THE INTEGRATED MENTAL HEALTH ATLAS OF THE AUSTRALIAN CAPITAL TERRITORY PRIMARY HEALTH NETWORK REGION

2016

phn ACT
An Australian Government Initiative

Capital Health Network
ACT's primary health network

Australian National University

UNIVERSIDAD LOYOLA ANDALUCÍA

PSI•COST
ASOCIACION CIENTIFICA

AUTHORS

AUSTRALIAN NATIONAL UNIVERSITY
PROF. LUIS SALVADOR-CARULLA (CHIEF INVESTIGATOR-HEAD OF THE PROJECT)
MS. MARYANNE COURTENAY FURST (RESEARCH ASSISTANT)
DR.NASSER BAGHERI
DR.MICHELLE BANFIELD

UNIVERSIDAD LOYOLA ANDALUCÍA SPAIN)
DR. JOSE-A. SALINAS-PEREZ (GEOGRAPHICAL INFORMATION SYSTEMS)

ACT PRIMARY HEALTH NETWORK
MS. LAUREN ANTHES

ACT HEALTH- MENTAL HEALTH, JUSTICE HEALTH, ALCOHOL AND DRUG SERVICES
MR. BRUNO ALOISI

DOI:

ISBN:

ACKNOWLEDGMENTS

We are grateful to all the service providers who participated in this study. We want to thank all the Steering Committee members who have helped us to contact the services and understand the territory: Julie Porritt, Bruno Aloisi, Carrie Fowlie, Simon Vierick, Richard Bromhead, Jill Hughes, Lauren Anthes, Prudence Spence, Jackie Brooker. We would like to acknowledge the collaboration of Dr Tianxi Xu (University of Sydney), and A/Prof James Gillespie (Menzies Centre for Health Policy,University of Sydney) and the international collaboration of the Psicost Scientific Association and Universidad Loyola Andalucia (Spain)

SUGGESTED CITATION

Furst, M.C., Salinas-Perez, J.A., Anthes,L.,Bagheri,N.,Banfield,M.,Aloisi,B., Salvador-Carulla, L. (2018). *The Integrated Mental Health Atlas of the Australian Capital Territory Primary Health Network Region*. Centre for Mental Health Research, Australian National University

TABLE OF CONTENTS

INDEX OF TABLES

INDEX OF FIGURES

ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ACT PHN	Australian Capital Territory Primary Health Network
ADC	Acute Day Care
AOD	Alcohol and other drugs
ARIA	Accessibility/Remoteness Index of Australia
ATAPS	Access to Allied Psychological Services
AW	Aboriginal Worker
BSIC	Basic Stable Inputs of Care
CALD	Culturally and Linguistically Diverse
CCG	Clinical Commission Groups
CCM	Clinical Case Manager
CHN	Capital Health Network
CESPHN	Central and Eastern Sydney Primary Health Network
DESDE- LTC	Description and Evaluation of Services and Directories in Europe for Long-Term Care
GIS	Geographical Information System
HASI	Housing and Accommodation Support Initiative
IN	Aboriginal and Torres Strait Islander peoples
ICF	International Classification of Functioning
IRSD	Index of Relative Socio-Economic Disadvantage
LGA	Local Government Area
LHD	Local Health District
LTC	Long Term Care
MHN	Mental Health Nurse
MHNIP	Mental Health Nurse Incentive Program
NA	Not Available at the Time of Publication
NGO	Non-Governmental Organisation
NDIS	National Disability Insurance Scheme
NHSD	National Health Services Directory
NICE	National Institute for Health and Care Excellence
NSW	New South Wales

OT	Occupational Therapist
PARC	Prevention and Recovery Care
PC	Primary Care
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PIR	Partners In Recovery
PW	Peer Worker
SA1	Statistical area 1
SF	Support Facilitator
SLA	Statistical Local Area
SW	Social Worker
TAMHSS	Transforming Australia's Mental Health Service Systems
WHO	World Health Organisation

A note on the language

The language used in some of the service categories mapped in this report e.g. outpatient-clinical, outpatient-social, day hospital is not aligned with the most recent advances in the terminology of community mental health care and recovery-oriented support. However, these terms are employed for international comparability following a standard glossary of terms and classification of services. This terminology is not intended to replace the current terms used for naming and understanding service provision in this region. The actual name of the services is provided together with the assigned international code using the "Description and Evaluation of Services and Directories in Europe for long- term care" model (DESDE-LTC).

EXECUTIVE SUMMARY

The 2014 *National Review of Mental Health Programmes and Services* by the National Mental Health Commission drew attention to the need for local planning of care for people with a lived experience of mental illness in Australia, and to the relevance of a bottom-up approach to understanding "services available locally [in] the development of national policy" (National Mental Health Commission, 2014). It also called for responsiveness to the diverse local needs of different communities across Australia. In its response to this review, the Australian Government prioritised integrated regional planning and service delivery, and the development of a stepped model of care: a model predicated on the availability to consumers of a mental health care system characterised by a broad range of different types of services at several levels of need (Australian Government Department of Health, 2015). Integrated regional planning and service delivery is a focus of the Fifth National Mental Health and Suicide Plan, which "commits all governments to work together to achieve integration in planning and service delivery at a regional level" and "recognises that PHNs and LHNs provide the core architecture to support integration at the regional level" (Health, 2017).

The Primary Health Network (PHN) operating in the Australian Capital Territory (ACT), the Capital Health Network, has a vision for person-centred and integrated health and social care, with clear health pathways. This aligns with the national plan, as well as with the key Primary Health Network objectives set out by the Commonwealth Government of increasing effectiveness and efficiency, and improving co-ordination of care (Capital Health Network, 2015). The ACT government has embarked on whole-of-system agendas which include a focus on joined up support between sectors, reducing duplication, and improving access in government service delivery (Capital Health Network, 2015). The ACT PHN has committed to "responding to the needs and priorities of the local community by commissioning programs and services that fill service gaps and provide integrated care solutions to some of our most vexing health and social care challenges" (Capital Health Network, 2015). Areas of focus include "achieving system integration through new or strengthened models of care, enhanced and information technology (IT) enabled health pathways and inter-professional collaboration tailored to the needs of the individual" (Capital Health Network, 2015). In mental healthcare, the ACT PHN acknowledges the importance of "a focus on ensuring regional needs are met" and of "integrated, more accessible and equitable primary mental health care services" (ACT PHN, 2016). It aims to develop a primary mental health stepped care model which is well integrated, and which meets local needs (ACT PHN, 2016).

The Integrated Mental Health Atlas of the ACT PHN region aligns with these objectives. The Atlas is the region's first inventory of available services specifically targeted for people with a lived experience of mental illness, from which it will be possible to derive

benchmarks and comparisons with regions of NSW and elsewhere which have been similarly mapped. This will inform service planning and the allocation of resources. It is a tool for evidence-informed planning that critically analyses the pattern of mental health care provided within the boundaries of the ACT PHN region. The Atlas revealed major differences between the provision of mental health care in the ACT PHN region and other regions and countries. These are:

1) the good availability of inpatient acute care and outpatient care;
2) a comparative lack of services providing acute day care and non-acute day care (i.e. day centres providing structured activities to promote health and social inclusion); and
3) a lack of specific employment services for people with a lived experience of mental illness.

Taken together, the information in this Atlas highlights key areas for consideration for future planning for the provision of mental health services in the ACT PHN region. The findings also mirror some of the issues raised more broadly by the National Mental Health Commission's 2014 Review.

To conduct this mapping, we used a standard classification system, the "*Description and Evaluation of Services and Directories in Europe for long-term care"* model (DESDE-LTC)(Salvador-Carulla et al., 2013), to describe and classify the services; as well as geographical information systems to geo-locate the services.

Utilisation of the DESDE-LTC tool, a system widely used in Europe, has enabled a more robust understanding of what services actually provide, and will enable planners to make comparisons across areas and regions.

1. FRAMEWORK

The Integrated Mental Health Atlas of the ACT PHN region provides information on all services specifically for people with a lived experience of mental illness in the ACT PHN region. It includes health, social, home, education, employment and justice services. The Atlas does not map all the services used by people with a lived experience of mental illness: for example primary care, fee-for-service care, or services designed primarily for other target groups, such as people who are homeless, or who have an intellectual disability. Although very relevant, these services fall outside the scope of the ACT PHN commissioned project.

1.1. PRIMARY HEALTH NETWORKS IN AUSTRALIA

Primary Health Networks were established in 2015 as key components of primary health care reform. PHNs are tasked with increasing the efficiency and effectiveness of services, and improving co-ordination of care "to ensure patients receive the right care in the right place at the right time", through an analysis of local need and identification of available services and gaps in service delivery (Department of Health, 2016c).

Funding for PHNs is based on a number of elements, including population, rurality and socio-economic factors. In addition, funding has been specifically provided to PHNs for mental health, suicide prevention, drug and alcohol treatment services, and Aboriginal and Torres Strait Islander health.

The Department of Health has indicated that future PHN infrastructure may include:

- a "National Health Services Directory (NHSD)" which will provide a consistent directory of key primary health services, including after-hours services;
- a "Primary Health Map" that will enable capability to view health needs, overlaid with the location of the health services identified from the NHSD; and
- PHN websites with centralised content and "reporting dashboard" – providing a template website solution to support centralised reporting and sharing of content and service information (Health, 2016).

The above PHN initiatives emphasise the importance of activities that support service planners and consumers to understand the comprehensive structure of the health system, and to identify available services and service capacity within individual PHN regions.

1.2. MENTAL HEALTH CARE REFORM

The philosophy of mental health care reform has been built on key principles of community

psychiatry, with four interlinked areas of action (Vazquez-Bourgon, Salvador-Carulla, & Vazquez-Barquero, 2012):

- deinstitutionalisation and the end of the traditional model of care of internment in mental hospitals;
- development of alternative community services and programs;
- integration with other health services; and
- integration with social and community services.

More recently, this has also included a focus on recovery oriented and person-centred care. Australia started its journey of reform in 1983, with David Richmond's report on care for people experiencing mental illness and intellectual disabilities in New South Wales (NSW): *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled*. It took ten years to establish the first National Mental Health Strategy (Mendoza, 2013). Since then, there have been considerable systemic changes made, including the closure or downsizing of many large psychiatric hospitals, and the development of the community mental health and consumer movement.

Australia's reform journey continues, and application of reform is variable. The assessment of the current mental health system as having developed on an ad hoc basis, resulting in a system which is "poorly planned and badly integrated" (National Mental Health Commission, 2014) is despite a succession of national mental health plans and strategies in the years since the first National Mental Health Strategy. A national approach to a system of accountability to measure outcomes in areas such as service delivery, financial efficiency, consumer outcome and policy objectives is lacking, impeding meaningful quality improvement, jurisdictional comparisons and justifications for calls to increase resources (Rosenberg & Salvador-Carulla, 2017). The Australian mental health system has high rates of readmission to acute care, with at least 46% of hospitalised patients being readmitted during the following year following (Zhang, Harvey, & Andrew, 2011). There are also high rates of compulsory community treatment orders, ranging from 30.2 per 100,000 population in Tasmania to 98.8 per 100,000 population in Victoria (Light, Kerridge, Ryan, & Robertson, 2012); and high rates of seclusion, with 10.6 seclusion events per 1,000 bed days in 2011-12 (Australian Institute of Health and Welfare, 2015). These features are associated with a system characterised by a fragmented, hospital-based, and inefficient provision of care (Mendoza, 2013).

The balanced care model developed by Tansella and Thornicroft (Thornicroft & Tansella, 2013) is an evidence-informed approach to the planning of mental health care delivery, relevant to different resource settings.

According to that model, high-resources settings, such as Australia, need to focus on:

- the recognition and treatment of common mental illness **in primary care** for common mental illnesses;
- a good range of **'general adult mental health services'**, including outpatient clinics, community mental health teams, acute inpatient services, community residential care and work/occupation;
- provision of '**specialised mental health services'** in the categories listed under 'general mental health'. This implies the provision of:
- **specialised out-patient facilities** (for instance for eating disorders, based on an analysis of the local context);
- **specialised community mental health teams**, such as assertive community treatment or early intervention teams;
- **alternatives to acute inpatient care**, including acute day care, crisis houses; and home treatments;
- **alternative types of long-stay community residential care**, ranging from 24-hour staffed residential care to lower supported accommodation; and
- **specialised services for increasing access to employment**, such as the Individual Placement and Support model, in addition to vocational rehabilitation.

Similarly, the Transforming Australia's Mental Health Service Systems (TAMHSS) group has recently recommended *The Essential Components of Care for Community-Oriented Mental Health Services* to be provided in Australia (Department of Health and Ageing, 2013). In addition to inpatient hospital care, the Australian mental health system should guarantee the provision of:

- access and triage;
- early intervention;
- care co-ordination;
- crisis intervention and acute treatment in the community;
- recovery oriented practices for community living;
- engagement and community based support for people with complex needs;
- medication;
- physical health care; and
- effective psychological therapies.

Both models are quite similar, highlighting the need to improve integrated and coordinated care which enables the inclusion of people with lived experience of mental illness in the community.

A key part of the reform agenda is the stepped care approach (Australian Government

Department of Health, 2015; Health, 2016). The stepped care approach is a staged system comprising a hierarchy of interventions from the least to the most intensive, matched to individual need and building more options and range into the market (See *Figure 1*).

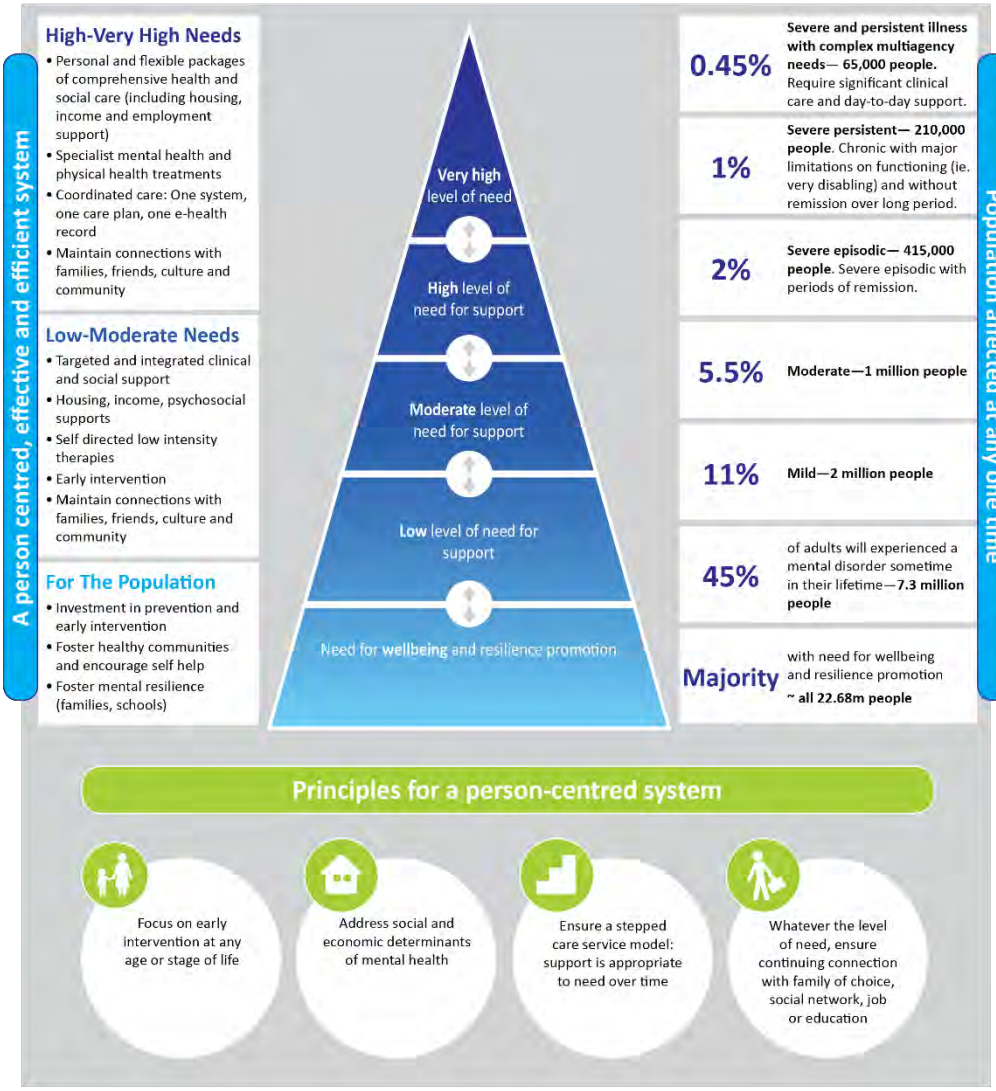


Figure 1 System changes to strengthen the stepped care model in primary mental health care clinical service delivery

Source: (National Mental Health Commission. (2014). Report of the National Review of Mental Health Programmes and Services. Canberra: Australian Government)

As part of this approach, The National Mental Health Commission review in 2014 recommended shifting funding to rebalance the system (National Mental Health Commission, 2014). The review recommended redirecting funding away from separate siloed payments to primary and secondary and post-acute services, and towards prevention and promotion for the general community and Integrated Care Pathways for those at risk, for a more efficient use of resources, and reduced pressure on "downstream" services through

better resourced “upstream” services (see Figure 2).

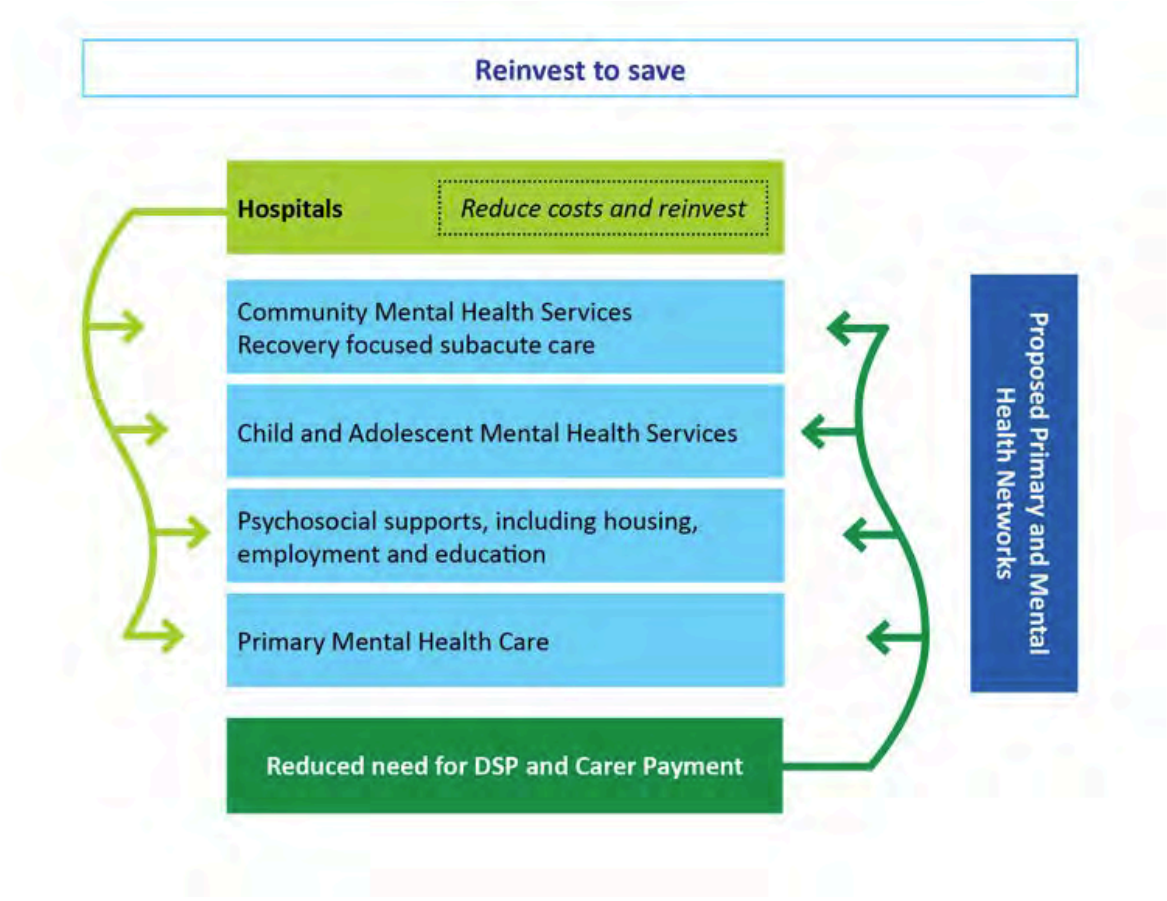


Figure 2 Reinvesting to save through regional integrators.

Source: (National Mental Health Commission. (2014). Report of the National Review of Mental Health Programmes and Services. Canberra: Australian Government).

The stepped care model focuses on promotion and prevention for healthy populations; increasing early interventions for at risk groups; providing and promoting access to lower cost and lower intensity services for individuals with mild mental illness; increasing service access and evidence-based intervention for individuals with moderate mental illness; improving access to primary mental health care intervention; and coordinated care for individuals with severe mental illness (Australian Government Department of Health, 2015). A comprehensive and integrated system is a key requirement of an effective stepped care model, as it assumes both availability of, and clear pathways between, services required at an individual level. The Integrated Mental Health Atlas of the ACT PHN region has mapped the available services for people with a lived experience of mental illness in the ACT to identify service availability and gaps in the system of service delivery in the region.

1.3. CAPITAL HEALTH NETWORK AND MENTAL HEALTH CARE REFORM

The ACT PHN, the Capital Health Network, is one of 31 PHNs in Australia. It covers a population of 385,996 (according to the 2011 census). In 2015, the Commonwealth government announced six priorities for the PHN's commissioning role for mental health and suicide prevention services (Minister for Health, 2015). They represent a combination of populations to target, and services to develop and commission (Department of Health, 2016a):

- early intervention for children and young people with or at risk of mental illness;
- enhancing and integrating Aboriginal and Torres Strait Islander mental health services;
- services for people who experience severe and complex mental illness who are supported in primary care;
- addressing service gaps in the provision of psychotherapies for underserviced groups and/or hard to reach populations;
- improving targeting of and development of low intensity mental health services; and
- promotion of a regional approach to suicide prevention.

These priorities are expected to be implemented in the frame of a stepped care model adapted to the local characteristics and health needs of each PHN, with a focus on the specific priority groups.

The ACT PHN has created a Primary Mental Health Strategic Reform Group which contributed to a baseline needs assessment and to informing the mental health reform process in the ACT, as well as developing an evidence-based, integrated psychological interventions model to form the base of the stepped care model and increase access to early intervention and appropriate care. In April 2017, the ACT PHN, in combination with CatholicCare and Woden Community Service, launched a stepped care program, known as "Next Step", aimed at providing seamless care between low and high intensity psychological interventions for people with mild to moderate, and moderate to severe illness.

The areas covered by the ACT PHN are mainly urban, and characterised by high accessibility of services, according to the Accessibility/Remoteness Index of Australia (ARIA) (Australian Bureau of Statistics (ABS), 2010, 2014). The ARIA is a continuous index developed by the Australian Bureau of Statistics (ABS) to assess remoteness of Australian areas based on road distances between localities and services such as education and health. It allows for classification areas within five groups from "Major Cities of Australia" (high accessibility) to "Very remote Australia" (high remoteness) (Australian Bureau of Statistics (ABS), 2014). The provision of mental health care in urban areas presents specific

challenges that require tailored planning, as mental illnesses are particularly prevalent in urban Australia (Australian Bureau of Statistics (ABS), 2009; Caldwell, Jorm, & Dear, 2004; Jablensky et al., 2000).

In this context, it is crucial to provide policy and service decision makers with every tool and opportunity to make better, more informed choices about future investments in urban mental health care, including which services are needed, and where, and how they can be most effectively delivered. In other words, they need a map that will guide them through the mental health reform journey in urban areas.

The Atlas of the ACT PHN region is an ideal tool to support this process.

1.4. WHAT ARE INTEGRATED MENTAL HEALTH ATLASES?

The WHO Mental Health Gap Action Program (mhGAP) (WHO, 2008) highlighted the need for a comprehensive and systematic description of all the mental health resources available, and the utilisation of these resources. It is not only important to know the numbers of services in each health area, but also to describe what they are doing, and where they are located. This information enables an understanding of the context of health-related interventions essential for the development of evidence-informed policy.

Evidence-informed policy is an approach to policy decisions intended to ensure that the decision making process is well-informed by the best available research evidence. Evidence gathered from the local context needs to be valued and interpreted by policymakers. Context is generally understood as all the variables related to "where" the process is happening, including organisational and divisional structures, group norms, leadership, political processes and broader economic, social and cultural trends (Foundation, 2014). Evidence-informed policy combines 'global evidence' available from around the world with 'local evidence' from the specific setting in which decisions and actions will be taken. This includes a detailed analysis of the area, taking into account the prevalence of mental illness and other demand driven indicators, together with the availability of resources (Oxman, Lavis, Lewin, & Fretheim, 2009). An in-depth understanding of the local context is crucial to the implementation of any new strategy.

The 'integrated care model' (Goodwin, 2013) has challenged the way health-related care should be assessed and planned. It enables us to identify new routes for linked, consumer-centred approaches to care. Greater integration relies on an overall picture of all the services available in a mental health system, regardless of which sector is funding them (e.g. health, social welfare and family, employment, justice). Such 'systems thinking' enables policy planners to capture the complexity of service provision holistically, and ensures that planning of health services accounts for contextual factors that might affect its implementation and

sustainability (context analysis). It offers a way of anticipating synergies and mitigating problems and barriers, with direct relevance for creating policies that integrate the different systems of care (Aslanyan et al., 2010; Savigny, 2009). A systems approach is particularly important in the mental health care sector, with an increasing personalisation of services, the co-ordination of care in programs such as Partners in Recovery (PIR), and the transfer of social services to the National Disability Insurance Scheme (NDIS).

Within this context, Integrated Atlases of Mental Health are essential tools for decision making and quality assessment. Integrated Atlases include detailed information on socio-economic and demographic characteristics and health-related needs, as well as data on service availability and care capacity. Integrated Atlases of Mental Health allow comparison between small health areas, highlighting variations of care, and detecting gaps in the system. The holistic service maps produced through an Integrated Atlas of Mental Health also allow policy planners and decision makers to build bridges between the different sectors and to better allocate services (Salinas-Pérez, García-Alonso, Molina-Parrilla, Jordà-Sampietro, & Salvador-Carulla, 2012).

Integrated Atlases of Health include maps and graphics as a main form of presenting the data. As a visual form of communicating health information, visual tools crucially bridge the gap between complex epidemiological presentations of statistics, and the varied educational backgrounds represented by policymakers, other decision makers, and consumers (Parrott, Hopfer, Ghetian, & Lengerich, 2007). Policy makers and health planners may use the information presented in the Atlas as a visual reference point from which to quickly present and structure their ideas. In addition, the new knowledge presented in an Atlas will quickly increase a planner's self-efficacy and personal mastery of the field. Consequently, policy makers and health planners will be more willing to make informed decisions bolstered by solid evidence. In addition, as Atlases are integrated (e.g. they include all funding providers and sectors) they may increase collaboration across services, acting as a shared reference point from which to discuss the system. It is therefore expected that the Integrated Mental Health Atlas of the ACT PHN region will change the culture of planning and, from this, the provision of care, through facilitating the integration and co-ordination of services. This will be reflected in the quality of care provided and, in the longer term, better health outcomes for people with a lived experience of mental illness (Fernandez et al., 2014).

The *National Review of Mental Health Programmes and Services* (National Mental Health Commission, 2014) indicates that the current mental health system is highly fragmented, difficult to navigate, and characterised by disjointed policy, financing and service delivery systems at national and state levels. Furthermore, there is a mismatch between top-down policies developed centrally at national and state levels, and the local need for efficient resource allocation. The lack of a comprehensive mapping of the available services constitutes an additional barrier to understanding the accessibility of mental health services

in this disjointed system, as well as to system accountability (Rosenberg & Salvador-Carulla, 2017).

The Integrated Mental Health Atlas of the ACT PHN region can help us to understand the current scenario in the provision of mental health care.

1.5. HOW WAS THE INTEGRATED ATLAS OF MENTAL HEALTH ASSEMBLED?

Typically, general Atlases of health are formed through lists or directories of the services, and inclusion of services is based on their official, or everyday, titles. This is particularly problematic for several reasons, including (Salvador-Carulla et al., 2015):

- the wide variability in the terminology of services and programs, even in the same geographical area, and the lack of relationships between the names of services and their actual functions (e.g. day hospitals, day centres, social clubs, etc.), as the service name may not reflect the actual activity performed in the setting; and

- the lack of a common understanding of what a service is. The word 'services' is an umbrella term used to describe very different components of the organisation of care. It merges permanent, highly structured services, with clinical units, or even short-term programs and interventions.

As an example, the Department of Health defines "mental health services" as "services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus their efforts on mental health service provision, or provide such activities as part of a broader range of health or human services" (Australian Government Department of Health, 2015). This broad definition does not provide a formal description of "services" for their standard description and comparison.

In order to overcome these limitations, we have used the "*Description and Evaluation of Services and Directories in Europe for Long-Term Care"* (DESDE-LTC) (Salvador-Carulla et al., 2013). This is an open-access, validated, international instrument for the standardised description and classification of services for Long Term Care. It includes a taxonomy tree and coding system that allows for the classification of services in a defined catchment area according to the main care structure/activity offered, and determines their level of availability and utilisation. Classification is based on the activities of the service, rather than simply the name of the service provider. The classification of services based on the actual activity of the service thus reflects the real provision of care in a defined catchment area.

It is important to note that in research on health and social services there are different units of analysis, and that comparisons must be made across a single and common 'unit of analysis' group. Different units of analysis include: macro-organisations (e.g. a Local Health District), meso-organisations (e.g. a hospital), and micro-organisations (e.g. a service). They could also include smaller units within a service: Main Types of Care, Care Modalities, Care Units, Care Intervention Programs, Care Packages, Interventions, Activities, Micro Activities or Philosophy of Care. Our analysis, based on DESDE-LTC, is focused on the evaluation of the minimal service organisation units or Basic Stable Inputs of Care (BSIC).

1.6. WHAT ARE BASIC STABLE INPUTS OF CARE (BSIC)?

A Basic Stable Input of Care (BSIC) can be defined as a team of professionals working together to provide care for a defined group of people. They have time stability (typically they have been funded for more than three years) and structural stability. Structural stability means that they have administrative support, their own space, their own finances (for instance a specific cost centre) and their own forms of documentation (i.e. they produce their own report by the end of the year)

Criterion A: Has its own professional staff
Criterion B: All activities are used by the same clients/consumers
Criterion C: Time continuity (more than three years)
Criterion D: Organisational stability
Criterion D.1: The service is registered as an independent legal organisation (with its own company tax code or an official register). This register is separate and the organisation does not exist as part of a meso- organisation (for example a service of rehabilitation within a general hospital) → **IF NOT:**
Criterion D.2.: The service has its own administrative unit and/or secretary's office and fulfils two additional descriptors (see below) → **IF NOT:**
Criterion D.3.: The service does not have its own administrative unit but it fulfils **three** additional descriptors:
D3.1. To have its own premises and not as part of other facility (e.g. a hospital)
D3.2. Separate financing and specific accountability (e.g. the unit has its own cost centre)

We identified the BSIC using these criteria, and then labelled them. The typology of care provided by the BSIC (or service) is broken down into a smaller unit of analysis that identifies the "Main Type(s) of Care" (MTC) offered by the BSIC. Each service is described using one or more MTC codes based on the main care structure and activity offered by the service. For instance, the same service might include a principal structure or activity (for example a 'residential' code) and an additional one (for example, a 'day care' code). Figure 2 depicts the different types of care used in our system.

There are six main types of care (Salvador-Carulla et al., 2013):

- **Residential care:** The codes related to residential care are used to classify facilities which provide beds overnight for clients for a purpose related to the clinical and social management of their health condition. It is important to note that consumers do not make use of such services simply because they are homeless, or unable to reach home. Residential care can be divided into acute and non-acute branches, and each one of these in subsequent branches (see Figure 5).
- **Day care:** The day care branch is used to classify facilities which (i) are normally available to several consumers at a time (rather than delivering services to individuals one at a time);(ii) provide some combinations of treatment for problems related to long-term care needs (e.g. providing structured activities or social contact/and or support); (iii) have regular opening hours during which they are normally available; and (iv) expect consumers to stay at the facility beyond the periods during which they have face to face contact with staff (see Figure 6). **Please note that the term "day care" is not often used in the Australian context and these types of services are more commonly referred to as day programs.**
- **Outpatient care:** The outpatient care branch is used to code facilities which (i) involve contact between staff and consumers for some purpose related to the management of their condition and associated clinical and social needs and (ii) are not provided as a part of delivery of residential or day services, as defined above (see Figure 7).
- **Accessibility to care:** The accessibility branch classifies facilities whose main aim is to facilitate accessibility to care for consumers with long term care needs. These services, however, do not provide any therapeutic care (see Figure 8).
- **Information for care:** These codes are used for facilities that provide consumers with information and/or assessment of their needs. Services providing information are not involved in subsequent monitoring/follow up or direct provision of care (see Figure 9).
- **Self-help and voluntary Care:** These codes are used for facilities which aim to provide consumers with support, self-help or contact, with un-paid staff that offer any type of care as described above (i.e. residential, day, outpatient, accessibility or information). See Figure 10.

A detailed description of each one of the branches is available here: http://www.eDESDEproject.eu/images/documents/eDESDE-LTC_Book.pdf

In the result section of the Atlas, the figures, rates per 100,000 residents, and comprehensive description of MTC by age group and specific population are provided by MTC, while the detailed analysis of the service delivery system in the tables is provided by functional teams or BSIC. These different approaches facilitate comparisons of main types of care and the care system in other local jurisdictions, and at the same time allow a detailed description of the

structure of service organisation at macro (e.g., hospital), meso (e.g., service of mental health) and micro-levels (e.g., functional teams). In the terms of a modified version of Thornicroft and Tansella's matrix for mental health services, service activity and capacity at the individual service, or "micro", level, will be described and measured, to provide a picture of total care provision at the "meso" or small area level (Tansella & Thornicroft, 1998) (See Figure 3).

	INPUT	**THROUGHPUT**	**OUTPUT**
Macro Country/region	1A	1B	1C
Meso Local área	2A	2B	2C
Micro Service	3A*	3B	3C
Nano Individual	4A	4B	4C

Figure 3 Mental Health Matrix (adapted Tansella & Thornicroft, 1998)

**STC or BSICs are part of 3A.*

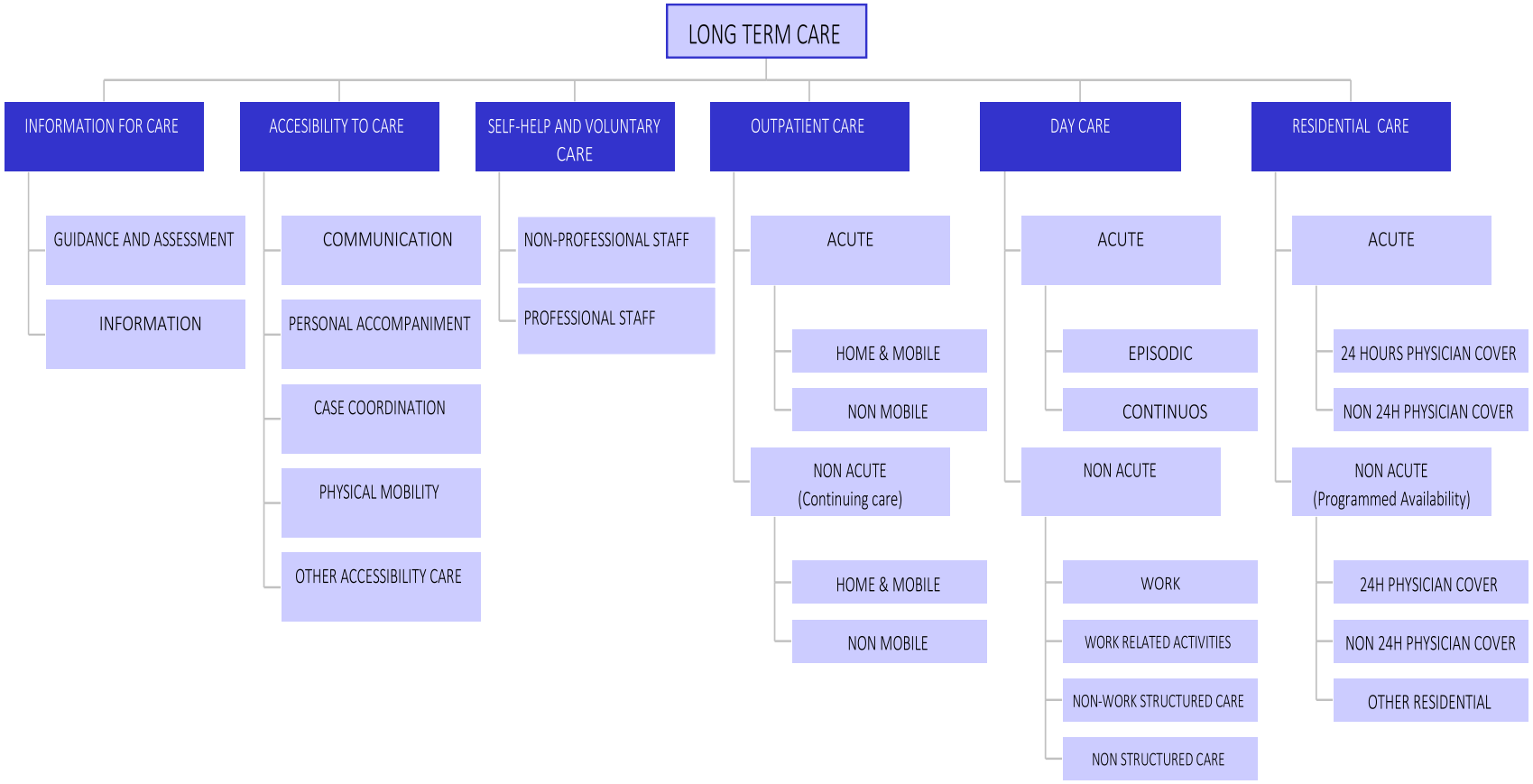


Figure 4 Main Types of care: core codes.

