CENTRE FOR HEALTH
PROGRAM EVALUATION

RESEARCH REPORT 13

Setting Priorities in South Australian Community Health I: The Mental Health Program Budget

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1 INTRODUCTION

Priority setting is a major issue facing health systems throughout the world. Resources for providing health services are finite, whilst the demand for those services is very large, and rising over time. In all countries health systems have insufficient resources to provide all the health services which may yield potential health related benefits to individuals and populations. Health service planners therefore need to decide what health services to provide, as well as where, how, and for whom, to provide those services. This process inevitably involves setting priorities between different health services. The problem then is how to determine what those priorities should be.

Program Budgeting and Marginal Analysis (PBMA) is an aid to setting priorities which is enjoying increasing popularity both in Australia and overseas (Shiell et al, 1993). It represents a practical application of economic principles to the issue of setting priorities in health services, with a particular emphasis on problem solving at the local, regional, and State levels.

The Health Economics Unit, at the Centre for Health Program Evaluation, was commissioned to advise the South Australian Health Commission on the use of PBMA in the Community Health Sector. The Unit was asked to conduct two pilot studies, applying PBMA to priority setting in the Community Health sector. The first pilot study examines priorities in mental health services provided by the Community Health sector in metropolitan South Australia. This report covers the principles of PBMA and its application, and the development and results of the program budget for the first pilot PBMA study. Results from the marginal analysis phase of this study are the subject of a later report (Peacock, Richardson and Carter, 1997) which should be read in conjunction with this paper.

2 PRIORITY SETTING IN HEALTH CARE

To introduce PBMA it is important to first ask the question why do we need to set priorities in health services? The answer to this questions stems from what economists have called the economic problem: within the whole of society there are scarce resources and infinite wants. This problem provides the foundation for the whole of the economics discipline. The economic problem can be rephrased in terms of the health sector to what we might call the 'health economic' problem: society faces a finite level of health resources which are insufficient to meet all the health services needs of individuals within the population. Alternatively, there are insufficient health service resources to provide all health services which may yield some potential benefits to individuals within the population. Even if the health sector budget was increased dramatically as a proportion of Gross Domestic Product, we would still face a position where some potential benefits to individuals from health services could not be provided. Under the situation of scarce health service resources for meeting health services needs and providing health benefits to individuals, health sector planners and decision makers have to address a series of questions:

1. What health services should be provided?

2. For whom to provide those services?

3. How to provide those services?

4. Where such services should be provided?

Priority setting tools in health economics seek to aid health service planners in making these decisions.

In attempting to answer these questions we can start from the basic premise that for a given level of resources, or budget, health services should seek to maximise the welfare of the population they serve. If we seek to maximise the welfare of the population we then need to consider exactly what is meant by welfare. In the context of health services, welfare is most often considered in terms of the health of individuals, or the sum of the health of individuals which make up a population. More specifically, we can look at the improvements in welfare to individuals and populations in terms of the health gains or health outcomes they obtain from receiving health services.

However, given we face scarce resources for the provision of health services, consideration of health gains in isolation is not enough to fully answer the above questions. If resources are scarce not all health services can be provided, and by using resources to provide one type of service we are foregoing the provision of a range of other potential services, which may have been made available using those resources. That is, providing one particular health service which results in health gains for the population will mean foregoing providing a range of other services, which could also yield health gains for that population. This notion underpins a concept which economists call opportunity cost. The opportunity cost of using a set of resources to provide a particular health service is the benefit which is foregone by not using those resources to

provide other health services. In economics this is the only true cost of providing a service: the health gains, or benefits, which could have been achieved by using those resources to provide other types of health services. In terms of planning services we should then be attempting to provide services which yield the most health gains for the dollars spent. Otherwise those dollars could be used to provide other services which offer greater health gains, and would serve to improve the welfare of the population further. Health service planners must, therefore, consider both the health gains which are provided by different services, and the costs of providing those services.

Economists refer to the principle of maximising health gains from a given level of health service resources in terms of the concept of allocative efficiency. Allocative efficiency is achieved when the welfare, or health status, of a population is maximised given the resources available. This occurs when the marginal cost of a service is equal to the marginal benefit provided by that service. In other terms, allocative efficiency asks the question: if we have an extra health service dollar to spend, what is the best way to spend that dollar so it will maximise health gains? Clearly, if we have an extra sum of money to spend on health services we should seek to provide the services which offer the greatest benefits in terms of health gain or health outcome to individuals.

The notion of allocative efficiency underpins much of the health economics discipline, and is the guiding principle of economic evaluation which is becoming adopted across the world as a method for assessing alternative health service interventions. Economic evaluation is often of limited to use to health service planners, however, for two major reasons. Firstly, reliable evidence from economic evaluations is only currently available for a limited number of health service interventions from the vast array of health care services which are actually provided. Health service planners routinely have to make decisions about the provision of different health services without the benefit of sound evidence from an economic evaluation. Secondly, economic evaluation is usually limited to comparing resources and health gains for two or three alternative interventions, and generally only for a single condition or health related problem. Health service planners, however, are frequently faced with decisions on a much broader scale. The next question to ask then is: how may we apply the principle of allocative efficiency when we may be considering a whole range of services covering a number of different condition areas, and where evidence on costs and effectiveness is limited?

3 PROGRAM BUDGETING AND MARGINAL ANALYSIS

3.1 Key Principles of PBMA

One response to these problems has been the use of PBMA, which offers a pragmatic approach to applying the principle of allocative efficiency (Mooney et al, 1992). PBMA examines how benefits, or health gains, to individuals and populations may be maximised for a given budget covering a wide range of services and interventions. The technique first gained favour in the health services context in the 1980s, and has become increasingly popular in publicly run health systems, most notably the UK (Donaldson, 1995). The approach was adopted due to a lack of useful aids in setting priorities in the health services context. Historically, health services have used tools such as needs assessment and historic budgets in health service planning. However, both approaches are of limited use in setting priorities as they often take no account of the costs of, and the health gains from, specific health services designed to meet the needs identified (Donaldson and Mooney, 1991; Cohen, 1994). PBMA on the other hand has been developed as a systematic approach to maximising benefits for a given budget, considering both the health gains from services and the costs of the providing those services.

PBMA is a practical problem solving tool which offers guidelines for identifying major improvements in health service delivery with only limited effort. In its simplest form PBMA asks three questions:

1. For budget increases: how should the extra dollars be allocated between health services to maximise benefits?

2. For budget reductions: how should service reductions be made to minimise the impact on benefits?

3. For a given budget: how do we allocate dollars between services so that benefits are maximised?

The approach works within the organisational context, existing budget areas, and health service objectives. PBMA can be applied to any organisation within the health sector, and is typically used to aid problem solving within the confines of the organisation concerned. The objectives of the organisation and the existing budgets can then be used to define which services are to be examined. For example PBMA can been applied to services within hospital specialties, services for particular diseases, or services for particular population groups, depending on the organisational context. Emphasis in Australia and overseas has been on the local, regional, and State levels of health care planning and commissioning.

3.2 PBMA Methodology

PBMA can be broken down into several discrete steps. The first stage of a PBMA study consists of defining program areas to be studied. The exact choice and nature of the programs to be examined will depend on the organisation, its objectives, and existing budget areas, as outlined above. It is desirable that any chosen program structure is manageable, and that program areas are comprehensive, covering all services provided, but without overlap between program areas. Services provided within programs are then identified and activity data collected for each service. The costs of providing different services are estimated, and are added to the activity information to construct the program budget. The program budget establishes a link between the costs of providing different services, and the activity levels of those services.

The second stage is to identify services which may be potential options for contraction or expansion in the future. That is, a range of services are identified which may be considered for change in the future to attempt to improve the overall levels of benefits, or health gains, which individuals and populations receive. In considering services which are options for change, PBMA may be used to examine changes in services within a given program, or between programs. For example, if programs are defined by disease areas, PBMA can be used to consider options for changes in services within a given disease area (such as the balance between primary, secondary and tertiary care services), or PBMA can be used to examine options for changes in services between different disease areas (such as the balance between services for diabetes and end stage renal failure). By identifying only a relatively small number of services to be considered as options for change, the focus of PBMA is on incremental change to services and programs, and the not global reform of health care service delivery.

The third step is to take the identified options for changes in services and evaluate those services in terms of their effectiveness, and in terms of the costs of providing those services. Published evidence on the effectiveness of services can be used, where available, to evaluate the options for change. Where published evidence is not available expert opinion can be used to estimate effectiveness, using techniques such as options appraisal and decision analysis. Estimates of effectiveness and costs can then be combined to determine cost-effectiveness of the services which are to be considered as options for change. If the notion of allocative efficiency is followed (and we are seeking to maximise health gains to individuals and populations) then the study results will indicate which options are the most and least cost-effective, with the implication that resources are better employed in providing the most cost-effective services. Following this process, the equity implications of any change in the configuration of services can be assessed, and any decisions modified accordingly.

The fourth, and final, step is to reallocate money according to the cost-effectiveness criteria and equity judgements. The process can then be repeated over a period of time, perhaps a number of years, so that progressively more and more difficult services to evaluate are assessed. By sequentially repeating the process the emphasis of PBMA is to gradually move towards the allocative efficiency goal of maximising health gains for a given level of resources.

3.3 Applications of PBMA

Applications of PBMA have concentrated on three types of program structure, reflecting differences in objectives, definitions of output, and organisational context. The types of program structure adopted include programs defined by: client/service group (eg women, the elderly); specialty (eg general surgery, orthopaedics); and disease group/problem area (eg cardiovascular diseases, asbestosis)

Client or service group programs have been used in a significant number of PBMA studies to date. The major rationale is that client groups tend to be the focus of the strategic priority setting and planning process. Analysis based on client groups provides a clearer focus on health gain than under specialty based studies. However, the allocation of costs from several different specialty or treatment areas to a client based program can provide problems with this approach to PBMA. Some studies have faced significant problems in attributing costs to elements of client based programs, but have maintained the approach as stakeholders viewed the client focus to be pivotal in their objectives for the service.

Specialty based PBMA studies have been most common in PBMA studies which assess marginal changes within a single program. Many such studies have been undertaken within a relatively short time frame, with the relative ease of obtaining specialty based program costs and activity data being an important factor in the choice of this program structure. Where specialty based costing systems have been used this has also avoided the need to make the sometimes difficult cost allocation decisions which are required for a client or disease based approach. Typically the focus of these studies has been on shorter term goals, rather than strategic long term planning, for which client groups have frequently be found to be more appropriate.

Disease based programs have been used in a limited number of hospital sector studies (for example cardiovascular diseases and cancers). The boundary between a client based and a disease based approach can be somewhat blurred, however. For instance, it could be argued that a study on care of the elderly with dementia is following either a disease based model or a client based model depending on the perspective adopted. In practice, a client group approach tends to relate more closely to strategic planning, whereas the disease based approach conforms more closely with operational issues. Disease group programs have the same drawback as client based programs, in that it may be difficult to allocate costs to diseases from available local data. However, published literature on both costs and outcomes is much more common for the disease based approach than the client or specialty based approach. The disease based approach is consistent with specific health priorities and goals. However, some services may not conform to strict disease area boundaries, and the focus of the study may tend to revert to inputs rather than outputs in such cases.

The majority of published PBMA studies have been based in the UK, primarily because the purchaser/provider split has produced a clear priority setting role for Health Authorities (purchasers) which is compatible with the PBMA approach. Table 1 gives a brief summary of some of the published studies to indicate the types of program structures adopted by different groups. Three of these studies were only designed to provide a monitoring tool for the service in question through program budgets, and as these studies were not used for priority setting marginal analysis was not undertaken. Table 2 summarises the approach adopted in marginal analysis, where marginal was reported.

Table 1: Program structure used in published PBMA studies

Authors	Study Setting	Study Objective	Program Structure	Program(s)	PBMA type	Marginal Analysis
Mooney 1977	Grampian Health Board	Information and Monitoring	Client/Service groups	Medicine, surgery, elderly, mental, dental, ophthalmology, maternity, child	Between Programs	No
Steele and Gray 1980	Grampian Health Board	Information and Monitoring	Client/Service group	Maternity	Within Programs	No
Jones and Wright 1995	Health/Local Authority	Information and Monitoring	Client/Service group	People with learning disabilities	Within Programs	No
Craig et al 1995	Newcastle District Health Authority	Priority Setting	Specialty	Orthopaedics	Within Programs	Yes
Donaldson and Farrar 1993	Grampian Health Board	Priority Setting	Client/Service group	Elderly people with dementia	Within Programs	Yes
Cohen 1994	Mid Glamorgan District Health Authority	Priority Setting	Client/Service group	Maternal and early child health	Within Programs	Yes
Cohen 1995	Mid Glamorgan District Health Authority	Priority Setting	Client/Service groups and Disease groups	Maternal and early child health, injuries, cardiovascular diseases, respiratory diseases, cancers, oral health, disabilities, palliative care, healthy living	Between Programs	Yes
Twaddle and Walker 1995	Greater Glasgow Health Board	Priority Setting	Specialty	Gynaecology	Within Programs	Yes

Table 2: Marginal Analysis methods used in published PBMA studies

Authors	Program(s)	Option Assessment	Cost Measurement	Benefit Measurement	Implemented
Craig et al 1995	Orthopaedics	Expert group No areas for contraction identified	Local cost data Local judgement	Option Appraisal No weighting of criteria	Not stated
Donaldson and Farrar 1993	Elderly people with dementia	Expert group Only two options generated	Published literature Local cost data	Published literature	Yes
Cohen 1994	Maternal and early child health	Expert group	Local cost data Local judgement	Option Appraisal No weighting of criteria	Yes
Cohen 1995	Maternal/early child health, injuries, cardiovascular diseases, respiratory diseases, cancers, oral health, disabilities, palliative care, healthy living	Expert groups for each program Core evaluation team	Local cost data Local judgement	Option Appraisal by core evaluation team No weighting of criteria	Not stated
Twaddle and Walker 1995	Gynaecology	Expert group No community representation	Local cost data	Option Appraisal Limited analysis only	Yes

Experiences in published PBMA studies have suggested that successful implementation of study results can be difficult to accomplish. In PBMA studies problems in implementation may be significant due to potential misconceptions and a lack of understanding about issues in priority setting in the health service and in the general community. In the first instance health service staff and the community should be informed and educated about the nature of priority setting in health services, within the context of such possible goals as maximising health gains for the community, equal access for equal need, and improvements in the quality of care provided. PBMA studies have highlighted several factors which need careful attention if the study is to be successful.

