symptoms			
Service specifications and other useful descriptors to illustrate service elements.				
Target Age:	**Diagnostic Profile**			
Children and Adolescents **0-17 yrs**	Children and adolescents may present with severe behavioural, emotional or stress-related illnesses, depression/mood illnesses, psychotic illnesses, autistic spectrum illnesses, post-traumatic stress illness or disruptive illnesses. Children often present with co-morbid illnesses in relation to development issues such as learning and language difficulties, emotional expression and eating illnesses. Issues such as deliberate self-harm, suicidal attempts or ideation, anxiety, aggression or uncontrollable behaviour, drug and alcohol issues and persistent school refusal or suspension.			
Adults **18-64 yrs**	Adults with a possible or diagnosed severe mental illness, often accompanied by behavioural disturbance, which could not be adequately assessed, investigated, treated in a less restrictive setting. Primary diagnoses usually include schizophrenia, psychosis or severe mood illness. Co-morbid or concurrent secondary illnesses such as substance abuse are common. People with complicated, severe adjustment illnesses and personality illnesses may also be admitted. Beds maybe be arranged to provide separate specialised services for younger people. e.g. Youth Early Psychosis services (16-24) provide specialist treatment and care for young people who are experiencing or at high risk of, a first episode of psychosis and are best engaged in a comprehensive assessment process in an acute setting or who need urgent care to manage risk.			
Older Adults **65+ yrs**	Conditions in older adults that may require inpatient care include mood illnesses, psychotic illnesses, complex anxiety and somatoform illnesses and acute stress and adjustment illnesses in the context of personality illness. Other common characteristics of people referred include issues related to polypharmacy and co-morbid acute and chronic complicating physical conditions.			
Older Adults **65+ yrs BPSD**	Older adults with severe behavioural and psychological symptoms associated with dementia (BPSD), who are unable to be managed in a less restrictive environment. Some younger people with dementia and severe BPSD may also be admitted.			
Target Age	0-17	18-64	65+	65+BPSD
Average unit	• 12 beds	• 24 beds	• 16	• 16 Beds

size		• Intensive care beds generally represent 10-20% of total beds.	• Intensive care beds generally represent 10-20% of total beds.	
Whole of population at a rate Hours	24hrs / 7 days	24hrs / 7 days.	24hrs / 7 days	24hrs / 7 days
Suggested Modelling Attributes				
% Occupancy	85%	85%	85%	85%
Average LOS	14 days (range 11-14 days within the care packages)	14 days (range 7-21 days within the care packages))	14 days	14 days
Annual readmission rate	10%	10%	10%	10%
Indicative staffing FTE/Bed	Multi-disciplinary 2.49 FTE Clinical Staff per Bed Assumes access to teaching staff, speech therapists and the capacity for overnight accommodation of family members engaged in therapy	Multi-disciplinary 2.0. FTE Clinical Staff per Bed	Multi-disciplinary 1.94 FTE Clinical Staff per Bed. Physiotherapists are included in clinical staff	Multi-disciplinary 2.16 FTE Clinical Staff per Bed
Sources	• National Health Data Dictionary V.15. • MH-CPP 2010. • Models of Service Delivery (Various), QPMHS, Queensland. The acute phase of early psychosis: a handbook of management, Orygen Youth Health, Victoria, 2004. • Youth Early Psychosis Status Report, Dr Ruth Vine, Victorian Government, 2007. • National Benchmarking Project, Review of Key Performance Indicators, NMHS, 2008. • NMHSPF Expert Working Group			

Service Element – Acute – Child and Youth – Staffing Profile

Acute - Child and Youth (0-17 years) (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**29.87**	**2.49**	134.43	11.20	49,066	1,642	$103,881	$3,103,257	12.4	30%
NMHSPF	Vocationally Qualified	3.56	0.30	16.00	1.33	5,840	1,639	$74,547	$265,556	1.5	30%
NMSPF	Peer Worker	1.16	0.10	5.43	0.45	1,981	1,715	$54,844	$63,349	0.5	30%
NMHSPF	Tertiary Qualified	22.03	1.84	97.86	8.15	35,718	1,622	$103,633	$2,282,559	9.1	30%
NMHSPF	Medical	3.13	0.26	15.14	1.26	5,527	1,766	$157,108	$491,793	1.4	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**3.13**	**0.26**	**15.14**	**1.26**	5,527	1,766		$491,793	1.4	30%
NMHR	Psychiatrist	1.00	0.08	4.86	0.40	1,773	1,766	$200,564	$201,377	0.4	30%
NMHR	Registrar	1.65	0.14	8.00	0.67	2,920	1,766	$129,399	$213,992	0.7	30%
NMHR	Junior Medical Officer	0.47	0.04	2.29	0.19	834	1,766	$161,745	$76,424	0.2	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$200,564	$0	-	30%
NMHR	**Total Nursing**	**22.70**	**1.89**	**100.29**	8.36	36,604	1,613		$2,290,945	9.3	30%
NMHR	Registered Nurse	17.87	1.49	78.57	6.55	28,679	1,605	$102,673	$1,834,305	7.3	30%
NMHR	Nurse Practitioner	1.27	0.11	5.71	0.48	2,086	1,639	$150,196	$191,084	0.5	30%
NMHR	Enrolled Nurse	3.56	0.30	16.00	1.33	5,840	1,639	$74,547	$265,556	1.5	30%
NMHR	**Total Allied Health**	**2.89**	**0.24**	**13.57**	**1.13**	4,954	1,715		$257,170	1.3	30%
NMHR	Psychologist	**1.16**	**0.10**	**5.43**	**0.45**	1,981	1,715	$89,058	$102,868	0.5	30%
NMHR	Social Worker	**1.16**	**0.10**	**5.43**	**0.45**	1,981	1,715	$89,058	$102,868	0.5	30%
NMHR	Occupational Therapist	**0.58**	**0.05**	**2.71**	**0.23**	991	1,715	$89,058	$51,434	0.3	30%
NMHR	Other TQ (eg pharmacis	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$56,511	$0	-	30%
NMHR	**VQ and Peer Workers**	**1.16**	**0.10**	**5.43**	**0.45**	1,981	1,715		$63,349	0.5	30%
NMHR	Consumer Peer Worker	**0.58**	**0.05**	**2.71**	**0.23**	991	1,715	$54,844	$31,674	0.3	30%
NMHR	Carer Peer Worker	**0.58**	**0.05**	**2.71**	**0.23**	991	1,715	$54,844	$31,674	0.3	30%
NMHR	VQMH Worker	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$42,626	$0	-	30%
NMHR	VQ Other	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$51,717	$0	-	30%

Annual Cost Salaries		$3,103,257
*** Including Overheads**	30%	$4,034,234
Average Daily Available Bed Day C		$921
Average Cost per Patient per annu		$15,760

Bed Based Service Parameters	
Beds	12
Availability	100%
Average Available Beds	12
ABD/Bed/Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	14
Admissions/Bed/Year	23.46
Annual Readmit Rate	10%
Patients/Bed/Year	21.33

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Required		224
Cost		$75,148,096
Staffing		
NMHR	**Total Medical**	58.3
NMHR	Psychiatrist	18.7
NMHR	Registrar	30.8
NMHR	Junior Medical Officer	8.8
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	422.8
NMHR	Registered Nurse	332.8
NMHR	Nurse Practitioner	23.7
NMHR	Enrolled Nurse	66.4
NMHR	**Total Allied Health**	53.8
NMHR	Psychologists	21.5
NMHR	Social Workers	21.5
NMHR	Occupational Therapists	10.8
NMHR	Other	0.0
NMHR	**VQ and Peer Workers**	21.5
NMHR	Consumer Peer Worker	10.8
NMHR	Carer Peer Worker	10.8
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		556.5

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VO MH Worker	VO Other	VO Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	8	16		8	8	50	8	8			16	7.6	7.6	3.8		19.0					-	85
	Evening	-	-	8	16	8			32			8		8					-	3.8	3.8			7.6	48
	Night	-	-	8	8	8			24					-					-					-	24
Tuesday	Day		8	8	16		8	8	48	4	8			12	7.6	7.6	3.8		19.0					-	79
	Evening	-	-	8	16	8			32					-					-	3.8	3.8			7.6	40
	Night	-	-	8	8	8			24					-					-					-	24
Wednesday	Day	2	8	8	16		8	8	50	8	8			16	7.6	7.6	3.8		19.0					-	85
	Evening		-	8	16	8			32					-					-	3.8	3.8			7.6	40
	Night	-	-	8	8	8			24					-					-					-	24
Thursday	Day		8	8	16		8	8	48	6	8			14	7.6	7.6	3.8		19.0					-	81
	Evening	-	-	8	16	8			32					-					-	3.8	3.8			7.6	40
	Night	-	-	8	8	8			24					-					-					-	24
Friday	Day	2	8	8	16		8	8	50	8	8			16	7.6	7.6	3.8		19.0					-	85
	Evening	-	-	8	16	8			32			8		8					-	3.8	3.8			7.6	48
	Night	-	-	8	8	8			24					-					-					-	24
Saturday	All shifts	-	-	24	40	16	8		88		8			8					-					-	96
Sunday	All shifts	-	-	24	40	16	8		88		8			8					-					-	96
Total Hours per week		6	40	168	280	112	56	40	702	34	56	16	-	106	38.0	38.0	19.0	-	95	19.0	19.0	-	-	38.0	941
Annual & Other Leave Relief weeks		6	6	9	9	9	17	9		6	6	6	6		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		6	40	40	80	-	40	40	246	34	40	-	-	74	38	38	19	-	95	-	-	-	-	-	415
Evening Hours (Mon-Fri)		-	-	40	80	40	-	-	160	-	-	16	-	16	-	-	-	-	-	19	19	-	-	38	214
Night Hours (Mon-Fri)		-	-	40	40	40	-	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Saturday Hours		-	-	24	40	16	8	-	88	-	8	-	-	8	-	-	-	-	-	-	-	-	-	-	96
Sunday Hours		-	-	24	40	16	8	-	88	-	8	-	-	8	-	-	-	-	-	-	-	-	-	-	96
Total Hours		6	40	168	280	112	56	40	702	34	56	16	-	106	38	38	19	-	95	19	19	-	-	38	941
Weekly FTE's		0.2	1.1	4.4	7.4	2.9	1.5	1.1	18.5	0.9	1.4	0.4	-	2.7	1.0	1.0	0.5	-	2.5	0.5	0.5	-	-	1.0	23.6
Relief FTE's		0.0	0.2	0.9	1.5	0.6	0.7	0.2	4.2	0.2	0.3	0.1	-	0.5	0.2	0.2	0.1	-	0.4	0.1	0.1	-	-	0.2	5.1
Annual FTE's		0.2	1.2	5.3	8.9	3.6	2.2	1.3	22.7	1.0	1.7	0.5	-	3.1	1.2	1.2	0.6	-	2.9	0.6	0.6	-	-	1.2	29.9

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from QLD staffing profiles for new servcies 2012 and Victoria (RMH).
Validation BK
Does not includes capacity for day program.
ALOS, Occup & Readm rates estimates only.
Effective age range 12 to 17
Children predominately to peadiarteic units

Service Element – Acute – Adult - Staffing Profile

Acute - Adult (18-64 years) (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**48.09**	**2.00**	213.91	8.91	78,079	1,624	$107,167	$5,153,253	9.9	30%
NMHSPF	Vocationally Qualified	3.56	0.15	16.00	0.67	5,840	1,639	$74,547	$265,556	0.7	30%
NMSPF	Peer Worker	1.50	0.06	7.06	0.29	2,576	1,715	$54,844	$82,353	0.3	30%
NMHSPF	Tertiary Qualified	36.94	1.54	161.43	6.73	58,921	1,595	$102,523	$3,787,089	7.5	30%
NMHSPF	Medical	6.08	0.25	29.43	1.23	10,741	1,766	$167,383	$1,018,255	1.4	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**6.08**	**0.25**	**29.43**	**1.23**	10,741	1,766		$1,018,255	1.4	30%
NMHR	Psychiatrist	2.01	0.08	9.71	0.40	3,546	1,766	$212,167	$426,055	0.4	30%
NMHR	Registrar	3.07	0.13	14.86	0.62	5,423	1,766	$136,885	$420,405	0.7	30%
NMHR	Junior Medical Officer	1.00	0.04	4.86	0.20	1,773	1,766	$171,102	$171,796	0.2	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$212,167	$0	-	30%
NMHR	**Total Nursing**	**37.04**	**1.54**	**161.14**	6.71	58,817	1,588		$3,762,837	7.5	30%
NMHR	Registered Nurse	32.20	1.34	139.43	5.81	50,891	1,580	$102,673	$3,306,198	6.5	30%
NMHR	Nurse Practitioner	1.27	0.05	5.71	0.24	2,086	1,639	$150,196	$191,084	0.3	30%
NMHR	Enrolled Nurse	3.56	0.15	16.00	0.67	5,840	1,639	$74,547	$265,556	0.7	30%
NMHR	**Total Allied Health**	**3.47**	**0.14**	**16.29**	**0.68**	5,944	1,715		$289,808	0.8	30%
NMHR	Psychologist	**0.58**	**0.02**	**2.71**	**0.11**	991	1,715	$89,058	$51,434	0.1	30%
NMHR	Social Worker	**1.16**	**0.05**	**5.43**	**0.23**	1,981	1,715	$89,058	$102,868	0.3	30%
NMHR	Occupational Therapist	**1.16**	**0.05**	**5.43**	**0.23**	1,981	1,715	$89,058	$102,868	0.3	30%
NMHR	Other TQ (eg pharmacis	**0.58**	**0.02**	**2.71**	**0.11**	991	1,715	$56,511	$32,637	0.1	30%
NMHR	**VQ and Peer Workers**	**1.50**	**0.06**	**7.06**	**0.29**	2,576	1,715		$82,353	0.3	30%
NMHR	Consumer Peer Worker	**0.92**	**0.04**	**4.34**	**0.18**	1,585	1,715	$54,844	$50,679	0.2	30%
NMHR	Carer Peer Worker	**0.58**	**0.02**	**2.71**	**0.11**	991	1,715	$54,844	$31,674	0.1	30%
NMHR	VQMH Worker	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$42,626	$0	-	30%
NMHR	VQ Other	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$51,717	$0	-	30%

Annual Cost Salaries	$5,153,253
*** Including Overheads** 30%	$6,699,229
Average Daily Available Bed Day C	$765
Average Cost per Patient per annu	$13,086

Bed Based Service Parameters	
Beds	24
Availability	100%
Average Available Beds	24
ABD/Bed/Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	14
Admissions/Bed/Year	23.46
Annual Readmit Rate	10%
Patients/Bed/Year	21.33

Calculator	
Number of standardised admissions per annum multiplied by target population	5245
Beds Requirred	224
Cost	$62,395,281

Staffing		
NMHR	**Total Medical**	56.7
NMHR	Psychiatrist	18.7
NMHR	Registrar	28.6
NMHR	Junior Medical Officer	9.4
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	344.9
NMHR	Registered Nurse	299.9
NMHR	Nurse Practitioner	11.8
NMHR	Enrolled Nurse	33.2
NMHR	**Total Allied Health**	32.3
NMHR	Psychologists	5.4
NMHR	Social Workers	10.8
NMHR	Occupational Therapists	10.8
NMHR	Other	5.4
NMHR	**VQ and Peer Workers**	14.0
NMHR	Consumer Peer Worker	8.6
NMHR	Carer Peer Worker	5.4
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		447.9

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	4	12	16	16	8	8	8	72	12	8	6		26	3.8	7.6	7.6	3.8	22.8	7.6	3.8			11.4	132
	Evening	-	-	16	24	8	8		56		8			8					-					-	64
	Night	-	-	16	16	-	8		40					-					-					-	40
Tuesday	Day	4	12	16	16	8	8	8	72	10	8	6		24	3.8	7.6	7.6	3.8	22.8	7.6	3.8			11.4	130
	Evening	-	-	16	24	8	8		56		8			8					-					-	64
	Night	-	-	16	16	-	8		40					-					-					-	40
Wednesday	Day	4	12	16	16	8	8	8	72	12	8	8		28	3.8	7.6	7.6	3.8	22.8		3.8			3.8	127
	Evening	-	-	16	24	8	8		56		8			8					-					-	64
	Night	-	-	16	16	-	8		40					-					-					-	40
Thursday	Day	4	12	16	16	8	8	8	72	10	8	6		24	3.8	7.6	7.6	3.8	22.8	7.6	3.8			11.4	130
	Evening	-	-	16	24	8	8		56		8			8					-					-	64
	Night	-	-	16	16	-	8		40					-					-					-	40
Friday	Day	4	12	16	16	8	8	8	72	12	8	8		28	3.8	7.6	7.6	3.8	22.8	7.6	3.8			11.4	134
	Evening	-	-	16	24	8	8		56		8			8					-					-	64
	Night	-	-	16	16	-	8		40					-					-					-	40
Saturday	All shifts	-	-	48	56	16	24		144	6	12			18					-					-	162
Sunday	All shifts	-	-	48	56	16	24		144	6	12			18					-					-	162
Total Hours per week		20	60	336	392	112	168	40	1,128	68	104	34	-	206	19.0	38.0	38.0	19.0	114	30.4	19.0	-	-	49.4	1,497
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		20	60	80	80	40	40	40	360	56	40	34	-	130	19	38	38	19	114	30	19	-	-	49	653
Evening Hours (Mon-Fri)		-	-	80	120	40	40	-	280	-	40	-	-	40	-	-	-	-	-	-	-	-	-	-	320
Night Hours (Mon-Fri)		-	-	80	80	-	40	-	200	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	200
Saturday Hours		-	-	48	56	16	24	-	144	6	12	-	-	18	-	-	-	-	-	-	-	-	-	-	162
Sunday Hours		-	-	48	56	16	24	-	144	6	12	-	-	18	-	-	-	-	-	-	-	-	-	-	162
Total Hours		20	60	336	392	112	168	40	1,128	68	104	34	-	206	19	38	38	19	114	30	19	-	-	49	1,497
Weekly FTE's		0.5	1.6	8.8	10.3	2.9	4.4	1.1	29.7	1.7	2.6	0.9	-	5.2	0.5	1.0	1.0	0.5	3.0	0.8	0.5	-	-	1.3	37.8
Relief FTE's		0.1	0.3	1.8	2.2	0.6	2.1	0.2	7.4	0.3	0.5	0.2	-	0.9	0.1	0.2	0.2	0.1	0.5	0.1	0.1	-	-	0.2	8.8
Annual FTE's		0.6	1.9	10.7	12.5	3.6	6.6	1.3	37.0	2.0	3.1	1.0	-	6.1	0.6	1.2	1.2	0.6	3.5	0.9	0.6	-	-	1.5	46.1

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from QLD staffing profiles for new servcies 2012.
ACT MOSD New Acut Inpatient Unit, RMH, AH
ALOS, Occup & Readm rates estimates only.
Modelled to include IC Services at 15-20%

Service Element – Acute – Older Adult BPSD - Staffing Profile

Acute - Older Adult (65+ years BPSD) (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**34.57**	**2.16**	156.63	9.79	57,169	1,654	$97,553	$3,372,234	10.9	30%
NMHSPF	Vocationally Qualified	10.69	0.67	48.00	3.00	17,520	1,639	$74,547	$796,667	3.3	30%
NMSPF	Peer Worker	1.85	0.12	8.69	0.54	3,170	1,715	$54,844	$101,358	0.6	30%
NMHSPF	Tertiary Qualified	18.14	1.13	81.09	5.07	29,596	1,632	$99,029	$1,795,913	5.6	30%
NMHSPF	Medical	3.90	0.24	18.86	1.18	6,883	1,766	$174,007	$678,297	1.3	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**3.90**	**0.24**	**18.86**	**1.18**	6,883	1,766		$678,297	1.3	30%
NMHR	Psychiatrist	1.65	0.10	8.00	0.50	2,920	1,766	$212,167	$350,869	0.6	30%
NMHR	Registrar	1.65	0.10	8.00	0.50	2,920	1,766	$136,885	$226,372	0.6	30%
NMHR	Junior Medical Officer	0.59	0.04	2.86	0.18	1,043	1,766	$171,102	$101,056	0.2	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$212,167	$0	-	30%
NMHR	**Total Nursing**	**25.13**	**1.57**	**111.71**	6.98	40,776	1,623		$2,309,389	7.8	30%
NMHR	Registered Nurse	13.80	0.86	60.86	3.80	22,213	1,609	$102,673	$1,417,181	4.2	30%
NMHR	Nurse Practitioner	0.64	0.04	2.86	0.18	1,043	1,639	$150,196	$95,542	0.2	30%
NMHR	Enrolled Nurse	10.69	0.67	48.00	3.00	17,520	1,639	$74,547	$796,667	3.3	30%
NMHR	**Total Allied Health**	**3.70**	**0.23**	**17.37**	**1.09**	6,341	1,715		$283,190	1.2	30%
NMHR	Psychologist	**0.35**	**0.02**	**1.63**	**0.10**	594	1,715	$89,058	$30,860	0.1	30%
NMHR	Social Worker	**1.16**	**0.07**	**5.43**	**0.34**	1,981	1,715	$89,058	$102,868	0.4	30%
NMHR	Occupational Therapist	**0.58**	**0.04**	**2.71**	**0.17**	991	1,715	$89,058	$51,434	0.2	30%
NMHR	Other TQ (eg pharmacis	**1.62**	**0.10**	**7.60**	**0.48**	2,774	1,715	$60,619	$98,028	0.5	30%
NMHR	**VQ and Peer Workers**	**1.85**	**0.12**	**8.69**	**0.54**	3,170	1,715		$101,358	0.6	30%
NMHR	Consumer Peer Worker	**0.92**	**0.06**	**4.34**	**0.27**	1,585	1,715	$54,844	$50,679	0.3	30%
NMHR	Carer Peer Worker	**0.92**	**0.06**	**4.34**	**0.27**	1,585	1,715	$54,844	$50,679	0.3	30%
NMHR	VQMH Worker	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$42,626	$0	-	30%
NMHR	VQ Other	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$51,717	$0	-	30%

Annual Cost Salaries	$3,372,234
*** Including Overheads** 30%	$4,383,905
Average Daily Available Bed Day C	$751
Average Cost per Patient per annu	$12,845

Bed Based Service Parameters	
Beds	16
Availability	100%
Average Available Beds	16
ABD/Bed/Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	14
Admissions/Bed/Year	23.46
Annual Readmit Rate	10%
Patients/Bed/Year	21.33