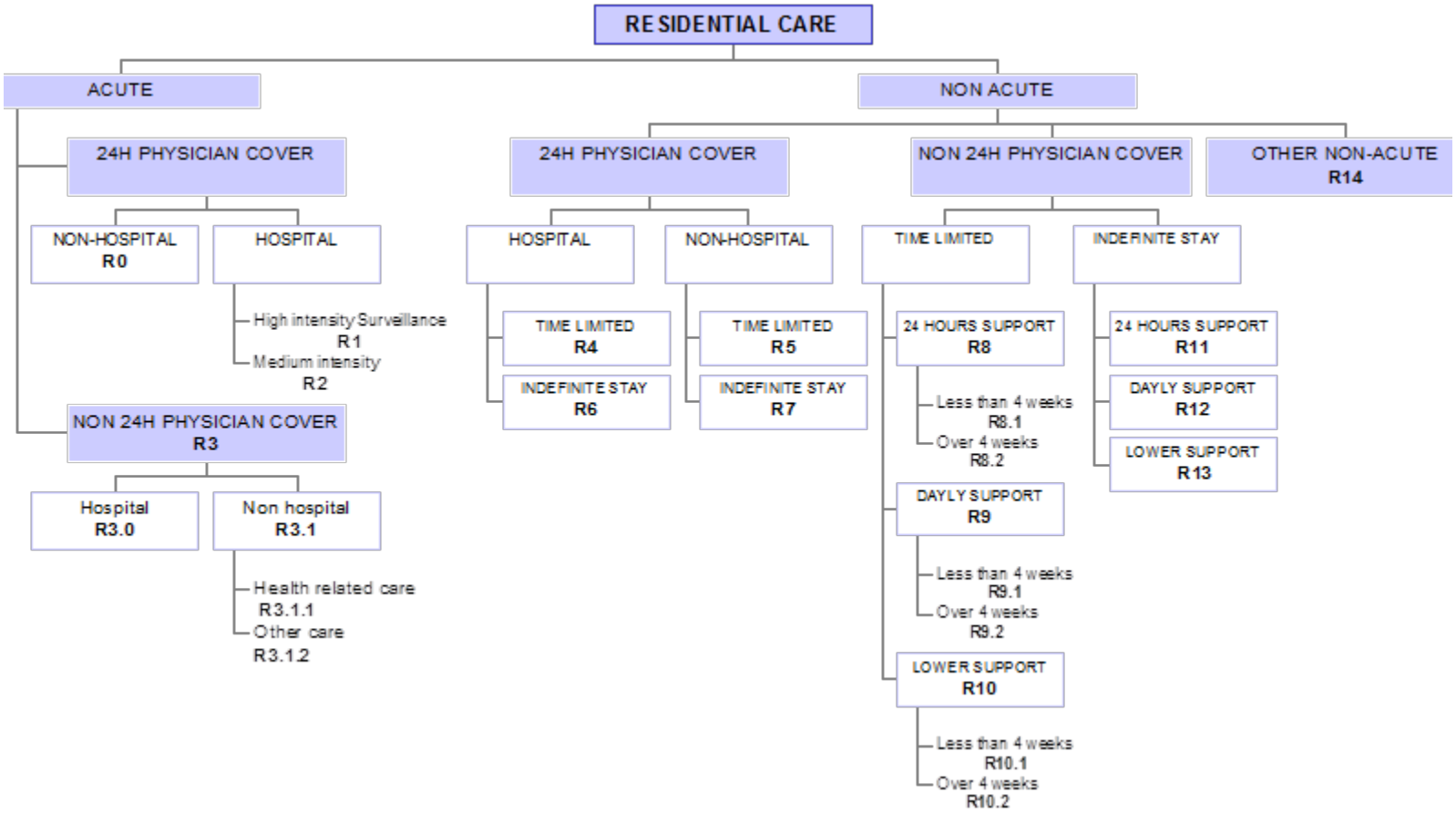


Figure 5 Residential care coding branch.

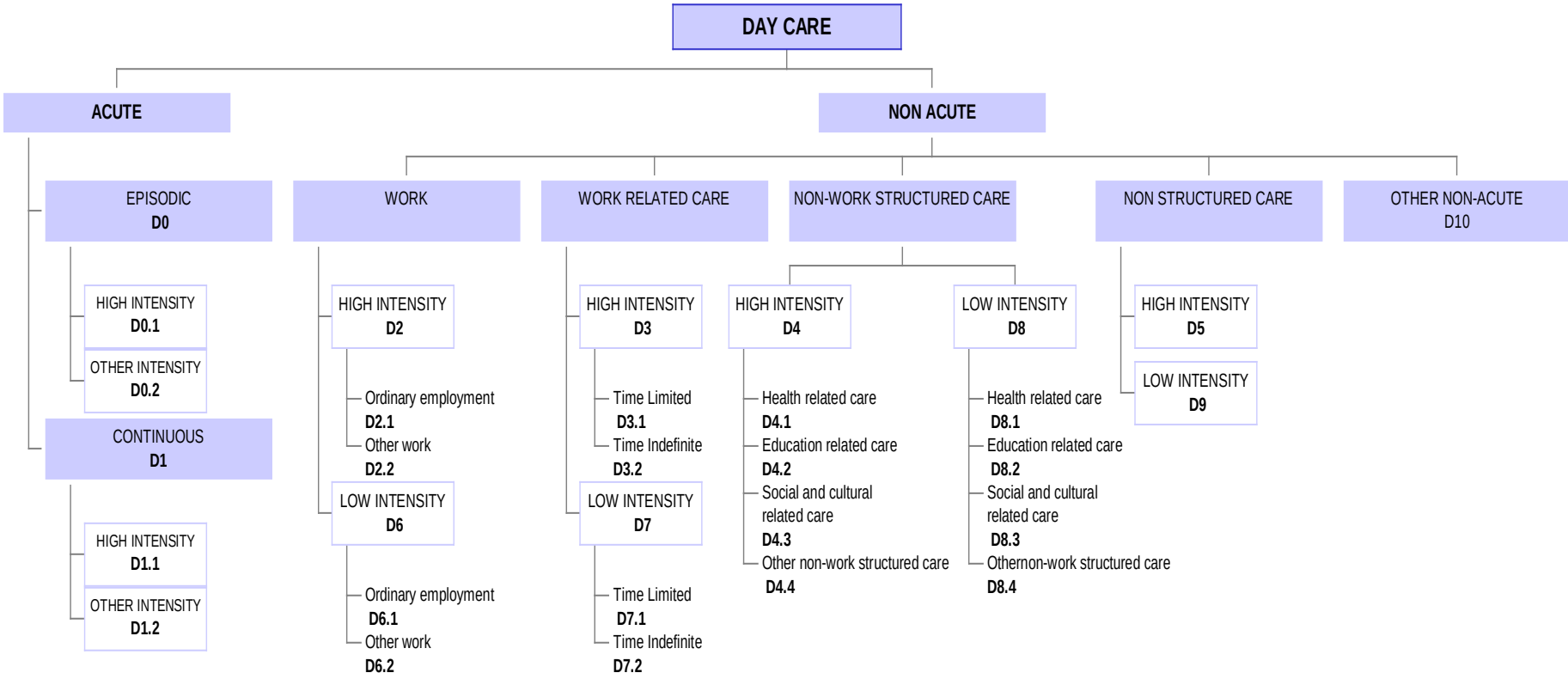


Figure 6 Day care coding branch.

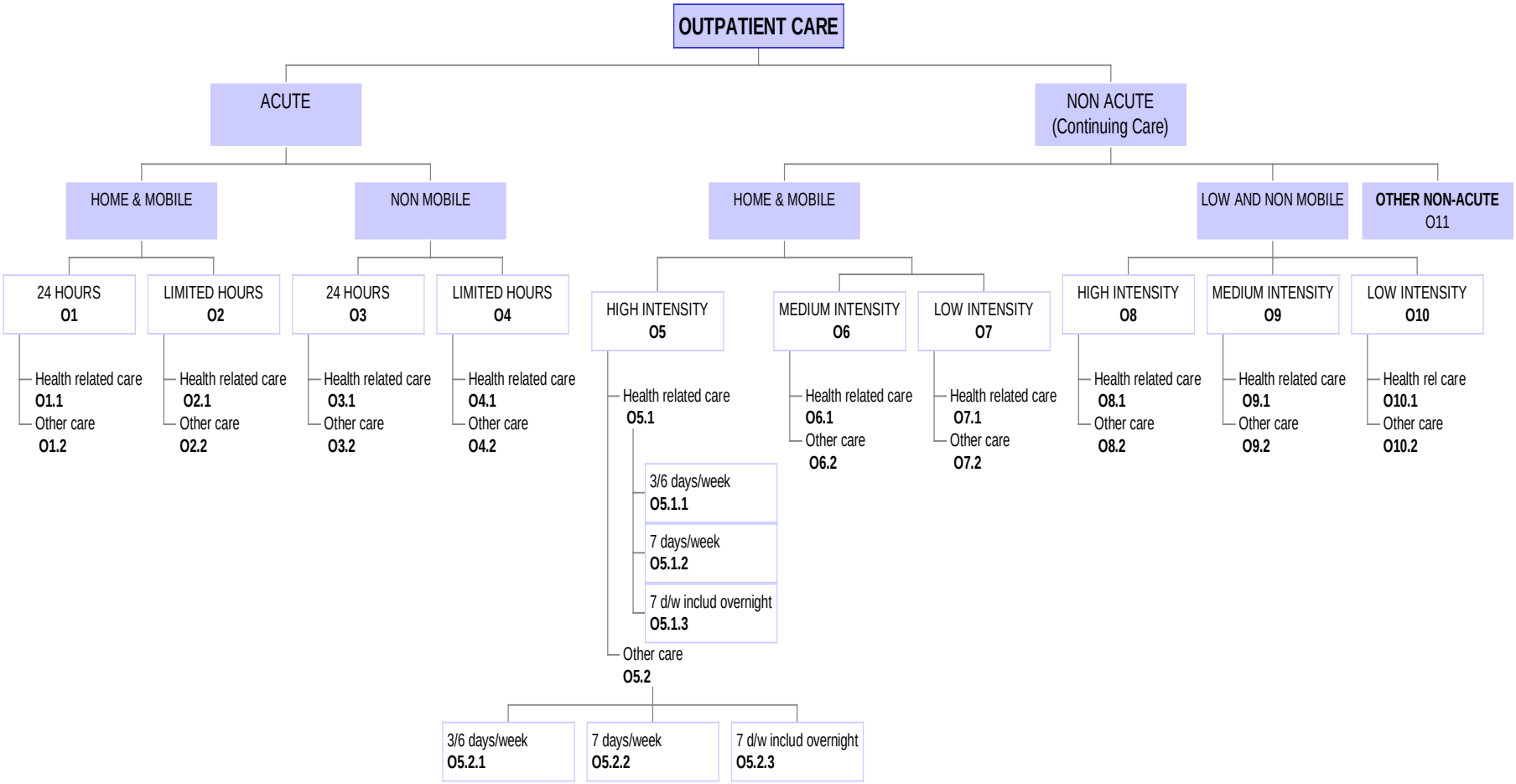


Figure 7 Outpatient care coding branch

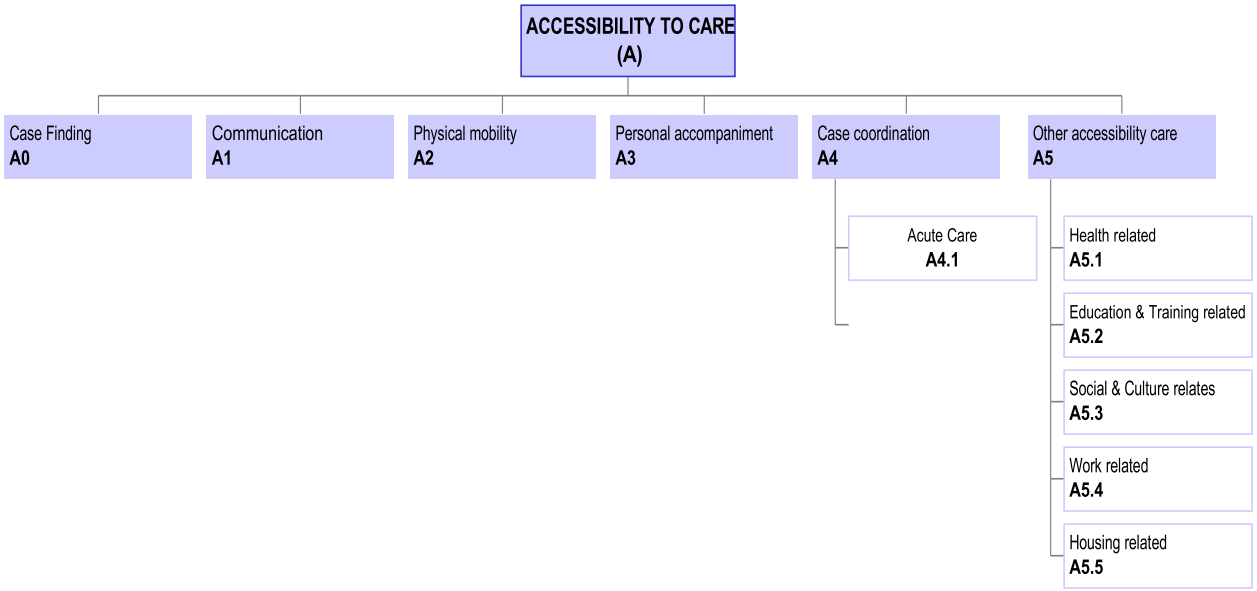


Figure 8 Accessibility to care coding branch

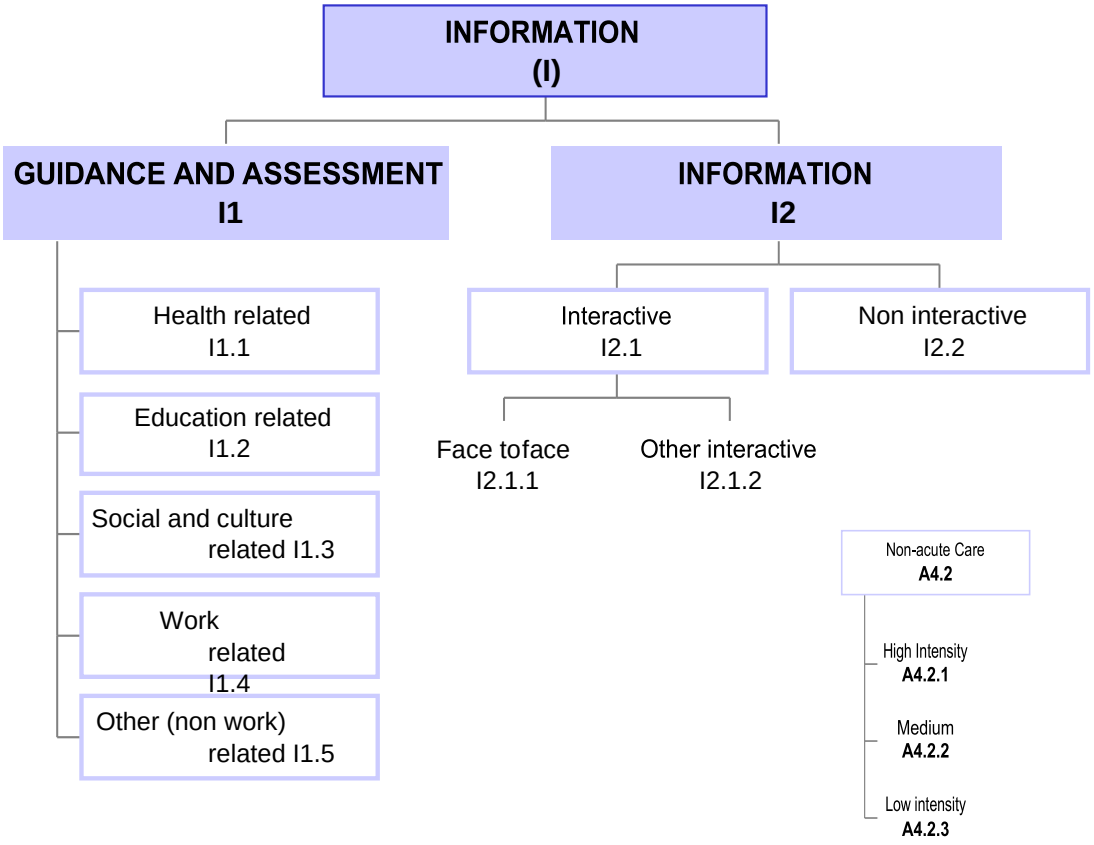


Figure 9 Information and Guidance coding branch.

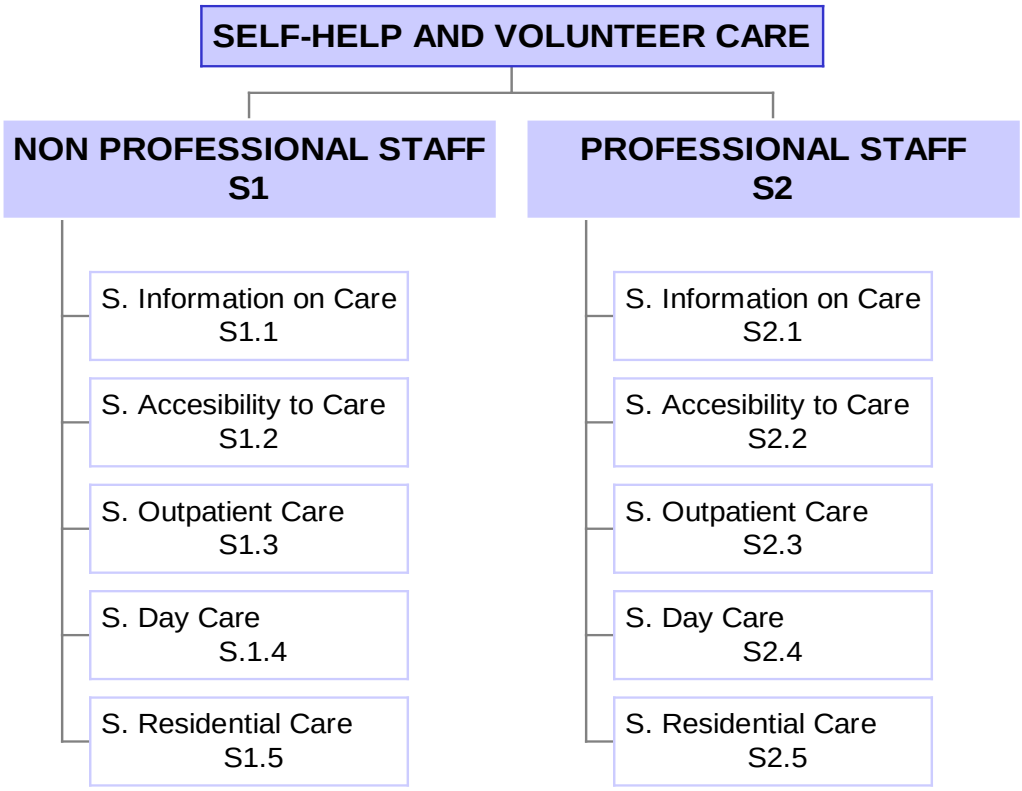


Figure 10 Self-Help and Volunteer coding branch

1.7. INCLUSION CRITERIA

In order to be included in the Atlas, a service had to meet certain inclusion criteria:

1 **The service targets people with a lived experience of mental illness**: The primary reason for using the service is a mental health issue or a psychosocial disability. The inclusion of services that are generic, and lack staff with the specialised training and experience to treat people with a lived experience of mental illness, may lead to bias which obscures the availability of services providing the specialised focus and expertise needed in mental health.

2 **The service is universally accessible**: The study focuses on services that are universally accessible, regardless of if they are publicly or privately funded. We have included services that do not have a significant out-of-pocket cost. In spite of the availability of Medicare- subsidised mental health-related services, access to most private mental health services in Australia requires an individual to have additional private health insurance coverage, high income or savings. The inclusion of private providers would give a misleading picture of the resources available to most people living with mental illness and obscures the data for evidence-informed planning of the public health system. Most private services have some level of public funding, for example Medicare subsidies of private hospitals or community- based psychiatric specialist services. It would be useful in future mapping exercises to include an additional layer of private service mapping to inform those who can afford private health care and for planning in the private sector. However, as a baseline the importance of establishing the nature of universal and equitably accessible health care necessitates that these maps remain distinct.

3 **In other atlases, we have only included services that have received funding for more than three years:** the inclusion of stable services (rather than those provided through short term grants) guarantees that we are mapping the robustness of the system. Generally, if we include services with less than three years of funding it will jeopardize the use of the Atlas for evidence-informed planning. However, in the case of the ACT PHN region, we have found that up to one third of services do not have such stable funding. To exclude such a large number of services would produce a biased picture of service availability in the region, and thus these services have not been excluded in this atlas. We have, however, identified such services, as explained below.

4 **The service is within the boundaries of the ACT PHN region:** The inclusion of services that are within the boundaries of the ACT PHN region is essential to have a clear picture of the local availability of resources. Although some ACT residents access services in Queanbeyan, no formal agreement is in place between the two jurisdictions to facilitate this, and so we have not included Queanbeyan services in the atlas.

5 **The service provides direct care or support to consumers:** We excluded services that were only concerned with the co-ordination of other services or

system improvement, without any contact with people with a lived experience of mental illness.

1.8. WHAT PROCESS WAS FOLLOWED?

There were four distinct steps in the creation of the Integrated Mental Health Atlas of the ACT PHN region. These steps are explained below, and summarised in Figure 12.

Step 1: Data collection: First we developed a list of all health related services providing care for people with a lived experience of mental illness. Then we contacted the services by phone to gather the following information: a) basic service information (e.g. name, type of service, description of governance); b) location and geographical information about the service (e.g. service of reference, service area); c) service data (e.g. opening days and hours, staffing, management, economic information, legal system, user profile, number of consumers, number of contacts or admissions, number of days in hospital or residential accommodation, number of available beds or places, links with other services); d) additional information (name of coder, date, number of observations and problems with data collection). We then contacted the providers via email, and asked them to fill in an online survey. Alternatively, they could ask for a face-to-face on-site interview with one of the researchers.

Step 2: Codification of the services followed criteria defined in DESDE-LTC, according to their MTC (not the official service name). The codes can be split into four different components:

a) **Client age group:** This represents the main target group for which the service is intended or currently accessed by, using capital letters.

GX All age groups

NX None/undetermined

CX Child & Adolescents (e.g. 0-17)

CC Only children (e.g. 0-11)

CA Only adolescent (e.g. 12 – 17)

CY Adolescents and young adults (e.g. 12-25)

AX Adult (e.g. 18-65)

AY Young adults (e.g. 18-25)

AO Older Adults (e.g. 50- 65)

OX Older than 65

TC Transition from child to adolescent (e.g. 8-13)

TA Transition from adolescent to adult (e.g. 16-25)

TO Transition from adult to old (e.g. 55-70)

b) **Diagnostic group:** ICD-10 codes in brackets after the age group code but before DESDE-LTC code were used to describe the main diagnostic group covered by the service. In the majority of the services we have used the code [F0-F99], which means that the service includes all types of mental illnesses or does not specify any. If the client of the service is a child, but the professional is working with the family, or if the service is for Carers, we have included the code [e310] (immediate family) from the International Classification of Functioning (ICF).

F0-F99	All types of mental disorders
F10-F19	Alcohol and Other Drug disorders
F2X	Unspecified psychosis not due to a substance or known physiological condition. Includes early psychosis
F3X	Mood (affective) Disorders
F50	Eating Disorders
F53	Puerperal psychosis; also used as proxy for perinatal mental health disorders
e310	Services for immediate family or carers
Z63	Other problems related to primary support group, including family circumstances
Z63.4	Disappearance and death of family member (with T14.91 it denotes bereavement by suicide)

c) **DESDE-LTC code:** The third component of the code is the core DESDE-LTC code which is the MTC. As we have explained before, the services were classified according to their main type of care. This care can be related to: a) Residential care (codes starting with R); b) Day care (codes starting with D); c) Outpatient care (codes starting with O); d) Accessibility to care (codes starting with A); e) Information for care (codes starting with I); and f) Self-help and voluntary care (codes starting with S).

d) **Qualifiers:** In some cases, a fourth component may be incorporated to facilitate a quick appraisal of those characteristics of the services which may be relevant to local policy. The qualifiers used in this Atlas are:

- **"c" Closed care:** This qualifier describes secluded MTCs with high level of security provided under locked doors;

- **"g" Group:** This qualifier refers to outpatient services where most of their care

is provided through group activities (typically over 80% of their overall care activity);

- **"h" Hospital (Care provided in a hospital setting):** This qualifier describes non- residential MTCs ("O", "D") provided in a meso-organisation registered as a "hospital" but which is different from acute residential care (e.g. an outpatient unit or a day hospital placed in a general hospital setting in order to differentiate these SCTs from similar units placed in the community);

- **"i" Institutional care:** This qualifier describes residential facilities characterised by indefinite stay for a defined population group, which usually have over 100 beds and which could be described as "Institutional care"

- **"j" Justice care:** This qualifier describes BSIC whose main aim is to provide care to individuals in contact with criminal and justice services;

- **"l" Liaison care:** This qualifier describes a liaison BSIC where specific consultation for a subgroup of consumers is provided to other area (e.g. outpatient consultation on intellectual disabilities to a general medical service, or consultation on mental illness for the general medical services of a hospital);

- **"m" Management**: This qualifier describes BSICs whose main aim is defined as management, planning, co-ordination or navigation of care, but which also includes several forms of clinical care as part of their activity (e.g. the care team typically provides therapeutic counselling as part of its case management activities).

- **"q" Mobile-care:** This qualifier is used in those non-mobile services, which have between 20% and 49% mobile contacts;

- **"s" Specialised care:** This qualifier describes a BSIC for a specific subgroup within the target population of the catchment area (e.g. services for Elderly people with Alzheimer's disease within the "E" group, or services for Eating Disorders within the "MD" group);

- **"u" Unique:** This qualifier describes a single-handed BSIC provided by a health professional;

- **"v" Variable** : This qualifier is used when the code applied at the moment of the interview could vary significantly in the near future (from example from acute outpatient care to non- acute). This depends on the capacity of the service to provide the type of care described by the code due to fluctuations in the demand or the supply capacity. For example a crisis accommodation team for homeless or a crisis domestic violence refuge may fluctuate in its capacity of providing

acute care within 24 hours depending on the demand and the availability of places. This code can be also applied to services under transition due to a health reform, a change in the whole financing system of health or social care, or the development of a new disability scheme. This variability in the pattern of service provision is independent of the time continuity of the service. For example, a continuous service can have a 'v' code due to a health reform while a care program limited to two years may show organisational stability during the period when it is funded.

- **"w" Whole:** This qualifier indicates that the centre only provides the extreme level of the activity described by MTC. For example, applied to a mobile service (O6) it indicates that 100% of its activity is mobile.

Example: A sub-acute forensic unit in a hospital for adults with lived experience of mental illness will receive the following code presented in Figure 11.

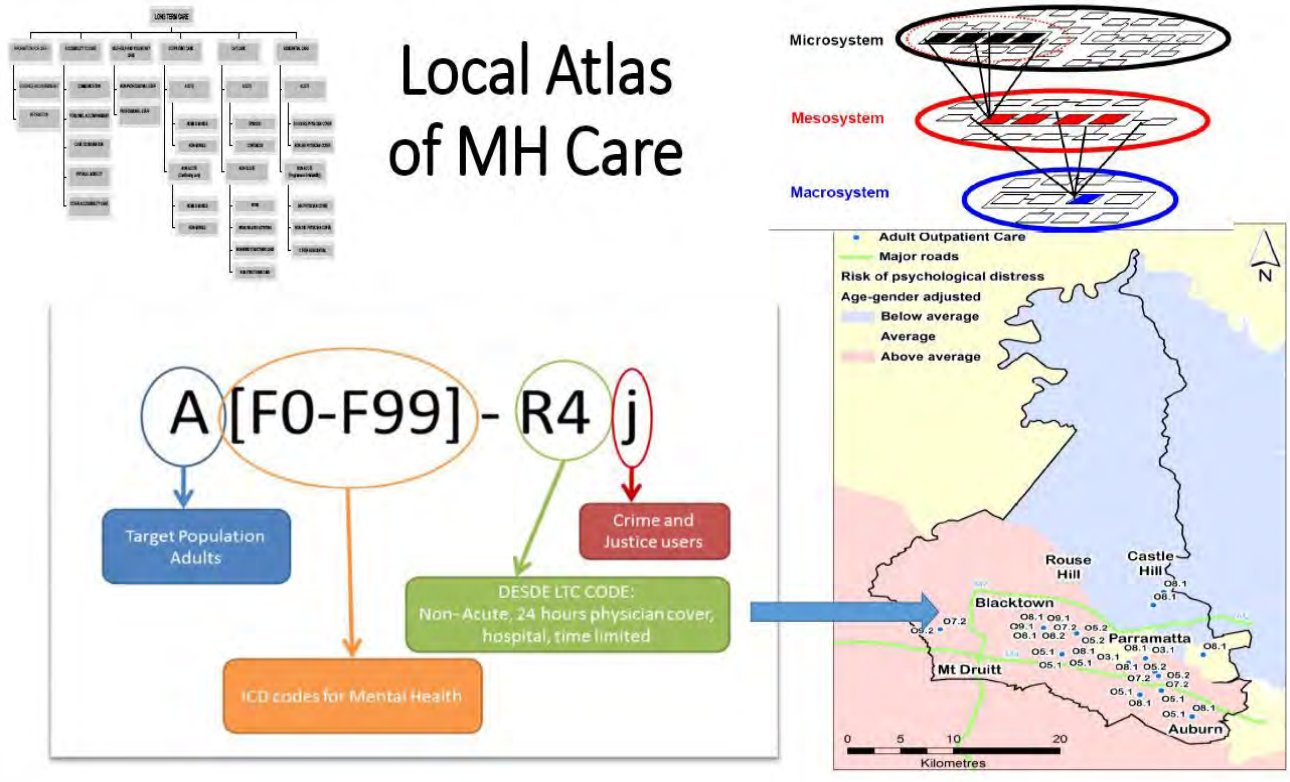


Figure 11 Components of the code- an example of a sub-acute forensic unit based in a hospital

Step 3: Mapping the BSIC:

BOUNDARIES

The importance of the boundaries of the PHN has been signaled in the 2016 PHN Guidelines (Department of Health, 2016b). In general, the boundaries of PHNs include factors such as population size, state and territory borders, patient flow, stakeholder input and administration efficiencies. In the case of the ACT, the ACT PHN boundaries include the entire territory.

JURISDICTIONS AND GEOGRAPHICAL UNITS OF ANALYSIS

This report displays data at statistical Area 3 (SA3) in the table of socio-demographic indicators, at statistical Area 2 (SA2) in the maps, and at Population Health Areas (PHA), a specific area used by the Public Health Information Development Unit (PHIDU), for the psychological distress indicator.

For the Geographical Information Systems (GIS) analysis of an area the size of the ACT PHN region, the most effective unit of analysis is the SA2. The use of SA2 ensures that concentrated pockets of deprivation and disadvantage, and risk factors for mental disorders are captured, enabling the design of targeted programs and services.

Socio-demographic indicators are visualised using choropleth maps (maps that use different colours inside defined geographical areas), which were depicted using the GIS to illustrate the distributions and small-area variations (SA2) in each of the indicators calculated. The maps are structured in a large zoom-in inset which shows the ACT's urban areas, and a small zoom-out inset displaying the whole ACT. In each map, the values have been divided in four intervals based on the mean value. Thus, the intervals 1 and 2 represent the SA2 below the mean, and the intervals 3 and 4 above the mean. The SA2 with population density below 100 inhabitants per km^2 have been removed due to they have large surfaces with very low number of residents what may distort the interpretation. Even so, their values can be seen in the zoom-out inset.

A second set of maps was then constructed to visualise the locations of the services/BSIC in relation to two indicators: population density and percentage of population with psychological distress.

INDICATORS

A series of indicators were calculated to describe the area. They were built based on information extracted from Australian Bureau of Statistics (ABS) census data (2011), and from the Social Health Atlases of Australia of the Torrens University Australia (2011-

12), developed by PHIDU.

The indicators which were used as base layers for the mapping in ACT PHN region are as follows:

- Density index: population/km^2
- Ageing index: (population >64 years old/ population 0-15) *100
- Dependency index: (population between 0-15 + and >64 years old/ population 16-64) *100
- Unemployed rate: (number of unemployed people/ population 16-64 years old) *100
- Percentage of lone parents: (number of lone parents/total population) *100
- Percentage of people living alone: (number of households with just 1 person/ total population) *100
- Percentage of Aboriginal and/or Torres Strait Islanders living in the area: (number of Aboriginal and/or Torres Strait Islanders living in the area/ total population) *100
- Percentage of people with low English proficiency: (population speaking English not well or not at all/total population) *100
- Percentage of women in the population: (number of women/total population) *100
- Percentage of people not married or in a de facto relationship: (number of people non married or in a de facto relationship/population >17 years old) *100
- Percentage of people who expressed need of assistance with core activities: (Number of people who express they are in need of assistance with core activities/ population 16-64 years old) *100
- Index of Relative Socio-Economic Disadvantage (IRSD): decile of the area (lowest to highest corresponds to the most disadvantaged to the least). The IRSD is a general socio-economic index summarising a range of information about the economic and social conditions of people and households within an area. It includes variables related mostly to education level, employment status, level of income and disabilities.
- Percentage of private dwellings with no internet connection: (number of private dwellings with no internet connection/total number of private dwellings) *100
- Percentage of people born overseas: (population born overseas/ total population) *100
- Percentage of people with year 12 of high school or equivalent completed: (population with year 12 of high school completed or equivalent or more/ population ≥ 15 years old) *100
- Percentage of people with less than $600 income per week: (number of people with less than $600 income per week/population 16-64 years old) *100
- Percentage of people with psychological distress: age standardized ratio of people with high or very high levels of psychological distress according to the Kessler psychological distress scale (K10) which is a scale of non-specific psychological distress based on ten questions related to negative emotional states in the prior four weeks (calculated from PHIDU data) (Andrews & Slade, 2001; Kessler et al.,

2002).

Step 4: Description of the pattern of care: service availability and capacity
We have analysed the availability of services, by MTC as well as the capacity.

- **Availability:** Defined as the presence, location and readiness for use of services or other organisational units in a care organisation or a catchment area at a given time. A service is available when it is operable or usable upon demand to perform its designated or required function. The availability rates of MTC are calculated by 100,000 residents.
- **Placement capacity**: Maximum number of beds in residential care, and of places in day care, in a care delivery organisation or a catchment area at a given time. Rates have been calculated by 100,000 residents.
- **Workforce capacity:** Maximum number of staff available in a care delivery organization, or in a catchment area at a given time. Care workforce capacity usually refers to paid staff providing direct care (e.g. it excludes voluntary care providers and administrative staff). It is typically measured in Full Time Equivalents units (FTE), in this case 37.5 hours per week. Rates have been calculated by 100,000 residents.

This analysis allowed us to compare the availability and capacity rates with other areas, and to estimate if the provision is adequate for populations need. We have compared the ACT PHN region with urban and rural areas from Northern Europe (Norway, Finland), and Southern Europe (Italy, Spain), and the UK. The information on the other countries has been mainly developed as part of the REFINEMENT project (The Refinement Project Research Consortium, 2013), funded by the European Commission, which focused on the links between the financing of mental health care in Europe and the outcomes of mental health services. The information on Spain is from the Integrated Mental Health Atlas of Catalonia.

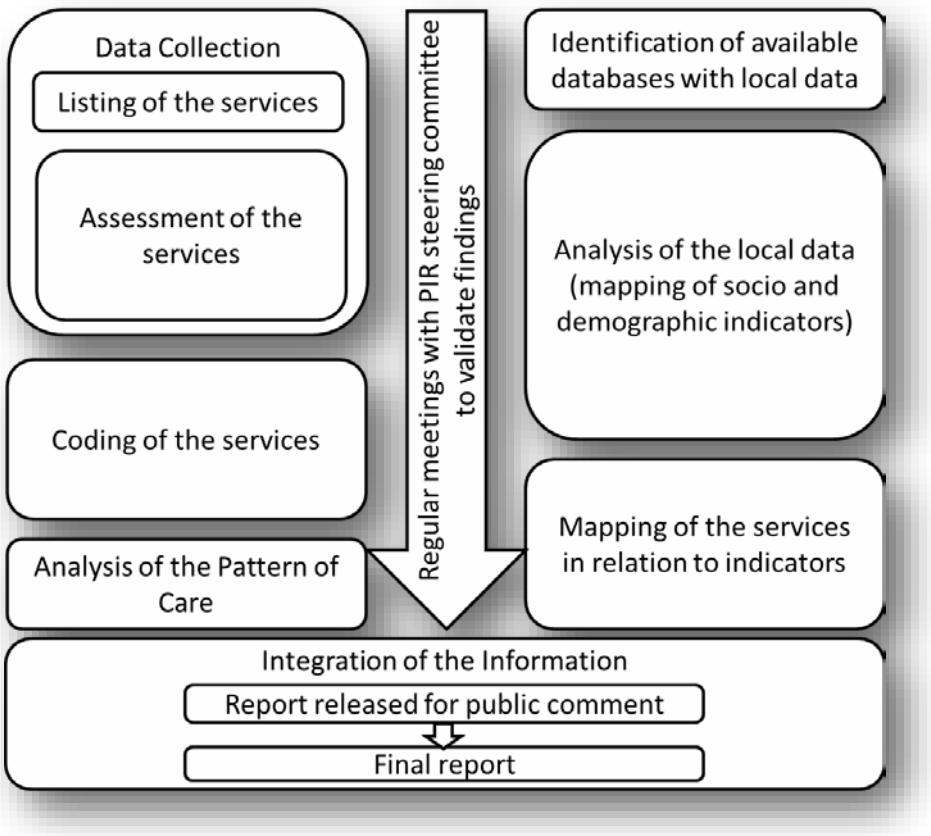


Figure 12 Steps followed in the development of the Atlas

2. MAPPING THE AREA: BOUNDARIES AND INDICATORS

2.1. THE BOUNDARIES AND JURISDICTION

Australian Capital Territory has an area of 2,351 km^2. Around 55% of this territory corresponds to protected areas such as a National Park, Botanic Gardens, a Wilderness Zone and several Nature Reserves. The most relevant natural area is the Namadgi National Park located in the South-West, which comprises around 46% of the ACT. Canberra is its only city, with around 390,000 inhabitants in 2015. The ACT is the fastest growing jurisdiction in Australia (http://www.abc.net.au/news/2017-06-27/census-results-canberra-what-data-shows-for-the-act/8655110). The city is organized in seven districts: North Canberra, South Canberra, Woden Valley, Belconnen, Weston Creek, Tuggeranong and Gungahlin. It is necessary to note that the city of Queanbeyan (about 40,000 inhabitants), in the Eastern border with the neighbouring State of New South Wales, has a strong functional link with Canberra, given its proximity.

