Health and Human Services Gap Analysis Report - 2026

MITCHELL SHIRE COUNCIL

Stakeholder acknowledgment

Mitchell Shire Council acknowledges our valued service providers and partners who contributed to the preparation of this Report. We sincerely thank you for the essential role you play in supporting the health and wellbeing of our community.

Version Control

Prepared for the Mitchell Shire Council
Health and Human Service Gap Analysis

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Acknowledgement of Country

Mitchell Shire Council acknowledges the Taungurung and Wurundjeri Woi-wurrung people as the Traditional Owners of the lands and waterways in the area now known as Mitchell Shire.

We pay our respect to their rich cultures and to Elders, past, present, and emerging, as well as other Aboriginal and Torres Strait Islander people who live, work and play in the area.

Contents

Tables and Figures

Executive Summary

Mitchell Shire has entered a period of extraordinary transformation. Its population is forecast to grow from 64,175 in 2025 to 221,636 by 2046—an increase of more than 245%[1], making it the fastest growing local government area in Victoria. The southern parts of the Shire, particularly Beveridge and Wallan, are rapidly urbanising, while Kilmore, Broadford, and Seymour continue to play vital regional roles. This dual identity, simultaneously metropolitan growth area and dispersed rural community creates unique planning, service delivery, and governance challenges.

The Health and Human Services Gap Analysis (HHSGA) has been commissioned to assess the capacity of existing services, highlight emerging gaps, and provide an evidence base to guide advocacy and planning. This volume draws on limited available datasets, policy and planning reviews, and extensive engagement with local service providers.

Key Observations

1. **Unprecedented Growth Without Guarantees** – While Mitchell Shire is carefully planning for its future, state and federal investment has not kept pace. Business-as-usual planning and budget processes leave health and community services absent from Precinct Structure Plans (PSP), resulting in residential housing estates delivered years before schools, clinics, and community hubs.
2. **Dual Role, Divided Regions** – Mitchell must manage growth on metropolitan terms in the south while maintaining regional service delivery in the north. Splits across planning boundaries (Primary Health Network (PHN), SA3/SA4 regions, education, and other catchments) undermine integrated planning and fragment funding eligibility.
3. **Accountability Gaps** – Local government transparently plans and reports on its responsibilities, but most health and human services fall under opaque state and federal processes. Communities experience shortages in GPs, allied health, and hospital access without clear accountability for how decisions are made.
4. **Entrenched Inequities** – Service lags identified in earlier interface reports (2003–2017) persist and appear to have deepened. Mitchell is the only growth area council without a committed major hospital or post-secondary training facility. Allied health, mental health, housing support, and family services remain below metropolitan benchmarks.
5. **Community at Risk** – Indicators such as high rates of family violence, housing stress, National Disability Insurance Scheme (NDIS) underspend, and child protection involvement point to growing vulnerability. Service providers report chronic workforce shortages, rising demand, and increasing reliance on crisis services rather than prevention.

Findings from Engagement

Consultations with hospitals, community health agencies, disability providers, housing services, and NGOs confirmed that demand already exceeds local capacity. Waitlists are common, workforce shortages acute, and reliance on private providers entrenches inequity. In towns like Seymour and

[1] https://forecast.id.com.au/mitchell/

Kilmore, small hospitals are stretched, while in Beveridge and Wallan, essential services are years behind residential growth. Providers emphasised the urgent need for integrated, place-based planning, predictable funding, and early delivery of community hubs that co-locate health, education, and social services.

Data Insights

A limited review of datasets confirms systemic issues. NDIS utilisation rates in Mitchell remain below state averages due to lack of local disability providers and specialist allied health workers. Liveability indicators highlight poor access to public transport, higher rates of housing stress, and limited proximity to services compared with metropolitan Melbourne. These findings align with engagement insights and reinforce that without structural reform; Mitchell's service deficits will widen.

Key Recommendations

- **Establish a Northern Growth Corridor Infrastructure Commission** – A dedicated intergovernmental body commissioned by the Premier and Treasurer to fast-track planning and delivery of health, education, and community infrastructure in Mitchell's PSP areas (and timetabling of delivery of regional infrastructure in the adjacent Cloverton Metropolitan Activity Centre (MAC)).
- **Mandate State Agency Participation in Precinct Structure Plans** – Require health, human and other service departments to contribute directly to growth planning, including early land acquisition and committed capital funding for community health, primary care clinics, and human service hubs. This would be best based on approved service provision standards and infrastructure plans which currently do not exist.
- **Invest in Local Self-Sufficiency** – Commit to delivery of a major public hospital for the Northern Growth Corridor, community hospitals to service Mitchell's local needs, and post-secondary training facility within Mitchell to reduce reliance on neighbouring Local Government Areas (LGA).
- **Improve Transparency and Accountability** – Introduce place-based reporting for health and human service provision, enabling communities and councils to monitor whether investment meets local demand.
- **Support Workforce Development** – Expand training pipelines and retention initiatives for GPs, allied health, and mental health professionals, particularly in Seymour, Wallan, and Kilmore. Consider key-worker housing affordability as part of strategy development.
- **Embed Prevention and Early Intervention** – All evidence points to the lower cost and higher social benefit of early intervention, prioritise community hubs, child and family services, and mental health outreach to reduce reliance on crisis-driven models.

Conclusion

Mitchell Shire stands at a crossroads. Its growth trajectory is unmatched, yet its service network and supporting infrastructure lags dangerously behind.

Without decisive, coordinated intervention from all levels of government, the Shire risks embedding long-term disadvantage and escalating costs for communities and governments alike.

Key graphs

Analysis of population growth estimates has been undertaken for metropolitan Melbourne LGAs. Mitchell Shire will experience:

- Three times more population growth when compared with the 2025 base than any other LGA,
- Twice the compound rate of growth, and
- Accommodate almost 8% of the total population growth anticipated for the greater Melbourne metropolitan area

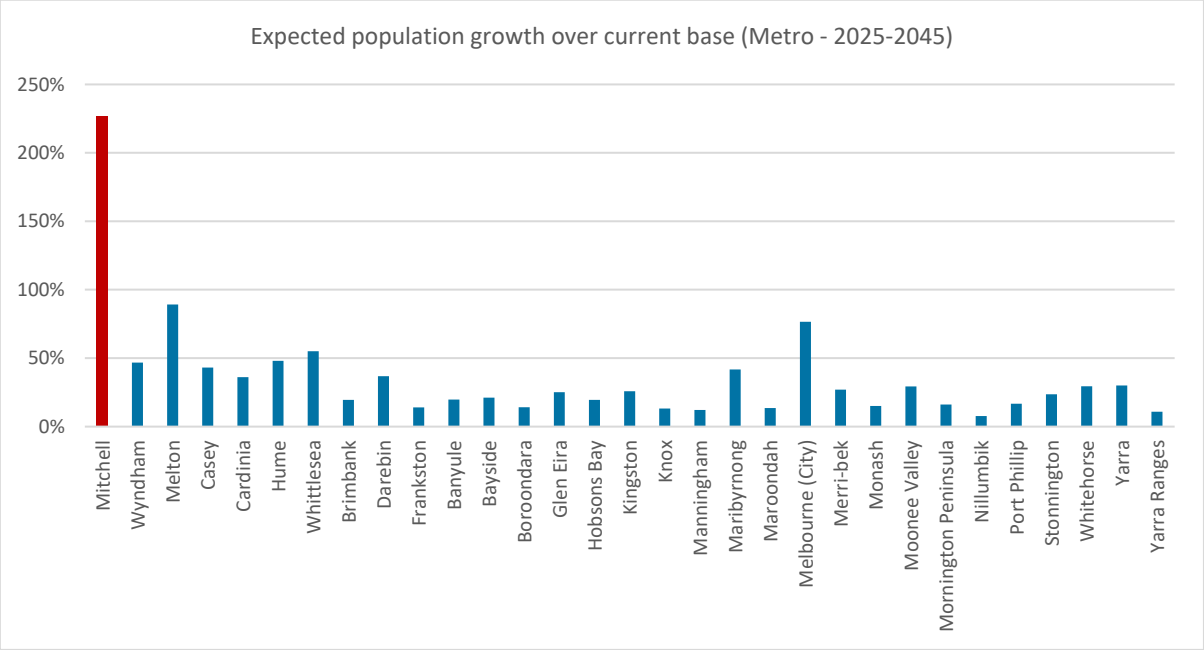

Figure 1 Expected population growth (%) over current base (id Profile and other sources, 2025)

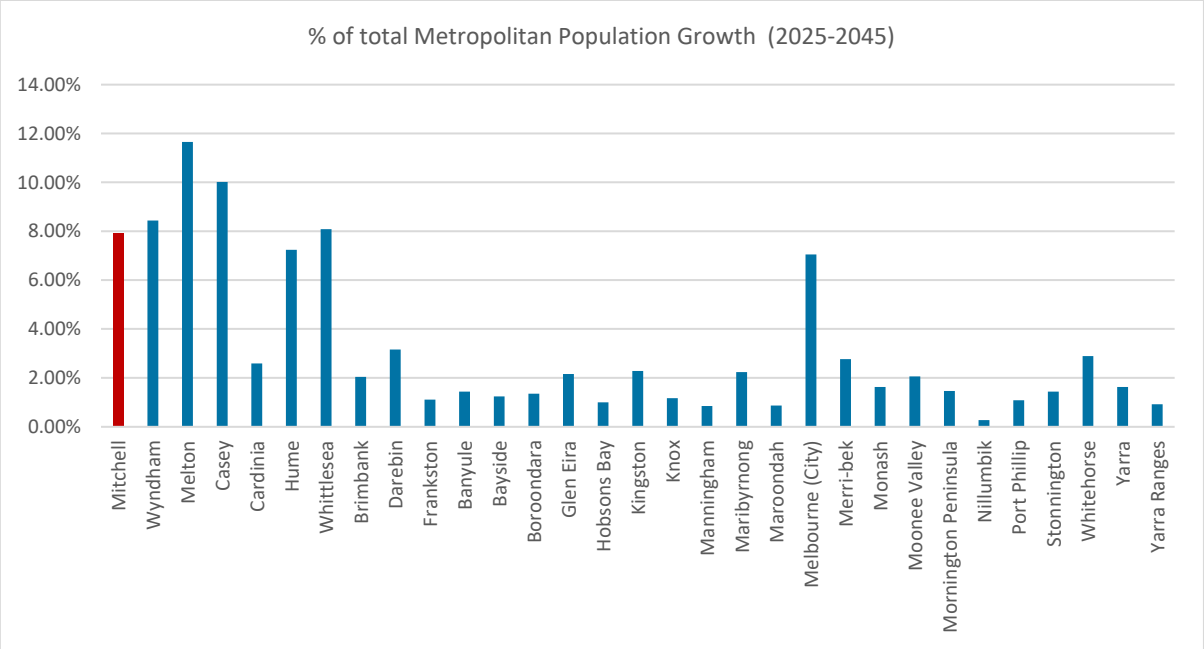

Figure 2 – Percentage of expected total Metropolitan Population Growth (2025 – 2045) (id Profile and other sources, 2025)

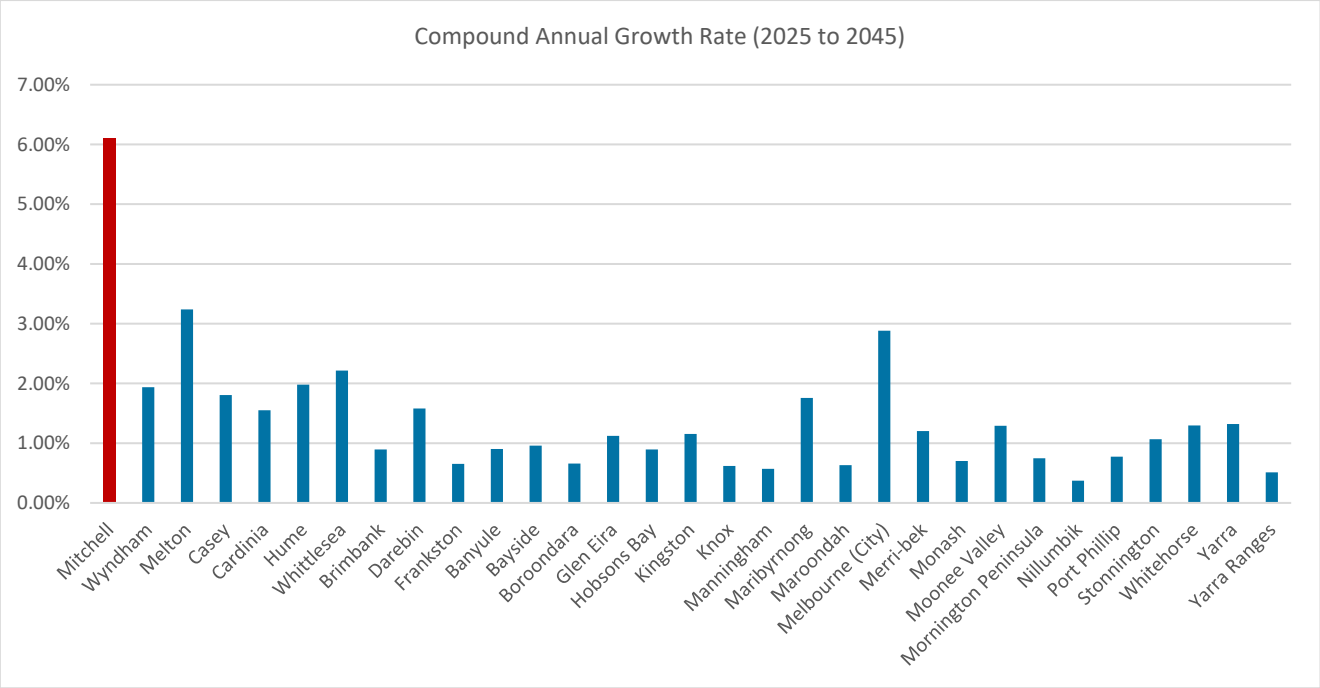

Figure 3 - Compound Annual Growth Rate - Metropolitan Councils (2025 - 2045) – (id Profile and other sources, 2025)

1. Introduction

1.1 Purpose of the Health and Human Service Gap Analysis

By 2046 the population of Mitchell Shire is forecast to grow from the current 64,175 to 221,636, an increase of over **245%**. The next highest growth rates for metropolitan councils over this period are Melton (89%), City of Melbourne (76%), Whittlesea (55%), Hume (48%), Wyndham (47%), and Casey (43%)[2].

The compound annual growth rate in Mitchell Shire over this time will be **~6.1%** compared with Melton and the City of Melbourne experiencing half the rate of growth at around 3%; Wyndham, Casey, Cardinia, Hume, Whittlesea, and Maribyrnong having a third of the rate of growth at or around 2%, and the rest of metropolitan Melbourne at 1% annual growth or below (ibid).

Over this period Mitchell Shire is expected to house to just under **8%** (one in twelve) of the anticipated total growth of metropolitan Melbourne, the majority of this in the Beveridge and Wallan areas.

The growth has already started with Wallan growing by 25% between 2021 and 2026 and Beveridge almost tripling in size over the same period.

This Health and Human Service Gap Analysis (HHSGA) aims to highlight key issues facing the Mitchell community and act as a clarion call to responsible authorities for urgent action to address and mitigate current risk and to prevent future economic and social burdens and costs.

This report provides an overview of on-ground engagement with key health and community service delivery agencies and a summary of public health and human service data and information.

1.2 Scope and Limitations

Scope

The focus of the Health and Human Service Gap Analysis is on identifying current and emerging service delivery gaps within Mitchell Shire in the context of unprecedented projected population growth. The scope of work has included review of available demographic and service data, engagement with key health and community service providers, and analysis of relevant state and regional policy frameworks. The analysis has also benchmarked Mitchell's circumstances against other growth area councils to highlight systemic inequities and structural planning challenges. The report provides initial findings and recommendations to inform Council's advocacy, planning, and partnerships, with a view to building the evidence base for long-term, sustainable solutions.

Limitations

The report has been prepared as an initial assessment and reflects both the strengths and constraints of the available information. While extensive engagement was undertaken with local service providers, data from key state and federal commissioning agencies was not available at the time of publication.

Requests were made to access relevant State Government datasets; however, these were not available within the timeframe for finalising this report. Findings are based on the best available data at the time of publication.

[2] Various sources: id.Profile and other LGA population projections

1.3 Methodology

The Health and Human Services Gap Analysis has been developed using a mixed-method approach, combining quantitative data analysis with qualitative engagement. Demographic and service utilisation data was sourced from publicly available datasets, including ABS population forecasts, health workforce statistics, NDIS expenditure data, and the RMIT Urban Observatory liveability indicators. Comparative analysis with other growth area councils was undertaken to situate Mitchell Shire's circumstances within a broader metropolitan and regional context. This ensured that findings reflected not only local realities but also systemic challenges affecting growth corridors more generally.

In parallel, targeted consultations were conducted with key health and community service providers across Mitchell Shire, including hospitals, primary health networks, disability providers, family support agencies, and local non-government organisations. These discussions explored on-the-ground experiences of service demand, workforce challenges, infrastructure constraints, and systemic barriers to access. The combination of data analysis and provider insights enabled a more nuanced understanding of both quantitative shortfalls and qualitative impacts on residents. Findings were then synthesised into observations and recommendations designed to inform Council's advocacy and planning.

2. The challenge

2.1 Mitchell Shire Council

Mitchell Shire is unique and faces distinct challenges to every other metropolitan council, because of its peri-urban location it is being asked to incorporate very significant growth in its southern region whilst continuing to provide services and assets to a vast rural area in the north (see Fig.4 below).

The ability of Mitchell to deliver on its aspirations of building a resilient and liveable community is linked to:

- Its own financial sustainability and capacity to deliver assets and services that are responsive to growing demand and needs – something that it is aware of and particularly good at planning, and
- Other levels of government living up to their obligations and accountabilities to effectively plan for population growth and provision of basic services and programs to new communities.