(i) Ownership

Key stakeholders in health services must have ownership of the project. This includes not only the Steering Committee and the Management Committee for the project, but also service providers and community representatives. Training sessions for these groups should be arranged, and relevant staff should be involved from the outset where ever possible.

(ii) Strong leadership from health service management

Senior health service management have to ensure that relevant staff are represented on the Management Committee for the project, and ensure that other key staff are kept informed of the study's progress. The senior management have an important role in guiding the study through what may be seen as some rather uncomfortable issues.

(iii) Training and education of staff priority setting issues and techniques

Concepts such as efficiency and prioritisation can often be misinterpreted. Key concepts should be covered in training sessions, and the evaluation methodology to be adopted. The study results should not be seen to be merely a method of cutting costs, the emphasis of PBMA is clearly on achieving the best possible benefits from given resources. It is also important that the process is open, and that key decision areas are made explicit for acceptance of the project.

(iv) Program choice

The area(s) chosen for study should be high on the local agenda, but not so important that analysis becomes pressurised or hurried. Ultimately this could lead to a poor understanding of the issues and weakened analysis, and a lack of acceptance by staff if results are to be implemented. Background data on the program should be readily available, preferably with indications of current inefficiencies to help with the difficult issue of identifying areas for potential contraction. It is also preferable that no major service development or policy review has recently been undertaken in the area(s) to be studied, as this may limit the options available for change.

(v) Generating options for changes in programs

This is largely the responsibility of the project Management Committee. It is an area where some PBMA studies have found difficulties, where some staff have been willing to identify areas for services expansion, but less willing to identify areas for contraction. It is important that a full range of options is generated, as failure to do so weakens the analysis and ultimately reduces the chances of meeting local objectives. The chair of the Management Committee has a vital role in ensuring all options are considered, and that hidden agendas do not hamper the process.

(vi) Implementation

Implementation of results must be a gradual process, otherwise severe financial dislocation of services may occur. For instance, if the study recommends a shift away from acute care services to health promotion activities the shift of resources should be gradual so existing acute care services are not jeopardised in the short run.

4 THE MENTAL HEALTH PROGRAM

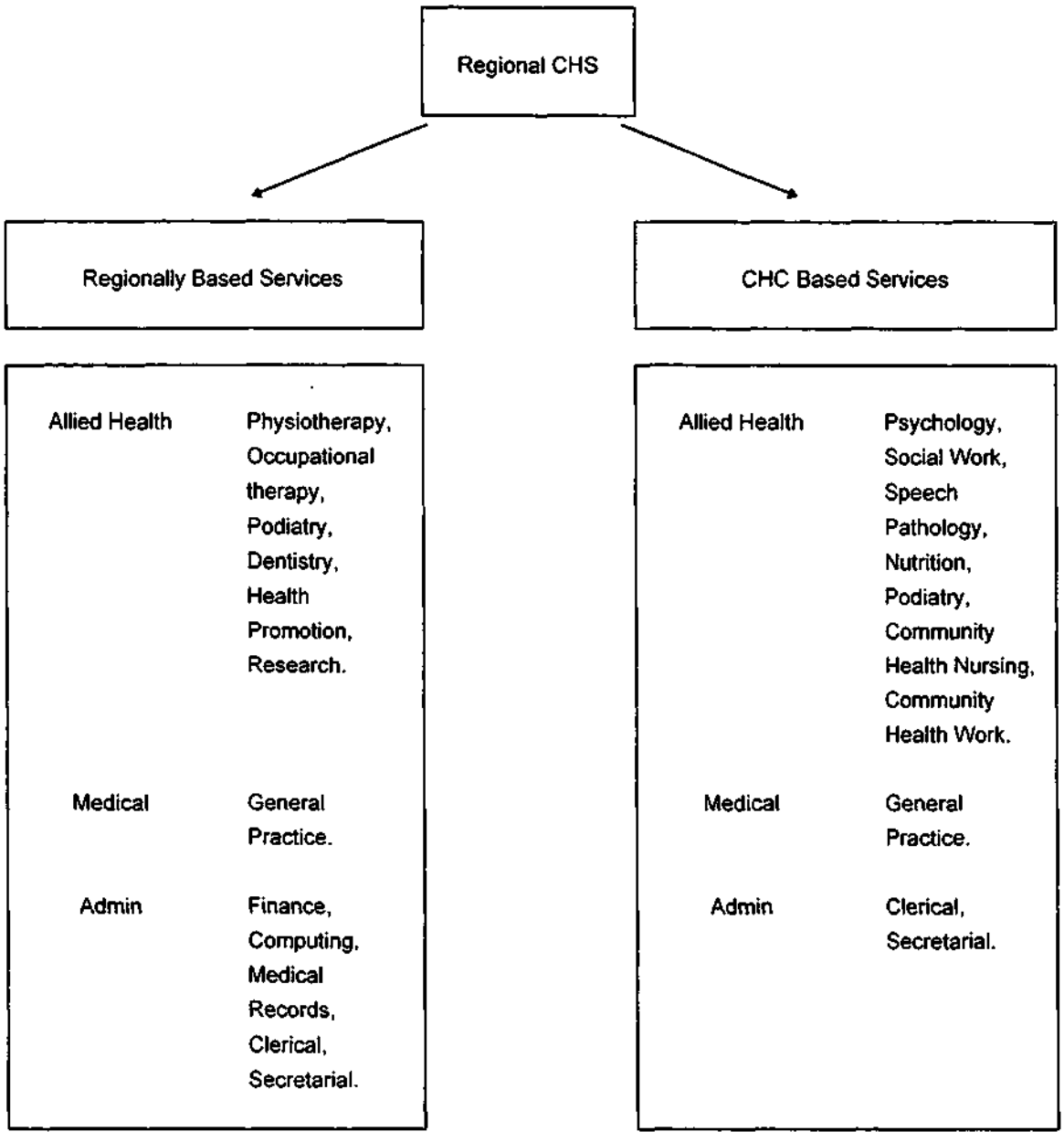
4.1 Community Health in Metropolitan South Australia

Following a recent reorganisation of Community Health Services (CHS) in metropolitan South Australia, three Community Health Services regions have been established: Northern Metropolitan CHS, Central Adelaide CHS, and Noarlunga CHS[1]. Each CHS region acts as an administrative centre for the delivery of Community Health Services to the population within their geographically defined boundary. Each region is responsible for several Community Health Centres (CHCs), and provides a range of services through these centres. Some services are coordinated on a regional basis and delivered through individual CHCs (the extent of coordination of regional services varies between regions), whilst other services are managed and provided directly by individual CHCs. The South Australian Health Commission influences service organisation through the use of Health Service Agreements.

There are several major staffing groups within the three CHS regions. Staffing groups are defined in terms of discipline or work tasks. Figure 1 gives a summary of staff groups according to service organisation. The diagram is by no means definitive as staff groups and the organisation of services varies between regions, rather it is intended to provide a broad overview across metropolitan South Australia.

[1] Noarlunga Community Health Services does not include Southern Women's Community Health Centre.

Figure 1: Metropolitan South Australian CHS staffing structure



Client based services offered by Community Health Services include: direct primary health care (including medical, nursing, dental and allied health care); psychosocial and family support services; screening, prevention and health education services; services for particular population groups (eg recent migrant groups); group and one to one counselling and support services; and community planning, development and advocacy work. Non-client based activities include staff development, research, and administration.

Historically service activity has been grouped into one to one services, group services, and community based services and initiatives, which may be organised regionally or by individual CHCs. Services offered by CHCs can also be thought of in terms of "core" services and local priority services. Core services may be those services which are provided by most, if not all, CHCs within metropolitan South Australia. Possible examples include counselling and national priority areas for health promotion. Local priority services may include services for specific local community health problems. Examples in South Australia may include health education on occupational safety in wineries in rural areas, and services for the homeless in Central Adelaide.

Service delivery in metropolitan South Australia is currently grouped into a range of service programs. Such service programs cover a wide range of clients, for example domestic violence services for women; speech pathology services for children; needle exchange facilities; health promotion for specific problems (including diabetes, osteoporosis, arthritis etc); and services for the Aboriginal and Torres Strait Islander community. Service program areas may include one to one contacts, group sessions, and community initiatives (such as services for domestic violence), or only specific types of activity (such as group sessions for stress management).

Figure 2 shows examples of current service programs across Metropolitan South Australia according to the client group targeted by programs. Several of the current service programs span several client groups (for example domestic violence and diabetes services), but individual services offered to different client groups may be quite different.

Figure 2: Examples of CHS service programs in Metropolitan South Australia

Client/Service Group	Examples of service program/problem area
Youth	Young parenting Enuresis Needle exchange Childhood abuse
Women	Domestic violence Young parenting Mental Health Gynaecology
Men	Domestic violence
Elderly	Arthritis Osteoporosis
Aboriginal and Torres Strait Islanders	Domestic violence Diabetes Women's health
Multicultural groups	Domestic violence Diabetes Women's health
Whole community	Health promotion and education Environmental Health Diabetes Healthy cities

The organisational structure shown above highlights some areas of services provided by Community Health Services. Many services are provided in conjunction with other agencies however, providing a rather complex overall structure for Community Health in metropolitan South Australia. Moreover, funding for some CHS activities is drawn from a range of sources and some services are provided by community volunteers who are not directly employed by the Community Health Centres.

4.2 The Study Process

The first stage of the study involved setting up two committees: a Steering Committee to oversee the whole study (consisting of executives from the South Australian Health Commission, representatives of the three Community Health Service regions in Adelaide including the Chief Executive Officers of each region, and representatives from the Health Economics Unit and the South Australian Community Health Research Unit); and a management committee to act as the expert panel (consisting of service providers, finance officers, and systems controllers from each region, and representatives from the Purchasing Office of the South Australian Health Commission). A full list of committee members is given in Appendix 1.

The steering committee decided that two pilots were to be run, the first examining options for changes in services within a program area, and the second assessing options for changes in services between program areas. Mental health services provided within the Community Health sector were chosen as the program area for the first pilot study. Mental health services were chosen for the first pilot for several reasons: mental health services represent a significant part of the services provided by Community Health in Adelaide; mental health is currently a priority at the international, national, and state levels; and mental health services will remain a significant program area in Community Health after completion of the pilot study.

The approach adopted for the whole of the PBMA study was "hands on", with significant emphasis placed on educating and training Community Health staff in priority setting and PBMA techniques. The emphasis was placed firmly on the management committee understanding, owning, and running the project, with the Health Economics Unit providing expert advice, and the steering committee acting as an overseer to the process. By including service providers and managers from the outset, and encouraging, (where ever possible) ownership of the project by the management committee the intention was to remove some, or all, of the barriers to a successful PBMA study.

Prior to the first management committee meeting the Health Economics Unit felt it was important to familiarise itself with Community Health in the metropolitan South Australian context. Consequently, a week was spent in Adelaide visiting service providers and managers at all three Community Health Service regions, and visiting as many Community Health Centres as possible across the metropolitan area. Time was also spent meeting with members of the South Australian Community Health Research Unit (SACHRU) and the South Australian Health Commission. The week provided an opportunity to explain the study to service providers, hopefully to dispel any myths about the approach and to increase ownership and understanding of the process by Community Health workers.

The week produced valuable information for this study in learning about the objectives and underlying philosophy of Community Health in Adelaide, the range of services provided, the population groups served and their individual health care needs, and the current issues facing Community Health. Several themes became evident through this process: the holistic approach to health services provided by Community Health; the focus on primary health care approaches and the importance of the Ottawa Charter and CHASP in guiding Community Health policy (World Health Organisation, 1986); the diversity of health service needs and Community Health services provided across Adelaide; the complex multicultural issues which underlie health care needs and service provision; and the importance of collaboration with other health and social services agencies.

The management committee formally met seven times over the 10 month duration of the study. The emphasis in these meetings was placed on education and discussion, with the committee as a whole taking responsibility for making major decisions relating to the project. At all stages it was attempted to provide the committee with enough information and understanding to make informed choices about how the study was to progress. Specifically the committee received training and advice on: economic principles which underpin priority setting and PBMA; options for program structure relating to organisational context and objectives; output and outcomes definition and measurement; resource use and cost definitions and measurement; the PBMA process and experiences to date; the meaning and importance of marginal analysis; and the need for explicit and informed decision making. Throughout the study the emphasis was placed very firmly on this study being a pilot study, which would not lead to direct changes in services. Instead, the emphasis was on encountering issues and problems, learning and understanding, and establishing a framework for health service planning in the longer term.

Outside of the formal meetings members of the management committee also met to undertake work for the study. Significant work was undertaken at the regional level in defining mental health and mental health services, in identifying services for inclusion in the mental health program, in collecting activity and cost information, in developing the costing model, and in preparation for the marginal analysis phase of the study. A small working group, covering all three regions, met several times to discuss and develop the costing model and issues around collecting activity and cost information. At each stage these groups were provided with advice on possible approaches to problems, and their relative merits, with the aim of making recommendations to the full management committee. The committee then made decisions about the relevant approach to take.

An integral part of this study was also to evaluate the process undertaken, and the approaches used. The results from this evaluation will be presented elsewhere.