ACT Medicare Local (ACTML) transitioned to Capital Health Network, ACT PHN on 1 July 2015. ACT PHN has a major impact on the health care planning and service utilization in the Southern NSW Local Health District (SNSWLHD) (SNSWLHD, 2013). This neighboring Local Health District does not have a major hospital, so Canberra Hospital is its principal tertiary referral hospital, and provides specialised care such as mental health services. This relationship is especially strong for the Queanbeyan Health Service (QHS), and the Yass Valley Health Service, for whom ACT hospitals also provide acute services. It has been estimated that ACT public hospitals met half of the demand for inpatient services in 2013 (QHS, 2015). Thus, health administrations on both sides of the border have compensation agreements for cross border activities. This strong relationship in the delivery of health care between both territories is highlighted in the Southern NSW services plan (SNSWLHD, 2013), where one of its stated objectives is to build stronger strategic and clinician relationships with the ACT PHN. In addition, the QHS health care service plan (QHS, 2015) stated that one of the key themes is to work closely with ACT to build a functional relationship.

2.2. SOCIO-ECONOMIC INDICATORS

The ACT has the highest percentage of population with mental health problems of all states and territories (15.5%, compared to a national figure of 13.4%) (ACT Health, 2014). Canberra, in the northeast of the ACT, is the area of highest population density in the territory, bounded to the south and west by a mountainous and sparsely populated area, which includes Namadgi National Park.

In comparison to the rest of Australia, the ACT has a lower ageing and dependency index, lower unemployment, higher rate of people having attained Year 12 or equivalent, fewer Aboriginal and Torres Strait Islander people, and significantly lower percentage of households on a low income. However, variations exist within the region.

In Fyshwick-Pialligo-Hume, more than 10% of the population have a high or very high risk of psychological distress, and almost half the population in this district is in the lowest 20% of the IRSD indicators. This SA3 has the lowest rates in the territory for completion of Year 12 or equivalent, the lowest incomes, and highest unemployment rates, due to fact that the Alexander Maconochie Centre is located here. In addition, people living alone, the ratio of females and of ageing show unusual values. This area also has the highest number of Aboriginal and Torres Strait Islander peoples, thus most of the ATSI population in the ACT live in a deprived area.

Another singular SA3 is Cotter-Namadgi, which is linked to the National Park and only has 548 residents and a population density of 0.32 inhabitants per km^2. The size of the populations of older people and of younger people are extremely low, so the dependency index and the percentage of people with needs of assistance are the lowest in the ACT. However, it is also the area with the highest ageing index because there are more old people than children. Most adults are employed.

On the other hand, Tuggeranong has the lowest rate in the territory for completion of Year 12 or equivalent, and the highest rates of lone parents. North Canberra, South Canberra and Woden have the highest rates of people with a level of education of Year 12 or equivalent. North Canberra, however, also has one of the higher rates of households earning less than $600 per week relative to the rest of the ACT, as well as the second highest unemployment rate in the ACT. This may be due to its proximity to the Australian National University, as many students would live in this area.

Also noteworthy, the percentage of lone parents is mainly higher in the districts in the South of Canberra, together with Belconnen in the North. The figures of people living alone and non-married are higher around the CBD and the administrative areas in North Canberra and South Canberra districts.

The following table summarises the main socio and economic indicators in the ACT PHN region at SA3 level in 2011. Later figures will present visualisations of key indicators using choropleth maps at SA2 level.

Table 1 Description of the socio and economic characteristics of the area (2011)

SA3	Population (% of the PHN)	Density index	Women (%)	Aging index	Dependency index	Unemployment rate (%)	Lone parent (%)	Living alone (%)	Not married or in a de facto relationship (%)	Needs assistance for core activities (%)	% people within 20% lower IRSD
Belconnen	92,445 (25.9)	1200.76	50.60	21.74	44.21	3.76	3.90	8.01	40.65	3.41	1.60
Cotter - Namadgi	548 (0.2)	0.32	46.25	122.22	29.23	1.17	2.39	6.97	37.13	1.09	NA
Fyshwick - Pialligo - Hume	1,502 (0.4)	6.78	32.89	18.27	44.03	5.44	2.80	19.31	55.14	3.00	45.54
Gungahlin	47,304 (13.3)	522.26	50.64	82.85	31.57	3.08	3.31	5.42	34.86	2.01	NA
North Canberra	48,029 (13.5)	1274.49	49.38	93.36	44.62	5.12	2.85	11.81	49.38	3.31	4.24
South Canberra	24,152 (6.8)	697.17	51.10	35.50	42.75	3.35	3.20	12.25	43.95	4.35	4.52
Tuggeranong	86,900 (24.4)	577.57	50.75	83.96	59.65	3.09	4.84	6.37	39.84	3.10	1.01
Weston Creek	22,748 (6.4)	1437.91	51.20	98.23	56.23	3.11	3.98	9.17	38.11	4.50	NA
Woden	32,958 (9.2)	1152.37	51.24	57.11	44.18	3.32	3.40	11.22	41.39	4.31	NA
ACT PHN	356,586	151.23	50.53	54.09	43.83	3.60	3.81	8.48	40.97	3.35	1.57 (incomplete)
Australia	21.507.719	2.8	50.6	68.1	54.5	5.6	4.2	8.8	41.3	4.9	18.9

SA3	Aboriginal and Torres Strait Islander People (%)	Born abroad (%)	Low English proficiency (%)	Year 12 of high school or equivalent completed (%)	Income <$600 per week (%)	Dwellings with no internet connection (%)	% of the population with high or very high psychological distress (K10)
Belconnen	1.26	25.02	2.63	69.47	7.57	11.84	9.24
Cotter - Namadgi	0.55	17.12	0.00	64.58	6.72	19.02	NA
Fyshwick - Pialligo - Hume	4.92	17.08	0.45	46.07	12.32	35.23	13.16
Gungahlin	1.22	30.09	3.65	72.63	5.75	7.83	8.04
North Canberra	1.12	30.29	2.38	81.37	8.02	15.63	9.87
South Canberra	1.47	25.54	1.55	77.84	5.39	13.52	8.39
Tuggeranong	2.08	19.45	1.48	61.51	7.04	10.79	9.49
Weston Creek	1.24	21.85	1.65	70.31	6.61	13.30	8.64
Woden	1.10	29.65	2.39	74.36	6.59	14.11	8.32
ACTPHN	1.45	25.24	2.28	70.65	6.94	12.19	9.06
Australia	2.5	26.0	3.2	47.6	51.4	19.7	10.8

NA: not available

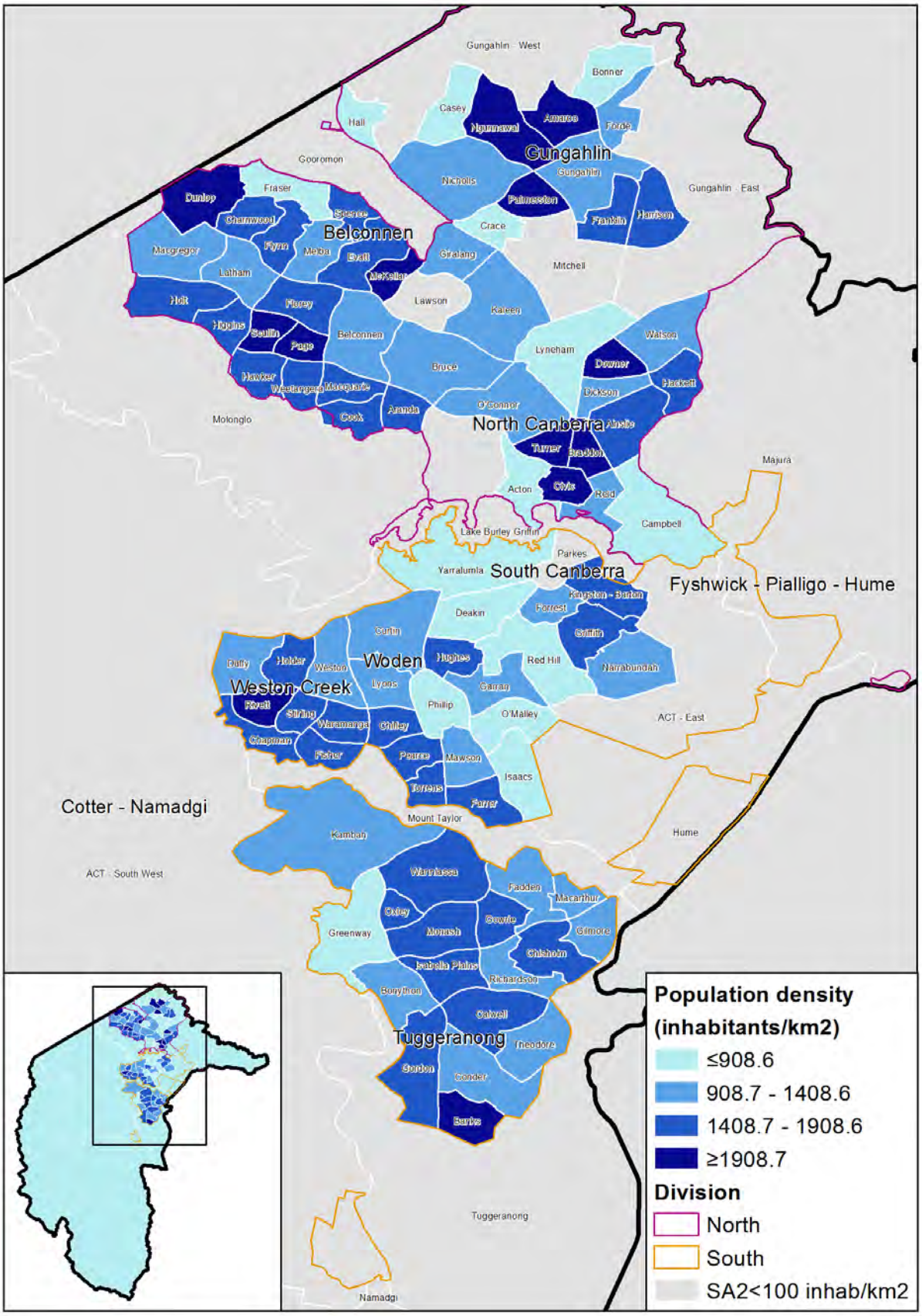


Figure 13 Population Density

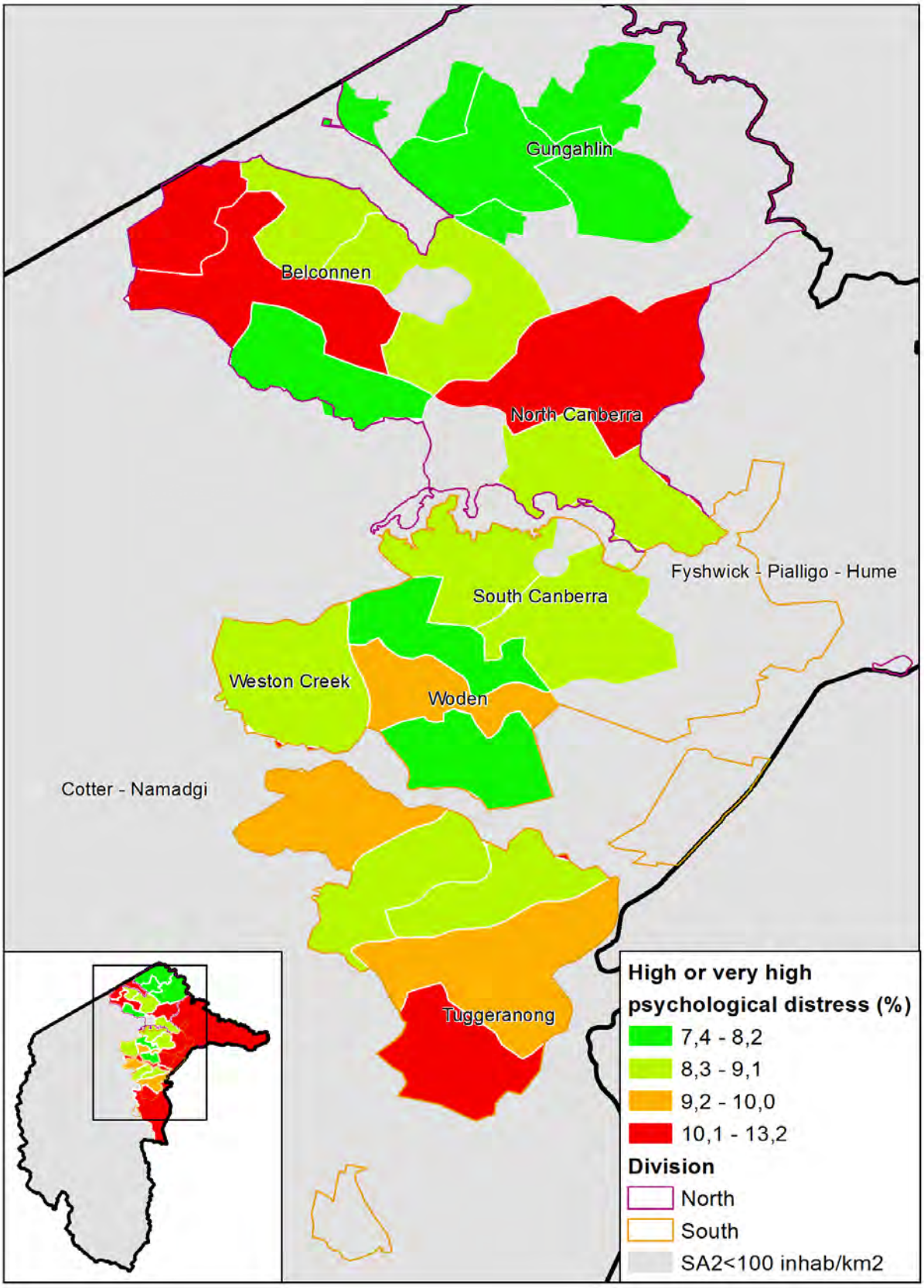


Figure 14 Risk of Psychological Distress

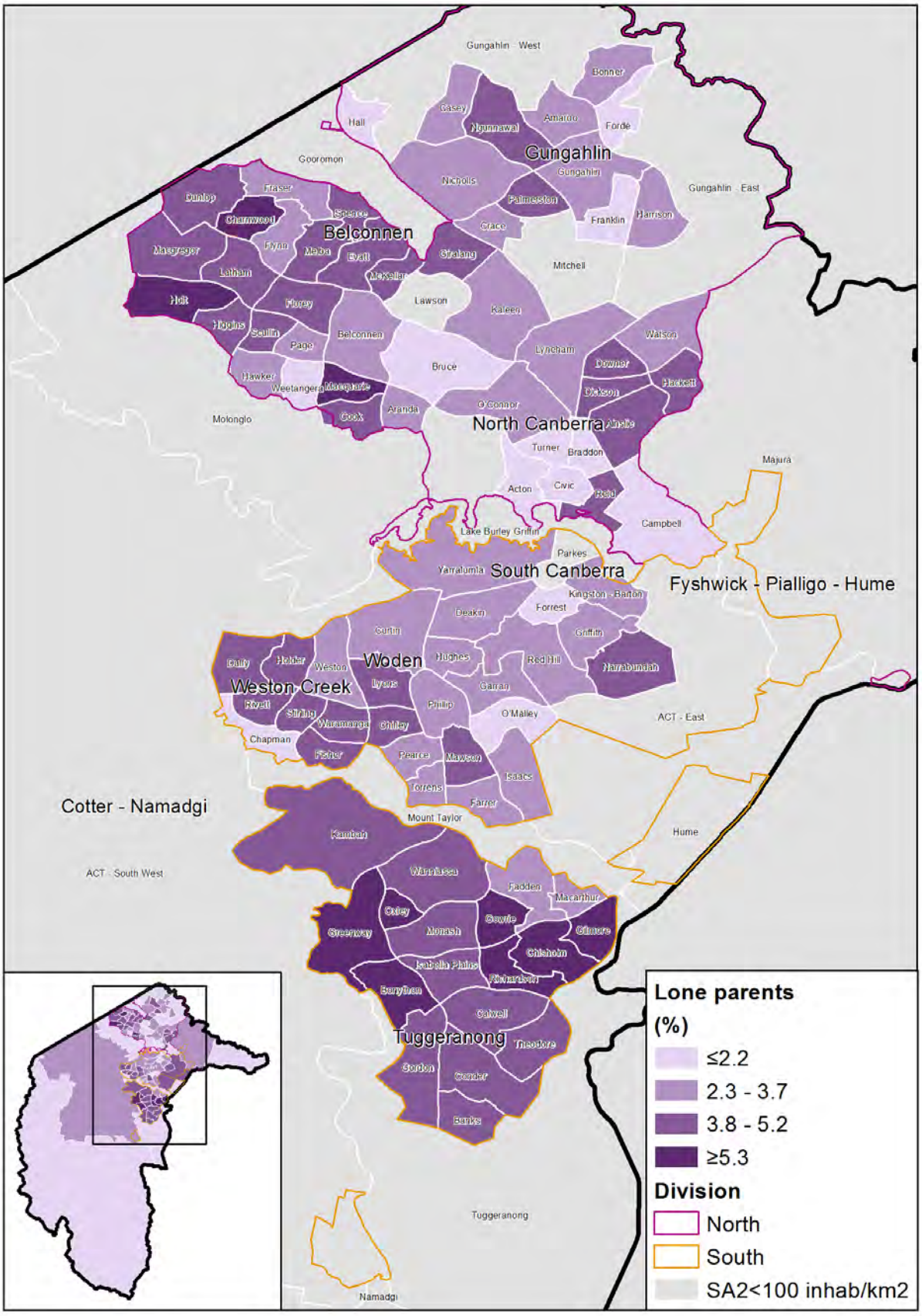


Figure 15 Distribution of Lone Parents.

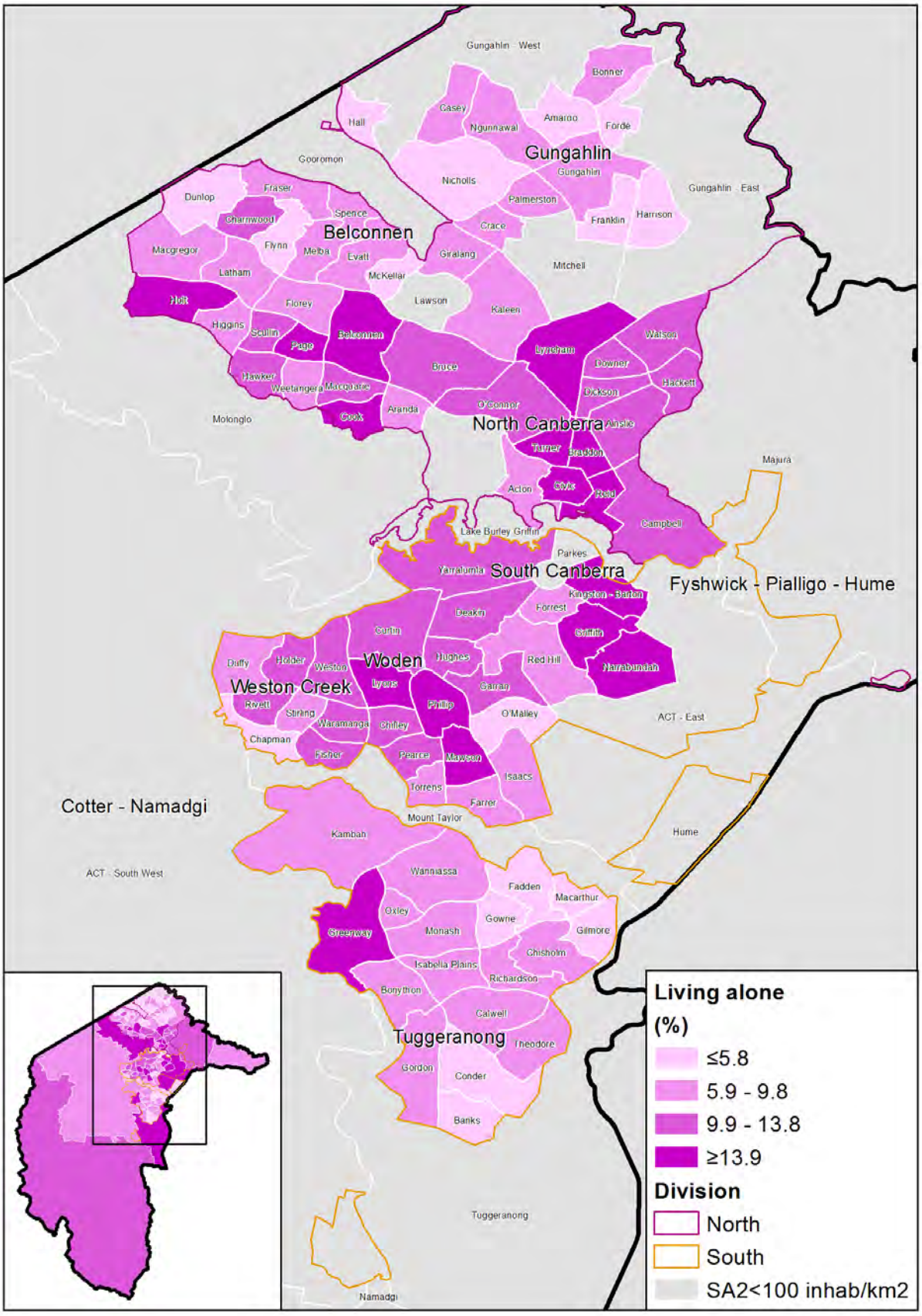


Figure 16 Distribution of People Living Alone.

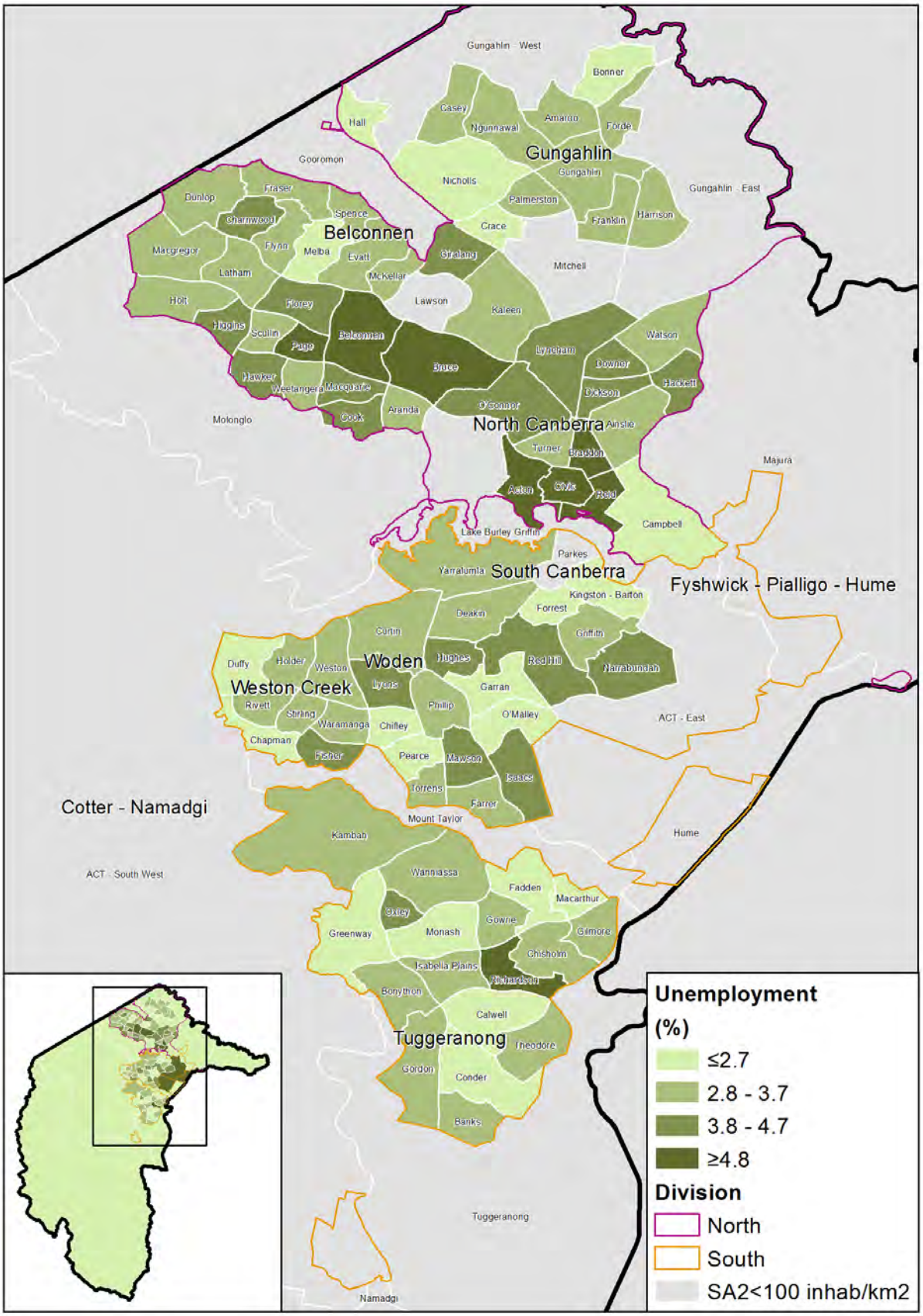


Figure 17 Distribution of Unemployment.

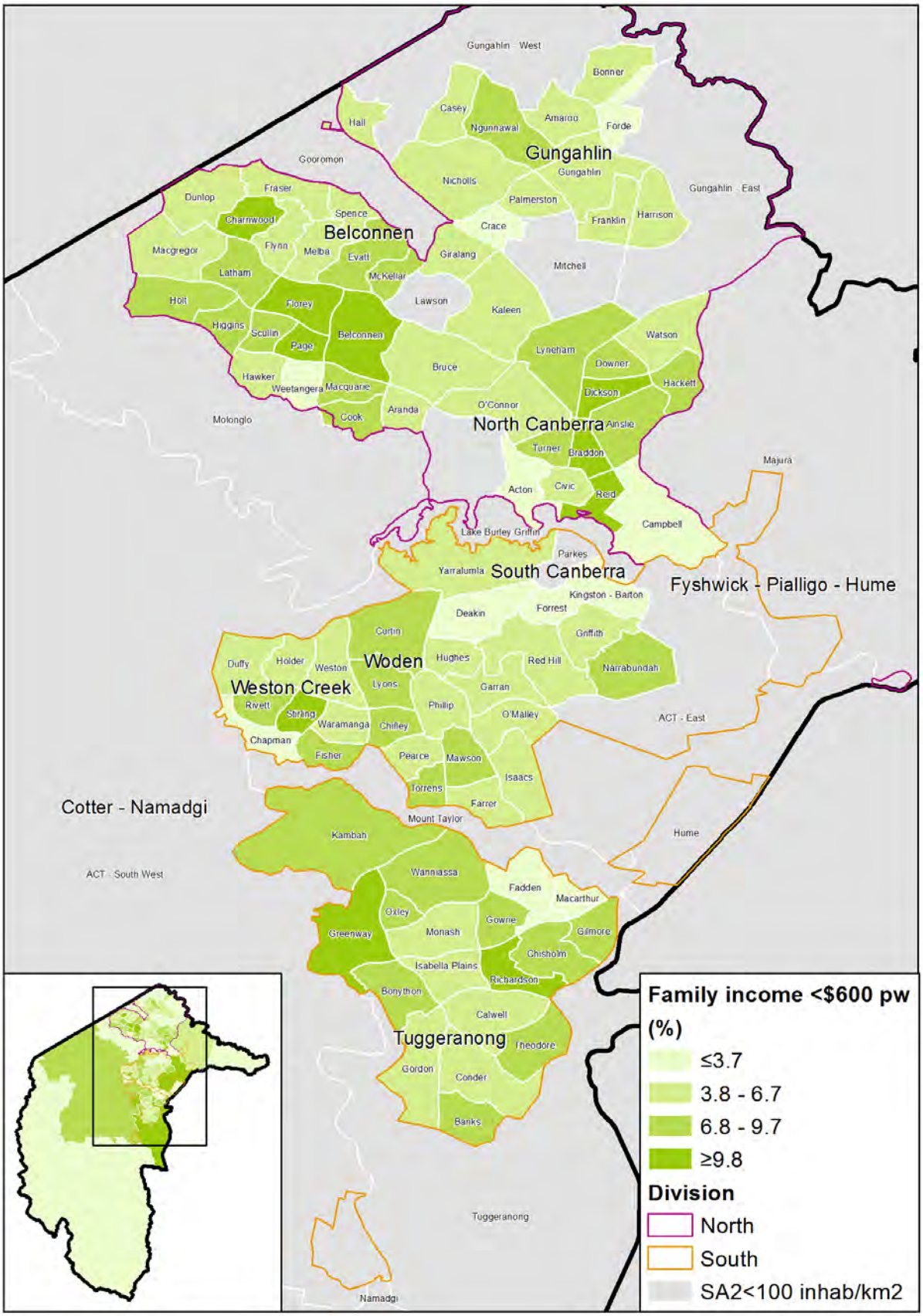


Figure 18 Distribution of Family Income < $600 pw.

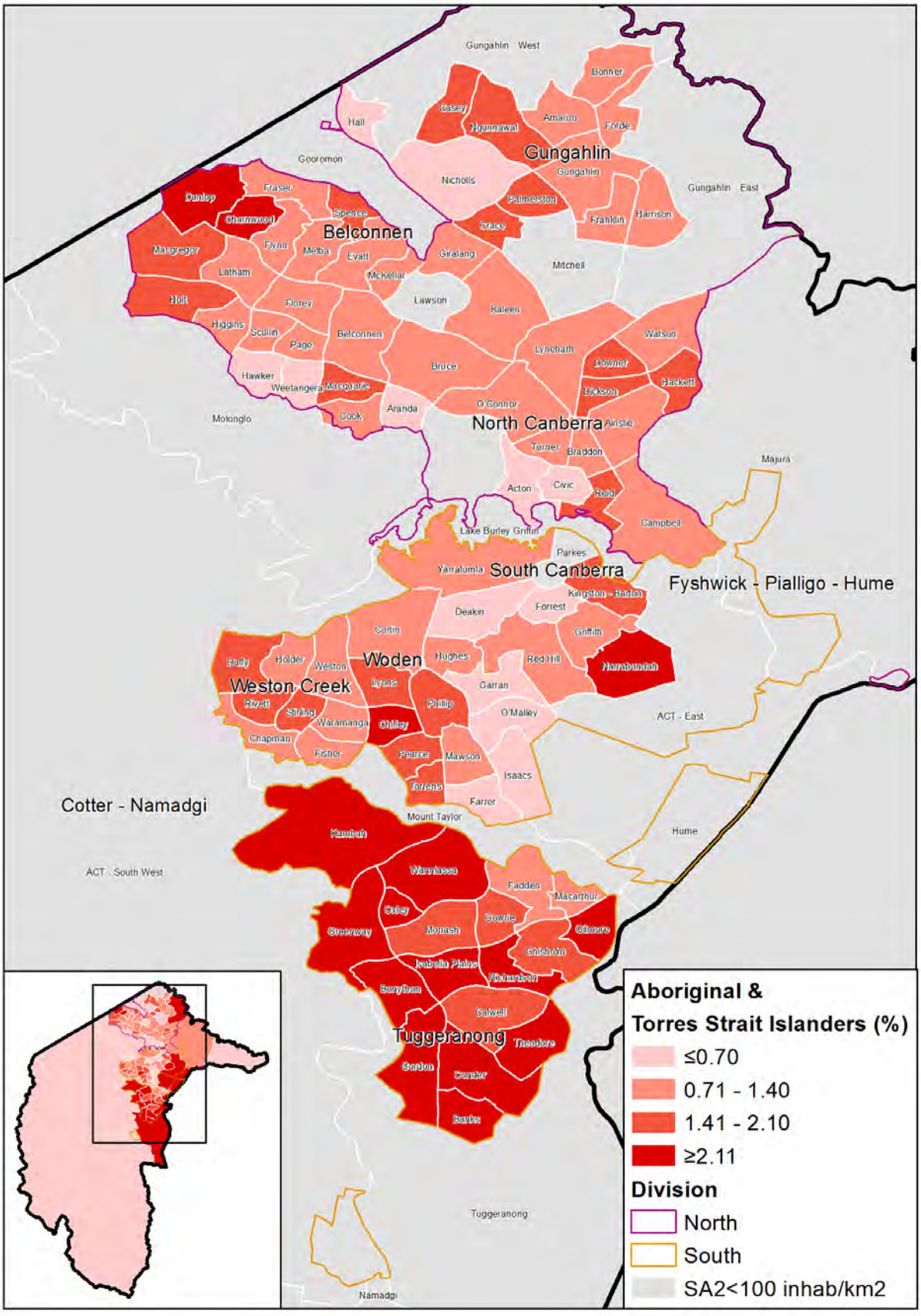


Figure 19 Distribution of Aboriginal and Torres Strait Islanders.

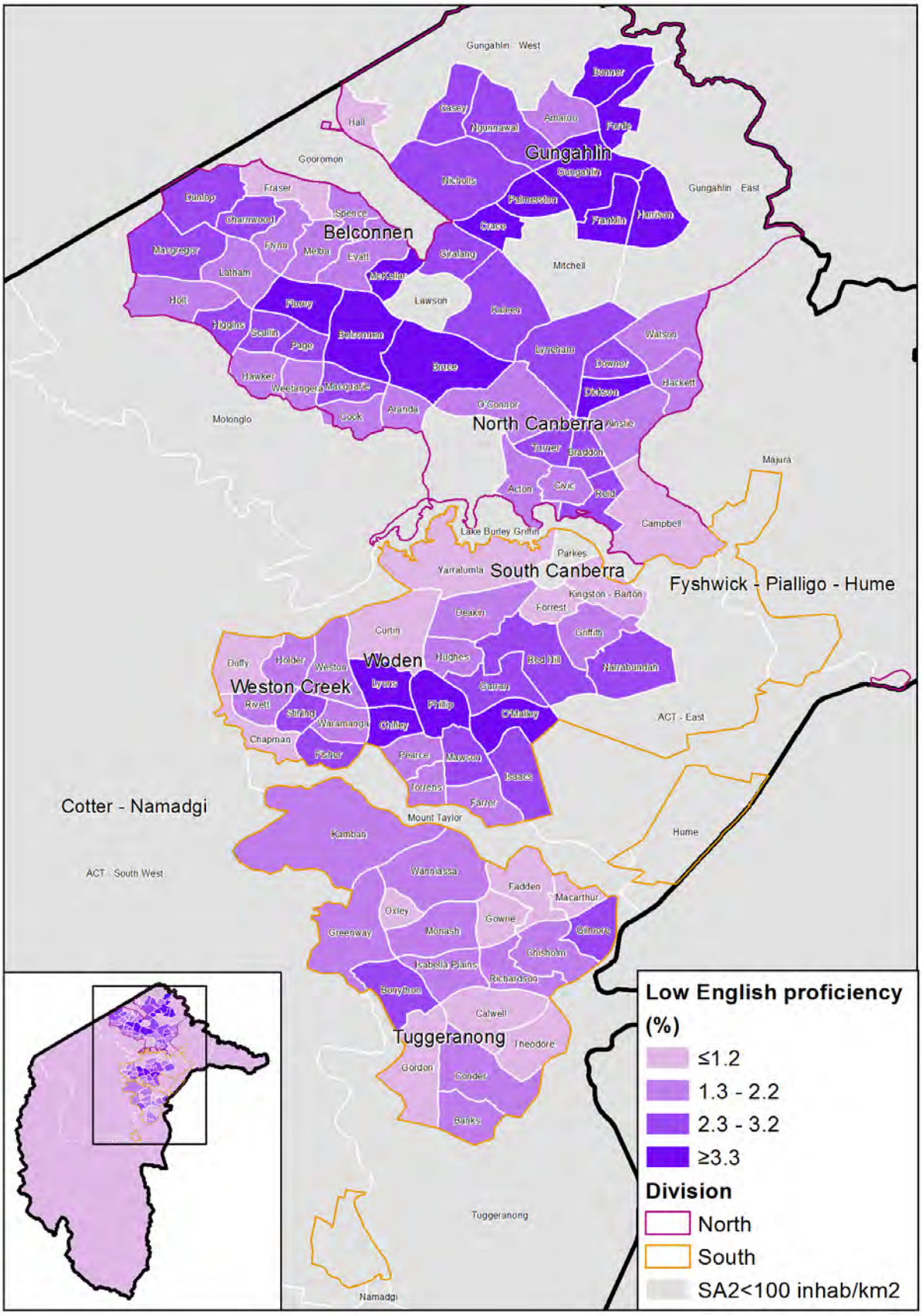


Figure 20 Distribution of Low English Proficiency.