Mitchell Shire is a growth area council emerging from its early-stage development and faces a triple threat or challenge:

- Renewing and maintaining services to an existing population and extensive asset base over a vast geographic area,
- Engaging and managing strategic land use planning challenges and significant unconstrained housing development across multiple growth fronts, and
- Building organisational service capability and assets and infrastructure for future communities.

All Victorian councils have operated within an increasingly constrained financial environment over the past two decades. The introduction of a system of rate capping in Victoria in 2015 has additionally enforced an artificial efficiency mechanism that has resulted in the main source of self-generated income increasing at a much lower rate than actual costs.

Figure 4 below demonstrates the relative growth of Mitchell and Victoria with 2021 populations used to generate the starting index of 100.

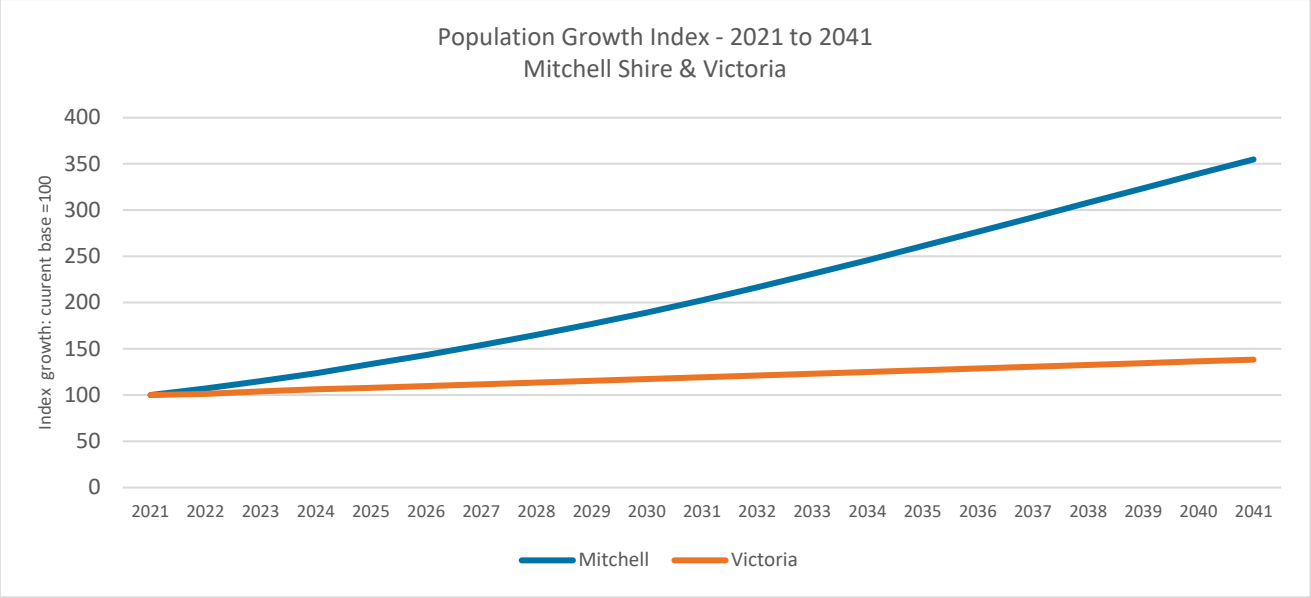

Figure 4 - Population Growth Index - *Mitchell Shire cf. Victoria (id Profile and Victoria in Future)*

Policy decisions and changes initiated by state and federal governments have not considered the significant financial and social impacts on local government, which, due to limited resources and resilience, are unable to effectively absorb the impact.

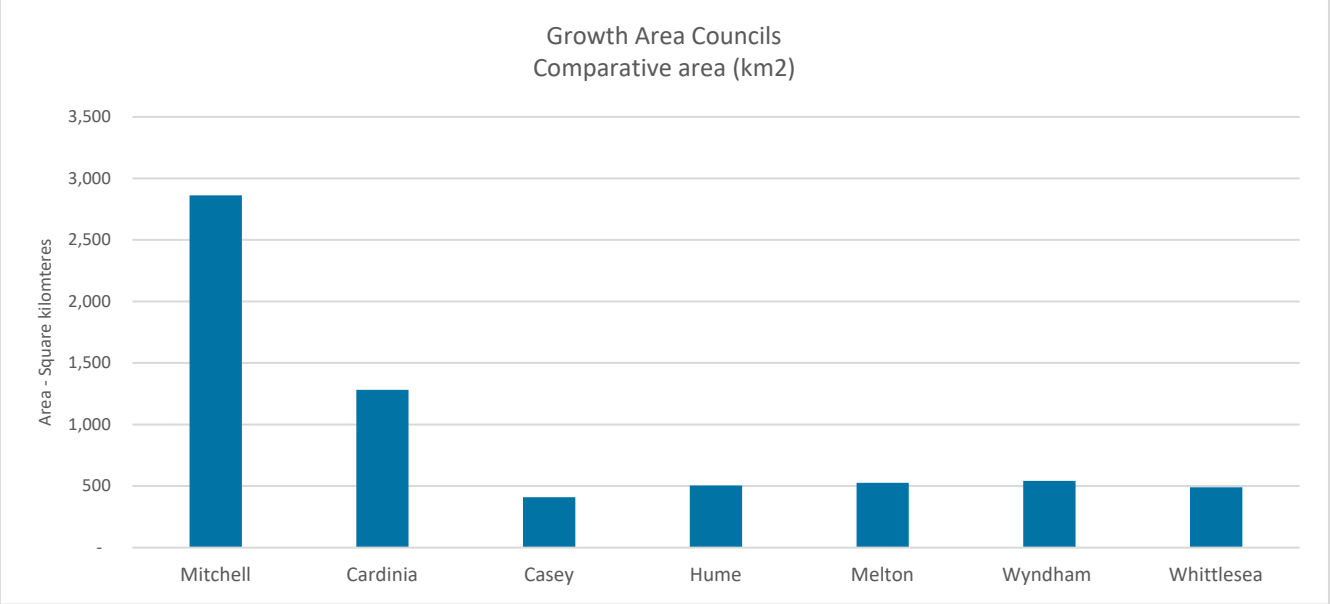

Figure 5 - Comparative area (km2) - Growth area councils (DHHS LGA Profile)

At the same time, external sources of funding for major assets, infrastructure, and services have become less predictable, more competitive, and therefore less certain. Indexation of core financial assistance grants from the Federal government were frozen for three years from 2017 creating a significant financial black hole for local government.

Revenue generated through growth and development activities are beneficial but come with additional risks, including the requirement to deliver the assets, infrastructure, and services many years before the developer contributions (that do not fully cover the costs of development let alone operation) are received.

LGAs with relatively low population and large geographic areas (such as Mitchell Shire, refer Figure 5 above) are unable to maintain expenditure levels on core asset maintenance and renewal functions as well as provide important quality services to their communities. For Mitchell Shire this is compounded as it has high demands for both legacy asset renewal plus development of new assets for future population settlements.

2.2 The growth journey

All growth areas experience a very similar pattern of evolution, the early years of growth are usually very painful, and the scale of local government operations is vulnerable to shock and impact.

The former Mitchell Shire CEO, David Turnbull (deceased), had decades of experience working in growth areas (including CEO of the City of Whittlesea) and he expressed his insights and thoughts in the diagram at Figure 6 below. This diagram indicates that all growth areas require additional support and investment at the beginning of their growth cycle, but Mitchell Shire is in a more difficult position because of its starting point of low levels of reserves (both cash and land) and the last decade of constrained income due to the state-policy of rate capping.

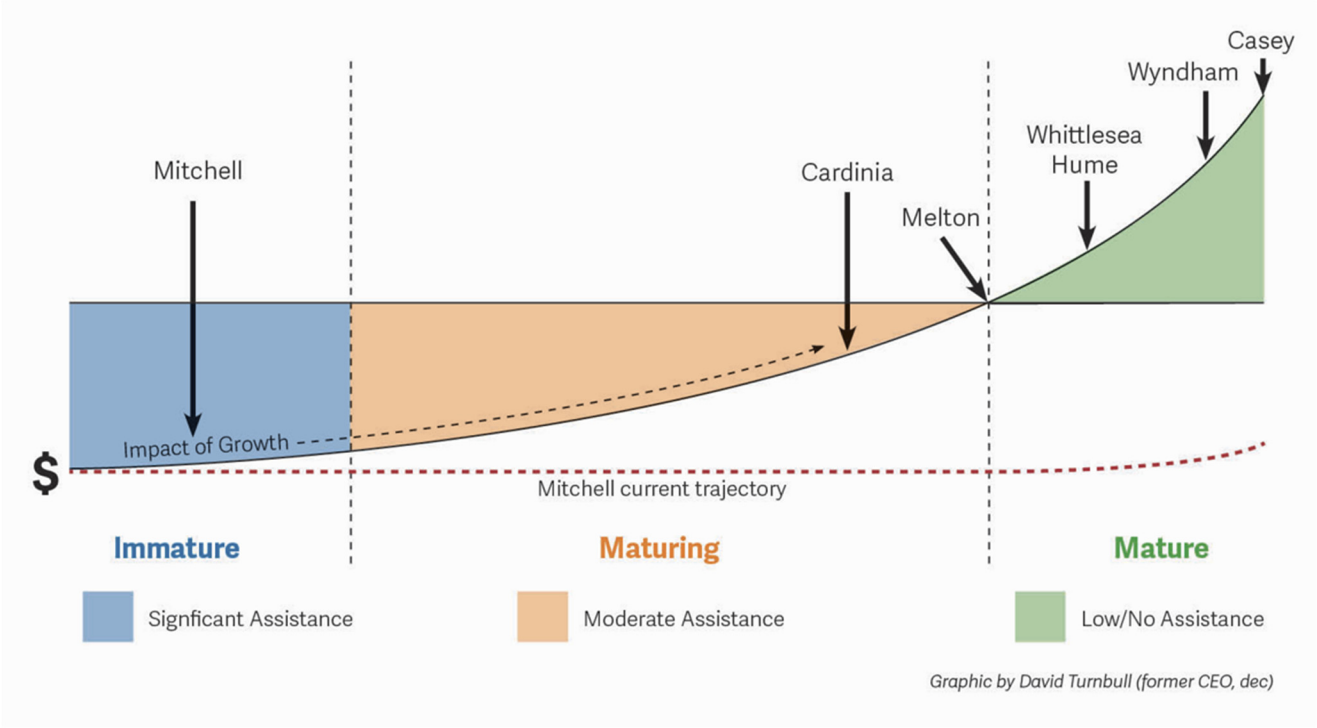

Figure 6 - Growth continuum – Graphic by David Turnbull (former CEO, dec.)

Mitchell Shire faces a difficult 20-25 years before it reaches a breakeven stage in its growth cycle, there will be a time where economies of scale and operating size will allow Council to operate effectively with self-generated income. Until this time, Mitchell Shire will require additional targeted assistance if it is to avoid significant social and economic cost to itself and other levels of government.

Observation 1 Split between two worlds: Mitchell Shire is uniquely split between rapid suburbanisation in the south and dispersed rural communities in the north—forced to act simultaneously as a metropolitan growth area and a regional service provider. No other council in Victoria faces this duality at such scale.

Observation 2 Growth without guarantees: Mitchell Shire is planning carefully for unprecedented population growth, but its success depends on others: unless State and Federal governments identify emerging need and fund required infrastructure and services commensurate with growth, local planning alone will not deliver a resilient, liveable community.

Observation 3 Vulnerability in the early growth cycle: Mitchell Shire is in the most difficult phase of the growth cycle, where rapid population increases outpace its financial capacity. With historically low reserves and a decade of constrained rate income, the Council is more exposed than other growth areas to shocks and service gaps. Without targeted external support, Mitchell faces a prolonged 20-to-25-year period before reaching a sustainable "breakeven" stage, with significant social and economic costs likely to fall on all levels of government.

2.3 Responsibility and accountability

A critical issue in analysing gaps in service delivery within health and human services is recognising responsibility and accountability and the level of transparency into by planning by government. (Refer Table 1 below.)

Local government operates within a clear legislative framework and is required to publicly demonstrate how it plans, funds, and delivers the services within its responsibility. Councils are obligated to prepare community-facing strategies, publish annual plans and budgets, and report against service performance measures. This enables residents to see how services are performing and holds the Council accountable for delivery within its defined remit.

By contrast, state and federal government service accountability is far less transparent, despite their dominant roles in health and human service provision. For instance, general practice availability in Mitchell Shire is well below the state average, but there is no accessible process by which communities can understand how health and human service allocation decisions are made. Similarly, hospital access and funding decisions sit with the state government, yet data is typically only reported at a regional or statewide level, making it difficult for communities to track whether investment is meeting local demand.

In the case of community mental health services, frequent program changes and shifting funding streams make it hard to see how local need is being addressed. These types of decisions have profound impacts on local communities but are made through opaque processes with limited public reporting.

This imbalance places local government in a difficult position. Councils are accountable to their communities for outcomes they cannot directly influence, while state and federal governments remain insulated from the same level of scrutiny. Residents often approach council to resolve issues with GP shortages, hospital waiting times, or mental health service gaps—areas where the council has no direct authority. The absence of transparent, place-based reporting from higher levels of government undermines the ability of councils to advocate effectively and creates significant gaps in service accountability.

Domain	Lead policy	System planning and commissioning	Funding split (typical)	Delivery lead	Key governance instrument
Primary care (GP, Medicare)	Cth	Joint (PHN's with State input)	Cth 100% (benefit)	Private/NGO; Cth programs	National agreements; PHN compacts
Public hospitals and ED	Joint (national standards; state ops)	State (HHS/LHN level)	Cth ~50% / State ~50% (varies)	State	Health reform agreements; safety and quality standards
Ambulance	State	State	State (fees + grants)	State	State legislation; performance service agreements
Mental Health	Joint	Joint (Cth programs + State services)	Mixed	State + NGOs	Bilateral agreements; joint plans; suicide prevention frameworks
Aged care	Cth	Cth (market stewardship) + State interface	Cth	Non-gov providers	National Aged Care Act + regulator
Disability (NDIS and foundational supports)	Cth (NDIS)	Joint (foundational supports via States)	Cth (NDIS) + State (foundational)	Mixed	Bilateral NDIS/foundational supports plans
Early childhood education and care	Cth (fee subsidies)	Joint (State quality and preschool)	Cth (CCS) + State (preschool)	Mixed	National Quality Framework; state preschool compacts
Schools	Joint	State	Joint	State (gov schools) + non-gov	Schooling resource standards; bilateral agreements
VET/TAFE and skills	Joint	State	Joint	State + RTOs	Skills agreements; industry compacts
Housing and homeless	Joint	State (system and assets)	Joint	State + NGOs	Housing accords; homelessness action plans
Family violence, child and family services	State	State	State + Cth grants	State + NGOs	State acts; national strategies

Domain	Lead policy	System planning and commissioning	Funding split (typical)	Delivery lead	Key governance instrument
Justice and policies	State	State	State	State	State justice strategies
Transport (public)	State	State	Joint for major projects	State (operators/ contractors)	City deals; transport strategies
First Nations services and justice	Joint with community control	Joint with ACCOs	Joint	ACCOs + State	Closing the Gap partnerships

Table 1 - Government service domains - responsibility matrix

Addressing this challenge requires greater openness from state and federal agencies, with transparent data sharing, clearer delineation of responsibilities, and stronger collaboration with local government.

A consistent accountability framework across all levels of government would not only improve community trust but also ensure resources are better aligned to actual need. Local government's example—where responsibility, planning, delivery, and reporting are transparent and publicly tested—provides a model that higher levels of government should emulate to strengthen the integrity and effectiveness of health and human services in places like Mitchell Shire.

Observation 4 Accountability and opacity: Local governments plan, deliver, and report on the health and human services within their jurisdiction (such as Maternal and Child Health, immunisation, and children's services) with transparent processes and visible performance measures, allowing communities to monitor council actions. State and federal governments, which oversee most health and human service funding and provision (including GP distribution, hospitals, and mental health services), often use aggregated reporting and have less visible decision-making processes. As a result, accountability for local outcomes may be less clearly defined.

Observation 5 Growth outpacing government: Mitchell is growing faster than the systems designed to support it—State and Federal policy settings lag well behind the lived reality of new communities arriving ahead of infrastructure, services, and funding.

Observation 6 Local plans, national neglect: No amount of local planning can offset structural neglect—Mitchell's future liveability hinges not on vision, but on intergovernmental commitment to timely, fair, and sustained investment.

2.4 Structural and coordination challenges

A key issue for Mitchell Shire is that the municipality sits across planning regions which created a range of challenges for coordinated and integrated planning, these include:

- Data and evidence headaches – many datasets are published at SA3/SA4 or PHN Level, not by LGA. For Mitchell, the north and south are categorised in different regions and therefore planning and data can sometimes not consider the whole context (i.e., demand for services in the north coming from the south).
- Funding eligibility and incentive differences – programs keyed to PHN, MMM or 'regional vs metro' rules can result in Wallan and Beveridge being treated very differently to Kilmore/Seymour.
- Health system alignment problems – commissioning and partnerships differ across PHN and the new Local Health Service Networks (LHSN) structures which can result in misalignment of primary care, hospital pathways, and place-based prevention strategies in these communities.

Issues with current commissioning models

Human service commissioning models generally utilise 'unit cost capitated funding models' that work most effectively in mature high-population areas and therefore funded agencies are not incentivised to provide services into low population or growth areas during the early stage of suburb development. Common issues include:

- Providers avoid implementation risk and avoid risk associated with complexity and low service numbers
- Low scale of service operations cannot support the fixed overheads in emerging population areas
- Weighting formulas under-recognise rurality, travel-time, and complexity of populations which results in misallocation of funding
- Inability to properly project real demand in fast-growth areas leads to multi-year service shortfalls
- Under-provision is amplified where monitoring is weak and alternative providers are absent.

Because there are no local service outlets, emerging populations are forced to travel longer distances from growth areas on the perimeter of Melbourne to centrally located services. This is a major barrier to access and imposes an additional time tax on young families.