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Requirred		224
Cost		$61,246,217
Staffing		
NMHR	**Total Medical**	54.5
NMHR	Psychiatrist	23.1
NMHR	Registrar	23.1
NMHR	Junior Medical Officer	8.3
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	351.0
NMHR	Registered Nurse	192.8
NMHR	Nurse Practitioner	8.9
NMHR	Enrolled Nurse	149.3
NMHR	**Total Allied Health**	51.6
NMHR	Psychologists	4.8
NMHR	Social Workers	16.1
NMHR	Occupational Therapists	8.1
NMHR	Other	22.6
NMHR	**VQ and Peer Workers**	25.8
NMHR	Consumer Peer Worker	12.9
NMHR	Carer Peer Worker	12.9
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		482.9

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours	All Total Hours
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38	Worked	Worked
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	8	8	16	8	4	54	8	8	4		20	3.8	7.6	3.8	7.6	22.8	7.6	7.6			15.2	112
	Evening	-	-	8	8	24			40					-					-					-	40
	Night	-	-	8	8	8			24					-					-					-	24
Tuesday	Day	2	8	8	8	16	8	4	54	8	8	4		20		7.6	3.8	7.6	19.0	7.6	7.6			15.2	108
	Evening	-	-	8	8	24			40					-					-					-	40
	Night	-	-	8	8	8			24					-					-					-	24
Wednesday	Day	2	8	8	8	16	8	4	54	8	8	4		20	3.8	7.6	3.8	7.6	22.8					-	97
	Evening	-	-	8	8	24			40					-					-					-	40
	Night	-	-	8	8	8			24					-					-					-	24
Thursday	Day	2	8	8	8	16	8	4	54	8	8	4		20		7.6	3.8	7.6	19.0	7.6	7.6			15.2	108
	Evening	-	-	8	8	24			40					-					-					-	40
	Night	-	-	8	8	8			24					-					-					-	24
Friday	Day	2	8	8	8	16	8	4	54	8	8	4		20	3.8	7.6	3.8	7.6	22.8	7.6	7.6			15.2	112
	Evening	-	-	8	8	24			40					-					-					-	40
	Night	-	-	8	8	8			24					-					-					-	24
Saturday	All shifts	-	-	24	24	48			96	8	8			16				7.6	7.6					-	120
Sunday	All shifts	-	-	24	24	48			96	8	8			16				7.6	8					-	120
Total Hours per week		10	40	168	168	336	40	20	782	56	56	20	-	132	11.4	38.0	19.0	53.2	122	30.4	30.4	-	-	60.8	1,096
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		10	40	40	40	80	40	20	270	40	40	20	-	100	11	38	19	38	106	30	30	-	-	61	537
Evening Hours (Mon-Fri)		-	-	40	40	120	-	-	200	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	200
Night Hours (Mon-Fri)		-	-	40	40	40	-	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Saturday Hours		-	-	24	24	48	-	-	96	8	8	-	-	16	-	-	-	8	8	-	-	-	-	-	120
Sunday Hours		-	-	24	24	48	-	-	96	8	8	-	-	16	-	-	-	8	8	-	-	-	-	-	120
Total Hours		10	40	168	168	336	40	20	782	56	56	20	-	132	11	38	19	53	122	30	30	-	-	61	1,096
Weekly FTE's		0.3	1.1	4.4	4.4	8.8	1.1	0.5	20.6	1.4	1.4	0.5	-	3.3	0.3	1.0	0.5	1.4	3.2	0.8	0.8	-	-	1.6	27.1
Relief FTE's		0.0	0.2	0.9	0.9	1.8	0.5	0.1	4.5	0.3	0.3	0.1	-	0.6	0.0	0.2	0.1	0.2	0.5	0.1	0.1	-	-	0.2	5.6
Annual FTE's		0.3	1.2	5.3	5.3	10.7	1.6	0.6	25.1	1.7	1.7	0.6	-	3.9	0.3	1.2	0.6	1.6	3.7	0.9	0.9	-	-	1.8	34.6

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
No models available

Validation RMcK
ALOS, Occup & Readm rates estimates only.

Service Element – Acute – Older Adult - Staffing Profile

Acute - Older Adult (65+ years) (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**31.01**	**1.94**	140.63	8.79	51,329	1,655	$103,427	$3,206,869	9.8	30%
NMHSPF	Vocationally Qualified	3.56	0.22	16.00	1.00	5,840	1,639	$74,547	$265,556	1.1	30%
NMSPF	Peer Worker	1.85	0.12	8.69	0.54	3,170	1,715	$54,844	$101,358	0.6	30%
NMHSPF	Tertiary Qualified	21.70	1.36	97.09	6.07	35,436	1,633	$99,627	$2,161,659	6.7	30%
NMHSPF	Medical	3.90	0.24	18.86	1.18	6,883	1,766	$174,007	$678,297	1.3	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**3.90**	**0.24**	**18.86**	**1.18**	6,883	1,766		$678,297	1.3	30%
NMHR	Psychiatrist	1.65	0.10	8.00	0.50	2,920	1,766	$212,167	$350,869	0.6	30%
NMHR	Registrar	1.65	0.10	8.00	0.50	2,920	1,766	$136,885	$226,372	0.6	30%
NMHR	Junior Medical Officer	0.59	0.04	2.86	0.18	1,043	1,766	$171,102	$101,056	0.2	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$212,167	$0	-	30%
NMHR	**Total Nursing**	**21.56**	**1.35**	**95.71**	5.98	34,936	1,620		$2,144,025	6.6	30%
NMHR	Registered Nurse	17.37	1.09	76.86	4.80	28,053	1,615	$102,673	$1,782,927	5.3	30%
NMHR	Nurse Practitioner	0.64	0.04	2.86	0.18	1,043	1,639	$150,196	$95,542	0.2	30%
NMHR	Enrolled Nurse	3.56	0.22	16.00	1.00	5,840	1,639	$74,547	$265,556	1.1	30%
NMHR	**Total Allied Health**	**3.70**	**0.23**	**17.37**	**1.09**	6,341	1,715		$283,190	1.2	30%
NMHR	Psychologist	**0.35**	**0.02**	**1.63**	**0.10**	594	1,715	$89,058	$30,860	0.1	30%
NMHR	Social Worker	**1.16**	**0.07**	**5.43**	**0.34**	1,981	1,715	$89,058	$102,868	0.4	30%
NMHR	Occupational Therapist	**0.58**	**0.04**	**2.71**	**0.17**	991	1,715	$89,058	$51,434	0.2	30%
NMHR	Other TQ (eg pharmacis	**1.62**	**0.10**	**7.60**	**0.48**	2,774	1,715	$60,619	$98,028	0.5	30%
NMHR	**VQ and Peer Workers**	**1.85**	**0.12**	**8.69**	**0.54**	3,170	1,715		$101,358	0.6	30%
NMHR	Consumer Peer Worker	**0.92**	**0.06**	**4.34**	**0.27**	1,585	1,715	$54,844	$50,679	0.3	30%
NMHR	Carer Peer Worker	**0.92**	**0.06**	**4.34**	**0.27**	1,585	1,715	$54,844	$50,679	0.3	30%
NMHR	VQMH Worker	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$42,626	$0	-	30%
NMHR	VQ Other	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$51,717	$0	-	30%

Annual Cost Salaries	$3,206,869
*** Including Overheads** 30%	$4,168,930
Average Daily Available Bed Day C	$714
Average Cost per Patient per annu	$12,215

Bed Based Service Parameters	
Beds	16
Availability	100%
Average Available Beds	16
ABD/Bed/Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	14
Admissions/Bed/Year	23.46
Annual Readmit Rate	10%
Patients/Bed/Year	21.33

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Required		224
Cost		$58,242,874
Staffing		
NMHR	**Total Medical**	54.5
NMHR	Psychiatrist	23.1
NMHR	Registrar	23.1
NMHR	Junior Medical Officer	8.3
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	301.3
NMHR	Registered Nurse	242.6
NMHR	Nurse Practitioner	8.9
NMHR	Enrolled Nurse	49.8
NMHR	**Total Allied Health**	51.6
NMHR	Psychologists	4.8
NMHR	Social Workers	16.1
NMHR	Occupational Therapists	8.1
NMHR	Other	22.6
NMHR	**VQ and Peer Workers**	25.8
NMHR	Consumer Peer Worker	12.9
NMHR	Carer Peer Worker	12.9
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		433.2

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	8	8	8	8	4	46	8	8	4		20	3.8	7.6	3.8	7.6	22.8	7.6	7.6			15.2	104
	Evening	-	-	8	16	8			32					-					-					-	32
	Night	-	-	8	16	-			24					-					-					-	24
Tuesday	Day	2	8	8	8	8	8	4	46	8	8	4		20		7.6	3.8	7.6	19.0	7.6	7.6			15.2	100
	Evening	-	-	8	16	8			32					-					-					-	32
	Night	-	-	8	16	-			24					-					-					-	24
Wednesday	Day	2	8	8	8	8	8	4	46	8	8	4		20	3.8	7.6	3.8	7.6	22.8					-	89
	Evening	-	-	8	16	8			32					-					-					-	32
	Night	-	-	8	16	-			24					-					-					-	24
Thursday	Day	2	8	8	8	8	8	4	46	8	8	4		20		7.6	3.8	7.6	19.0	7.6	7.6			15.2	100
	Evening	-	-	8	16	8			32					-					-					-	32
	Night	-	-	8	16	-			24					-					-					-	24
Friday	Day	2	8	8	8	8	8	4	46	8	8	4		20	3.8	7.6	3.8	7.6	22.8	7.6	7.6			15.2	104
	Evening	-	-	8	16	8			32					-					-					-	32
	Night	-	-	8	16	-			24					-					-					-	24
Saturday	All shifts	-	-	24	40	16			80	8	8			16				7.6	7.6					-	104
Sunday	All shifts	-	-	24	40	16			80	8	8			16				7.6	8					-	104
Total Hours per week		10	40	168	280	112	40	20	670	56	56	20	-	132	11.4	38.0	19.0	53.2	122	30.4	30.4	-	-	60.8	984
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		10	40	40	40	40	40	20	230	40	40	20	-	100	11	38	19	38	106	30	30	-	-	61	497
Evening Hours (Mon-Fri)		-	-	40	80	40	-	-	160	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	160
Night Hours (Mon-Fri)		-	-	40	80	-	-	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Saturday Hours		-	-	24	40	16	-	-	80	8	8	-	-	16	-	-	-	8	8	-	-	-	-	-	104
Sunday Hours		-	-	24	40	16	-	-	80	8	8	-	-	16	-	-	-	8	8	-	-	-	-	-	104
Total Hours		10	40	168	280	112	40	20	670	56	56	20	-	132	11	38	19	53	122	30	30	-	-	61	984
Weekly FTE's		0.3	1.1	4.4	7.4	2.9	1.1	0.5	17.6	1.4	1.4	0.5	-	3.3	0.3	1.0	0.5	1.4	3.2	0.8	0.8	-	-	1.6	24.1
Relief FTE's		0.0	0.2	0.9	1.5	0.6	0.5	0.1	3.9	0.3	0.3	0.1	-	0.8	0.0	0.2	0.1	0.2	0.5	0.1	0.1	-	-	0.2	5.0
Annual FTE's		0.3	1.2	5.3	8.9	3.6	1.6	0.6	21.6	1.7	1.7	0.6	-	3.9	0.3	1.2	0.6	1.6	3.7	0.9	0.9	-	-	1.8	31.0

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from QLD staffing profiles
for new servcies 2012 and St George H, NSW.
Validation R Mc Kay
ALOS, Occup & Readm rates estimates only.

2.3.1.6 Service Element – Acute – Adult Eating Disorders (Hospital)

Note: In the current model, this service element has not been used within the care packages, instead the expert working group decided to model this care as:

- SEV_AMB_Eat (Severe, Ambulatory only, Eating Disorders), with a day program rather than a bed based stay, and
- SEV_ABB_Eat (Severe, Ambulatory and Bed-Based, including hospital stay), which is modelled as ambulatory care following a stay in one of : Acute – Adult(18-64 years) hospital bed, Acute – Intensive Care Unit (hospital) bed or Acute medical/surgical bed (hospital non-MH).

Attribute	Details
Status	Gazetted
Services Delivered	Short to medium term voluntary and involuntary, inpatient care for adults with an eating disorder that meet defined medical and/or psychological risk factors, who cannot be managed safely or effectively in a community setting. Clinical treatments include medical monitoring, weight restoration and supportive meal therapies, individual and group therapies and recovery oriented discharge planning.
Key Distinguishing Features	Units are located on general hospital campuses and designed and operated to meet the special needs of people with eating illnesses. Units usually operate as specialist sub programs collocated with general adult inpatient units. This arrangement reflects the unique challenges of meeting the needs of this group of people. The inpatient unit works as part of an integrated model which includes specialist day programs and consultation liaison and ambulatory care services. Staffing profiles include dieticians.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Adults.
Diagnostic Profile	People with Anorexia Nervosa, Bulimia Nervosa, Eating Disorder Not Otherwise Specified or Binge Eating Disorder who meet defined physical, mental and eating disorder signs and symptoms. Key criteria include, BMI <14, BP < 90/60, level of suicide risk, severity of clinical depression and presence of substance misuse.
Average unit size	5 beds
Hours	24hrs / 7 days.
Suggested Modelling Attributes	
% Occupancy	85%
Average LOS	21 days
Annual readmission rate	10%
Indicative staffing FTE/Bed	Multi-disciplinary 2.56. FTE Clinical Staff per Bed. Assumes collocation with acute inpatient mental health unit and dietician engaged as part of unit staffing profile.
Sources	• Eating Disorders Services Model of Service Delivery, QPMHS, 2011 (Draft). Primary source. • ANZAED Position Statement, Inpatient Services for Eating disorders, 2007. • Service Model: South Australian Statewide Specialist Eating Disorder Services, SA Health, 2011. • Clinical mental health service responses for people with eating disorders in Victoria, Department of Human Services, Victorian Government, 2009 • NMHSPF Expert Working Group

Service Element – Acute – Adult Eating Disorders – Staffing Profile

Acute - Adult Eating Disorders (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**12.81**	**2.56**	58.89	11.78	21,493	1,678	$98,274	$1,258,771	12.4	30%
NMHSPF	Vocationally Qualified	1.78	0.36	8.00	1.60	2,920	1,639	$74,547	$132,778	1.7	30%
NMSPF	Peer Worker	0.92	0.18	4.34	0.87	1,585	1,715	$54,844	$50,679	0.9	30%
NMHSPF	Tertiary Qualified	8.39	1.68	38.26	7.65	13,964	1,664	$96,049	$805,919	8.1	30%
NMHSPF	Medical	1.71	0.34	8.29	1.66	3,024	1,766	$157,284	$269,396	1.7	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**1.71**	**0.34**	**8.29**	**1.66**	3,024	1,766		$269,396	1.7	30%
NMHR	Psychiatrist	0.30	0.06	1.43	0.29	521	1,766	$200,564	$59,229	0.3	30%
NMHR	Registrar	0.59	0.12	2.86	0.57	1,043	1,766	$129,399	$76,426	0.6	30%
NMHR	Junior Medical Officer	0.83	0.17	4.00	0.80	1,460	1,766	$161,745	$133,742	0.8	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$200,564	$0	-	30%
NMHR	**Total Nursing**	**7.75**	**1.55**	**34.86**	6.97	12,723	1,642		$745,229	7.3	30%
NMHR	Registered Nurse	5.97	1.19	26.86	5.37	9,803	1,643	$102,673	$612,452	5.7	30%
NMHR	Nurse Practitioner	0.00	0.00	0.00	0.00	-	-	$150,196	$0	-	30%
NMHR	Enrolled Nurse	1.78	0.36	8.00	1.60	2,920	1,639	$74,547	$132,778	1.7	30%
NMHR	**Total Allied Health**	**2.43**	**0.49**	**11.40**	**2.28**	4,161	1,715		$193,467	2.4	30%
NMHR	Psychologist	**1.16**	**0.23**	**5.43**	**1.09**	1,981	1,715	$89,058	$102,868	1.1	30%
NMHR	Social Worker	**0.58**	**0.12**	**2.71**	**0.54**	991	1,715	$89,058	$51,434	0.6	30%
NMHR	Occupational Therapist	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$89,058	$0	-	30%
NMHR	Other TQ (eg pharmaci	**0.69**	**0.14**	**3.26**	**0.65**	1,189	1,715	$56,511	$39,165	0.7	30%
NMHR	**VQ and Peer Workers**	**0.92**	**0.18**	**4.34**	**0.87**	1,585	1,715		$50,679	0.9	30%
NMHR	Consumer Peer Worker	**0.58**	**0.12**	**2.71**	**0.54**	991	1,715	$54,844	$31,674	0.6	30%
NMHR	Carer Peer Worker	**0.35**	**0.07**	**1.63**	**0.33**	594	1,715	$54,844	$19,005	0.3	30%
NMHR	VQMH Worker	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$42,626	$0	-	30%
NMHR	VQ Other	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$51,717	$0	-	30%

Annual Cost Salaries	$1,258,771
*** Including Overheads** 30%	$1,636,403
Average Daily Available Bed Day C	$897
Average Cost per Patient per annu	$87,212

Bed Based Service Parameters	
Beds	5
Availability	100%
Average Available Beds	5
ABD/Bed/Year	365
Occupancy	95%
OBD/Bed Year	346.8
ALOS (days)	84
Admissions/Bed/Year	4.13
Annual Readmit Rate	10%
Patients/Bed/Year	3.75

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Requirred		1271
Cost		$415,842,126
Staffing		
NMHR	**Total Medical**	435.3
NMHR	Psychiatrist	75.0
NMHR	Registrar	150.1
NMHR	Junior Medical Officer	210.1
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	1968.5
NMHR	Registered Nurse	1515.8
NMHR	Nurse Practitioner	0.0
NMHR	Enrolled Nurse	452.6
NMHR	**Total Allied Health**	616.4
NMHR	Psychologists	293.5
NMHR	Social Workers	146.8
NMHR	Occupational Therapists	0.0
NMHR	Other	176.1
NMHR	**VQ and Peer Workers**	234.8
NMHR	Consumer Peer Worker	146.8
NMHR	Carer Peer Worker	88.1
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		3255.0

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours	All Total Hours
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38	Worked	Worked
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	4	8	8		8			28	2	4	8		14	7.6	3.8		3.8	15.2	7.6	3.8			11.4	69
	Evening	-	-	8					8					-					-					-	8
	Night	-	-	8					8					-					-					-	8
Tuesday	Day			8		8			16	2	4			6	7.6	3.8		3.8	15.2					-	37
	Evening	-		8					8					-					-					-	8
	Night	-		8					8					-					-					-	8
Wednesday	Day			8		8			16	2	4	8		14	7.6	3.8		3.8	15.2	3.8	3.8			7.6	53
	Evening	-		8					8					-					-					-	8
	Night	-		8					8					-					-					-	8
Thursday	Day			8		8			16	2	4	4		10	7.6	3.8		7.6	19.0					-	45
	Evening	-		8					8					-					-					-	8
	Night	-		8					8					-					-					-	8
Friday	Day	-	8	8		8			24	2	4	8		14	7.6	3.8		3.8	15.2	7.6	3.8			11.4	65
	Evening	-	-	8		-			8					-					-					-	8
	Night	-	-	8		-			8					-					-					-	8
Saturday	All shifts	-	-	24		8			32					-					-					-	32
Sunday	All shifts	-	-	24		8			32					-					-					-	32
Total Hours per week		4	16	168	-	56	-	-	244	10	20	28	-	58	38.0	19.0	-	22.8	80	19.0	11.4	-	-	30.4	412
Annual & Other Leave Relief week		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		4	16	40	-	40	-	-	100	10	20	28	-	58	38	19	-	23	80	19	11	-	-	30	268
Evening Hours (Mon-Fri)		-	-	40	-	-	-	-	40	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	40
Night Hours (Mon-Fri)		-	-	40	-	-	-	-	40	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	40
Saturday Hours		-	-	24	-	8	-	-	32	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	32
Sunday Hours		-	-	24	-	8	-	-	32	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	32
Total Hours		4	16	168	-	56	-	-	244	10	20	28	-	58	38	19	-	23	80	19	11	-	-	30	412
Weekly FTE's		0.1	0.4	4.4	-	1.5	-	-	6.4	0.3	0.5	0.7	-	1.5	1.0	0.5	-	0.6	2.1	0.5	0.3	-	-	0.8	10.0
Relief FTE's		0.0	0.1	0.9	-	0.3	-	-	1.3	0.0	0.1	0.1	-	0.3	0.2	0.1	-	0.1	0.3	0.1	0.0	-	-	0.1	1.9
Annual FTE's		0.1	0.5	5.3	-	1.8	-	-	7.7	0.3	0.6	0.8	-	1.7	1.2	0.6	-	0.7	2.4	0.6	0.3	-	-	0.9	12.8

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate only drawn from existing comparable servcies QLD (RBH).
Other AH is a Dietician
ALOS, Occup & Readm rates estimates only.