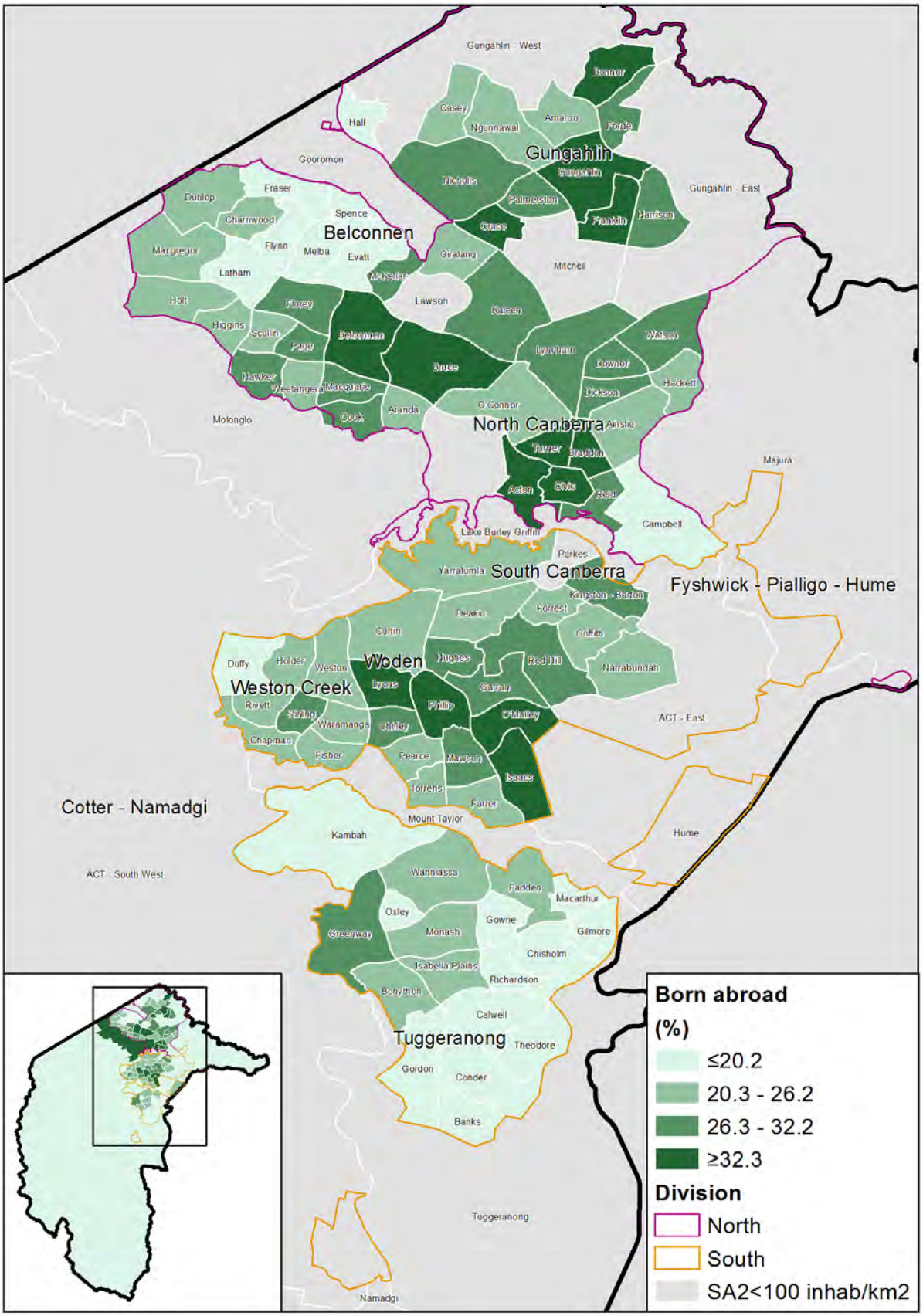


Figure 21 Distribution of People Born Abroad.

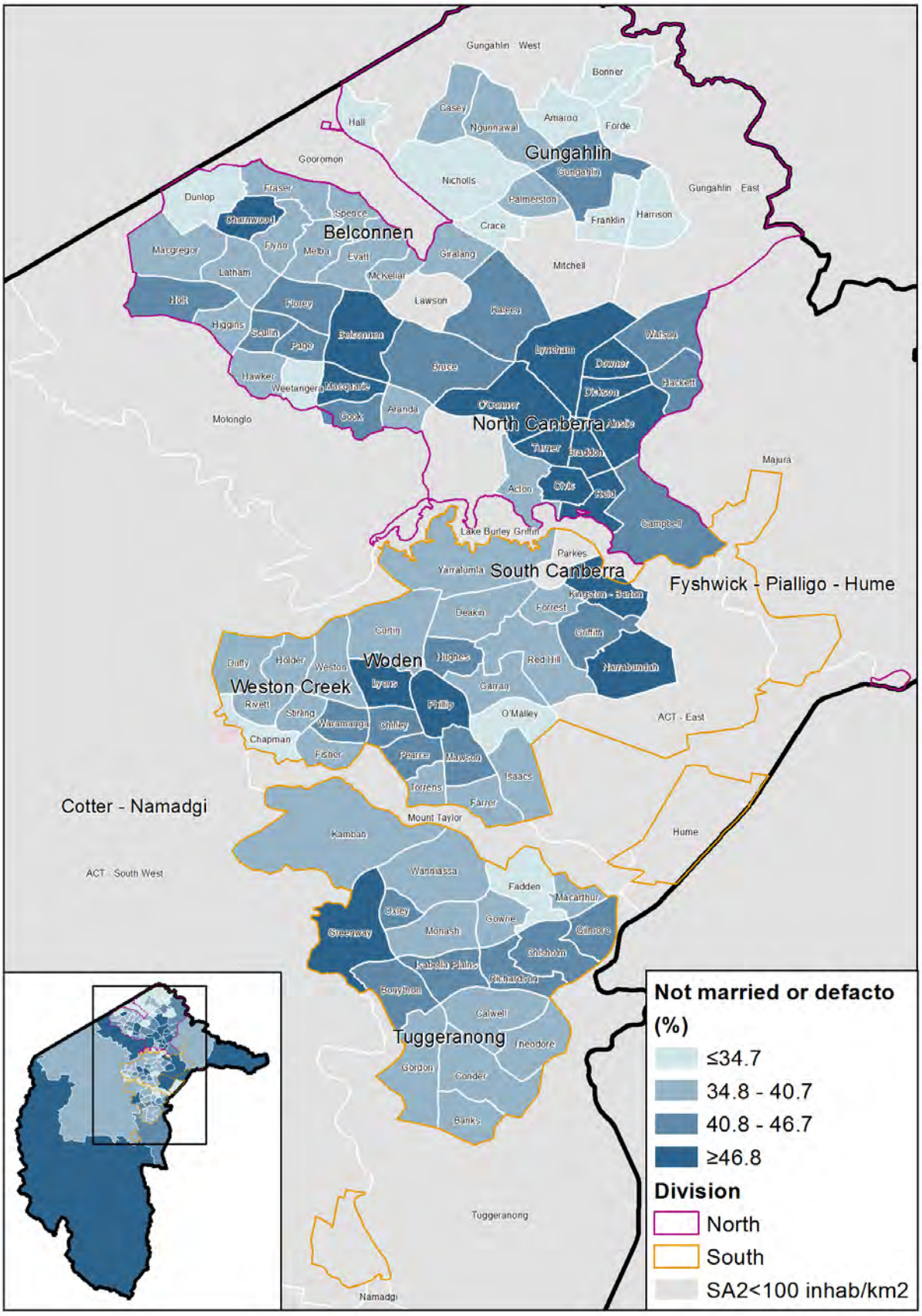


Figure 22 Distribution of people not married or living in a de facto relationship.

.

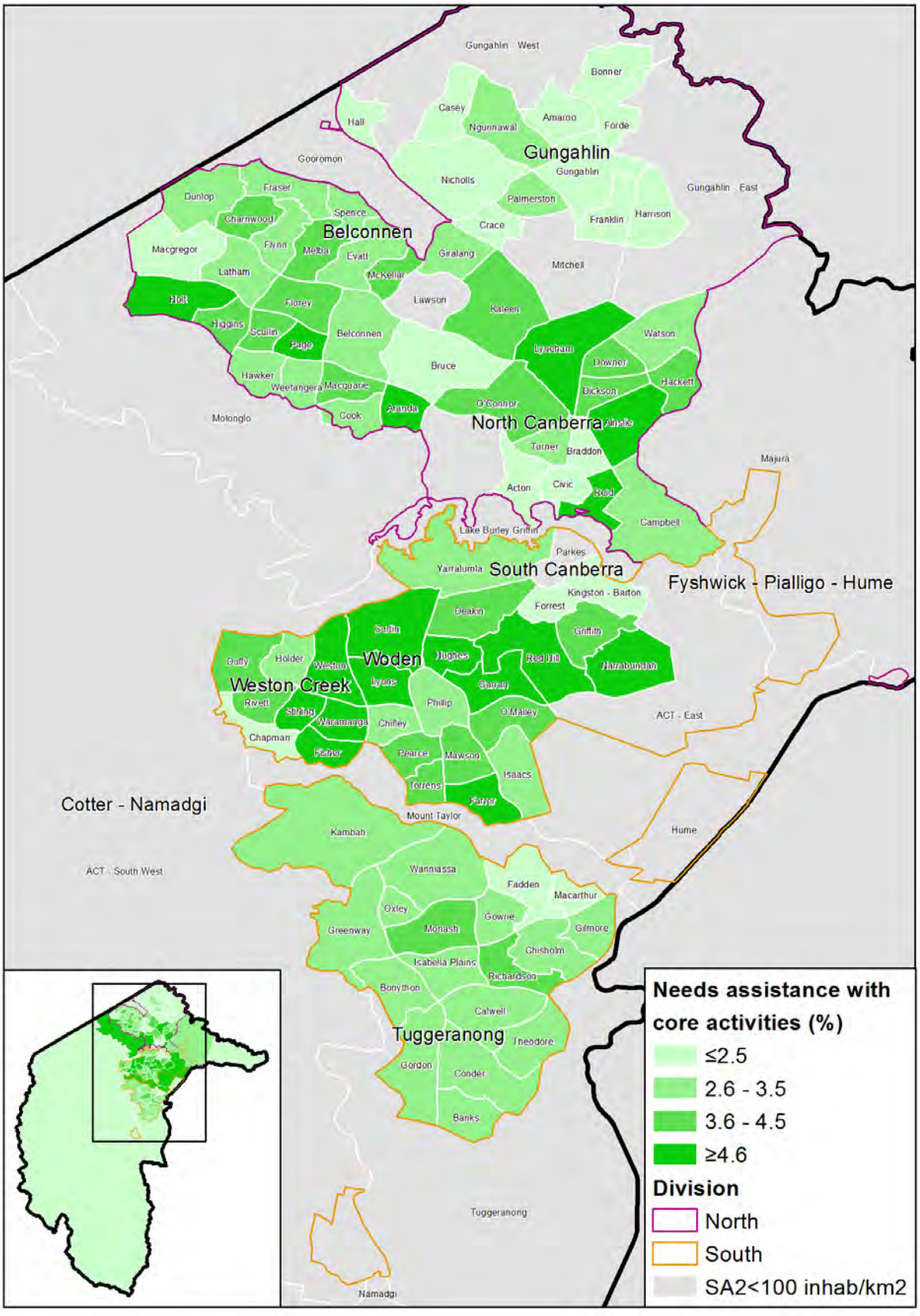


Figure 23 Distribution of People Needing Assistance with Core Activities

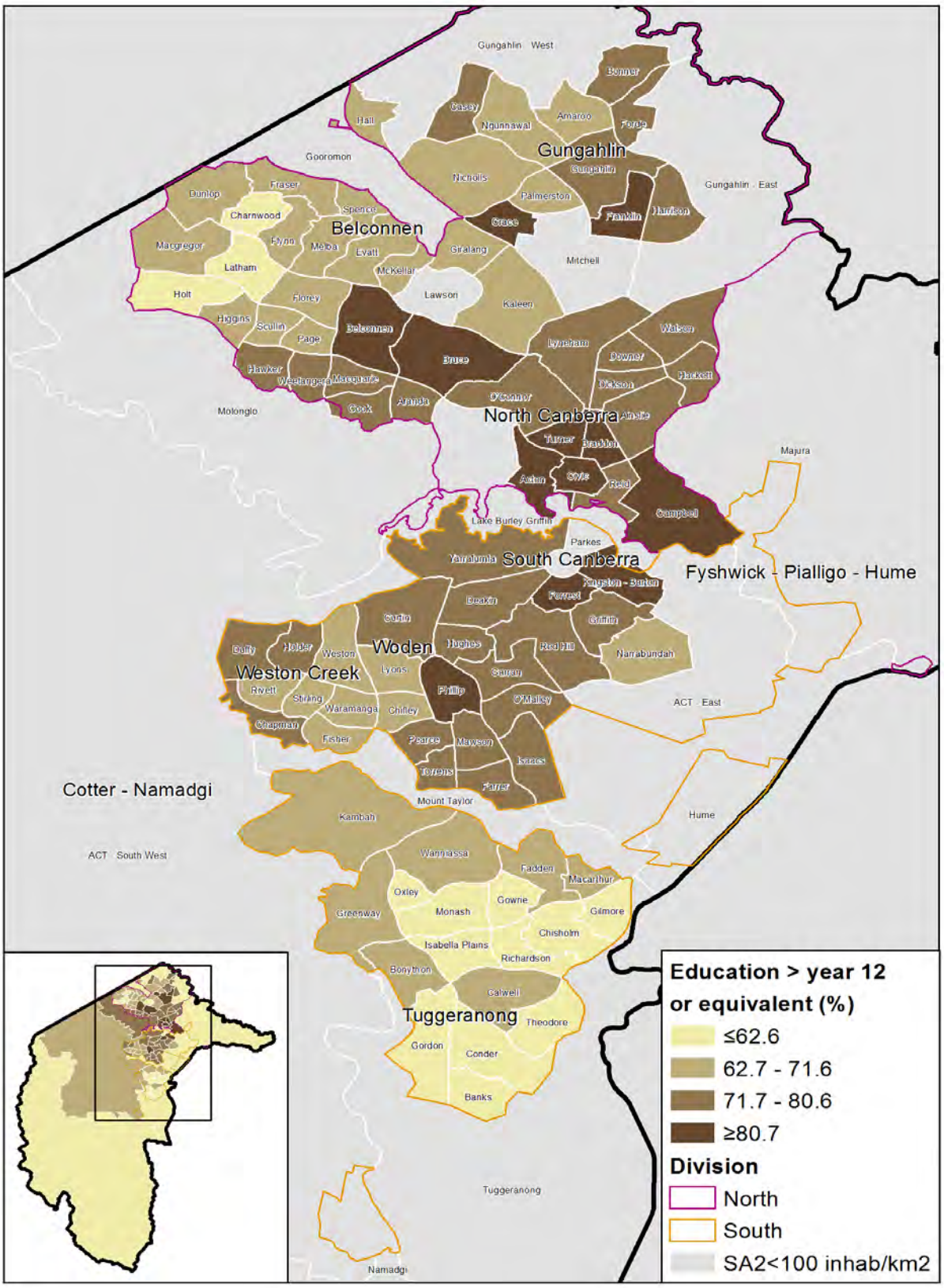


Figure 24 Distribution of people with year 12 or equivalent level of education.

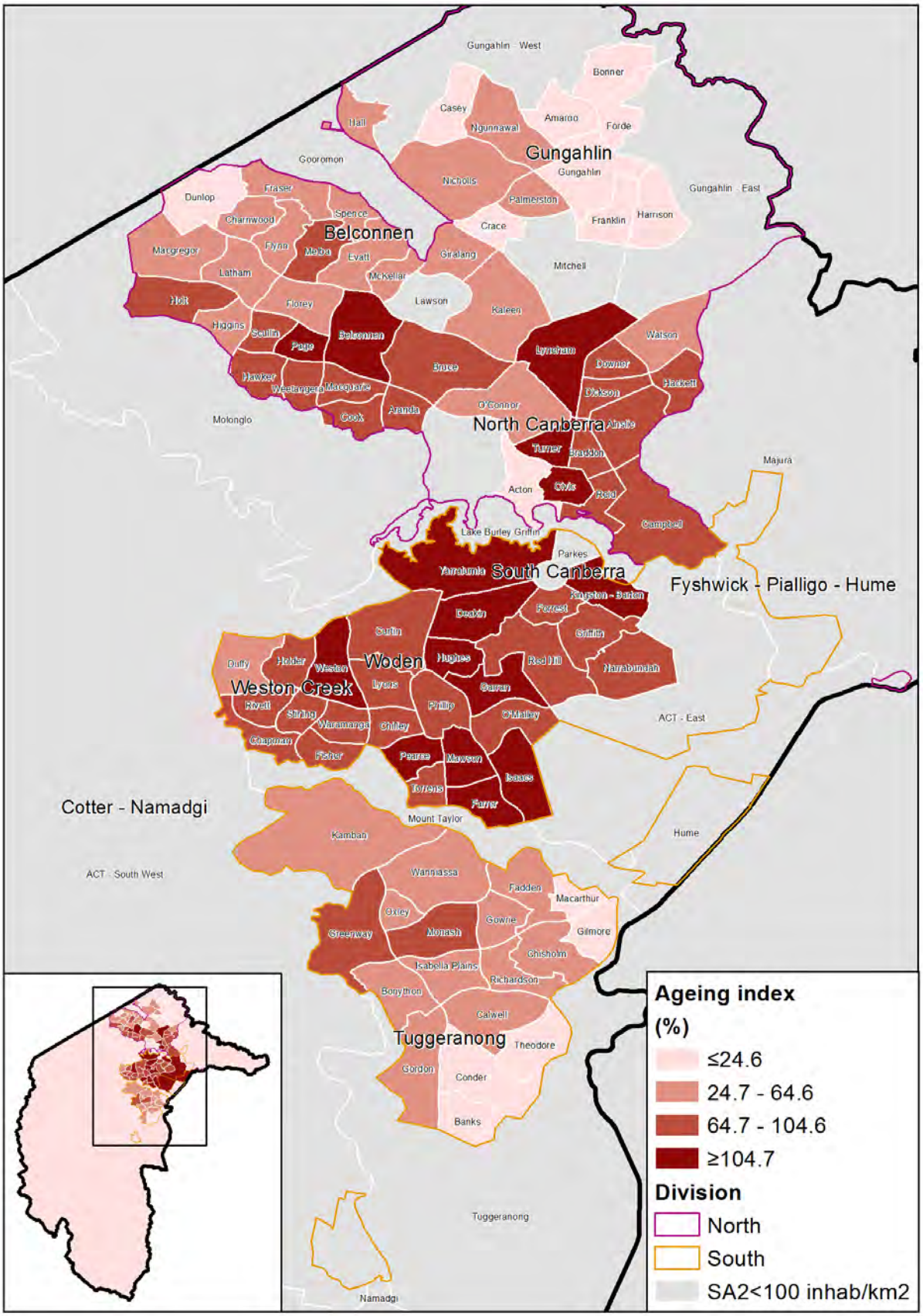


Figure 25 Ageing Index.

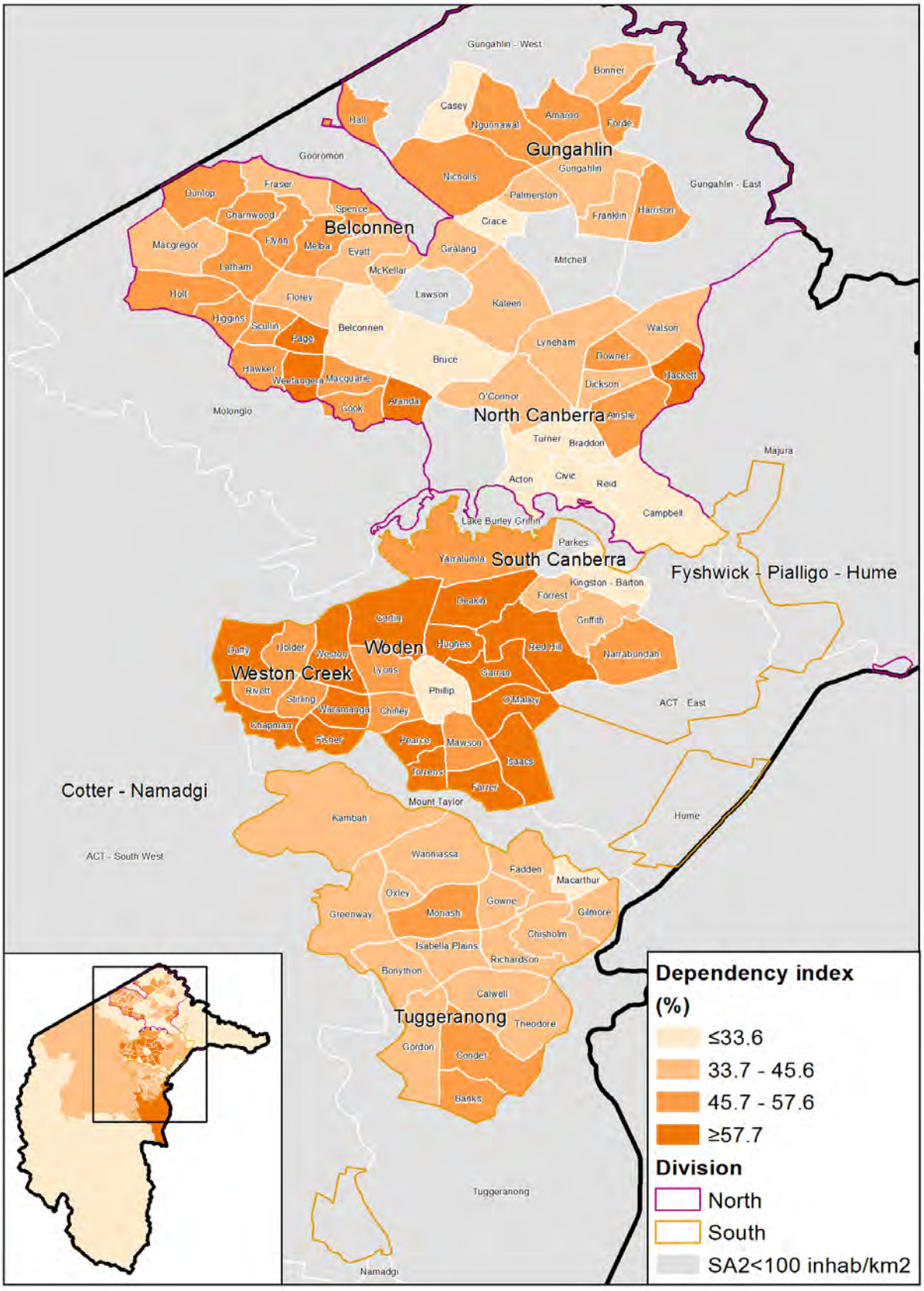


Figure 26 Dependency Index.

3. DESCRIBING THE SERVICES PROVIDING CARE FOR PEOPLE WITH A LIVED EXPERIENCE OF MENTAL ILLNESS

3.1. GENERAL DESCRIPTION

Data on services providing care for people with a lived experience of mental illness in the ACT PHN region was collected from the 3rd June to the 25th November 2016. Data was collected via 33 face-to-face or telephone interviews with mental health provider organisations. A total of 110 BSICs were identified, providing 122 MTC. 11 functional teams had more than one MTC. Services for whom the primary presentation criteria is not for mental health, such as those providing support to people with needs related to intellectual disability, homelessness, and alcohol and other drugs, were excluded from this coding as they require independent mapping.

76 MTCs (62.3%) of support provided is for adults in general (without a target specific population); 3 MTCs (2.46%) for older people; 7 MTCs (5.74%) for those transitioning to adulthood (this includes services for young carers and gender specific services for young people); 10 MTCs (8.2%) for both children and adolescents; and 26 (21.31%) for non-age related specific groups (including carers, offenders, gender specific, CALD, Aboriginal and Torres Strait Islander population, veterans, parents with mental illness).

The "core" health sector, provided in the ACT by public health (ACT Health), and including Children and Adolescent Mental Health Service (CAMHS), provides 38 MTCs (31.1%) of available support, while 84 MTCs are provided by "other" care : 79 MTCs (64.8%) are provided by the NGO sector, and 5 MTCs (4.1%) by Justice Health.

Four (40%) of services for children and adolescents, are core public health services, and 6 (60%) by NGOs.

In the public health sector, 8 MTCs (21.1%) of support provided was classified as residential; 26 MTCs (68.4.%) as outpatient; 2 MTCs (5.3%) as Information and Guidance; and 2 MTCs (5.3%) as Daycare/programs. Regarding other services, 17 MTCs (20.2%) of services were classified as Residential; 38 MTCs (45.2%) as Outpatient, 17 MTCs (20.2%) as Accessibility; 5 MTCs (6%) as Daycare/programs; 5 MTCs (6%) as Information and Guidance; and 2 (2.4%) as Voluntary and Self Help.

A detailed description of the MTCs identified is provided in the following figures.

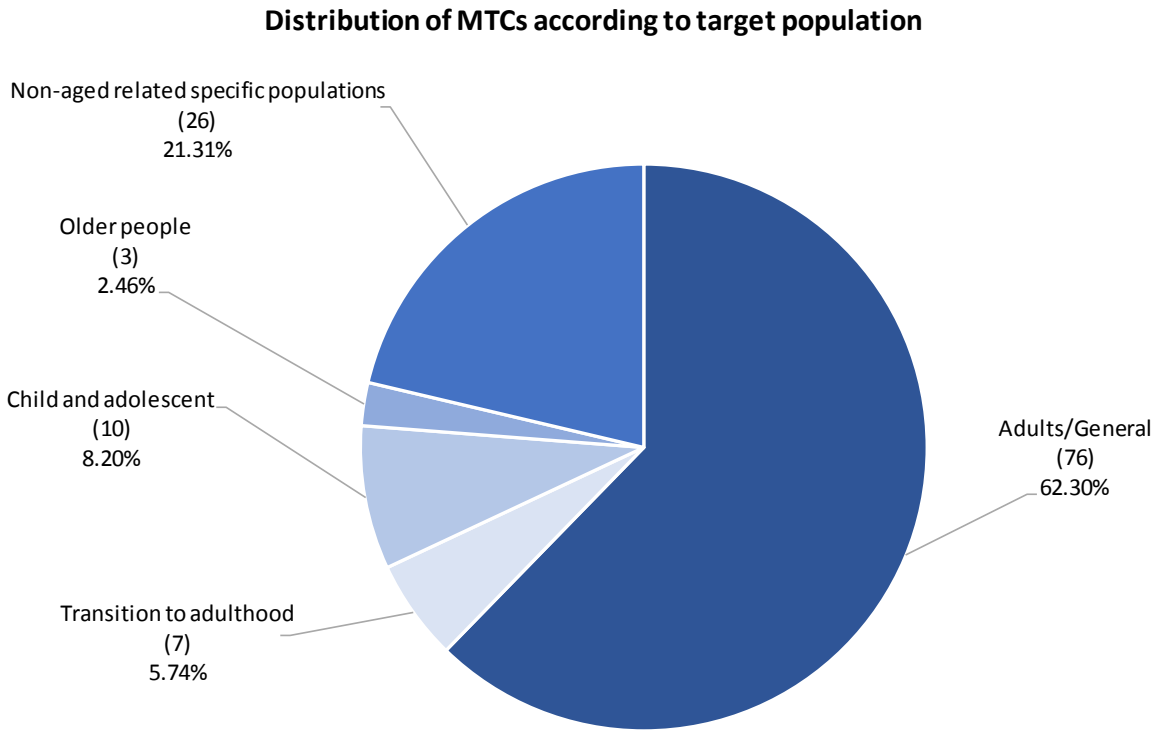


Figure 27 Distribution of MTCs in ACT according to target population (2016)

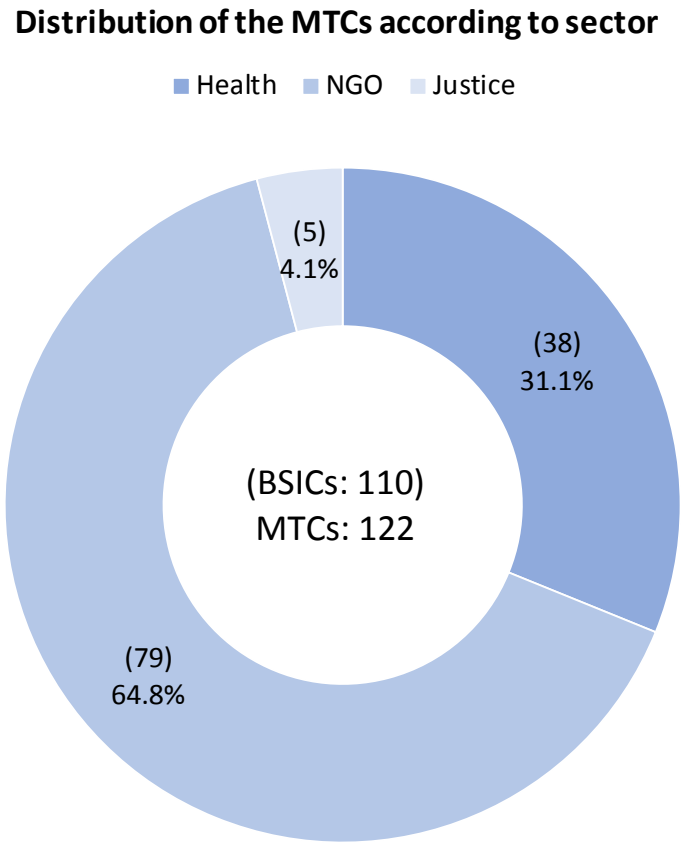


Figure 28 Distribution of MTCs in ACT according to sector (2016)

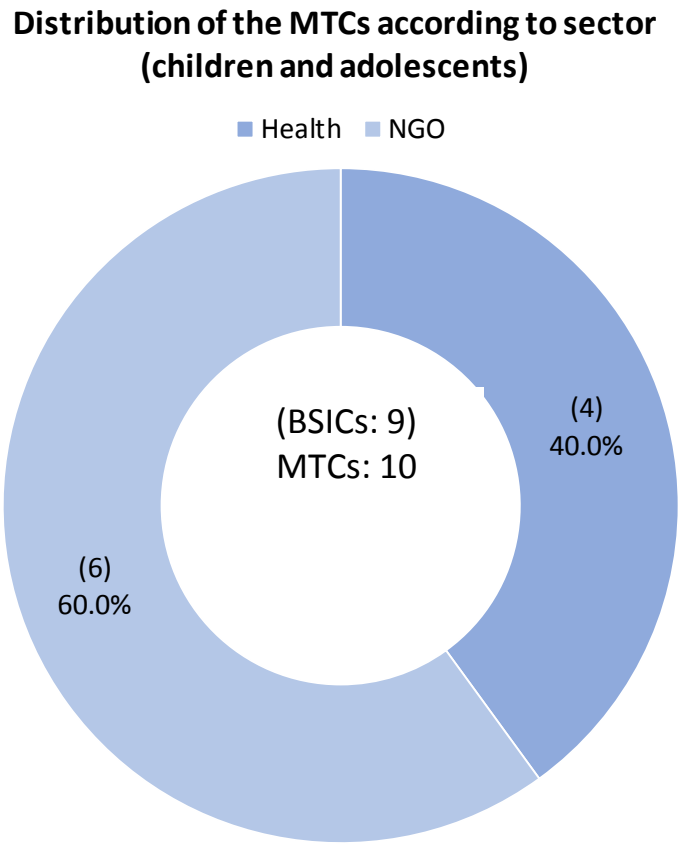


Figure 29 Distribution of Child and Adolescent MTCs in ACT according to sector (2106)

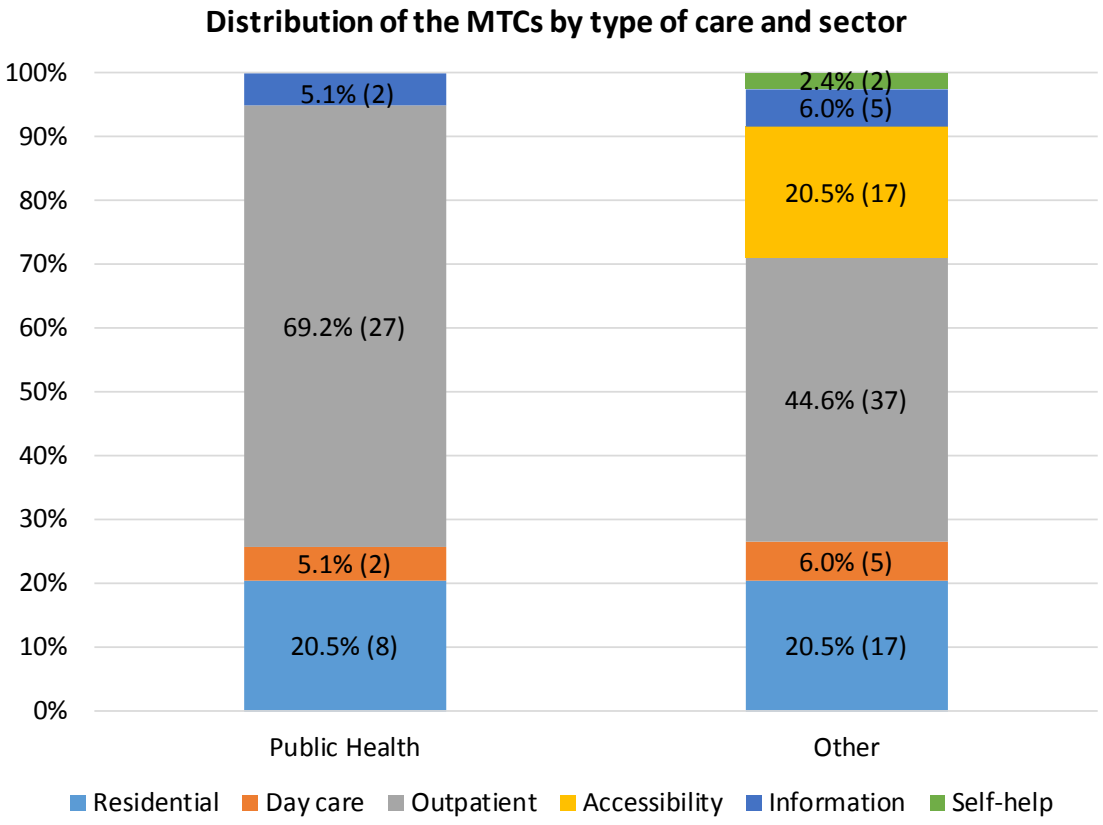


Figure 30 Distribution of MTCs in ACT according to type of care and sector (2016)

Table 2 Description of the MTCs per target population and care sector

MTC	Adults				Specific populations																Total			
					Children & adolescents				Transition to adulthood				Older adults				Non-age related specific populations							
	H	NGO	J	TOT	H	NGO	J	TOT	H	NGO	J	TOT	H	NGO	J	TOT	H	NGO	J	TOT	H	NGO	J	**TOT**
R	6	12	1	19	0	1	0	1	0	1	0	1	2	0	0	2	0	2	0	2	8	16	1	**25**
D	1	3	0	4	1	0	0	1	0	2	0	2	0	0	0	0	0	0	0	0	2	5	0	**7**
O	20	15	0	35	4	4	0	8	0	3	0	3	1	0	0	1	1	13	3	17	26	35	3	**64**
A	0	12	0	12	0	1	0	1	0	0	0	0	0	0	0	0	0	4	0	4	0	17	0	**17**
I	2	2	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	3	2	4	1	**7**
S	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	**2**
TOTAL	29	46	1	76	5	6	0	11	0	6	0	6	3	0	0	3	1	21	4	26	38	79	5	**122**

R:Residential: D:Daycare; O:Outpatient; A:Accessibility; I:Information and Guidance;S:Self-help and Voluntary MTC:Main Types of Care
H:Public Health; NGO: Non- Government Organisation; J:Justice

Please note the following with regard to ACT Health data:
The total FTEs for each service area based on budgeted FTE as of March 2017 with the exception of Medical FTE (psychiatrists/registrars) as this was based on staffing estimates at the time of data collection so may vary from current actual and budgeted FTE.
FTE shown do not include management or administrative staff.
Breakdown of clinical staff into health professional subcategories (Psychologists/Occupational Therapists/Social Workers) is based on a combination of actual staff mix composition at time of data collection and expected staff mix composition (noting that there are a number of multi-classified positions within a number of areas) so FTE for each listed professional group (Psychologist/Social Worker/Occupational Therapist) may not accurately reflect current composition based on a number of staff movements.

3.2. ADULTS

In this section we describe the availability and placement capacity (number of places or beds available in every functional team) of the BSICs/services providing care for adults (residents over the age of 17 years) with a lived experience of mental illness, by care sector. Specific age related services, including services for adults over 65 years, and services providing support to specific groups, such as carers and Aboriginal and Torres Strait Islander people, or gender specific services, are described in other sections.

3.2.1. RESIDENTIAL CARE

3.2.1.1. RESIDENTIAL CARE PROVIDED BY THE PUBLIC HEALTH SECTOR

ACUTE RESIDENTIAL SERVICES

Three acute residential services (BSICs) provided by the public health sector in the ACT PHN region were identified. These services provided a total of 4 MTC. At Canberra Hospital, a 6 bed Mental Health Short Stay Unit (MHSSU) provides a 24 hour mental health care presence in the Emergency Department for short stays of up to 48 hours. **The total number of acute adult inpatient beds provided by the public health sector is 63, or 22.74 per 100,000 residents over the age of 17 years. The number of acute residential BSICs per 100,000 residents over the age of 17 years is 1.1.**

Table 3 Acute Residential services: availability and capacity (2016).