This dynamic must be countered by proactive commissioning design:

- Pair small, capitated component with block funding to build baseline capacity
- Provide minimum volume guarantees and minimum revenue floor for growing services
- Direct commissioning where market models fail
- Flexible growth area ramp-up funding to support services in emerging population areas

- Government infrastructure funding for service platforms (i.e., potentially shared service outlets with local government) that are co-developed with local government in early-stage growth areas.

Other examples of the structural challenges include:

- Primary Health Networks – Mitchell is on the boundary of Eastern Melbourne PHN and the Murray PHN
- ABS statistical regions – Mitchell straddles two SA3 regions that rollup into different SA4 regions (metro Melbourne NE vs Hume) which means that Mitchell data is often split in federal data sets.
- Education – Mitchell is included in Goulburn Region for school planning and provisioning whereas all other growth areas are included in metropolitan regions.
- Remoteness and rurality classifications (used for funding and incentives) – Mitchell is split between metro fringe and inner regional categories – these are important for GP/health workforce programs and grant eligibility.
- Employment and workforce planning regions – Workforce Australia uses Employment Regions and Mitchell Shire is aligned to NE Melbourne in the south and Goulburn Murray in the north.

Observation 7 Integrated Planning Regions: Mitchell Shire is split across multiple Victorian and Commonwealth planning regions (e.g., Hume Regional Partnership vs. metropolitan VPA growth areas; Murray Primary Health Network vs. Eastern Melbourne Primary Health Network; Melbourne Water vs. Goulburn Broken Catchment Management Authority). This means that service planning, funding eligibility, and data reporting often fall under different boundaries depending on locality. As a result, there is no single "Mitchell Shire profile" used consistently across state and federal programs.

Observation 8 Regional vs Growth: The metropolitan growth-area logic applied to Wallan and Beveridge contrasts sharply with the regional development priorities of Seymour, Kilmore and Broadford. This dual identity generates mismatched infrastructure pipelines and service delivery models, with southern communities linked to metropolitan transport, education, and housing growth agendas, while northern communities align more closely to regional health, industry and water security priorities.

2.5 Business as usual PSP planning – is it enough?

The business-as-usual PSP planning process is flawed and does not engage key agencies, when it does allocate financial resources and land for schools, parks, and community facilities, delivery often lags the rapid population growth.

In areas like Beveridge and Wallan, growth has already "outpaced infrastructure", meaning residents have arrived long before state delivered facilities are in place. For example, the plans outlined in Table 2 call for well over a dozen new government schools and numerous community centres and sports complexes but there is no mention of health and social infrastructure because the responsible departments do not participate in the PSP planning process. (Refer VPA Funded Streamlining for Growth (2023/24)).

Mitchell Shire Council has a transparent capital works program that commits it to delivery of social infrastructure it is responsible for, and despite this these projects are often delayed because of reliance on competitive external grant processes.

Health and human service social infrastructure which is the responsibility of the Victorian government is not identified in the PSPs, land is not allocated for these uses, and project funding is dependent on annual budget decisions and allocations which are opaque and can be driven by politics.

Growth Area PSP	Estimated Population	Local (Council) Infrastructure	State (Victorian Government) Infrastructure
Lockerbie North PSP (2012)	~12,400 residents (4,400 households)	2 local sports reserves; multiple community centres (Level 1–3 hubs planned)	2 new government primary schools; 1 new government secondary school 0 community and health infrastructure
Beveridge Central PSP (2018)	~10,000 residents (3,400 homes)	1 community centre (multipurpose); local parks and sports fields (land for 4 parks/sports fields)	0 new government schools in precinct (served by existing Beveridge Primary and planned Mandalay primary) 0 community and health infrastructure
Beveridge North West PSP (2025)	>47,000 residents (15,000 homes)	5 community hubs (multi-purpose centres); ~79 ha of parks and sports fields	8 new government schools (primary and secondary) 0 community and health infrastructure
Wallan South PSP (draft)	~21,700 residents (7,000 homes)	3 community centres (adjacent to new primary schools); multiple new sports reserves (active open space)	3 new government primary schools; 1 new government secondary school; 1 specialist school (planned) 0 community and health infrastructure
Wallan East PSP (Part 1) (draft) [3]	~7,000 residents (2,250 homes)	1 community centre (Level 2 multipurpose facility); local open space (sports field)	1 new government primary school; (no new secondary school – relies on Wallan Secondary College nearby) 0 community and health infrastructure

Table 2 - Listed social infrastructure – planned and current PSPs in Mitchell Shire

[3] Mitchell Shire Council, through a formal Council resolution, has endorsed Wallan East PSP (Part 1) as an employment / industrial area.

Beveridge Central PSP is a critical current case study as it is already developing rapidly without any plan for the delivery of core social or human service infrastructure. This situation is exacerbated by poor car access due to lack of state investment in critical interchanges and road upgrades.

Population Density

A key issue identified in recent years by all growth area interface councils is that the delivered population density can exceed planned population density as outlined in PSP documents by as much as 20 to 30%.

In Mitchell, most PSPs appear to be exceeding the originally planned dwelling density. Beveridge Central PSP is a clear example of this 'dwelling density creep'. Gazetted in 2018, the Beveridge Central PSP Land Budget assumed a residential development yield of 15 dwellings per hectare. This would result in 3,389 dwellings. With a population assumption of 2.8 persons per dwelling this resulted in an estimated, and planned for, population of 9,489 persons (page 13 of the PSP).

However, as the PSP has begun to develop, the yield average is closer to 20 or 21 dwellings per hectare. Even at the lower of these figures, this results in a dwelling yield of 4,519 dwellings, an increase of 1,130 dwellings. At the same time, the assumption of 2.8 persons per dwelling has been proven inaccurate with corridor figure averaging above 3.1, and often closer to 3.4 persons per dwelling. Again, assuming the lower figure of 3.1, the resulting Beveridge Central PSP population yield is 14,009 persons. This represents an increase of 4,520 persons or 48% compared to what was planned for.

Similar percentage increases are also likely to be witnessed in Donnybrook PSP, Lockerbie PSP, and Lockerbie North PSP. It is positive that the VPA has increased assumptions for the newer PSPs (Beveridge Northwest PSP, Wallan South PSP, and Wallan East PSP). However, the historical PSPs still present significant challenges. The dwelling densities, and persons per household require continued monitoring in all PSPs as any increases have significant ramifications on need and provision for almost all services.

It is key to note here that, as described above, it is not just the dwelling density increases which are having an impact, but also increases (or under-assumptions) with regards to the persons per household. As noted, combined in Beveridge Central PSP, even on the most conservative figures, the impact is an almost 50% increase in residents over planning assumptions.

Affordability pressures are creating two key dynamics which are resulting in these outcomes:

- Housing yield per hectare – original PSPs are adopted with housing yields of 17-19 blocks per hectare but delivered housing is being built on physically smaller blocks with densities of 20-22 blocks per hectare in some areas
- People per household – original PSP assumptions would have been for 1.8-1.9 persons per household, data and feedback from growth areas planners suggests that household size is growing and 2.2 – 2.4 persons per household is not unusual

Because most of the PSP planning for roads, paths, schools, and open space is based on population projections this will likely create a situation where provision standards for transport, social infrastructure, schools, and open space are under-estimated.

Considering these challenges, a special intervention or coordinated strategy is required to avoid a critical infrastructure lag in Mitchell Shire. This could mean dedicated funding programs or fast-tracked

delivery authorities to build key facilities earlier than usual. For instance, the government might establish an outer-north growth infrastructure fund to bring forward schools, or a taskforce to deliver a regional health hub and expanded public transport for Mitchell's growth areas.

Mitchell Shire's leadership have emphasised aligning growth plans with a "guaranteed infrastructure pipeline" for transport, schools and health services – essentially calling for extraordinary measures to ensure infrastructure (and services) keep pace with population growth.

Without such intervention, normal planning and funding processes will not resolve the gap between rapid population growth and the slow delivery of essential community infrastructure. A bolder, well-funded approach is needed so that these new suburbs become liveable communities rather than "housing estates waiting for schools and clinics." Only a concerted effort – beyond business-as-usual – will bridge that gap and meet the needs of Mitchell's fast-growing population.

Observation 9 Outpaced by Growth: In Beveridge and Wallan, population density and growth is much higher than planned for in PSPs and families are moving in years before promised schools, health, and community facilities—leaving new suburbs as "housing first, services later."

Observation 10 Invisible health gap: PSPs deliver parks and classrooms on paper, but health and social infrastructure is consistently missing because the responsible state departments are not at the table.

Recommendation 1 Establish a Northern Growth Infrastructure Commission: Ideally this would be a dedicated and appropriately authorised integrated (inter-governmental) planning commission established by Premier and Cabinet and the Treasurer to plan for and fund the delivery of health and human service infrastructure, schools, and public transport in Mitchell's PSP areas, ensuring facilities are developed in pace with proposed population growth.

Recommendation 2 Mandate health and social planning in PSPs: Require Victorian government departments (particularly the Departments of Health; Families, Fairness and Housing; and Justice) to participate directly in PSP development, identifying and projecting human service needs, allocating land and identifying projects for regional and local hospitals, community health centres, and social services from the outset.

2.6 Activity Centres in Mitchell Shire

Mitchell Shire's inclusion in Plan Melbourne 2017-2050 and related frameworks sets the long-term vision for the Shire.

Wallan and Beveridge in the south were brought inside Melbourne's Urban Growth Boundary meaning they will be planned as future urban communities. Wallan's town centre has been identified as a Major Activity Centre, implying it will be the location for a large expansion of retail, jobs, and services to city-like status. Kilmore and Seymour are identified as peri-urban towns with significant growth potential.

Wallan, Kilmore, and Seymour will evolve as a hierarchy of key activity centres – collectively providing jobs, services and social infrastructure for both new suburban communities and longstanding rural populations. The challenge is ensuring this planning vision is matched by timely investment in health, education and community facilities, so that Mitchell Shire's role as a vital growth corridor and regional network hub is fully realised.

Infrastructure Victoria's 30-year strategy included specific recommendations related to Mitchell Shire:

- Extending metropolitan rail services beyond Craigieburn to Beveridge by 2031, with longer-term exploration of extension to Wallan
- Reserving land for future hospital sites in the next five years
- A new TAFE campus in the Craigieburn-Wallan growth corridor to improve access to skills and training

Wallan

Wallan, in the Shire's south, is transforming from a small township into a potential city-scale hub, yet its social infrastructure is still catching up.

As part of Melbourne's outer suburbs, Wallan has rapidly expanding housing estates and a growing population but currently lacks higher-order health and education facilities. Residents rely on distant hospitals and tertiary institutions – for example, the nearest major hospital (Northern Health, Epping) is 30km away.

Planning strategies acknowledge this gap and aim to remedy it: by around 2041, the Shire's population will be large enough to support its own community public hospital, a full-service TAFE or other tertiary campus, and even a regional cultural centre, ideally anchored in Wallan.

Wallan's designation as a future Major Activity Centre means it should ultimately host many of these services. State assessments note that current medical facilities in Melbourne's northern growth corridor are "insufficient to meet the needs" of the booming population. While new primary schools, childcare centres, and a planned family and children's hub are in the pipeline for Wallan's young families, the town still awaits clear commitments on a local community health, urgent care, emergency healthcare, or higher-education hub.

Delivering these will be key to achieving the 20-minute neighbourhood ideal in Wallan and avoiding a dormitory-town outcome where people must travel long distances for work, study, and medical care.

Kilmore

Kilmore is celebrated as Mitchell's cultural and historic heart and is poised for steady growth, but it faces its own infrastructure gaps and needs a boost in services.

The Kilmore Structure Plan lays out a long-term vision for this township: it identifies enough land to accommodate a future population of over 20,000 (more than double today's residents) and even plans for a bypass to divert heavy traffic from the town centre. These measures show a commitment to sustainable growth and preserving Kilmore's village character as it expands. Kilmore already has some important facilities – notably the Kilmore District Hospital, which provides urgent care, maternity, and acute services.

However, this is a small rural hospital (around 30 acute beds with limited specialties) unlikely to cope alone with a significantly larger population. Kilmore has no government secondary school, post-secondary campus or major community hub - school leavers and jobseekers often commute out of town for TAFE courses, higher education, or vocational training.

The town's historic importance is unquestioned, but its future will depend on closing these service gaps. Upgrading health services (for instance, expanding the hospital or integrating more allied health and specialist clinics) and establishing local training or satellite tertiary facilities would greatly strengthen Kilmore's role as an activity centre. In other words, bricks-and-mortar investment in social infrastructure must keep pace with the bricks-and-mortar of new housing estates – so that Kilmore's growth is supported by accessible healthcare, community spaces, and learning opportunities for its residents.

Seymour

Seymour, at the northern end of the Shire, is emerging as a pivotal regional centre – a role it can only fulfill with sustained investment in community and health infrastructure.

Located on the Melbourne-Sydney rail line and near the Puckapunyal army base, Seymour has long served a broad hinterland, but it has lacked the scale of services found in larger regional cities. Strengthening Seymour as a true regional hub is a clear policy aim: the Mitchell planning strategy explicitly seeks to "promote and strengthen Seymour as a regional centre, and the Hume Regional Growth Plan similarly calls for bolstering employment opportunities and higher-order services in Seymour.

This vision is now starting to translate into action. A flagship project is the Seymour Community Wellbeing Hub, a multi-purpose social infrastructure development right in town. This new two-story hub will co-locate health, welfare, and learning services under one roof – including community mental health and veterans' support, a Centre Against Sexual Assault, dental and primary health clinics, as well as a modern library, learning spaces, and meeting areas.

It is essentially a one-stop shop designed so locals have "no wrong door" in accessing support. Stage One of the Wellbeing Hub has secured a $15 million federal grant (plus $2m from Council), which is a huge win for Seymour. However, further funding is needed to fully realize the project's later stages and ensure all planned services can operate at scale.

In parallel, Seymour continues to rely on Seymour Health, a small 30-bed public hospital, and a recently upgraded GOTAFE campus that offers vocational training (including a new health training facility) to local students. These are valuable assets, but as the Lower Hume regional plan warns, more will be required – both to meet local demand and to attract new residents.

Upgrading Seymour's hospital capacity, expanding its TAFE course offerings, and leveraging projects like the Community Wellbeing Hub to address gaps (in mental health, family services, etc.) are all clear investment needs. With the right support, Seymour can truly anchor the northern part of the Shire, serving as a thriving service centre for surrounding communities and complementing the growth in the Shire's south.

Observation 11 Wallan is fast-tracked as a future city-scale hub: Wallan is earmarked as a Major Activity Centre in Melbourne's northern growth corridor, but risks becoming a dormitory town without urgent investment in health and other higher-order services.

Observation 12 Kilmore's historic heart is outpacing its service base: Kilmore's population is set to more than double, yet its small rural hospital and absence of tertiary facilities leave critical infrastructure gaps that must be addressed to sustain growth.

Recommendation 3 Seymour is poised to anchor the north: With projects like the Community Wellbeing Hub and GOTAFE upgrades, Seymour can become a true regional centre, but only if hospital capacity, training pathways, and social services expand in step with policy ambitions.

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3. Previous planning, policy, initiatives, and reports

Over the past two decades, a substantial body of policy, research, and planning work has examined the challenges of providing health and human services in Victoria's growth corridors and interface councils. These initiatives—ranging from state-wide infrastructure strategies and Auditor-General's reviews to place-based liveability assessments and advocacy reports—have consistently highlighted the systemic under-provision of services in rapidly expanding peri-urban areas. For Mitchell Shire, these documents provide essential context: they demonstrate that many of the service gaps being experienced today are not new, but rather the result of long-standing structural inequities and delayed investment. This section summarises the most relevant policies and reports, drawing out key findings and recommendations that inform the current analysis and frame the urgency of addressing Mitchell's unique growth trajectory. Key issues identified across reports include:

- Persistent service lag between population growth and service provision.
- High rates of low birth weight, post-natal depression, and child protection involvement.
- Youth disadvantage: low school completion, high unemployment, drug/alcohol use, and self-harm.
- Funding models fail to recognise rapid growth or outreach costs.
- Transport barriers and dispersed populations limit access.
- Lack of real-time data and transparent service mapping for planning.
- Workforce shortages across GPs, allied health, and mental health professionals.
- Continued shortfall in infrastructure investment for early years, health, and community hubs.
- Weak cross-government coordination, with Mitchell split between PHNs and health service catchments.

3.1 Activity Centres in Mitchell Shire

Victorian policy and planning frameworks have progressively sharpened their focus on health infrastructure in growth areas. Early strategies emphasised land release and coordinated planning for new suburbs but often treated health only as an implied component of "community infrastructure."

By contrast, more recent plans and reforms — from Infrastructure Victoria's 30-Year Strategy to the Community Hospitals Program, the Royal Commission into Victoria's Mental Health, and establishment of Local Health Service Networks in 2025 — place health services at the centre of liveability, equity, and growth management. This evolution highlights a growing recognition that rapid population expansion must be matched by equally rapid investment in hospitals, community health facilities, and localised care systems.