4.3 Defining Mental Health

The next stage of the study was to determine which services were to be included in the mental health program. The starting point was to define mental health, which is, at best, a rather nebulous concept. The management committee identified several possible definitions which highlighted the breadth of mental health, and the difficulties associated in obtaining a clear and concise understanding. Mental health is integral to just about every aspect of individual's health, and virtually all Community Health services will lead to some form of mental health outcomes. Moreover, health services cannot be taken in isolation in considering mental health, as a whole range of social and environmental factors (including transport, education, and employment) affect individuals' mental health in complex and diverse ways. Following considerable debate by the management committee, the following broad definition of mental health was adopted:

> *'Expressed in its most simple terms, for the individual, mental health arises from a balance between our capabilities and the demands made on us. The pressures of the physical and social environment, the opportunities and the resources available to us, and our individual constitution, all in some part shape our mental well-being. But mental health does not fit easily within the usual boundaries of a health system tailored largely to the needs of the medically ill. Many of the pre-conditions for mental health are not under the control of the health system. They are influenced by broader social and economic policies in the intersectoral domain, which are the responsibilities of all the participants in social life.' (Baum, Fry and Lennie, 1992).*

In arriving at this definition of mental health the management committee also defined the focus of mental health services in Community Health, which make them distinct from other mental health services. In Community Health Services, activities with a primary mental health focus include:

- Counselling - preventative and crisis; providing individuals with strategies to maintain their mental health and not become clients of the mental health system;
- Groups - a range of groups provide health information, strategies, and supports to strengthen people's capacity to maintain their mental health;
- Support and direct links with people living in the community who have received a diagnosis from the mental health system by providing contacts and networks, and developing skills to prevent further problems;
- Services to families to support and maintain their ability to function and thrive when they have experienced severe trauma;
- Medical services - to clients who have, as part of their range of problems, mental health difficulties;
- Advocacy on behalf of groups and supporting groups who are already advocating for the needs of people with mental health problems;

- Being a resource to mental health services through working together on specific issues and developing alternative ways of perceiving and working with mental health and strengthening a preventative focus to it.

The community health focus is therefore on:

- Promotion of mental health;
- Prevention of mental illness;
- Provision of early intervention and support to individuals and populations with mental health problems;
- Systems and individual advocacy.

This involves:

- Promotion of healthy environments which enhance mental health;
- Strengthening supports for positive mental health;
- Strengthening community action for positive mental health through mutual aid, self help and community supports;
- Reducing inequities which increase vulnerability, such as poverty, discrimination, and isolation.

The next step was to identify the specific mental health services to be included in the program budget. Whilst the mental health definition for the study was extremely useful in providing the foundations which are crucial for such a project, it proved to be only of limited use in deciding which services should be considered as mental health services. The problem is that the definition is so broad that one might legitimately put almost all types of health services into a mental health program, if this definition is the sole criteria for identifying mental health services. Virtually all health services will provide individuals with some form of mental health benefits. For instance, hernia repair operations may well provide individuals with significant relief from the pain and discomfort of having a hernia, and in that sense they would gain mental health benefits under this type of definition.

4.4 Defining Mental Health services in Community Health

The challenge was to take this definition of mental health and to use it as the basis for a meaningful method to construct the mental health program. To do this the management committee used the distinct focus of mental health services in Community Health, in conjunction with their objectives in providing different Community Health services. A service was chosen to be included in the mental health program if the direct aim or objective of the service was to address a mental health problem for an individual or a group of individuals. That is, the main problem being directly addressed by a particular service (or the main reason for attendance by an individual) had to be a mental health problem if it that service was to be included in the mental health program. The mental health program did not include services which directly addressed other underlying problems, such as services for domestic violence or drug alcohol dependency, etc. Whilst services for problems such as domestic violence or drug and alcohol dependency will have mental outcomes, the primary problem being tackled by the service is not the individual's mental health. For such services we may consider that mental health is an indirect objective or goal of providing the service, but the direct objective of the service is to address some other underlying health related problem.

To identify services to be included in the mental health program the management committee were given distinctions between three types of services, according to the objective or aim of providing a given service.

(i) Services with a direct mental health objective

A service with a direct mental health objective is one which is aimed directly at treating or preventing a recognised mental health problem such as anxiety, stress, or depression. The individuals treated are not receiving that service as a result of some other major underlying problem such as domestic violence.

(ii) Services with an indirect mental health objective

Where mental health problems are part of the co-morbidity associated with a specific health related problem, and the service is directed at that underlying problem, the service has an indirect mental health objective. Mental health problems in such cases are a result of the another underlying problem or issue, and are not the problem in its own right. For example, is the service provided because the individual concerned is in a situation of domestic violence and as a result suffers from anxiety and stress, or because the individual is suffering from anxiety and stress not directly related to another underlying health related problem?

(iii) Services with no mental health objective, but which yield mental health benefits

The third distinction which can be made is to identify services where there is no mental health objective, but from which individuals may still receive mental health benefits. This type of service may be referred to as a service which has a mental health benefit as an externality effect (any mental health benefits are external to the aims of providing the service). Some services clearly have no real mental health focus, and are not directly aimed at the individual's mental health, but result in an improvement in the individuals mental well-being. An example of this would be a GP consultation for the treatment of osteoporosis. The aim of the service is to improve the functional capabilities of the patient, but that patient may also feel a sense of relief in being treated, and in the improved physical quality of life they may enjoy. Clearly, this is not a mental health service, but it may impact on an individual's mental health (albeit unintentionally).

Obviously not all Community Health services fell neatly under these headings, so where there was some ambiguity the committee was asked to choose the type of objective which they felt most closely fitted the service being considered. Using the distinctions between types of objectives the management committee then constructed the mental health program, which included only those services which had a direct mental health objective.

The management committee identified over one hundred individual services provided by the Community Health Regions across Adelaide which were to be included in the mental health program. However, such services were defined as mental health services only within the specific context of Community Health services in Adelaide. The criteria for choosing services for inclusion in the mental health program in other health service sectors may well be different, reflecting differences in the organisational context, objectives, approaches to mental health and mental health problems, and the range of services provided by other organisations. Whilst the approach taken in this study may not be appropriate in other contexts, this reflects a major strength of PBMA: the approach is intended to be a practical tool which is adapted to the particular set of problems and issues which an organisation faces.

Within the large array of services in the mental health program, the management committee identified four sub-programs reflecting specific mental health objectives and issues. Each service in the mental health program was then placed into one of these four sub-programs. The aim was to break down the large range of diverse services into coherent groups, making planning and monitoring less opaque by clarifying the objectives of the regions and the issues they face. Again, the process of determining and agreeing upon coherent objectives for use in defining sub-program areas took much discussion by the management committee. The four sub-program areas adopted for the study were:

1. Services which increase access to services which promote personal development.
2. Services which reduce the effects of psychosocial crisis and distress.
3. Services which increase awareness of issues which impact on psychosocial well-being.
4. Services which address systems issues which impact on psychosocial well-being.

For each service under the four sub-program areas the exact type of service and the client group addressed by the service were identified. The types of services provided within the Community Health sector in Adelaide cover: health promotion; education, information, and resources; advocacy and intersectoral (other health and welfare organisations) work; one-to-one client counselling; group sessions for clients; referrals to other agencies; and community action and initiatives. Client groups which are addressed by specific services include: child and youth; women; men; Aboriginal and Torres Strait Islanders; non-English speaking background; and older people. Many other services are not directed at a specific client group, but address the general population as a whole.

The services included in the mental health program and sub-programs are shown by each Community Health region in tables 3 to 5. Brief descriptions of the individual services for each region, where they were available, are given in Appendix 2.

Table 3: Northern Metropolitan Community Health Service Mental Health Program (January - June 1996)

Sub-Program	One to One	Groups	Community Initiatives
1. Increase community access to services that promote personal development.	• Registered Client Contacts • Neighbourhood House	• Multi-Cultural Women's Group • Spanish speaking Women's Group	• Emotional/Mental Health - General . • Emotional/Mental Health - Vietnamese Women • Panic Attack/Agoraphobia Drop-in • Body Image General • Cambodian Women's Group • Isolation - General • Cambodian Elderly Group
2. Reduce the negative effects of psychosocial crisis and distress on individuals and families in the community.	• Registered Client Contacts (Counselling) • Unregistered Client Contacts (Counselling, Assessment, and Information)	• Panic Attack/Agoraphobia Drop-in • Beginners Meditation • Claim your space with B&T • Confidence Building for Women • Glance Backwards, Look Forwards • Marvellous Matriarchs Moments • Motherhood and Myths • Self Esteem • Strategies for Change • Stress Management	• Relationships - General • Cancer Support Group • Gender Issues - General

Table 3 (contd): Northern Metropolitan Community Health Service Mental Health Program (January - June 1996)

Sub-Program	One to One	Groups	Community Initiatives
3. Increase community awareness of issues which impact on psychosocial well-being.		• Health Education for NESB Women	• Post Natal Distress • Self Esteem and Confidence - General • Parenting • Stress/Anxiety - General • Social Health - General • Health General NESB • Health - General • Aboriginal Community • Sexuality -General
4. Address systems issues which impact on individual's psychosocial well-being.			• Women for Better Births • Northfield Women's Prison Project • Cambodian Working Party • Community Action - General • Community Participation • Youth Participation Project • Supportive Environment - General

Table 4: Adelaide Central Community Health Service Mental Health Program (January - June 1996)

Sub-Program	One to One	Groups	Community Initiatives
1. Increase community access to services that promote personal development.		• Assertiveness and Confidence • Working Through Conflict • Women, Health and Well-being • McMhap Support Group • Aboriginal Well-being • Aboriginal Elders	• Mental Health Women's Group • IPPON • Stress/Relaxation Group • Western Aboriginal Health Program • Taperoo/Osborne Steering Group • Aboriginal Primary Health • McMhap Project
2. Reduce the negative effects of psychosocial crisis and distress on individuals and families in the community.	• Registered Client Contacts • Unregistered Client Contacts	• Take a Break	• Great Expectations
3. Increase community awareness of issues which impact on psychosocial well-being.		• Port Owls • Krinkly Wobblies (Elders) • Silver Threads (Elders) • Tuesday Social Group (Elders)	• Mental Health Friendly Lunch • Mental Health Music Club • Mental Health Travel Club • Mental Illness Community Education
4. Address systems issues which impact on individual's psychosocial well-being.			• Well-being Project • Inner City Homeless • Aged Homeless Working Party • Better Health Homeless Project • WOW Safe

Table 5: Noarlunga Health Services (Community Health) Mental Health Program (January - June 1996)

Sub-Program	One to One	Groups	Community Initiatives
1. Increase community access to services that promote personal development.		• Self-Healing/Letting Go of Pain • Stress Management and Relaxation • Open Group - Women	• Assertiveness for Women • Women's Healing Circle • Young Peoples Drop In • Youth Answers Peer Research
2. Reduce the negative effects of psychosocial crisis and distress on individuals and families in the community.	• Registered Client Contacts • Unregistered Client Contacts	• Anxiety Management • Being a Mum and Stressed • Group for Violent Men • Improving Self-Esteem • What About You? Support Mother • Confidence Building • Learn to Relax and Manage Stress • Positive Changes • Time to Relax	• After Suicide • Food with Friends • Overcoming Postnatal Depression • Panic and Anxiety Treatment • Women Supporting Women • Young Women Assertive/Confident
3. Increase community awareness of issues which impact on psychosocial well-being.			• Coffee and Chat Cafe
4. Address systems issues which impact on individual's psychosocial well-being.			

Note: Between January and June 1996 Noarlunga CHS did not provide any services under sub-program 4.

5 THE MENTAL HEALTH PROGRAM BUDGET

Using the mental health program structure shown above the program budget was constructed, providing a complete summary of costing and activity information for all Community Health mental health services. This involved collecting activity information from community based health information systems (CHSS) and from service providers. Activity data was collected separately for one to one counselling, group, and community initiative services to reflect differences in the nature of these activities. A costing model was constructed to attach cost information to each service provided in the mental health program. The final program budget represents the first time that activity and costs associated with individual services in Community Health in South Australia have been available.

5.1 Activity

Each Region collected activity information for the services identified in the mental health program. Activity data was collected for the 6 month period January 1996 to June 1996, as this represented the most up to date data which was relatively straightforward to collect from the CHSS information system. Each region was asked to collate as much activity data as possible within the time frame of the project, to build up as comprehensive picture as possible about services provided in the mental health program. However, as the regionalisation of Community Health Services had only recently be completed the collection of activity data was difficult at times, as not all information is currently collected at the regional level for the three regions in Adelaide.

The Community Health regions were sent documents outlining the types of information which are useful in examining activity within the program budget. The Northern region then developed an activity reporting framework which it presented to the management committee, and was subsequently adopted by the other two regions for this project. Information collected covered activity under the three main types of services: one to one, groups, and community initiative services. The specific activity measures adopted for the study were:

(i) One to one services

Unique client:	An individual registered client that attends for a service (A unique client may attend more than once)
Client attendances:	The total number of attendances by clients (registered and unregistered clients)

(ii) Groups

Number of sessions	Total number of sessions held for that group
Hours per session	Contact time with participants
Unique client	An individual registered client who attended one or more sessions of a group program
Client attendances	The total number of attendances by unique clients

(iii) Community Initiatives

Number of sessions	Number of incidents of activity recorded for a program
Number receiving services	Total number of participants at sessions where a service was provided

Full activity data relating to individual services provided under the mental health program is shown in Appendix 3 in tables A1 to A4 (Northern), tables A13 to A16 (Central), and tables A25 to A27 (Noarlunga). Some differences occurred between regions in the information collected, and some data was unavailable for some regions. Where differences occurred, they are outlined in the notes for the activity tables shown in Appendix 3.

Presented below is summary information about activity in the mental health programs for the three regions for the six month period January 1996 to June 1996. Table 6 shows the number of sessions, and table 7 the number of client attendances/numbers receiving services by region, sub-programs, and service type. Tables 8 to 13 show sessions and client attendances/numbers receiving services across the whole of Adelaide.