Provider	Name	Main DESDE code	Other DESDE Codes	Beds/Places	Town/ Suburb	Area of coverage
ACT Health-Mental Health, Justice Health, Alcohol and Drug Services-Adult Acute Mental Health Services	Adult Mental Health Unit (AMHU)-Low dependency Beds/High Dependency	AX[F00-F99]-R2	AX[F00-F99]-R1	27/10	Garran	ACT
ACT Health-Mental Health, Justice Health, Alcohol and Drug Services-Adult Acute Mental Health Services	Mental Health Short Stay Unit (MHSSU)	AX[F00-F99]-R2		6	Garran	ACT
Calvary Healthcare Mental Health Services-Calvary Hospital	2N-Adult MH Inpatient Services	AX[F00-F99]-R2		20	Bruce	Primarily northern suburbs of Canberra, but depends on bed availability

Total	**3**	**63**
Rate per 100,000 residents (>17 years old)	**1.1**	**22.74**

The following table shows workforce capacity in acute adult residential services provided by the public health sector in the ACT PHN region. As would be expected, psychiatrists, psychiatric registrars and mental health nurses comprise the bulk of the workforce, with additional support provided by an allied health workforce of psychologists, social workers and occupational therapists, as well as Health Services Officers and a Recovery Support Officer in the AMHU. The Metal Health Short Stay Unit also uses Allied Health Support accessed from the AMHU.

Table 4 Acute Residential services: workforce capacity (2016).

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT	Other
ACT Health-Mental Health, Justice Health, Alcohol and Drug Services-Adult Acute Mental Health Services	Adult Mental Health Unit (AMHU)-Low dependency Beds/ High Dependency beds	81.76	7.0	3.78	61.82	3.0	3.0	3.16
ACT Health-Mental Health, Justice Health, Alcohol and Drug Services-Adult Acute Mental Health Services	Mental Health Short Stay Unit (MHSSU)	12.57	2.0		10.57			
Calvary Healthcare Mental Health Services-Calvary Hospital	2N-Adult MH Inpatient Services	NA	NA	1.3	28.0	1.0	0.5	
Total		**NA**						
Rate per 100,000 residents (>17 years old)		**NA**						

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist.NA: Data not available or incomplete

**Please note Psychiatry Cover is shared with ED Consultation Liaison Services*

NON- ACUTE RESIDENTIAL SERVICES

One BSIC/service providing non-acute residential care in the ACT PHN region by the public health sector was identified, incorporating 2 MTC. The Brian Hennessy Rehabilitation Centre provides 20 beds for supported accommodation such as respite, rehabilitation, and sub-acute care, with an additional smaller secure facility with 10 beds providing appropriate care for consumers with higher needs. The rehabilitation services provided at BHRC will be transferred to the University of Canberra Public Hospital in 2018. **There is 1 BSIC, or 0.4 BSICs per 100,000 residents over the age of 17 years. There are 30 non- acute residential beds, or 10.8 per 100,000 people over the age of 17 years, in the ACT PHN region.**

Table 5 Non-acute Residential services: availability and capacity (2016).

Provider	Name	Main DESDE Code	Other DESDE Codes	Beds/ Places	Town/ Suburb	Area of Coverage
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Rehabilitation and Specialty MHS	Brian Hennessy Rehabilitation Centre (BHRC)	AX[F00-F99]-R11	AX[F00-F99]-R11vc	20/10	Bruce	ACT
Total	**1**			**30**		
Rate per 100,000 residents (>17 years old)	**0.4**			**10.8**		

The workforce capacity in non- acute residential care is again comprised mostly of mental health nurses, along with psychiatric physicians and allied health staff. **There are 42.08 FTEs, or 15.19 FTEs per residents over 17 years of age, providing non-acute inpatient care in the public health sector in the ACT PHN region.**

Table 6 Non- acute Residential services: workforce capacity (2016).

Provider	Name	Total FTE	Psych/Reg	Psychol	MHN	SW	OT	Other
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Rehabilitation and Specialty MHS	Brian Hennessy Rehabilitation Centre (BHRC)	42.08	2.0	0.8	27.28	1.0	1.0	10.0

Total	**42.08**
Rate per 100,000 residents (>17 years old)	**15.19**

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist..

OTHER RESIDENTIAL CARE PROVIDED BY THE PUBLIC SECTOR

It is important when coding services to distinguish between those providing accommodation and support, and those providing in-home support to people living in housing provided by other means, such as community housing. Thus, services which provide both accommodation and in-home support to people with a lived experience of mental illness are coded as residential care, and services which provide in-home support only, are coded as outpatient care. Additionally, it is not always possible to identify the percentage of beds specifically designated for people with mental health needs. An example is the HASI (Housing Accommodation and Support Initiative)/HARI (Mental Health Housing and Recovery Initiative) programs. These support sustainable tenancies in public housing for people with moderate to severe mental health issues, and can be delivered at an individual's privately owned or rented property or through social housing. It could be argued that the way housing for people with mental illness is provided is more accurately conceptualised as a financing mechanism than a service providing care. In the ACT PHN region, a HASI/HARI supportive tenancy service, funded by the ACT and provided by a partnership of Woden Community Services and the YWCA, ended on June 30, 2016, with the transitioning of programs to the NDIS.

There are no acute residential BSICs provided by NGOs.

3.2.1.2. RESIDENTIAL CARE PROVIDED BY THE NGO SECTOR

Twelve BSICs/services providing non-acute residential support for people with a lived experience of mental illness in the ACT PHN region were identified. Richmond Fellowship provide a Residential Recovery Program, which comprises 6 services in different locations around the ACT, one of which (North Lyneham) provides transitional support. The homes in Page, Scullin, Holt, Lyneham and Curtin provide 24 hour support. Richmond Fellowship liaises when necessary with Mental Health Services, Justice Services and Alcohol and Drug Services. The Mental Health Foundation provide a Supported Accommodation and Rehabilitation Program (SARP), which at the time of interview provided homes at three satellite sites, served by the same team, and comprising 7 beds, but which has since expanded to 5 sites, with a further site potentially to be added. Mental Health Foundation both leases the properties, and provides the support. Mental Health Foundation also provide a Residential Respite program at Warren I'Anson House which can provide respite accommodation either to the person with a lived experience of mental illness, or, if preferred, to their carer. GROW- Community Based Mental Health Support provide 5 beds for long-stay residential rehabilitation, accommodation (up to

nine months) in a long lease from Barton Housing of purpose built housing, with daily structured support. Wellways (previously known as Mental Illness Fellowship) also provides five beds in its Adult Step Up and Step Down program, aimed at assisting recovery from acute episodes of illness, and preventing relapse. Wellways also manages a Youth Step Up Step Down service in Kambah in partnership with ACT Health with 6 beds for people aged 18-25 years (coded in Transition to Adulthood section). A residential service provided by Catholic Care specifically for men, is included in the gender specific section later in the report.

Ten BSIC have been coded with the "v" qualifier as they do not have guaranteed funding for three years.

There are 12 BSICs, or 4.3 BSICs per 100,000 residents over the age of 17 years, providing a total of 55 beds, or 19.9 beds per 100,000 residents over the age of 17 years.

Table 7 Residential care provided by the NGO sector: availability and capacity (2016).

Provider	Name	Main DESDE Code	Other DESDE Code(s)	Beds/ Places	Town / Suburb	Area of Coverage
Grow - ACT	Residential Rehabilitation Program	AX[F10- F19]-R10.2		5	Narrabundah	ACT predominantly-NSW if space available
Mental Health Foundation	Residential respite-Warren I'Anson House	AX[F00-F99]-R9.1v	AX[e310][F00-F99]-R9.1	9	Chifley	ACT
Mental Health Foundation	The Supported Accommodation Rehabilitation Program (SARP) (satellite)	AX[F00-F99]-R12v		3	Kambah	ACT
Mental Health Foundation	The Supported Accommodation Rehabilitation Program (SARP) (satellite)	AX[F00-F99]-R12v		3	Narrabundah	ACT
Mental Health Foundation	The Supported Accommodation Rehabilitation Program (SARP) (satellite)	AX[F00-F99]-R12v		2	Griffith	ACT
Richmond fellowship ACT	Residential Recovery program - Curtin	AX[F00-F99]-R11v		5	Curtin	ACT
Richmond fellowship ACT	Residential Recovery program -Holt	AX[F00-F99]-R11v		5	Holt	ACT

Richmond fellowship ACT	Residential Recovery program -Lyneham	AX[F00-F99]-R11v		5	Lyneham	ACT
Richmond fellowship ACT	Residential Recovery program -Page	AX[F00-F99]-R11v		5	Page	ACT
Richmond fellowship ACT	Residential Recovery program -Scullin	AX[F00-F99]-R11v		5	Scullin	ACT
Richmond fellowship ACT	Residential Recovery Program- North Lyneham	AX[F00-F99]-R9v		3	North Lyneham	ACT
Well Ways (previously known as Mental Illness Fellowship) Mental Health Services	Step up and Step down	AX[F00-F99]-R8.2		5	North Lyneham	ACT
Total	**12**			**55**		
Rate per 100,000 residents (>17 years old)	**4.3**			**19.9**		

Support workers are the largest group of professionals employed in residential care provided by NGOs. Warren I'Anson House and the SARP program provide support from staff with a minimum qualification of Certificate IV, and which may also include health professionals, such as psychologists. Mental Health Foundation provides on call support overnight, and also has a small (0.2 FTE) peer workforce. Wellways provides the support of three FTE during business hours, and 1 FTE outside of business hours. This program includes support from a mental health nurse. **There are 31 FTE, or 11.2 per 100,000 residents over the age of 17 years, providing residential care in the NGO sector.**

Table 8 Residential care provided by NGOs: workforce capacity (2016).

Provider	Name	Total FTE	OT	SupW	Peers	Others
Grow - ACT	Residential Rehabilitation Program	1.8		1.8		
Mental Health Foundation	Residential respite-Warren I'Anson House	4.0		3.8	0.2	

Mental Health Foundation	The Supported Accommodation Rehabilitation Program (SARP) (satellite)	0.5			0.5
Mental Health Foundation	The Supported Accommodation Rehabilitation Program (SARP) (satellite)	0.5			0.5
Mental Health Foundation	The Supported Accommodation Rehabilitation Program (SARP) (satellite)	0.4			0.4
Richmond Fellowship ACT	Residential Recovery program - Curtin	3.3	0.1	3.2	
Richmond Fellowship ACT	Residential Recovery program - Holt	3.3	0.1	3.2	
Richmond F Fellowship ACT	Residential Recovery program - Hyneham	3.3	0.1	3.2	
Richmond Fellowship ACT	Residential Recovery program - Page	3.3	0.1	3.2	
Richmond f Fellowship ACT	Residential Recovery program - Scullin	3.3	0.1	3.2	
Richmond Fellowship ACT	Residential Recovery Program- North Lyneham	3.3	0.1	3.2	
Well Ways -(previously known as Mental Illness Fellowship)/Mental Health Services	Step up and Step down	4.0		4.0	
Total		**31**			
Rate per 100,000 residents (>17 years old)		**11.2**			

FTE: Full Time Equivalents; OT: Occupational therapist; SupW: Support Worker/Community worker; Peer: Peer worker.

3.2.2. DAY CARE (STRUCTURED PROGRAMS)

3.2.2.1 DAY CARE/PROGRAMS PROVIDED BY THE PUBLIC HEALTH SECTOR

We identified one service providing day care funded by the public health sector. This is a program which, while treating adults, is actually operated by Child and Adolescent Mental Health Services (CAMHS). It is an Eating Disorders Program located at Phillip Health Centre in Woden, staffed by a multidisciplinary team, including social work, psychology, occupational therapy and nursing staff. It provides support to people of all ages, and their families, in the ACT. **There are 0.4 Daycare BSICs provided by the**

public health sector per 100,000 residents in the ACT PHN region. There are 4.52 FTE, or 1.63 per 100,000 residents in the ACT PHN region.

Table 9 Day programs provided by the public health sector: availability and capacity (2016).

Provider	Name	Main DESDE Code	Beds/ Places	FTE	Town / Suburb	Area of Coverage
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Eating Disorders Program	GX [F50]-D8.1	NA	4.1	Woden	ACT
Total	**1**					
Rate per 100,000 residents (>17 years old)	**0.4**					

Table 10 Day programs provided by the public health sector: workforce capacity (2016).

Provider	Name	Total FTE	Psych/Reg	Psychol	MHN	SW	OT
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Eating Disorders Program	4.52	0.1	1.51	1.0	1.0	1.0
FTE Total		**4.52**					
Rate per 100,000 residents (>17 years old)		**1.63**					

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist..

3.2.2.2 DAY CARE/PROGRAMS PROVIDED BY THE NGO SECTOR

SOCIAL/CULTURE RELATED

We have identified three NGO funded BSICs/services offering structured day care/day programs.

The Day to Day Living program provided by Belconnen Community Service Inc. provides sessional tutoring in a range of areas, including arts based programs: for example, participants have recently been given support to run an art exhibition. It has recently also been supporting participants to prepare for their NDIS interview. Funding of this program has been reduced in line with the move to NDIS. Sunflower Services (previously Schizophrenia Fellowship) also provide a service which incorporates two

MTC, one of which is also a Day to Day Living program. This program includes workshops teaching participants skills such as furniture restoration, or art based skill; or skills based on participant's needs such as barista training to support work readiness. It also provides a service for consumers who are not linked in with other services. At the time of data collection, the Mental Health Foundation offered The Rainbow Psychosocial Rehabilitation program, combined with a Skills for Life program. These provided centre based group activities including the development of individual plans and teaching of basic skills such as computer skills or other work skills, and a safe place for participants to spend time during the day. *Please note that The Rainbow has since closed, in December 2016*. Belconnen Day to Day have staff from a range of backgrounds including teaching or other degrees, and lived experience. Staffing qualifications required for The Rainbow were a minimum of Certificate IV; Sunflower Services is also staffed by professionals with diploma level qualifications, such as Counselling, Mental health and Wellbeing, and Youth Drug and Alcohol.

Two BSIC have been coded with the "v" qualifier as they do not have guaranteed funding for three years.

There are 3 BSICs or 1.1 BSICs per 100,000 residents over the age of 17 years, with a workforce capacity of 7.3, or 2.6 per 100,000 residents.

Table 11 Social and culture-related Day programs provided by NGOs: availability (2016).

Provider	Name	Main DESDE Code	Other DESDE Code(s)	Town / Suburb	Area of Coverage
Belconnen Community Service	Day to Day living program	AX[F00-F99]-D8.2v		Belconnen	ACT
Mental Health Foundation	The Rainbow psychosocial rehabilitation program + The Skills for Life Program*	AX[F00-F99]-D5v		Chifley	ACT
Sunflower Services (previously Schizophrenia Fellowship NSW)	Day to Day Living Canberra City	AX[F00-F99]-D5	AX[F00-F99]-A4	Ainslie	ACT
Total	**3**				
Rate per 100,000 residents (>17 years old)	**1.1**				

**Please note: The Rainbow has since closed, in December 2016.*

Table 12 Social and culture-related Day programs provided by NGOs: workforce capacity (2016).

Provider	Name	Total FTE	Others
Belconnen Community Service	Day to Day Living program	3.0	3.0
Mental Health Foundation	The Rainbow psychosocial rehabilitation program + The Skills for Life Program *	1.5	1.5
Sunflower Services (previously Schizophrenia Fellowship NSW)	Day to Day Living Canberra City	2.8	2.8
Total		**7.3**	
Rate per 100,000 residents (>17 years old)		**2.6**	

FTE: Full Time Equivalents.
**Please note: The Rainbow has since closed, in December 2016.*

WORK RELATED

We did not identify any BSICs providing work related day programs: that is, services where users carry out an activity closely resembling work, and for which payment would be expected in the open market, but where they are paid less than 50% of the expected wage for the type of work.

However, the Richmond Fellowship PHAMS program includes one employment specialist. Wellways (previously known as Mental Illness Fellowship) previously provided a vocational rehabilitation program, which is no longer funded.

3.2.3 OUTPATIENT CARE

3.2.3.1 OUTPATIENT CARE PROVIDED BY THE PUBLIC HEALTH SECTOR

ACUTE MOBILE OUTPATIENT CARE

We identified one BSIC/service provided by the public health sector, incorporating two MTC, offering acute mobile outpatient care. The Crisis Assessment and Treatment Team (CATT) provide a mental health triage service, crisis support and short term intervention 24 hours a day. It is staffed by a range of health and allied health professionals, including medical staff (psychiatrist or registrar), as well as psychology, social work and nursing

staff. Nurses are the largest group of health professionals employed in this service. **There is 1 BSIC, or 0.4 BSICs per 100,000 residents over 17 years providing acute mobile outpatient care in the public health sector in the ACT PHN region, with 29.56 FTE, or 12.30 per 100,000 residents over the age of 17 years.**

Table 13 Acute mobile Outpatient care provided by the public health sector: availability (2016).

Provider	Name	Main DESDE Code	Other DESDE Code(s)	Town/ Suburb	Area of Coverage
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Crisis Assessment and Treatment Team (CATT)	GX[F00-F99]-O1.1	GX[F00-F99]- O1.1	ACT	ACT
Total	**1**				
Rate per 100,000 residents (>17 years old)	**0.4**				

Table 14 Acute mobile Outpatient care provided by the public health sector: workforce capacity (2016).

Provider	Name	Total FTE	Psych/Reg	Psychol	MHN	SW	OT
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Crisis Assessment and Treatment Team (CATT)	29.56	2.0	10.0	12.16	4.4	1.0
Total		**29.56**					
Rate per 100,000 residents (>17 years old)		**12.3**					

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker

ACUTE NON-MOBILE OUTPATIENT CARE

We identified two public health sector BSIC/service providing acute non- mobile outpatient care in the ACT PHN region. Consultation Psychiatry Liaison Services provide specialist assessment to patients on medical wards at Calvary Hospital. Emergency Department Mental Health Consultation Liaison Services at Canberra Hospital are for the Emergency Department and other non-MH inpatient wards. **There are 2 BSIC, or 0.8 BSIC per 100,000 residents over 17 years of age providing acute non-mobile outpatient care in the public health sector.**

Table 15 Acute non-mobile Outpatient care provided by the public health sector: availability and workforce capacity(2016).

Provider	Name	Main DESDE Code	FTE MHN	Town/ Suburb	Area of Coverage
Calvary Healthcare Mental Health Services- Calvary Hospital	Consultation Psychiatry Liaison Team	AX[F00-F99]-O4.1lh	6.0	Bruce	Primarily North Canberra, Belconnen and the Gungahlin precinct, but may include some people from southside.
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Acute Mental Health Services	Emergency Department Consultation Liaison Services	AX-[F00-F99]-O4.1lh	5.37*	Garran	ACT
Total	**2**		**11.37**		
Rate per 100,000 residents (>17 years old)	**0.8**		**4.55**		

** Please note 2 FTE Psychiatry cover is shared with MHSSU*

NON-ACUTE MOBILE OUTPATIENT CARE

We have identified two public health BSICs/services providing non-acute mobile outpatient care. The Mobile Intensive Treatment Team (Northside) is a specialist mobile service, providing care which includes medication monitoring of people with low adherence to medication regimes. MITT is staffed predominantly by mental health nurses, with psychiatric and allied health support. They also have three recovery support workers. The CAMHS Early Intervention Team provides care for people aged 14-25 years of age, and their families, experiencing a severe initial episode of mental illness including psychosis. Both BSICs are staffed mostly by nurses, with medical and allied health support. The CAMHS team also includes 1 Recovery Support Officer/ Youth Worker. **There are 2 BSICs or 0.7 BSICs per 100,000 residents over the age of 17 years providing non- acute mobile outpatient care in the public health sector with a workforce capacity of 23.1, or 8.34 FTEs per 100,000 residents.**

Table 16 Non-acute mobile Outpatient care provided by the public health sector: availability (2016).

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Mobile Intensive Treatment Team (MITT)- Northside	GX[F00-F99]-O5.1.2	Belconnen	City/ Belconnen MH regions
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Early Intervention Team 14-25.	AY[F2X]-O6.1	Woden	ACT
Total	**2**			
Rate per 100,000 residents (>17 years old)	**0.7**			

Table 17 Non-acute mobile Outpatient care provided by the public health sector: workforce capacity (2016).

Provider	Name	Total FTE	Psych/Reg	Psychol	MHN	SW	OT	Other
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Mobile Intensive Treatment Team (MITT)- Northside	14	0.1	1.0	8.0	1.0	1.0	3.0.0
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Early Intervention Team 14-25.	9.1	0.1	2.0	4.0	1.0	1.0	1.0
Total		**23.1**						
Rate per 100,000 residents (>17 years old)		**8.34**						

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist.

NON-ACUTE NON-MOBILE OUTPATIENT CARE

We identified 15 BSICs in the public health sector providing non-acute, non-mobile, outpatient care. This includes the five Community Mental Health Teams (CMHT) providing high intensity care to their designated catchment areas within the region. The CMHT provide assessment, management and treatment of people with moderate to severe mental health conditions. The interventions include medication clinics, outpatient

psychiatric reviews, clinical management, individual therapeutic interventions and care coordination and linkages. Emergency care provided by CMHT during working hours is covered after hours by the Crisis Assessment and Treatment Team. It is important to note that BSICs are considered non-mobile unless greater than 50% of their care is to people's homes. We have used the "q" qualifier here to indicate non-mobile care that nevertheless provides between 20- 49% of care as mobile. There are 10 Health In Mind (formerly known as ATAPS) providers. Health In Mind is a free service targeting hard to reach groups with a mild-moderate mental health condition. ACT PHN receives referrals, triages and allocates participants to an appropriate Health In Mind provider. **There are 1.8 BSICs per 100,000 residents over the age of 17 years**. If we include the Health In Mind providers, there are 5.4 BSICs per 100, 000 residents over the age of 17 years.

Addendum. ACT MHJHADS- Rehabilitation and Specialty Mental Health Services provide the Adult Mental Health Day Service, currently located at Belconnen Health Centre, but due to relocate to the University of Canberra Public Hospital in July 2018. This service provides weekly group based activities to consumers who have been assigned to, or are clinically managed by, any of the five Community Mental Health teams. Referrals are internal. Groups include psychological therapy, creative art therapy, metabolic monitoring, medication clinics (e.g. clozapine), Activities of Daily Living groups such as cooking, walking, mindfulness, and sleep hygiene, and a Dialectical Behaviour Therapy group. The planned relocation to the originally intended site at the hospital may provide the potential to increase capacity of the service, including the possibility of operating as a Day Centre, where consumers would spend time at the centre apart from their scheduled attendance in group activities. The service is open from 8.30 a.m. to 4.51 p.m. on weekdays. Staff include 1 FTE Team Leader who is a clinical psychologist with a clinical role in addition to management role, 2 FTE psychologists, 1 FTE intern psychologist, 2 FTE nursing staff, 0.2 FTE consultant psychiatrist and 0.6 FTE registrar.

Table 18 Non-acute non-mobile Outpatient care provided by the public health sector: availability (2016).

Provider	Name	Main DESDE Code	Town/ Suburb	Area of Coverage
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Community Mental Health Team - City	GX[F00-F99]-O8.1q	Canberra	All suburbs of City catchment area
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Community Mental Health Team - Gungahlin	GX[F00-F99]-O8.1q	Gungahlin	All suburbs of Gungahlin catchment area
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult	Community Mental Health Team - Tuggeranong	GX[F00-F99]-O8.1q	Greenway	All suburbs of Tuggeranong catchment

Community Mental Health Services				area
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Community Mental Health Team - Woden at Phillip Health Centre	GX[F00-F99]-O8.1q	Phillip	All suburbs of Woden catchment area
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Community Mental Health Team- Belconnen	GX[F00-F99]-O8.1q	Belconnen	All suburbs of Belconnen catchment area
Capital Health Network	Health In Mind	GX[F00-F99]-O9.1u	ACT	0
Capital Health Network	Health In Mind	GX[F00-F99]-O9.1u	ACT	0
Capital Health Network	Health In Mind	AX[F00-F99]-O9.1u	ACT	0
Capital Health Network	Health In Mind	GX[F00-F99]-O9.1u	ACT	0
Capital Health Network	Health In Mind	GX[F00-F99]-O9.1u	ACT	0
Capital Health Network	Health In Mind	GX[F00-F99]-O9.1u	ACT	0
Capital Health Network	Health In Mind	GX[F00-F99]-O9.1u	ACT	0
Capital Health Network	Health In Mind	GX[F00-F99]-O9.1u	ACT	0
Capital Health Network	Health In Mind	GX[F00-F99]-O9.1u	ACT	0
Capital Health Network	Health In Mind	GX[F00-F99]-O9.1u	ACT	0
Total	**15**			
Rate per 100,000 residents (>17 years old)	**5.4**			

CMHT are staffed by a range of health and allied health professionals, predominantly nurses, but also medical and allied health staff, and recovery support workers. The panel of Health In Mind providers may include psychologists, mental health nurses or mental health credentialed social workers. **There are 73.88, or 26.67 FTE per 100,000 residents providing non-acute non-mobile care in the public health sector.**

Table 19 Non-acute non-mobile Outpatient care provided by the public health sector: workforce capacity (2016).

Provider	Name	Total FTE	Psych/Reg	Psychol	MHN	SW	OT	Other
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Community Mental Health Team - City	17.74	3.0	4.0	5.74	2.0	1.0	2.0
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Community Mental Health Team - Gungahlin	8.1	1.6	1.0	3.0	2.0		0.5
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Community Mental Health Team - Tuggeranong	12.4	2.4	2.0	4.0	2.0	1.0	1.0
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Community Mental Health Team - Woden at Phillip Health Centre	14.0	2.0	3.0	6.0	1.0	1.0	1.0
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Adult Community Mental Health Services	Community Mental Health Team - Belconnen	19.64	3.0	3.8	6.84	3.0	2.0	1.0
Capital Health Network	Health In Mind	0.2		0.2				
Capital Health Network	Health In Mind	0.2		0.2				
Capital Health Network	Health In Mind	0.2		0.2				
Capital Health Network	Health In Mind	0.2		0.2				
Capital Health Network	Health In Mind	0.2		0.2				
Capital Health Network	Health In Mind	0.2		0.2				
Capital Health Network	Health In Mind	0.2		0.2				

Capital Health Network	Health In Mind	0.2	0.2
Capital Health Network	Health In Mind	0.2	0.2
Capital Health Network	Health In Mind	0.2	0.2
Total		73.88	
Rate per 100,000 residents (>17 years old)		26.67	

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist.

3.2.3.2 OUTPATIENT CARE PROVIDED BY THE NGO SECTOR

ACUTE MOBILE AND NON-MOBILE OUTPATIENT CARE

We were unable to identify any acute mobile or acute non- mobile BSICs provided by NGOs in the ACT PHN region.

NON-ACUTE MOBILE OUTPATIENT CARE

We identified eight BSIC/services in the NGO sector providing non- acute mobile outpatient care to adults.

One of these BSICs provides health related care. The Transition to Recovery (TRec) program provided by Woden Community Service provides step up/step down support from 9am to 9pm, seven days a week, for up to three months, for people discharged from hospital It aims to assist people to transition to the community following an acute episode of mental illness and to prevent relapse and also to provide additional support for people with sub-acute symptoms to prevent hospitalisation. It is a partnership with ACT Health, providing individual programs and recovery plans. Support is commenced prior to discharge, with assistance related to the transfer from hospital to community: this second MTC is coded as Accessibility and is included later in the report in the relevant section.

Four BSICs are Personal Helpers and Mentors (PHAMs). PHAMs is a recovery based program which provides practical assistance to people over 16 years whose lives are severely affected by mental illness, to manage their daily activities, prevent social isolation, and to live independently in the community. Woden Community Service PHAMs has two programs, one of which is general PHAMs support, and the other employment related. The general program's coverage area is the southside of Canberra, while the employment program covers the whole of the ACT. Richmond Fellowship ACT provides a PHAMs program in Queanbeyan (NSW) and also in Goulburn/Crookwell (NSW), and therefore not mapped here. The PHAMs program is closing at the end of 2017, with funding decreasing and consumers being redirected into NDIS packages.

Woden Community Service Partners in Recovery program (PIR) includes two social workers who provide care co-ordination. In the ACT PHN region, a consortium of providers act as agencies for the provision of PIR support facilitators. Partners In Recovery is a program to assist individuals with severe and persistent mental health concerns to develop plans and access and integrate available supports. This suggests that all PIR BSICs will be coded as Accessibility services. Interestingly, though, some PIRs are providing more direct care provision, as we see here, and thus being coded accordingly, as Outpatient care.

Catholic Care provide a Home Care Support program providing daily psychosocial support with living skills. St. Vincent de Paul Family Services' Mental Health Services Team predominantly provides case co-ordination but also provides some direct support.

A Supportive Tenancy program provided jointly between Woden, Belconnen and YWCA is not specific to people with mental health needs and is therefore not coded here.

Five BSIC have been coded with the "v" qualifier as they do not have guaranteed funding for three years.

There are 8 BSICs, or 2.8 per 100,000 residents over the age of 17 years providing non- acute mobile care in the NGO sector.

Non- acute mobile outpatient care that is gender specific is described elsewhere.

Table 20 Non-acute mobile Outpatient care provided by NGOs: availability and capacity (2016).

Provider	Name	Main Desde Code	Other Desde Code(s)	Beds/Places	FTE	Town / Suburb	Area of Coverage
Catholic Care	Home care support	GX[F00-F99]-O6.2			1.0	0	0
Mental Health Foundation	PHAMS	AX[F00-F99]-O6.2v			3.7	Chifley	ACT
Richmond fellowship ACT	PHAMS - Belconnen/ Gunghalin	AX[F00-F99]-O6.2v			1.0	Pialligo	Belconnen/ Gunghalin
St Vincent De Paul Family Services ACT	Mental Health Services Team	AX[F00-F99]-O6.2m,v			8.0	Deakin	ACT
Well Ways - previously known as Mental Illness Fellowship	Detention Exit program	AX[F00-F99]-O5.2.1		16	3.0	O'Connor	ACT
Woden Community Service	PHAMS	AX[F00-F99]-O6.2m,g,v			6.1	Woden	Southside of Canberra

Woden Community Service	PIR	AX[F00-F99]-O6.2v		2.0	Woden	Woden area
Woden Community Service	Transition to recovery program (TRec)	AX[F00-F99]-O5.1.2g	AX[F00-F99]-A4.1h	6.8	Woden	ACT
Total	**8**					
Rate per 100,000 residents (>17 years old)	**2.8**					

The workforce in non-acute mobile care services provided by NGOs are mostly support workers, or other social care workers. There are 31.6 FTE, or 12.8 per 100,000 residents over the age of 17 years, providing non-acute mobile care in the NGO sector.

Table 21 Non-acute mobile Outpatient care provided by NGOs: workforce capacity (2016).

Provider	Name	Total FTE	SW	nCCM	SupW	Peer	Others
CatholicCare	Home care support	1.0			1.0		
Mental Health Foundation	PHAMS	3.7			3.5	0.2	
Richmond fellowship ACT	PHAMS - Belconnen/ Gunghalin	1.0					1.0
St Vincent De Paul Family Services ACT	Mental Health Services Team	8.0		3.0	5.0		
Well Ways - previously known as Mental Illness Fellowship	Detention Exit Program	3.0					3.0
Woden Community Service	PHAMS	6.1					6.1
Woden Community Service	PIR	2.0	2 .0				
Woden Community Service	Transition to recovery program (TRec)	6.8			5.0		1.8
Total			**31.6**				
Rate per 100,000 residents (>17 years old)			**12.8**				

NON-ACUTE NON-MOBILE OUTPATIENT CARE

We identified six NGO funded BSICs/services, including seven MTCs, providing non-acute non- mobile outpatient care. All except one provide health related care. New Access is a guided self- help model service, originally marketed particularly towards men at increased risk of suicidality who would not usually access mental health services, but now more generally focused. It is a short term (six session) coaching based program, co-located at Headspace and ACT PHN, providing low intensity cognitive behavioural therapy (CBT). It was initially funded by Beyond Blue until October 2016, with interim funding then provided by the ACT PHN until the commissioning of services in early 2017.

Relationships Australia provides two BSICs in this category: the Gambling Counselling & Support Service, which has two arms: an intake and screening service operated from Relationships Australia (Queensland), which is included in the Information section of this report; and a service staffed by counsellors and psychologists or social workers operating from the Deakin office, providing follow up to calls made to the intake service, counselling, and case facilitation. It also provides an outreach service to the prison. The service is funded by the ACT government through the Racing and Gambling Commission. The second BSIC provided by Relationships Australia in this category is Coronial Counselling, which is a relatively new service, providing bereavement/grief counselling to people affected by suicide. Referrals come via the Magistrates' Court. While not a crisis service, it can provide support fairly immediately.

The Better Access and ATAPS team is provided by Catholic Care include a bulk-billing Better Access program to assist people to access no cost counselling, and access to ATAPS.

We identified one specialised BSIC providing counselling specifically to the deaf and deaf-blind community. Unique Psychological Services provides psychological support to people from the age of seven years up, who are deaf or deaf/blind. The service is based outside the ACT, but the practitioner travels to the ACT once a fortnight to work with ACT clients.

Social support to prevent or reduce isolation, and provide linkages to relevant support services where necessary, for gender diverse and intersex people, is provided by A Gender Agenda, who have also established a network of mental health service providers able to support other health professionals to understand issues related to intersex and gender diverse clients.

Three BSIC have been coded with the "v" qualifier as they do not have guaranteed funding for three years.

There are 6 BSICs, or 2.2 per 100,000 residents over 17 years of age providing non-acute non-mobile care in the NGO sector.

Table 22 Non-acute non-mobile outpatient care provided by NGOs: availability (2016).

Provider	Name	Main DESDE Code	Other DESDE code(s)	Town/ Suburb	Area of Coverage
A Gender Agenda (AGA)	Social Support & Linkage	AX[F00-F99]-O10.2		Ainslie	ACT
Capital Health Network	NewAccess	AX[F3X]-O9.1v		Deakin	0
CatholicCare	Better Acess and ATAPS Team	GX[F00-F99]-O8.1	GX[F00-F99]- O9.1	Woden	0
Relationships Australia ACT	ACT Coronial Counselling Service	AX[Z63.4][T14.91]]-O9.1		Deakin	ACT
Relationships Australia ACT	ACT Gambling Counselling & Support Service	AX[F00-F99]-O8.1v		Deakin	ACT strictly only
Unique Psychological Services	Deaf and deaf/blind person Mental Health Counselling Service	AX[F00-F99]-O10.1uv		Civic	ACT
Total	**6**				
Rate per 100,000 residents (>17 years old)	**2.2**				

The workforce here is mixed, including psychologists, which reflects the counselling services largely available in this category, as well as other care workers. **There are 10.1 FTEs, or 3.6 per 100,000 residents over the age of 17 years, providing non-acute non-mobile care in the NGO sector.**

Table 23 Non-acute non-mobile outpatient care provided by NGOs: workforce capacity (2016).

Provider	Name	TotalFTE	Psych/Reg	Psychol	SW	Others
A Gender Agenda(AGA)	Social Support and Linkage	2.6				2.6
Capital Health Network	New Access	4.0	2.0			2.0
CatholicCare	Better Access and ATAPS Team	NA				

Relationships Australia ACT	ACT Coronial Counselling Service	1.2			1.2
Relationships Australia ACT	ACT Gambling Counselling and Support Service	2.1	1.0	1.0	0.1
Unique Psychological Services	Deaf and Deaf/Blind Person Mental Health Counselling Service	0.2	0.2		
Total		**10.1**			
Rate per 100,000 residents (>17 years old)		**3.6**			

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; SW: Social worker.NA: Not Available

3.2.4. ACCESSIBILITY SERVICES

3.2.4.1 ACCESSIBILITY SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR

We did not identify any BSICs providing accessibility support in the public health sector.

3.2.4.2. ACCESSIBILITY SERVICES PROVIDED BY THE NGO SECTOR

We identified 9 BSICs/services providing Accessibility support to people with lived experience of mental illness in the NGO sector. In addition, a 2nd MTC to the Day to Day Living program, (coded as Day care/programs) run by Sunflower Services (previously Schizophrenia Fellowship NSW) assists clients to link with other services and work at achievable goals, and is also now assisting with NDIS paperwork ; and a 2nd MTC to Transition to Recovery, (coded in Outpatients non- acute mobile) provided by Woden Community Service, also provides accessibility services, bringing to 11 the total number of MTC in the NGO sector assisting with accessibility.

The PIR teams at Richmond Fellowship, Catholic Care, ACT PHN and Northside Community Service provide mostly care co-ordination and accessibility to support. Roles played by support facilitators include assisting consumers with the process of transition to the NDIS, and in some cases, a level of direct care provision is also occurring, such as taking people to doctor's appointments. See separate PIR section for more information on PIR services.Referrals to ACT PHN PIR closed from July 2016, with funding for remaining clients until 2017.

Woden Community Service provide The Wayback Support Service, commencing in late 2016. Funded by ACT Health via Beyond Blue, and one of three trial sites (the others being the Hunter Valley and the Northern Territory), this is a time limited (up to three months) referral pathway for people newly discharged from hospital post suicide attempt, to connect with supports. Clinical referral is made prior to discharge, with the intensity of

care co- ordination provided according to individual need. Suicide as a coping mechanism is an exclusion criteria for access to this program. As mentioned above in the Outpatient section, Woden TRec service also provide a second MTC in Accessibility support prior to hospital discharge, with assistance related to the transfer from hospital to community.

Catholic Care provide a mental health social worker, as well as an Alcohol and other Drugs worker, to help people co-ordinate NDIS supports. The Trauma Support Service provided by Relationships Australia is to assist with information such as file searching for people who have suffered from past systemic abuse. Community Connections, while mostly serving people with other disability, such as intellectual disability, provides some case co-ordination, and occasional direct care if needed, for a small number of people with mental health issues such as schizophrenia and anxiety. They also provide a Homeshare service which matches and monitors volunteers to support a person to live independently in their home through sharing the home with them. We have not mapped this service as it is not specifically for people with mental health needs. Volunteering and Contact ACT provides a Connections service which matches people with mental health issues with a volunteer in order to establish a supportive relationship. It is hoped that relationships will last for at least 18 months, or even go on to develop into friendships.

Six BSIC have been coded with the "v" qualifier as they do not have guaranteed funding for three years.

There are 9 BSICs, or 3.2 per 100,000 residents over the age of 17 years, providing accessibility support in the NGO sector.

Table 24 Accessibility services provided by NGO: availability (2016).