2.3.1.7 Service Element – Acute – Intensive Care Unit (Hospital)

Attribute	Details
Status	Gazetted
Services Delivered	Intensive Care Units (ICU) provide higher levels of supervision and support to people with severe mental illness or mental disorder who require containment, stabilisation and engagement in a therapeutic relationship. In general terms people admitted to an ICU have/experience/present with a high level of behavioural disturbance and complex symptoms such that management in a less restrictive setting is not suitable. A specific risk assessment and management plan is developed to respond to the person's distress and any associated behavioural disturbance. The plan usually identifies predictors, triggers and signs and symptoms of increasing agitation/potential aggression. The plan identifies preventative strategies, de-escalation strategies, and if required, the use of prescribed medication.
Key Distinguishing Features	An ICU is a lockable area usually within an acute mental health unit designed to provide short term safe, secure low stimulus care for involuntary people experiencing severe/complex behavioural disturbance. The emphasis is on containment, management and stabilisation of the distress/disturbance with transfer to a less restrictive environment as soon as indicated and appropriate. When in use the ICU is staffed specifically to meet the high level needs of those requiring this level of care, supervision and support. Treatment in an ICU should not be confused with seclusion.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Adults, young people and older adults.
Diagnostic Profile	A person who, as a result of their illness, distress or dysfunction, exhibits levels of clinical risk, including potential risk of harm to themselves or others, to a degree that they cannot be safely treated in a less restrictive area of the acute mental health unit
Average incidence	Between 10% and 20% of all acute beds will be occupied by people requiring intensive care.
Average unit size	5 beds
Hours	24hrs / 7 days.
Suggested Modelling Attributes	
% Occupancy	85%
Avg length of stay	14 days (specified within the care packages, range is 7-49 days for this bed type)
Annual readmission rate	10%
Indicative staffing FTE/Bed	Multi-disciplinary 4.1FTE Clinical Staff per Bed
Sources	• Adult Acute Inpatient Model of Service Delivery, QPMHS, 2011. • MH-CPP 2010 • Guidelines for Operation of Mental Health High Dependency Units in Queensland. Queensland Government, 2004. • NMHSPF Expert Working Group

Service Element – Acute – Intensive Care Unit – Staffing Profile

Acute - Intensive Care Unit (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**20.49**	**4.10**	86.97	17.39	31,745	1,549	#DIV/0!	$2,216,162	19.3	30%
NMHSPF	Vocationally Qualified	0.00	0.00	0.00	0.00	-	-	#DIV/0!	$0	-	30%
NMSPF	Peer Worker	0.00	0.00	0.00	0.00	-	-	#DIV/0!	$0	-	30%
NMHSPF	Tertiary Qualified	19.72	3.94	83.26	16.65	30,389	1,541	$106,486	$2,099,996	18.5	30%
NMHSPF	Medical	0.77	0.15	3.71	0.74	1,356	1,766	$151,296	$116,166	0.8	30%
NMHR	**TOTAL**	**FTE**	**FTE/Bed**	**Hours/ day**	**Hours/ ABD**	**Hrs annual**	**FTE scalar**	**Salary ****	**Cost**		**O'heads %**
NMHR	**Total Medical**	**0.77**	**0.15**	**3.71**	**0.74**	1,356	1,766		$116,166	0.8	30%
NMHR	Psychiatrist	0.24	0.05	1.14	0.23	417	1,766	$200,564	$47,383	0.3	30%
NMHR	Registrar	0.53	0.11	2.57	0.51	939	1,766	$129,399	$68,783	0.6	30%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$161,745	$0	-	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$200,564	$0	-	30%
NMHR	**Total Nursing**	**19.03**	**3.81**	**80.00**	16.00	29,200	1,535		$2,038,275	17.8	30%
NMHR	Registered Nurse	17.25	3.45	72.00	14.40	26,280	1,524	$102,673	$1,770,757	16.0	30%
NMHR	Nurse Practitioner	1.78	0.36	8.00	1.60	2,920	1,639	$150,196	$267,518	1.8	30%
NMHR	Enrolled Nurse	0.00	0.00	0.00	0.00	-	-	$74,547	$0	-	30%
NMHR	**Total Allied Health**	**0.69**	**0.14**	**3.26**	**0.65**	1,189	1,715		$61,721	0.7	30%
NMHR	Psychologist	0.35	0.07	1.63	0.33	594	1,715	$89,058	$30,860	0.4	30%
NMHR	Social Worker	0.00	0.00	0.00	0.00	-	-	$89,058	$0	-	30%
NMHR	Occupational Therapist	0.35	0.07	1.63	0.33	594	1,715	$89,058	$30,860	0.4	30%
NMHR	Other TO (eg pharmaci	0.00	0.00	0.00	0.00	-	-	$56,511	$0	-	30%
NMHR	**VQ and Peer Workers**	**0.00**	**0.00**	**0.00**	**0.00**	-	-		$0	-	30%
NMHR	Consumer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	30%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	30%
NMHR	VQMH Worker	0.00	0.00	0.00	0.00	-	-	$42,626	$0	-	30%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$51,717	$0	-	30%

Annual Cost Salaries	$2,216,162
*** Including Overheads** 30%	$2,881,010
Average Daily Available Bed Day C	$1,579
Average Cost per Patient per annu	$9,647

Bed Based Service Parameters	
Beds	5
Availability	100%
Average Available Beds	5
ABD/Bed/Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	5
Admissions/Bed/Year	65.70
Annual Readmit Rate	10%
Patients/Bed/Year	59.73

Calculator	
Number of standardised admissions per annum multiplied by target population	5245
Beds Requirred	80
Cost	$45,999,692
Staffing	
NMHR **Total Medical**	12.3
NMHR Psychiatrist	3.8
NMHR Registrar	8.5
NMHR Junior Medical Officer	0.0
NMHR Other Specialist	0.0
NMHR **Total Nursing**	303.8
NMHR Registered Nurse	275.4
NMHR Nurse Practitioner	28.4
NMHR Enrolled Nurse	0.0
NMHR **Total Allied Health**	11.1
NMHR Psychologists	5.5
NMHR Social Workers	0.0
NMHR Occupational Therapists	5.5
NMHR Other	0.0
NMHR **VQ and Peer Workers**	0.0
NMHR Consumer Peer Worker	0.0
NMHR Carer Peer Worker	0.0
NMHR VQMH Worker	0.0
NMHR VQ Other	0.0
Total	327.1

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day			8	8		8	8	32	2	4			6	3.8		3.8		7.6					-	46
	Evening	-	-	8	8		8		24					-					-					-	24
	Night	-	-	8	8		8		24					-					-					-	24
Tuesday	Day			8	8		8	8	32	2	4			6					-					-	38
	Evening	-	-	8	8		8		24					-					-					-	24
	Night	-	-	8	8		8		24					-					-					-	24
Wednesday	Day			8	8		8	8	32	2	2			4	3.8		3.8		7.6					-	44
	Evening	-	-	8	8		8		24					-					-					-	24
	Night	-	-	8	8		8		24					-					-					-	24
Thursday	Day			8	8		8	8	32		4			4					-					-	36
	Evening	-	-	8	8		8		24					-					-					-	24
	Night	-	-	8	8		8		24					-					-					-	24
Friday	Day	-		8	8		8	8	32	2	4			6	3.8		3.8		7.6					-	46
	Evening	-	-	8	8		8		24					-					-					-	24
	Night	-	-	8	8		8		24					-					-					-	24
Saturday	All shifts	-	-	24	24		24	8	80					-					-					-	80
Sunday	All shifts	-	-	24	24		24	8	80					-					-					-	80
Total Hours per week		-	-	168	168	-	168	56	560	8	18	-	-	26	11.4	-	11.4	-	23	-	-	-	-	-	609
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	40	40	-	40	40	160	8	18	-	-	26	11	-	11	-	23	-	-	-	-	-	209
Evening Hours (Mon-Fri)		-	-	40	40	-	40	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Night Hours (Mon-Fri)		-	-	40	40	-	40	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Saturday Hours		-	-	24	24	-	24	8	80	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	80
Sunday Hours		-	-	24	24	-	24	8	80	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	80
Total Hours		-	-	168	168	-	168	56	560	8	18	-	-	26	11	-	11	-	23	-	-	-	-	-	609
Weekly FTE's		-	-	4.4	4.4	-	4.4	1.5	14.7	0.2	0.5	-	-	0.7	0.3	-	0.3	-	0.6	-	-	-	-	-	16.0
Relief FTE's		-	-	0.9	0.9	-	2.1	0.3	4.3	0.0	0.1	-	-	0.1	0.0	-	0.0	-	0.1	-	-	-	-	-	4.5
Annual FTE's		-	-	5.3	5.3	-	6.6	1.8	19.0	0.2	0.5	-	-	0.8	0.3	-	0.3	-	0.7	-	-	-	-	-	20.5

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from QLD staffing profiles for new servcies 2012.

ALOS, Occup & Readm rates estimates only.

2.3.1.8 Service Element – Acute – Psychiatric Emergency Care Unit (Hospital)

Note: In the current model, this service element has not been used within the care packages.

Attribute	Details
Status	Gazetted
Services Delivered	To provide mental health triage, assessment and brief treatment in a safe environment for people presenting to hospital emergency departments with acute mental health problems. Psychiatric Emergency Care Units (PECU's) provide a short term alternative which may prevent admission, support effective use of available inpatient acute beds and support Emergency Department staff to safely and effectively respond to the needs of people with mental health problems and associated behavioural disturbance and distress.
Key Distinguishing Features	The PECU is usually located within or adjacent to a Hospital Emergency Department. In some cases it may be collocated with an acute inpatient unit. It is designed to provide a low stimulus environment with combinations of open bays and single rooms with controlled entry and egress. Also referred to as Psychiatric Assessment and Planning Units (PAPU) and Mental Health Assessment Unit (MHAU)
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Adults, older adults and young people.
Diagnostic Profile	A person with an acute mental health problem and associated behavioural disturbance and distress who is medically stabilised and requires psychiatric assessment, brief treatment and support to return to the community or to transition to inpatient care.
Average unit size	4 beds One unit for each hospital with > 500 general hospital beds.
Hours	24hrs / 7 days.
Suggested Modelling Attributes	
% Occupancy	95%
Average LOS	2 days
Annual readmission rate	Not applicable.
Indicative staffing FTE/Bed	Multi-disciplinary primarily nursing and medical 4.52FTE Clinical Staff per Bed
Sources	• Emergency Department Mental Health Service Mapping Project (Report B), Department of Human Services, Victorian Government, December 2007. • MH-CPP 2010 • Mental Health Care, framework for emergency Department Services, Victorian Government, 2007. • Review of Emergency Mental Health Services in North Metropolitan Perth, Department of Health, Western Australia, 2007. • Development of Australia's first Psychiatric Emergency Centre, Australasian Psychiatry, Vol13, September 2005. • NMHSPF Expert working groups

Service Element – Acute – Psychiatric Emergency Care Unit – Staffing Profile

Acute - Psychiatric Emergency Care Unit (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**18.07**	**4.52**	82.00	20.50	29,930	1,656	#DIV/0!	#DIV/0!	21.6	30%
NMHSPF	Vocationally Qualified	1.78	0.45	8.00	2.00	2,920	1,639	$74,547	$132,778	2.1	30%
NMSPF	Peer Worker	0.00	0.00	0.00	0.00	-	-	#DIV/0!	$0	-	30%
NMHSPF	Tertiary Qualified	14.05	3.51	63.14	15.79	23,047	1,641	#DIV/0!	#DIV/0!	16.6	30%
NMHSPF	Medical	2.24	0.56	10.86	2.71	3,963	1,766	$156,696	$351,682	2.9	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**2.24**	**0.56**	**10.86**	**2.71**	3,963	1,766		$351,682	2.9	30%
NMHR	Psychiatrist	0.59	0.15	2.86	0.71	1,043	1,766	$212,167	$125,310	0.8	30%
NMHR	Registrar	1.65	0.41	8.00	2.00	2,920	1,766	$136,885	$226,372	2.1	30%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$171,102	$0	-	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$212,167	$0	-	30%
NMHR	**Total Nursing**	**15.83**	**3.96**	**71.14**	17.79	25,967	1,641		$1,574,837	18.7	30%
NMHR	Registered Nurse	14.05	3.51	63.14	15.79	23,047	1,641	$102,673	$1,442,060	16.6	30%
NMHR	Nurse Practitioner	0.00	0.00	0.00	0.00	-	-	$150,196	$0	-	30%
NMHR	Enrolled Nurse	1.78	0.45	8.00	2.00	2,920	1,639	$74,547	$132,778	2.1	30%
NMHR	**Total Allied Health**	**0.00**	**0.00**	**0.00**	**0.00**	-	-		$0	-	30%
NMHR	Psychologist	0.00	0.00	0.00	0.00	-	-	$89,058	$0	-	30%
NMHR	Social Worker	0.00	0.00	0.00	0.00	-	-	$89,058	$0	-	30%
NMHR	Occupational Therapist	0.00	0.00	0.00	0.00	-	-	$89,058	$0	-	30%
NMHR	Other TQ (eg pharmacis	0.00	0.00	0.00	0.00	-	-	$56,511	$0	-	30%
NMHR	**VQ and Peer Workers**	**0.00**	**0.00**	**0.00**	**0.00**	-	-		$0	-	30%
NMHR	Consumer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	30%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	30%
NMHR	VQMH Worker	0.00	0.00	0.00	0.00	-	-	$42,626	$0	-	30%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$51,717	$0	-	30%

Annual Cost Salaries	$1,926,519
*** Including Overheads** 30%	$2,504,475
Average Daily Available Bed Day C	$1,715
Average Cost per Patient per annu	$3,972

Bed Based Service Parameters	
Beds	4
Availability	100%
Average Available Beds	4
ABD/Bed/Year	365
Occupancy	95%
OBD/Bed Year	346.8
ALOS (days)	2
Admissions/Bed/Year	173.38
Annual Readmit Rate	10%
Patients/Bed/Year	157.61

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Requirred		30
Cost		$18,941,561
Staffing		
NMHR	**Total Medical**	17.0
NMHR	Psychiatrist	4.5
NMHR	Registrar	12.5
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	119.7
NMHR	Registered Nurse	106.2
NMHR	Nurse Practitioner	0.0
NMHR	Enrolled Nurse	13.5
NMHR	**Total Allied Health**	0.0
NMHR	Psychologists	0.0
NMHR	Social Workers	0.0
NMHR	Occupational Therapists	0.0
NMHR	Other	0.0
NMHR	**VQ and Peer Workers**	0.0
NMHR	Consumer Peer Worker	0.0
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		136.7

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	16	8				34	4	4			8					-					-	42
	Evening	-	-	16	8				24		4			4					-					-	28
	Night	-	-	8	8	8			24					-					-					-	24
Tuesday	Day			16	8				24	4	4			8					-					-	32
	Evening	-	-	16	8				24		4			4					-					-	28
	Night	-	-	8	8	8			24					-					-					-	24
Wednesday	Day			16	8				24	4	4			8					-					-	32
	Evening	-	-	16	8				24		4			4					-					-	28
	Night	-	-	8	8	8			24					-					-					-	24
Thursday	Day			16	8				24	4	4			8					-					-	32
	Evening	-	-	16	8				24		4			4					-					-	28
	Night	-	-	8	8	8			24					-					-					-	24
Friday	Day	-	8	16	8				32	4	4			8					-					-	40
	Evening	-	-	8	8				16		4			4					-					-	20
	Night	-	-	8	8	8			24					-					-					-	24
Saturday	All shifts	-	-	32	24	8			64		8			8					-					-	72
Sunday	All shifts	-	-	32	24	8			64		8			8					-					-	72
Total Hours per week		2	16	256	168	56	-	-	498	20	56	-	-	76	-	-	-	-	-	-	-	-	-	-	574
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		2	16	80	40	-	-	-	138	20	20	-	-	40	-	-	-	-	-	-	-	-	-	-	178
Evening Hours (Mon-Fri)		-	-	72	40	-	-	-	112	-	20	-	-	20	-	-	-	-	-	-	-	-	-	-	132
Night Hours (Mon-Fri)		-	-	40	40	40	-	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Saturday Hours		-	-	32	24	8	-	-	64	-	8	-	-	8	-	-	-	-	-	-	-	-	-	-	72
Sunday Hours		-	-	32	24	8	-	-	64	-	8	-	-	8	-	-	-	-	-	-	-	-	-	-	72
Total Hours		2	16	256	168	56	-	-	498	20	56	-	-	76	-	-	-	-	-	-	-	-	-	-	574
Weekly FTE's		0.1	0.4	6.7	4.4	1.5	-	-	13.1	0.5	1.4	-	-	1.9	-	-	-	-	-	-	-	-	-	-	15.0
Relief FTE's		0.0	0.1	1.4	0.9	0.3	-	-	2.7	0.1	0.3	-	-	0.3	-	-	-	-	-	-	-	-	-	-	3.1
Annual FTE's		**0.1**	**0.5**	**8.1**	**5.3**	**1.8**	**-**	**-**	**15.8**	**0.6**	**1.7**	-	-	**2.2**	-	-	-	-	-	-	-	-	-	-	**18.1**

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from existing QLD staffing profiles and Australasian Psychiatry, Frank, Fawcett, Emmerson, 2005.

ALOS, Occup & Readm rates estimates only.
Registrar time split 50/50 across PECc and ED
Throughput 400 per month with 130 admitted as day or o/night
of the 130, 60 admitted o/night.

2.3.1.9 Service Element – Same day admission for the administration of ECT (Hospital)

Attribute	Details
Status	Day Hospital
Services Delivered	Electroconvulsive Therapy (ECT) for day patients.
Key Distinguishing Features	Day only admission for the administration of ECT in a day surgery unit or an ECT suite operated as part of an Acute Mental Health Inpatient Unit. ECT will often be a coordinated treatment procedure jointly managed by the Acute Mental Health Inpatient Unit and Operating Theatre.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Adults, older adults and young people.
Diagnostic Profile	The principal indication for ECT is Major Depressive Disorder. It may also be given in certain circumstances for Mania, Schizophrenia or Schizoaffective illness, and other indications such as Catatonia, and Neuroleptic Malignant Syndrome. Indications for day treatment include those people with a low risk of suicide, no impairment of nutrition or hydration, no unstable concurrent medical illness, low anaesthetic risk, adequate social supports, ability to fast, and minimal cognitive impairment during treatment.
Average incidence	In Australia in 2010-2011 there were 12,700 same day separations from public hospitals for the administration of ECT. This represented .45% of all same day admissions to public hospitals in Australia.
Average unit size	If above data is accepted – it indicates that in public system there are approx 55 administrations of same day ECT per day across the country.
Hours	Business hours.
Suggested Modelling Attributes	
% Occupancy	N/A
Average LOS	Same day
Annual readmission rate	N/A
Indicative staffing FTE/Bed	3.42 FTE per day to operate a 5 bed unit. Staffing includes Anaesthetist and appropriately credentialed Consultant Psychiatrist, Registrar, ECT Coordinator – Anaesthetist Assistant (RN), Recovery Nurse.
Sources	• Guidelines for the Administration of ECT, Director of Mental Health, Queensland Government, 2006. • Royal Australian and New Zealand College of Psychiatrists. Clinical memorandum 12. • The Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia, Department of Health, Western Australia, 2006 • ECT Policy, South Eastern Sydney Illawarra Area Mental Health Program, NSW Health, 2009. • Australian Hospital Statistics 2010-2011, Australian Institute of Health and Welfare, Australian Government, November 2011. • NMHSPF Expert Working Group • Sample – Cairns Base Hospital Acute Inpatient Unit Queensland

Service Element – Same day admission for the administration of ECT – Staffing Profile

Same Day Admission for Administration of ECT (Hospital)

* Note worked on 5 day week.

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day/ person	Overheads %
NMHSPF	**TOTAL**	**4.06**	**0.81**	26.40	5.28	9,636	2,372	#DIV/0!	#DIV/0!	5.3	30%
NMHSPF	Vocationally Qualified	0.76	0.15	3.43	0.69	1,251	1,639	$59,218	$45,203	0.7	30%
NMSPF	Peer Worker	0.00	0.00	0.00	0.00	-	-	#DIV/0!	$0	-	30%
NMHSPF	Tertiary Qualified	2.06	0.41	9.43	1.89	3,441	1,671	#DIV/0!	#DIV/0!	1.9	30%
NMHSPF	Medical	1.24	0.25	6.00	1.20	2,190	1,766	$149,062	$184,882	1.2	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**1.24**	**0.25**	**6.00**	**1.20**	2,190	1,766		$184,882	1.2	30%
NMHR	Psychiatrist	0.35	0.07	1.71	0.34	626	1,766	$186,972	$66,258	0.3	30%
NMHR	Registrar	0.71	0.14	3.43	0.69	1,251	1,766	$120,630	$85,496	0.7	30%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$150,783	$0	-	30%
NMHR	Other Medical Specialist	0.18	0.04	0.86	0.17	313	1,766	$186,972	$33,129	0.2	30%
NMHR	**Total Nursing**	**2.82**	**0.56**	**12.86**	2.57	4,693	1,663		$213,166	2.6	30%
NMHR	Registered Nurse	2.06	0.41	9.43	1.89	3,441	1,671	$81,560	$167,963	1.9	30%
NMHR	Nurse Practitioner	0.00	0.00	0.00	0.00	-	-	$119,310	$0	-	30%
NMHR	Enrolled Nurse	0.76	0.15	3.43	0.69	1,251	1,639	$59,218	$45,203	0.7	30%
NMHR	**Total Allied Health**	**0.00**	**0.00**	**0.00**	**0.00**	-	-		$0	-	30%
NMHR	Psychologist	0.00	0.00	0.00	0.00	-	-	$89,058	$0	-	30%
NMHR	Social Worker	0.00	0.00	0.00	0.00	-	-	$89,058	$0	-	30%
NMHR	Occupational Therapist	0.00	0.00	0.00	0.00	-	-	$89,058	$0	-	30%
NMHR	Other TQ (eg pharmacist)	0.00	0.00	0.00	0.00	-	-	$56,511	$0	-	30%
NMHR	**VQ and Peer Workers**	**0.00**	**0.00**	**0.00**	**0.00**	-	-		$0	-	30%
NMHR	Consumer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	30%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	30%
NMHR	VQMH Worker	0.00	0.00	0.00	0.00	-	-	$42,626	$0	-	30%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$51,717	$0	-	30%

Annual Cost Salaries		$398,048
*** Including Overheads at**	30%	$517,463
Average Daily Available Bed Day Cost		$284
Average Cost per Patient per annum		$66

Bed Based Service Parameters	
Beds	5
Availability	100%
Average Available Beds	5
ABD/Bed/Year	365
Occupancy	100%
OBD/Bed Year	315.0
ALOS (days)	0.2
Admissions/Bed/Year	1575.00
Annual Readmit Rate	0%
Patients/Bed/Year	1575.00

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Requirred		3
Cost		$344,647
Staffing		
NMHR	**Total Medical**	0.8
NMHR	Psychiatrist	0.2
NMHR	Registrar	0.5
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.1
NMHR	**Total Nursing**	1.9
NMHR	Registered Nurse	1.4
NMHR	Nurse Practitioner	0.0
NMHR	Enrolled Nurse	0.5
NMHR	**Total Allied Health**	0.0
NMHR	Psychologists	0.0
NMHR	Social Workers	0.0
NMHR	Occupational Therapists	0.0
NMHR	Other	0.0
NMHR	**VQ and Peer Workers**	0.0
NMHR	Consumer Peer Worker	0.0
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		2.7

Description		Nursing								Medical					Allied Health						Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	PN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Other peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day		8	8		8			24	4	8		2	14					-					-	38
	Evening	-	-						-					-					-					-	-
	Night	-	-						-					-					-					-	-
Tuesday	Day	2	8						10					-					-					-	10
	Evening	-	-						-					-					-					-	-
	Night	-	-						-					-					-					-	-
Wednesday	Day		8	8		8			24	4	8		2	14					-					-	38
	Evening	-	-						-					-					-					-	-
	Night	-	-						-					-					-					-	-
Thursday	Day		8						8					-					-					-	8
	Evening	-	-						-					-					-					-	-
	Night	-	-						-					-					-					-	-
Friday	Day	-	8	8		8			24	4	8		2	14					-					-	38
	Evening	-	-						-					-					-					-	-
	Night	-	-						-					-					-					-	-
Saturday	All shifts	-	-			-			-					-					-					-	-
Sunday	All shifts	-	-			-			-					-					-					-	-
Total Hours per week		2	40	24	-	24	-	-	90	12	24	-	6	42	-	-	-	-	-	-	-	-	-	-	132
Annual & Other Leave Relief weeks			8	9		9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)												9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		52.14	44.14	43.14	52.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		2	40	24	-	24	-	-	90	12	24	-	6	42	-	-	-	-	-	-	-	-	-	-	132
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday Hours		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Hours		2	40	24	-	24	-	-	90	12	24	-	6	42	-	-	-	-	-	-	-	-	-	-	132
Weekly FTE's		0.1	1.1	0.6	-	0.6	-	-	2.4	0.3	0.6	-	0.2	1.1	-	-	-	-	-	-	-	-	-	-	3.4
Relief FTE's		-	0.2	0.1	-	0.1	-	-	0.5	0.1	0.1	-	0.0	0.2	-	-	-	-	-	-	-	-	-	-	0.6
Annual FTE's		0.1	1.2	0.8	-	0.8	-	-	2.8	0.4	0.7	-	0.2	1.2	-	-	-	-	-	-	-	-	-	-	4.1

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate only
May be consolidated into Acute Unit profile.
ALOS, Occup & Readm rates estimates only.
Validation Qld model - Cairns and Rod Mckay
Modelled for avg 5 treatments per day

2.3.2 Service Category – Sub-Acute Services (Residential and Hospital or Nursing Home Based)

Descriptor

The category of Sub-acute services comprise three elements:

- **Step up/step down services**

  These community based residential services are provided for people who have recently experienced or who are at increasing risk of experiencing an acute episode of mental illness. The person usually requires higher intensity of treatment and care to reduce symptoms and/or distress that cannot be adequately provided in the person's home but does not require the treatment intensity provided by acute inpatient units.