Note, number of sessions refers only to groups and community initiatives (number of sessions for each group, and number of incidents of activity for community initiatives). Information for number of one to one sessions was not available for all regions, hence all sessions based activity reported here does not provide a comprehensive description of all mental health services activity. Client attendances refer to one to one contacts and groups, and are the total number of attendances by clients. Numbers receiving services refers only to community initiatives, giving the total number of participants for the service provided.

Table 6: Mental Health Program - Number of Sessions *(January - June 1996)

(a) Northern

	One to One	Groups	Community Initiatives	Sub-Program Total Sessions
Sub-Program 1	-	10	219	**229**
Sub-Program 2	-	70	38	**108**
Sub-Program 3	-	6	436	**442**
Sub-Program 4	-	-	155	**155**
Regional Total	-	**86**	**848**	**934**

(b) Central

	One to One	Groups	Community Initiatives	Sub-Program Total Sessions
Sub-Program 1	-	38	147	**185**
Sub-Program 2	-	20	17	**37**
Sub-Program 3	-	46	17	**63**
Sub-Program 4	-	-	193	**193**
Regional Total	-	**104**	**374**	**478**

(c) Noarlunga

	One to One	Groups	Community Initiatives	Sub-Program Total Sessions
Sub-Program 1	-	32	108	**140**
Sub-Program 2	-	58	130	**188**
Sub-Program 3	-	-	10	**10**
Sub-Program 4	-	-	-	**0**
Regional Total	-	**90**	**248**	**338**

* Sessions refer to group and community initiative activity only.

Table 7: Mental Health Program - Client Attendances/Numbers Receiving Services (January - June 1996)

(a) Northern

	One to One (Client Attendances)	Groups (Client Attendances)	Community Initiatives (Numbers)	**Sub-Program Total**
Sub-Program 1	7	64	591	**662**
Sub-Program 2	3489	635	538	**4662**
Sub-Program 3	-	58	1161	**1219**
Sub-Program 4	-	-	264	**264**
Regional Total	**3496**	**757**	**2554**	**6807**

(b) Central

	One to One (Client Attendances)	Groups (Client Attendances)	Community Initiatives (Numbers)	**Sub-Program Total**
Sub-Program 1	-	437	1013	**1450**
Sub-Program 2	4917	120	24	**5061**
Sub-Program 3	-	440	187	**627**
Sub-Program 4	-	-	788	**788**
Regional Total	**4917**	**997**	**2012**	**7926**

(c) Noarlunga

	One to One (Client Attendances)	Groups (Client Attendances)	Community Initiatives (Numbers)	**Sub-Program Total**
Sub-Program 1	-	225	478	**703**
Sub-Program 2	6419	385	313	**7117**
Sub-Program 3	-	-	79	**79**
Sub-Program 4	-	-	-	**0**
Regional Total	**6419**	**610**	**870**	**7899**

Table 8: Mental Health Program - Service Type Total Number of Sessions* by Region, and as a Percentage of All Adelaide Mental Health Total (January - June 1996)

	One to One		Groups		Community Initiatives		**Regional Program Total Sessions**	
	Sessions	(%)	Sessions	(%)	Sessions	(%)	Sessions	(%)
Northern	-	-	86	4.9	848	48.5	**934**	**53.4**
Central	-	-	104	5.9	374	21.4	**478**	**27.3**
Noarlunga	-	-	90	5.1	248	14.2	**338**	**19.3**
All Adelaide	-	-	**280**	**15.9**	**1470**	**84.1**	**1750**	**100**

* Sessions refer to group and community initiative activity only.

Table 9: Mental Health Program - Service Type Total Client Attendances/Numbers Receiving Services by Region, and as a Percentage of All Adelaide Mental Health Total (January - June 1996)

	One to One		Groups		Community Initiatives		**Regional Program Total**	
	Attends/ Nos.	(%)	Attends/ Nos.	(%)	Attends/ Nos.	(%)	Attends/ Nos.	(%)
Northern	3496	15.5	757	3.3	2554	11.3	**6807**	**30.1**
Central	4917	21.7	997	4.4	2012	8.9	**7926**	**35.0**
Noarlunga	6419	28.4	610	2.7	870	3.8	**7889**	**34.9**
All Adelaide	**14832**	**65.6**	**2364**	**10.4**	**5436**	**24.0**	**22632**	**100**

Table 10: Mental Health Program - Sub-Program Total Number of Sessions* by Region (January - June 1996)

	Sub-Program 1	Sub-Program 2	Sub-Program 3	Sub-Program 4	**Regional Program Total**
	Sessions	Sessions	Sessions	Sessions	Sessions
Northern	229	108	442	155	**934**
Central	185	37	63	193	**478**
Noarlunga	140	188	10	0	**338**
All Adelaide	**554**	**333**	**515**	**348**	**1750**

* Sessions refer to group and community initiative activity only.

Table 11: Mental Health Program: Sub-Program Total Number of Sessions* by Region as a Percentage of All Adelaide Total (January - June 1996)

	Sub-Program 1	Sub-Program 2	Sub-Program 3	Sub-Program 4	**Regional Program Total**
	(%)	(%)	(%)	(%)	(%)
Northern	13.1	6.2	25.3	8.9	**53.5**
Central	10.6	2.1	3.6	11.0	**27.3**
Noarlunga	8.0	10.8	0.1	0	**18.9**
All Adelaide	**31.7**	**19.1**	**29.0**	**19.9**	**100**

* Sessions refer to group and community initiative activity only.

Table 12: Mental Health Program - Sub-Program Total Client Attendances/Numbers Receiving Services by Region (January - June 1996)

	Sub-Program 1	Sub-Program 2	Sub-Program 3	Sub-Program 4	**Regional Program Total**
	Attends/Nos	Attends/Nos	Attends/Nos	Attends/Nos	Attends/Nos.
Northern	662	4662	1219	264	**6807**
Central	1450	5061	627	788	**7926**
Noarlunga	703	7117	79	0	**7899**
All Adelaide	**2815**	**16840**	**1925**	**1052**	**22632**

Table 13: Mental Health Program: Sub-Program Total Client Attendances/Numbers Receiving Services by Region as a Percentage of All Adelaide Total (January - June 1996)

	Sub-Program 1	Sub-Program 2	Sub-Program 3	Sub-Program 4	**Regional Program Total**
	(%)	(%)	(%)	(%)	(%)
Northern	2.9	20.6	5.4	1.2	**30.1**
Central	6.4	22.4	2.8	3.5	**35.1**
Noarlunga	3.1	31.5	0.0	0	**34.6**
All Adelaide	**12.4**	**74.5**	**8.2**	**4.7**	**100**

5.2 Costs

Prior to this study cost data was only collected in standard accounting format for Community Health in metropolitan South Australia, with costs appearing in input based cost centres in the health service accounts. The purpose of the program budget is to take input based cost data, and use it to construct cost estimates for services provided. To achieve this a costing model was needed, as no service based cost information was available. It was important that any costing model was developed in conjunction with the management committee if cost estimates were to hold credibility with service providers and planners. Moreover, the committee's judgement on resource use issues in service delivery is often vital in developing a costing model, as accurate resource use information is frequently unavailable or extremely time consuming to obtain.

The committee received training about the nature of the different types of costs, and their importance in setting priorities and planning services. Two sets of distinctions in types of costs were made for the group: between direct, indirect, and overhead costs; and between fixed, semi-fixed, and variable costs. The distinctions are:

Direct costs	Costs which can be directly attributed to activity
Indirect costs	Costs which can indirectly be attributed to activity
Overhead costs	Costs for which there is no information on the link between resource use and the individuals who receive benefits from those resources
Fixed costs	Costs which do not vary with activity over the decision period (usually a year)
Semi-fixed costs	Costs which vary unevenly with activity
Variable costs	Costs which vary directly with activity

The relative merits of the bottom up costing method verses the top down method to develop a costing model were then presented. The bottom up method uses disaggregated resource use data for the different inputs used in the provision of each service to provide a cost estimate, whereas the top down method uses aggregated data and allocation rules to apportion costs to services. Whilst the bottom up method tends to provide more accurate estimates of service costs, it has large data requirements. The top down method gives slightly less accurate estimates but with significantly reduced demands on the data. The committee was also presented with possible suggestions for allocation rules if the top down method was to be employed.

At first, the committee found the task of deciding upon the appropriate cost model quite difficult, particularly in determining which allocation rules to adopt, and which assumptions may be reasonable to make in constructing cost estimates. Following discussion by the committee, Northern Region again agreed to take the lead and construct a costing methodology following the principles outlined above. Their methodology was based on a combination of the top down and bottom up approaches, due to difficulties in obtaining disaggregated data on all areas of resource use. The methodology was then presented to the management committee, and the model was subsequently adopted across all three Community Health regions. The costing model distinguished between direct, indirect, and overhead costs.

(i) Direct Costs

Within the context of this study it became evident that disaggregated data linking resource use to individual services was only available for the time workers spent in direct contact with individuals receiving services. In many cases direct worker time spent on the provision of services was available on the Community Health CHSS information system. Direct worker time is defined as the time a Community Health service provider spends actually providing a given service to individuals. Where data was not recorded on the CHSS system the committee felt it could, in conjunction with service providers, give reasonable estimates of the direct worker time spent in providing services for individuals. As a result the bottom up approach was used in estimating the costs of worker time spent directly providing services, with the remaining costs allocated to individual services under the top down approach.

Each region provided data on the direct worker hours spent in contact with individuals receiving the service. These data were applied to an hourly cost for the worker based on a wage rate estimate, with adjustments for the employers contribution to superannuation, annual leave loading, sick leave, and workers compensation levy. These adjustments were based on the South Australian Health Commission's "on-cost" recharge policy.

The management committee decided that it was inappropriate to base the wage rate estimate for different services on different staff grades, as the staff member(s) who actually provided a given service varied according to the availability and the particular interests and expertise of staff, and not according to their grade or level of experience. The management committee therefore decided to use a representative wage rate estimate for all services, intended to reflect the average wage rate across service providers. The committee chose this representative wage rate to be approximately the mid-point of the ASO5/PSO2 salary scale, at a basic wage rate of $23.00 per hour.

The hourly estimate for direct worker time was then calculated as:

Basic wage rate:	$23.00
"On-cost" component (% of basic wage rate)	
Superannuation (minimum SA Govt. contribution)	6.0%
Annual Leave and Leave Loading	8.5%
Sick Leave	2.5%
Administration and Workers Compensation	3.0%
Total "on-costs"	20.0%

Giving an hourly estimated cost = $23.00 x 1.2 = $27.60 per hour

For one to one services this hourly cost estimate was applied directly to the number of hours spent by workers in contact with individuals. For groups the total direct worker time in contact with the group was calculated as the total number of sessions multiplied by the hours per session multiplied by the number of workers involved, and the hourly cost was then applied to this total group contact time. For community initiatives the total direct worker time in contact with participants was calculated as the total number of hours for the activity multiplied by the number of workers involved at sessions, and the hourly cost was then applied to this total.

(ii) Indirect costs

Indirect costs in the program budget include the costs of additional worker time spent outside of direct contacts with individuals, in preparing services, advocacy, and follow up after services have been provided. The management committee agreed on an estimate that for every hour a worker spends in direct service provision (in contact with individuals), another hour is spent on preparation, writing of notes, data collection, and follow up. Indirect worker costs were then calculated as being 100 per cent of direct worker costs, yielding an estimated total worker cost (direct and indirect) which was equal to double the direct worker cost.

(iii) Overheads

Overheads consisted of the costs of administration and clerical staff, and of goods and services. The committee decided, following discussion about the Northern Region's approach to overheads, on allocation rules for each of these two areas of overheads. The decision was that 75 per cent of all Community Health administration and clerical staff time could reasonably be attributed to the support of service delivery, and equally that 75 per cent of Community Health goods and services were used in service support. The remaining 25 per cent of both areas of overheads was allocated to infrastructure necessary for the running of Community Health as a whole, and were not included in the costs of services in the program budget. Elements included in goods and services varied slightly across the three regions, but in general included motor vehicle expenses, building leases, information technology, equipment and repairs, supplies, food, photocopying, advertising, telephones and postage, and power.

To obtain estimates of the overhead costs of individual services, the committee then needed to adopt an allocation rule for apportioning the overheads for service support to the mental health program as a whole, and to services within that program. Two suggestions were made for the allocation rule: direct worker hours, or numbers of clients/participants. The committee decided to use direct worker hours as the basis of allocating overheads, but to also develop a cost model using numbers of clients/participants for comparison. However, the second model could not be used as data for unique clients across all three regions was incomplete. As a result the costing model presented here only used direct worker hours as the basis for allocating overheads.

Overheads were allocated to the whole mental health program on the basis of the proportion of all Community Health direct worker hours which were spent in the provision of mental health services. The allocation percentages for the three regions were:

Northern	38.07%
Central	26.30%
Noarlunga	30.00%

The figures for Northern and Central were based on CHSS data and worker advice on direct worker hours. Full CHSS data for Noarlunga was not available however, and the 30 per cent figure is based on the region's estimate of the proportion of worker time spent in mental health. Application of this allocation rule gave an overhead total for the mental health program. The proportion of direct worker hours spent on each service of the total direct worker hours for each region's mental health program was then used to allocate overheads to individual services. This proportion was then applied to each region's estimate of mental health program overheads. The mental health program direct worker hours and overheads for each region were:

	Program direct worker hours	Program Overheads
Northern	5428	$260,796
Central	7387	$237,315
Noarlunga	4259	$167,357

Estimates of the total cost for each service consisted of the sum of direct, indirect, and overhead costs. Total costs for all individuals mental health services in the program, for the period January to June 1996, are shown in Appendix 3 in tables A5 to A7 (Northern), tables A17 to A20 (Central), and A28 to A30 (Noarlunga). The approaches and assumptions used in costing services varied slightly between regions, and details of these differences are provided in the notes for Appendix 3. Presented below is summary information relating to the program budget and mental health services provided by Community Health in Adelaide over the period January 1996 to June 1996. Table 14 shows the mental health program total costs for each region by service type and sub-program. Tables 15 and 16 show the mental health program total costs by service type across the whole of Adelaide, and table 17 and 18 show the mental health program total costs by sub-program across Adelaide.