Provider	Name	Main DESDE Code	Town/Suburb	Area of Coverage
Capital Health Network PIR	PIR	GX[F00-F99]-A4.2v	Deakin	0
CatholicCare	NDIS Program	GX[F00-F99]-A4.2	0	0
CatholicCare	PIR	AX[F00-F99]-A4.2.2	0	0
Community Connections - ACT	Community Connections	AX[F00-F99]-A4.2.2v	Kambah	ACT
Northside Community Service	PIR	GX[F00-F99]-A4.2.2v	Dickson	ACT
Relationships Australia ACT	Trauma SupportService	AX[F43]-A4.2	Deakin	ACT
Richmond fellowship ACT	PIR	AX[F00-F99]-A4.2v	Pialligo	ACT
Volunteering and Contact ACT	Connections	GX[F00-F99]-A4.2v	Canberra City	ACT

Woden Community Service	The Way Back Support Service	GX[Z63.4][T14.91]-A4.2.1v		ACT and surrounding region if geographically possible
Total	**9**			
Rate per 100,000 residents (>17 years old)	**3.2**			

The workforce capacity providing accessibility services funded by NGOs is 24.2 FTE, or 8.7 per 100,000 residents over the age of 17 years. As well as a range of care workers, there are also some social work and psychology staff employed by NGOs in this category of care. *Please note PIR services are also coded in a separate PIR section.*

Table 25 Accessibility services provided by NGO: workforce capacity (2016).

Provider	Name	Total FTE	Psychol	SW	MHW	Sup W	Others
Capital Health Network PIR	PIR-CHN	12.0		2.8	9.2		
CatholicCare	NDIS Program	1.0		1.0			
CatholicCare	PIR	3.5		1.8			1.7
Community Connections - ACT	Community Connections	1.0					1.0
Northside Community Service	PIR	1.0				1.0	
Relationships Australia ACT	Trauma Support Service	0.2					0.2
Richmond fellowship ACT	PIR	2.0					2.0
Volunteering and Contact ACT	Connections	1.0	1.0				
Woden Community Service	The Way Back Support Service	2.5					2.5
Total		**24.2**					

Rate per 100,000 residents (>17 years old)	**8.7**

FTE: Full Time Equivalents; Psychol: Psychologist; SW: Social worker; MHW: Mental health worker; SupW: Support worker/Community worker.

PARTNERS IN RECOVERY

In the ACT PHN region, Partners in Recovery is provided by a consortium of five providers: ACT PHN at Deakin, CatholicCare, Northside Community Service, Richmond Fellowship and Woden Community Service. Anglicare previously also provided PIR. The main objective of the PIR program is to increase accessibility to a different range of services for people with a lived experience of mental illness. Theoretically, the code of the PIR program should be an A4 (accessibility/care manager), but some organisations in other regions report that they are providing more intensive direct day care, so they received an outpatient code (O5.2). Unlike these other regions, in the ACT, with one exception, Partners in Recovery BSICs are providing accessibility through case management type activities, so have been coded as Accessibility services. **There are 5 PIR, or 1.8 per 100,000 residents over the age of 17 years.**

These BSIC have been coded with the "v" qualifier as they do not have guaranteed funding for three years.

Table 26 PIR programs: availability (2016).

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Capital Health Network PIR	PIR-CHN	GX[F00-F99]-A4.2v	Deakin	0
CatholicCare	PIR	AX[F00-F99]-A4.2.2	0	0
Northside Community Service	PIR	GX[F00-F99]-A4.2.2v	Dickson	ACT
Richmond fellowship ACT	PIR	AX[F00-F99]-A4.2v	Pialligo	ACT
Woden Community Service	PIR	AX[F00-F99]-O6.2vm	Woden	Woden area
Total	**5**			
Rate per 100,000 residents (>17 years old)	**1.8**			

PIR services are also coded in the Outpatient and Accessibility sections.

The workforce capacity of PIR programs is 20.5, or 7.4 per 100,000 residents over the age of 17 years in the ACT PHN region, and is comprised of a range of care workers, as well as some social workers.

Table 27 PIR programs: workforce capacity (2016).

Provider	Name	Total FTE	MHW	SW	SupW	Others
Capital Health Network PIR	PIR-CHN	12.0	9.2	2.8		
CatholicCare	PIR	3.5		1.8		1.7
Northside Community Service	PIR	1.0			1.0	
Richmond fellowship ACT	PIR	2.0				2.0
Woden Community Service	PIR	2.0		2.0		
Total		**20.5**				
Rate per 100,000 residents (>17 years old)		**7.4**				

FTE: Full Time Equivalents; MHW: Mental health worker; SW: Social worker; SupW: Support worker/Community worker.

3.2.5. INFORMATION AND GUIDANCE SERVICES

3.2.5.1 INFORMATION AND GUIDANCE SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR

We identified two Information and Guidance BSICs/services provided by the public health sector. The Mental Health Neuropsychology service located at Woden Health Centre provides specialised neuropsychology assessment and consultation, and the Dual Diagnosis Service, also at Woden, liaises with health professionals and services about issues related to substance abuse and mental illness comorbidity. **There are 2 BSICs, or 0.7 per 100,000 residents over the age of 17 years, providing Information or Guidance in the public health sector, with a workforce capacity of four, or 1.4 per 100,000 residents.**

Table 28 Information and Guidance services provided by the public health sector: availability (2016).

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Rehabilitation and Specialty MHS	Mental Health Neuropsychology	GX[F00-F99]-I1.1s	Phillip	ACT
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Rehabilitation and Specialty MHS	MH&ADS Comorbidity Worker (Dual Diagnosis Service)	GX[F10-F19]-I1.1	Phillip	ACT
Total	**2**			
Rate per 100,000 residents (>17 years old)	**0.7**			

Table 29 Information and Guidance services provided by the public health sector: workforce capacity (2016).

Provider	Name	Total FTE	Psychol	MHN
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Rehabilitation and Specialty MHS	Mental Health Neuropsychology	3.0	3.0	
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Rehabilitation and Specialty MHS	MH&ADS Comorbidity Worker (Dual Diagnosis Service)	1.0		1.0
Total		**4.0**		
Rate per 100,000 residents (>17 years old)		**1.4**		

FTE: Full Time Equivalents; Psychol: Psychologist; MHN: Mental health nurse.

3.2.5.2 INFORMATION AND GUIDANCE SERVICES PROVIDED BY THE NGO SECTOR.

We have identified 2 Information and Guidance BSICs/services provided by the NGO sector. Advocates with backgrounds in law, social work, or community services from the A.C.T. Disability, Aged and Carer Advocacy Service (ADACAS) work with the consumer to provide independent individual advocacy and supported decision making.

ADACAS provides support to a range of people with disabilities but has some specifically mental health funding. Relationships Australia provides an Information and assessment service as part of their Gambling Counselling & Support Service. A 24 hour telephone triage system provides information, assessment and therapeutic intake. Consumers can also at this time be booked into for an appointment with the service. The service is available both to the person with the issues themselves and to those affected.

One BSIC has been coded with the "v" qualifier as it does not have guaranteed funding for three years.

There are 2 BSICs, or 0.7 BSICs per 100,000 residents over the age of 17 years providing Information or Guidance in the NGO sector.

Table 30 Information and Guidance services provided by NGOs: availability (2016).

Provider	Name	Main DESDE Code	Town/Suburb	Area of Coverage
Relationships Australia ACT	ACT Gambling Counselling & Support Service: Information	AX[F00-F99]-I1.1	0	0
The A.C.T. Disability, Aged and Carer Advocacy Service (ADACAS)	ADACAS	GX[F00-F99]-I1v	Watson	ACT
Total	**2**			
Rate per 100,000 residents (>17 years old)	**0.7**			

Table 31 Information and Guidance services provided by NGOs: workforce capacity (2016).

Provider	Name	Total FTE
Relationships Australia ACT	ACT Gambling Counselling & Support Service: Information	NA
The A.C.T. Disability, Aged and Carer Advocacy Service (ADACAS)	ADACAS	1.5
Total		**1.5**
Rate per 100,000 residents (>17 years old)		**0.5**

FTE: Full Time Equivalents. NA: Not Available

3.2.6 SELF AND VOLUNTARY SUPPORT

3.2.6.1 SELF-HELP AND VOLUNTARY SUPPORT PROVIDED BY THE PUBLIC HEALTH SECTOR

We did not identify any BSICs providing Self-help and Voluntary support provided by the Public Health sector.

3.2.6.2 SELF AND VOLUNTARY SUPPORT PROVIDED BY THE NGO SECTOR

We have identified two Self-help and Voluntary BSICs/services provided by the NGO sector for people with a lived experience of mental illness in the ACT PHN region. GROW provide a once a week group program, focussing on personal growth, and self-support. Peer support is available. A field worker supports the group once a month and there is also access to a counsellor (a naturopath). The Compeer service run by St Vincent de Paul Society, aims to improve the quality of life of adults with a mental illness through one-to-one friendship with a caring volunteer. Applicants for the Compeer program must be receiving ongoing care from a health professional who actively supports their participation in the program. This service provides non clinical case management support. **There are 2 BSICs, or 0.7 per 100,000 residents over the age of 17 years providing self help or voluntary support in the NGO sector.**

Table 32 Self and Voluntary support provided by NGOs: availability (2016).

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Grow - ACT	Group program workshops	AX[F00-F99]-S1.3g	Narrabundah	ACT
St Vincent De Paul Family Services ACT	Compeer	AX[F00-F99]-S1.3	Deakin	ACT
Total	**2**			
Rate per 100,000 residents (>17 years old)	**0.7**			

Table 33 Self and Voluntary support provided by NGOs: workforce capacity (2016).

Provider	Name	Total FTE	nCCM	SupW
Grow - ACT	Group program workshops	0.1		0.1
St Vincent De Paul Family Services ACT	Compeer	1.0	1.0	
Total		**1.1**		
Rate per 100,000 residents (>17 years old)		**0.4**		

FTE: Full Time Equivalents; nCCM: Non-clinical case manager; SupW: Support worker/Community worker.

3.3. AGE SPECIFIC POPULATIONS

3.3.1 CHILD AND ADOLESCENT SERVICES

3.3.1.1 CHILD AND ADOLESCENT SERVICES PROVIDED BY THE PUBLIC SECTOR

The public sector provides four BSICs for children and adolescents. Three of these are provided by Children and Adolescent Mental Health Service (CAMHS), and the fourth by Child and Youth Protection Services (CYPS). An Early Intervention Program for those aged 14-25 years is coded in the general services section above.

CAMHS provide care through the Woden and Belconnen Community Teams, and the Cottage Adolescent Day Program, which assists adolescents to reduce symptoms of moderate to severe mental health issues and improve functioning in education, and life and social skills. Melaleuca Place is a service provided by Child and Youth Protection Services (CYPS). It provides targeted interventions for children up to the age of 12 years presenting with a history of trauma, who are also involved with Child and Youth Protection Services. It is an outreach service working with the child's support system-schools, care placement or similar. It also runs groups for children on issues such as grief and loss, and groups working on children's ability for emotion control and sense of safety.

Melaleuca Place accepts referrals from CYPS. **There are 4 BSICs, or 5 per 100,000 residents under the age of 18 years, providing care to children and adolescents in the public health sector.**

Table 34 Services for children and adolescents provided by the public health sector: availability and capacity (2016).

Provider	Name	Main DESDE Code	Beds/Places	Town/ Suburb	Area of Coverage
Child and Youth Protection Services	Melaleuca Place	CC[F00-F99]-O5.1.1g	40	Dickson	ACT

ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Cottage Adolescents Day program	CA[F00-F99]-D4.1		Bruce	ACT
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Northside Community Team - Belconnen	CX[F00-F99]-O8.1		Belconnen	Northside- City, Belconnen, Gungahlin areas
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Southside Community Team- Woden	CX[F00-F99]-O8.1		Woden	Southside- Woden, Tuggeranong, Weston Creek areas
Total	**4**		40		
Rate per 100,000 residents (<17 years old)			50.3		

The Melaleuca Place team includes a psychiatrist one day a week, clinical psychology, social workers, and occupational therapists. The Cottage Adolescents Day Program includes one Recovery Support Officer. This Workforce also covers CAMHS DBT Program. **There are 34.7 FTEs, or 37.9 per 100,000 residents under the age of 18 years, providing care for children and adolescents in the public health sector.**

Table 35 Services for children and adolescents provided by the public health sector: workforce capacity (2016).

Provider	Name	Total FTE	Psych/ Reg	Psychol	MHN	SW	OT	Other
Child and Youth Protection Services	Melaleuca Place	4.1	0.2				0.2	3.7
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Cottage Adolescents Day program	7.1		5.1	1.0			1.0

ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Northside Community Team - Belconnen	11.0	0.6	4.4	2.0	4.0
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Southside Community Team- Woden	12.5	0.4	4.0	3.5	4.6
Total		**34.7**				
Rate per 100,000 residents (<17 years old)		**37.9**				

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; SW: Social worker; OT: Occupational therapist..

**FTE also covers CAMHS DBT program*

3.3.1.2. CHILD AND ADOLESCENT SERVICES PROVIDED BY THE NGO SECTOR

We identified six BSICs, provided by NGOs, incorporating seven MTC, providing care to children and adolescents. Residential care for adolescents and young adults for up to three months is provided by Catholic Care - these services also include 0.8 support from a CAMHS mental health nurse. Catholic Care also provide Youth Wellbeing service, which provides outreach based case management.

New Horizons, provided by Marymead, is an early intervention, mostly outreach service providing care for children in Canberra and Queanbeyan from 0-18 years, within a family context. Waiting lists for care are supported by an "Active Hold" strategy which takes phonecalls, refers people when necessary, and by the provision of groups such as Circle of Security (intensive therapy), and anger management groups.

Barnardo's Therapeutic Services Team works with foster families of children who are in respite, due to their own or their family member's mental health issues, to provide children therapeutic specialist care, from professionals including psychologists, social workers or counsellors. Circles of Support, provided by the YWCA, is a counselling service, providing support for traumatised children and adolescents aged 8-15 years and their families. Circles of Support see children at the community centre at Lanyon, Kippax, and also via outreach. The Bungee Youth Resilience Program provided by the Belconnen Community Centre is a school based, activity based, arts based service supporting children aged 8-16 years, with mild to moderate mental health needs, or facing other challenges such as bullying, with one to one counselling, groups, and in school programs.

Two BSIC have been coded with the "v" qualifier as they do not have guaranteed funding for three years.

There are 6 BSICs, or 7.5 BSICs per 100,000 residents under the age of 17 years providing care for children and adolescents in the NGO sector, with a workforce capacity of 20.9, or 26.3 per 100,000 children and adolescents.

Table 36 Services for children and adolescents provided by NGO: availability and capacity (2016).

Provider	Name	Main DESDE Code	Other DESDE Code(s)	Beds/Places	Town/ Suburb	Area Coverage
Barnardos Australia - Canberra	Therapeutic Services Team	CC[F00-F99]-O6.2m	CC[F00-F99]-A4.2		Downer	ACT
Belconnen Community Service	Bungee	CX[F00-F99]-O9.2g			Belconnen	ACT
CatholicCare	Steps Residential Service	CA[F00-F99]-R8.2		5	Watson	0
Headspace	Headspace Canberra	TA[F00-F99]-O10.1v			Bruce	ACT
Marymead	New Horizons	CX[F00-F99]-O6.1			Narrabundah	ACT and southern and western regional areas of NSW
YWCA	Circles of Support	CX-[F00-F99]O9.1v			Canberra City	ACT
Total	**6**					
Rate per 100,000 Residents(<18 years old)	**7.5**					

Table 37 Services for children and adolescents provided by NGOs: workforce capacity (2016).

Provider	Name	Total FTE	Psychol	SW	OT	SupW	Other
Barnardos Australia Canberra	Therapeutic Services Team	6.0					6.0
Belconnen Community Service	Bungee	2.0					2.0

CatholicCare	Steps Residential Service	NA					
Headspace	Headspace Canberra	5.0	3.0			2.0	
Marymead	New Horizons	5.8	1.0	2.0	0.8		2.0
YWCA	Circles of Support	2.1					2.1
Total		**20.9**					
Rate per 100,000 residents (<18 years old)		**26.3**					

FTE: Full Time Equivalents; Psychol: Psychologist; SW: Social worker; OT: Occupational therapist; SupW: Support worker/Community worker; Edu: Educator.

3.3.2 TRANSITION TO ADULTHOOD

3.3.2.1 TRANSITION TO ADULTHOOD SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR

We did not identify any Transition to Adulthood Services provided by the public health sector. However, it is important to mention the CAMHS Early Intervention team for people aged 14-25 years, which is described above in the section on adult non-acute mobile care.

3.3.2.2 TRANSITION TO ADULTHOOD SERVICES PROVIDED BY THE NGO SECTOR

We identified seven BSICs providing care to this population in the ACT PHN region.

Anglicare provides one outpatient, and two day support services aimed at the transition to adulthood age group. The Junction provides a multidisciplinary team including general practitioner, nursing and allied health. The service works closely with Headspace. The Youth Education Program supports young people unable to engage with mainstream education to gain life skills, and a Year 10 equivalent qualification. The Drop-In (Youth Engagement) daycare service provides "drop-in" food and internet access, emergency relief such as sleeping bags or brokerage for groceries, and may also refer to other services. Approximately 70-80% of clients have mental health issues.

Catholic Care provides a Youth and Wellbeing Outreach service which is wholly mobile, and Wellways provides the Youth Step and Step Down residential service, which is the only residential service specifically for this age group.

Headspace provides assessment and psychological interventions, mostly through

counselling, to adolescents aged 12-25 years. It also provides group work such as the Cognitive Behavioural Therapy based "Healthy Skills Workshop". It also mitigates waiting list times through the provision of information and engagement sessions twice a month. Its area of coverage includes a small area outside the ACT as well as the whole of the ACT.

One BSIC, provided by Menslink, is gender specific. This service provides counselling and mentoring to young men, travelling to schools and other organisations to talk about young men's issues, men's mental health, mental fitness, suicide prevention, volunteering or about the work Menslink does in the community

Five of the seven BSICs are coded v" for lack of guaranteed funding for three years.

There are 7 BSICs, or 12.4 BSICs per 100,000 residents aged between 16 and 25 years, providing care for young people transitioning to adulthood, with a workforce capacity of 27.3, or 48.3 FTEs per 100,000 young people aged between 16 and 25 years of age.

Table 38 Services for transition to adulthood provided by NGOs: availability and capacity (2016).

Provider	Name	Main DESDE Code	Bed/Places	Town /Suburb	Area of Coverage
Anglicare ACT	Cyclops	CY[e310][F00-F99]-O6.1v	36	Canberra City	ACT
Anglicare ACT	The Junction	CY[F00-F99]-O9.2v		Canberra City	ACT
Anglicare ACT	Youth Education Program	CY[F00-F99]-D4.2v	25	Canberra City	ACT
Anglicare ACT	Youth Engagement Program	CY[F00-F99]-D5v		Canberra City	ACT
CatholicCare	Youth & Wellbeing Outreach Service	TA[F00-F99]-O6.2w	25	Watson	ACT
Menslink	Counselling Service	CY[M][F00-F99]-O9.1v		Holder	ACT plus Queanbeyan, have had people as far away as Goulburn and Cooma
Well Ways - (previously known as Mental Illness Fellowship)/Mental Health Services	Youth Step up and Step down	TA[F00-F99]-R8.2	6	Kambah	ACT
Total	**7**				

Rate per 100,000 residents (16-25 years old)	**12.4**								

Table 39 Services for transition to adulthood provided by NGOs: workforce capacity (2016).

Provider	Name	Total FTE	Psychol	GP	MHN	SW	SupW	Edu	Others
Anglicare ACT	Cyclops	3.0	1.0				1.0		1.0
Anglicare ACT	The Junction	10.8	1.0	2.0	1.0		5.0		1.8
Anglicare ACT	Youth Education Program	3.0					2.0	1.0	
Anglicare ACT	Youth Engagement Program	3.0					3.0		
CatholicCare	Youth & Wellbeing Outreach Service	1.0				1.0			
Menslink	Counselling Service	2.5							2.5
Well Ways (previously known as Mental Illness Fellowship)/Mental Health Services	Youth Step up and Step down	4.0							4.0
Total		**27.3**							
Rate per 100,000 residents (16-25 years old)		**48.3**							

FTE: Full Time Equivalents; Psychol: Psychologist; GP: General practitioner; MHN: Mental health nurse; SW: Social worker; SupW: Support worker/Community worker; Edu: Educator.

3.3.3 SERVICES FOR OLDER ADULTS

We have identified two BSICs/services providing care to people aged 65 years and over with a lived experience of mental illness in the ACT PHN region. Both services are provided by the public health sector and located at Calvary Hospital, and are delivered by a range of health professionals. One BSIC is the inpatient unit for older persons, and the other is the Older Persons Mental Health Service (OPMHS) Community Team, which includes a Recovery Support Officer in addition to clinical staff. There is an additional

1.0 junior medical officer on rotation to the Older Persons Mental Health Inpatient Unit on rotation between Canberra and Calvary Hospitals.

There are 2 BSICs, or 5.2 BSICs per 100,000 adults over the age of 64 year providing care specifically for adults over the age of 64 years in the public health sector.

Table 40 Services providing care for older people in the public health sector: availability and capacity (2016).

Provider	Name	Main DESDE Code	Other DESDE Code(s)	Beds/ Places	Town/ Suburb	Area Of Coverage
Calvary Healthcare Mental Health Services-Calvary Hospital	Older Persons Mental Health Inpatient Unit	OX[F00-F99]-R2	OX[F00-F99]-R2	15	Bruce	ACT
Calvary Healthcare Mental Health Services-Calvary Hospital	Older Persons Mental Health Service (OPMHS) Community Team	OX[F00-F99]-O6.1			Bruce	ACT
Total	**2**			**15**		
Rate per 100,000 residents (>64 years old)	**5.2**			**39.3**		

Table 41 Services providing care for older people in public health: workforce capacity (2016).

Provider	Name	Total FTE	Psych/Reg	Psychol	MHN	SW	OT	Other
Calvary Healthcare Mental Health Services-Calvary Hospital	Older Persons Mental Health Inpatient Unit	NA	NA	0.6	23	0.5	1.5	
Calvary Healthcare Mental Health Services-Calvary Hospital	Older Persons Mental Health Service (OPMHS) Community team	20.5	2.5	4.0	9.0	3.0	1.0	1.0
Total		NA						
Rate per 100,000 residents (>64 years old)								

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist.NA: Not Available or incomplete

3.4. NON AGE –RELATED SPECIFIC POPULATIONS

3.4 .1 GENDER SPECIFIC SERVICES

We have identified a total of ten BSICs providing gender specific support in the ACT PHN region. An additional gender specific service for young men is described in the Transition to Adulthood section.

3.4.1.1 GENDER SPECIFIC SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR

The Perinatal Mental Health Consultation Liaison Service provides mental health assessment, treatment and other services including support, advice and referrals for women from conception to 12 months after giving birth. It does not provide crisis care. Clients in crisis are referred to the Mental Health Crisis Team. Referrals are triaged using the Mental Health Triage scale, and may proceed to full face to face assessment if indicated, either at their Woden offices or at the Centenary Hospital for Women and Children. Following the full assessment there are a number of pathways that may follow in discussion with the client. This may include referral to another service and +/- ongoing supportive contact from PMHCS. In some cases the client may be offered short term therapeutic intervention, individually or in a group setting. Also if indicated an appointment with the Consultant Psychiatrist or Psychiatric Registrar (in a one day a week clinic) may be offered. This service may often be the only service clients are connected with and it will provide support until they are linked in with an adult community team if clinical management is indicated.

There is 1 BSIC, or 2.6 BSICs per female residents over the age of 17 years in the ACT PHN region provided by the public health sector), with a workforce capacity of 4.2, or 10.9 per 100,000 women in the public health sector.

Table 42 Services providing gender specific care in the public health sector: availability (2016).

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Perinatal MH Consultation Liaison Service	GX[F][F53]-O8.11	Woden	ACT
Total	**1**			
Rate per 100,000 residents (female <18 years old)	**2.6**			

Table 43 Services providing gender specific care in the public health sector: workforce capacity (2016).

Provider	Name	Total FTE	Psych/Reg	Psychol	MHN	SW	OT
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Child and Adolescent Mental Health Services	Perinatal MH Consultation Liaison Service	4.2	0.2	1.0	1.0	1.0	1.0
Total		**4.2**					
Rate per 100,000 residents (female <18 years old)		**10.9**					

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist.

3.4.1.2 GENDER SPECIFIC SERVICES PROVIDED BY THE NGO SECTOR

We have identified nine gender specific BSICs provided by the NGO sector. Seven of these are for men, and two are for women.

Three organisations provide support for male mental health. Everyman (previously known as Canberra Men's Centre) is a community provider which provides four services, including a counselling service for men, their partners and families; an outreach service, a Complex Needs Service, and supported accommodation (managed tenancy).

The OzHelp Foundation is a workplace based engagement program to identify men at risk of mental health issues and to provide early intervention and referral. Teams provide support, counselling and "tradies' tune-ups", which include physical and mental health assessments conducted through field visits to workplaces, with nursing staff support; and also training and information to improve awareness and understanding of mental health issues, health literacy, and resilience.

The Lodge Program at Ainslie Village, provided by Catholic Care, provides residential support for up to 19 men, and includes assistance with the gaining of life and social skills, referrals to other services, housing issues and other services. Men need an appropriate NDIS plan to fund their use of the service.

An additional service provided by Menslink for young men is described in the Transition to Adulthood section.

Post and Ante Natal Support and Information (PANDSI) provides telephone support, referral, information, activities and a playgroup for those affected by perinatal depression or anxiety. Although we have included this as a gender specific service, it is important to

note that the service is also available to partners and families.

Wellways' Womens' Respite and supported accommodation service provides recovery oriented psychosocial rehabilitation through case management and outreach support.

There are 7 gender specific BSICs, or 5.2 per 100,000 men over the age of 17 years provided by the NGO sector.

There are 2 gender specific services, or 1.4 per 100,000 women over the age of 17 years, provided by the NGO sector.

Table 44 Services providing gender specific care in the NGO sector: availability and capacity (2016).

Provider	Name	Main DESDE Code	Beds/Places	Town/ Suburb	Area of Coverage
CatholicCare	The Lodge Program – Ainslie Village Complex	AX[M][F00-F99]-R12	19	Campbell	NA
EveryMan Australia (previously known as Canberra Men's Centre)	Supported Accomm odation-Everyman	GX[M][F00-F99]-O6.2		0	
EveryMan Australia (previously known as Canberra Men's Centre)	Complex Needs Service	AX[M][F00-F99]-O6.2		Canberra	ACT
EveryMan Australia (previously known as Canberra Men's Centre)	Counselling Service	AX[M][F00-F99]-O9.1		Canberra	ACT
EveryMan Australia (previously known as Canberra Men's Centre)	Outreach	AX[M][F00-F99]-O6.2		Canberra	ACT
Oz Help Foundation	Training	AX[M][F00-F99]-I2.1		Fyshwick	ACT
Oz Help Foundation	Tune ups/Support/ Counselling	AX[M][F00-F99]-O7.2		Fyshwick	ACT

Post and Ante Natal Depression Support and Information (PANDSI)	Playgroup	AX[F][F53]-O9.2		Holder	ACT
Well Ways - previously known as Mental Illness Fellowship	Women's Respite and Short Term Supported Accommodation	AX[F][F00-F99]-O5.2.1	8	O'Connor	ACT
Total: **Male**	**7**		**19**		
Rate per 100,000 residents (male >18 years old)	**5.2**				
Total : **Female**	**2**		**8**		
Rate per 100,000 residents (female >18 years old)	**1.4**				

Table 45 Services providing gender specific care in the NGO sector: workforce capacity (2016).

Providers	Name	Total FTE	MHN	SupW	Others
CatholicCare	The Lodge Program – Ainslie Village Complex	NA			
EveryMan Australia (previously known as Canberra Men's Centre)	Supported Accommodation-Everyman	5.0			5.0
EveryMan Australia (previously known as Canberra Men's Centre)	Complex needs service	0.3			0.3
EveryMan Australia (previously known as Canberra Men's Centre)	Counselling Service	3.0			3.0

EveryMan Australia (previously known as Canberra Men's Centre)	Outreach	5.0			5.0
Oz Help Foundation	Training	5.0			5.0
Oz Help Foundation	Tune ups/ Cupport/ counselling	0.4	0.4		
Post and Ante Natal Depression Support and Information (PANDSI)	Playgroup	2.6		2.6	
Well Ways - previously known as Mental Illness Fellowship	Women's Respite and Short Term Supported Accommodation	2.0			2.0
Total: male		**19.0**			
Rate per 100,000 residents (male >18 years old)		**14.0**			
Total : female		**8.0**			
Rate per 100,000 residents (female >18 years old)		**5.7**			

FTE: Full Time Equivalents; MHN: Mental health nurse; SupW: Support worker/Community worker.NA:Not available or incomplete

3.4.2 SERVICES FOR CARERS

We have identified five BSICs/services, incorporating eight MTCs, providing support for carers of people with mental health needs in the ACT PHN region. Carers ACT provides several services to carers, including individual advocacy, information, counselling, programs such as suicide prevention training, and linking with and brokering respite. Additionally, they support carers to sit on policy advisory boards.

There is a service for young carers described in the Transition to Adulthood section. Warren I'Anson House, provided by the Mental Health Foundation, also includes carers as well as people with mental health needs in its target groups, and thus is counted as an additional MTC here. Warren I'Anson House is described in the Residential section. This BSIC provides care for 2 target populations, so the staff are coded in the Adult Residential section. Six of the 8 MTCs are coded with a "v" qualifier as they do not have guaranteed funding for three years.

There are 5 BSICs, or 1.8 BSCs services per 100,000 residents providing support

for carers of people with a lived experience of mental illness in ACT PHN region.

Table 46 Services for carers: availability (2016).

Provider	Name	Main DESDE Code	Other DESDE code(s)	Town / Suburb	Area of Coverage
Carers ACT	Advocacy Team	AX[e310][F00-F99] - A5v		Holt	ACT and Southern Highlands
Carers ACT	Counselling Team	AX[e310][F00-F99]-O10.2v		Holt	ACT and Southern Highlands
Carers ACT	Policy, Representation and Advice Team	AX[e310][F00-F99]- A5v	AX[e310][F00-F99]-I2.1.1	Holt	ACT and Southern Highlands
Carers ACT	Programs Team	AX[e310[F00-F99]]-O10.2g,v		Holt	ACT and Southern Highlands
Carers ACT	Respite/ Replacement Care	AX[e310][F00-F99]-A4.1v		Holt	ACT and Southern Highlands
Total	**5**				
Rate per 100,000 residents (>18 years old)	**1.8**				

Table 47 Services for carers: workforce capacity (2016).

Provider	Name	Total FTE	Others
Carers ACT	Advocacy Team	1.0	1.0
Carers ACT	Counselling Team	3.0	3.0
Carers ACT	Policy, Representation and Advice Team	1.5	1.5
Carers ACT	Programs Team	2.0	2.0
Carers ACT	Respite/Replacement Care	5.0	5.0
Total		**12.5**	
Rate per 100,000 residents (>18 years old)		**4.5**	

FTE: Full Time Equivalents

3.4.3 SERVICES FOR PARENTS WITH A LIVED EXPERIENCE OF MENTAL ILLNESS

We have found two services providing support to parents with a lived experience of mental illness: these are coded in the Gender specific section. One of these is Post and Ante Natal Depression Support and Information Inc, and the second is the Perinatal Mental Health Consultation Liaison Service. Both services provide support to women in the perinatal period, but also to partners and families.

3.4.4 SERVICES FOR OFFENDERS

We have identified five BSICs/services providing support for offenders with mental health needs. A service for young adults is provided by Forensic Mental Health Services (FMHS), with care provided at Bimberi Youth Justice Centre. The Bimberi Youth Justice Centre Mental Health Services (BMHS) provides specialist mental health services to children and young people held in custody at the Bimberi Youth Justice Centre. Children and young people remanded in custody are screened for mental health and risk issues on entry to the Centre. Individuals with mental illness are provided ongoing care and support. There is a strong focus on early intervention activities. Clinicians are able to see individuals on a regular basis in the Health Services Building (facility within the centre). Clinicians are often involved in case conferences with key agencies, and families and carers. Release planning includes linking children and young people with community mental health teams for ongoing care. Each Wednesday, two clinicians are on-site and once a fortnight a consultant is located on-site. At all other times FMHS are available on-call for inductions, individual risk assessments and any mental health concerns.

Forensic Mental Health Services (FMHS) is a specialist service that provides mental health services to people at risk or involved in the criminal justice system. FMHS provides mental health services to adults held in custody at the Alexander Maconochie Centre This team provides specialist mental health services to people held in custody (remand or sentenced) at the Alexander Maconochie Centre. People remanded in custody are screened for mental health or risk issues on entry to the prison. Individuals with mental illness are provided ongoing care and support by clinicians, who see individuals on a regular basis in the Hume Health Centre (a facility within the prison). A mental health clinic is held at the Hume Health Centre daily.

A Court Assessment and Liaison Service provides guidance and information, while the Forensic Community Outreach Service works with consumers of Mental Health Services whose behaviour leads to contact with law enforcement agencies.

The Dhulwa Mental Health Unit is a secure mental health facility opened in November 2016. It provides 24-hour treatment and care for adults with complex mental health needs

that are not met by existing mental health facilities in the Canberra region. It has a total capacity of 25 beds, with 10 acute beds currently open and with a planned Stage 2 opening (of another seven longer-term rehabilitation beds) in 2017.

There are 5 BSICs, or 1.8 per 100,000 residents over the age of 17 years providing forensic mental health care in the ACT PHN region.

Table 48 Services for offenders: availability (2016).

Provider	Name	Main DESDE Code	Town/Suburb	Area of Coverage
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Justice Health Services	Alexander Maconochie Centre Mental Health Services (AMC MHS)	AX[F00-F99]-O8ji	Hume	ACT
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Justice Health Services	Bimberi Youth Justice Centre Mental Health Services (BMHS)	TA[F00-F99]-O8.1ji	Kenny	ACT
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Justice Health Services	Court Assessment and Liaison Service	AX[F00-F99]-I1.1j	Canberra	ACT
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Justice Health Services	Forensic Community Outreach Service	AX[F00-F99]-O8.1j	Canberra	ACT
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Justice Health Services	Dhulwa Mental Health Unit (DMHU)	AX-[F00-F99]-R5	Canberra	ACT
Total	**5**			
Rate per 100,000 residents (>18 years old)	**1.8**			

In the following table, the workforce provided for Forensic Community Outreach Service also covers the previous three Justice services. The Dhulwa Mental Health Unit workforce includes 3.5 Allied Health Assistants along with the other health professionals.

Table 49 Services for offenders: workforce capacity (2016).

Provider	Name	Total FTE	Psych/Reg	Psychol	MHN	SW	OT	Others
ACT Health-Mental Health, Justice Health, Alcohol and Drug Services-Justice Health Services	Alexander Maconochie Centre Mental Health Services (AMC MHS)							
ACT Health-Mental Health, Justice Health, Alcohol and Drug Services-Justice Health Services	Bimberi Youth Justice Centre Mental Health Services (BMHS)							
ACT Health-Mental Health, Justice Health, Alcohol and Drug Services-Justice Health Services	Court Assessment and Liaison Service							
ACT Health-Mental Health, Justice Health, Alcohol and Drug Services-Justice Health Services	Forensic Community Outreach Service	20.0*	1.0	8.0	8.0	2.0	1.0	
ACT Health-Mental Health, Justice Health, Alcohol and Drug Services-Justice Health Services	Dhulwa Mental Health Unit (DMHU)	51.26	3.0	2.0	40.76	1.0	1.0	3.5
Total		**71.26**						
Rate per 100,000 residents (>18 years old)		**28.5**						

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker.
**FTE shared across the first 4 services on the table*

3.4.5 MULTICULTURAL SERVICES (CALD)

We did not identify any services providing care to people from Culturally and Linguistically Diverse (CALD) backgrounds in the ACT PHN region.

3.4.6 SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

We identified one BSIC/service providing support to Aboriginal and Torres Strait Islander peoples in the ACT PHN region. ACT Health has a senior Registered Nurse and a Psychiatry Registrar, co-located at the Winnunga Nimmityjah Aboriginal Health Service, which provides specialist mental health assessment and interventions for this population.

***Addendum*:** MHJHADS also has three Aboriginal Liaison Officers who specifically assist clinicians with regard to culturally sensitive approaches in working with this population. Winnunga also has a Social Health Team which we have been unable to interview at the time of data collection.

Table 50 Services for Aboriginal and Torres Strait Islander Peoples: availability (2016).

Provider	Name	Main DESDE Code	Town/ Suburb	Area of Coverage
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Rehabilitation and Specialty MHS	Aboriginal and Torres Strait Islander Mental Health Service	AX[IN][F00-F99]-O10.1s	Narrabundah	ACT
Total	**1**			
Rate per 100,000 residents (>18 years old)	**0.4**			

Table 51 Services for Aboriginal and Torres Strait Islander Peoples: workforce capacity (2016).

Provider	Name	Total FTE	Psych/ Reg	MHN	Aboriginal Liaison Officer
ACT Health- Mental Health, Justice Health, Alcohol and Drug Services- Rehabilitation and Specialty MHS	Aboriginal and Torres Strait Islander Mental Health Service	5.0	1.0	1.0	3.0
Total		**5.0**			
Rate per 100,000 residents (>18 years old)		**1.8**			

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; MHN: Mental health nurse.

3.4.7 SERVICES FOR VETERANS

We identified one BSIC, incorporating three MTC, providing support to past and present members of the Defence Forces, and their families. The Veterans and Veterans' Families Counselling Service provides case management, group and counselling services for people with any type of service experience for any length of time, and their families, including children over the age of six. As well as providing staff onsite, they can use the services of a large number of local psychologists. They also provide a crisis assistance program, which brokers short term (up to five days) crisis accommodation, most frequently accessed for domestic violence, and for which mental health issues are related more than 20% of the time.

Table 52 Services for veterans and families: availability (2016).