Year	Policy/Plan	Description and Relevance
2005	A Plan for Melbourne's Growth Areas	Established Growth Areas Authority to plan new suburbs. Emphasised coordinated infrastructure in growth corridors (though health not explicitly detailed).
2008	Melbourne@5 Million	Aimed to accommodate rapid population growth; flagged need for new infrastructure in growth areas (hospitals implied as part of "community infrastructure").
2010	Urban Growth Boundary Expansion and GAIC	Brought more fringe land into development; Growth Area Infrastructure Contribution (GAIC) levy introduced to help fund state infrastructure (indirectly supporting health facility land in growth areas).
2012	Growth Corridor Plans (GAA/VPA)	High-level land use plans for four growth corridors, mapping future town centres, transport and likely health/education precincts to guide long-term development.
2014	Plan Melbourne 2014	Metropolitan strategy promoting 20-minute neighbourhoods and calling for local health services in outer suburbs. Highlighted need to integrate health facilities into new communities for liveability.
2015	Infrastructure Victoria established	Independent authority to advise on long-term infrastructure needs. Health in growth areas identified as a priority in its research.
2016	30-Year Infrastructure Strategy (IV)	Recommended planning new hospitals in high-growth corridors and improving outer-suburban service access. Informed subsequent government infrastructure plans.
2017	Plan Melbourne 2017–2050 (refresh)	Reiterated the vision for localised services. Strengthened directives for planning authorities to reserve land for health and integrate service planning with development.
2017	Statewide Health Infrastructure Plan 2017–2037	20-year DHHS plan guiding service and capital investment. Prioritized growth area needs, integration across sectors, and set initial 5-year project pipeline.
2018	Community Hospitals Program (Election Commitment)	$675m program for 10 community hospitals in major growth areas. Aimed at enhancing access and reducing pressure on big hospitals by 2024 (later delayed).
2019	Royal Commission into Victoria's Mental Health System (interim)	Exposed gaps in mental health infrastructure. Government responded with immediate funding for 170 acute mental health beds, including some in growth area hospitals, ahead of final report.
2021	Final Royal Commission into Victoria's Mental Health System Report and Reform Plan	Government pledged $3.8B to transform mental health, including new local service hubs and 500+ new beds (260 funded initially). Infrastructure projects launched for mental health in outer areas (e.g. Epping, Sunshine).
2025	Annual State Budgets	Record capital investments in health: new Footscray Hospital ($1.5B PPP), Melton Hospital (~$900M), Frankston redevelopment ($1.1B),

Year	Policy/Plan	Description and Relevance
		upgrades at Northern, Casey, Werribee, etc. Emphasis on outer metro and regional equity.
2025	Establishment of the Local Health Service Networks	On 1 July 2025, Victoria's Local Health Service Networks (Networks) were officially established. The Networks group health services within a geographical region and are responsible for supporting collaborative care for their community, as close to home as possible. There are 12 Networks across Victoria. Each Network is responsible for: ■ meeting their communities' care needs as close to home as possible ■ supporting more equitable and consistent care for patients ■ increasing consistency of quality and safety of care ■ strengthening workforce attraction, retention and support ■ delivering support services at scale

Table 3 - Key policy and planning initiatives - Victoria (2005 - 2025)

Observation 13 Planning for Growth: State policy has shifted from planning for growth to planning for services within growth. Where the 2005–2012 frameworks largely concentrated on land supply and urban form, the last decade has seen explicit commitments to hospital sites, community health hubs, and mental health infrastructure as essential pillars of suburban liveability.

Observation 14 Lagging delivery: Despite record health investment, delivery lags persist in growth corridors. Programs like the Community Hospitals initiative and major capital builds demonstrate intent, but delays, uneven roll-out, and reliance on election commitments risk leaving fast-growing communities underserved — particularly in the northern and western corridors where population growth is steepest.

3.2 Major investment decisions

Mitchell Shire sits at the heart of Melbourne's northern growth corridor, yet it remains the only growth area without good access to a major regional hospital, committed community hospital, or tertiary training facility in the current state investment pipeline. While neighbouring LGAs — Whittlesea, Hume, Melton, and Brimbank — are receiving billions in new health projects, Mitchell's residents must continue relying on small rural hospitals in Kilmore and Seymour or travel long distances to Northern or Goulburn Valley hospitals. This leaves the Shire without the service self-sufficiency needed to support its unprecedented population growth.

Without urgent, integrated planning, Mitchell risks falling further behind. Wallan and Beveridge are forecast to grow to city-like scale, yet no emergency or acute care facilities have been committed locally. Kilmore's and Seymour's small hospitals cannot absorb this demand, and gaps in higher-order education, allied health, and mental health services compound the problem. To secure a resilient, liveable future, Mitchell Shire requires a coordinated investment approach that brings health, education, and community infrastructure planning together — ensuring new communities have equitable access to the full spectrum of services, close to home.

Project	Location (Growth Area)	Type	Status/Year	Key Details	Source
Northern Hospital Expansion (Stage 1 and 2)	Epping (North) – City of Whittlesea	Major public hospital expansion (add towers, beds, theatres)	Stage 1 opened 2016; Stage 2 completed ~2021	$162.7M investment; added 128 beds (incl. ICU, cardiac) and 3 theatres. Increased Northern's capacity by ~10,000 patients/year to meet outer north demand.	VHBA Project Overview
Northern Hospital Redevelopment (Stage 3)	Epping (North)	Major hospital redevelopment (ED tower, etc.)	Construction 2025–2029	$813M project to build new ED (with peds zone) and inpatient tower. Adds ~200 treatment spaces; boosts ED throughput by 30k/year for growing northern suburbs.	Premier Media Release (2025)
Casey Hospital Expansion	Berwick (South-East) – City of Casey	Major hospital expansion	Completed 2020	$135M (approx.) to expand outer south-east's Casey Hospital. Added 128 beds, 4 theatres, 12 ICU beds. Part of plan to meet needs in Casey/Cardinia growth corridor.	VHBA / DTF project summary

Project	Location (Growth Area)	Type	Status/Year	Key Details	Source
Joan Kirner Women's and Children's Hospital	Sunshine (West) – City of Brimbank	New specialist hospital (co-located Sunshine Hospital)	Opened May 2019	$200M+ project delivered 20 birthing rooms, neonatal ICU, and 128 beds for women's/children's care in western growth region. Addresses historically low local access to maternity services.	Vic. Infrastructure Plan Update
Footscray Hospital (New)	Footscray (West – inner fringe)	New general hospital (504 beds)	Under construction, due 2025	$1.5B project (PPP). Will double capacity of old Footscray Hospital. Benefits outer west indirectly by increasing western metro health capacity. Largest health investment in Victoria to date.	Vic. Infrastructure Plan Update
Melton Hospital (New)	Cobblebank (West) – City of Melton	New general hospital (~274 beds)	Planning; Enabling works start 2023; opening ~2029	~$900M project to give fast-growing Melton area its first hospital. Includes ED, surgery, maternity. Land acquired 2021; funded 2022. Integrated in new town centre.	Government Announcements (Budget 2022–23)
Frankston Hospital Redevelopment	Frankston (Outer South)	Major hospital expansion/rebuild	Under construction (2019–2025)	$1.1B redevelopment adding 120 beds, new surgical and oncology facilities. Will serve Mornington Peninsula growth and relieve Monash/Casey. Some delays/cost increase noted.	VAGO 2025 Report
Whittlesea (Mernda) Community Hospital	Mernda (North) – City of Whittlesea	New community hospital (small hospital)	Construction complete 2024;	Part of $675–800M program for 10 community hospitals. Single-storey facility	Premier/VHBA releases

Project	Location (Growth Area)	Type	Status/Year	Key Details	Source
			opening 2025	offering urgent care, day surgery, chemo, family services. Operated by Northern Health; alleviates pressure on Northern Hospital.	
Craigieburn Community Hospital	Craigieburn (North) – City of Hume	Upgrade of community health centre to community hospital	Completed 2024 (services starting)	Expands Northern Health's Craigieburn Centre. Provides urgent care, imaging, day procedures, etc. Brings hospital-like services to Craigieburn which has grown rapidly.	Government announcement / VHBA
Sunbury Community Hospital	Sunbury (NW) – City of Hume	Upgrade of day hospital to community hospital	Under construction; due 2024	Will expand Sunbury Day Hospital into a community hospital (urgent care, day surgery, dialysis). Supports Sunbury/Bulla growth area and decongests Sunshine and Northern Hospitals.	Government announcement / VHBA
Northern Hospital Mental Health Expansion	Epping (North) – Northern Hospital campus	New acute mental health wing (30 beds)	Completed 2023	Part of $801M post-Royal Commission program adding 260 beds statewide. 30-bed unit at Northern Hospital will provide 10,900 bed-days/year for mental health patients locally. First dedicated psych beds in outer north, easing ED load.	VHBA Project Summary
Mental Health and Wellbeing Locals (multiple)	E.g. Whittlesea, Hume,	Community mental health centres	2022–2024 (rollout of first 6 locals)	New walk-in mental health hubs serving local communities (no cost). E.g. one in	Royal Commission Implementation reports

Project	Location (Growth Area)	Type	Status/Year	Key Details	Source
	Wyndham, etc.			Whittlesea LGA opened 2022. Provide counselling, early intervention, and connect to bigger services. Key Royal Commission initiative to integrate with primary care.	

Table 4 - Major health infrastructure commitments (Victoria)

Observation 15 Self-sufficiency as a goal: Mitchell Shire should not have to rely on neighbouring LGAs for health access indefinitely — achieving service self-sufficiency will require direct investment in (community) hospitals, urgent and emergency care, and workforce training facilities within the Shire itself.

Observation 16 Integrated planning is now urgent: Health, education, and human services must be planned and delivered together in Wallan, Kilmore, and Seymour to avoid a fragmented "catch-up" model that leaves residents underserviced for decades.

3.3 One Melbourne or Two (2018)

This report updated earlier research and quantified the scale of the infrastructure and service deficit across Melbourne's interface councils, including Mitchell. It found that outer-suburban growth areas had absorbed over 440,000 new residents in the prior decade and would add another 765,000 by 2031, yet investment in schools, health, transport, and community facilities had not kept pace. To meet projected demand, the report estimated that interface councils would require $11 billion in new infrastructure by 2031, including $1.58 billion for schools, $1.175 billion for health facilities, and $8.1 billion for transport upgrades. For Mitchell, these findings underlined the scale of population-driven service pressures that already outstrip available provision.

The recommendations emphasised the need to "close the gaps" and prevent a two-speed city where outer growth communities remain underserviced. Priorities included investing in local employment hubs, expanding public transport, and ensuring equitable access to schools and healthcare. The report highlighted that without urgent intervention, residents of growth councils like Mitchell would face widening disadvantage, longer commutes, and entrenched service inequity compared to metropolitan Melbourne.

3.4 Interface Councils Liveability Policy (2018)

The Liveability Policy positioned Melbourne's outer suburbs as areas of high growth and high need. It identified critical gaps in service provision across transport, healthcare, education, and employment in the 10 interface councils, with direct relevance for Mitchell. Key findings included poor access to public transport (over 40% of residents beyond a viable service), a significant jobs deficit, and below-average access to GPs and allied health. These deficits combine with high levels of mortgage and rental stress to undermine family wellbeing.

The policy called on the Victorian Government to prioritise outer-suburban liveability, aligning investment with the goals of *Plan Melbourne 2017–2050*. Recommendations included a fairer funding model to deliver schools, health facilities, and transport links in growth corridors; a stronger focus on equitable access to local employment; and recognition that interface councils like Mitchell are carrying disproportionate growth without corresponding infrastructure. For the HHSGA, the policy highlights the systemic inequities that have left Mitchell's communities underserved in essential social infrastructure.

3.5 Neighbourhood Liveability Assessment – Mitchell Shire Townships

This place-based study (RMIT University 2018) assessed the liveability of Mitchell Shire's major townships – Beveridge, Broadford, Kilmore, Seymour, and Wallan – against indicators of access to services, transport, jobs, and facilities. It found that Mitchell's growth areas, particularly Wallan and Beveridge, were rapidly urbanising but lacked access to essential infrastructure such as public transport, local jobs, health services, and tertiary education. Smaller towns like Broadford and Seymour also faced access challenges, with residents often needing to travel long distances for basic services. Overall, Mitchell's communities scored below metropolitan benchmarks for liveability, highlighting entrenched disadvantage.

The report recommended better integration of land use and transport planning, early delivery of schools, health centres, and community facilities in growth areas, and strategies to foster local employment hubs. For Mitchell, the study provided a clear evidence base for targeting investments to improve walkability, service access, and community resilience in rapidly growing townships. The findings are directly relevant to this report as they demonstrate how spatial inequities contribute to health and social gaps.

3.6 Building Resilience in New and Emerging Communities

This report (Northern Metropolitan Partnership, 2020) examined the challenges faced by new communities in Melbourne's northern growth corridor, including Mitchell. It found that rapid development often left families moving into new estates without timely access to schools, healthcare, childcare, or public transport. Residents in emerging suburbs reported long travel times to reach essential services, high dependence on cars, and limited opportunities for social connection. The report also noted limited local employment, forcing many families to commute long distances and reducing community cohesion.

Recommendations focused on early and collaborative social planning. This included delivering interim or multipurpose community hubs upfront in new estates, co-locating maternal and child health services, childcare, and social spaces, and supporting community development workers to foster local networks. For Mitchell, the report reinforced the importance of early investment in community infrastructure in new estates like Beveridge and Wallan, where population growth is outstripping social service provision.

3.7 Effectively Planning for Population Growth (2017)

The Victorian Auditor General's report reviewed how effectively agencies plan and deliver infrastructure in growth areas, including Mitchell Shire. It concluded that while precinct structure plans (PSPs) were in place, implementation was failing. There was no single agency responsible for ensuring that the infrastructure promised in PSPs – schools, health centres, transport links – was delivered on time. Coordination between departments was weak, and monitoring of delivery almost non-existent. This meant families were moving into new suburbs without the infrastructure envisaged in planning documents.

The report recommended stronger governance and accountability, including a lead entity to oversee PSP implementation, better integration of population forecasts across agencies, and regular reporting on delivery outcomes. For Mitchell, these findings confirm that planning frameworks alone will not meet community needs without systemic changes to governance and funding.

3.8 Addressing Infrastructure Inequality

Addressing Infrastructure Inequality: A Path to Equality for Melbourne's Outer Suburbs, a think-tank report (McKell Institute, 2022) analysed infrastructure distribution across Melbourne and concluded that outer growth suburbs, including Mitchell, face the greatest infrastructure deficits. It found that public transport accessibility is significantly lower in interface councils, and that outer growth communities have poorer access to health, education, and recreational facilities compared to established suburbs. The report highlighted that infrastructure inequality has direct social impacts, including longer commutes, reduced access to services, and entrenched disadvantage for lower-income families who are concentrated in outer areas.

Recommendations included prioritising infrastructure investment in outer suburbs, exploring innovative financing models such as private capital partnerships, and deploying existing project delivery expertise to growth areas once major metropolitan projects are completed. It also urged Infrastructure Victoria and the VPA to regularly measure and report on infrastructure inequality. For Mitchell, the report reinforces the case that significant structural investment is required to ensure new residents are not permanently disadvantaged compared to metropolitan peers.

3.9 Dropping Off the Edge 2021

Dropping Off the Edge 2021 (Jesuit Social Services/ University of Canberra) offers the most recent and comprehensive national snapshot of entrenched, place-based disadvantage. Drawing on 37 indicators across domains including health, economic security, education, community safety, environment, and intergenerational outcomes, the study maps where disadvantage is concentrated and persistent throughout Australia. In Victoria, just 3–5% of Statistical Areas (SA2s) account for a disproportionately high share of disadvantage across multiple measures. Indicators such as public housing prevalence, family violence exposure, long-term unemployment, and child maltreatment were notably elevated—often 2 to 3 times higher—in these areas compared to less disadvantaged locations.

The report underscores that interrelated risk factors—such as limited access to health and allied services, school retention challenges, and economic strain—reinforce each other over time, creating deeply entrenched disadvantage that is difficult to overcome. Crucially, Dropping Off the Edge emphasizes the importance of tailored, community-led, and long-term interventions to break these cycles; one-size-fits-all or short-term funding approaches are unlikely to yield lasting change.

While the report is not Mitchell Shire–specific, its methodology and findings align with local data showing high rates of housing stress, family violence, and child protection involvement—underscoring the persistent, multidimensional nature of disadvantage in places like Mitchell.

3.10 VPA Funded Streaming for Growth

The findings of the VPA-funded Streamlining for Growth (Regional Planning for Services and Infrastructure 2023/24) report highlight that Mitchell Shire is particularly exposed to the weaknesses of the current planning system. With projected population growth of more than 245% by 2046, the Shire faces a future where demand for health and human services will far exceed supply unless planning and delivery practices change. The standard PSP framework secures land for roads, open space, and some local infrastructure, but does not compel state agencies to plan or commit to health, education, or human service facilities at the pace required. As a result, new communities in Beveridge, Wallan, and Kilmore are at risk of developing without adequate community hospital access, medical and health clinics, schools, or family services, embedding disadvantage from the outset.

Mitchell is further disadvantaged by the absence of early land acquisition mechanisms and the fragmentation of planning responsibilities across state agencies. By the time land is acquired for hospitals or service hubs, prices have escalated, and optimal sites are lost, leading to higher costs and poor locations. This is compounded by underestimates of density in PSPs, meaning that service demand outstrips planning assumptions within a few years of development. Smaller councils like Mitchell also lack the resources to intervene by securing land or financing infrastructure ahead of time, leaving them dependent on state action that often lags by a decade or more.

To avoid these systemic failures, Mitchell requires a bespoke, whole-of-government approach to health and human service planning. This must include mandated participation of state agencies in PSPs, regional infrastructure planning frameworks, early land acquisition reform, and funding models that separate essential services from annual budget cycles. Without these structural changes, the Shire will face a growing gap between service need and provision, rising community disadvantage, and escalating costs to retrofit infrastructure into already established suburbs.

Observation 17 Fragmented and delayed service planning: Current PSP and state planning processes do not adequately integrate health, and human service needs assessment, service provision, and planning for supporting infrastructure. Agencies do not have mandated provision standards and often are not required to participate in PSP planning. This leads to delayed service delivery, missed opportunities for early land acquisition, and fragmented outcomes that leave new communities without essential services.

Observation 18 Exponential growth outpacing capacity: With population projected to grow by 245% by 2046, existing service models and funding frameworks will be overwhelmed. Workforce shortages, infrastructure deficits, and lack of capital commitments already place Mitchell behind peer councils, and the gap will widen without systemic reform.

Recommendation 4 Mandate state agency participation in growth planning: Require health, education, and human service agencies to be referral authorities within PSP processes, bringing forward regional service plans and securing land early for key infrastructure.

Recommendation 5 Integrated planning and delivery: Create a whole-of-government delivery framework that includes early land acquisition, indexed and expanded developer contributions, and forward capital commitments to ensure health and human services are delivered in line with population growth rather than decades behind.

3.11 Interface Councils Human Service Gap Analysis

The Interface Councils Human Service Gap Analysis was completed a decade ago, yet the core issues it identified remain highly relevant to Mitchell Shire. With population growth accelerating faster than anticipated and service delivery models struggling to adapt, it is highly likely that the situation has worsened rather than improved. In 2017, Mitchell already faced structural inequities in health and human service provision, and since then growth pressures, workforce shortages, and housing stress have only intensified.