Table 14: Mental Health Program - Service Type and Sub-Program Total Costs, and as a Percentage of Regional Program Total Costs (January - June 1996)

(a) Northern

	One to One		Groups		Community Initiatives		**Sub-Program Total Cost**	
	Cost ($)	(%)	Cost ($)	(%)	Cost ($)	(%)	**Cost ($)**	**(%)**
Sub-Program 1	878	0.2	5,988	1.1	61,745	11.0	**68,610**	**12.3**
Sub-Program 2	239,525	42.7	28,082	5.0	9,963	1.8	**277,570**	**49.5**
Sub-Program 3	-	-	1,239	0.2	157,098	28.0	**158,337**	**28.2**
Sub-Program 4	-	-	-	-	55,924	10.0	**55,924**	**10.0**
Regional Total	**240,403**	**42.9**	**35,309**	**6.3**	**284,730**	**50.8**	**560,442**	**100**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

(b) Central

	One to One		Groups		Community Initiatives		**Sub-Program Total Cost**	
	Cost($)	(%)	Cost ($)	(%)	Cost ($)	(%)	**Cost ($)**	**(%)**
Sub-Program 1	-	-	18,469	2.9	83,134	12.9	**101,604**	**15.8**
Sub-Program 2	429,382	66.6	3,493	0.5	9,781	1.5	**442,656**	**68.6**
Sub-Program 3	-	-	8,820	1.4	6,724	1.0	**15,544**	**2.4**
Sub-Program 4	-	-	-	-	85,274	13.2	**85,274**	**13.2**
Regional Total	**429,382**	**66.6**	**30,782**	**4.8**	**184,913**	**28.7**	**645,077**	**100**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

(c) Noarlunga

	One to One		Groups		Community Initiatives		**Sub-Program Total Cost**	
	Cost ($)	(%)	Cost ($)	(%)	Cost ($)	(%)	**Cost ($)**	**(%)**
Sub-Program 1	-	-	7,560	1.9	20,412	5.1	**27,972**	**7.0**
Sub-Program 2	334,322	83.1	13,701	3.4	24,569	6.1	**372,592**	**92.6**
Sub-Program 3	-	-	-	-	1,890	0.1	**1,890**	**0.1**
Sub-Program 4	-	-	-	-	-	-	**0**	**0**
Regional Total	**334,322**	**83.1**	**21,261**	**5.3**	**46,871**	**11.3**	**402,454**	**100**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table 15: Mental Health Program - Service Type Total Costs by Region (January - June 1996)

	One to One	Groups	Community Initiatives	**Regional Program Total Cost**
	Cost ($)	Cost ($)	Cost ($)	**Cost ($)**
Northern	240,403	35,309	284,730	**560,442**
Central	429,382	30,782	184,913	**645,077**
Noarlunga	334,322	21,261	46,871	**402,454**
All Adelaide	**1,004,107**	**87,352**	**516,514**	**1,607,973**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table 16: Mental Health Program - Service Type Total Costs by Region as a Percentage of All Adelaide Total Cost (January - June 1996)

	One to One	Groups	Community Initiatives	**Regional Program Total Cost**
	(%)	(%)	(%)	**(%)**
Northern	15.0	2.2	17.7	**34.9**
Central	26.7	1.9	11.5	**40.1**
Noarlunga	20.8	1.3	2.9	**25.0**
All Adelaide	**62.5**	**5.4**	**32.1**	**100**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table 17: Mental Health Program - Sub-Program Total Costs by Region (January - June 1996)

	Sub-Program 1	Sub-Program 2	Sub-Program 3	Sub-Program 4	**Regional Program Total Cost**
	Cost ($)	Cost ($)	Cost ($)	Cost ($)	**Cost ($)**
Northern	68,610	277,570	158,337	55,924	**560,442**
Central	101,604	442,656	15,544	85,274	**645,077**
Noarlunga	27,972	372,592	1,890	-	**402,454**
All Adelaide	**198,186**	**1,092,818**	**175,771**	**141,198**	**1,607,973**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table 18: Mental Health Program - Sub-Program Total Costs by Region as a Percentage of All Adelaide Total Cost (January - June 1996)

	Sub-Program 1	Sub-Program 2	Sub-Program 3	Sub-Program 4	Regional Program Total Cost
	(%)	(%)	(%)	(%)	(%)
Northern	4.3	17.3	9.9	3.5	**34.9**
Central	6.3	27.5	1.0	5.3	**40.1**
Noarlunga	1.7	23.2	0.1	-	**25.0**
All Adelaide	**12.3**	**68.0**	**10.9**	**8.8**	**100**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

The following tables show average cost figures from the program budget. Table 19 shows the all Adelaide and regional average costs per client attendance (one to one services and groups)/per individual receiving services (community initiatives) by service type, and table 20 shows the all Adelaide and regional average costs per client attendance/per individual receiving services by sub-program.

Table 19: Mental Health Program - Service Type Average Cost per client attendance/individual receiving service by Region (January - June 1996)

	One to One	Groups	Community Initiatives	Regional Program Ave Cost
	Cost ($)	Cost ($)	Cost ($)	**Cost ($)**
Northern	68.77	46.64	111.48	**82.33**
Central	87.33	30.88	91.91	**81.39**
Noarlunga	52.08	34.85	53.88	**51.02**
All Adelaide	**67.70**	**36.95**	**95.07**	**71.05**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table 20: Mental Health Program - Sub-Program Average Costs per client attendance/individual receiving service by Region (January - June 1996)

	Sub-Program 1	Sub-Program 2	Sub-Program 3	Sub-Program 4	Regional Program Ave Cost
	Cost ($)	Cost ($)	Cost ($)	Cost ($)	**Cost ($)**
Northern	103.64	59.54	129.89	211.83	**82.33**
Central	70.07	87.46	24.79	108.22	**81.39**
Noarlunga	37.79	52.35	23.92	-	**51.02**
All Adelaide	**70.40**	**64.89**	**91.31**	**134.22**	**71.05**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

In developing the costing model for mental health services several areas of resource use were identified which could only be partially addressed in the costing methodology used, and within the remit of this study.

(i) Infrastructure costs

25 percent of administration and goods and services costs were allocated to infrastructure costs. These are the costs of running the infrastructure necessary to support the whole of community health. Infrastructure costs were not allocated to individual services in the costing model. As a result service cost estimates are not the full costs of providing services. The intention of the study was not to develop unit costs for purchasing decisions, and the cost estimates should not be regarded as unit costs. The cost estimates were developed for management and planning information within the confines of existing cost information and knowledge. A larger costing study would be able to address the issue of infrastructure costs more fully.

(ii) Worker time spent in planning services and in systems administration

The costing model could not fully pick up the time workers spent in planning and preparing individual services, and the time spent in administering the Community Health Service system. Such time includes planning meetings, liaison with other providers and agencies, networking, and multidisciplinary meetings etc. Some of this time will have been picked up in direct costs. However, significant part of this time will have not been included in the service cost estimates, and included instead in infrastructure costs (and hence will not appear in service cost estimates).

(iii) Community volunteer time

Cost estimates relate only to the costs to the Community Health Sector. The costs to community volunteers of the time they spend in providing services and support of services has not been included in this study. Community volunteer time may be a significant input into some services, and may be crucial in the provision of such services. A more detailed costing study would seek to determine the size and importance of community volunteer time in service delivery.

(iv) Inter-sectoral links

Some Community Health services are provided in conjunction with other government and non-government health and social service agencies. Again, the costs associated with non Community Health Sector inputs in service were not considered in this study. Such inputs may be large, and important in the provision of a range of services.

(v) Capital and buildings

The costs of building space were not considered as part of this study. Arrangements concerning ownership and leasing of buildings vary between regions and Community Health Centres. A more detailed cost study would explore these costs more fully.

6 CONCLUSIONS AND RECOMMENDATIONS

The main purpose of constructing the program budget is to provide information for the marginal analysis section of PBMA, which looks directly at issues around priorities in health services and options for change in the future. Whilst it has been suggested that construction of the program budget is not necessary to undertake marginal analysis, experiences from this pilot suggest, at least in the context of this study, that the process of constructing the program budget is vital for the undertaking of marginal analysis. The process of constructing the program budget involved clarifying Community Health objectives and the nature of mental health services in the context of Community Health. The program budget gave the first clear guidelines to which Community Health services may be considered as mental health services, and linked cost and activity data to those services. Without this process priority setting would have been beset with problems in definitional issues, in identifying services to be considered as mental health services, and in estimating the activity and resource implications of future levels of services. In such a situation it is doubtful that a marginal analysis study would be fully informed which could limit the usefulness of the planning information generated by the study.

Indeed the process of constructing the program budget has been important in its own right. Construction of the program budget has involved service providers directly addressing their objectives in providing services, and specifically the objectives underpinning mental health services. If strategic planning of health services is to be advanced it is clear that both health authorities and service providers will need to clarify their objectives underlying the services they provide, not least to assess whether the objectives of health services coincide with the desires of the community they serve.

During the process of constructing the program budget a significant change in the organisational culture of Community Health was also facilitated, and a large number of new issues and concepts were introduced which will help inform Community Health planning both now, and in the future. The process has raised service providers awareness of costs (and hopefully opportunity costs), activity levels, and outcomes in Community Health planning. Within the Community Health sector the process has provided an increased emphasis on strategic approaches to priorities and planning. This is leading to a move away from implicit (and potentially ad hoc) decision making, to more explicit and transparent decision making in planning health services.

The project has established the need for an ongoing framework for the collection of activity information, and has included the development of a new costing methodology for Community Health. This framework was developed as a common model for all three Community Health service regions within the context of this study. The project will also inform the development of a new Community Health information system in South Australia. In developing this framework, the project has also raised a number of issues. They include the need for the development of an integrated model for data collection to provide consistent information across regions, the identification of areas where cost modeling should be refined, and the need for more qualitative and quantitative research on outcomes in Community Health.

The program budget has provided a guide to assessing the relative balance between individual services provided, and between sub-programs, across all Community Health mental health services in Adelaide. This information is vital for strategic planning in health services. However, the program budget in its own right is not sufficient to determine whether the balance between services provided is the appropriate balance. To determine the appropriate balance consideration of the benefits and the costs of services provided is necessary. The benefits and costs of selected Community Health mental health services are to be addressed by the marginal analysis phase of this pilot study.

On completion of this phase of the first PBMA pilot in mental health we would like to make the following recommendations:

- That strategic based planning moves away from an input based focus to an outcome based focus, using programs which are consistent with the objectives and organisation of Community Health Services in metropolitan South Australia.

- That resources are made available for the data collection and analysis required to construct, and potentially implement, a program budgeting planning model in Community Health Services.

- That further research be conducted into to needs for, and the outcomes from, Community Health Services in metropolitan South Australia, to inform strategic planning and to improve the welfare of the population through the provision of cost-effective health services.

- That work is undertaken to establish the size and importance of links with other government and non-government agencies in the provision of Community Health Services.

- That work is undertaken to establish the size and importance of service provision by unpaid community members and volunteers of the community as part of, or as a result of Community Health Services.

- That the costing model should be refined in the future, especially in relation to gathering data on worker time spent in preparation, follow up, and advocacy; that a common costing model is applied across all three regions; and that further work is undertaken to determine the costs of capital to Community Health with respect to the costs of building space. The costing model for PBMA should be developed jointly by the Community Health Sector and the SAHC, following economic principles.

- That information technology systems be developed which are responsive to both the requirements of strategic planning and financial and management accounting.

- That, whilst members of the Pilot Study Management Committee have received training and education in priority setting methods, further education, training, and dissemination of knowledge is needed throughout Community Health organisations in South Australia.

- That the areas where difficulties in gathering cost and activity data outlined in the text and appendices of this report inform the development of the new South Australian Community based Health information system (the CHIME project), specifically:

    - The new information system should provide consistent information across all Community Health Service region to be of use in strategic planning. Data fields should be common for all regions with the same definitions for activity and worker time information, and should include the introduction of a single set of reason for attendance codes across all regions.

    - Worker time spent in contact with clients/participants should be routinely collected for all regions.

    - Worker time spent in preparation, follow up, and advocacy should be routinely collected for all regions.

    - Activity information for one to one, group, and community initiatives should be routinely collected for all regions.

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Appendix 1

Pilot Study Management Committee Membership

Mr Richard Hicks (Chairperson)	(Noarlunga Health Services)
Ms Roslyn Street	(Noarlunga Health Services)
Ms Sandy Edwards	(Noarlunga Health Services)
Mr Geoff Evans	(Noarlunga Health Services)
Ms Raven North	(Northern Metropolitan CHS)
Ms Cathy LeComu	(Northern Metropolitan CHS)
Ms Bron Marie	(Northern Metropolitan CHS)
Ms Rosie Bonnin	(Adelaide Central CHS)
Mr Matt Dougherty	(Adelaide Central CHS)
Ms Pam Quick	(Adelaide Central CHS)
Ms Joanne Gell	(Purchasing Office, SAHC)
Mr Ian Hender	(Purchasing Office, SAHC)
Ms Nancy McWaters (Project Manager)	(Purchasing Office, SAHC)
Ms Alexandra Hurley (Project Assistant)	(Purchasing Office, SAHC)
Mr Stuart Peacock (Academic Consultant)	(Health Economics Unit, Monash University)

Project Steering Committee Membership

Ms Marguerite Tohl (Chairperson)	(Purchasing Office, SAHC)
Mr Richard Hicks	(Noarlunga Health Services)
Ms Liz Fudge	(Noarlunga Health Services)
Ms Adaire Garrett	(Northern Metropolitan CHS)
Ms Raven North	(Northern Metropolitan CHS)
Ms Marj Ellis	(Adelaide Central CHS)
Ms Claire Shuttleworth	(Adelaide Central CHS)
Mr Rob Carter	(Health Economics Unit, Monash University)
Mr Richard Cooke	(South Australian Community Health Research Unit)
Ms Nancy McWaters (Project Manager)	(Purchasing Office, SAHC)
Mr Stuart Peacock (Academic Consultant)	(Health Economics Unit, Monash University)

Appendix 2

Service Descriptions

A2.1 Northern Metropolitan Community Health Service

SUB PROGRAM 1

Emotional/Mental Health - General
Programs which address a wide range of emotional and mental health issues. Usually as combinations. Eg. Stress/anxiety, self esteem/confidence, body image, sexuality.