  Typically, people enter facility-based sub-acute care through one of two pathways:

  - By *'stepping down'* from a period of treatment in an acute inpatient unit to allow continued treatment in a supportive environment aimed at achieving further symptom reduction and recovery from the acute episode
    OR
  - By *'stepping up'* from the community when experiencing an increase in symptoms/distress to receive treatment in a supportive environment designed to prevent further deterioration and relapse and so avoid admission to hospital.

- **Rehabilitation services**

  Community based sub-acute residential rehabilitation services have a primary focus on interventions to improve functioning and reduce difficulties that may limit the person's independence. Rehabilitation services are primarily focused on addressing the disability dimension of mental illness and promoting personal recovery.

  These services are characterised by an expectation that they can offer a range of interventions that will assist the person to live successfully in the community of their choice, over the short to mid-term. People admitted to rehabilitation services have complex needs associated with a mental illness. Clinical symptoms, while severe, are usually relatively stable allowing engagement in rehabilitation activities.

- **Intensive Care Services**

  Intensive care services are provided as collocations with other mental health inpatient services on hospital campuses. They provide medium term recovery oriented treatment and rehabilitation in a safe, secure, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes them receiving support safely in a less restrictive environment. Services include, specialist behavioural and symptom management programs, individualised and group rehabilitation programs aimed at maximising individual functioning and recovery oriented pre-discharge and community placement planning to support safe transition to more independent living.

Distinguishing Features

- Sub-acute step up/down and sub acute rehabilitation units for adults may also be placed on sub acute hospital campuses or delivered in community residential settings.
- Sub-acute step up/down and sub acute rehabilitation units young people (12-17) and/or adolescents (16-25) are delivered in community residential settings.
- Sub-acute rehabilitation services are often provided as collocations with non-acute residential services.
- Sub-acute rehabilitation services for older adults (65+) are generally co-located on hospital campuses with generic aged care or acute older persons inpatient services.

- Sub-acute intensive care services are provided for ages 16 to 65+ as collocations with other inpatient services on general hospital campuses or in some cases psychiatric hospital campuses.
- Services are delivered by multidisciplinary teams operating as part of a local integrated mental health service system.
- Services are delivered as collaborations between specialist clinical and community support sector services with staff available on site 24 hours per day.
- The person's needs for care are complex and require significantly higher levels of support from clinical and specialist rehabilitation staff than would normally be provided in the community.
- Improvements are expected to occur in the short to medium term and stays are measured in weeks and months, not years.
    - Step up/step down care has an average length of stay of 14 days for adults and 28 days for younger people. For adults the expected length of stay does not exceed 30 days.
    - Sub-acute service for older persons operate with an average length of stay of 70 days
    - Sub-acute rehabilitation services have average lengths of stay of 70 days for adults and older adults with expected lengths of stay not exceeding 6 months. The model for older people is a combination of step up/down and rehabilitation services.
    - Intensive care services operate with average lengths of stay of 120 days
- In contrast, non-acute services have expected lengths of stay greater than 6 months.
- Sub-acute and non-acute intensive care units are usually provided as secure units gazetted to allow for involuntary detention.

Inclusions

- Community based residential units which provide sub-acute services.
- Sub-acute community residential units are defined as bed-based facilities (usually around 5 to 20 beds) that provide overnight care with mental health trained staff available on site 24 hours per day.
- While sub-acute rehabilitation services are optimally delivered in community residential settings, this service category may include inpatient units located on general or psychiatric hospital campuses.
- Sub-acute services may be provided as a collocation with or sub-program of a residential non-acute service.
- Includes intensive care sub-acute services which are generally provided as co-locations with the non-acute hospital based intensive care program.
- Older person's mental health sub-acute units are located in nursing homes and on general or psychiatric hospital campuses.

Exclusions

- Intensive treatment and rehabilitation provided by specialist community mental health teams in homes or other places in the community.
- Personalised support with varying levels of intensity linked to housing or otherwise provided by a support worker in the persons home. These services are generally provided by the community support sector and are represented elsewhere in the NMHSPF model.
- Hospital based inpatient care in units which have been arranged to respond to the varying acuity needs of people admitted and continuing to require acute inpatient care.
- Support provided by older person's mental health teams to people with complex needs in generic nursing home beds.
- Non-acute services. While non-acute services also have a focus on recovery and rehabilitation, the expectation is a length of stay of more than 6 months
- Crisis accommodation and respite accommodation generally provided by the community support sector which does not meet criteria for a non-acute staffed residential service (i.e. not staffed for a minimum of 6 hours per day).

Example Services

- Adult prevention and recovery care (PARC) units in Victoria.

- Youth prevention and recovery care (Y-PARC) units in Victoria.
- Transitional Recovery Program, Queensland
- Sutherland Hospital sub-acute mental health unit. New South Wales.
- Sub-Acute treatment and rehabilitation provided in Community Care Units and Secure Rehabilitation Units in Queensland and Victoria.
- Intermediate Care and Community Rehabilitation centres in South Australia
- Barrett Adolescent Unit – TPCMH. Queensland
- Older person's mental health sub-acute unit, Calvary Hospital. Australian Capital Territory.

2.3.2.1 Service Element – Step Up/Step Down – Youth (Residential)

Attribute	Details
Status	Not gazetted, although people may be subject to community treatment orders and forensic orders.
Services Delivered	The aim of the service is prevent further deterioration of a person's mental state and associated disability and so reduce the likelihood of admission to an acute inpatient unit (step up). The service also aims to enable early discharge from acute care through the provision of an intensive safe and supportive residential community residential program (step-down). The service aims to provide short term transitional recovery oriented care and support to minimise the trauma and impact of a first episode or relapse of a mental illness. The service takes an integrated approach to clinical recovery and psychosocial interventions with a focus on stabilisation and management of illness, engagement or reengagement in positive and supportive social, family, educational and vocational connections.
Key Distinguishing Features	Services are located in the community, and delivered in a community residential environment. They are delivered as partnerships and/or collaborations between clinical services and the community support sector. There is a strong focus on early and active engagement of family/friend/support person or carer in a young person friendly environment. Services operate as a component of a district or area integrated mental health system.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Youth (12-17) or (16-24)
Diagnostic Profile	People who meet the criteria for admission to an area mental health service inpatient unit but whose level of risk is such that they can be safely supported in a less restrictive environment than an acute inpatient unit.
Average unit size	14 beds
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	85%
Average LOS	21 days
Annual readmission rate	10%
Indicative staffing FTE/Bed	1.37 FTE per bed
Sources	• Youth prevention and recovery care (Y-PARC) framework and operational guidelines. Victorian Government 2010. Primary source. • Statewide Youth Sub-Acute Unit: An Integrated Service Approach. Government of South Australia. April 2012. • Presentation for NMHSPF EWG, Models of Residential Services, Dr Gerry Naughtin, Mind Australia.

Service Element – Step Up/Step Down – Youth – Staffing Profile

Step Up/ Step Down - Youth (Residential)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**19.24**	**1.37**	89.83	6.42	32,787	1,704	$75,136	$1,445,485	7.5	25%
NMHSPF	Vocationally Qualified	8.09	0.58	38.00	2.71	13,870	1,715	$53,660	$433,869	3.2	25%
NMSPF	Peer Worker	1.85	0.13	8.69	0.62	3,170	1,715	$54,844	$101,358	0.7	25%
NMHSPF	Tertiary Qualified	8.18	0.58	37.71	2.69	13,766	1,682	$90,391	$739,625	3.2	25%
NMHSPF	Medical	1.12	0.08	5.43	0.39	1,981	1,766	$152,055	$170,633	0.5	25%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**1.12**	**0.08**	**5.43**	**0.39**	1,981	1,766		$170,633	0.5	25%
NMHR	Psychiatrist	0.53	0.04	2.57	0.18	939	1,766	$186,972	$99,387	0.2	25%
NMHR	Registrar	0.59	0.04	2.86	0.20	1,043	1,766	$120,630	$71,246	0.2	25%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$150,783	$0	-	25%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$186,972	$0	-	25%
NMHR	**Total Nursing**	**3.56**	**0.25**	**16.00**	**1.14**	5,840	1,639		$365,746	1.3	25%
NMHR	Registered Nurse	3.56	0.25	16.00	1.14	5,840	1,639	$102,673	$365,746	1.3	25%
NMHR	Nurse Practitioner	0.00	0.00	0.00	0.00	-	-	$150,196	$0	-	25%
NMHR	Enrolled Nurse	0.00	0.00	0.00	0.00	-	-	$74,547	$0	-	25%
NMHR	**Total Allied Health**	**4.62**	**0.33**	**21.71**	**1.55**	7,926	1,715		$373,879	1.8	25%
NMHR	Psychologist	1.16	0.08	5.43	0.39	1,981	1,715	$89,058	$102,868	0.5	25%
NMHR	Social Worker	1.16	0.08	5.43	0.39	1,981	1,715	$89,058	$102,868	0.5	25%
NMHR	Occupational Therapist	1.16	0.08	5.43	0.39	1,981	1,715	$89,058	$102,868	0.5	25%
NMHR	Other TQ (eg pharmacis	1.16	0.08	5.43	0.39	1,981	1,715	$56,511	$65,275	0.5	25%
NMHR	**VQ and Peer Workers**	**9.93**	**0.71**	**46.69**	**3.33**	17,040	1,715		$535,227	3.9	25%
NMHR	Consumer Peer Worker	0.92	0.07	4.34	0.31	1,585	1,715	$54,844	$50,679	0.4	25%
NMHR	Carer Peer Worker	0.92	0.07	4.34	0.31	1,585	1,715	$54,844	$50,679	0.4	25%
NMHR	VQMH Worker	8.09	0.58	38.00	2.71	13,870	1,715	$53,660	$433,869	3.2	25%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$65,105	$0	-	25%

Annual Cost Salaries	$1,445,485
*** Including Overheads** 25%	$1,806,856
Average Daily Available Bed Day C	$354
Average Cost per Patient per annu	$12,813

Bed Based Service Parameters	
Beds	14
Availability	100%
Average Available Beds	14
ABD/Bed/Year	365
Occupancy	85%
OBD/Bed Year	310.3
ALOS (days)	28
Admissions/Bed/Year	11.08
Annual Readmit Rate	10%
Patients/Bed/Year	10.07

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Required		475
Cost		$61,092,423
Staffing		
NMHR	**Total Medical**	37.9
NMHR	Psychiatrist	18.0
NMHR	Registrar	20.0
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	120.4
NMHR	Registered Nurse	120.4
NMHR	Nurse Practitioner	0.0
NMHR	Enrolled Nurse	0.0
NMHR	**Total Allied Health**	156.2
NMHR	Psychologists	39.1
NMHR	Social Workers	39.1
NMHR	Occupational Therapists	39.1
NMHR	Other	39.1
NMHR	**VQ and Peer Workers**	335.9
NMHR	Consumer Peer Worker	31.2
NMHR	Carer Peer Worker	31.2
NMHR	VQMH Worker	273.4
NMHR	VQ Other	0.0
Total		650.5

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day			8					8	4	4			8	7.6	7.6	7.6	7.6	30.4	7.6	7.6	15.2		30.4	77
	Evening			8					8					-					-			15.2		15.2	23
	Night								-					-					-			7.6		7.6	8
Tuesday	Day			8					8	4	4			8	7.6	7.6	7.6	7.6	30.4	7.6	7.6	15.2		30.4	77
	Evening			8					8					-					-			15.2		15.2	23
	Night								-					-					-			7.6		7.6	8
Wednesday	Day			8					8	4	4			8	7.6	7.6	7.6	7.6	30.4			15.2		15.2	62
	Evening			8					8					-					-			15.2		15.2	23
	Night								-					-					-			7.6		7.6	8
Thursday	Day			8					8	4	4			8	7.6	7.6	7.6	7.6	30.4	7.6	7.6	15.2		30.4	77
	Evening			8					8					-					-			15.2		15.2	23
	Night								-					-					-			7.6		7.6	8
Friday	Day			8					8	2	4			6	7.6	7.6	7.6	7.6	30.4	7.6	7.6	15.2		30.4	75
	Evening			8					8					-					-			15.2		15.2	23
	Night	-	-						-					-					-			7.6		7.6	8
Saturday	All shifts	-	-	16		-			16					-					-			38.0		38.0	54
Sunday	All shifts	-	-	16		-			16					-					-			38.0		38	54
Total Hours per week		-	-	112	-	-	-	-	112	18	20	-	-	38	38.0	38.0	38.0	38.0	152	30.4	30.4	266.0	-	326.8	629
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	40	-	-	-	-	40	18	20	-	-	38	38	38	38	38	152	30	30	76	-	137	367
Evening Hours (Mon-Fri)		-	-	40	-	-	-	-	40	-	-	-	-	-	-	-	-	-	-	-	-	76	-	76	116
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	38	-	38	38
Saturday Hours		-	-	16	-	-	-	-	16	-	-	-	-	-	-	-	-	-	-	-	-	38	-	38	54
Sunday Hours		-	-	16	-	-	-	-	16	-	-	-	-	-	-	-	-	-	-	-	-	38	-	38	54
Total Hours		-	-	112	-	-	-	-	112	18	20	-	-	38	38	38	38	38	152	30	30	266	-	327	629
Weekly FTE's		-	-	2.9	-	-	-	-	2.9	0.5	0.5	-	-	1.0	1.0	1.0	1.0	1.0	4.0	0.8	0.8	7.0	-	8.6	7.9
Relief FTE's		-	-	0.6	-	-	-	-	0.6	0.1	0.1	-	-	0.2	0.2	0.2	0.2	0.2	0.6	0.1	0.1	1.1	-	1.3	1.4
Annual FTE's		-	-	3.6	-	-	-	-	3.6	0.5	0.6	-	-	1.1	1.2	1.2	1.2	1.2	4.6	0.9	0.9	8.1	-	9.9	19.2

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed a
a proportion of clinical services labour costs
** Average annual salary escalated to include overtime, on call and other penalty rate allowance

Variable inputs
Variable Inputs

Comments:
Estimates Based on YPARC Victoria,
MIND Youth sub-acute, SA YSAC
Validated B Kotze

2.3.2.2 Service Element – Step Up/Step Down – Adult (Residential)

Attribute	Details
Status	Not gazetted although people may be subject to community treatment or forensic orders.
Services Delivered	Intensive recovery –focussed treatment and support including crisis support planning aimed at improving symptom management and building capacity for maintaining wellbeing and preventing relapse. Short-term residential care with psychosocial rehabilitation, assistance and support to build, maintain and resume living in the community. The service takes an integrated approach to promoting clinical, psychosocial and personal recovery with a focus on stabilisation and management of illness, engagement or reengagement in positive and supportive social, family, educational and vocational connections. Services are aimed at two groups of people: first, those who no longer require acute inpatient care but would benefit from short term intensive treatment and support to build on gains made during the period of hospitalisation (step-down) secondly, people who are living in the community and require short term residential support and intensive clinical treatment and intervention to prevent risk of further deterioration or relapse which may lead to a hospital (step-up).
Key Distinguishing Features	Services are located in the community, and delivered in a community residential environment. They are delivered as partnerships and/or collaborations between clinical services and the community support sector. These services operate as a component of a district or area integrated mental health system.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Adults (16 to 64).
Diagnostic Profile	People who meet the criteria for admission to an area mental health service inpatient unit but whose level of risk is such that they can be safely supported in a less restrictive environment than an acute inpatient unit.
Average unit size	10 beds
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	85%
Average LOS	14 days with an expected maximum of 30 days
Annual readmission rate	10%
Indicative staffing FTE/Bed	1.33 FTE per bed
Sources	• Adult prevention and recovery care (PARC) services framework and operational guidelines, 2010, Victorian Government. Primary source. • Presentation for EWG, Models of Residential Services, Dr Gerry Naughtin, Mind Australia. • Intermediate Care – summary service model, 2010, Government of South Australia. • NMHSPF Expert Working Groups

Service Element – Step Up/Step Down – Adult – Staffing Profile

Step Up/Step Down - Adult_(Residential)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**13.32**	**1.33**	62.51	6.25	22,818	1,713	$70,873	$944,152	6.9	25%
NMHSPF	Vocationally Qualified	8.09	0.81	38.00	3.80	13,870	1,715	$53,660	$433,869	4.2	25%
NMSPF	Peer Worker	1.16	0.12	5.43	0.54	1,981	1,715	$54,844	$63,349	0.6	25%
NMHSPF	Tertiary Qualified	3.14	0.31	14.51	1.45	5,298	1,689	$96,790	$303,553	1.6	25%
NMHSPF	Medical	0.94	0.09	4.57	0.46	1,669	1,766	$151,728	$143,382	0.5	25%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**0.94**	**0.09**	**4.57**	**0.46**	1,669	1,766		$143,382	0.5	25%
NMHR	Psychiatrist	0.44	0.04	2.14	0.21	782	1,766	$186,972	$82,822	0.2	25%
NMHR	Registrar	0.50	0.05	2.43	0.24	886	1,766	$120,630	$60,559	0.3	25%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$150,783	$0	-	25%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$186,972	$0	-	25%
NMHR	**Total Nursing**	**1.78**	**0.18**	**8.00**	0.80	2,920	1,639		$182,873	0.9	25%
NMHR	Registered Nurse	1.78	0.18	8.00	0.80	2,920	1,639	$102,673	$182,873	0.9	25%
NMHR	Nurse Practitioner	0.00	0.00	0.00	0.00	-	-	$150,196	$0	-	25%
NMHR	Enrolled Nurse	0.00	0.00	0.00	0.00	-	-	$74,547	$0	-	25%
NMHR	**Total Allied Health**	**1.36**	**0.14**	**6.51**	**0.65**	2,378	1,755		$120,680	0.7	25%
NMHR	Psychologist	0.00	0.00	0.00	0.00	-	-	$89,058	$0	-	25%
NMHR	Social Worker	1.16	0.12	5.43	0.54	1,981	1,715	$89,058	$102,868	0.6	25%
NMHR	Occupational Therapist	0.20	0.02	1.09	0.11	396	1,981	$89,058	$17,812	0.1	25%
NMHR	Other TQ (eg pharmaci	0.00	0.00	0.00	0.00	-	-	$56,511	$0	-	25%
NMHR	**VQ and Peer Workers**	**9.24**	**0.92**	**43.43**	**4.34**	15,851	1,715		$497,218	4.8	25%
NMHR	Consumer Peer Worker	0.58	0.06	2.71	0.27	991	1,715	$54,844	$31,674	0.3	25%
NMHR	Carer Peer Worker	0.58	0.06	2.71	0.27	991	1,715	$54,844	$31,674	0.3	25%
NMHR	VQMH Worker	8.09	0.81	38.00	3.80	13,870	1,715	$53,660	$433,869	4.2	25%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$65,105	$0	-	25%

Annual Cost Salaries	$944,152
*** Including Overheads** 25%	$1,180,190
Average Daily Available Bed Day C	$323
Average Cost per Patient per annu	$5,533

Bed Based Service Parameters	
Beds	10
Availability	100%
Average Available Beds	10
ABD/Bed/Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	14
Admissions/Bed/Year	23.46
Annual Readmit Rate	10%
Patients/Bed/Year	21.33

Calculator	
Number of standardised admissions per annum multiplied by target population	5245
Beds Required	224
Cost	$26,380,929

Staffing		
NMHR	**Total Medical**	21.1
NMHR	Psychiatrist	9.9
NMHR	Registrar	11.2
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	39.8
NMHR	Registered Nurse	39.8
NMHR	Nurse Practitioner	0.0
NMHR	Enrolled Nurse	0.0
NMHR	**Total Allied Health**	30.3
NMHR	Psychologists	0.0
NMHR	Social Workers	25.8
NMHR	Occupational Therapists	4.5
NMHR	Other	0.0
NMHR	**VQ and Peer Workers**	206.6
NMHR	Consumer Peer Worker	12.9
NMHR	Carer Peer Worker	12.9
NMHR	VQMH Worker	180.7
NMHR	VQ Other	0.0
Total		297.8