The key issues identified then — many of which remain unresolved — included:

- Significant service under-provision in allied health (occupational therapy, psychology, physiotherapy, pharmacy), mental health, disability support, AOD services, and family violence responses.
- Over-representation in child protection, with higher-than-average reports, investigations, and substantiations.
- Housing and homelessness pressures, including limited crisis accommodation and transport barriers to access.
- A systemic funding and service distribution shortfall (estimated at ~$175m across interface councils).
- Planning and commissioning failures, with PSP and budget cycles unable to keep pace with growth.

A decade later, these issues are compounded by Mitchell's extraordinary population growth trajectory (245% projected increase by 2046), ongoing workforce shortages across health and community sectors, and rising costs of living and housing. Without structural reform in planning, funding, and delivery, Mitchell risks falling even further behind metropolitan averages, embedding cycles of disadvantage and escalating demand for crisis interventions.

Key Issue	2017 (Report Findings)	2025 (Current Likely Situation)
Service under-provision (allied health, mental health, disability, AOD, family violence)	Significant service gaps across critical areas, well below metropolitan averages.	Gaps have widened due to rapid population growth; waitlists longer, thin markets in peri-urban towns.
Child protection over-representation	Above average rates of reports, investigations, and substantiations.	Rates remain high; demand rising faster than prevention services can respond.
Housing and homelessness pressures	Limited crisis accommodation, transport barriers, housing insecurity emerging.	Crisis accommodation still minimal; rental affordability crisis has deepened, rough sleeping rising.
Funding and service distribution shortfall	Estimated ~$175m annual shortfall across interface councils.	Shortfall likely far greater given growth, inflation, and static funding models.
Planning and commissioning failures	State agencies absent from PSPs; services delivered too late and fragmented.	Systemic planning issues persist; two PHNs split Mitchell, capital investment lags, workforce shortages worsening.

Table 5 - Key policy and planning initiatives - Victoria (2005 - 2025)

3.12 Interface Councils – Supporting Interface Families (2026)

The Supporting Interface Families report highlighted that Interface Councils, including Mitchell, face systematic service and infrastructure gaps compared with metropolitan Melbourne. It found that growth areas experience a "service lag" — with health, education, family, and community services arriving years after housing developments, leaving communities without critical supports in their formative years. For Mitchell, this means that new suburbs like Wallan, Beveridge, and Kilmore have been growing rapidly but without matching investment in allied health, mental health, family support, and transport-enabled access to care.

Key issues identified included:

- Persistent service and infrastructure gaps compared with metropolitan Melbourne (health, allied health, mental health, family services).
- Service lags in growth areas: services delivered years after housing, undermining prevention and early intervention.
- Higher rates of child protection involvement and children's emotional/behavioural problems compared with metro averages.
- Low education attainment and higher financial stress (mortgage stress, low income, welfare dependence).
- Under-provision of GPs, allied health, and dental services relative to metropolitan averages.
- Weak integration between land-use planning (PSPs) and health/social service delivery.
- Over-reliance on waiting lists to manage demand; families often wait months for support.
- Lack of transparent service-level data from State Government, making planning and advocacy difficult.
- Absence of whole-of-government coordination and framework agreements for consistent service planning in growth corridors.
- Need for flexible, long-term funding models and place-based commissioning to match local realities.

The report emphasised the need for new funding and commissioning models that are flexible, place-based, and responsive to local needs. Traditional metropolitan service frameworks were seen as inadequate for peri-urban growth corridors, where higher proportions of low-income households, mortgage stress, social disadvantage, and low education attainment intersect with rapid population growth. For Mitchell, this creates unique challenges: child protection reports are significantly higher than metropolitan averages, emotional and behavioural issues among children are more prevalent, and there is lower access to GPs, allied health, and specialist services.

A further theme was the failure of integrated planning between land-use development (PSPs) and the timely delivery of social and health infrastructure. While planning for roads, utilities, and open space was strong, there was no parallel process to guarantee service provision. For Mitchell, this reinforces the mismatch between growth and services—new housing estates are built, but MCH centres, schools, clinics, crisis housing, and youth services lag years behind demand. This structural gap leads to

entrenched disadvantage and reliance on crisis services like child protection and ambulance rather than early help.

Finally, the report underscored the importance of data access and transparency. Councils lacked the ability to see where state-funded services were located or how resources were distributed. This created a blind spot in planning and advocacy. For Mitchell, having a reliable common data framework would be essential to demonstrate gaps, cost service shortfalls, and advocate for fairer resource allocation. Without it, the Shire risks remaining under-serviced despite having one of the fastest-growing populations in Victoria.

Observation 19 Persistent service lag and inequity: Despite a decade of warnings, Mitchell Shire continues to experience late delivery of health and community services in growth areas such as Wallan and Beveridge. Families move into new estates long before MCH centres, allied health, mental health, or youth services are available, embedding disadvantage and forcing reliance on crisis interventions.

Observation 20 Structural under-investment: The health and human service systemic funding shortfall identified in 2016 has not been corrected. With Mitchell's population projected to grow by 245% by 2046, the lack of indexed, place-based funding and fragmented state planning processes means gaps in allied health, mental health, housing support, and family services have widened.

Recommendation 6 Implement integrated growth area service planning: Mandate that health, education, and human service agencies are active partners in Precinct Structure Plans (PSPs), ensuring early land acquisition, service co-location, and parallel delivery of infrastructure with housing development.

Recommendation 7 Adopt place-based funding models: Move beyond annual budget allocations and legacy metro funding footprints by establishing long-term, indexed funding tied to population projections. This would enable Mitchell to build allied health, mental health, and family service capacity before communities reach crisis point.

3.13 Human Service Gaps at the Interface between urban and rural

This RMIT study from 2003 was commissioned by the Interface Human Service Directors Group and it identified structural service disadvantages for Interface councils, particularly around:

- Rapid population growth creating a lag in service provision and infrastructure.
- High numbers of young families with above-average rates of low birth weight, lower breastfeeding, and higher post-natal depression.
- Elevated child protection notifications and substantiations, showing children were at higher risk than in metropolitan areas.
- Youth vulnerabilities including lower school completion, higher youth unemployment, drug use, and self-harm.
- Funding models that lagged population growth, especially for maternal and child health, with services resourced on previous years' numbers.
- Gaps in outreach and transport, as Interface municipalities were classified "metropolitan" and denied rural loadings, despite dispersed populations and rural-like conditions.
- Proposed solutions: real-time population-based funding, service hubs/one-stop shops, outreach models, and stronger partnerships across state, local, and community agencies.

Despite being written 20 years ago, the 2003 findings echo strongly through later Interface reports:

- Service Lag and Growth Pressure – The 2016 Supporting Interface Families and 2017 Interface Health and Human Services Gap Analysis reaffirmed that services in Mitchell and other Interface areas arrive years after housing, leaving families unsupported during critical early years.
- Funding Shortfall – The 2017 analysis quantified a ~$175m annual service gap across Interface councils, showing that underinvestment persisted well beyond the warnings of 2003.
- Child Protection and Family Stress – Both older and newer reports highlighted disproportionately high rates of child protection, compounded by housing stress, family violence, and lack of early help services.
- Fragmented Planning and Commissioning – Weak coordination between state agencies, health services, and local government remains a recurring barrier.
- Workforce and Access – Shortages of GPs, allied health, and mental health staff remain critical. Thin markets and long waitlists are even more pronounced today, with peri-urban communities still underserved.

For Mitchell, the RMIT report was an early warning that has not been adequately acted upon. Population growth in Wallan, Beveridge, and Kilmore has accelerated, while service infrastructure and funding mechanisms have not kept pace.

What were once emerging vulnerabilities (child health, youth disengagement, underfunded outreach) are now entrenched structural deficits—exacerbated by affordability crises, workforce shortages, and fragmented governance across PHNs and health service networks.

Observation 21 From emerging to entrenched gaps: – In 2003, the RMIT report highlighted early warning signs: high child protection notifications, youth disadvantage, and service models unable to keep pace with rapid growth. Two decades later, these pressures have deepened into structural inequities. Current engagement confirms widening service gaps in allied health, mental health, housing, and family supports, with Mitchell now facing entrenched disadvantage rather than early stress signals.

Observation 22 Persistent planning and funding failures: The 2003 call for real-time population-based funding, early land acquisition, and integrated service hubs has not been delivered. Later Interface reports (2016–2017) and recent engagement show the same barriers: services still lag growth, funding is not indexed to demand, and fragmented planning across PHNs and health service networks continues to disadvantage Mitchell.

4 What the data says

This report includes only a limited selection of quantitative data to illustrate emerging gaps in health and human service provision within Mitchell Shire. At this stage, datasets have been confined to NDIS utilisation and liveability indicators and are intended to provide an initial snapshot rather than a comprehensive picture.

The original intention was to replicate a 2016 Service Gap Analysis Study which gained access to significant service and program data from the Department of Health and Human Services. That study benefited from political support from the office of Gavin Jennings MP, then Special Minister of State, who supported the release of data to inform a broader project focused on the interface growth area councils.

4.1 Health snapshot

Mitchell Shire Council collects a range of data on the current health status of its population, key observations from the 2024 Health Profile[4] include:

Mitchell	Indicator	Victoria
25%	Higher levels of people experiencing psychological stress	19%
25%	Women experiencing psychological stress	18%
18%	Men experiencing psychological stress	12%
14.2%	Rate of suicide per 100,000 population	9.2%
43%	Felt that they have waited too long to see a GP	33%
66.5%	Overweight	54.4%
33.2%	Obese	23%
23%	Say they cannot get to a GP	19%
13%	Have had a medical or procedure appointment cancelled	7%
27%	Have a disability	19%
22%	Do no physical activity	16%
16%	At increased risk of harm from alcohol use	13%
13%	Smoke	10%
8%	Vape	4%
43%	Consume sugar sweetened beverages daily	34%
33%	Babies partially or fully breastfed at 6 months	74%
2,371	Rate of family violence incidents per 100,000 population	1.418
25%	Have skipped a meal due to cost-of-living pressures	n/a
36%	Cannot raise $2,000 in an emergency	n/a
9.5%	Young people disengaged from employment	7.5%

[4] Mitchell Shire Council Health Profile 2024

Mitchell is entering a period of sustained growth already carrying a heavy health and wellbeing burden: on nearly every key indicator – from psychological distress and obesity to access to primary care, family violence and economic stress – the community is falling behind Victorian averages. This means Mitchell is not just growing; it is growing from a position of disadvantage, with compounding risks that demand early, targeted investment.

4.2 SEIFA Index

The Socio-Economic Indexes for Areas provides a relative ranking of disadvantage for Australia. Puckapunyal is one of the least disadvantaged towns in Australia and Seymour is in placed in the top 10% of most disadvantaged areas in Australia.

Mitchell Shire anticipates that there will be a continuing decline in the SEIFA index and other measures of vulnerability in parts of its community.

Area	2021 index	Percentile
Puckapunyal	1117.2	99
Wandong - Heathcote Junction area	1045.5	70
Beveridge	1043.0	68
Pyalong - Rural North West	1030.7	60
Rural North East	1027.9	58
Kilmore - Kilmore East	1009.6	47
Wallan	1002.6	43
Broadford area	982.8	32
Seymour	901.7	10
Mitchell Shire	999.5	42
Victoria	1010.0	48
Australia	1001.2	42

Figure 7 - SEIFA Index (id.community, 2024)

4.3 NDIS under-spend

The table at Figure 8 below summarises the annual NDIS funding allocated to participants within Mitchell Shire versus the actual amount spent to arrive at the utilisation rate per year. The utilisation rate has improved in recent years but there is a substantial gap between funding allocated and services delivered each year.

Year	Allocated Funding (A$ million)	Actual Spending (A$ million)	Underspend (A$ million)	Utilisation (% of funds spent)
2021	22.0	14.3	7.7	~65%
2022	~25.0	~17.5	~7.5	~70%
2023	~28.0	~21.0	~7.0	~75%
2024	~30%	~24.0	~6.0	~80%

Figure 8 - NDIS Plan Underspend - Mitchell Shire (NDIS, 2025)

Multiple factors are contributing to the persistent underspend:

- Thin Service Market – a primary reason is the availability of disability service providers in the area, this includes direct support workers, and the specialist allied health and other skilled professional required to provide reports to justify or maintain service provision.
- Workforce and infrastructure gaps – engagement with agencies has indicated that there are difficulties attracting and retaining disability support workers and a shortage of community health and health infrastructure and funding contributes significantly.
- Plan complexity – some underspend results from plans being too complex for families to navigate the system or fully utilise funding. The absence of coordination and navigator support in under-serviced areas has bene cited as a reason for underspend.

The impact on NDIS clients includes:

- Delayed or forgone services – in the absence of specialist allied health support a child may wait months for therapy or not receive it at all.
- Reduced choice and quality of life – under-utilisation means qualified participants are not getting the full benefit from the scheme.
- Travel and cost burdens – some families will travel outside the municipality to access services; this imposes additional costs and strains on families and clients.
- Financial strain on providers and carers – underspending can also strain the viability of local service providers which threatens the creation of a viable local market.
- Plan reductions – chronic underspend has been used a rationale for reducing plans through the review process, this can lead to unwise and sub-optimal decisions on plan spending.

4.4 Liveability scorecard

The Australian Urban Observatory Liveability Scorecard is a research-based framework for assessing the relative liveability of a municipality. It is developed by a team of researchers at the Centre for Urban Research at RMIT University. The Liveability scorecard only covers the southern 'urban' end of the municipality.

Figure 9 below gives an overview of key index results and illustrates that Mitchell has very poor ratings on most important index ratings, other key results include:

- Average distance to closest GP clinic (3.66km, 3%) – worst in metropolitan Melbourne.
- Health social infrastructure (0.7 out of 6, 6%) –worst in the metropolitan Melbourne.
- Average distance to closest playground (2.7km, 9%)
- Education social infrastructure (1.4 out of 4, 12%) – worst in metropolitan Melbourne.

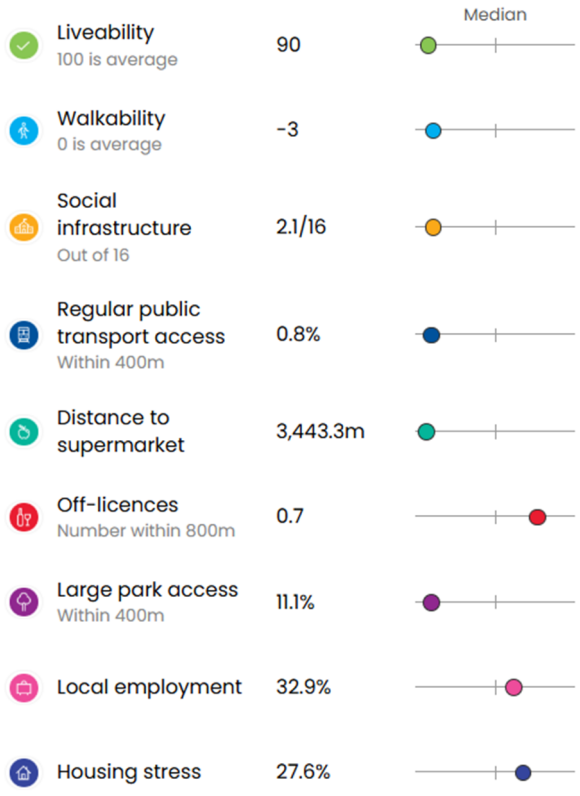
Liveability (90) – Mitchell has the lowest overall liveability index score in Melbourne. Walkability (-3) – Mitchell is amongst the lowest walkability scores in Melbourne. Social infrastructure (2.1/16) – Mitchell has the second lowest social infrastructure score, only Murrindindi is lower. Public transport access (0.8%) – Mitchell has appalling regular access to public transport, Whittlesea by comparison has 54% (5th percentile). Distance to supermarket (3.4km) – this index result is twice as high than all other Melbourne LGAs Off-licences (0.7) – Mitchell has fewer off-licence stores Large Park access (11.1%) – apart from neighbouring Murrindindi, Mitchell has the lowest rate of access to large parks in the metropolitan area. Local employment (32.9%) – car dependence and commuting to work is high in Mitchell Shire. Housing stress (27.6%) – this indicator in on the 62nd percentile indicating that this is an emerging problem.	

Figure 9 - Urban Observatory - Key Indicators

4.5 Median Wait Time – Northern Health

A key issue identified through consultation was the overwhelming demand on all elements of the health service system, and the consequential waiting time for appointments. The following graphs depicting median waiting time for Northern Health across several specialist services were drawn from the Victorian Agency for Health Information in November 2025.