Emotional/Mental Health Vietnamese Women
Activities which address emotional and mental health issues for Vietnamese Women.

Panic Attacks/Agoraphobia Drop-In Centre-Salisbury West
Regular Drop in Service for clients dealing with panic attacks and/or agoraphobia.

Body Image - General
Program aimed at developing a healthy body image.

Cambodian Women's Group - Salisbury West
Program which address various health issues for women from Cambodia.

Isolation - General
Program to reduce the isolation felt by member of our community. Isolation may be cultural, economic, geographical, educational etc.

Cambodian elderly Group - Salisbury West
Program to meet the emotional and mental health needs for the elderly members of the Cambodian community.

SUB PROGRAM 2

Relationships - General
Activities which deal with relationship issues.

Cancer Support Group
Program to assist clients with cancer, their carers and loved ones with coping with terminal illness and bereavement.

Gender Issues - General
Program to explore the role and impact that the media and society have in development of gender roles.

SUB PROGRAM 3

Post Natal Distress
Program to assist women with overcoming Post Natal Distress.

Self-Esteem/Confidence - General
Activities which are designed to build clients self esteem and confidence.

Parenting
Program to develop parenting skills.

Stress/Anxiety - General
Activities which are designed to assist clients to better deal with stress and anxiety in their lives.

Social Health - General
Various activities which deal with many social health issues including unemployment, housing, self esteem, drug related issues, school issues, and stress, often in combinations, where identifying one issue alone would not accurately describe the activity.

Health General - NESB
Activities which address various health issues affecting those from non-English speaking backgrounds in our community.

Sexuality - General
Activity which address the issue of sexuality and developing a health sexual identity.

SUB PROGRAM 4

Women For Better Births - Northern Women's
Program developed to listen to and support women who have given birth, and to advocate for women and improve services for women giving birth and caring for their babies.

Northfield Women's Prison Project - Northern Women's
Support and information for women in prison with a range of mental and emotional health issues including stress management and pre and post release issues.

Cambodian Working Party - Salisbury West
Interagency Working Party who's aim is to develop guidelines for culturally appropriate service delivery to the Cambodian Community.

Community Action - General
Activities to assist the community respond to health system issues which impact on their health.

Community Participation
Activities aimed at increasing community participation in all areas of service provision including identifying needs and development of appropriate services.

Youth Participation Project - Tee Tree Gully
Self help program developed to assess the issues for your people in the Tee Tree Gully area. This included the Boredom Survey and looking at youth space and school holiday programs.

Supportive Environment - General
Range of programs aimed at providing supportive environment for community members.

A2.2 Adelaide Central Community Health Service

SUB PROGRAM 1

Taperoo Young Mums Reference Group
Women meeting monthly to address mental health and other issues as a group.

Promoting Mentally Healthy Communities Project
Mental Health Women's group - fortnightly - skills development, information.

I.P.P.O.N.
St Peter's/Norwood, Isolated and Homeless Persons group meeting to address health issues.

McMhap Project
Multi-cultural Mental Health Access Project now incorporated to increase access and address issues initially with Vietnamese, Chinese, Polish and Cambodian Communities.

Assertiveness and Confidence
COPE lead course - 4-6 sessions.

Women, Health & Well-being
COPE lead course - 4-6 sessions increasing awareness of Mental Health issues and health promotion lifestyles.

SUB PROGRAM 2

Take a Break Group
Women's group - take a break from the children - discussions and outings.

Great Expectations Group
Issues of post natal depression addressed in a group setting.

Aboriginal Family Health & Well-being Programme
Mixture of groups - community initiatives meeting the needs of Western Nunga population.

SUB PROGRAM 3

Promoting Mentally Healthy Communities Project

- Mental Health Friendly Club - once a month for isolated men addressing mental health issues.
- Mental Health Music Club - promotes mental health music groups with SAMHS.
- Mental Health Travel Club - organise trips ad theatre outings for mental health groups.

Decrease Social Isolation Groups

- Krinkly Wobblies - Elders
- OWLS - decrease social isolation by outings - groups and individual sessions.
- Tuesday Social Group - fortnightly group for the housebound elderly.
- Silver Threads - activities of the socially isolated.

SUB PROGRAM 4

WOWSafe - Action Group
Women of the West meet as an action group to help promote the health and safety of women particularly regarding family safety around domestic violence issues.

Aged Homeless Working Party
Group addressing the needs of homeless people particularly in the city area.

Inner City Homeless Health Network Project

- Better Health Homeless Programme
- Inner City Homeless
  - Group and individual programmes to meet the needs of homeless people and promote health. Information screening and group sessions are general city venues.

A2.3 Noarlunga Health Services

SUB PROGRAM 1

Self Healing - Letting Go of the Pain
Aims to provide information on the short and long term effects of trauma. Provide nurturing and supportive environment to allow participants to safely explore past traumas and the effects they have had on their lives. Identify and recognise the qualities and skills which have allowed participants to cope.

Stress Management and Relaxation
Each session provides half to three quarters of an hour of practical relaxation, three quarters to one hour of education, information sharing, small group work and discussion.

Open Group - The Power of Women's Stories
This group is for women to come together for support and to talk about worries, fears, experiences and how they can make us feel "crazy" (especially when they keep going round and round in your head). By sharing women's life stories we stop the silencing of our realities and often find that many others have similar stories to tell.

Assertiveness for Women - Confidence Building
Just what is this magical thing call "confidence"? The group will explore what confidence is, what help and hinders and ways to feel better about ourselves.

Youth Answers - Peer Research Project
Aims to work with local youth to improve services fro them and to foster a positive image of young people in the community.

Women's Healing Circle
Aims to reduce the isolation of women by encouraging supportive networks - for women to practise and explore healing skills in a safe supportive environment and to assist participants in identifying issues relevant to them.

Young People Drop In
Provides informal counselling, access to free pregnancy testing, free condoms available, referrals to other services and information on a range of health issues.

SUB PROGRAM 2

Anxiety Management - Understanding and Coping with Anxiety
This course will utilise cognitive/behavioural techniques to provide participants with information and skills training in anxiety management.

Being a Mum and Stressed
Includes issues of post-natal depression, stress, parenting and isolation.

Men Managing Their Anger
Includes taking responsibility for self and control of violence against a partner. Understand that violence is never justified regardless of provocation. Use of "time out" methods of control.

Improving Self Esteem
To provide participants information about self esteem and offer strategies to entrance a positive self-esteem.

What About You? Support and Fun for Mothers
Aims to form a self supporting network for parents of children with special needs. Provide a safe environment to explore the broader issues of parenting, as well as issues specific to parenting children who have special needs. Provide social support and a venue in which participants can share resources, ideas and strategies.

Confidence Building for Women
Aims to develop participants ability to appreciate themselves. Increase participants awareness re women in society. Develop listening skills and assertiveness skills.

Learn to Relax and Manage Stress
This is a four week group to learn a variety of ways to relax and manage the day to day stresses of living full, satisfying lives. Women can learn to identify what stresses them, how to change it, and ways of looking after themselves.

Positive Changes
A chance to share ideas, learn some skills, give and receive support in a group-
1. Feeling good about yourself (self esteem and confidence building),
2. Facing the future (getting started, making changes),
3. Taking care of yourself (reducing stress, relaxing).

Time to Relax
This is a four week group to explore what relaxation means, who needs it, different kinds of relaxation methods, and how to do it. Each session will include one and a half hours of information and discussion plus thirty minutes of practising different relaxation methods.

After Suicide
- To provide social support for adults who have been bereaved through suicide.
- Normalise grief experiences through education recognitive, behavioural, emotional and physiological sequelae of bereavement through suicide.
- Promote improved psychological functioning through identification of maladaptive cognition's/behaviours and education re coping strategies.
- Act as referral source for individual/family therapy if indicated or requested.

Food With Friends

Stage 1 Community involvement in planning initial events to attract target group members (ie socially isolated community residents eg single parents living alone, recently single, low income earners and people from non-English speaking backgrounds).

Stage 2 Preparation and running of a series of community meals.

Stage 3 Self management of the group.

Overcoming Post Natal Depression

Provides support and encouragement to women suffering from post natal depression, give information on PND and other relevant issues to assist participants and to provide information on other services to refer as appropriate.

Panic and Anxiety Treatment Service (PATS)

A treatment program formalised by the Clinical Psychology Department designed to assist people who suffer from anxiety disorders.

Women Supporting Women

A ten week course for women who are interested in extending and developing their skills in order to provide support to local women on issues that affect their emotional health and well-being. Participants will have the opportunity to explore these issues within a number of cultural frameworks and social settings. Discussion will centre around the strategies that can be used to provide effective support, the resources that can be utilised and how to take care of yourself in the process.

SUB PROGRAM 3

Coffee and Chat Cafe (Sidewalk Cafe)

Come and have a cuppa and a chat. All women and children are welcome.

Appendix 3

The Mental Health Program Budget

A3.1 Northern Metropolitan Community Health Service

Table A1: Service Activity for Sub-Program 1 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 1 Activity (January – June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Attendances**	**Number Receiving Services**
One to One Services					
Registered Client Contacts					
Neighbourhood House			7	7	
Total One to One Service			**7**	**7**	
Group Activity					
Multi-Cultural Women's Group	6		12	26	
Spanish Speaking Women's Group	4		12	38	
Total Group Activity	**10**		**24**	**64**	
Community Initiative Activity					
Emotional/Mental Health – General	111				359
Emotional/Mental Health – Viet. Women	34				9
Panic Attack/Agor.Drop-in-Centre SW	37				78
Body Image – General	3				11
Cambodian Women's Group – SW	16				91
Isolation – General	8				18
Cambodian Elderly Group – SW	10				25
Total Community Initiatives	**219**				**591**
TOTAL SUB-PROGRAM 1	**229**		**31**	**71**	**591**

Table A2: Service Activity for Sub-Program 2 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 2 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Atten-dances**	**Number Receiving Services**
One to One Services					
Registered Client Contacts					
Counselling			567	1409	
Unregistered Client Contacts					
Counselling				709	
Assessment				485	
Information				886	
Total One to One Service		**567**	**3489**		
Group Activity					
Drop in Centre Panic/Agoraphobia	4	2	15	46	
Beginners Meditation	4	2	13	52	
Claim your Space with B&T	4	2	13	43	
Confidence Building for Women	7	2	18	68	
Confidence Building for Women	2	2	8	11	
Glance Backwards, Look Forward	6	2.5	14	61	
Marvellous Matriarchs Moments	4	2.5	5	18	
Motherhood and Myths	5	2	16	52	
Self Esteem	8	2	11	68	
Self Esteem for Young Women	7	2	11	62	
Strategies for Change	6	3	7	30	
Stress Management	3	2	16	31	
Stress Management	5	2	18	36	
Stress Management	4	2	16	48	
Stress M'ment and Relax. Seminar	1	2	9	9	
Total Group Activity	**70**		**190**	**635**	

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Table A2: Service Activity for Sub-Program 2 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 2 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Atten-dances**	**Number Receiving Services**
Community Initiative					
Relationships – General	3				0
Cancer Support Group	23				534
Gender Issues – General	12				4
Total Community Initiative	**38**				**538**
TOTAL SUB-PROGRAM 2	**108**		**757**	**4124**	**538**

Table A3: Service Activity for Sub-Program 3 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 3 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Attendances**	**Number Receiving Services**
Group Activity					
Health Education for NESB Women	6	2	16	58	
Total Group Activity	**6**		**16**	**58**	
Community Initiative Activity					
Post Natal Distress	58				201
Self Esteem/Confidence – General	96				166
Parenting	5				7
Stress/Anxiety – General	84				229
Social Health – General	43				175
Health General NESB	133				296
Health – General Aboriginal Community	12				59
Sexuality – General	5				28
Total Community Initiatives	**436**				**1161**
TOTAL SUB-PROGRAM 3	**442**		**16**	**58**	**1161**

Table A4: Service Activity for Sub-Program 4 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICES

Sub-Program 4 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Attendances**	**Number Receiving Services**
Community Initiative Activity					
Women for Better Births – NW	10				38
Northfield Women's Prison Project – NW	4				2
Cambodian Working Party – SW	37				45
Community Action – General	15				32
Community Participation	51				52
Youth Participation Project	14				70
Supportive Environment – General	24				25
Total Community Initiatives	**155**				**264**
TOTAL SUB-PROGRAM 4	**155**				**264**