		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
Description		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day			8					8	3	4			7		7.6			7.6	3.8	3.8	15.2		22.8	45
	Evening								-					-					-			15.2		15.2	15
	Night								-					-					-			7.6		7.6	8
Tuesday	Day			8					8	3	4			7		7.6	7.6		15.2	3.8	3.8	15.2		22.8	53
	Evening								-					-					-			15.2		15.2	15
	Night								-					-					-			7.6		7.6	8
Wednesday	Day			8					8	3	3			6		7.6			7.6	3.8	3.8	15.2		22.8	44
	Evening								-					-					-			15.2		15.2	15
	Night								-					-					-			7.6		7.6	8
Thursday	Day			8					8	3	3			6		7.6			7.6	3.8	3.8	15.2		22.8	44
	Evening								-					-					-			15.2		15.2	15
	Night								-					-					-			7.6		7.6	8
Friday	Day			8					8	3	3			6		7.6			7.6	3.8	3.8	15.2		22.8	44
	Evening								-					-					-			15.2		15.2	15
	Night								-					-					-			7.6		7.6	8
Saturday	All shifts			8					8					-					-			38.0		38.0	46
Sunday	All shifts			8					8					-					-			38.0		38	46
Total Hours per week		-	-	56	-	-	-	-	56	15	17	-	-	32	-	38.0	7.6	-	46	19.0	19.0	266.0	-	304.0	438
Annual & Other Leave Relief week		8	8	9	9	9	17	9		8	8	8	8		7	7		7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	52.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		-	-	40	-	-	-	-	40	15	17	-	-	32	-	38	8	-	46	19	19	76	-	114	232
Evening Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	76	-	76	76
Night Hours (Mon-Fri)		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	38	-	38	38
Saturday Hours		-	-	8	-	-	-	-	8	-	-	-	-	-	-	-	-	-	-	-	-	38	-	38	46
Sunday Hours		-	-	8	-	-	-	-	8	-	-	-	-	-	-	-	-	-	-	-	-	38	-	38	46
Total Hours		-	-	56	-	-	-	-	56	15	17	-	-	32	-	38	8	-	46	19	19	266	-	304	438
Weekly FTE's		-	-	1.5	-	-	-	-	1.5	0.4	0.4	-	-	0.8	-	1.0	0.2	-	1.2	0.5	0.5	7.0	-	8.0	3.5
Relief FTE's		-	-	0.3	-	-	-	-	0.3	0.1	0.1	-	-	0.1	-	0.2	-	-	0.2	0.1	0.1	1.1	-	1.2	0.6
Annual FTE's		-	-	1.8	-	-	-	-	1.8	0.4	0.5	-	-	0.9	-	1.2	0.2	-	1.4	0.6	0.6	8.1	-	9.2	13.3

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
PARC model Victoria
RMH allocat 6 weeks leave, 4% sick leaveand 4% ADO's
Does not include support from Acute Care Team

2.3.2.3 Service Element – Rehabilitation – Adult and Older Adult (Residential)

Attribute	Details
Status	Not gazetted
Services Delivered	These services are residential in nature and delivered in a collaboration/partnership between clinical and community support services. They provide accommodation and recovery oriented treatment and rehabilitation for people whose needs are associated with severe mental illness, the associated clinical symptoms, and unresolved psychosocial or functional disability. Staffing is available on-site 24 hours a day to deliver recovery oriented psychosocial rehabilitation and support to achieve agreed outcomes identified in an individualised person centred recovery plan inclusive of support networks and build links with in the community to promote and sustain community integration and social connectedness. Programs have a focus on developing skills and strategies for managing mental and general health, promoting wellbeing, sustainable community living and meaningful engagement in the social, recreational and vocational activities of choice. Services also include clinical support and treatment including specialist medical psychiatric review and support of people receiving involuntary community treatment under the provisions of the relevant legislation.
Key Distinguishing Features	Residential services are provided as congregate self contained living arrangements (may be 5 to 20 beds per dwelling) in which people have their own kitchen, dining room or family room and bathroom and bedroom. In some cases kitchen and dining/family areas may be shared. Clinical support is provided on site. This program is often delivered as a collocation with, or sub-program of, the non-acute adult 24 hour community residential program.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Adults and Older Adults.
Diagnostic Profile	Primary diagnoses usually include schizophrenia, psychosis or severe mood illnesses. Also may have complex presentations with exacerbations of underlying personality traits and /or issues with personality illness, drug and alcohol illnesses and significant deficits in psychosocial functioning. People will typically have significant needs affecting their ability to live in the community that can be addressed through skills development, adaptation, and provision of psychosocial support. The person may be referred to address severe unremitting symptoms which may be complicated by lack of support, difficulty accessing services, other health issues, deterioration in cognitive and coping skills, difficulties maintaining tenure of accommodation and lack of quality of life.
Average unit size	Maximum 20 beds.
Hours	Staffed 24 hours per day 7 days per week.
Suggested Modelling Attributes	
% Occupancy	85%
Average LOS	Average 120 days with an expected length of stay of no more than 180 days (6 months).
Annual readmission rate	10%
Indicative staffing FTE/Bed	Multidisciplinary 1.13 FTE/ bed.
Sources	• Country Community Rehabilitation Centres, Service Model, Draft, Jan 2012, Government of South Australia. Primary source. • Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. Primary source. • Extended Recovery Services (Draft). Mind Australia. October 2012. • Community Care Unit – Model of Service, QPMHS, Queensland, 2011. Primary source. • Overview of Future Directions, Transitional Recovery Program, Queensland

	Government 2008. • Service Model Guidelines (Draft), Transitional Recovery Program, Queensland government, 2011. • Planning Estimates for the Community Support Sector in Queensland: Harris, Siskind, Buckingham, Pirkis, Whiteford, QCMHR, 2009 • Multi-Site Benchmarking of Community Care Units and Extended Treatment and Rehabilitation Units, Queensland Mental Health Benchmarking Unit, QH, 2010. • NMHSPF Expert Working Group.

Service Element – Rehabilitation – Adult and Older Adult – Staffing Profile

Rehabilitation - Adult_and Older Adult (Residential)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**22.69**	**1.13**	103.86	5.19	37,908	1,671	$86,893	$1,971,413	5.8	25%
NMHSPF	Vocationally Qualified	6.47	0.32	30.40	1.52	11,096	1,715	$53,660	$347,095	1.7	25%
NMSPF	Peer Worker	1.85	0.09	8.69	0.43	3,170	1,715	$54,844	$101,358	0.5	25%
NMHSPF	Tertiary Qualified	13.43	0.67	60.20	3.01	21,973	1,637	$103,189	$1,385,455	3.3	25%
NMHSPF	Medical	0.94	0.05	4.57	0.23	1,669	1,766	$145,508	$137,504	0.3	25%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**0.94**	**0.05**	**4.57**	**0.23**	1,669	1,766		$137,504	0.3	25%
NMHR	Psychiatrist	0.35	0.02	1.71	0.09	626	1,766	$186,972	$66,258	0.1	25%
NMHR	Registrar	0.59	0.03	2.86	0.14	1,043	1,766	$120,630	$71,246	0.2	25%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$150,783	$0	-	25%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$186,972	$0	-	25%
NMHR	**Total Nursing**	**8.46**	**0.42**	**36.86**	**1.84**	13,453	1,590		$868,561	2.0	25%
NMHR	Registered Nurse	8.46	0.42	36.86	1.84	13,453	1,590	$102,673	$868,561	2.0	25%
NMHR	Nurse Practitioner	0.00	0.00	0.00	0.00	-	-	$150,196	$0	-	25%
NMHR	Enrolled Nurse	0.00	0.00	0.00	0.00	-	-	$74,547	$0	-	25%
NMHR	**Total Allied Health**	**4.97**	**0.25**	**23.34**	**1.17**	8,520	1,715		$516,894	1.3	25%
NMHR	Psychologist	0.58	0.03	2.71	0.14	991	1,715	$89,058	$51,434	0.2	25%
NMHR	Social Worker	1.16	0.06	5.43	0.27	1,981	1,715	$89,058	$102,868	0.3	25%
NMHR	Occupational Therapist	3.23	0.16	15.20	0.76	5,548	1,715	$112,112	$362,592	0.8	25%
NMHR	Other TQ (eg pharmaci	0.00	0.00	0.00	0.00	-	-	$56,511	$0	-	25%
NMHR	**VQ and Peer Workers**	**8.32**	**0.42**	**39.09**	**1.95**	14,266	1,715		$448,453	2.2	25%
NMHR	Consumer Peer Worker	0.92	0.05	4.34	0.22	1,585	1,715	$54,844	$50,679	0.2	25%
NMHR	Carer Peer Worker	0.92	0.05	4.34	0.22	1,585	1,715	$54,844	$50,679	0.2	25%
NMHR	VQMH Worker	6.47	0.32	30.40	1.52	11,096	1,715	$53,660	$347,095	1.7	25%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$65,105	$0	-	25%

Annual Cost Salaries	$1,971,413
*** Including Overheads** 25%	$2,464,266
Average Daily Available Bed Day C	$338
Average Cost per Patient per annu	$49,510

Bed Based Service Parameters	
Beds	20
Availability	100%
Average Available Beds	20
ABD/Bed/Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	120
Admissions/Bed/Year	2.74
Annual Readmit Rate	10%
Patients/Bed/Year	2.49

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Required		1916
Cost		$236,074,399
Staffing		
NMHR	**Total Medical**	90.5
NMHR	Psychiatrist	33.9
NMHR	Registrar	56.6
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	810.4
NMHR	Registered Nurse	810.4
NMHR	Nurse Practitioner	0.0
NMHR	Enrolled Nurse	0.0
NMHR	**Total Allied Health**	475.8
NMHR	Psychologists	55.3
NMHR	Social Workers	110.7
NMHR	Occupational Therapists	309.8
NMHR	Other	0.0
NMHR	**VQ and Peer Workers**	796.7
NMHR	Consumer Peer Worker	88.5
NMHR	Carer Peer Worker	88.5
NMHR	VQMH Worker	619.7
NMHR	VQ Other	0.0
Total		2173.5

		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
Description		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	8			8		26	4	4			8	3.8	7.6	7.6		19.0	7.6	7.6	7.6		22.8	76
	Evening	-	-	8					8					-			7.6		7.6			15.2		15.2	31
	Night	-	-	8					8					-					-			7.6		7.6	16
Tuesday	Day	2	8	8			8		26		4			4	3.8	7.6	7.6		19.0	7.6	7.6	7.6		22.8	72
	Evening	-	-	8					8					-			7.6		7.6			15.2		15.2	31
	Night	-	-	8					8					-					-			7.6		7.6	16
Wednesday	Day	2	8	8			8		26	4	4			8	3.8	7.6	7.6		19.0			7.6		7.6	61
	Evening	-	-	8					8					-			7.6		7.6			15.2		15.2	31
	Night	-	-	8					8					-					-			7.6		7.6	16
Thursday	Day	2	8	8			8		26		4			4	3.8	7.6	7.6		19.0	7.6	7.6	7.6		22.8	72
	Evening	-	-	8					8					-			7.6		7.6			15.2		15.2	31
	Night	-	-	8					8					-					-			7.6		7.6	16
Friday	Day	2	8	8			8		26	4	4			8	3.8	7.6	7.6		19.0	7.6	7.6	7.6		22.8	76
	Evening	-	-	8					8					-			7.6		7.6			15.2		15.2	31
	Night	-	-	8					8					-					-			7.6		7.6	16
Saturday	All shifts	-	-	24					24					-			15.2		15.2			30.4		30.4	70
Sunday	All shifts	-	-	24					24					-			15.2		15			30.4		30	70
Total Hours per week		10	40	168	-	-	40	-	258	12	20	-	-	32	19.0	38.0	106.4	-	163	30.4	30.4	212.8	-	273.6	727
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		10	40	40	-	-	40	-	130	12	20	-	-	32	19	38	38	-	95	30	30	38	-	99	356
Evening Hours (Mon-Fri)		-	-	40	-	-	-	-	40	-	-	-	-	-	-	-	38	-	38	-	-	76	-	76	154
Night Hours (Mon-Fri)		-	-	40	-	-	-	-	40	-	-	-	-	-	-	-	-	-	-	-	-	38	-	38	78
Saturday Hours		-	-	24	-	-	-	-	24	-	-	-	-	-	-	-	15	-	15	-	-	30	-	30	70
Sunday Hours		-	-	24	-	-	-	-	24	-	-	-	-	-	-	-	15	-	15	-	-	30	-	30	70
Total Hours		10	40	168	-	-	40	-	258	12	20	-	-	32	19	38	106	-	163	30	30	213	-	274	727
Weekly FTE's		0.3	1.1	4.4	-	-	1.1	-	6.8	0.3	0.5	-	-	0.8	0.5	1.0	2.8	-	4.3	0.8	0.8	5.6	-	7.2	11.9
Relief FTE's		0.0	0.2	0.9	-	-	0.5	-	1.7	0.1	0.1	-	-	0.1	0.1	0.2	0.4	-	0.7	0.1	0.1	0.9	-	1.1	2.5
Annual FTE's		0.3	1.2	5.3	-	-	1.6	-	8.5	0.4	0.6	-	-	0.9	0.6	1.2	3.2	-	5.0	0.9	0.9	6.5	-	8.3	22.7

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from QLD staffing profiles for new servcies 2012.
AH and RMH allocat 6 weeks leave, 4% sick leave and 4% ADO's

2.3.2.4 Service Element –Sub Acute Older Adult 65+ (Hospital)

Attribute	Details
Status	Gazetted.
Services Delivered	Provides assessment, ongoing specialised clinical treatment, rehabilitation and support for people who require sub-acute mental health care in order to regain function lost due to an acute mental illness and to prevent or delay admission to a residential aged care facility. Services are delivered in close collaboration with the general aged care sector.
Key Distinguishing Features	Services may be co-located on a hospital campus with acute older adult services or a geriatric medical ward. These services operate as a component of a district or area integrated mental health system, with that district or area mental health service having continuing responsibility for clinical governance. Should not to be confused with staffed residential support services for older adults which may be supported by area ambulatory clinical mental health services but whose primary function is residential rehabilitation for older adults whose primary needs are associated with the need for additional functional support rather than clinical symptoms.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Older Adults > 64.
Diagnostic Profile	The person will have met the criteria for acute admission and have completed their acute treatment phase but still have a need for continued treatment of symptoms of mental illness that may have responded poorly or only partially to treatment. A person may be experiencing severe unremitting clinical symptoms. The person may also present with a level of risk, functional difficulties or other complicating factors that preclude living in the community or generic aged care setting at the time.
Average unit size	16 beds
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	85%
Average LOS	35 days
Annual readmission rate	10%
Indicative staffing FTE/Bed	Multidisciplinary 1.88 clinical FTE/ bed
Sources	▪ Older persons Sub Acute Program Model of Service Delivery (Draft), QPMHS, 2012 ▪ NMHSPF Expert Working Group

Service Element –Sub Acute Older Adult – Staffing Profile

Sub-Acute Older Adult (65+ years)(Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**30.51**	**1.91**	138.37	8.65	50,506	1,656	#DIV/0!	$2,944,934	9.6	30%
NMHSPF	Vocationally Qualified	9.43	0.59	42.86	2.68	15,643	1,658	$67,844	$640,084	3.0	30%
NMSPF	Peer Worker	0.00	0.00	0.00	0.00	-	-	#DIV/0!	$0	-	30%
NMHSPF	Tertiary Qualified	17.53	1.10	78.37	4.90	28,606	1,632	$101,627	$1,781,195	5.4	30%
NMHSPF	Medical	3.54	0.22	17.14	1.07	6,257	1,766	$147,770	$523,654	1.2	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**3.54**	**0.22**	**17.14**	**1.07**	6,257	1,766		$523,654	1.2	30%
NMHR	Psychiatrist	1.18	0.07	5.71	0.36	2,086	1,766	$186,972	$220,859	0.4	30%
NMHR	Registrar	1.77	0.11	8.57	0.54	3,129	1,766	$120,630	$213,739	0.6	30%
NMHR	Junior Medical Officer	0.59	0.04	2.86	0.18	1,043	1,766	$150,783	$89,056	0.2	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$186,972	$0	-	30%
NMHR	**Total Nursing**	**21.56**	**1.35**	**95.71**	5.98	34,936	1,620		$2,043,834	6.6	30%
NMHR	Registered Nurse	13.80	0.86	60.86	3.80	22,213	1,609	$102,673	$1,417,181	4.2	30%
NMHR	Nurse Practitioner	0.64	0.04	2.86	0.18	1,043	1,639	$150,196	$95,542	0.2	30%
NMHR	Enrolled Nurse	7.12	0.45	32.00	2.00	11,680	1,639	$74,547	$531,111	2.2	30%
NMHR	**Total Allied Health**	**3.09**	**0.19**	**14.66**	**0.92**	5,350	1,733		$268,473	1.0	30%
NMHR	Psychologist	0.58	0.04	2.71	0.17	991	1,715	$89,058	$51,434	0.2	30%
NMHR	Social Worker	1.16	0.07	5.43	0.34	1,981	1,715	$89,058	$102,868	0.4	30%
NMHR	Occupational Therapist	1.16	0.07	5.43	0.34	1,981	1,715	$89,058	$102,868	0.4	30%
NMHR	Other TQ (eg pharmaci	0.20	0.01	1.09	0.07	396	1,981	$56,511	$11,302	0.1	30%
NMHR	**VQ and Peer Workers**	**2.31**	**0.14**	**10.86**	**0.68**	3,963	1,715		$108,973	0.8	30%
NMHR	Consumer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	30%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	30%
NMHR	VQMH Worker	1.16	0.07	5.43	0.34	1,981	1,715	$42,626	$49,236	0.4	30%
NMHR	VQ Other	1.16	0.07	5.43	0.34	1,981	1,715	$51,717	$59,737	0.4	30%

Annual Cost Salaries		$2,944,934
*** Including Overheads**	30%	$3,828,414
Average Daily Available Bed Day C		$656
Average Cost per Patient per annu		$56,086

Bed Based Service Parameters	
Beds	16
Availability	100%
Average Available Beds	16
ABD/Bed/Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	70
Admissions/Bed/Year	4.69
Annual Readmit Rate	10%
Patients/Bed/Year	4.27

Calculator	
Number of standardised admissions per annum multiplied by target population	5245
Beds Requirred	1118
Cost	$267,428,147

Staffing		
NMHR	**Total Medical**	247.5
NMHR	Psychiatrist	82.5
NMHR	Registrar	123.8
NMHR	Junior Medical Officer	41.3
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	1506.3
NMHR	Registered Nurse	964.2
NMHR	Nurse Practitioner	44.4
NMHR	Enrolled Nurse	497.7
NMHR	**Total Allied Health**	215.7
NMHR	Psychologists	40.3
NMHR	Social Workers	80.7
NMHR	Occupational Therapists	80.7
NMHR	Other	14.0
NMHR	**VQ and Peer Workers**	161.4
NMHR	Consumer Peer Worker	0.0
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	80.7
NMHR	VQ Other	80.7
Total		2130.9

		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
Description		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	8	8	8	8	4	46	8	12	4		24	3.8	7.6	7.6	3.8	22.8			7.6	7.6	15.2	108
	Evening	-	-	8	8	16			32					-					-					-	32
	Night	-	-	8	8	8			24					-					-					-	24
Tuesday	Day	2	8	8	8	8	8	4	46	8	12	4		24	3.8	7.6	7.6	3.8	22.8			7.6	7.6	15.2	108
	Evening	-	-	8	8	16			32					-					-					-	32
	Night	-	-	8	8	8			24					-					-					-	24
Wednesday	Day	2	8	8	8	8	8	4	46	8	12	4		24	3.8	7.6	7.6		19.0			7.6	7.6	15.2	104
	Evening	-	-	8	8	16			32					-					-					-	32
	Night	-	-	8	8	8			24					-					-					-	24
Thursday	Day	2	8	8	8	8	8	4	46	8	12	4		24	3.8	7.6	7.6		19.0			7.6	7.6	15.2	104
	Evening	-	-	8	8	16			32					-					-					-	32
	Night	-	-	8	8	8			24					-					-					-	24
Friday	Day	2	8	8	8	8	8	4	46	8	12	4		24	3.8	7.6	7.6		19.0			7.6	7.6	15.2	104
	Evening	-	-	8	8	16			32					-					-					-	32
	Night	-	-	8	8	8			24					-					-					-	24
Saturday	All shifts	-	-	24	24	32			80					-					-					-	80
Sunday	All shifts	-	-	24	24	32			80					-					-					-	80
Total Hours per week		10	40	168	168	224	40	20	670	40	60	20	-	120	19.0	38.0	38.0	7.6	103	-	-	38.0	38.0	76.0	969
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7			7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	52.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		10	40	40	40	40	40	20	230	40	60	20	-	120	19	38	38	8	103	-	-	38	38	76	529
Evening Hours (Mon-Fri)		-	-	40	40	80	-	-	160	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	160
Night Hours (Mon-Fri)		-	-	40	40	40	-	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Saturday Hours		-	-	24	24	32	-	-	80	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	80
Sunday Hours		-	-	24	24	32	-	-	80	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	80
Total Hours		10	40	168	168	224	40	20	670	40	60	20	-	120	19	38	38	8	103	-	-	38	38	76	969
Weekly FTE's		0.3	1.1	4.4	4.4	5.9	1.1	0.5	17.6	1.0	1.5	0.5	-	3.0	0.5	1.0	1.0	0.2	2.7	-	-	1.0	1.0	2.0	23.3
Relief FTE's		0.0	0.2	0.9	0.9	1.2	0.5	0.1	3.9	0.2	0.3	0.1	-	0.5	0.1	0.2	0.2	-	0.4	-	-	0.2	0.2	0.3	4.9
Annual FTE's		**0.3**	**1.2**	**5.3**	**5.3**	**7.1**	**1.6**	**0.6**	**21.6**	**1.2**	**1.8**	**0.6**	**-**	**3.5**	**0.6**	**1.2**	**1.2**	**0.2**	**3.1**	**-**	**-**	**1.2**	**1.2**	**2.3**	**30.5**

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
St George Sub Acute Unit.- in constrruction.
Planning information only.
Sub-acute colocated at the hospital with acute adult.
Acute older persons beds integrated as module of adult.
BPSD beds as part of Gereric aged care with c/l mh support
* Does not include specialist 2 consultation/liaision positions.
Medical staff does not include time for community and support to acute unit. Total 2 consul, 2 regs and 1 resident.
No allowance for AHP working in community or supporting acute unit.