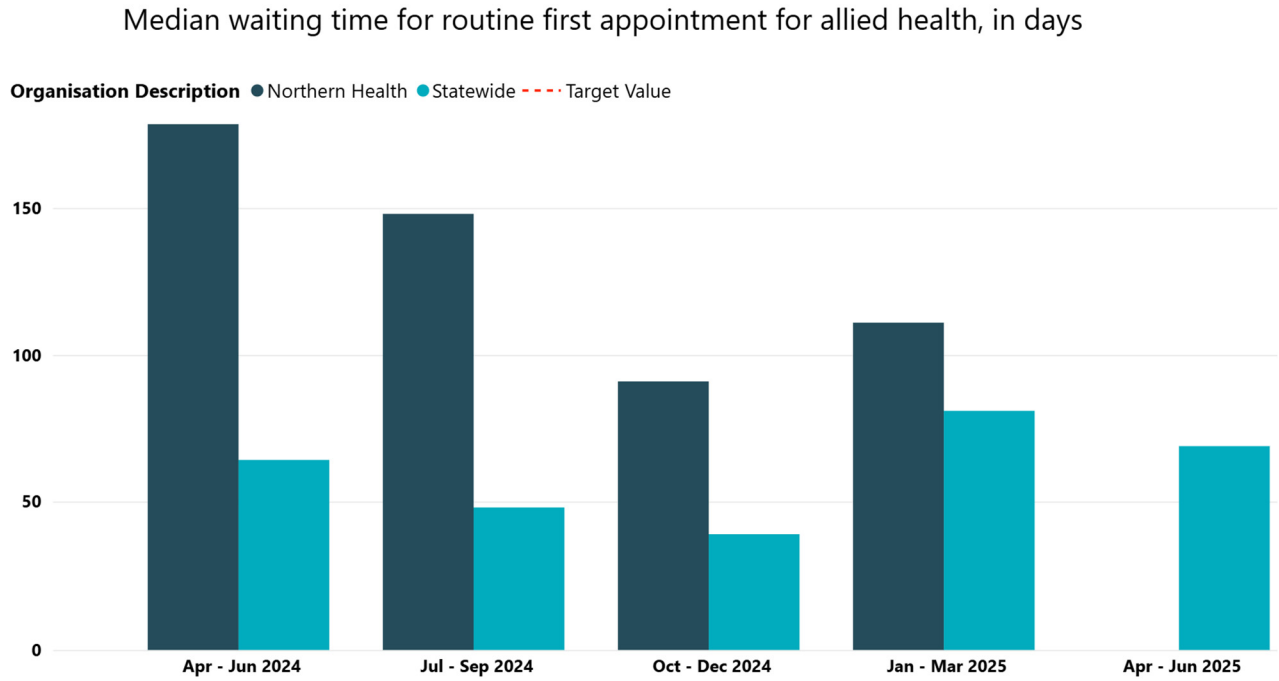


Figure 10 - Median waiting times – allied health (2025)

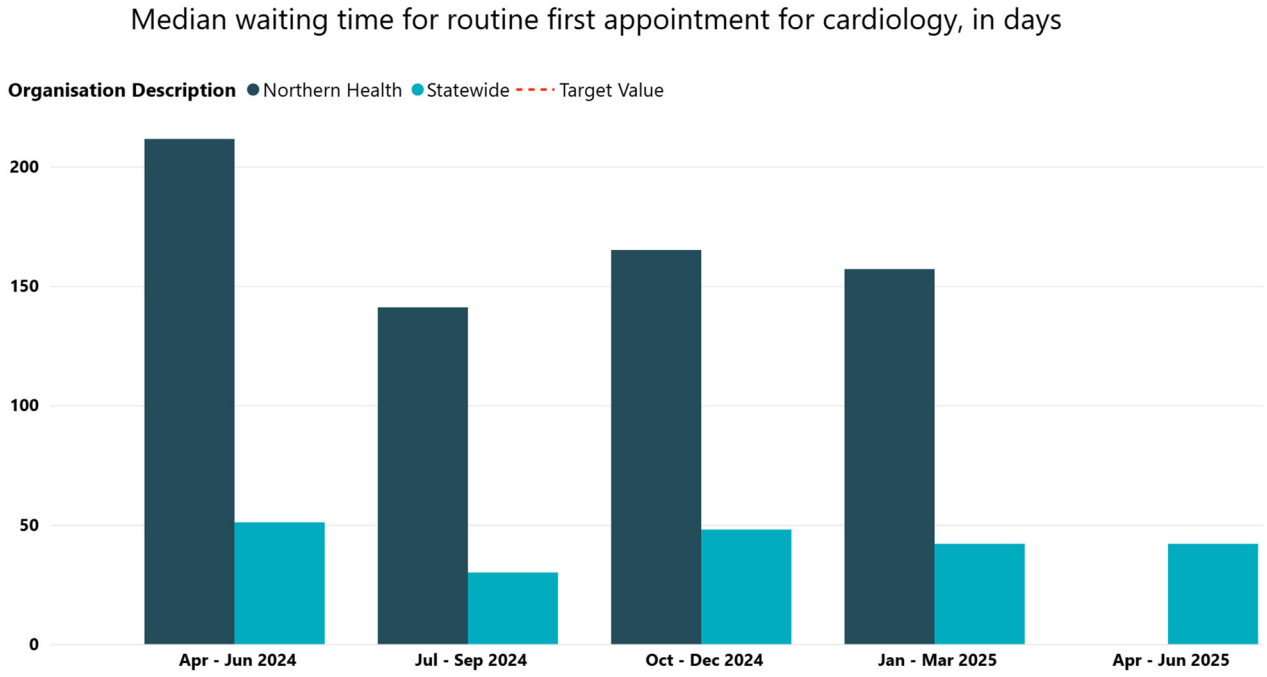


Figure 11 - Median waiting times – cardiology (2025)

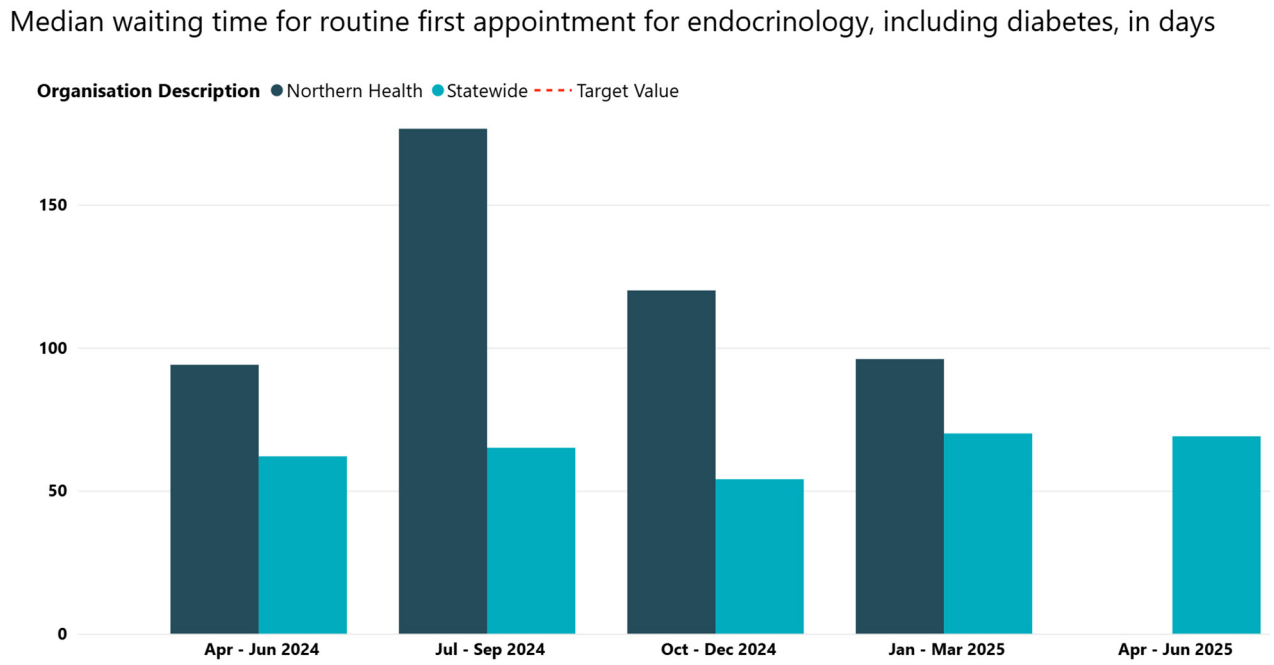


Figure 12 - Median waiting times – endocrinology (2025)

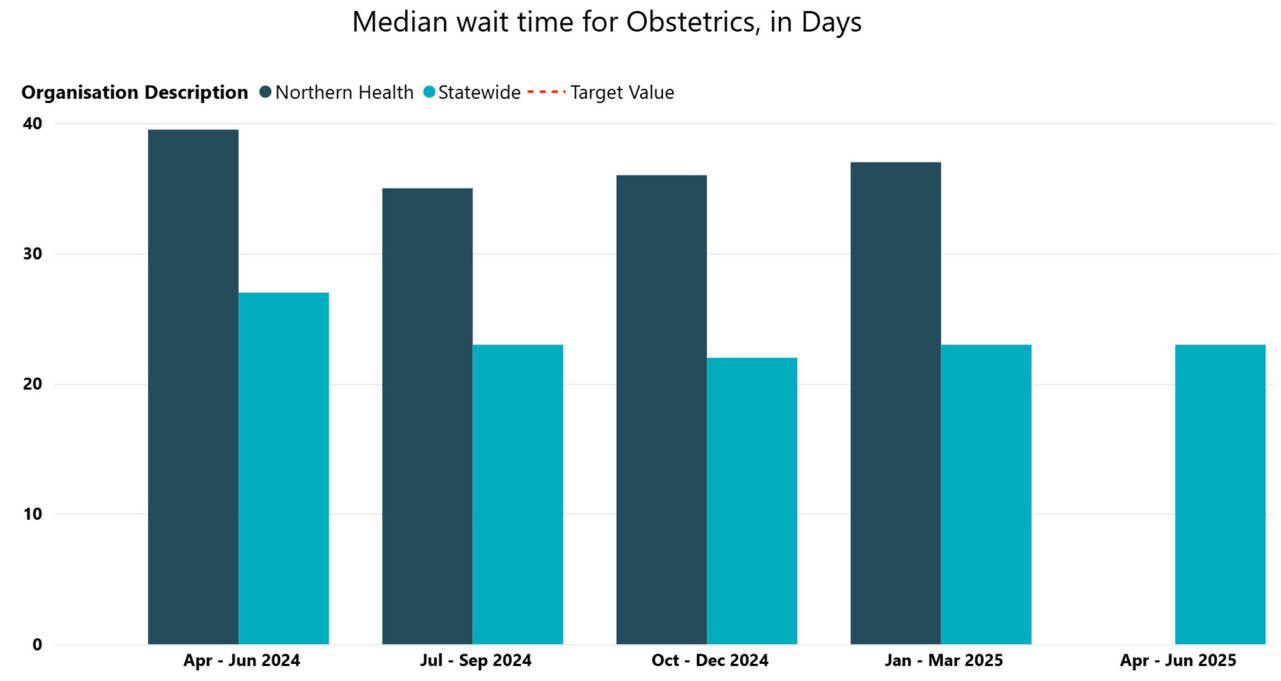


Figure 13 - Median waiting times – obstetrics (2025)

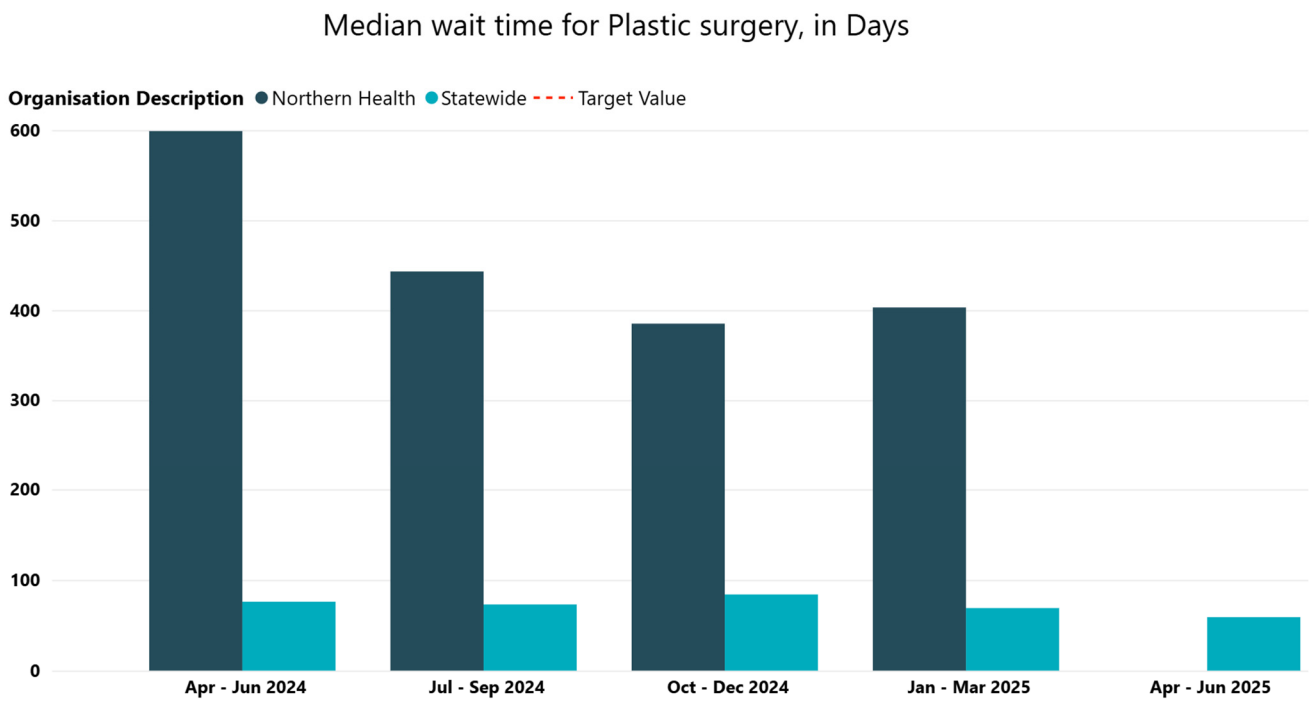


Figure 14 - Median waiting time – plastic surgery (2025)

5 Findings from engagement

The engagement process formed a critical component of this report, providing direct insights from the health, community, and social service organisations working on the ground in Mitchell Shire.

While quantitative data highlights the scale of growth and service shortfalls, it is through the experiences of providers that the practical impacts of these gaps are most clearly understood. Consultations were undertaken with a broad cross-section of agencies – including hospitals, primary health networks, disability providers, legal and housing services, and local community organisations – to capture a comprehensive view of current challenges, strengths, and opportunities.

Agencies engaged in the process included:

- Kids First, Wallan
- Mitchell Shire Council, Maternal and Child Health Team
- Our Place, Seymour
- Northern Community Legal Centre, Wallan
- Primary Health Networks
    - Murray
    - Eastern Melbourne
- Northern Health
- The Bridge, Wallan and Seymour
- Ambulance Victoria
- Seymour Health
- Omnia Community Health
- Beyond Housing

Agency perspectives reveal the pressures of rapid population growth, systemic funding and workforce constraints, and the consequences for residents who face barriers in accessing timely and appropriate care. The following subsections synthesise these insights, identifying common themes across providers as well as issues specific to individual service domains.

5.1 Summary of engagement

Service Provider (by type and area)	Key Issues and Challenges	Critical Service Gaps	Systemic Risks	Strategic Directions
Early Intervention Children and Family Service (Peri-urban, north Mitchell)	■ Program sustained beyond trial but reliant on annual budget cycles ■ Insufficient staffing (2.5 FTE) for community size and need ■ Low community awareness; confusion with other intake services ■ Families face barriers: low literacy, stigma, distrust of services	■ Allied health, OT, and NDIS services mostly out of region ■ Weak integration with state child protection systems ■ Limited reach into schools and broader community networks	■ Funding discontinuity undermining program momentum and trust ■ Staff burnout from short-term contracts and under-resourcing ■ Families cycling between services without consistent support	■ Secure multi-year funding commitment ■ Scale family coaching/navigation function ■ Expand school and community partnerships ■ Address allied health and NDIS service gaps locally
Universal Family Focused Service	■ High prevalence of substance abuse; no local detox or rehabilitation ■ Structural gap between service and Medicare / hospital systems ■ No crisis brokerage for emergency food, formula, or family needs ■ Minimal staffing relative to demand	■ No aftercare pathways post-hospital for vulnerable families ■ Family planning and allied health referral pathways absent ■ Southern growth areas effectively unserviceable	■ Families falling through cracks between service, Medicare, and hospitals ■ Workforce burnout from severe under-resourcing ■ Substance abuse and family violence trends outpacing capacity	■ Establish emergency brokerage fund for immediate family needs ■ Rebuild hospital collaboration pathways (Kilmore, tertiary) ■ Expand telehealth for isolated communities ■ Increase EFT to meet growing demand

Service Provider (by type and area)	Key Issues and Challenges	Critical Service Gaps	Systemic Risks	Strategic Directions
Integrated Community Hub (Education-based, north-central Mitchell)	■ 18-month+ waitlists for speech/OT; no local psychology services ■ No integrated family violence response despite high local rates ■ Chronic poverty, generational unemployment, and substance use ■ Poor school attendance rates limiting program effectiveness	■ No local Orange Door or crisis mental health services ■ Housing shortage and transport barriers to accessing services ■ Limited support for non-traditional family structures	■ Service system unable to keep pace with demand; facilitator burnout ■ Families cycling through crisis without preventative intervention ■ Entrenched disadvantage deepening without economic pathways	■ Establish mental health and psychology services locally ■ Advocate for local Orange Door or equivalent crisis response ■ Build digital/telehealth options for speech, OT, parenting ■ Develop employment and economic participation pathways
Community Legal Centre (Peri-urban corridor)	■ Forced to turn away as many clients as are seen due to prioritisation criteria; unmet demand rising ■ Lack of tailored multicultural legal services despite population diversity ■ Resource constraints limit intensive support for complex cases ■ Youth disengagement and risk of criminalisation pathways	■ Mental health referral pathways thin; Headspace oversubscribed ■ Financial counselling integration absent ■ Housing and tenancy advocacy under-resourced	■ Service overload and reporting burdens undermining service quality ■ Housing insecurity and social isolation in peri-urban estates ■ Juvenile justice risks without early intervention for disengaged youth	■ Address workforce and triage bottlenecks ■ Develop multicultural-specific legal services ■ Integrate financial counselling into service model ■ Expand youth-focused legal education programs in schools