Table A5: Service Total Costs for Sub-Program 1 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 1 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
One to One					
Registered Client Contacts					
Neighbourhood House	8.5	17	469	408	878
Total One to One	**8.5**	**17**	**469**	**408**	**878**
Groups					
Multi-Cultural Women's Group	36	72	1,987	1,730	3,717
Spanish Speaking Women's Group	22	44	1,214	1,057	2,271
Total Groups	**58**	**116**	**3,202**	**2,787**	**5,988**
Community Initiatives					
Emotional/Mental Health – General	302.82	605.64	16,716	14,548	31,264
Emotional/Mental Health – Viet. Women	94.25	188.5	5,203	4,528	9,731
Panic Attack/Agor.Drop-in-Cen-SW	76.31	152.62	4,212	3,666	7,879
Body Image – General	6	12	331	288	619
Cambodian Women's Group – SW	55.17	110.34	3,045	2,651	5,696
Isolation – General	28	56	1,546	1,345	2,891
Cambodian Elderly Group – SW	35.5	71	1,960	1,706	3,665
Total Community Initiatives	**598.05**	**1196.1**	**33,012**	**28,732**	**61,745**
TOTAL SUB-PROGRAM 1	**664.55**	**1329.1**	**36,683**	**31,927**	**68,610**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A6: Service Total Costs for Sub-Program 2 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 2 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
One to One					
Registered Client Contacts					
Counselling	1378	2756	76,066	66,204	142,269
Unregistered Client Contacts					
Counselling	348	696	19,210	16,719	35,929
Assessment	245	490	13,524	11,771	25,295
Information	349	698	19,265	16,767	36,032
Total One to One	**2320**	**4640**	**128,064**	**111,461**	**239,525**
Groups					
Drop-in-Centre Panic/Agoraphobia	16	32	883	769	1,652
Beginners Meditation	8	16	442	384	826
Claim your Space with B&T	16	32	883	769	1,652
Confidence Building for Women	24	48	1,325	1,153	2,478
Confidence Building for Women	8	16	442	384	826
Glance Backwards, Look Forward	15	30	828	721	1,549
Marvellous Matriarchs Moments	10	20	552	480	1,032
Motherhood and Myths	20	40	1,104	961	2,065
Self Esteem	32	64	1,766	1,537	3,304
Self Esteem for Young Women	26	52	1,435	1,249	2,684
Strategies for Change	43	86	2,374	2,066	4,439
Stress Management	12	24	662	577	1,239
Stress Management	20	40	1,104	961	2,065
Stress Management	18	36	994	865	1,858
Stress M'ment and Relax. Seminar	4	8	221	192	413
Total Groups	**272**	**544**	**15,014**	**13,068**	**28,082**

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Table A6: Service Total Costs for Sub-Program 2 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 2 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
Community Initiatives					
Relationships – General	9	18	497	432	929
Cancer Support Group	55	110	3,036	2,642	5,678
Gender Issues – General	32.5	65	1,794	1,561	3,355
Total Community Initiatives	**96.5**	**193**	**5,327**	**4,636**	**9,963**
TOTAL SUB-PROGRAM 2	**2688.5**	**5377**	**148,405**	**129,165**	**277,570**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A7: Service Total Costs for Sub-Program 3 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 3 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
Groups					
Health Education for NESB Women	12.00	24.00	662	577	1,239
Total Groups	**12.00**	**24.00**	**662**	**577**	**1.239**
Community Initiatives					
Post Natal Distress	194.66	389.32	10,745	9,352	20,097
Self Esteem/Confidence - General	272.25	544.50	15,028	13,080	28,108
Parenting	12.00	24.00	662	577	1,239
Stress/Anxiety - General	241.40	482.80	13,325	11,598	24,923
Social Health - General	83.17	166.34	4,591	3,996	8,587
Health General NESB	624.48	1248.96	34,471	30,002	64,473
Health - General Aboriginal Community	74.17	148.34	4,094	3,563	7,658
Sexuality - General	19.50	39.00	1,076	937	2,013
Total Community Initiatives	**1521.63**	**3043.26**	**83,994**	**73,104**	**157,098**
TOTAL SUB-PROGRAM 3	**1533.63**	**3067.26**	**84,656**	**73,681**	**158,337**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A8: Service Total Costs for Sub-Program 4 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 4 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
Community Initiatives					
Women for Better Births - NW	26.50	53.00	1,463	1,273	2,736
Northfield Women's Prison Project - NW	7.50	15.00	414	360	774
Cambodian Working Party - SW	217.00	434.00	11,978	10,425	22,404
Community Action - General	51.50	103.00	2,843	2,474	5,317
Community Participation	131.75	263.50	7,273	6,330	13,602
Youth Participation Project	40.50	81.00	2,236	1,946	4,181
Supportive Environment - General	66.92	133.84	3,694	3,215	6,909
Total Community Initiatives	**541.67**	**1083.34**	**29,900**	**26,024**	**55,924**
TOTAL SUB-PROGRAM 4	**541.67**	**1083.34**	**29,900**	**26,024**	**55,924**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A9: Service Average Costs for Sub-Program 1 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 1 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
One to One Services					
Registered Client Contacts					
Neighbourhood House	878		125	125	
Total One to One Services	**873**				
Group Activity					
Multi-Cultural Women's Group	3,717	619	310	143	
Spanish Speaking Women's Group	2,271	568	189	60	
Total Group Activity	**5,988**				
Community Initiative Activity					
Emotional/Mental Health - General	31,264	282			87
Emotional/Mental Health - Viet. Women	9,731	286			1,081
Panic Attack/Agor. Drop-in-Centre SW	7,879	213			101
Body Image - General	619	206			56
Cambodian Women's Group - SW	5,696	356			63
Isolation - General	2,891	361			161
Cambodian Elderly Group - SW	3,665	367			147
Total Community Initiatives	**61,745**				
TOTAL SUB-PROGRAM 1	**68,610**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A10: Service Average Costs for Sub-Program 2 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 2 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
One to One Services					
Registered Client Contacts					
Counselling	142,269		251	101	
Unregistered Client Contacts					
Counselling	36,929			51	
Assessment	25,295			52	
Information	36,032			41	
Total One to One Services	**239,525**				
Group Activity					
Drop-in Centre Panic/Agoraphobia	1,652	413	110	36	
Beginners Meditation	826	206	64	16	
Claim your Space with B&T	1,652	413	127	38	
Confidence Building for Women	2,478	354	138	36	
Confidence Building for Women	826	413	103	75	
Glance Backwards, Look Forward	1,549	258	111	25	
Marvellous Matriarchs Moments	1,032	258	206	57	
Motherhood and Myths	2,065	413	129	40	
Self Esteem	3,304	413	300	49	
Self Esteem for young Women	2,684	383	244	43	
Strategies for Change	4,439	740	634	148	
Stress Management	1,239	413	77	40	
Stress Management	2,065	413	115	57	
Stress Management	1,858	465	116	39	
Stress M'ment and Relax. Seminar	413	413	46	46	
Total Group Activity	**28,082**				

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Table A10: Service Average Costs for Sub-Program 2 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 2 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
Community Initiative					
Relationships - General	929	310			
Cancer Support Group	5,678	247			11
Gender Issues - General	3,355	280			839
Total Community Initiative	**9,963**				
TOTAL SUB-PROGRAM 2	**277,570**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A11: Service Average Costs for Sub-Program 3 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICE

Sub-Program 3 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
Group Activity					
Health Education for NESB Women	1,239	206	77	21	
Total Group Activity	**1,239**				
Community Initiative Activity					
Post Natal Distress	20,097	347			100
Self Esteem/Confidence - General	28,108	293			169
Parenting	1,239	248			177
Stress/Anxiety - General	24,923	297			109
Social Health - General	8,587	200			49
Health General NESB	64,473	485			218
Health - General Aboriginal Community	7,658	638			130
Sexuality - General	2,013	403			72
Total Community Initiatives	**157,098**				
TOTAL SUB-PROGRAM 3	**158,337**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A12: Service Average Costs for Sub-Program 4 (January-June 1996)

NORTHERN METROPOLITAN COMMUNITY HEALTH SERVICES

Sub-Program 4 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
Community Initiative Activity					
Women for Better Births - NW	2,736	274			72
Northfield Women's Prison Project - NW	774	194			387
Cambodian Working Party - SW	22,404	606			498
Community Action - General	5,317	354			166
Community Participation	13,602	267			262
Youth Participation Project	4,181	299			60
Supportive Environment - General	6,909	288			276
Total Community Initiatives	**55,924**				
TOTAL SUB-PROGRAM 4	**55,924**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

A3.2 Adelaide Central Community Health Service

Table A13: Service Activity for Sub-Program 1 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 1 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Attendances**	**Numbers Receiving Services**
Group Activity					
Assertiveness & Confidence	10			107	
Working Through Conflict	1			9	
Women, Health & Well Being	3			31	
McMhap Support Group	10			120	
Aboriginal Wellbeing	4			20	
Aboriginal Elders	10			150	
Total Group Activity	**38**			**437**	
Community Initiative Activity					
Mental Health Women's Group	12				120
I.P.P.O.N.	8				65
Stress/Relaxation Group	7				15
Western Ab. Health Program	5				13
Taperoo/Osborne Steering Group	5				0
Aboriginal Primary Health	50				500
McMhap Project	60				300
Total Community Initiative Activity	**147**				**1013**
Total for Sub-program 1	**185**			**437**	**1013**

Table A14: Service Activity for Sub-Program 2 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 2 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Attendances**	**Numbers Receiving Services**
One to One Contacts					
Registered Client Contacts				3668	
Unregistered Client Contacts				1249	
Total One to One Services				**4917**	
Group Activity					
Take a Break	20			120	
Total Group Activity	**20**			**120**	
Community Initiative Activity					
Great Expectations	17				24
Total Community Initiative Activity	**17**				**24**
TOTAL SUB-PROGRAM 2	**37**			**5037**	**24**

Table A15: Service Activity for Sub-Program 3 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 3 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Attendances**	**Numbers Receiving Services**
Group Activity					
Port Owls	6			40	
Krinkley Wobblies (Elders)	20			200	
Silver Threads (Elders)	10			120	
Tuesday Social Group (Elders)	10			80	
Total Group Activity	**46**			**440**	
Community Initiative Activity					
Mental Health Friendly Lunch	5				89
Mental Health Music Club	6				70
Mental Health Travel Club	3				10
Mental Illness Community	3				18
Education					
Total Community Initiative Activity	**17**				**187**
TOTAL SUB-PROGRAM 3	**63**			**440**	**187**

Table A16: Service Activity for Sub-Program 4 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 4 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Attendances**	**Numbers Receiving Services**
Community Initiative Activity					
Well Being Project	145				587
Inner City Homeless	16				56
Aged Homeless Working Party	2				22
Better Health Homeless Project	10				43
WOW Safe	20				80
Total Community Initiative Activity	**193**				**788**
TOTAL SUB-PROGRAM 3	**193**				**788**

Table A17: Service Total Costs for Sub-Program 1 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 1 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
Groups					
Assertiveness & Confidence	35	70	1,932	1,124	3,056
Working Through Conflict	3.5	7	193	112	306
Women, Health & Well Being	21	42	1,159	675	1,834
McMhap Support Group	40	80	2,208	1,285	3,493
Aboriginal Wellbeing	42	84	2,318	1,349	3,668
Aboriginal Elders	70	140	3,864	2,249	6,113
Total Groups	**211.5**	**423**	**11,675**	**6,795**	**18,469**
Community Initiatives					
Mental Health Women's Group	84	168	4,637	2,699	7,335
I.P.P.O.N	28	56	1,546	900	2,445
Stress/Relaxation Group	24.5	49	1,352	787	2,139
Western Ab. Health Program	28	56	1,546	900	2,445
Taperoo/Osborne Steering Group	17.5	35	966	562	1,528
Aboriginal Primary Health	350	700	19,320	11,244	30,564
McMhap Project	420	840	23,184	13,493	36,677
Total Community Initiatives	**952**	**1904**	**52,550**	**30,584**	**83,134**
TOTAL SUB-PROGRAM 1	**1163.5**	**2327**	**64,225**	**37,379**	**101,604**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A18: Service Total Costs for Sub-Program 2 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 2 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
One to One					
Registered Client Contacts	3668	7336	202,474	117,838	320,312
Unregistered Client Contacts	1249	2498	68,945	40,125	109,070
Total One to One	**4917**	**9834**	**271,418**	**157,964**	**429,382**
Groups					
Take a Break	40	80	2,208	1,285	3,493
Total Groups	**40**	**80**	**2,208**	**1,285**	**3,493**
Community Initiatives					
Great Expectations	112	224	6,182	3,598	9,781
Total Community Initiatives	**112**	**224**	**6,182**	**3,598**	**9,781**
TOTAL SUB-PROGRAM 2	**5069**	**10138**	**279,809**	**162,847**	**442,656**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A19: Service Total Costs for Sub-Program 3 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 3 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
Group Activity					
Port Owls	21	42	1,159	675	1,834
Krinkley Wobblies (Elders)	40	80	2,208	1,285	3,493
Silver Threads (Elders)	20	40	1,104	643	1,747
Tuesday Social Group (Elders)	20	40	1,104	643	1,747
Total Groups	**101**	**202**	**5,575**	**3,245**	**8,820**
Community Initiatives					
Mental Health Friendly Lunch	35	70	1,932	1,124	3,056
Mental Health Music Club	21	42	1,159	675	1,834
Mental Health Travel Club	10.5	21	580	337	917
Mental Illness Community	10.5	21	580	337	917
Education					
Total Community Initiatives	**77**	**154**	**4,250**	**2,474**	**6,724**
Total Sub-Program 3	**178**	**356**	**9,826**	**5,718**	**15,544**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A20: Service Total Costs for Sub-Program 4 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 4 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	***Infra-structure* Costs $**	**Service Total Cost $**
Community Initiatives					
Well Being Project	766.5	1533	42,311	24,625	66,935
Inner City Homeless	94.5	189	5,216	3,036	8,252
Aged Homeless Working Party	7	14	386	225	611
Better Health Homeless Project	38.5	77	2,125	1,237	3,362
WOW Safe	70	140	3,864	2,249	6,113
Total Community Initiatives	**976.5**	**1953**	**53,903**	**31,371**	**85,274**
Total Sub-Program 4	**976.5**	**1953**	**53,903**	**31,371**	**85,274**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A21: Service Average Costs for Sub-Program 1 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 1 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
Group Activity					
Assertiveness & Confidence	3,056	306		29	
Working Through Conflict	306	306		34	
Women, health & Well Being	1,834	611		59	
McMhap Support Group	3,493	349		29	
Aboriginal Wellbeing	3,668	917		183	
Aboriginal Elders	6,113	611		41	
Total Group Activity	**18,469**				
Community Initiative Activity					
Mental Health Women's Group	7,335	611			61
I.P.P.O.N.	2,445	306			38
Stress/Relaxation Group	2,139	306			143
Western Ab. Health Program	2,445	489			188
Taperoo/Osborne Steering Group	1,528	306			
Aboriginal Primary Health	30,564	611			61
McMhap Project	36,677	611			122
Total Community Initiative Activity	**83,134**				
Total Sub-Program 1	**101,604**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A22: Service Average Costs for Sub-Program 2 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 2 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
One to One Contacts					
Registered Client Contacts	320,312			87	
Unregistered Client Contacts	*109,070*			87	
Total One to One Services	**429,382**				
Group Activity					
Take a Break	3,493	175		29	
Total Group Activity	**3,493**				
Community Initiative Activity					
Great Expectations	9,781	575			408
Total Community Initiative Activity	**9,781**				
Total Sub-Program 2	**442,656**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A23: Service Average Costs for Sub-Program 3 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 3 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
Group Activity					
Port Owls	1,834	306		46	
Krinkley Wobblies (Elders)	3,493	175		17	
Silver Threads (Elders)	1,747	175		15	
Tuesday Social Group (Elders)	1,747	175		22	
Total Group Activity	**8,820**				
Community Initiative Activity					
Mental Health Friendly Lunch	3,056	611			34
Mental Health Music Club	1,834	306			26
Mental Health Travel Club	917	306			92
Mental Illness Community	917	306			51
Education					
Total Community Initiative Activity	**6,724**				
Total Sub-Program 3	**15,544**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A24: Service Average Costs for Sub-Program 4 (January-June 1996)