2.3.2.5 Service Element – Sub-Acute Intensive Care Service (Hospital)

Attribute	Details
Status	Gazetted
Services Delivered	Sub-acute intensive care services provide short to medium term treatment and rehabilitation in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their receiving treatment in a less restrictive environment. Services include, specialist behavioural and symptom management programs, individualised and group rehabilitation programs aimed at maximising individual functioning and minimising the effects of long term care and recovery oriented pre-discharge and community placement planning to support safe transition to more independent living.
Key Distinguishing Features	Sub-acute intensive care services are located on hospital campuses usually operating as a sub-program collocated with non-acute intensive care services. Units are designed to provide a reasonably high level of security. Programs have a strong focus on safety, security and risk assessment and management. They operate as a component of a district or area integrated mental health service system. Not to be confused with low, medium and high security forensic units.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Adults, older adults and selected young people with special needs.
Diagnostic Profile	Primary diagnoses usually include schizophrenia, psychosis or severe mood illnesses. Also may have complex presentations including issues with personality illness or exacerbations of underlying personality traits, drug and alcohol illnesses, complex trauma and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised behaviour leading to difficulty in managing activities of daily living, impaired impulse control, vulnerability, ongoing risk of aggression, and significant risk of self harm.
Average unit size	8 beds .
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	85%
Average LOS	120 days with an expected maximum stay of less than 180 days (6 months)
Annual readmission rate	10%
Indicative staffing FTE/Bed	Multidisciplinary 1.61 FTE/ bed.
Sources	• Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. • Secure Mental Health Rehabilitation Unit Model of Service, QPMHS, Queensland, 2011. Primary source. • Multi-Site Benchmarking of Medium Secure Units, Queensland Mental Health Benchmarking Unit, QH, 2010.

Service Element – Sub-Acute Intensive Care Service – Staffing Profile

Sub-Acute Intensive Care Service (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	TOTAL	38.73	1.61	170.69	7.11	62,300	1,609	$102,468	$3,968,683	7.9	30%
NMHSPF	Vocationally Qualified	1.78	0.07	8.00	0.33	2,920	1,639	$74,547	$132,778	0.4	30%
NMSPF	Peer Worker	1.85	0.08	8.69	0.36	3,170	1,715	$54,844	$101,358	0.4	30%
NMHSPF	Tertiary Qualified	32.44	1.35	141.14	5.88	51,517	1,588	$101,923	$3,306,798	6.5	30%
NMHSPF	Medical	2.66	0.11	12.86	0.54	4,693	1,766	$160,941	$427,749	0.6	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	Total Medical	2.66	0.11	12.86	0.54	4,693	1,766		$427,749	0.6	30%
NMHR	Psychiatrist	1.00	0.04	4.86	0.20	1,773	1,766	$200,564	$201,377	0.2	30%
NMHR	Registrar	1.65	0.07	8.00	0.33	2,920	1,766	$136,885	$226,372	0.4	30%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$171,102	$0	-	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$212,167	$0	-	30%
NMHR	Total Nursing	30.76	1.28	132.86	5.54	48,493	1,576		$3,168,565	6.2	30%
NMHR	Registered Nurse	27.71	1.15	119.14	4.96	43,487	1,570	$102,673	$2,844,703	5.5	30%
NMHR	Nurse Practitioner	1.27	0.05	5.71	0.24	2,086	1,639	$150,196	$191,084	0.3	30%
NMHR	Enrolled Nurse	1.78	0.07	8.00	0.33	2,920	1,639	$74,547	$132,778	0.4	30%
NMHR	Total Allied Health	3.47	0.14	16.29	0.68	5,944	1,715		$271,011	0.8	30%
NMHR	Psychologist	0.58	0.02	2.71	0.11	991	1,715	$89,058	$51,434	0.1	30%
NMHR	Social Worker	1.16	0.05	5.43	0.23	1,981	1,715	$89,058	$102,868	0.3	30%
NMHR	Occupational Therapist	0.58	0.02	2.71	0.11	991	1,715	$89,058	$51,434	0.1	30%
NMHR	Other TQ (eg pharmaci	1.16	0.05	5.43	0.23	1,981	1,715	$56,511	$65,275	0.3	30%
NMHR	VQ and Peer Workers	1.85	0.08	8.69	0.36	3,170	1,715		$101,358	0.4	30%
NMHR	Consumer Peer Worker	0.92	0.04	4.34	0.18	1,585	1,715	$54,844	$50,679	0.2	30%
NMHR	Carer Peer Worker	0.92	0.04	4.34	0.18	1,585	1,715	$54,844	$50,679	0.2	30%
NMHR	VQMH Worker	0.00	0.00	0.00	0.00	-	-	$42,626	$0	-	30%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$51,717	$0	-	30%

Annual Cost Salaries	$3,968,683
* Including Overheads 30%	$5,159,288
Average Daily Available Bed Day C	$589
Average Cost per Patient per annu	$86,381

Bed Based Service Parameters	
Beds	24
Availability	100%
Average Available Beds	24
ABD/Bed/Year	365
Occupancy	90%
OBD/Bed Year	328.5
ALOS (days)	120
Admissions/Bed/Year	2.74
Annual Readmit Rate	10%
Patients/Bed/Year	2.49

Calculator	
Number of standardised admissions per annum multiplied by target population	5245
Beds Required	1916
Cost	$411,879,216

Staffing		
NMHR	Total Medical	212.2
NMHR	Psychiatrist	80.2
NMHR	Registrar	132.0
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	Total Nursing	2455.6
NMHR	Registered Nurse	2211.9
NMHR	Nurse Practitioner	101.6
NMHR	Enrolled Nurse	142.2
NMHR	Total Allied Health	276.6
NMHR	Psychologists	46.1
NMHR	Social Workers	92.2
NMHR	Occupational Therapists	46.1
NMHR	Other	92.2
NMHR	VQ and Peer Workers	147.5
NMHR	Consumer Peer Worker	73.8
NMHR	Carer Peer Worker	73.8
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		3092.0

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	16	16	8	8	8	66	8	8			16	3.8	7.6	3.8	7.6	22.8	7.6	7.6			15.2	120
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Tuesday	Day	2	8	16	16	8	8	8	66	6	8			14	3.8	7.6	3.8	7.6	22.8	7.6	7.6			15.2	118
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Wednesday	Day	2	8	16	16	8	8	8	66	8	8			16	3.8	7.6	3.8	7.6	22.8					-	105
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Thursday	Day	2	8	16	16	8	8	8	66	6	8			14	3.8	7.6	3.8	7.6	22.8	7.6	7.6			15.2	118
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Friday	Day	2	8	16	16	8	8	8	66	6	8			14	3.8	7.6	3.8	7.6	22.8	7.6	7.6			15.2	118
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Saturday	All shifts	-	-	40	48	8	24		120		8			8					-					-	128
Sunday	All shifts	-	-	40	48	8	24		120		8			8					-					-	128
Total Hours per week		10	40	280	336	56	168	40	930	34	56	-	-	90	19.0	38.0	19.0	38.0	114	30.4	30.4	-	-	60.8	1,195
Annual & Other Leave Relief wee		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		10	40	80	80	40	40	40	330	34	40	-	-	74	19	38	19	38	114	30	30	-	-	61	579
Evening Hours (Mon-Fri)		-	-	80	80	-	40	-	200	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	200
Night Hours (Mon-Fri)		-	-	40	80	-	40	-	160	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	160
Saturday Hours		-	-	40	48	8	24	-	120	-	8	-	-	8	-	-	-	-	-	-	-	-	-	-	128
Sunday Hours		-	-	40	48	8	24	-	120	-	8	-	-	8	-	-	-	-	-	-	-	-	-	-	128
Total Hours		10	40	280	336	56	168	40	930	34	56	-	-	90	19	38	19	38	114	30	30	-	-	61	1,195
Weekly FTE's		0.3	1.1	7.4	8.8	1.5	4.4	1.1	24.5	0.9	1.4	-	-	2.3	0.5	1.0	0.5	1.0	3.0	0.8	0.8	-	-	1.6	29.7
Relief FTE's		0.0	0.2	1.5	1.8	0.3	2.1	0.2	6.3	0.2	0.3	-	-	0.4	0.1	0.2	0.1	0.2	0.5	0.1	0.1	-	-	0.2	7.2
Annual FTE's		0.3	1.2	8.9	10.7	1.8	6.6	1.3	30.8	1.0	1.7	-	-	2.7	0.6	1.2	0.6	1.2	3.5	0.9	0.9	-	-	1.8	36.7

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Drawn from
Recommendations for Planning -
Qld MHPI and SECU, RMH.
May operate as part of combined non/sub acute unit

2.3.3 Service Category – Non-Acute Extended Treatment Services (Residential and Hospital or Nursing Home Based)

Descriptor

Sub-acute and non-acute bed-based services are part of a spectrum of services and, as such, share some characteristics – for example, a focus on rehabilitation. The key difference is that non-acute services provide care over an extended period – with an expected length of stay in excess of 6 months.

People accessing non-acute services present with a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness and severe levels of need for additional support, resulting in a limited capacity to function independently. The goal is to provide treatment and rehabilitation over an extended period, aimed at promoting personal recovery and reducing difficulties that limit independence.

Distinguishing Features

- Services are provided over an extended period with an expected length of stay greater than 6 months.
- Includes treatment and rehabilitation services for people with high intensity needs for clinical care and treatment over an extended period (needs dominated by positive symptoms and associated problems in context of functional disability).
- Includes residential services for people with high intensity needs for psycho-social rehabilitation (needs dominated by functional disabilities in context of unremitting but relatively stable positive symptoms).
- Services are delivered by multidisciplinary teams operating as part of a local integrated mental health service system.
- Services are usually delivered as collaborations between specialist clinical and community support services.
- The person's needs for services are complex and require significantly higher levels of support than can be provided at home or in other non residential settings.
- Gains are expected to occur slowly and stays are measured in months and years. Measures of average lengths of stay are often distorted by the need to provide continuing care for some people over decades.
- Specialist services are generally provided for adults and for older adults. These extended stay programs are not suitable for young people.
- Intensive care bed based units are provided as secure units gazetted to allow for involuntary detention.

Inclusions

- Non-acute intensive care units are located on general or psychiatric hospital campuses.
- Non-acute intensive care units provided in specialist units in prisons and/or forensic units (These units are out of scope for this project, however the people are included in the epidemiology and are included in the model).
- Bed based units located on general or psychiatric hospital campuses or community based units which provide non-acute services.
- Residential services that provide domestic style overnight accommodation staffed with a minimum of 6 hours support per day and at least 50 hours support per week. Residential services may be further categorised by level of intensity of need in terms of those providing < 24 hours support per day and those providing 24 hours of support per day.
- Older person's mental health extended treatment and rehabilitation units are located in nursing homes and in some cases on general or psychiatric hospital campuses.

- Specialist extended treatment and rehabilitation bed based units are located on general or psychiatric hospital campuses or collocated with generic specialist services which provide services for people with complex co-morbidities (eg acquired brain injury).
- Non-acute services may be co-located with sub-acute services.

Exclusions

- Personalised support with varying levels of intensity linked to housing or otherwise provided by a support worker.
- Facilities that provide an extensive range of hotel services and limited personalised support.
- Intensive treatment and rehabilitation provided by specialist community mental health teams in homes or other places in the community.
- Support provided by older person's mental health teams to people with complex needs in generic nursing home beds.

Example Services

- Mind, Victoria
- Mid West AMHS – Sunshine Hospital Secure Extended Care Unit. Melbourne, Victoria
- Townsville Mental Health Services – Medium Secure Unit. Queensland.
- Mid West AMHS – Community Care Unit. Melbourne, Victoria.
- Tasmania MHS – South – Campbell Street Residential Unit. Hobart, Tasmania.
- NWMH Aged Persons MH Program – Westside Lodge NH Sunshine, Melbourne, Victoria.
- WMIMH Older Persons Mental Health Service – Extended Treatment and Rehabilitation Unit – Ipswich General Hospital. Queensland.
- Redcliffe Caboolture MHS – Acquired Brain Injury Unit – Eventide, Queensland.

2.3.3.1 Service Element – Non-Acute – Intensive Care Service (Hospital)

Attribute	Details
Status	Gazetted
Services Delivered	Non-acute intensive care services provide medium to long term treatment and rehabilitation in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their living in a less restrictive environment. Services include, specialist behavioural and symptom management programs, individualised and group rehabilitation programs aimed at maximising individual functioning and minimising the effects of long term care and recovery oriented pre-discharge and community placement planning to support safe transition to more independent living.
Key Distinguishing Features	Non-acute intensive care services are located on hospital campuses. Units are designed to provide a reasonably high level of security. Programs have a strong focus on safety, security and risk assessment and management. They operate as a component of a district or area integrated mental health service system. Not to be confused with low, medium and high security forensic units (Forensic units are out of scope for this project, however the people are included in the epidemiology and are included in the model). Usually incorporates sub-acute intensive care program beds.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Adults and selected young people with special needs.
Diagnostic Profile	Primary diagnoses usually include schizophrenia, psychosis or severe mood illnesses. Also may have complex presentations including issues with personality illness, drug and alcohol illnesses, complex trauma and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised behaviour leading to difficulty in managing activities of daily living, impaired impulse control, vulnerability, ongoing risk of aggression, and significant risk of self harm.
Average unit size	24 beds
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	95%
Average LOS	365 days
Annual readmission rate	10%
Indicative staffing FTE/Bed	Multidisciplinary 1.8 FTE/ bed.
Sources	• Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. Primary source • Secure Mental Health Rehabilitation Unit Model of Service, QPMHS, Queensland, 2011. Primary source. • Multi-Site Benchmarking of Medium Secure Units, Queensland Mental Health Benchmarking Unit, QH, 2010. • NMHSPF Expert Working Group.

Service Element – Non-Acute – Intensive Care Service – Staffing Profile

Non-Acute - Intensive Care Service (Hospital)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**37.81**	**1.58**	166.34	6.93	60,715	1,606	$103,632	$3,918,004	7.3	30%
NMHSPF	Vocationally Qualified	1.78	0.07	8.00	0.33	2,920	1,639	$74,547	$132,778	0.4	30%
NMSPF	Peer Worker	0.92	0.04	4.34	0.18	1,585	1,715	$54,844	$50,679	0.2	30%
NMHSPF	Tertiary Qualified	32.44	1.35	141.14	5.88	51,517	1,588	$101,923	$3,306,798	6.2	30%
NMHSPF	Medical	2.66	0.11	12.86	0.54	4,693	1,766	$160,941	$427,749	0.6	30%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**2.66**	**0.11**	**12.86**	**0.54**	4,693	1,766		$427,749	0.6	30%
NMHR	Psychiatrist	1.00	0.04	4.86	0.20	1,773	1,766	$200,564	$201,377	0.2	30%
NMHR	Registrar	1.65	0.07	8.00	0.33	2,920	1,766	$136,885	$226,372	0.4	30%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$171,102	$0	-	30%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$212,167	$0	-	30%
NMHR	**Total Nursing**	**30.76**	**1.28**	**132.86**	5.54	48,493	1,576		$3,168,565	5.8	30%
NMHR	Registered Nurse	27.71	1.15	119.14	4.96	43,487	1,570	$102,673	$2,844,703	5.2	30%
NMHR	**Nurse Practitioner**	1.27	0.05	5.71	0.24	2,086	1,639	$150,196	$191,084	0.3	30%
NMHR	Enrolled Nurse	1.78	0.07	8.00	0.33	2,920	1,639	$74,547	$132,778	0.4	30%
NMHR	**Total Allied Health**	**3.47**	**0.14**	**16.29**	**0.68**	5,944	1,715		$271,011	0.7	30%
NMHR	Psychologist	0.58	0.02	2.71	0.11	991	1,715	$89,058	$51,434	0.1	30%
NMHR	Social Worker	1.16	0.05	5.43	0.23	1,981	1,715	$89,058	$102,868	0.2	30%
NMHR	Occupational Therapist	0.58	0.02	2.71	0.11	991	1,715	$89,058	$51,434	0.1	30%
NMHR	Other TQ (eg pharmacis	1.16	0.05	5.43	0.23	1,981	1,715	$56,511	$65,275	0.2	30%
NMHR	**VQ and Peer Workers**	**0.92**	**0.04**	**4.34**	**0.18**	1,585	1,715		$50,679	0.2	30%
NMHR	Consumer Peer Worker	0.92	0.04	4.34	0.18	1,585	1,715	$54,844	$50,679	0.2	30%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	30%
NMHR	VQMH Worker	0.00	0.00	0.00	0.00	-	-	$42,626	$0	-	30%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$51,717	$0	-	30%

Annual Cost Salaries	$3,918,004
*** Including Overheads** 30%	$5,093,405
Average Daily Available Bed Day C	$581
Average Cost per Patient per annu	$245,734

Bed Based Service Parameters	
Beds	24
Availability	100%
Average Available Beds	24
ABD/Bed/Year	365
Occupancy	95%
OBD/Bed Year	346.8
ALOS (days)	365
Admissions/Bed/Year	0.95
Annual Readmit Rate	10%
Patients/Bed/Year	0.86

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Required		5521
Cost		$1,171,706,603
Staffing		
NMHR	**Total Medical**	611.4
NMHR	Psychiatrist	231.0
NMHR	Registrar	380.4
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	7076.1
NMHR	Registered Nurse	6373.7
NMHR	**Nurse Practitioner**	292.7
NMHR	Enrolled Nurse	409.7
NMHR	**Total Allied Health**	797.2
NMHR	Psychologists	132.9
NMHR	Social Workers	265.7
NMHR	Occupational Therapists	132.9
NMHR	Other	265.7
NMHR	**VQ and Peer Workers**	212.6
NMHR	Consumer Peer Worker	212.6
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		8697.3

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	16	16	8	8	8	66	8	8			16	3.8	7.6	3.8	7.6	22.8	7.6				7.6	112
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Tuesday	Day	2	8	16	16	8	8	8	66	6	8			14	3.8	7.6	3.8	7.6	22.8	7.6				7.6	110
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Wednesday	Day	2	8	16	16	8	8	8	66	8	8			16	3.8	7.6	3.8	7.6	22.8					-	105
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Thursday	Day	2	8	16	16	8	8	8	66	6	8			14	3.8	7.6	3.8	7.6	22.8	7.6				7.6	110
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Friday	Day	2	8	16	16	8	8	8	66	6	8			14	3.8	7.6	3.8	7.6	22.8	7.6				7.6	110
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Saturday	All shifts	-	-	40	48	8	24		120		8			8					-					-	128
Sunday	All shifts	-	-	40	48	8	24		120		8			8					-					-	128
Total Hours per week		**10**	**40**	**280**	**336**	**56**	**168**	**40**	**930**	**34**	**56**	**-**	**-**	**90**	**19.0**	**38.0**	**19.0**	**38.0**	**114**	**30.4**	**-**	**-**	**-**	**30.4**	**1,164**
Annual & Other Leave Relief weeks		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		10	40	80	80	40	40	40	330	34	40	-	-	74	19	38	19	38	114	30	-	-	-	30	548
Evening Hours (Mon-Fri)		-	-	80	80	-	40	-	200	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	200
Night Hours (Mon-Fri)		-	-	40	80	-	40	-	160	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	160
Saturday Hours		-	-	40	48	8	24	-	120	-	8	-	-	8	-	-	-	-	-	-	-	-	-	-	128
Sunday Hours		-	-	40	48	8	24	-	120	-	8	-	-	8	-	-	-	-	-	-	-	-	-	-	128
Total Hours		10	40	280	336	56	168	40	930	34	56	-	-	90	19	38	19	38	114	30	-	-	-	30	1,164
Weekly FTE's		0.3	1.1	7.4	8.8	1.5	4.4	1.1	24.5	0.9	1.4	-	-	2.3	0.5	1.0	0.5	1.0	3.0	0.8	-	-	-	0.8	29.7
Relief FTE's		0.0	0.2	1.5	1.8	0.3	2.1	0.2	6.3	0.2	0.3	-	-	0.4	0.1	0.2	0.1	0.2	0.5	0.1	-	-	-	0.1	7.2
Annual FTE's		**0.3**	**1.2**	**8.9**	**10.7**	**1.8**	**6.6**	**1.3**	**30.8**	**1.0**	**1.7**	**-**	**-**	**2.7**	**0.6**	**1.2**	**0.6**	**1.2**	**3.5**	**0.9**	**-**	**-**	**-**	**0.9**	**37.8**

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Drawn from
Recommendations for Planning -
Qld MHPI and SECU, RMH.

2.3.3.2 Service Element – Non-Acute -Intensive Care Service – Older Adult (65+) (Hospital Based)

Attribute	Details
Status	Gazetted
Services Delivered	Non-acute intensive care services provide medium to long term treatment and rehabilitation in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their living in a less restrictive environment. Services include, specialist behavioural and symptom management programs, individualised and group rehabilitation programs aimed at maximising individual functioning and minimising the effects of long term care and recovery oriented pre-discharge and community placement planning to support safe transition to more independent living.
Key Distinguishing Features	Non-acute intensive care services are located on hospital campuses. Units are designed to provide a reasonably high level of security. Programs have a strong focus on safety, security and risk assessment and management. They operate as a component of a district or area integrated mental health service system. Not to be confused with low, medium and high security forensic units. Usually incorporates sub-acute intensive care program beds.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Older adults
Diagnostic Profile	Late onset mental illness or, early onset severe mental illness complicated by the need for additional supports associated with ageing, or, severe mental illness as a complication of dementia or other age-related illnesses. Other common diagnoses include schizophrenia and organic and mood illnesses Also may have complex presentations including personality illness, drug and alcohol illnesses, complex trauma and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised behaviour leading to difficulty in managing activities of daily living, impaired impulse control, vulnerability, ongoing risk of aggression, and significant risk of self harm.
Average unit size	24 beds
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	95%
Average LOS	365 days
28 day readmission rate	10%
Indicative staffing FTE/Bed	Multidisciplinary 1.62 clinical FTE/ bed.
Sources	• Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. Primary source • Secure Mental Health Rehabilitation Unit Model of Service, QPMHS, Queensland, 2011. Primary source. • Multi-Site Benchmarking of Medium Secure Units, Queensland Mental Health Benchmarking Unit, QH, 2010. • NMHSPF Expert Working Group • MH-CCP Older persons modelling.