Provider	Name	Main DESDE Code	Other DESDE Codes	Town/ Suburb	Area of Coverage
Veterans and Veterans Families' Counselling Service	Veterans and Veterans Families Counselling Service	GX[F00-F99]-O9.1gm	GX[F00-F99]-A4.1 GX[z63]-A5	0	0
Total	**1**				
Rate per 100,000 residents (>18 years old)	**0.4**				

Table 53 Services for veterans and families: workforce capacity (2016).

Provider	Name	Total FTE	Psychol
Veterans and Veterans Families Counselling Service	Veterans and Veterans Families Counselling Service	4.0	4.0
Total		**4.0**	
Rate per 100,000 residents (>18 years old)		**1.4**	

FTE: Full Time Equivalents; Psychol: Psychologist.

3.4.8 HOMELESSNESS SERVICES

The complexity of homelessness requires a detailed analysis. We acknowledge that most people who experience homelessness also have an additional mental health issue. However, the main objective of this Atlas is to describe the services which target mental

illness/mental health. If we were to include the services for people experiencing homelessness in general in the analysis, we would bias the picture.

3.4.9 ALCOHOL AND OTHER DRUG SERVICES

Alcohol and Other Drugs (AOD) services have not been mapped in this atlas. A separated coding and mapping of these services is required to fully understand the mental health delivery system of the region.

4. MAPPING THE MENTAL HEALTH SERVICES

In this section we present a series of maps illustrating data on the supply of mental health services in relation to selected demand-related indicators and the spatial accessibility metric. Separate maps are shown for: (i) Adult Residential; (ii) Adult Outpatient Care (non-mobile);
(iii) Adult Outpatient Care (mobile); and (iv) Adult Day Care..

The background of the maps represents rate of psychological distress and population density.

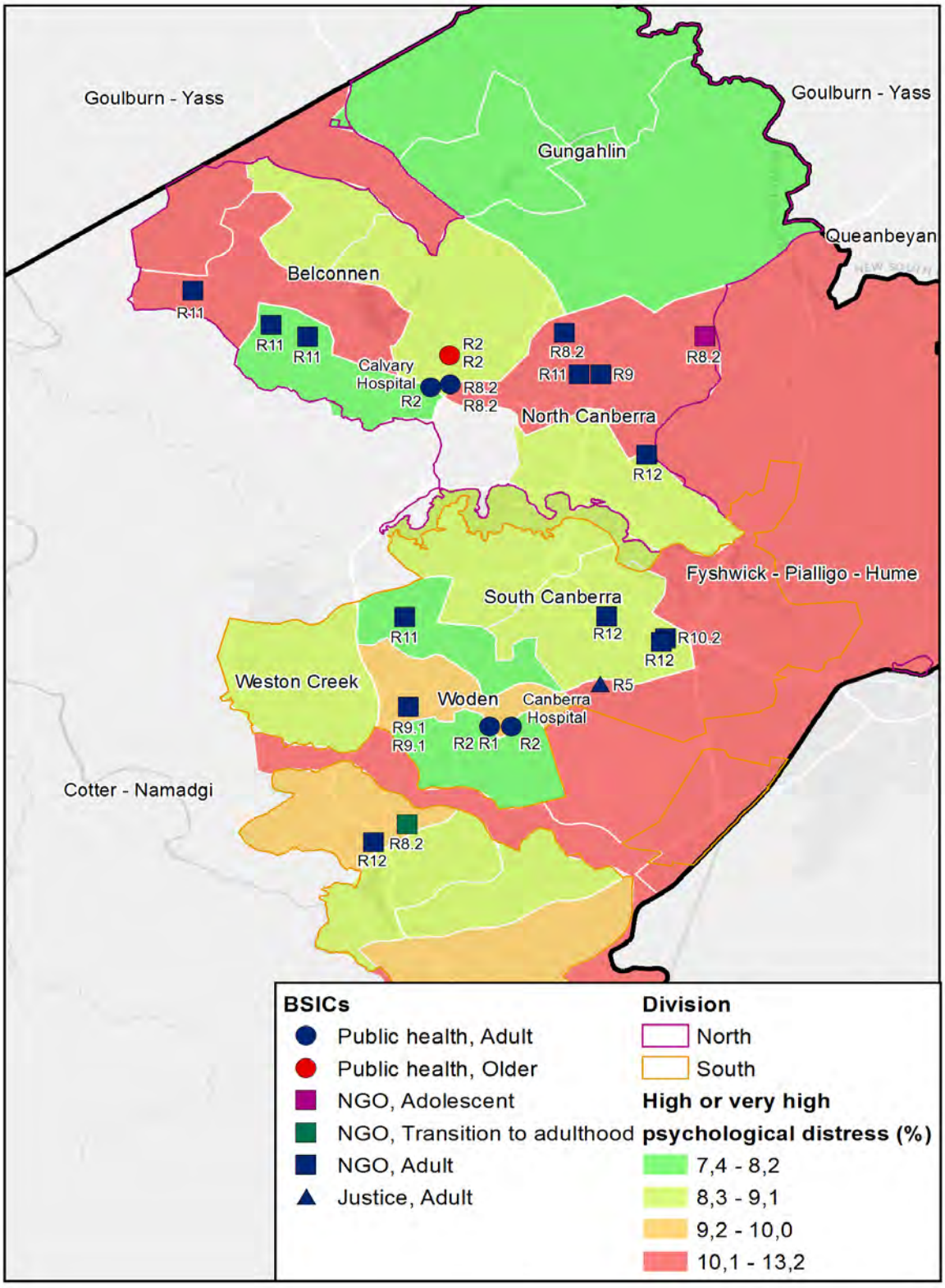


Figure 31 Psychological distress and Residential services.

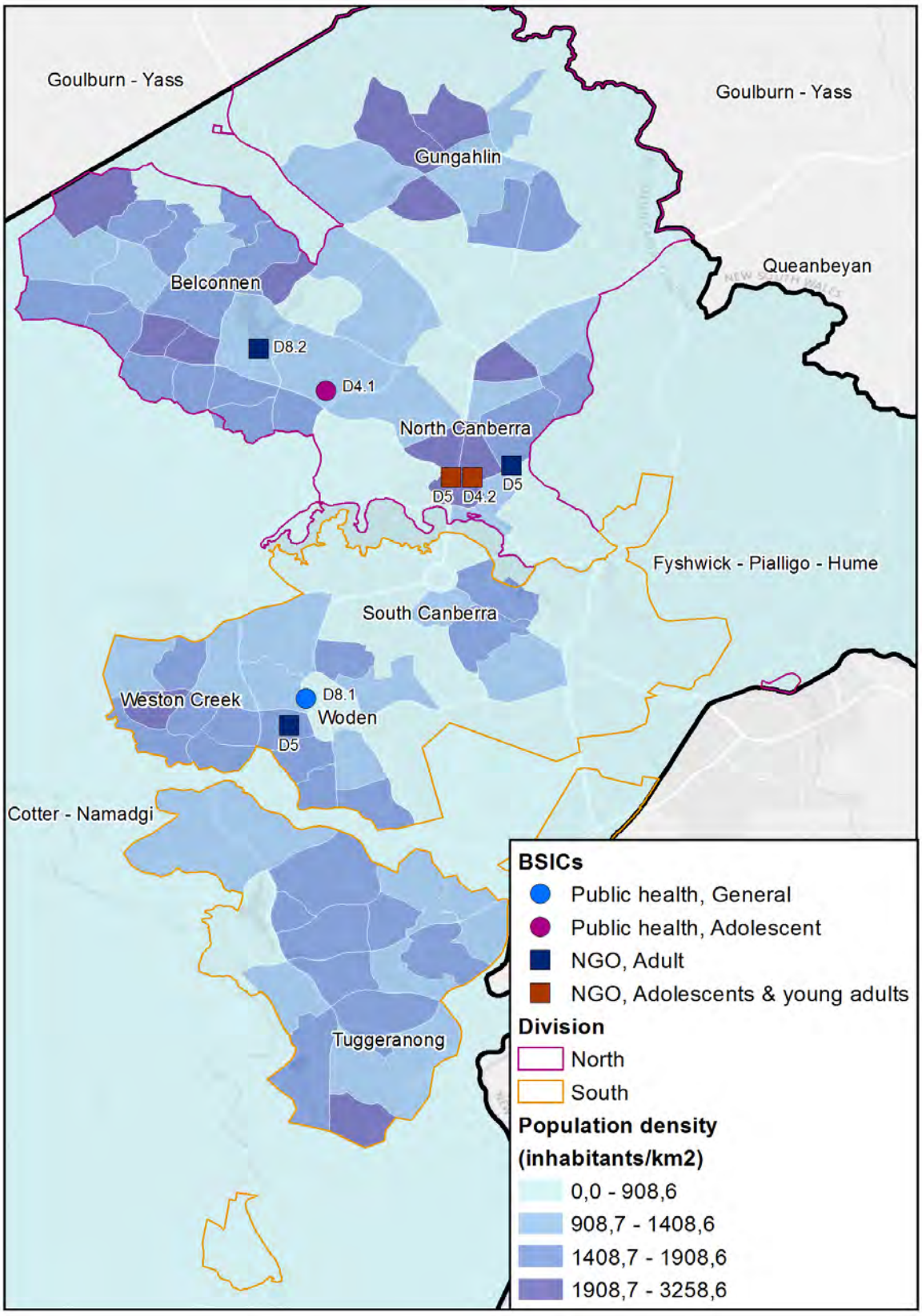


Figure 32 Population density with Day program services.

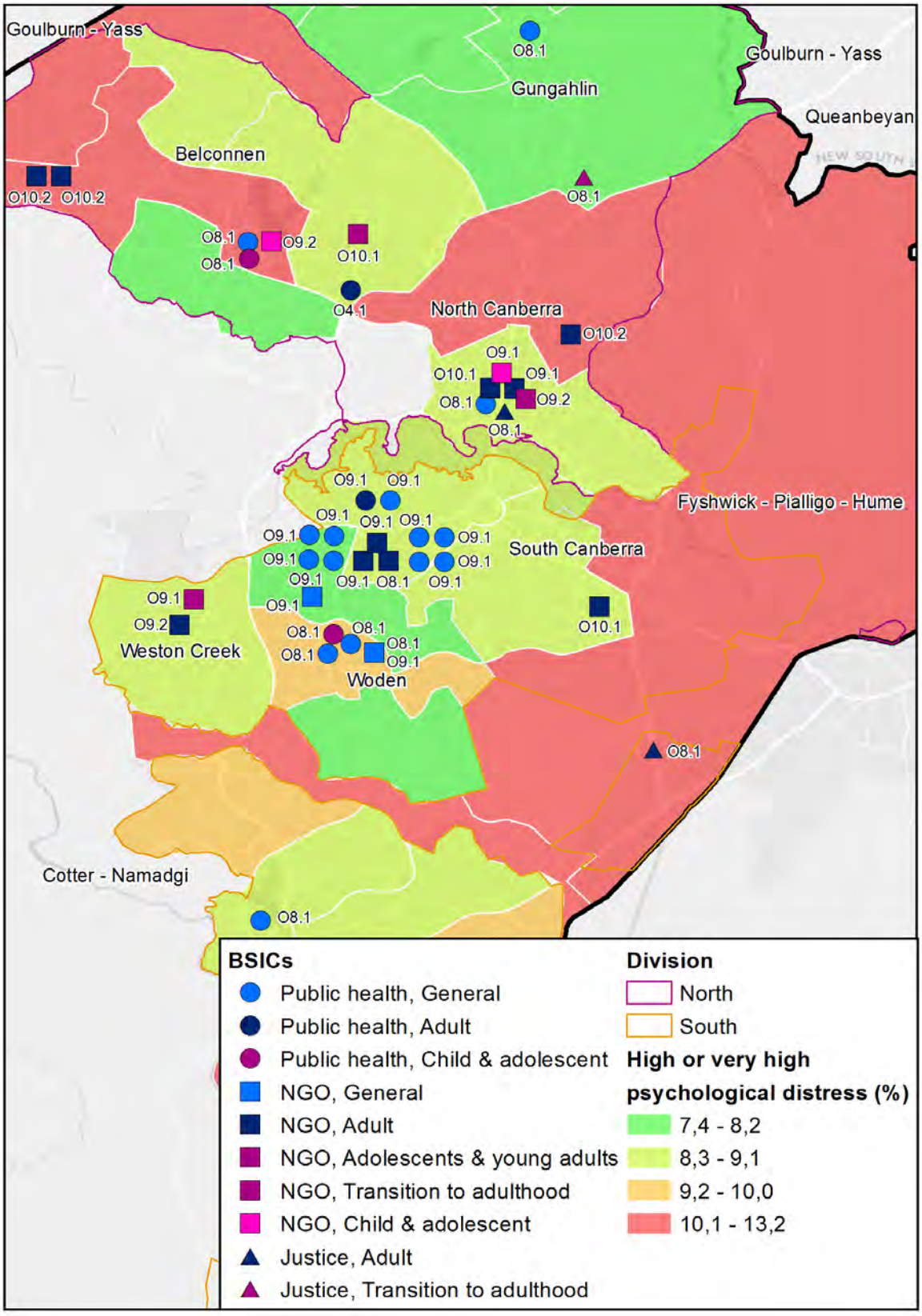


Figure 33 Psychological distress with Outpatient non-mobile services

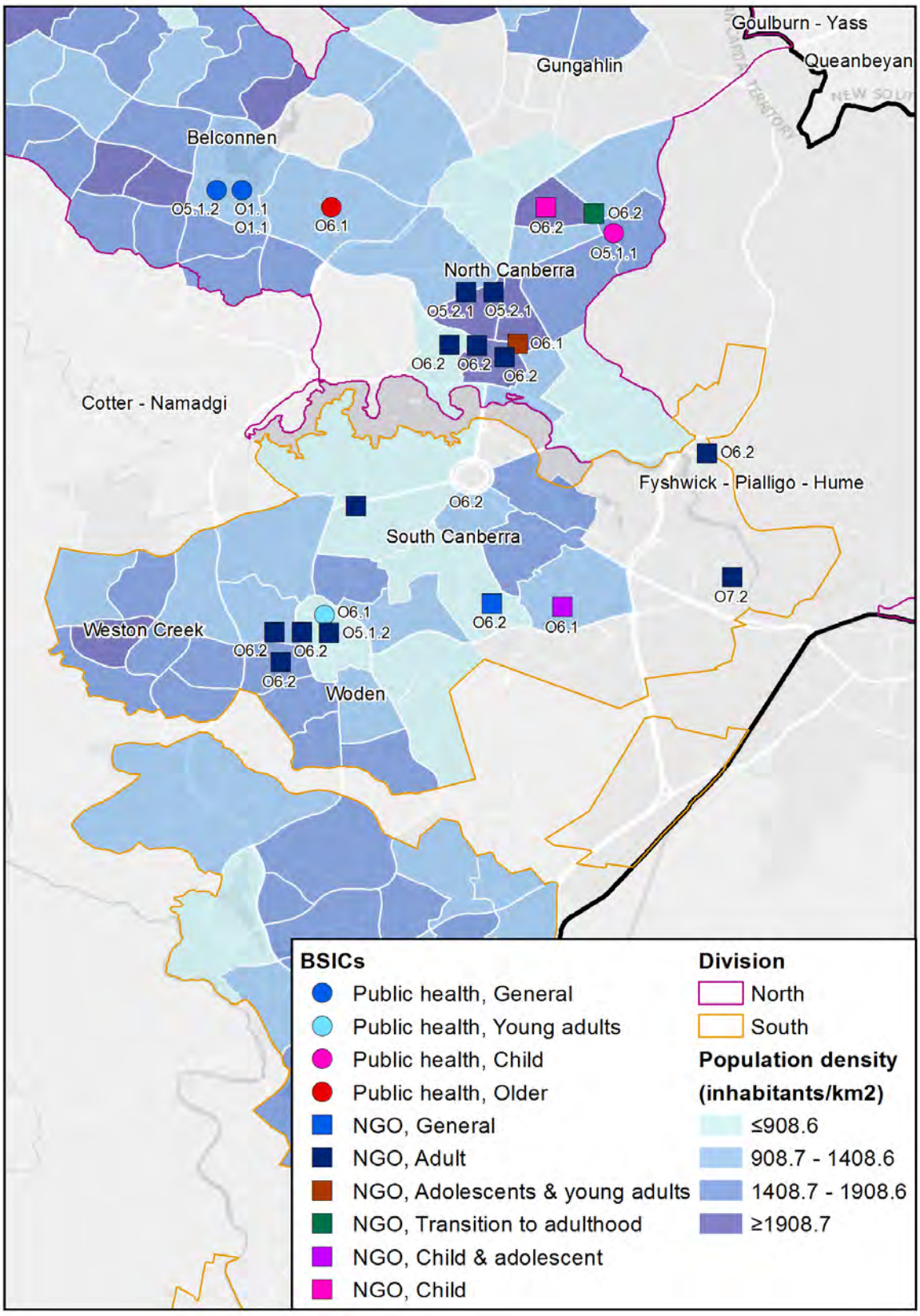


Figure 34 Population density with Outpatient mobile services.

5. DESCRIPTION OF THE PATTERN OF CARE

The figure below depicts the pattern of adult mental health care in the ACT PHN region. For this analysis, and to facilitate comparisons across jurisdictions, we focus on services for adults with a lived experience of mental illness (18-64 years old), excluding services for specific groups, i.e carers, CALD, IN, forensic, gender specific, parents, or veterans.

The blue area refers to residential care, the orange area to day care, the green to outpatient care and the yellow one to accessibility.

The main gaps identified are:

- a lack of acute and non-acute alternatives to hospitalisation;
- a lack of acute and non-acute health related day programs;
- a lack of employment related services: and
- a lack of CALD services.

Alternatives to hospitalisation are services staffed by mental health professionals which provide care for people with a lived experience of mental illness who are experiencing a crisis. They provide the same type of care as the hospital (in an inpatient unit) but are embedded into the community. These are small units, with a strong focus on recovery (e.g. crisis homes).

There is a lack of day care related to mental health. Acute mental health related day care services also provide an alternative to hospitalisation. People experiencing a mental health crisis are not admitted to a hospital, but treated in the community. They spend all day at the facility, but they sleep at home. Non-acute health related day care includes day care centres staffed with at least 20% of highly skilled mental health professionals, where people with lived experience of mental illness can spend the day, socialising and participating in structured activities related to mental health, such as cognitive training. There is also a lack of day programs related to cultural and leisure activities.

We found no employment related services. Employment alternatives for people with mental illness include supported employment for those who are unable to work on competitive employment, and services which assist people with severe mental illness transition to ordinary employment.

On the other hand, we found a good availability of residential care in the community, and a good availability of accessibility services. There is a higher provision of high intensity non- hospital accommodation, such as residential recovery and step up/step down MTCs, and long term accommodation, in comparison to other areas we have mapped. Most of these MTCs are provided by the NGO sector. There are four NGOs providing this type of care. The provision of accessibility services in the ACT PHN region is higher than in other areas we have mapped. This is partly due to PIR services being more likely in the

ACT PHN region to be coded as accessibility services than they have been in other areas, where they have more frequently been providing more direct care, and so have been coded as outpatient.

We also found a wide range of services for specialised groups, such as young carers, gender specific care, and veterans.

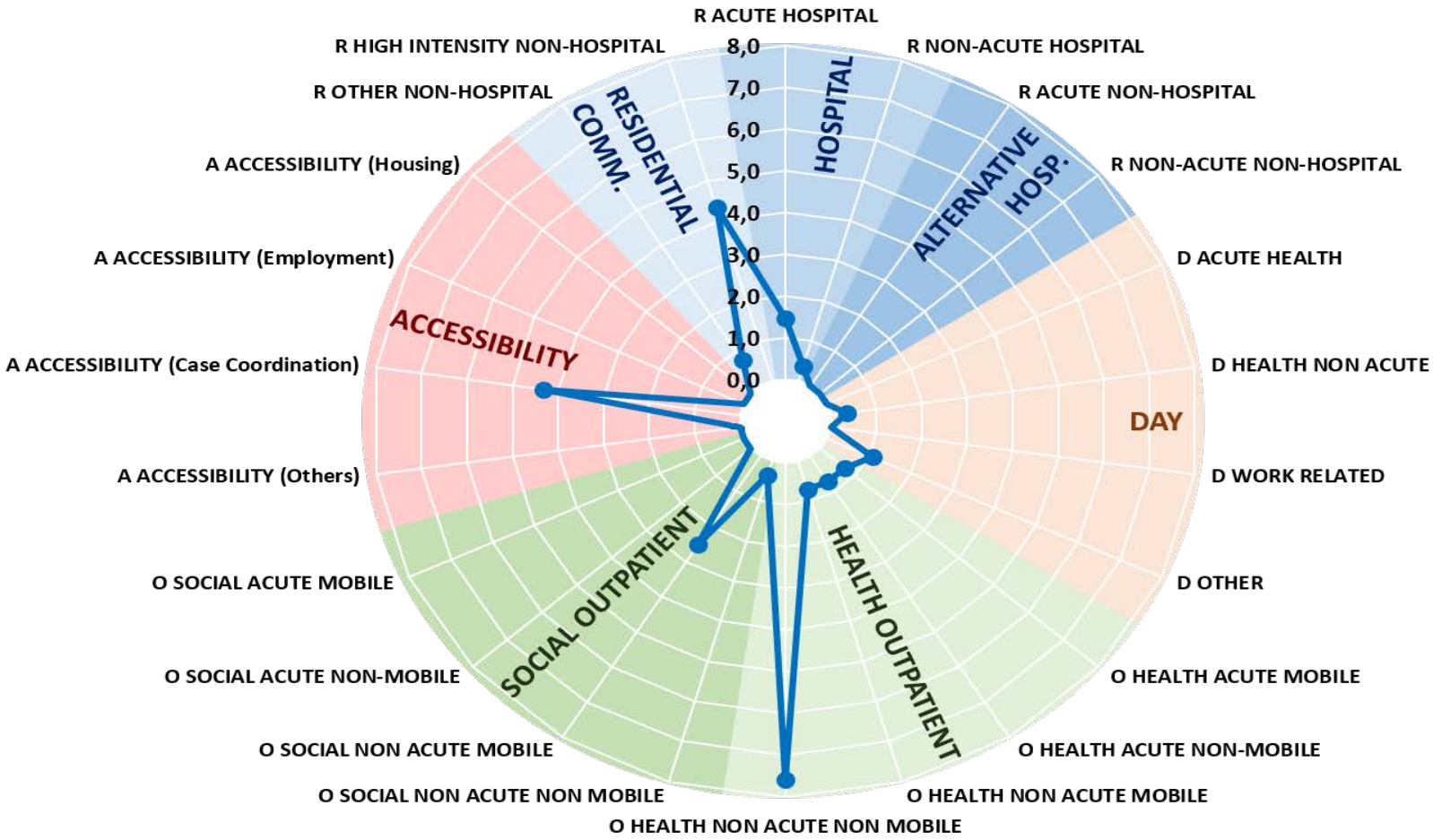


Figure 35 Pattern of availability of MTCs in ACT for adult population with lived experience of mental illness. Availability of MTCs per 100,000 population (2016)

In this section we present an overview of the workforce capacity in the ACT PHN region. This data has to be interpreted with caution as we did not get any response from some service providers. In addition, the different terminology used by the providers complicates the analysis (e.g. support facilitator, non-clinical care manager, linker facilitator, community worker). More research is needed in order to understand what the main differences between these positions are. This has to be seen as a first approximation of the data.

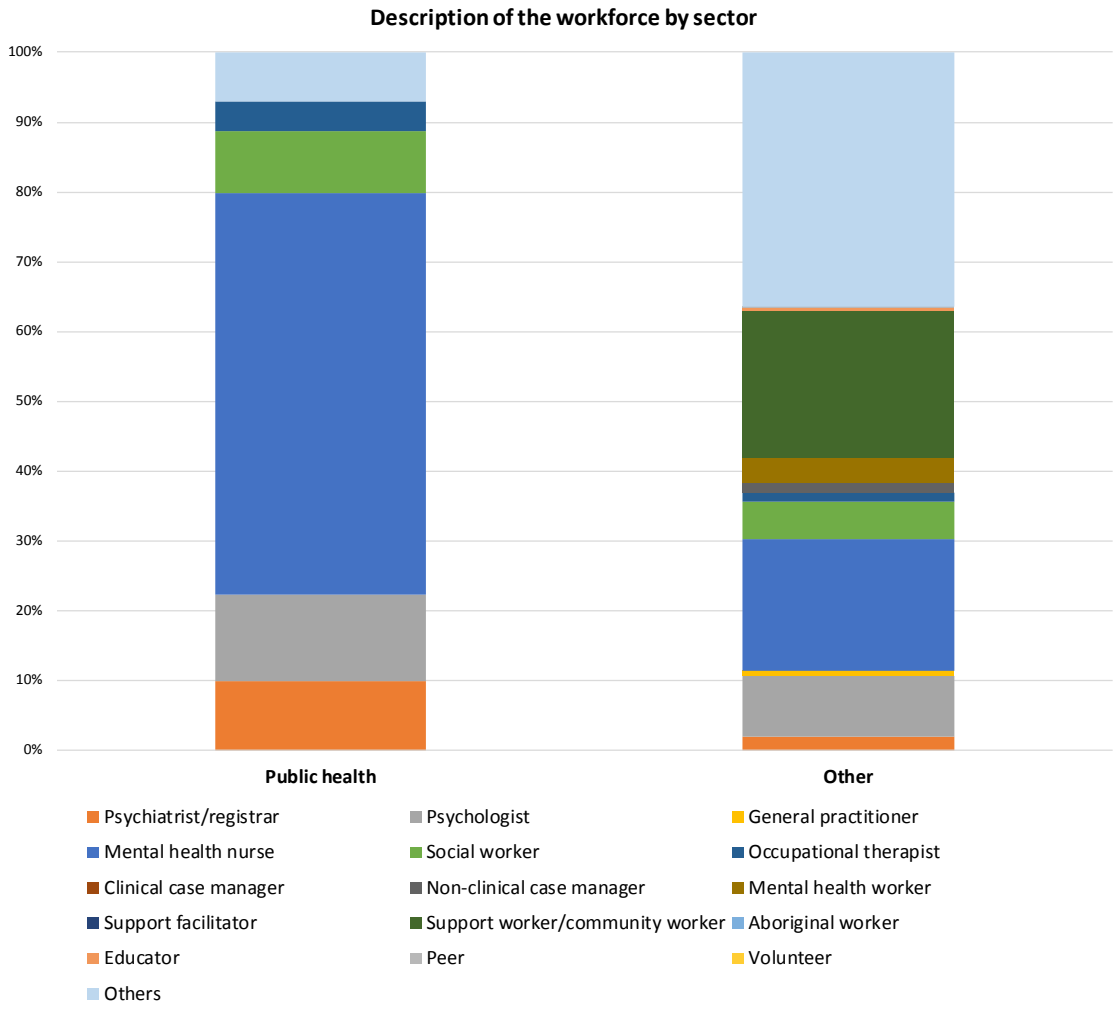


Figure 36 Description of the mental health workforce in ACT by sector (2016)

The rate of professionals in the public mental health sector providing care for people with a lived experience of mental illness per 100,000 residents in the ACT PHN region in 2016 is around 97.7 per 100,000 residents (excluding private providers under Health In Mind or the Better Access Program). The rate of professionals working in NGOs providing care for people with a lived experience of mental illness per 100,000 residents of the ACT PHN region amounts to 77.6. This can be compared to Central and Eastern Sydney Primary Health Network (CESPHN), where the rate of public health sector professionals is 83.71, and that of NGOs is 41.68, and to South West Sydney(SWS), where the ratio of the public health to the NGO workforce is similarly approximately 2:1

As can be observed in the previous figure, the profile of professionals in the health sector and the NGO sector is very different. In the health sector the most common professionals are mental health nurses followed by psychiatrists and social workers. In the NGO sector, there are fewer clinical professionals which may reduce their capacity to provide more intensive care, although some organisations may hire them on a casual position, according to need.

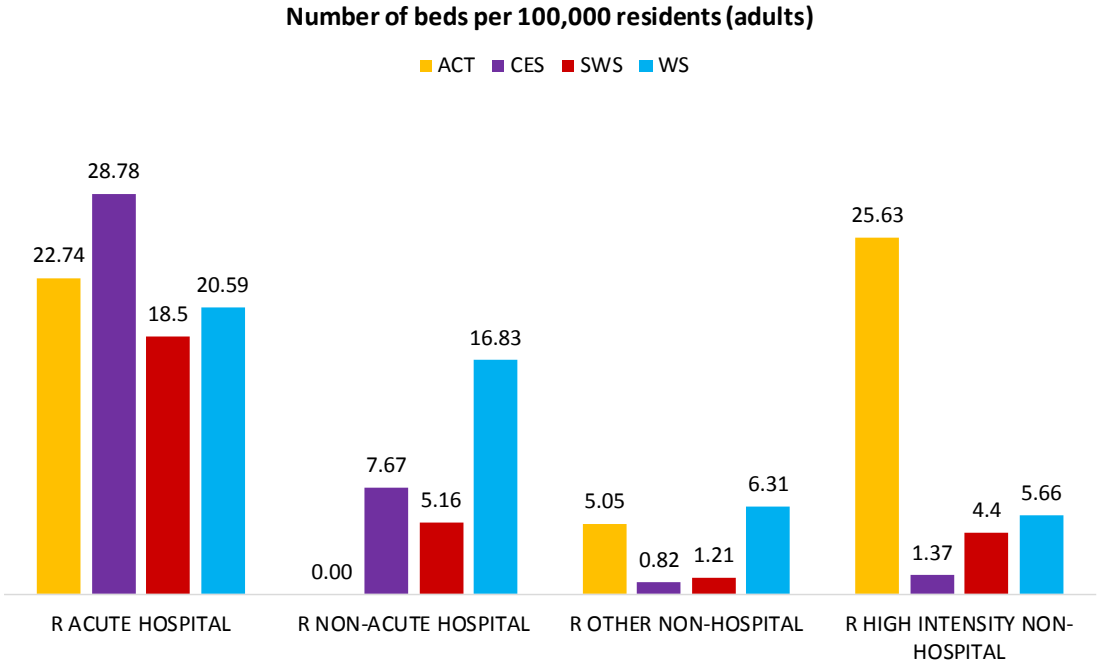
The next figures compare the mental health pattern of care between the ACT PHN region and South Western Sydney Local Health District (SWS), between the ACT PHN region and Western Sydney LHD (WS), and between the ACT PHN region and CESPHN. The main differences to be found are in the provision of non-hospital residential care, and accessibility services. The ACT PHN region has a higher availability in both these categories of care than either WS, SWS, or CESPHN. In the ACT PHN region, the rate of NGO funded residential care is higher than in WS and CESPHN. However, it should be noted that in the DESDE-LTC codification system, a distinction is made between services providing both accommodation and support,(coded as residential) and those providing support only to people living in community housing (which are coded as outpatient). The ACT PHN region also has a higher availability of acute inpatient hospital care than SWS or WS, but lower than CESPHN. It may be, however, that the CESPHN also has a higher number of people from outside the area using their services.

The ACT PHN region, like other regions we have mapped, has few day care programs/services. Unlike the other regions, the ACT PHN region has no employment related day services. The benefits of this type of service are discussed elsewhere in this report. One PHAMS currently provides a staff member assisting with accessibility to employment, however the PHAMs service does not have ongoing funding.

With regard to accessibility-related services, the main difference is related to coding issues: in the ACT PHN region, Partners in Recovery (PIR), was coded primarily as an Accessibility-related service, while in Western Sydney and South Western Sydney it was coded as an outpatient/community service. In South Eastern Sydney Local Health District, all PIR teams are coded as outpatient related and in Sydney Local Health District, only one of the PIR teams is coded as accessibility while the remaining were coded as outpatient. The difference in how the different organisations (and even inside the organisation) conceptualise the main activities of PIR requires further analysis. Additionally, the ACT PHN region provides two accessibility services for specific groups: the Trauma Support Service, specifically for people who have suffered past systemic abuse, and The WayBack Support Service for people who have been hospitalised for attempted suicide.

With regard to services for children and adolescents, we can see that the distribution follows a broadly similar pattern to that in SWS, SES, and WS. That is, most services provided are health related outpatient care, particularly non-acute, non-mobile care. Only SES provides more health related outpatient care than the ACT PHN region. The ACT

PHN region also has a higher rate of social outpatient care, non- hospital residential care, and daycare, particularly health related day care, while it is the only one of these areas to have no acute inpatient hospital care. If we compare child and adolescent services to adult services in the ACT PHN region, there is more health related day care, and more non-acute mobile health related care provided for children and adolescents, and a lower rate of social related outpatient care.



Acute Hospital: R1,R2,R3; Non-Acute Hospital: R4-R6; Other Non-Hospital: R 9,R10,R12, R13,R14; High Intensity Non-Hospital: R8,R11

Figure 37 Number of adult mental health beds in the ACT region vs. Central Eastern, South Western and Western Sydney

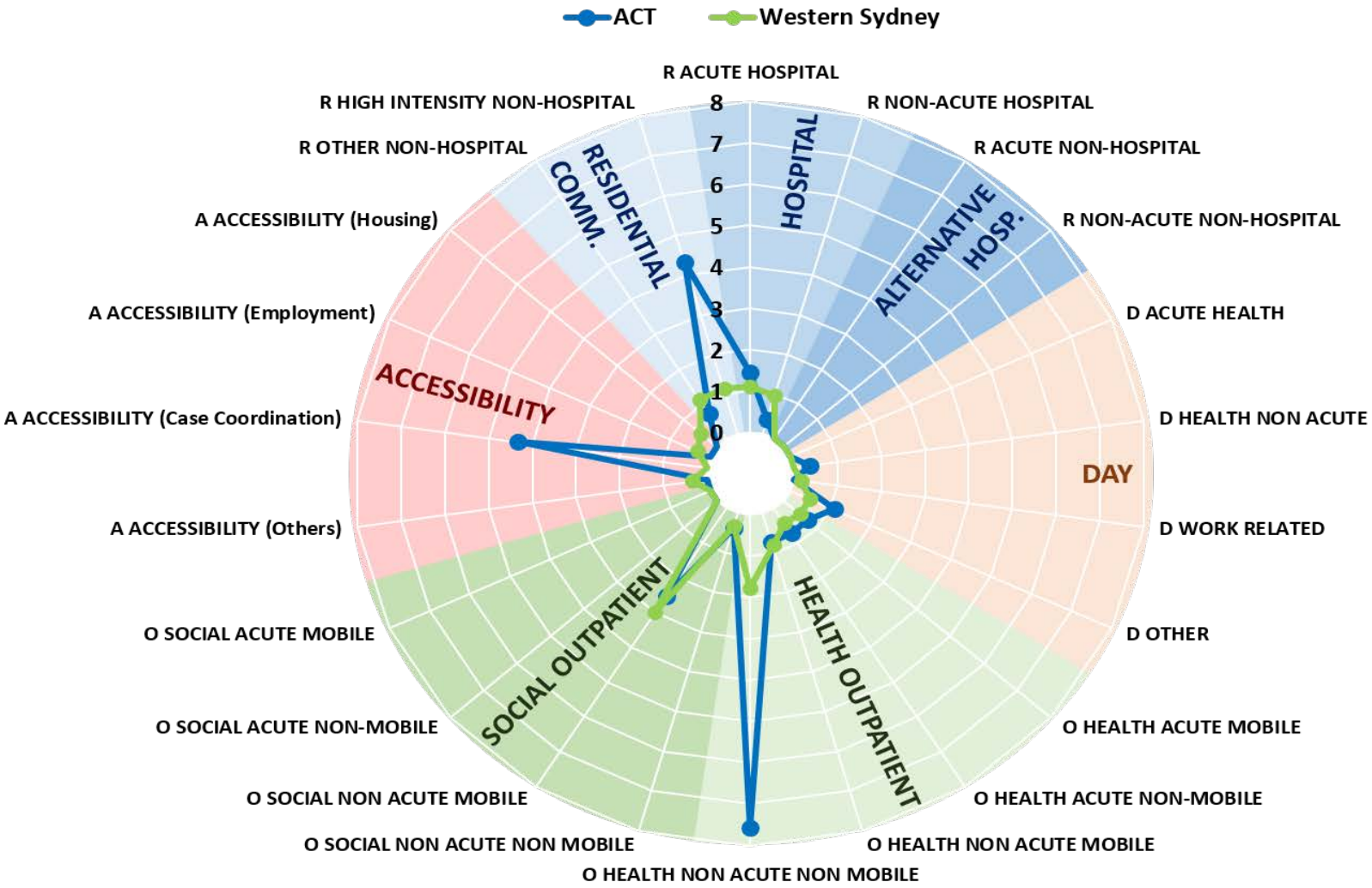


Figure 38 Pattern of availability of MTCs for adults with lived experience of mental illness. Comparison between ACT and Western Sydney LHD.