Service Provider (by type and area)	Key Issues and Challenges	Critical Service Gaps	Systemic Risks	Strategic Directions
Primary Health Networks (Two PHN boundaries across Mitchell)	▪ Mitchell Shire split across two PHN boundaries creating duplication and gaps ▪ Critical mental health shortfall across youth, adult, and psychosocial services ▪ Fragmented referral pathways; navigation barriers for consumers ▪ Workforce shortages across GPs, allied health, and after-hours care	▪ No coordinated cross-PHN commissioning for Mitchell ▪ Per capita model risks underfunding small but high-need populations ▪ After-hours primary care access largely absent	▪ 245% population growth by 2046 overwhelming service capacity ▪ Consumer harm from fragmented, difficult-to-navigate pathways ▪ Thin market fragility in peri-urban/rural towns	▪ Establish joint place-based commissioning for Mitchell ▪ Develop cross-PHN governance model for Mitchell-wide planning ▪ Address mental health shortfall as immediate priority ▪ Expand telehealth and nurse-led innovations for thin markets
Disability Support Organisation (NDIS, regional reach)	▪ Major workforce gaps in OT, speech, behaviour practitioners, and childhood clinicians ▪ NDIS travel funding restrictions making regional services unviable ▪ Waitlists closed for specialist services; under-12s largely unserviced ▪ Burdensome reporting/re-approval processes diverting clinician time	▪ No direct services for children under 12 ▪ Private sector reliance creating inequity for low-income families ▪ Limited ambulatory care access without private options	▪ Service delivery collapse risk without specialist clinicians ▪ Families unable to afford private sector left without support ▪ Community outmigration of skilled workers undermining local capacity	▪ Partner with universities/TAFEs to train and retain allied health graduates locally ▪ Develop child-focused programs (speech, OT, psychosocial under-12) ▪ Advocate for NDIS policy reforms on travel and plan approvals ▪ Position as place-based hub in growth corridors

Service Provider (by type and area)	Key Issues and Challenges	Critical Service Gaps	Systemic Risks	Strategic Directions
Public Hospital and Health Network (Regional acute and community)	■ Multi-day bed deficit and ED congestion at primary hospital site ■ Low local self-sufficiency; significant outflow to metropolitan hospitals ■ New infrastructure (Cloverton MAC) decades away and likely under-bedded ■ Funding limitations slowing infrastructure rollout	■ Limited specialist and sub-acute services in Mitchell catchment ■ Geographic barriers to acute care for rural and peri-urban residents ■ Integration between community health, acute, and mental health incomplete	■ 245% population growth deepening capacity crisis ■ Workforce strain outpacing service expansion ■ Ongoing metropolitan outflows undermining local hospital viability	■ Accelerate Northern Hospital expansion and capital planning ■ Develop 'care closer to home' strategies to reduce outflows ■ Strengthen partnerships with PHNs and community health ■ Expand virtual/digital care models for Mitchell catchment
Youth and Family Service (Independent Community Service Organisation, peri-urban and rural Mitchell)	■ Core funding at risk from 2026; reliance on short-term tenders and pilots ■ Limited service options for young people in rural Mitchell ■ Transport barriers (no bus links) excluding youth from services ■ Orange Door referral blockages reducing service responsiveness	■ Homelessness and housing pathways inadequate for families in transition ■ Multicultural and ATSI service provision underdeveloped ■ Small footprint limits reach compared to larger franchise organisations	■ Loss of trusted local service to larger organisations in funding competition ■ Staff retention undermined by sector instability and uncertainty ■ Program concentration in one area reducing regional reach	■ Secure longer-term funding to reduce reliance on short-term contracts ■ Explore hub co-location model to expand reach with shared resources ■ Address transport barriers as a structural access issue ■ Develop multicultural and ATSI service capacity in growth corridors

Service Provider (by type and area)	Key Issues and Challenges	Critical Service Gaps	Systemic Risks	Strategic Directions
Ambulance Service (Regional branches)	▪ High demand from chronic conditions and repeat users due to primary care gaps ▪ Ambulance becoming default entry point due to absent local alternatives ▪ Post-COVID complexity increasing workload across the network ▪ Over-reliance on distant hospital (Epping) for case transport	▪ Local GP, mental health, and community-based alternatives insufficient ▪ After-hours primary care largely absent, inflating 000 demand ▪ Preventative health programs for high-demand cohorts (CALD, ATSI, mental health) lacking	▪ Workforce fatigue and burnout from sustained high demand ▪ Rising population growth intensifying system pressure ▪ Hospital access bottlenecks creating delays and equity risks	▪ Expand virtual ED and secondary triage diversion models ▪ Strengthen local hospital utilisation (Kilmore, Seymour) ▪ Use demand data to advocate for primary and mental health investment ▪ Partner with community health on prevention for high-demand cohorts
Rural Community Hospital (Small regional, north Mitchell)	▪ GP-led hospital model under pressure; unsustainable as population grows ▪ Severe specialist and allied health workforce shortages; reliance on commuting staff ▪ Financial deficit ($1.2m last year); ongoing budget vulnerability ▪ Land-locked site restricts physical expansion	▪ No oncology services for over 10 years ▪ Limited pathology, imaging, and weekend diagnostics ▪ Non-urgent patient transport inconsistent	▪ Southern Mitchell residents bypassing Northern Hospital and overwhelming local capacity ▪ Financial instability jeopardising expansion and sustainability ▪ Infrastructure constraints preventing response to population growth	▪ Expand to 25 beds with new care model (rotating medical staff, nurse practitioners) ▪ Recruit oncology, diagnostics, and sub-acute specialists ▪ Develop back-transfer partnership with tertiary hospital ▪ Advocate for fast rail investment to improve staff recruitment

Service Provider (by type and area)	Key Issues and Challenges	Critical Service Gaps	Systemic Risks	Strategic Directions
Community Health Organisation (Primary care, regional Mitchell)	▪ Only 7–8 GPs; overseas-trained doctor restrictions limiting recruitment ▪ Allied health turnover driven by competition from private practice ▪ Block-funding not indexed for CPI or population growth ▪ Infrastructure absent in new growth areas	▪ Mental health services limited and under-resourced locally ▪ Urgent care capacity insufficient for growing population ▪ New graduate clinicians constrained in scope; supervision-intensive	▪ 250% population growth over 20 years massively outpacing capacity ▪ Funding erosion undermining long-term organisational viability ▪ Policy dependence on election outcomes for urgent care expansion	▪ Advocate for urgent care centres in growth areas ▪ Pursue policy change to relax overseas-trained doctor restrictions ▪ Diversify services and workforce pipeline through new partnerships ▪ Strengthen organisational integration and executive leadership
Housing and Homelessness Service (Mitchell, Murrindindi, Strathbogie)	▪ Only 8 staff; unable to meet rising demand across three shires ▪ 1–2 week waits for non-crisis cases undermining early intervention ▪ Limited crisis accommodation options within Mitchell Shire ▪ Client complexity increasing (intersecting mental health, AOD, family violence)	▪ Affordable housing supply critically low across the region ▪ Transport and infrastructure barriers limiting housing access ▪ Funding and referral dependency reducing operational flexibility	▪ Housing market stress increasing vulnerability across low-income families ▪ Demand growth from population expansion exceeding organisational reach ▪ Entrenched homelessness cases requiring long-term intensive support	▪ Expand workforce to meet growing demand ▪ Advocate for affordable housing, infrastructure, and transport investment ▪ Develop early intervention and wraparound supports to prevent crises ▪ Strengthen partnerships with health, AOD, and family violence services

5.2 Summary of findings

The following table summarises the key findings from engagement for health and social/community service providers in Mitchell Shire.

Domain	Health-related services	Social and community services
Workforce	Severe shortages of GPs, specialists, nurses, and allied health. Reliance on commuting staff, new graduates, and short-term contracts. Significant burnout risk.	Small teams with fragile retention compounded by short-term contracts. Competition with larger/statewide providers.
Infrastructure and access	Under-bedded hospitals with limited planned expansion. Limited urgent care, oncology, diagnostics. Ambulance often defaults to Epping Hospital. Poor referral pathways.	Few crisis housing options. Lack of integrated community hubs in growth areas. Transport barriers limit access, especially in peri-urban
System fragmentation	Split governance across planning boundaries. Poorly coordinated referral pathways. Mental health reform is slow to reach local level.	Agency bottlenecks delay family referrals. NDIS system inflexible and bureaucratic. Legal and other services overwhelmed and fragmented.
Demand and complexity	Population growth (245% by 2046) will overwhelm capacity. Higher rates of chronic illness, mental health complexity, frequent ambulance users. ATSI and CALD populations disproportionately impacted.	Escalating housing stress, family violence, youth disengagement, entrenched disadvantage. Children under 12 poorly served by mental health system. Rough sleeping becoming more complex.
Funding and sustainability	Non-indexed funding models (block, unit pricing, per capita) undermine viability. Service deficits and negative grants. Reliance on pilot/tender funding to fill gaps.	Services dependent on short-term, competitive contracts. Instability undermines workforce retention and long-term planning. Limited capacity to scale for growth. Very tight funding resources leads to constrained service provision and a demoralised workforce.
Critical issues	Workforce and infrastructure lag demand; fragmented governance prevents coordinated health system response.	Housing crisis, family violence, and youth disengagement escalating without stable, long-term community service funding.

Observation 23 Severe Workforce Fragility: Engagement highlighted that local service systems are being held together by small, overstretched teams, often reliant on commuting staff, short-term contracts, or graduate placements. This fragility creates high burnout risks and leaves essential services vulnerable to collapse if even a few staff leave.

Observation 24 Infrastructure and access bottlenecks: Hospitals are under-bedded and face physical constraints. Limited urgent care, diagnostic services, and oncology facilities at Seymour force residents to travel out of area, while ambulance services are often defaulting to Epping. Simultaneously, the lack of integrated community hubs in new growth areas and poor transport connections in peri-urban towns compound access inequities.

Observation 25 System fragmentation undermines service pathways: Providers consistently reported fragmented governance across planning regions, slow roll-out of mental health reforms, and bottlenecks in key intake systems for family violence referrals. The NDIS was described as bureaucratic and inflexible, leaving families and providers frustrated, while legal services were overwhelmed and unable to meet demand.

Observation 26 Escalating demand and complexity: Population growth, combined with high rates of chronic illness, mental health issues, housing stress, family violence, and youth disengagement, is driving escalating service demand. Aboriginal, Torres Strait Islander, and CALD communities are disproportionately affected, with children under 12 particularly poorly served by mental health and allied health systems.

Observation 27 Unstable and inadequate funding models: Non-indexed and short-term funding (block, per capita, or competitive tenders) undermines sustainability and prevents long-term workforce retention or planning. Providers reported deficits and an inability to scale up services in line with Mitchell's extraordinary growth projections.

Recommendation 8 Funding reform and sustainability: Introduce indexed, growth-responsive funding models (linked to population forecasts rather than historic usage). This would stabilise services currently undermined by non-indexed block funding and short-term tenders, particularly in mental health, family services, and housing support.

Recommendation 9 Early years and child/youth services: Prioritise investment in child and youth mental health services, maternal and child health, and early intervention programs. Engagement highlighted that children under 12 are poorly served, with families often waiting months for support. Addressing this gap early could prevent escalation into child protection.

Recommendation 10 Service integration and coordination: Develop formal cross-PHN and cross-agency governance mechanisms to overcome fragmentation. This could include shared referral pathways, data sharing agreements, and co-commissioning of local programs across Murray and Eastern Melbourne PHNs.

Recommendation 11 Transport and access equity: Alongside advocating for new local health and human service facilities and integrated transport planning to ensure communities in peri-urban towns can physically reach services. Transport barriers were repeatedly identified as a practical access constraint.

Recommendation 12 Data access and transparency: Establish a common local data framework in partnership with state agencies to improve planning and advocacy. Councils currently lack visibility of where services are funded and located, making it difficult to evidence gaps or cost service shortfalls.

Recommendation 13 Place-based service hubs in growth areas: That the Victorian government commit to the delivery of a new major regional hospital (Level 1) in the Northern Growth Corridor within a decade, and to the planning and delivery of smaller, multi-use urgent care facilities, community hospitals and hubs in Beveridge, Wallan, and Kilmore. These would potentially co-locate primary care, allied health, maternal and child health, and family services, providing “no wrong door” access and reducing reliance on fragmented referral systems.

6 Case studies

The following case studies[5] illustrate the lived experience behind Mitchell Shire's health and human service gaps, demonstrating how structural fragmentation, long waitlists, and limited local service availability translate into real impacts on children, families, and individuals.

These examples—drawn from disability support providers, community health organisations, legal services, and place-based early-years initiatives—show how workforce shortages, poor coordination across PHNs, and delayed service delivery compound vulnerability, particularly in growth-pressured communities such as Seymour, Wallan and Beveridge.

Together, the case studies provide a grounded, human-centred evidence base that reinforces the systemic issues identified throughout this report and highlights the urgent need for integrated, place-based planning and strengthened investment across Mitchell Shire.

6.1 Goulburn Options

Case One

Client	Individual – Male middle age
Service need	Allied health (OT, Mental Health, Complex support needs)
Barriers experienced	Long waiting lists and delayed care, poor referral pathways, service fragmentation, Mental Health Service vacuum (missed individual altogether), homelessness risk.
Location	Seymour
Impact	No primary carers, support worker burn-out and not enough qualifications to assist. Four months wait for OT and mental health with significant decline in cognition/capacity and high risk for losing housing.
Outcome	Ongoing: Urgent NDIS request for additional supports funded, intake complex needs initiative (still unable to fully assist), engagement of OT and mental health services.

Case Two

Client	Individual (Under 18 years old)
Service need	Service need -OT/habit coach, Speech, Psychology, Diagnostic, Behaviour Support Practitioner. Child is needing face-to-face allied health provider engagement. Telehealth is not an option and unsuccessful. There is a need for mainstream after-school and holiday programs that can support a person under-18 with complex needs and significant behaviours of concern. Mainstream provider for respite to support primary carer and maintain home stability. Grandmother is at risk of significant carer burnout.

[5] All case studies have been de-identified and approved for release by agencies.

Client	Individual (Under 18 years old)
Barriers experienced	There are minimal Allied Health providers (NDIS funding stream) available to offer face-to-face support, due to both a general shortage of providers and significant travel barriers associated with the regional location. Significant provider waitlist (mainstream and NDIS) for under 18 years old. Engagement with services is impacted by multiple barriers, including a complex home environment (the child resides with a grandparent), the presence of a complex disability, and behaviours of concern. Financial barriers and out-of-pocket expenses, combined with the limited availability of mainstream providers—particularly those accepting GP referrals—in the region, are restricting access to additional diagnostic assessments.
Location	School (inclusive education) in Seymour Home – Tallarook
Impact	Long provider waitlists delay a child's intake, which in turn postpones crucial capacity and skill development. These delays are often accompanied by a significant lack of support for families, increasing the risk of carer burnout and contributing to an unstable home environment. Significant carer burnout risk. Ongoing school attendance is reduced, with the child often sent home early due to behaviours of concern. Additionally, the child may form inappropriate relationships or friendships with peers. The child is at increased risk of future involvement with the justice system due to impaired decision-making and a lack of essential skill development, largely stemming from limited engagement with Allied Health providers. The child is at risk of school expulsion as behaviours of concern escalate with age. There is a critical need for face-to-face engagement with NDIS and mainstream supports to develop essential daily living skills. There is a significant lack of professional support to build the child's skills and capacity across all domains of everyday living. Efforts to engage with services have been unsuccessful due to a shortage of available providers in the Seymour/Tallarook region. The child is increasingly withdrawn from peer groups, demonstrating difficulty in forming friendships and experiencing reduced social engagement. The child experiences reduced social and community access, as behaviours of concern prevent participation in local activities such as sporting groups and Scouts. Attempts to support engagement have been hindered by the unavailability of suitably trained support workers with capacity.
Outcome	Unresolved – working towards. Has been waitlisted for significant periods with multiple providers both NDIS and mainstream.

Client	Individual (Under 18 years old)
	Child requires Allied Health engagement to take place within the school environment. Unable to connect with a direct support worker with skill set to support child with trauma responses and significant behaviours of concern. Unable to connect child with mainstream providers (Family Care / Bridge Youth / Orange Door) due to waitlists, do not provide service to Seymour, lives in Tallarook so outside of catchment. Carer has own barriers, and hesitant to link in with support group due to fear of judgement. The child's grandmother, who serves as the key advocate, faces barriers to engagement with the Local Area Coordinator due to the complexities of the home environment and the child's significant disabilities. She is experiencing considerable carer burnout, compounded by a lack of adequate support from both mainstream and NDIS providers

In summary:

We note there is currently a lack of coordination and the delayed provider engagement due to extensive waitlists between NDIS funded Allied Health providers and local mainstream services, leading to significant gaps in support for participants and their families.

This disconnection is worsened by the lack of navigation support between the NDIS and mainstream providers, leaving participants, nominees, and caregivers without the help they need to find and coordinate services. Long waitlists and other local barriers also make it difficult to access timely and appropriate support.

Collectively, these factors create substantial barriers to effective care, skill development, and family support which further exacerbates participants' complex needs and may contribute to increased social isolation, a loss of informal supports, increased hospital admissions / homelessness / contact with justice system.

Observation 28 Long waitlists translate directly into decline and crisis: Across multiple cases—including a middle-aged male client, the under-18 child requiring multidisciplinary allied health, and legal clients awaiting family violence case management—waitlists of 4–18 months resulted in deterioration of health, cognition, behaviour, or safety. In several instances, the delay significantly increased risk of homelessness, school disengagement, and family violence escalation.

Observation 29 Service fragmentation leaves families navigating systems alone: Case studies consistently highlight disconnected referral pathways between NDIS, mainstream allied health, schools, family violence services, and legal assistance. Participants and carers were frequently left to self-

navigate highly complex systems without adequate support, leading to missed opportunities for early intervention and compounding distress.

Observation 30 Workforce shortages create inequitable and inconsistent access: A lack of local face-to-face allied health capacity meant children and adults with complex needs could not secure regular therapy, resulting in developmental stagnation, behavioural escalation, and carer burnout. Where specialist services were co-located (e.g., Our Place Seymour), outcomes improved but demand quickly exceeded capacity.

Observation 31 Location and transport barriers remain significant access constraints: Families repeatedly faced long travel distances, poor public transport options, and cost barriers, contributing to high failure-to-attend rates for specialist appointments prior to local co-location. Peri-urban locations such as Seymour were particularly affected, reinforcing that physical proximity is a critical determinant of equitable access.

Observation 32 Escalating complexity is emerging in the absence of early support: Children showing early behavioural concerns, families experiencing violence, and individuals with compounding mental health and disability issues all demonstrated worsening outcomes when timely support was not available. In several cases, risks of justice involvement, school expulsion, homelessness, and harm increased substantially during periods of service inaccessibility.