Service Element – Non-Acute -Intensive Care Service – Older Adult – Staffing Profile

Non-Acute -Intensive Care Service - Older Adult(65+) (Hospital Based)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**38.86**	**1.62**	171.37	7.14	62,551	1,610	$103,859	$4,035,919	7.5	30%
NMHSPF	Vocationally Qualified	2.36	0.10	10.71	0.45	3,911	1,658	$68,957	$162,646	0.5	30%
NMSPF	Peer Worker	0.92	0.04	4.34	0.18	1,585	1,715	$54,844	$50,679	0.2	30%
NMHSPF	Tertiary Qualified	32.33	1.35	140.60	5.86	51,319	1,587	$101,885	$3,293,788	6.2	30%
NMHSPF	Medical	3.25	0.14	15.71	0.65	5,736	1,766	$162,789	$528,805	0.7	30%
NMHR	**TOTAL**	**FTE**	**FTE/Bed**	**Hours/ day**	**Hours/ ABD**	**Hrs annual**	**FTE scalar**	**Salary ****	**Cost**		**O'heads %**
NMHR	**Total Medical**	**3.25**	**0.14**	**15.71**	**0.65**	5,736	1,766		$528,805	0.7	30%
NMHR	Psychiatrist	1.00	0.04	4.86	0.20	1,773	1,766	$200,564	$201,377	0.2	30%
NMHR	Registrar	1.65	0.07	8.00	0.33	2,920	1,766	$136,885	$226,372	0.4	30%
NMHR	Junior Medical Officer	0.59	0.02	2.86	0.12	1,043	1,766	$171,102	$101,056	0.1	30%
NMHR	Other Medical Specialist	0.00	0.00	0.00	0.00	-	-	$212,167	$0	-	30%
NMHR	**Total Nursing**	**30.76**	**1.28**	**132.86**	5.54	48,493	1,576		$3,168,565	5.8	30%
NMHR	Registered Nurse	27.71	1.15	119.14	4.96	43,487	1,570	$102,673	$2,844,703	5.2	30%
NMHR	**Nurse Practitioner**	**1.27**	**0.05**	**5.71**	0.24	2,086	1,639	$150,196	$191,084	0.3	30%
NMHR	Enrolled Nurse	1.78	0.07	8.00	0.33	2,920	1,639	$74,547	$132,778	0.4	30%
NMHR	**Total Allied Health**	**3.35**	**0.14**	**15.74**	**0.66**	5,746	1,715		$258,001	0.7	30%
NMHR	Psychologist	0.58	0.02	2.71	0.11	991	1,715	$89,058	$51,434	0.1	30%
NMHR	Social Worker	0.58	0.02	2.71	0.11	991	1,715	$89,058	$51,434	0.1	30%
NMHR	Occupational Therapist	0.58	0.02	2.71	0.11	991	1,715	$89,058	$51,434	0.1	30%
NMHR	Other TQ (eg pharmacis	1.62	0.07	7.60	0.32	2,774	1,715	$64,126	$103,699	0.3	30%
NMHR	**VQ and Peer Workers**	**1.50**	**0.06**	**7.06**	**0.29**	2,576	1,715		$80,548	0.3	30%
NMHR	Consumer Peer Worker	0.92	0.04	4.34	0.18	1,585	1,715	$54,844	$50,679	0.2	30%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	30%
NMHR	VQMH Worker	0.00	0.00	0.00	0.00	-	-	$42,626	$0	-	30%
NMHR	VQ Other	0.58	0.02	2.71	0.11	991	1,715	$51,717	$29,869	0.1	30%

Annual Cost Salaries	$4,035,919
*** Including Overheads** 30%	$5,246,695
Average Daily Available Bed Day C	$599
Average Cost per Patient per annu	$253,130

Bed Based Service Parameters	
Beds	24
Availability	100%
Average Available Beds	24
ABD/Bed/Year	365
Occupancy	95%
OBD/Bed Year	346.8
ALOS (days)	365
Admissions/Bed/Year	0.95
Annual Readmit Rate	10%
Patients/Bed/Year	0.86

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Requirred		5521
Cost		$1,206,969,937
Staffing		
NMHR	**Total Medical**	747.3
NMHR	Psychiatrist	231.0
NMHR	Registrar	380.4
NMHR	Junior Medical Officer	135.9
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	7076.1
NMHR	Registered Nurse	6373.7
NMHR	**Nurse Practitioner**	292.7
NMHR	Enrolled Nurse	409.7
NMHR	**Total Allied Health**	770.6
NMHR	Psychologists	132.9
NMHR	Social Workers	132.9
NMHR	Occupational Therapists	132.9
NMHR	Other	372.0
NMHR	**VQ and Peer Workers**	345.4
NMHR	Consumer Peer Worker	212.6
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	0.0
NMHR	VQ Other	132.9
Total		8939.4

Description		Nursing								Medical					Allied Health						Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	16	16	8	8	8	66	8	8	4		20	3.8	3.8	3.8	7.6	19.0	7.6			3.8	11.4	116
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Tuesday	Day	2	8	16	16	8	8	8	66	6	8	4		18	3.8	3.8	3.8	7.6	19.0	7.6			3.8	11.4	114
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Wednesday	Day	2	8	16	16	8	8	8	66	8	8	4		20	3.8	3.8	3.8	7.6	19.0				3.8	3.8	109
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Thursday	Day	2	8	16	16	8	8	8	66	6	8	4		18	3.8	3.8	3.8	7.6	19.0	7.6			3.8	11.4	114
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Friday	Day	2	8	16	16	8	8	8	66	6	8	4		18	3.8	3.8	3.8	7.6	19.0	7.6			3.8	11.4	114
	Evening	-	-	16	16	-	8		40					-					-					-	40
	Night	-	-	8	16	-	8		32					-					-					-	32
Saturday	All shifts	-	-	40	48	8	24		120		8			8				7.6	7.6					-	136
Sunday	All shifts	-	-	40	48	8	24		120		8			8				7.6	8					-	136
Total Hours per week		10	40	280	336	56	168	40	930	34	56	20	-	110	19.0	19.0	19.0	53.2	110	30.4	-	-	19.0	49.4	1,200
Annual & Other Leave Relief week		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		10	40	80	80	40	40	40	330	34	40	20	-	94	19	19	19	38	95	30	-	-	19	49	568
Evening Hours (Mon-Fri)		-	-	80	80	-	40	-	200	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	200
Night Hours (Mon-Fri)		-	-	40	80	-	40	-	160	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	160
Saturday Hours		-	-	40	48	8	24	-	120	-	8	-	-	8	-	-	-	8	8	-	-	-	-	-	136
Sunday Hours		-	-	40	48	8	24	-	120	-	8	-	-	8	-	-	-	8	8	-	-	-	-	-	136
Total Hours		10	40	280	336	56	168	40	930	34	56	20	-	110	19	19	19	53	110	30	-	-	19	49	1,200
Weekly FTE's		0.3	1.1	7.4	8.8	1.5	4.4	1.1	24.5	0.9	1.4	0.5	-	2.8	0.5	0.5	0.5	1.4	2.9	0.8	-	-	0.5	1.3	30.1
Relief FTE's		0.0	0.2	1.5	1.8	0.3	2.1	0.2	6.3	0.2	0.3	0.1	-	0.5	0.1	0.1	0.1	0.2	0.4	0.1	-	-	0.1	0.2	7.2
Annual FTE's		0.3	1.2	8.9	10.7	1.8	6.6	1.3	30.8	1.0	1.7	0.6	-	3.2	0.6	0.6	0.6	1.6	3.3	0.9	-	-	0.6	1.5	38.9

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Drawn from
Recommendations for Planning -
Qld MHPI and SECU, RMH Adult Services.
Replicates adult model for older adult as per R McKay

2.3.3.3 Service Element – Non-Acute – Adult and Older Adult (24 Hour Support) (Residential)

Attribute	Details
Status	Not gazetted
Services Delivered	These services are residential in nature. They provide accommodation and recovery oriented treatment and rehabilitation for people whose needs are associated with severe mental illness, the associated clinical symptoms, and unresolved psychosocial or functional disability. Staffing is on-site up to 24 hours a day to deliver recovery oriented psychosocial rehabilitation and support to achieve agreed outcomes identified in an individualised person centred recovery plan inclusive of support networks and support to build links with in the community to sustain community integration and social connectedness. These services offer ongoing development of skills and strategies for managing mental and general health, promoting wellbeing, sustainable community living and meaningful engagement in the social, recreational and vocational activities of choice. Services also include clinical support and treatment including specialist medical psychiatric review and support of people receiving involuntary community treatment under the provisions of the relevant legislation.
Key Distinguishing Features	Residential services are provided as congregate living arrangements (may be 5 to 20 beds per dwelling) in which people may share living spaces such as a kitchen, dining room or family room and may have their own bathrooms and bedrooms. Services are provided in flexible arrangements which provide a minimum of 6 hours per day support up to 24 hours per day. Services may be categorised as providing less than 24 hours or 24 hours of support. Clinical support is provided on site generally by a local mental health service.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Adults and Older Adults.
Diagnostic Profile	Primary diagnoses usually include schizophrenia and related psychosis and mood illnesses. Also may have complex presentations including issues with personality illness, drug and alcohol illnesses and significant deficits in psychosocial functioning. Typically people have significant needs for community based functional support which make living independently even with high levels of personal support difficult in the context of a severe but relatively stable mental health status. The person will have access to a recovery based support program. The person may be referred to address severe unremitting symptoms which may be complicated by lack of support, difficulty accessing services, other health issues, deterioration in cognitive and coping skills, difficulties maintaining tenure of accommodation and lack of quality of life.
Average unit size	5-20 beds
Hours	Staffed 6 to 24 hours per day 7 days per week.
Suggested Modelling Attributes	
% Occupancy	95%
Average LOS	365 days
Annual readmission rate	10%
Indicative staffing FTE/Bed	Multidisciplinary 0.96 FTE/ bed where care is provided 24 hours per day for 20 people. For service provided at < 24 hours per day a range of hours per day direct care packages are provided.
Sources	• Presentation for NMHSPF EWG, Models of Residential Services, Dr Gerry Naughtin, Mind Australia. Primary source. • Key Principles Underpinning Residential Services (Draft). Mind Australia. 2012. • Community Care Unit – Model of Service, QPMHS, Queensland, 2011. • Handbook of Psychosocial Rehabilitation: King, Lloyd and Meehan, 2007

	• Overview of Future Directions, Transitional Recovery Program, Queensland Government 2008 • Service Model Guidelines (Draft), Transitional Recovery Program, Queensland government, 2011 • Planning Estimates for the Community Support Sector in Queensland: Harris, Siskind, Buckingham, Pirkis, Whiteford, QCMHR, 2009 • A Domains-Based Taxonomy of Supported Accommodation for People with Severe and Persistent Mental Illness: Siskind, Harris, Pirkis, Whiteford, Submitted for publication December 2011. • Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. • Community Care Unit Model of Service, QPMHS, Queensland, 2011. • Multi-Site Benchmarking of Community Care Units and Extended Treatment and Rehabilitation Units, Queensland Mental Health Benchmarking Unit, QH, 2010.

Service Element – Non-Acute – Adult and Older Adult (24 Hour Support) – Staffing Profile

Non-Acute - Adult and Older Adult (24 hour support) (Residential)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**19.48**	**0.97**	88.77	4.44	32,402	1,663	$89,650	$1,746,800	4.7	25%
NMHSPF	Vocationally Qualified	4.85	0.24	22.80	1.14	8,322	1,715	$53,660	$260,321	1.2	25%
NMSPF	Peer Worker	0.92	0.05	4.34	0.22	1,585	1,715	$54,844	$50,679	0.2	25%
NMHSPF	Tertiary Qualified	13.18	0.66	59.06	2.95	21,556	1,636	$103,199	$1,359,923	3.1	25%
NMHSPF	Medical	0.53	0.03	2.57	0.13	939	1,766	$142,744	$75,877	0.1	25%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**0.53**	**0.03**	**2.57**	**0.13**	939	1,766		$75,877	0.1	25%
NMHR	Psychiatrist	0.18	0.01	0.86	0.04	313	1,766	$186,972	$33,129	0.0	25%
NMHR	Registrar	0.35	0.02	1.71	0.09	626	1,766	$120,630	$42,748	0.1	25%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$150,783	$0	-	25%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$186,972	$0	-	25%
NMHR	**Total Nursing**	**8.21**	**0.41**	**35.71**	1.79	13,036	1,588		$843,028	1.9	25%
NMHR	Registered Nurse	8.21	0.41	35.71	1.79	13,036	1,588	$102,673	$843,028	1.9	25%
NMHR	Nurse Practitioner	0.00	0.00	0.00	0.00	-	-	$150,196	$0	-	25%
NMHR	Enrolled Nurse	0.00	0.00	0.00	0.00	-	-	$74,547	$0	-	25%
NMHR	**Total Allied Health**	**4.97**	**0.25**	**23.34**	**1.17**	8,520	1,715		$516,894	1.2	25%
NMHR	Psychologist	0.58	0.03	2.71	0.14	991	1,715	$89,058	$51,434	0.1	25%
NMHR	Social Worker	1.16	0.06	5.43	0.27	1,981	1,715	$89,058	$102,868	0.3	25%
NMHR	Occupational Therapist	3.23	0.16	15.20	0.76	5,548	1,715	$112,112	$362,592	0.8	25%
NMHR	Other TQ (eg pharmacis	0.00	0.00	0.00	0.00	-	-	$56,511	$0	-	25%
NMHR	**VQ and Peer Workers**	**5.78**	**0.29**	**27.14**	**1.36**	9,907	1,715		$311,000	1.4	25%
NMHR	Consumer Peer Worker	0.92	0.05	4.34	0.22	1,585	1,715	$54,844	$50,679	0.2	25%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	25%
NMHR	VQMH Worker	4.85	0.24	22.80	1.14	8,322	1,715	$53,660	$260,321	1.2	25%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$65,105	$0	-	25%

Annual Cost Salaries	$1,746,800
*** Including Overheads** 25%	$2,183,499
Average Daily Available Bed Day C	$299
Average Cost per Patient per annu	$126,413

Bed Based Service Parameters	
Beds	20
Availability	100%
Average Available Beds	20
ABD/Bed/Year	365
Occupancy	95%
OBD/Bed Year	346.8
ALOS (days)	365
Admissions/Bed/Year	0.95
Annual Readmit Rate	10%
Patients/Bed/Year	0.86

Calculator	
Number of standardised admissions per annum multiplied by target population	5245
Beds Requirred	5521
Cost	$602,760,754

Staffing		
NMHR	**Total Medical**	146.7
NMHR	Psychiatrist	48.9
NMHR	Registrar	97.8
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	2266.6
NMHR	Registered Nurse	2266.6
NMHR	Nurse Practitioner	0.0
NMHR	Enrolled Nurse	0.0
NMHR	**Total Allied Health**	1371.1
NMHR	Psychologists	159.4
NMHR	Social Workers	318.9
NMHR	Occupational Therapists	892.8
NMHR	Other	0.0
NMHR	**VQ and Peer Workers**	1594.3
NMHR	Consumer Peer Worker	255.1
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	1339.2
NMHR	VQ Other	0.0
Total		5378.8

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VO MH Worker	VO Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	8			8		26	2	4			6	3.8	7.6	7.6		19.0	7.6		7.6		15.2	66
	Evening	-	-	8					8					-			7.6		7.6			7.6		7.6	23
	Night	-	-	8					8					-					-			7.6		7.6	16
Tuesday	Day		8	8			8		24					-	3.8	7.6	7.6		19.0	7.6		7.6		15.2	58
	Evening	-	-	8					8					-			7.6		7.6			7.6		7.6	23
	Night	-	-	8					8					-					-			7.6		7.6	16
Wednesday	Day		8	8			8		24	2	4			6	3.8	7.6	7.6		19.0			7.6		7.6	57
	Evening	-	-	8					8					-			7.6		7.6			7.6		7.6	23
	Night	-	-	8					8					-					-			7.6		7.6	16
Thursday	Day		8	8			8		24					-	3.8	7.6	7.6		19.0	7.6		7.6		15.2	58
	Evening	-	-	8					8					-			7.6		7.6			7.6		7.6	23
	Night	-	-	8					8					-					-			7.6		7.6	16
Friday	Day		8	8			8		24	2	4			6	3.8	7.6	7.6		19.0	7.6		7.6		15.2	64
	Evening	-	-	8					8					-			7.6		7.6			7.6		7.6	23
	Night	-	-	8					8					-					-			7.6		7.6	16
Saturday	All shifts	-	-	24					24					-			15.2		15.2			22.8		22.8	62
Sunday	All shifts	-	-	24					24					-			15.2		15			22.8		23	62
Total Hours per week		2	40	168	-	-	40	-	250	6	12	-	-	18	19.0	38.0	106.4	-	163	30.4	-	159.6	-	190.0	621
Annual & Other Leave Relief weeks		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)										9	9	9	9												
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		2	40	40	-	-	40	-	122	6	12	-	-	18	19	38	38	-	95	30	-	38	-	68	303
Evening Hours (Mon-Fri)		-	-	40	-	-	-	-	40	-	-	-	-	-	-	-	38	-	38	-	-	38	-	38	116
Night Hours (Mon-Fri)		-	-	40	-	-	-	-	40	-	-	-	-	-	-	-	-	-	-	-	-	38	-	38	78
Saturday Hours		-	-	24	-	-	-	-	24	-	-	-	-	-	-	-	15	-	15	-	-	23	-	23	62
Sunday Hours		-	-	24	-	-	-	-	24	-	-	-	-	-	-	-	15	-	15	-	-	23	-	23	62
Total Hours		2	40	168	-	-	40	-	250	6	12	-	-	18	19	38	106	-	163	30	-	160	-	190	621
Weekly FTE's		0.1	1.1	4.4	-	-	1.1	-	6.6	0.2	0.3	-	-	0.5	0.5	1.0	2.8	-	4.3	0.8	-	4.2	-	5.0	11.3
Relief FTE's		0.0	0.2	0.9	-	-	0.5	-	1.6	0.0	0.1	-	-	0.1	0.1	0.2	0.4	-	0.7	0.1	-	0.7	-	0.8	2.4
Annual FTE's		0.1	1.2	5.3	-	-	1.6	-	8.2	0.2	0.4	-	-	0.5	0.6	1.2	3.2	-	5.0	0.9	-	4.9	-	5.8	19.5

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from QLD staffing profiles
for new servcies 2012 and Victorian models.
AH and RMH allocat 6 weeks leave, 4% sick leave
and 4% ADO's

2.3.3.4 Service Element – Non-Acute – Older Adult (Hospital/Nursing Home Based)

Attribute	Details
Status	May be gazetted
Services Delivered	Non-acute units for older adults are specifically designed for people who have severe and persistent symptoms of mental illness that have responded poorly or partially to treatment, and who have risk profiles often with behavioural disturbance that preclude them from living in either community or aged care settings. These service provide care over an indefinite period for people who have a relatively stable but severe level of need for additional support thus requiring extensive care and support. They offer assessment, ongoing treatment, rehabilitation and residential support for people who require non-acute mental health care and aged care services.
Key Distinguishing Features	These services are provided as partnerships within the generic aged care sector and are collocated with nursing homes and hostels or provided, as standalone units on hospital campuses. Units are designed to meet the special needs of older adults for longer-term accommodation, ongoing assessment, treatment and rehabilitation in a safe environment. People may remain in these units for lengthy periods but opportunities are sought where possible to achieve discharge to a less restrictive environment such as a generic nursing home place.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Older adults.
Diagnostic Profile	Late onset mental illness or, early onset severe mental illness complicated by the need for additional support associated with ageing, or, severe mental illness as a complication of dementia or other age-related illnesses. Common diagnoses include schizophrenia and organic and mood illnesses
Average unit size	16 beds
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	95%
Average LOS	365 days
Annual readmission rate	10%
Indicative staffing FTE/Bed	Multidisciplinary 1.28 FTE/ bed.
Sources	• Older Persons Extended Treatment Inpatient Unit Model of Service, QPMHS, Queensland, 2011. Primary source. • Southern Cross high Dependency Residential Care Service for older Persons – Protocols, Metropolitan Mental Health Services/Mental health commission, Western Australia, May 2012. • Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. • Multi-Site Benchmarking of Older Persons Extended Treatment Inpatient Units, Queensland Mental Health Benchmarking Unit, QH, 2011. • NMHSPF Expert Working Group.