ADELAIDE CENTRAL COMMUNITY HEALTH SERVICE

Sub-Program 4 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
Community Initiative Activity					
Well Being Project	66,935	462			114
Inner City Homeless	8,252	516			147
Aged Homeless Working Party	611	306			28
Better Health Homeless Project	3,362	336			78
WOW Safe	6,113	306			76
Total Community Initiative Activity	**85,274**				
Total Sub-Program 4	**85,274**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

A3.3 Noarlunga Community Health Service

Table A25: Service Activity for Sub-Program 1 (January-June 1996)

NOARLUNGA HEALTH SERVICES

Sub-Program 1 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Attendances**	**Numbers Receiving Services**
Group Activity					
Self-Healing/Letting Go Pain	2	2.5	8	14	
Stress Management & Relaxation	15	2.5	15	90	
Open Group	15	2.5	28	121	
Total Group Activity	**32**		**51**	**225**	
Community Initiatives					
Assertiveness for Women	6	2			
Peer Research Project - Youth	16	2			
Women's Healing Circle	44	2			92
Young Peoples Drop In	15	2			56
Youth Answers Peer Research	27	2			330
Total Community Initiatives	**108**				**478**
Total for Sub-Program 1	**140**		**51**	**225**	**478**

Table A26: Service Activity for Sub-Program 2 (January-June 1996)

NOARLUNGA HEALTH SERVICES

Sub-Program 2 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Attendances**	**Numbers Receiving Services**
One to One Contacts					
Registered Clients			940	2577	
Unregistered Clients (Informals)				3842	
Total One to One Services			**940**	**6419**	
Group Activity					
Anxiety Management	14	2.5	15	90	
Being a Mum and Stressed	7	2.5	5	32	
Group for Violent Men	6	2.5	10	57	
Improving Self-Esteem	4	2.5	11	31	
What About You? Support Mother	13	2.5	7	55	
Confidence Building	2	2.5	6	12	
Learn to Relax and Manage Stress	4	2.5	11	25	
Positive Changes	3	2.5	12	27	
Time to Relax	5	2.5	22	56	
Total Group Activity	**58**		**99**	**385**	
Community Initiatives					
After Suicide	19	2			33
Food with Friends	69	2			106
Overcoming Postnatal Depression	31	2			77
Panic & Anxiety Treatment Services	6	2			16
Women Supporting Women	4	2			16
Young Women Assertive/Confident	1	2			65
Total Community Initiatives	**130**				**313**
Total for Sub-Program 2	**188**		**1039**	**6804**	**313**

Table A27: Service Activity for Sub-Program 3 (January-June 1996)

NOARLUNGA HEALTH SERVICES

Sub-Program 3 Activity (January - June 1996)					
Service	**No. of Sessions**	**Hours per Session**	**No. of Unique Clients**	**Client Attendances**	**Numbers Receiving Services**
Community Initiatives					
Coffee and Chat Café	10	2			79
Total Community Initiatives	**10**	**2**			**79**
Total for Sub-Program 3	**10**	**2**			**79**

Table A28: Service Total Costs for Sub-Program 1 (January-June 1996)

NOARLUNGA HEALTH SERVICES

Sub-Program 1 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
Groups					
Self-Healing/Letting Go Pain	5	10	276	196	472
Stress Management & Relaxation	37.5	75	2,070	1,474	3,544
Open Group	37.5	75	2,070	1,474	3,544
Total Groups	**80**	**160**	**4,416**	**3,144**	**7,560**
Community Initiatives					
Assertiveness for Women	12	24	662	472	1,134
Peer Research Project - Youth	32	64	1,766	1,257	3,024
Women's Healing Circle	88	176	4,858	3,458	8,316
Young Peoples Drop In	30	60	1,656	1,179	2,835
Youth Answers Peer Research	54	108	2,981	2,122	5,103
Total Community Initiatives	**216**	**432**	**11,923**	**8,488**	**20,411**
Total for Sub-Program 1	**296**	**592**	**16,339**	**11,631**	**27,970**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A29: Service Total Costs for Sub-Program 2 (January-June 1996)

NOARLUNGA HEALTH SERVICES

Sub-Program 2 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
One to One					
Registered Clients	2577	5154	142,250	101,262	243,513
Unregistered Clients (Informals)	961	1922	53,047	37,762	90,809
Total One to One	**3538**	**7076**	**195,298**	**139,024**	**334,322**
Groups					
Anxiety Management	35	70	1,932	1,375	3,307
Being a Mum and Stressed	17.5	35	966	688	1,654
Group for Violent Men	15	30	828	589	1,417
Improving Self-Esteem	10	20	552	393	945
What About You? Support Mother	32.5	65	1,794	1,277	3.071
Confidence Building	5	10	276	196	472
Learn to Relax and Manage Stress	10	20	552	393	945
Positive Changes	7.5	15	414	295	709
Time to Relax	12.5	25	690	491	1,181
Total Groups	**145**	**290**	**8,004**	**5,698**	**13,702**
Community Initiatives					
After Suicide	38	76	2,098	1,493	3,591
Food with Friends	138	276	7,618	5,423	13,040
Overcoming Postnatal Depression	62	124	3,422	2,436	5,859
Panic & Anxiety Treatment Services	12	24	662	472	1,134
Women Supporting Women	8	16	442	314	756
Young Women Assertive/Confident	2	4	110	79	189
Total Community Initiatives	**260**	**520**	**14,352**	**10,217**	**24,569**
Total for Sub-Program 2	**3943**	**7886**	**217,654**	**154,939**	**372,592**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A30: Service Total Costs for Sub-Program 3 (January-June 1996)

NOARLUNGA HEALTH SERVICES

Sub-Program 3 Costs (January - June 1996)					
Service	**Worker Contact Hours**	**Estimated Worker Hours**	**Cost of Worker Time $**	**Infra-structure Costs $**	**Service Total Cost $**
Community Initiatives					
Coffee and Chat Café	20	40	1,104	786	1,890
Total Community Initiatives	**20**	**40**	**1,104**	**786**	**1,890**
Total for Sub-Program 3	**20**	**40**	**1,104**	**786**	**1,890**

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A31: Service Average Costs for Sub-Program 1 (January-June 1996)

NOARLUNGA HEALTH SERVICES

Sub-Program 1 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
Group Activity					
Self-Healing/Letting Go Pain	472	236	59	34	
Stress Management & Relaxation	3,544	236	236	39	
Open Group	3,544	236	127	29	
Total Group Activity	**7,560**				
Community Initiatives					
Assertiveness for Women	1,134	189			
Peer Research Project - Youth	3,024	189			
Women's Healing Circle	8,316	189			90
Young Peoples Drop In	2,835	189			51
Youth Answers Peer Research	5,103	189			15
Total Community Initiatives	**20,411**				
Total for Sub-Program 1	**27,970**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A32: Service Average Costs for Sub-Program 2 (January-June 1996)

NOARLUNGA HEALTH SERVICES

Sub-Program 2 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
One to One Contacts					
Registered Clients	243,513		259	94	
Unregistered Clients (Informals)	90,809			24	
Total One to One Services	**334,322**				
Group Activity					
Anxiety Management	3,307	236	220	37	
Being a Mum and Stressed	1,654	236	331	52	
Group for Violent Men	1,417	236	142	25	
Improving Self-Esteem	945	236	11	30	
What About You? Support Mother	3,071	236	439	56	
Confidence Building	472	236	79	39	
Learn to Relax and Manage Stress	945	236	86	38	
Positive Changes	709	236	59	26	
Time to Relax	1,181	236	54	21	
Total Group Activity	**13,702**				
Community Initiatives					
After Suicide	3,591	189			109
Food with Friends	13,040	189			123
Overcoming Postnatal Depression	5,589	189			76
Panic & Anxiety Treatment Services	1,134	189			71
Women Supporting Women	756	189			47
Young Women Assertive/Confident	189	189			3
Total Community Initiatives	**24,569**				
Total for Sub-Program 2	**372,592**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

Table A33: Service Average Costs for Sub-Program 3 (January-June 1996)

NOARLUNGA HEALTH SERVICES

Sub-Program 3 Average Costs (January - June 1996)					
Service	**Service Total Cost $**	**Cost per Session $**	**Cost per Unique Client $**	**Cost per Client A'dance $**	**Cost per Recipient $**
Community Initiatives					
Coffee and Chat Café	1,890	189			24
Total Community Initiatives	**1,890**				
Total for Sub-Program 3	**1,890**				

Costs presented here are based on the costing model developed for the PBMA study, and should be interpreted in light of the context of this study and the methodology adopted. They do not represent unit costs derived from an individual level costing exercise.

A3.4 Activity and Cost data notes

(i) Activity

(a) One to one services

Unique client:	An individual registered client that attends for a service (A unique client may attend more than once)

Data on the number of unique clients for one to one services was available only for Northern and Noarlunga regions.

Client attendances	The total number of attendances by clients (registered and unregistered clients)

Client attendances included registered and unregistered clients for all regions.

All regions determined client attendances for one to one services by including contacts with a primary reason for attendance code which related to a specific emotional /mental health problem or condition. Central region also included one to one contacts with primary reason for attendance codes for violence, which may lead to an overestimation of one to one client attendances in that region.

Noarlunga region did not have reason for attendance codes for informal and intake contacts (unregistered clients). Unregistered client attendances were estimated to be 30% of all Community Health unregistered attendances, following Noarlunga's assumption that 30% of direct worker hours were spent in providing mental health services.

(b) Groups

Number of sessions	Total number of sessions held for that group
Hours per session	Contact time with group participants

Data for group hours per session was available on the CHSS information system for Northern, but not for Central region. Central region assumed each group session ran for approximately 3.5 hours (a morning or an afternoon). Noarlunga region found the CHSS data on group hours per session to be unreliable, and adjusted the data according to worker estimates from estimates of service duration collected by worker discipline groups.

Unique client	An individual registered client who attended one or more sessions of a group program.

Data on the number of unique clients for group services was available only for Northern and Noarlunga regions.

Client attendances	The total number of attendances by registered clients.

(c) Community Initiatives

Number of sessions	Number of incidents of activity recorded for a program.
Number receiving services	Total number of participants at sessions where a service was provided.

Data relating to number of participants receiving services from community initiatives was found to be unreliable in places for all regions. Northern reported zero participants for one service, and very low numbers in three other services (number of participants under 10). Noarlunga reported two services with no participants, and Central reported one service with no participants. This may be due to problems in coding activity in some cases, where a session may have been recorded when it was actually a planning session for Community Health service staff where participants were not present. Central and Noarlunga had to rely on worker estimates of the number of participants in some, or many, community initiatives, and as a result potential exists for over and underestimation of numbers receiving care. This information must be interpreted with care.

Activity data in general from the CHSS information system appeared to be most complete and accurate for Northern region. Whilst most activity data was recorded on the CHSS system for Noarlunga, the region felt information was too unreliable in places, and used worker estimates to revise figures. Central reported that data was not available on the CHSS system for a significant number of services, this is mainly due to the recency of regionalisation in Central. Previously, data have been collected and kept at individual Community Health Centres, and remains difficult to collect. Moreover, in the past some Centres have not been collecting activity information for some services in Central region.

(ii) Costs

Worker contact	Worker time spent in direct provision of services hours (contact time with clients or participants)
Estimated worker	Worker contact time plus worker time spent time in preparation, data collection, follow up, and advocacy for client contacts. This additional worker time was estimated to be 100 per cent of worker contact time.

All regions assumed only one worker at a time provided one to one services.

Worker hours for one to one services in Northern region were based on CHSS information, Central and Noarlunga estimated that the direct contact time with registered one to one clients was on average 1 hour. Central also estimated that direct contact time with unregistered one to one clients was on average 1 hour. Noarlunga estimated the direct worker contact time with unregistered one to one clients to be 15 minutes on average.

Noarlunga only allowed for the primary worker to be used in calculating costs for worker contact time in providing groups and community initiatives. Where there was more than one worker involved in providing the group or community initiative this will lead to an underestimation of worker costs. Moreover, some preparation time for groups and one to one services may be recorded as community initiative time for Noarlunga region.

Superannuation was added at 6% (minimum SA Government contribution) to administration and clerical staff costs. No other "on costs" were added.

Cost per unique client was not available for Central region, as unique client data was unavailable.

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