6.2 Our Place Seymour

Our Place is a program funded by the Coleman Education Foundation operating in Seymour.

The approach is founded in research that children and families will do better when they can access high quality early learning and schooling with wraparound health and wellbeing services, enrichment and engagement activities and opportunities for further education and employment for parents and carers.

Our Place provides a Partnership Manager and two Community Facilitators to facilitate the work on site. Community Facilitators meet and greet all parents and carers as they bring their children to kindergarten, survey families and develop the program.

Most importantly all staff in the Family and Children's Centre operate on a system of warm referrals, introducing parents, carers and children to the services and professionals they need or are interested in exploring.

Our Place Seymour commenced in 2019 in the purpose-built Seymour Family and Children's Service in the grounds of Seymour College. A strategic partnership group includes representatives from key departments and service providers.

In May 2025, Kids First Australia provides 3-year-old and 4-year-old kindergarten for 66 children on site, 20 hours for 4-year-old and 15 hours for 3-year-old, with up to 25 hours for priority cohorts in 2026. There is a strong emphasis on developing Continuity of Learning for children from Kindergarten through Foundation to Year 2, and beyond.

Out of School Hours Care from 6.30 am to 6 pm is provided by Kelly Club, which has recently signed a 3 + 1 year contract extension and has begun providing remuneration to the College after the initial Department of Education funded 3-year startup.

Mitchell Shire Council Maternal and Child Health service is a mainstay service of the site having operated here since the doors opened in 2019. The Maternal and Child Health service sees about 180 clients per quarter. Council also provides immunisation and facilitated support groups for parents from the site.

Specialist Service Case Study

Prior to 2022, referrals made for specialist allied health services (Occupational Therapy and Speech Pathology) from Our Place had to travel to other Nexus Primary Health Care (now Omnia Community Health) sites at Broadford.

Failure to attend

A significant issue for families in peri-urban and growth areas is the need to travel for specialist services. Failure to attend rates for specialist allied health services prior to 2022 averaged approximately 60% due to length of travel, absence of transport and delays accessing services. Overall failure to attend rates in Australia and similar health care systems range from 10% to 25% according to studies.

Failure to attend is a key issue creating inefficiencies in the health care system leading to wasted clinical time, longer waitlists, and poorer outcomes for children and families.

Since 2022, Nexus Primary Health Care has been delivering Speech Therapy and Occupational Therapy on site. Failure to attend rates have reduced by half to approximately 30%.

Demand and waitlist

Unfortunately, due to the significant latent demand for specialist allied health services the available Nexus schedule for the Seymour-delivered program filled almost immediately and within a year the waitlist was 18 months for an appointment.

In May 2025, the waitlist was closed with no new referrals being accepted.

Internal referrals made between the Speech and OT have a wait time of 6-8 months for OT and 12-18 months for Speech.

In 2025, there are 66 children enrolled in Foundation to Year 2, based on Australian Early Development Census (AEDC) data a consulting paediatrician has estimated that around 30 children would benefit from specialist support services.

Service	2021	2022	2023	2024
Children's Occupational Therapy	14	10	21	13
Children's Speech Pathology	18	40	47	29
Total	32	50	68	42

Table 5 – Seymour-client appointments – specialist allied health

Causes and drivers of non-attendance

Multiple factors drive the failure to attend rates, these include:

- Transport and distance barriers: Difficulty in reaching the clinic is a well-documented contributor to missed appointments. Public transport options are sparse and long travel times can deter attendance.
- Socioeconomic factors and cost: Financial hardship is a major driver of non-attendance, many peri-urban communities are impacted disproportionately by cost-of-living challenges and research indicates people often forgo allied health services entirely due to cost and other financial pressures.
- Appointment scheduling and communication: Long wait times and scheduling contribute to failure to attend in community health in growth areas. Delays can cause clients to disengage or forget. Poor communication or reminder systems can further aggravate this.
- Cultural and linguistic factors: Mitchell Shire is an increasingly diverse community, and this can cause cultural barriers or lack of trust of comfort.

Conclusion

Locally delivered specialist services dramatically reduce missed appointments—cutting failure-to-attend rates in half—by removing transport, cost, and trust barriers. In growth communities like Mitchell Shire, proximity is not just convenient; it is essential for equitable access and effective early intervention.

6.3 Northern Community Legal Centre

Client	Individual
Service need	Long waiting lists and delayed care Chronic Housing Stress and Homelessness Risk
Barriers experienced	Services within Mitchell Shire are limited causing long wait times for community members accessing the services
Location	Mitchell Shire
Impact	Stacey is a single mother who has been subjected to severe and ongoing family violence from her ex-partner who has received multiple jail terms for breaches of family violence intervention orders (FVIOs). Stacey has expressed concern that police are not adequately responding to further breaches of the FVIO. Stacey was referred to Nexus Family Violence Service for family violence case management due to her urgent need for safe housing, financial assistance, safety planning and risk management; however, she was placed on a waiting list for assistance. Only through direct advocacy by Northern CLC with Nexus staff was Stacey prioritised, but even as a priority client she faced a four to six week wait for assistance from Nexus while remaining at significant risk of harm.
Outcome	Northern CLC provided Stacey with legal information about FVIO processes, possible reasons for delays and decisions in charging breaches, and guidance on registering for the Victims Register. The lawyer discussed immediate safety concerns, including her fear that the respondent knows her current location. In the interim period while waiting for family violence case-management, Northern CLC provided ongoing support and advocacy

Client	Family
Service need	Long waiting lists and delayed care
Barriers experienced	Services within Mitchell Shire for young people in the early intervention space are lacking.
Location	Mitchell Shire
Impact	Following significant family violence, Amanda separated from her partner in 2024 and is living in the family home with her child. Her former partner is pursuing property settlement proceedings, and they are in arrears on mortgage repayments. Her former partner has also threated to stop paying child support. A family violence intervention order (FVIO) has recently expired, and Amanda has ongoing safety concerns. Following exposure to family violence, her child is also displaying violent and aggressive behaviours towards her. There is minimal mental health, and disability supports available locally, and Amanda is pursuing NDIS funding to obtain more consistent care for her child. In addition, there is limited coordinated family violence case management to address both Amanda's safety needs and her child's wellbeing.
Outcome	Northern CLC has provided the Amanda with legal advice on property settlement, renewing the FVIO, and ongoing advocacy and safety planning. Northern CLC also supplied the her with information for Tuning into Teens online programs and have offered support for completing the NDIS application.

7 Consolidated observations

Observation 1 Split between two worlds: Mitchell Shire is uniquely split between rapid suburbanisation in the south and dispersed rural communities in the north, however, is forced to act simultaneously as a metropolitan growth area and a regional service provider. No other council in Victoria faces this duality at such scale.

Observation 2 Growth without guarantees: Mitchell Shire is planning carefully for unprecedented population growth, but its success depends on others: unless State and Federal governments identify emerging need and fund required infrastructure and services commensurate with growth, local planning alone will not deliver a resilient, liveable community.

Observation 3 Vulnerability in the early growth cycle: Mitchell Shire is in the most challenging phase of the growth cycle, where rapid population increases outpace its financial capacity. With historically low reserves and a decade of constrained rate income, the Council is more exposed than other growth areas to shocks and service gaps. Without targeted external support, Mitchell faces a prolonged 20 to 25-year period before reaching a sustainable "breakeven" stage, with significant social and economic costs likely to fall on all levels of government.

Observation 4 Accountability and opacity: Local governments plan, deliver, and report on the health and human services within their jurisdiction (such as Maternal and Child Health, immunisation, and children's services) with transparent processes and visible performance measures, allowing communities to monitor council actions. State and Federal governments, which oversee most health and human service funding and provision (including GP distribution, hospitals, and mental health services), often use aggregated reporting and have less visible decision-making processes. As a result, accountability for local outcomes may be less clearly defined.

Observation 5 Growth outpacing government: Mitchell is growing faster than the systems designed to support it—State and Federal policy settings lag well behind the lived reality of new communities arriving ahead of infrastructure, services, and funding.

Observation 6 Local plans, national neglect: No amount of local planning can offset structural neglect—Mitchell's future liveability hinges not on vision, but on intergovernmental commitment to timely, fair, and sustained investment.

Observation 7 Integrated Planning Regions: Mitchell Shire is split across multiple Victorian and Commonwealth planning regions (e.g., Hume Regional Partnership vs. metropolitan VPA growth areas; Murray Primary Health Network vs. Eastern Melbourne Primary Health Network; Melbourne Water vs. Goulburn Broken Catchment Management Authority). This means that service planning, funding eligibility, and data reporting often fall under different boundaries depending on locality. As a result, there is no single "Mitchell Shire profile" used consistently across state and federal programs.

Observation 8 Regional vs Growth: The metropolitan growth-area logic applied to Wallan and Beveridge contrasts sharply with the regional development priorities of Seymour, Kilmore and Broadford. This dual identity generates mismatched infrastructure pipelines and service delivery models, with southern communities linked to metropolitan transport, education, and housing growth agendas, while northern communities align more closely to regional health, industry and water security priorities.

Observation 9 Outpaced by Growth: In Beveridge and Wallan, population density and growth are both significantly higher than planned for in PSPs with families moving in years before promised schools, health, and community facilities, leaving new suburbs as "housing first, services later."

Observation 10 Invisible health gap: Precinct Structure Plans (PSP) deliver parks and classrooms on paper, but health and social infrastructure is consistently missing because the responsible state departments are not at the table.

Observation 11 Wallan is fast-tracked as a future city-scale hub: Wallan is earmarked as a Major Activity Centre in Melbourne's northern growth corridor, but risks becoming a dormitory town without urgent investment in health, education, and higher-order services.

Observation 12 Kilmore's historic heart is outpacing its service base: Kilmore's population is set to more than double, yet its small rural hospital and absence of tertiary facilities leave critical infrastructure gaps that must be addressed to sustain growth.

Observation 13 Planning for Growth: State policy has shifted from planning for growth to planning for services within growth. Where the 2005–2012 frameworks largely concentrated on land supply and urban form, the last decade has seen explicit commitments to hospital sites, community health hubs, and mental health infrastructure as essential pillars of suburban liveability.

Observation 14 Lagging delivery: Despite record health investment, delivery lags persist in growth corridors. Programs like the Community Hospitals initiative and major capital builds demonstrate intent, but delays, uneven roll-out, and reliance on election commitments risk leaving fast-growing communities underserved — particularly in the northern and western corridors where population growth is steepest.

Observation 15 Self-sufficiency as a goal: Mitchell Shire should not have to rely on neighbouring LGAs for health access indefinitely — achieving service self-sufficiency will require direct investment in (community or local) hospitals, urgent and emergency care, and workforce training facilities within the Shire itself.

Observation 16 Integrated planning is now urgent: Health, education, and human services must be planned and delivered together in Wallan, Kilmore, and Seymour to avoid a fragmented "catch-up" model that leaves residents underserviced for decades.

Observation 17 Fragmented and delayed service planning: Current PSP and state planning processes do not adequately integrate health, and human service needs assessment, service provision, and planning for supporting infrastructure. Agencies do not have mandated provision standards and often are not required to participate in PSP planning. This leads to delayed service delivery, missed opportunities for early land acquisition, and fragmented outcomes that leave new communities without essential services.

Observation 18 Exponential growth outpacing capacity: With population projected to grow by ~245% by 2046, existing service models and funding frameworks will be overwhelmed. Workforce shortages, infrastructure deficits, and lack of capital commitments already place Mitchell behind peer councils, and the gap will widen without systemic reform.

Observation 19 Persistent service lag and inequity: Despite a decade of warnings, Mitchell Shire continues to experience late delivery of health and community services in growth areas such as Wallan

and Beveridge. Families move into new estates long before Maternal and Child Health (MCH) centres, allied health, mental health, or youth services are available, embedding disadvantage and forcing reliance on crisis interventions.

Observation 20 Structural under-investment: The health and human service systemic funding shortfall identified in 2016 has not been corrected. With Mitchell's population projected to grow by 245% by 2046, the lack of indexed, place-based funding and fragmented state planning processes means gaps in allied health, mental health, housing support, and family services have widened.

Observation 21 From emerging to entrenched gaps: – In 2003, an RMIT report highlighted early warning signs: high child protection notifications, youth disadvantage, and service models unable to keep pace with rapid growth. Two decades later, these pressures have deepened into structural inequities. Current engagement confirms widening service gaps in allied health, mental health, housing, and family supports, with Mitchell now facing entrenched disadvantage rather than early stress signals.

Observation 22 Persistent planning and funding failures: The 2003 call for real-time population-based funding, early land acquisition, and integrated service hubs has not been delivered. Later Interface reports (2016–2017) and recent engagement show the same barriers: services still lag growth, funding is not indexed to demand, and fragmented planning across Primary Health Networks (PHN) and Local Health Service Networks (LHSN) continues to disadvantage Mitchell.

Observation 23 Severe Workforce Fragility: Engagement highlighted that local service systems are being held together by small, overstretched teams, often reliant on commuting staff, short-term contracts, or graduate placements. This fragility creates high burnout risks and leaves essential services (such as Beyond Housing, The Bridge, and legal assistance) vulnerable to collapse if even a few staff leave.

Observation 24 Infrastructure and access bottlenecks: Hospitals such as Seymour and Northern are under-bedded and face physical constraints (e.g., Seymour being landlocked). Limited urgent care, diagnostic services, and oncology facilities at Seymour force residents to travel out of area, while ambulance services are often defaulting to Epping. Simultaneously, the lack of integrated community hubs in new growth areas and poor transport connections in peri-urban towns compounds access inequities.

Observation 25 System fragmentation undermines service pathways: Providers consistently reported fragmented governance across Murray and Eastern PHNs, slow roll-out of mental health reforms, and bottlenecks in key systems such as The Orange Door for family violence referrals. The NDIS was described as bureaucratic and inflexible, leaving families and providers frustrated, while legal services were overwhelmed and unable to meet demand.

Observation 26 Escalating demand and complexity: Population growth, combined with high rates of chronic illness, mental health issues, housing stress, family violence, and youth disengagement, is driving escalating service demand. Aboriginal, Torres Strait Islander, and CALD communities are disproportionately affected, with children under 12 particularly poorly served by mental health and allied health systems.

Observation 27 Unstable and inadequate funding models: Non-indexed and short-term funding (block, per capita, or competitive tenders) undermines sustainability and prevents long-term workforce retention or planning. Providers reported deficits and an inability to scale up services in line with Mitchell's extraordinary growth projections.

Observation 28 Long waitlists translate directly into decline and crisis: Across multiple cases—including the middle-aged male client at Goulburn Options, the under-18 child requiring multidisciplinary allied health, and legal clients awaiting family violence case management—waitlists of 4–18 months resulted in deterioration of health, cognition, behaviour, or safety. In several instances, the delay significantly increased risk of homelessness, school disengagement, and family violence escalation.

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8 Consolidated recommendations

Recommendation 1 Establish a Northern Growth Infrastructure Commission: Ideally this would be a dedicated and appropriately authorised integrated (inter-governmental) planning commission established by Premier and Cabinet and the Treasurer to plan for and fund the delivery of health and human service infrastructure, schools, and public transport in Mitchell's PSP areas, ensuring facilities are developed in pace with proposed population growth.

Recommendation 2 Mandate health and social planning in Precinct Structure Plans: Require Victorian government departments (particularly the Departments of Health; Families, Fairness and Housing; and Justice) to participate directly in PSP development, identifying and projecting human service needs, allocating land and identifying projects for regional and local hospitals, community health centres, and social services from the outset.

Recommendation 3 Seymour is poised to anchor the north: With projects like the Community Wellbeing Hub and GOTAFE upgrades, Seymour can become a true regional centre, but only if hospital capacity, training pathways, and social services expand in step with policy ambitions.

Recommendation 4 Mandate state agency participation in growth planning: Require health, education, and human service agencies to be mandated referral authorities within PSP processes, bringing forward regional service plans and securing land early for key infrastructure.

Recommendation 5 Integrated planning and delivery: Create a whole-of-government delivery framework that includes early land acquisition, indexed and expanded developer contributions, and forward capital commitments to ensure health and human services are delivered in line with population growth rather than decades behind.

Recommendation 6 Implement integrated growth area service planning: Mandate that health, education, and human service agencies are active partners in PSPs, ensuring early land acquisition, service co-location, and parallel delivery of infrastructure with housing development.

Recommendation 7 Adopt place-based funding models: Move beyond annual budget allocations and legacy metro funding footprints by establishing long-term, indexed funding tied to population projections. This would enable Mitchell to build allied health, mental health, and family service capacity before communities reach crisis point.

Recommendation 8 Funding reform and sustainability: Introduce indexed, growth-responsive funding models (linked to population forecasts rather than historic usage). This would stabilise services currently undermined by non-indexed block funding and short-term tenders, particularly in mental health, family services, and housing support.

Recommendation 9 Early years and child/youth services: Prioritise investment in child and youth mental health services, maternal and child health, and early intervention programs. Engagement highlighted that children under 12 are poorly served, with families often waiting months for support. Addressing this gap early could prevent escalation into child protection.

Recommendation 10 Service integration and coordination: Develop formal cross-PHN and cross-agency governance mechanisms to overcome fragmentation. This could include shared referral

pathways, data sharing agreements, and co-commissioning of local programs across Murray and Eastern PHNs.

Recommendation 11 Transport and access equity: Alongside advocating for new local health and human service facilities and integrated transport planning to ensure communities in peri-urban towns can physically reach services. Transport barriers were repeatedly identified as a practical access constraint.

Recommendation 12 Data access and transparency: Establish a common local data framework in partnership with state agencies to improve planning and advocacy. Councils currently lack visibility of where services are funded and located, making it difficult to evidence gaps or cost service shortfalls.

Recommendation 13 Place-based service hubs in growth areas: That the Victorian government commit to the delivery of a new major regional hospital (Level 1) in the Northern Growth Corridor within a decade, and to the planning and delivery of smaller, multi-use urgent care facilities, community hospitals and hubs in Beveridge, Wallan, and Kilmore. These would potentially co-locate primary care, allied health, maternal and child health, and family services, providing “no wrong door” access and reducing reliance on fragmented referral systems.

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