Service Element – Non-Acute – Older Adult – Staffing Profile

Non-Acute - Older Adult (Hospital/Nursing Home Based)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**20.48**	**1.28**	91.60	5.73	33,434	1,632	$94,517	$1,935,935	6.0	25%
NMHSPF	Vocationally Qualified	3.56	0.22	16.00	1.00	5,840	1,639	$74,547	$265,556	1.1	25%
NMSPF	Peer Worker	0.92	0.06	4.34	0.27	1,585	1,715	$54,844	$50,679	0.3	25%
NMHSPF	Tertiary Qualified	15.46	0.97	68.69	4.29	25,070	1,621	$99,830	$1,543,823	4.5	25%
NMHSPF	Medical	0.53	0.03	2.57	0.16	939	1,766	$142,744	$75,877	0.2	25%
NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**0.53**	**0.03**	**2.57**	**0.16**	939	1,766		$75,877	0.2	25%
NMHR	Psychiatrist	0.18	0.01	0.86	0.05	313	1,766	$186,972	$33,129	0.1	25%
NMHR	Registrar	0.35	0.02	1.71	0.11	626	1,766	$120,630	$42,748	0.1	25%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$150,783	$0	-	25%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$186,972	$0	-	25%
NMHR	**Total Nursing**	**17.18**	**1.07**	**76.00**	4.75	27,740	1,615		$1,663,587	5.0	25%
NMHR	Registered Nurse	13.62	0.85	60.00	3.75	21,900	1,608	$102,673	$1,398,031	3.9	25%
NMHR	**Nurse Practitioner**	**0.00**	**0.00**	**0.00**	**0.00**	-	-	$150,196	$0	-	**25%**
NMHR	Enrolled Nurse	3.56	0.22	16.00	1.00	5,840	1,639	$74,547	$265,556	1.1	25%
NMHR	**Total Allied Health**	**1.85**	**0.12**	**8.69**	**0.54**	3,170	1,715		$145,792	0.6	25%
NMHR	Psychologist	0.58	0.04	2.71	0.17	991	1,715	$89,058	$51,434	0.2	25%
NMHR	Social Worker	0.35	0.02	1.63	0.10	594	1,715	$89,058	$30,860	0.1	25%
NMHR	Occupational Therapist	0.35	0.02	1.63	0.10	594	1,715	$89,058	$30,860	0.1	25%
NMHR	Other TQ (eg pharmacis	0.58	0.04	2.71	0.17	991	1,715	$56,511	$32,637	0.2	25%
NMHR	**VQ and Peer Workers**	**0.92**	**0.06**	**4.34**	**0.27**	1,585	1,715		$50,679	0.3	25%
NMHR	Consumer Peer Worker	0.92	0.06	4.34	0.27	1,585	1,715	$54,844	$50,679	0.3	25%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	25%
NMHR	VQMH Worker	0.00	0.00	0.00	0.00	-	-	$53,660	$0	-	25%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$65,105	$0	-	25%

Annual Cost Salaries		$1,935,935
*** Including Overheads**	25%	$2,419,918
Average Daily Available Bed Day C		$414
Average Cost per Patient per annu		$175,126

Bed Based Service Parameters	
Beds	16
Availability	100%
Average Available Beds	16
ABD/Bed/Year	365
Occupancy	95%
OBD/Bed Year	346.8
ALOS (days)	365
Admissions/Bed/Year	0.95
Annual Readmit Rate	10%
Patients/Bed/Year	0.86

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Requirred		5521
Cost		$835,030,984
Staffing		
NMHR	**Total Medical**	183.4
NMHR	Psychiatrist	61.1
NMHR	Registrar	122.3
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	5927.8
NMHR	Registered Nurse	4698.6
NMHR	**Nurse Practitioner**	0.0
NMHR	Enrolled Nurse	1229.2
NMHR	**Total Allied Health**	637.7
NMHR	Psychologists	199.3
NMHR	Social Workers	119.6
NMHR	Occupational Therapists	119.6
NMHR	Other	199.3
NMHR	**VQ and Peer Workers**	318.9
NMHR	Consumer Peer Worker	318.9
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		7067.8

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	8	8		8		34	2	4			6	3.8	3.8	3.8	3.8	15.2	7.6				7.6	63
	Evening	-	-	8	8	8			24					-					-					-	24
	Night	-	-	8	8	8			24					-					-					-	24
Tuesday	Day	2	8	8	8		8		34					-	3.8			3.8	7.6	7.6				7.6	49
	Evening	-	-	8	8	8			24					-					-					-	24
	Night	-	-	8	8	8			24					-					-					-	24
Wednesday	Day		8	8	8		8		32	2	4			6	3.8	3.8	3.8	3.8	15.2					-	53
	Evening	-	-	8	8	8			24					-					-					-	24
	Night	-	-	8	8	8			24					-					-					-	24
Thursday	Day		8	8	8		8		32					-	3.8			3.8	7.6	7.6				7.6	47
	Evening	-	-	8	8	8			24					-					-					-	24
	Night	-	-	8	8	8			24					-					-					-	24
Friday	Day		8	8	8		8		32	2	4			6	3.8	3.8	3.8	3.8	15.2	7.6				7.6	61
	Evening	-	-	8	8	8			24					-					-					-	24
	Night	-	-	8	8	8			24					-					-					-	24
Saturday	All shifts	-	-	24	24	16			64					-					-					-	64
Sunday	All shifts	-	-	24	24	16			64					-					-					-	64
Total Hours per week		4	40	168	168	112	40	-	532	6	12	-	-	18	19.0	11.4	11.4	19.0	61	30.4	-	-	-	30.4	641
Annual & Other Leave Relief week		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		4	40	40	40	-	40	-	164	6	12	-	-	18	19	11	11	19	61	30	-	-	-	30	273
Evening Hours (Mon-Fri)		-	-	40	40	40	-	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Night Hours (Mon-Fri)		-	-	40	40	40	-	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Saturday Hours		-	-	24	24	16	-	-	64	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	64
Sunday Hours		-	-	24	24	16	-	-	64	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	64
Total Hours		4	40	168	168	112	40	-	532	6	12	-	-	18	19	11	11	19	61	30	-	-	-	30	841
Weekly FTE's		0.1	1.1	4.4	4.4	2.9	1.1	-	14.0	0.2	0.3	-	-	0.5	0.5	0.3	0.3	0.5	1.6	0.8	-	-	-	0.8	16.1
Relief FTE's		0.0	0.2	0.9	0.9	0.6	0.5	-	3.2	0.0	0.1	-	-	0.1	0.1	0.0	0.0	0.1	0.2	0.1	-	-	-	0.1	3.5
Annual FTE's		0.1	1.2	5.3	5.3	3.6	1.6	-	17.2	0.2	0.4	-	-	0.5	0.6	0.3	0.3	0.6	1.8	0.9	-	-	-	0.9	20.5

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from QLD staffing profiles
for new servcies 2012 & RMH, Victoria.
Does not include GP time
ALOS, Occup & Readm rates estimates only.
Validation R Mckay

2.3.3.5 Service Element – Non-Acute – Specialised Services (Hospital/Nursing Home Based)

Attribute	Details
Status	May be gazetted
Services Delivered	Specialised extended treatment and rehabilitation services refer to those services which are established to provide a response to people who have severe mental illness and co-morbid illnesses which make treatment and rehabilitation in a standard unit impractical, unsafe and/or counter therapeutic. Specialised recovery oriented assessment and treatment is provided by staff with specialised training in the relevant area. Sub-specialities include acquired brain injury or neuro-psychiatry (ABI), intellectual disability (ID) and complicated drug and alcohol problems.
Key Distinguishing Features	These services are provided as partnerships with the relevant sector. For example ABI units may be collocated with generic ABI services or provided, as standalone units on hospital campuses. May be provided as state-wide or regionalised specialist service. Units are designed to meet the special needs of this group of people for longer-term accommodation, ongoing assessment, treatment and rehabilitation in a safe environment. People may remain in these units for lengthy periods but opportunities are sought where possible to achieve gains in capacity to live independently.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Adults.
Diagnostic Profile	Examples: ABI – Acquired brain damage and associated mental illness and/or severe behavioural disturbance. ID – mental illness and concomitant intellectual disability associated with severe behaviour disturbance.
Average unit size	16 beds
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	95%
Average LOS	365 days
Annual readmission rate	10%
Indicative staffing FTE/Bed	1.5 FTE/ bed.
Sources	• 10 Year Mental Health Strategy for Queensland, 1996. • Multi-Site Benchmarking of Acquired Brain Injury Inpatient Mental Health Services, Queensland Mental Health Benchmarking Unit, QH, 2011.

Service Element – Non-Acute – Specialised Services – Staffing Profile

Non-Acute - Specialised Services (Hospital/Nursing Home Based)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	**TOTAL**	**24.01**	**1.50**	107.49	6.72	39,232	1,634	$97,217	$2,333,767	7.1	25%
NMHSPF	Vocationally Qualified	5.92	0.37	26.57	1.66	9,699	1,639	$74,547	$441,012	1.7	25%
NMSPF	Peer Worker	0.92	0.06	4.34	0.27	1,585	1,715	$54,844	$50,679	0.3	25%
NMHSPF	Tertiary Qualified	16.04	1.00	71.14	4.45	25,967	1,619	$104,758	$1,680,705	4.7	25%
NMHSPF	Medical	1.12	0.07	5.43	0.34	1,981	1,766	$143,801	$161,371	0.4	25%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	**Total Medical**	**1.12**	**0.07**	**5.43**	**0.34**	1,981	1,766		$161,371	0.4	25%
NMHR	Psychiatrist	0.18	0.01	0.86	0.05	313	1,766	$186,972	$33,129	0.1	25%
NMHR	Registrar	0.47	0.03	2.29	0.14	834	1,766	$120,630	$56,997	0.2	25%
NMHR	Junior Medical Officer	0.47	0.03	2.29	0.14	834	1,766	$150,783	$71,245	0.2	25%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$186,972	$0	-	25%
NMHR	**Total Nursing**	**20.80**	**1.30**	**92.29**	5.77	33,684	1,619		$2,030,127	6.1	25%
NMHR	Registered Nurse	13.62	0.85	60.00	3.75	21,900	1,608	$102,673	$1,398,031	3.9	25%
NMHR	**Nurse Practitioner**	1.27	0.08	5.71	0.36	2,086	1,639	$150,196	$191,084	0.4	25%
NMHR	Enrolled Nurse	5.92	0.37	26.57	1.66	9,699	1,639	$74,547	$441,012	1.7	25%
NMHR	**Total Allied Health**	**1.16**	**0.07**	**5.43**	**0.34**	1,981	1,715		$91,590	0.4	25%
NMHR	Psychologist	0.12	0.01	0.54	0.03	198	1,715	$89,058	$10,287	0.0	25%
NMHR	Social Worker	0.35	0.02	1.63	0.10	594	1,715	$89,058	$30,860	0.1	25%
NMHR	Occupational Therapist	0.35	0.02	1.63	0.10	594	1,715	$89,058	$30,860	0.1	25%
NMHR	Other TQ (eg pharmacis	0.35	0.02	1.63	0.10	594	1,715	$56,511	$19,582	0.1	25%
NMHR	**VQ and Peer Workers**	**0.92**	**0.06**	**4.34**	**0.27**	1,585	1,715		$50,679	0.3	25%
NMHR	Consumer Peer Worker	0.92	0.06	4.34	0.27	1,585	1,715	$54,844	$50,679	0.3	25%
NMHR	Carer Peer Worker	0.00	0.00	0.00	0.00	-	-	$54,844	$0	-	25%
NMHR	VQMH Worker	0.00	0.00	0.00	0.00	-	-	$53,660	$0	-	25%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$65,105	$0	-	25%

Annual Cost Salaries	$2,333,767	TRUE	sumcheck
*** Including Overheads** 25%	$2,917,208		$2.92 mill
Average Daily Available Bed Day C	$500		
Average Cost per Patient per annu	$211,114		

Bed Based Service Parameters	
Beds	16
Availability	100%
Average Available Beds	16
ABD/Bed/Year	365
Occupancy	95%
OBD/Bed Year	346.8
ALOS (days)	365
Admissions/Bed/Year	0.95
Annual Readmit Rate	10%
Patients/Bed/Year	0.86

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Required		5521
Cost		$1,006,628,810
Staffing		
NMHR	**Total Medical**	387.2
NMHR	Psychiatrist	61.1
NMHR	Registrar	163.0
NMHR	Junior Medical Officer	163.0
NMHR	Other Specialist	0.0
NMHR	**Total Nursing**	7178.9
NMHR	Registered Nurse	4698.6
NMHR	**Nurse Practitioner**	439.0
NMHR	Enrolled Nurse	2041.4
NMHR	**Total Allied Health**	398.6
NMHR	Psychologists	39.9
NMHR	Social Workers	119.6
NMHR	Occupational Therapists	119.6
NMHR	Other	119.6
NMHR	**VQ and Peer Workers**	318.9
NMHR	Consumer Peer Worker	318.9
NMHR	Carer Peer Worker	0.0
NMHR	VQMH Worker	0.0
NMHR	VQ Other	0.0
Total		8283.6

Description		Nursing								Medical					Allied Health					Peer Workers		Voc Qual			AQMHP
		Director	CNC/NUM/NE	CN	RN	Enrolled Nurse	Graduate Nurse Training	Nurse Practitioner	Nursing Total	Psychiatrist	Registrar	Jun Med Off	Other Specialist	Medical Total	Psychologist	Social Worker	Occupational Therapist	Other	Allied Health Total	Consumer Peer Worker	Carer peer Worker	VQ MH Worker	VQ Other	VQ Total Hours Worked	All Total Hours Worked
Base Weekly Hours		38	38	38	38	38	38	38	Worked	40	40	40	40	Worked	38	38	38	38	Worked	38	38	38	38		
Day	Shift	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs		Hrs	Hrs	Hrs	Hrs				Hrs	Hrs		
Monday	Day	2	8	8	8		8	8	42	2	8	4		14	3.8	3.8	3.8	3.8	15.2	7.6				7.6	79
	Evening	-	-	8	8	16			32					-					-					-	32
	Night	-	-	8	8	8			24					-					-					-	24
Tuesday	Day	2	8	8	8		8	8	42					-					-	7.6				7.6	50
	Evening	-	-	8	8	16			32					-					-					-	32
	Night	-	-	8	8	8			24					-					-					-	24
Wednesday	Day		8	8	8		8	8	40	2	4	8		14		3.8	3.8	3.8	11.4					-	65
	Evening	-	-	8	8	16			32					-					-					-	32
	Night	-	-	8	8	8			24					-					-					-	24
Thursday	Day		8	8	8		8	8	40					-					-	7.6				7.6	48
	Evening	-	-	8	8	18			34					-					-					-	34
	Night	-	-	8	8	8			24					-					-					-	24
Friday	Day		8	8	8		8	8	40	2	4	4		10		3.8	3.8	3.8	11.4	7.6				7.6	69
	Evening	-	-	8	8	16			32					-					-					-	32
	Night	-	-	8	8	8			24					-					-					-	24
Saturday	All shifts	-	-	24	24	32			80					-					-					-	80
Sunday	All shifts	-	-	24	24	32			80					-					-					-	80
Total Hours per week		4	40	168	168	186	40	40	646	6	16	16	-	38	3.8	11.4	11.4	11.4	38	30.4	-	-	-	30.4	752
Annual & Other Leave Relief week		8	8	9	9	9	17	9		8	8	8	8		7	7	7	7		7	7	7	7		
On Call Episodes (weighted)																									
Public Holidays Worked		0	0	11	11	11	11	11			11	11	11												
Productive Weeks per FTE		44.14	44.14	43.14	43.14	43.14	35.14	43.14		44.14	44.14	44.14	44.14		45.14	45.14	45.14	45.14		45.14	45.14	45.14	45.14		
Day Shift Hours (Mon-Fri)		4	40	40	40	-	40	40	204	6	16	16	-	38	4	11	11	11	38	30	-	-	-	30	310
Evening Hours (Mon-Fri)		-	-	40	40	82	-	-	162	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	162
Night Hours (Mon-Fri)		-	-	40	40	40	-	-	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	120
Saturday Hours		-	-	24	24	32	-	-	80	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	80
Sunday Hours		-	-	24	24	32	-	-	80	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	80
Total Hours		4	40	168	168	186	40	40	646	6	16	16	-	38	4	11	11	11	38	30	-	-	-	30	752
Weekly FTE's		0.1	1.1	4.4	4.4	4.9	1.1	1.1	17.0	0.2	0.4	0.4	-	1.0	0.1	0.3	0.3	0.3	1.0	0.8	-	-	-	0.8	19.0
Relief FTE's		0.0	0.2	0.9	0.9	1.0	0.5	0.2	3.8	0.0	0.1	0.1	-	0.2	0.0	0.0	0.0	0.0	0.2	0.1	-	-	-	0.1	4.1
Annual FTE's		**0.1**	**1.2**	**5.3**	**5.3**	**5.9**	**1.6**	**1.3**	**20.8**	**0.2**	**0.5**	**0.5**	-	**1.1**	**0.1**	**0.3**	**0.3**	**0.3**	**1.2**	**0.9**	-	-	-	**0.9**	**24.0**

*Overheads is an estimate of costs associated with other services include corporate overheads, security services, laundry, cleaning and catering and other non-labour costs including drugs, utilities and maintenace etc. It is expressed as a proportion of clinical services labour costs.

** Average annual salary escalated to include overtime, on call and other penalty rate allowances

Variable inputs

Variable Inputs

Comments:
Estimate drawn from QLD staffing profiles for new servcies 2012 (ABI).

ALOS, Occup & Readm rates estimates only.

2.4 SERVICE STREAM – MEDICATIONS

Service Stream		Medication
Service Category	N06A	Antidepressants
Service Category	N05B	Anxiolytics
Service Category	N05C	Sedatives
Service Category	N06B	ADHD medications
Service Category	NO5A	Antipsychotics
Service Category	N03	Mood stabilisers

2.4.1 Service Category – Antidepressants

Antidepressants are indicated for major depression, premenstrual dysphoric disorder (SSRIs), anxiety disorders and eating disorders.

Medications included in class:

- SSRIs (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline)
- SNRIs (desvenlafaxine, duloxetine, reboxetine, venlafaxine)
- TCAs (amitriptyline, clomipramine, doxepin, dothiepin, imipramine, nortriptyline, trimipramine)
- MAOI/RIMAs (moclobemide, phenelzine, tranylcypromine)
- NaSSAs (mirtazapine, mianserin)
- Other (agomelatine)

2.4.2 Service Category – Anxiolytics

Anxiolytics are indicated for anxiety disorders.

Medications included in class:

- Benzodiazepines (alprazolam, bromazepam, clobazam, diazepam, lorazepam, oxazepam)
- Other (buspirone)

2.4.3 Service Category – Sedatives

Sedatives and hypnotics are indicated for use in anxiety disorders and acute behavioural disturbance (including in dementia). Depending on the dose, drugs classified as anxiolytics, sedatives or hypnotics (or sedative-hypnotics) have an anxiolytic affect (relief of anxiety) a sedative effect (promotes drowsiness) or a hypnotic effect (induces sleep). The distinction between drugs termed anxiolytic and sedative and hypnotic is often based on the dose and the intention of treatment.

Medications included in class:

- Benzodiazepines (flunitrazepam, midazolam, nitrazepam, temazepam, triazolam)
- Z drugs (zolpidem, zopiclone)
- Other (chloral hydrate, phenobarbitone)

2.4.4 Service Category – ADHD medications

ADHD drugs are classified as those drugs indicated for the treatment of attention deficit hyperactivity disorder (ADHD).

Medications included in class:

- Stimulants (dexamphetamine, methylphenidate)
- Other (atomoxetine)

2.4.5 Service Category – Antipsychotics

Antipsychotics are indicated for use in acute and chronic psychoses (e.g. schizophrenia) and bipolar disorder. Some antipsychotics have notable additional indications, including **quetiapine** (can also be used as adjunct in treatment-resistant major depression and generalised anxiety disorder); **chlorpromazine** and **trifluoperazine** (indicated for anxiety/agitation in non-psychotic disorders); and **risperidone** (indicated for behaviour disturbance in dementia, conduct and other disruptive behaviour disorders in people with sub-average intellectual functioning or mental retardation, and behavioural disorders in autism).

Medications included in class:

- Typical (chlorpromazine, flupenthixol, fluphenazine, haloperidol, pericyazine, thioridazine, trifluoperazine, zuclopenthixol)
- Atypical (amisulpride, aripiprazole, clozapine, olanzapine, paliperidone, quetiapine, risperidone, ziprasidone)

2.4.6 Service Category – Mood stabilisers

Mood stabilisers are indicated in bipolar disorder. Lithium is indicated for acute mania, schizoaffective disorder and chronic schizophrenia. Lithium is also clinically accepted as an adjunct treatment for treatment resistant depression (Therapeutic Guidelines Limited, 2013). Anticonvulsant mood stabilizers are clinically accepted for use as an adjunctive treatment with antipsychotics for treatment resistant schizophrenia, or in schizoaffective disorders (Therapeutic Guidelines Limited, 2013).

Medications included in class:

- Anticonvulsants (carbamazepine, lamotrigine, sodium valproate)
- Other (lithium)

References

- Australian Medicines Handbook. (2013). Australian Medicines Handbook. from Australian Medicines Handbook Pty Ltd http://www.amh.net.au
- Colman, A. M. (2009). *Oxford dictionary of psychology*: Oxford University Press.
- Stephenson, C. P., Karanges, E., and McGregor, I. S. (2013). Trends in the utilisation of psychotropic medications in Australia from 2000 to 2011. *Australian and New Zealand Journal of Psychiatry, 47*(1), 74-87.
- Therapeutic Guidelines Limited. (2013). eTG complete. Retrieved 28th August 2013, from Therapeutic Guidelines Limited http://www.tg.org.au/

2.5 SERVICE STREAM – NON MENTAL HEALTH CARE SERVICES

Only bed based non mental health services are included in the NMHSPF model. All other non mental health services are excluded.

Service Stream		Non-Mental Health care services
Service Category	**BN**	**Bed-Based Non-Mental Health Care Services**
Service Element	BH	Acute Medical/Surgical Bed (Hospital, non-MH)
Service Element	BC	Acute Paediatric Bed (Hospital, non-MH)
Service Element	DA	Non-Acute - Adult (<24 hour support) (Residential, non-MH)

2.5.1 Service Category – Specialised Bed-Based Non Mental Health care Services

Bed based non mental health services are included in the NMHSPF model only for bed counting purposes because if these beds were not available then extra demands would be expected to be placed on the mental health beds. The bed costs are also excluded as these are non-mental health beds.

It is important to include the mental health services provided to the people in these beds, for example Consultation Liaison general (Hospital).- The mental health staff costs are included in the modelling but non-mental health staff costs are not included and not counted.

2.5.1.1 Service Element – Acute – Medical/Surgical Bed (Hospital, non-MH)

For counting purposes only, attributes and details not modelled.

These beds are provided by the general hospital.

2.5.1.2 Service Element – Acute – Paediatric Bed (Hospital, non-MH)

For counting purposes only, attributes and details not modelled.

These beds are provided by the general hospital.

2.5.1.3 Service Element – Non-Acute – Adult (<24 hour support) (Residential)(non-MH)

For counting purposes only, attributes and details not modelled.

These services are provided in small group residential settings. In most cases public sector mental health staff provide clinical services and community support staff provide individual support and rehabilitation as part of an integrated model of service delivery.

Appendix 1 –Psychopharmacotherapeutic Drugs for the MHIC 1.0

Annex B: Psychopharmacotherapeutic drugs for the MHIC 1.0

Generic Drug Name	ATC Code	Group
Alprazolam	N05BA12	Anxiolytics, sedatives and hypnotics
Amisulpride	N05AL05	Antipsychotics
Amitriptyline	N06AA09	Antidepressants
Aripiprazole	N05AX12	Antipsychotics
Atomoxetine	N06BA09	Stimulant medication
Benztropine	N04AC01	Other psychoactive medication
Biperiden	N04AA02	Other psychoactive medication
Bromazepam	N05BA08	Anxiolytics, sedatives and hypnotics
Bromocriptine	G02CB01	Antiparkinsonian medication
Buspirone	N05BE01	Anxiolytics, sedatives and hypnotics
Carbamazepine	N03AF01	Mood stabilisers and anticonvulsants
Chlorpromazine	N05AA01	Antipsychotics
Citalopram	N06AB04	Antidepressants
Clobazam	N05BA09	Anxiolytics, sedatives and hypnotics
Clomipramine	N06AA04	Antidepressants
Clonazepam	N03AE01	Anxiolytics, sedatives and hypnotics
Clonidine	N02CX02	Antihypertensive medication
Clozapine	N05AH02	Antipsychotics
Dexamphetamine	N06BA02	Stimulant medication
Diazepam	N05BA01	Anxiolytics, sedatives and hypnotics
Diphenhydramine	D04AA32	Antiparkinsonian medication
Diphenhydramine	R06AA02	Other psychoactive medication
Donepezil	N06DA02	Other psychoactive medication
Dothiepin	N06AA16	Antidepressants
Doxepin	N06AA12	Antidepressants
Doxylamine	R06AA09	Anxiolytics, sedatives and hypnotics
Duloxetine	N06AX21	Antidepressants
Escitalopram	N06AB10	Antidepressants
Fluoxetine	N06AB03	Antidepressants
Flupenthixol	N05AF01	Antipsychotics
Fluphenazine	N05AB02	Antipsychotics
Fluvoxamine	N06AB08	Antidepressants
Galantamine	N06DA04	Other psychoactive medication
Haloperidol	N05AD01	Antipsychotics
Imipramine	N06AA02	Antidepressants