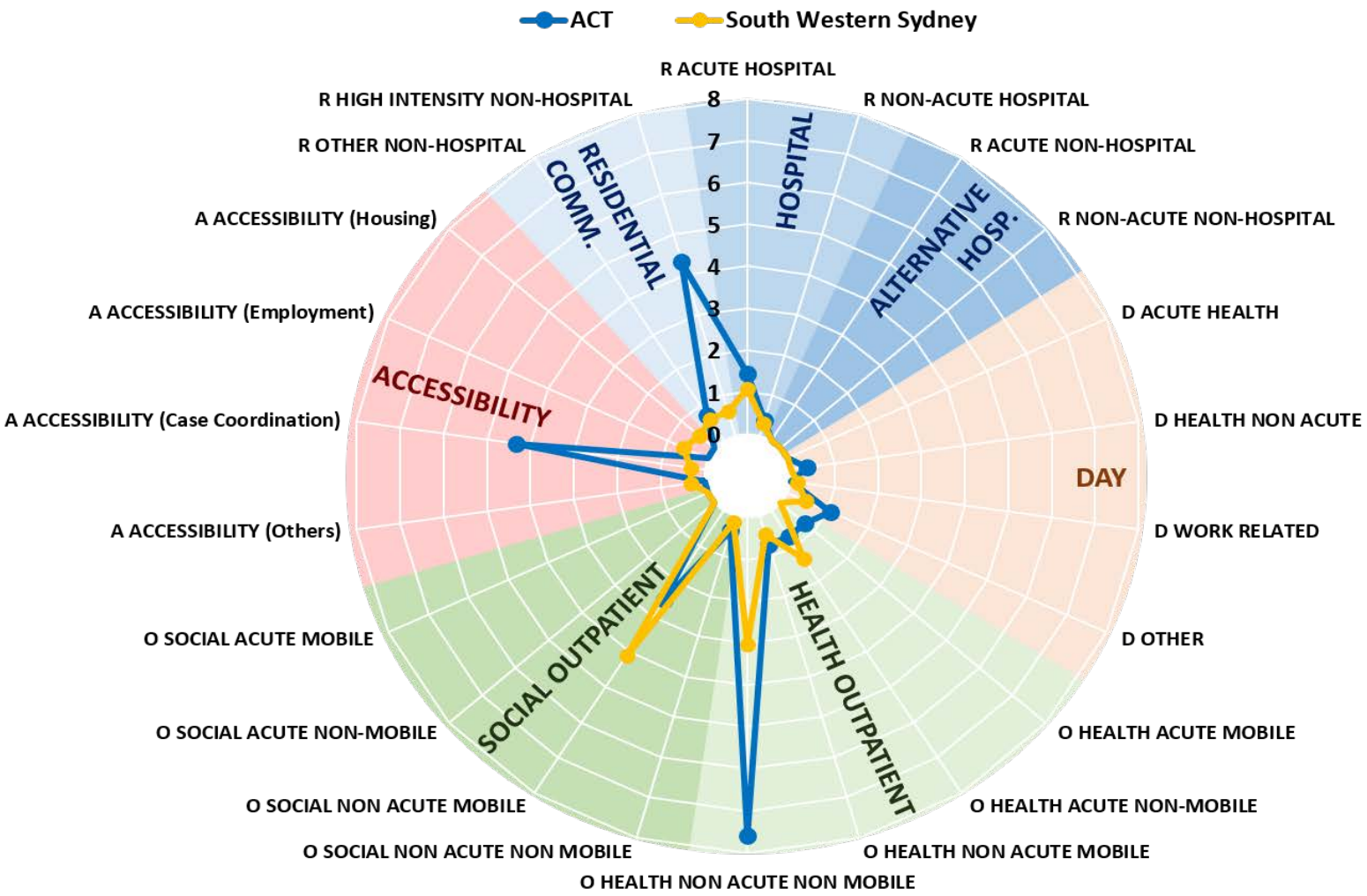


Figure 39 Pattern of availability of MTCs for adults with lived experience of mental illness. Comparison between ACT and South Western Sydney LHD.

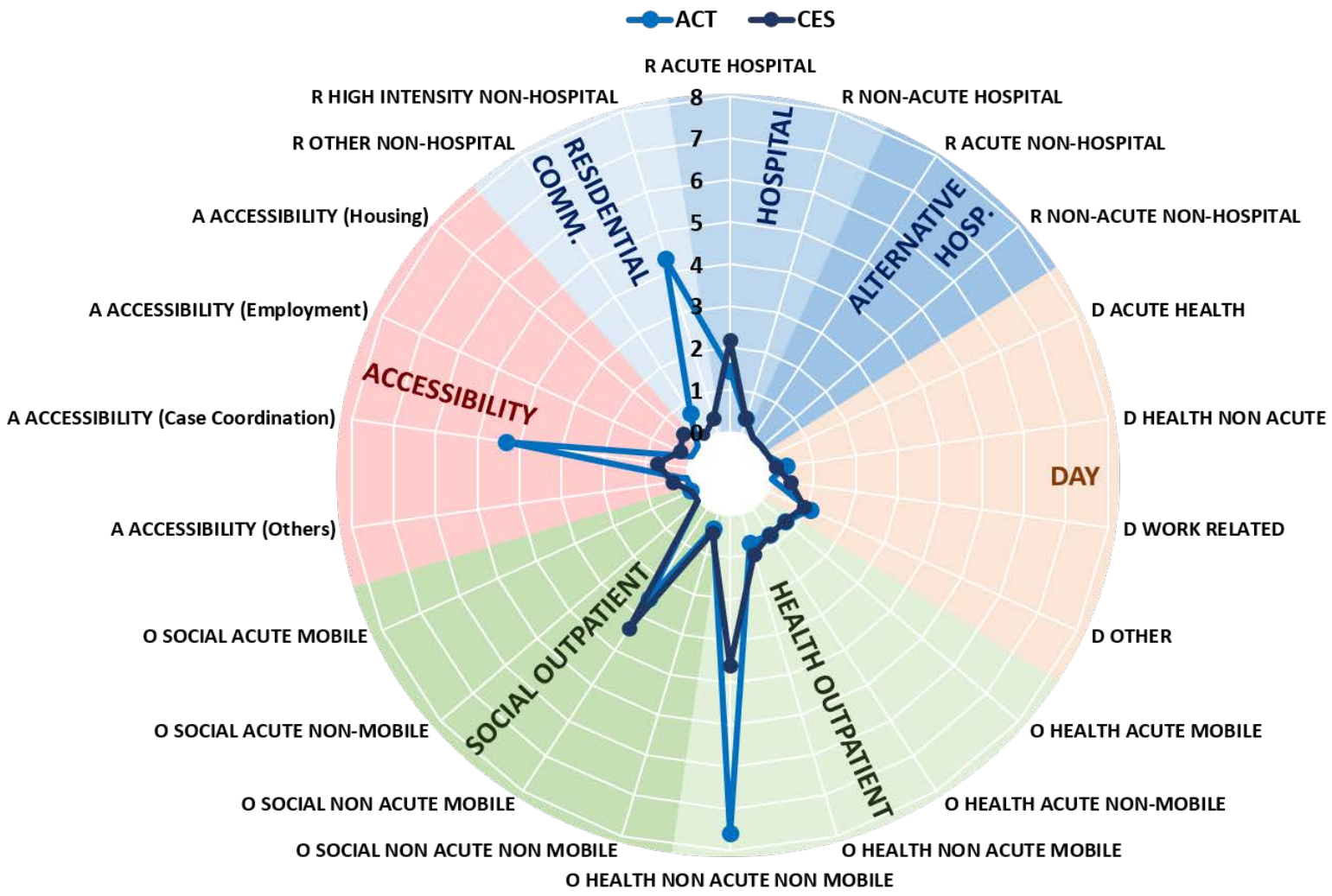


Figure 40 Pattern of availability of MTCs for adults with lived experience of mental illness. Comparison between ACT and Central and Eastern Sydney.

.

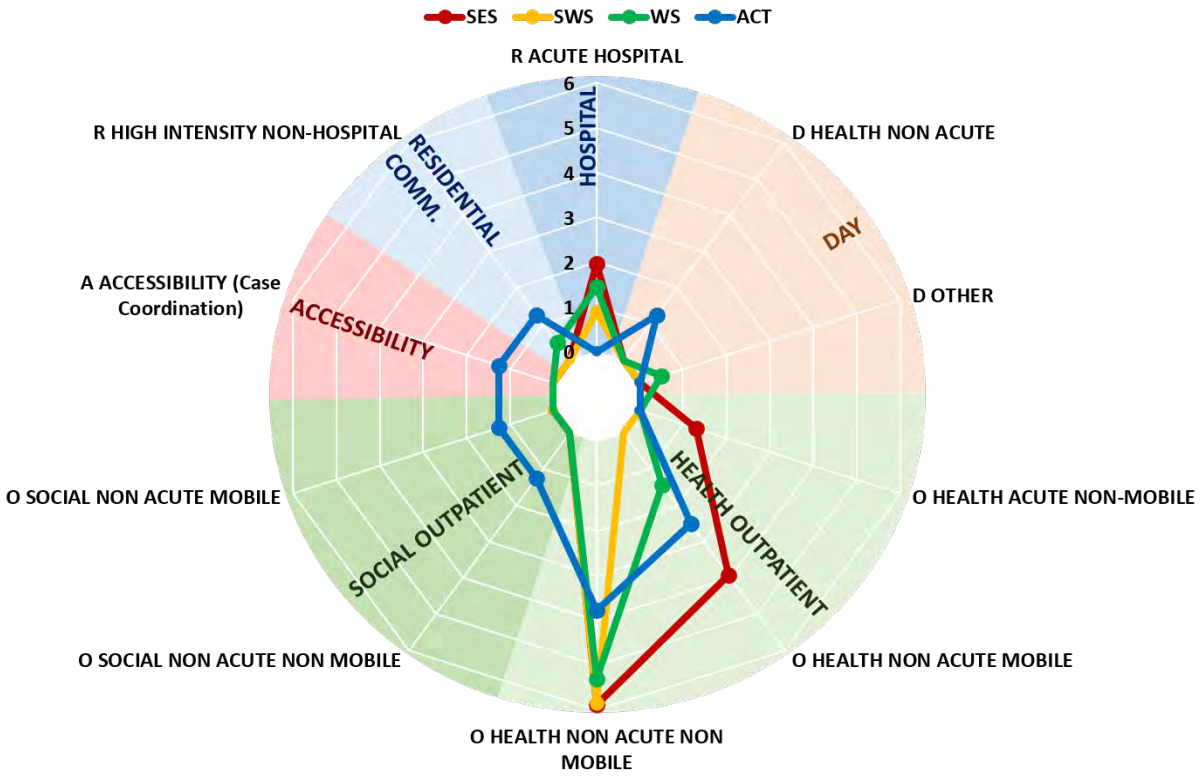


Figure 41 Pattern of availability for Child and Adolescent population with lived experience of mental illness. Comparison between SES,SWS, WS and ACT. Availability of MTCs per 100,000 population< 18 years

6. INTERNATIONAL COMPARISONS

International comparisons are useful for: 1) learning about national systems and policies; 2) learning why those systems take the forms they do; and 3) learning lessons from other countries for application elsewhere. In the absence of a gold standard for planning the provision of mental health services, international comparisons may also be useful for asking questions that are taken for granted.

To conduct meaningful comparisons, it is important to use a standardised tool that goes beyond terminological variability. We have mapped the pattern of mental health in different European areas using the DESDE-LTC. The use of a common language allows us to compare the CESPHN region with different community care models in Europe. The information on the different European countries has been presented as part of the REFINEMENT research project funded by the European Commission (The Refinement Project Research Consortium, 2013).

Table 54 Socio-demographic indicators in 5 local areas of mental health care in countries with different models of care.

	Sør-Trøndelag (Norway)	Helsinki and Uusimaa Hospital District (Finland)	ULSS20 - Verona (Italy)	Girona (Spain)	Hampshire[1] (England)
Population (>18 years old)	225,081 (2010)	1,206,446 (2010)	393,402 (2010)	599,473 (2010)	1,364,799 (2010)
Land area (km²)	18,856	8,751	1,061	5,585	3,769
Population density (inh./ km²)	15.60 (2011)	176.56 (2011-12)	416.85 (2001)	132.61 (2010)	459.45 (2010)
Ageing index (>65/<15x100)	81.42 (2012)	82.17 (2010)	144.10 (2010)	98.29 (2010)	100.66 (2011)
Dependency ratio (<15 & >65/15-4x100)	49.55 (2012)	44.82 (2010)	53.51 (2010)	46.20 (2010)	52.43 (2011)
People living alone (%)	40.78 (2011)	41.37 (2011)	29.16 (2001)	17.94 (2007)	27.73 (2001)
Average of people per household	2.21 (2011)	2.07 (2011)	2.44 (2001)	2.62 (2007)	2.37 (2011)
Immigrants (%)	6.64 (2012)	6.14 (2011)	12.24 (2010)	21.60 (2010)	-
Unemployment rate (%)	2.79 (2010)	7.35 (2010)	4.21 (2001)	18.28 (2010)	5.8 (2011)

Total health care expenditure per capita Purchasing Power Parity (in Euros) (2010)	€4156	€ 2504	€ 2282	€ 2345	€2626
Total health care expenditure as a share of GDP	9.4%	8.9%	9.3%	9.6%	9.6%

1 Including Portsmouth and Southampton Unitary Authorities.

6.1. NORTHERN EUROPEAN COMMUNITY MENTAL HEALTH CARE MODEL

The figures below compare the ACT PHN region with an area in Norway (Sør-Trøndelag) and with an area in Finland (Helsinki and Uusimaa).

The main characteristic of the Northern Europe Community Mental Care Model is the high availability of different types of services. Indeed, Norway has one of the highest per capita health care expenditures. Both Finland and Norway raise funds for mental health mainly from general taxes.

The provision of mental health services in Norway is organised within Health Authorities (HF), each one including several institutions/hospitals. The area in Norway (Sør-Trøndelag) covers 25 municipalities and it is the catchment area of the St Olavs Hospital HF. The municipalities are obliged to offer primary health care and long term care to all people in need of municipal services, regardless of diagnosis. The GP is responsible for planning and coordinating preventive work, evaluation and treatment and provides an important link between primary health care and the specialised health services.

With regard to socio and economic characteristics, Sør-Trøndelag has a low population density (15.60 inh/km2). It also has a very low unemployment index.

The main difference with the ACT PHN region is related to the high availability of non-acute care at the hospital, day programs related to employment and social and cultural issues, and outpatient non-acute care, both mobile and non-mobile. The addition of the Health In Mind providers, however, would reduce the difference related to the non-mobile non-acute outpatient care.

The Finnish area (Helsinki and Uusimaa Hospital District) is owned and governed by 26 municipalities. Each municipality is free to provide the universal accessible services as a municipal activity, or to purchase the services from an external provider. Primary care is organised by the municipalities, and represents the main access point for people with mental illness while specialised care is organised by the hospital districts.

More than 40% of the households of the area of Helsinki and Uusimaa are occupied by just one person.

When comparing the ACT PHN region and the Finnish area the main contrast is the high number of day care/programs in Finland, as well as the high availability of non-acute inpatient care.

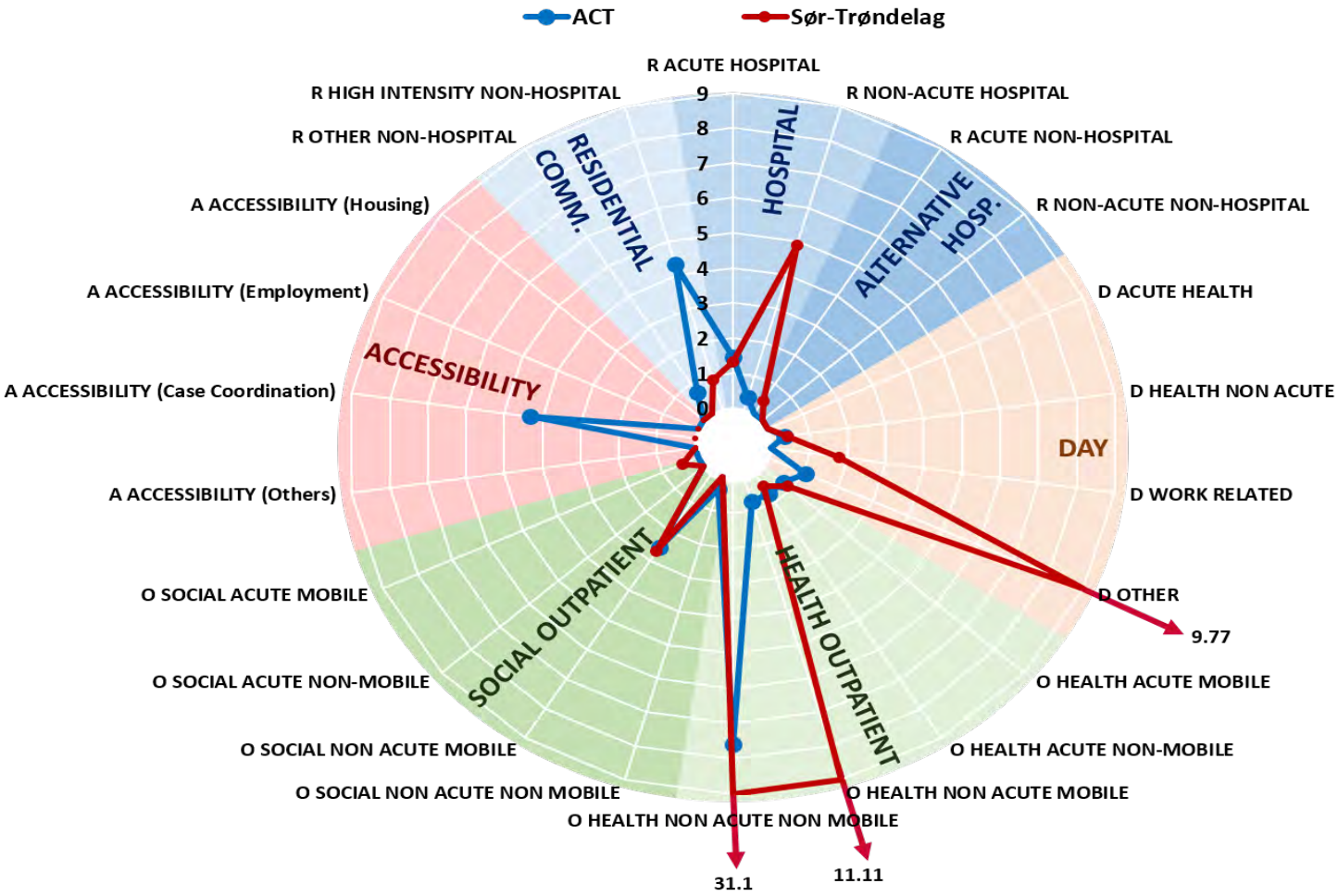


Figure 42 Pattern of availability of MTCs for adults with lived experience of mental illness. Comparison between ACT and Sor-Trondelag.

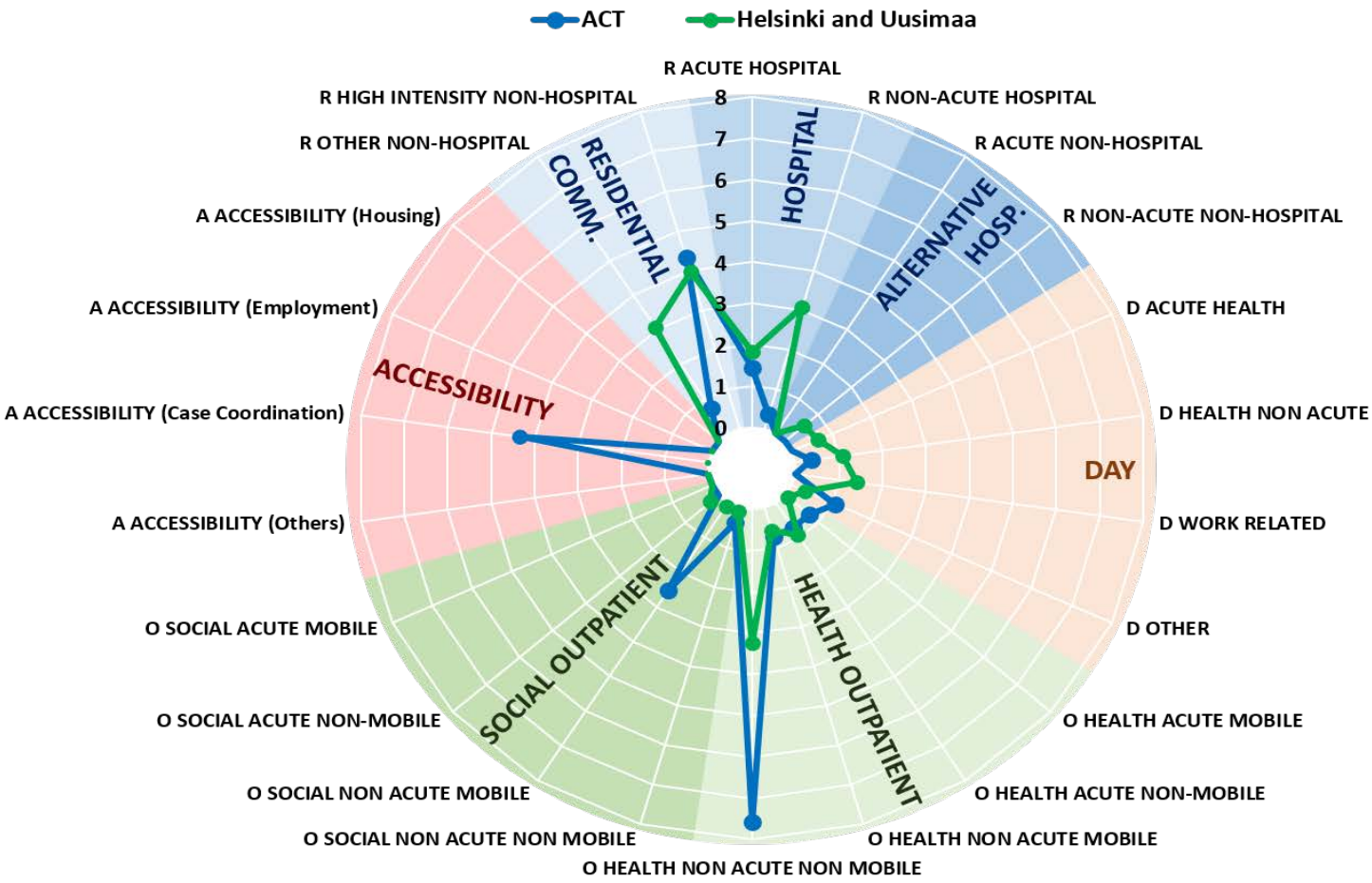


Figure 43 Pattern of availability of MTCs for adults with lived experience of mental illness. Comparison between ACT and Helsinkin and Uusimaa.

6.2. SOUTHERN EUROPEAN MODEL OF COMMUNITY MENTAL HEALTH CARE

The figures below compare the ACT PHN region with Italy (Veneto Region), and the ACT PHN region with Spain (Girona). The mental health system in Southern Europe is characterised by a strong emphasis on community care, and low availability of psychiatric hospitals. As in the case of Northern Europe, the public health sector is funded from general taxes.

In Italy, the Local Health Authorities, which are the local branches of the Regional National Health System, are the purchasers of health care services. They also finance social care services together with the municipalities. There are 21 Local Health Authorities in the Veneto Region. Each Local Health Authority has assigned a Mental Health Department, which is in charge of the planning and management of all medical and social resources related to prevention, treatment, and rehabilitation in mental health within the area.

Socio and economic indicators from the area are derived from data from 2001, which would have changed. However, this area registers a high ageing index and population density.

In Spain, most of the Mental Health Services are funded by the Regional Health Authorities. Social services are paid for by the social and employment authority. In the area of Girona the mental health system is organised according to two different levels, Hospitalisation and Community Care. Hospitalisation is located in the "Marti i Julia Hospital Park" in Salt that belongs to Institut d'Assistència Sanitària (IAS). The Community Mental Health care is organised in seven areas that include an Adult Mental Health Centre and other specific services. Mental health patients enter the system through primary care (PC) that fulfils a gatekeeping function.

The main points of difference between these countries and the ACT PHN region are: higher acute hospital inpatient availability, and high intensity non- hospital residential support in the ACT PHN region than in Italy or Spain, but lower non- acute hospital availability, and other community residential care. There is also a greater availability of day care/ programs in both Italy and Spain than in ACT PHN region.

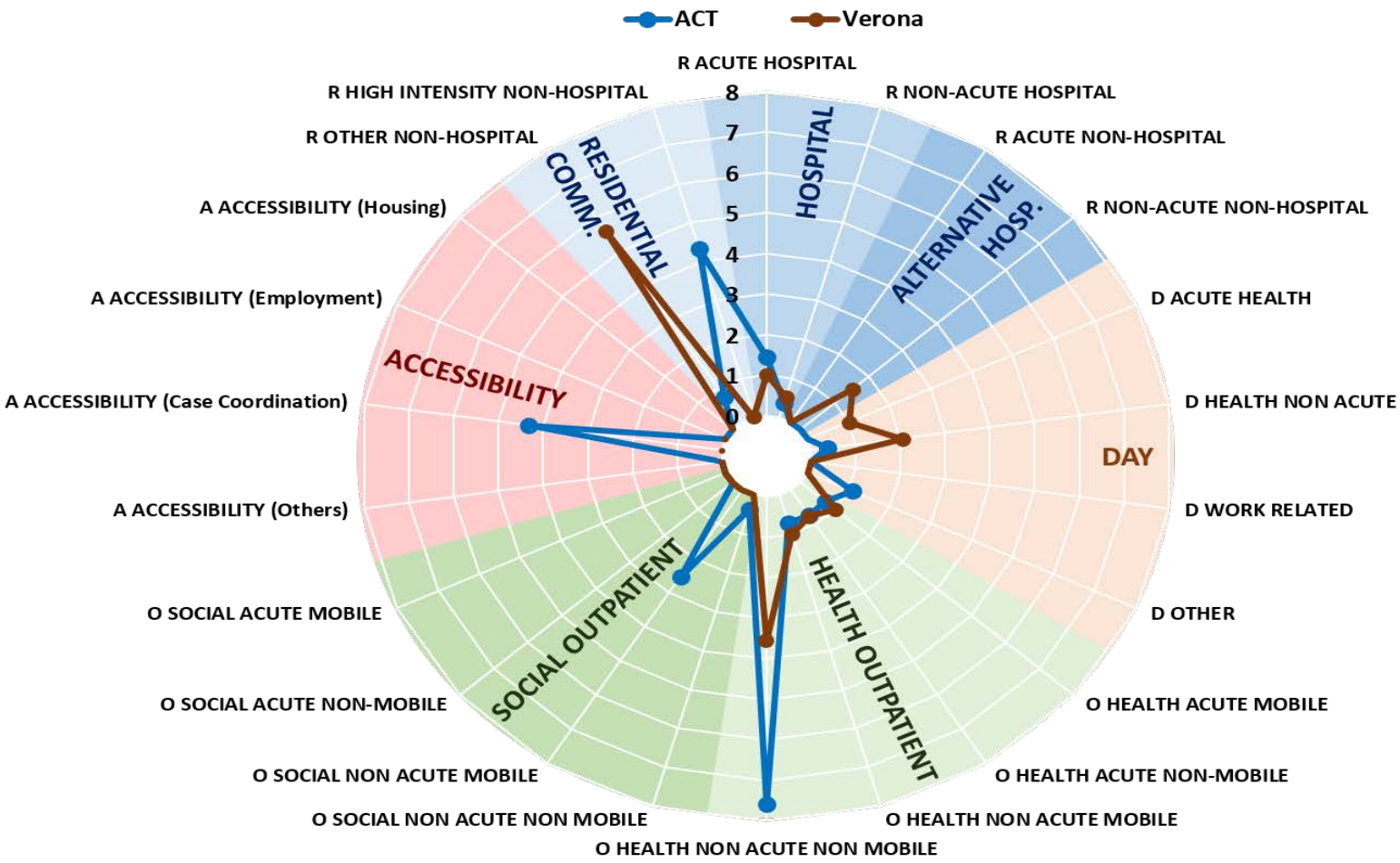
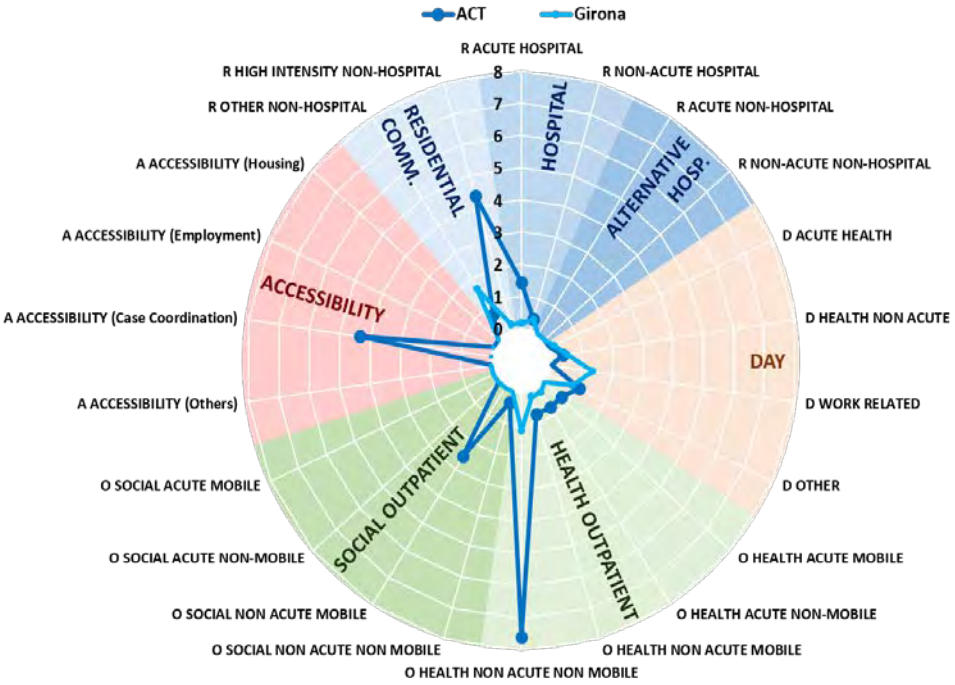


Figure 44 Pattern of availability of MTCs for adults with lived experience of mental illness. Comparison between ACT and Verona



.

Figure 45 Pattern of availability of MTCs for adults with lived experience of mental illness. Comparison between ACT and Girona

6.3. ENGLISH SYSTEM

Figure 46 compares the ACT PHN region with an area in England (Hampshire). England raises funds mainly from general taxes. There is one purchaser organisation for most health care services. Since 2013 this function is held by the Clinical Commission Groups (CCGs). Local Health authorities are involved in funding social care services, in addition to local authorities and the state. CCGs tend to contract one local Mental Health Trust, an organisation that will be responsible for providing most mental health services for a locality. These Trusts may also subcontract to others.

With regard to the socio-economic characteristics, Hampshire shows a high population density with relatively low unemployment figures. It is also an aged population

One of the main characteristics of the English model is the lack of day care/programs related to health and non-acute care in the hospital, which is similar to our findings in ACT PHN region.

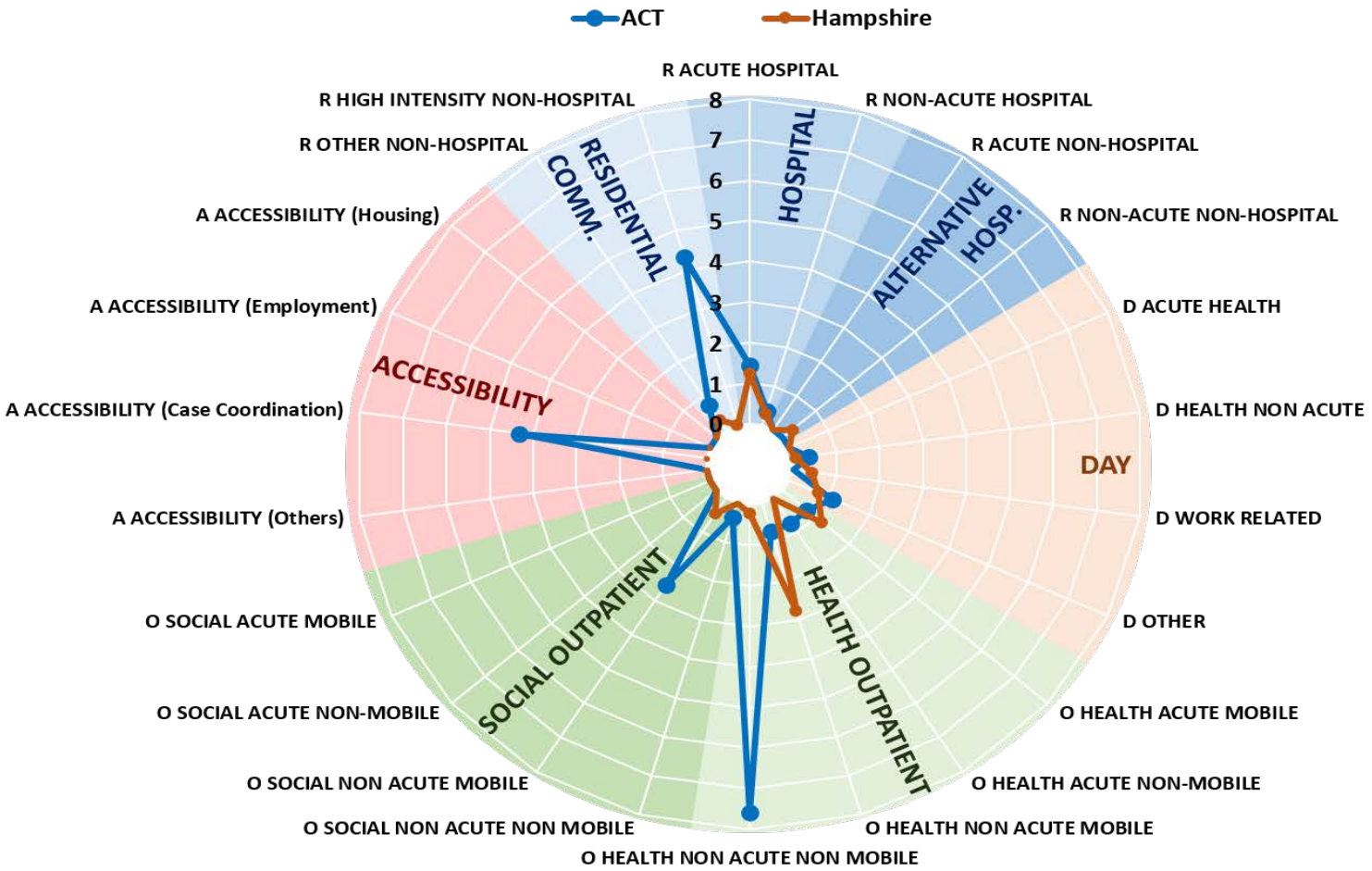


Figure 46 Pattern of availability of MTCs for adults with lived experience of mental illness. Comparison between ACT and Hampshire.

6.4. PLACEMENT CAPACITY: CROSS-NATIONAL COMPARISONS

6.4.1 PLACEMENT CAPACITY-RESIDENTIAL CARE

Table 55 Cross national comparisons-placement capacity, Residential care.

Groups	ACT	Sør-Trøndelag (Norway)	Helsinki and Uusimaa (Finland)	Verona (Italy)	Girona (Spain)	Hampshire (England)
Rate of beds per 100,000 residents in inpatient care (hospital)						
R Acute Hospital Care: R1 - R2 - R3.0	22.0	28.4	26.9	14.0	7.0	26.4
R Non-acute hospital: R4 – R6	0.0	75.1	52.2	12.0	15.4	4.8
Rate of beds per 100,000 residents in the community						
R Acute non-hospital: R0 R3.1.1	0.0	64.4	0.0	0.0	0.0	0.0
R Non acute non-hospital: R5 - R7	0.0	0.0	12.3	16.5	0.0	2.5
R other R9,R10,R12,R13,R14	5.1	0.0	58.6	35.8	12.0	7.5
R non-hospital high intensity R8 R11	25.6	8.9	113.6	0.0	9.7	0.0

6.4.2 PLACEMENT CAPACITY-DAY CARE/PROGRAMS

Some of the most advanced models, such as the Finnish one, are characterised by a good balance between beds at the hospital, and places at day health acute and day health non-acute centres. It is also important to develop work related centres, where people with a lived experience of mental illness can develop work related skills and be paid for their work. The day care sector is progressively disappearing from ACT and New South Wales. This scenario is very similar to the English one, where day care has been substituted by individual care. Day care/programs are important as they provide structured activities related to a range of life areas. It is important to note that in NSW, the lack of structured activities is an important unmet need perceived by PIR consumers. It may be a similar situation in the ACT. Additionally, day care centres providing care for health related needs may work as step down facilities, easing the transition from the hospital to the community and promoting recovery and rehabilitation.

Table 56 Cross country comparisons-placement capacity, Day programs.

Groups	ACT	Sør-Trøndelag (Norway)	Helsinki and Uusimaa (Finland)	Verona (Italy)	Girona (Spain)	Hampshire (England)
D Health acute	0.0	0.0	9.62	3.05	4.17	0.0
D Health non-acute	1.4	n.a.	17.99	40.67	12.51	n.a.
D Work-related	0.0	8* (a)	18.15	0.0	32.53	n.a.
D Other	0.0	0.0	12.35	0.0	27.52	n.a.

**(a)One group not available in Norway. Placement capacity per 100, 000 adults*

6.5 WORKFORCE CAPACITY

In addition to placement capacity, workforce capacity (Full Time Equivalents-FTEs) for the ACT PHN region was collected for the Integrated Atlas of Mental Health. Data was collected from 103 of the 107 teams identified, or 96.3 % of BSICs. Again, it is important to note that this data was collected during a period of significant change in the system, and thus for many services, workforce capacity and composition had either recently undergone, or were about to undergo, a period of instability.

Team sizes have been classified as either Extra small, Small, Medium or Large, according to the figures in Table 57 below. As can be seen, the vast majority of teams fall into the "Small" category, with between one and five FTEs. Of significance is the 18, or 17.5% of teams who provided FTEs, that have less than one FTE. However, it should be noted that 10 of these services are the individual psychologists in the Health In Mind program, for each of whom their FTE in relation to this program has been estimated at 0.2%.

Table 57 Mental Health Team Size (ACT, 2016).

Teams	X-Small (<1 FTE)	Small (1-5FTE)	Med (6-20 FTE)	Large (>20 FTE)	Not stated
Total	18	58	20	7	7
Percent*	17.5%	56.3	19.4	6.8	-

** (Percentage is of the teams providing FTEs)*

This can be compared to Perth North PHN, which has a similar proportion of very small teams, but a much lower rate of small teams and much higher rate of medium teams. However, it should be noted that 99 of the 224 teams in Perth North did not provide FTE, and thus should be considered with caution.

Table 58 Mental Health Team Size (Perth North, 2015)

Teams	X-Small (<1 FTE)	Small (1-5FTE)	Med (6-20 FTE)	Large (>20 FTE)	Not stated
Total	16	44	48	17	99
Percent*	12.8%	35.2%	38.4%	13.6%	-

Terminology around job description varies considerably in the workforce, particularly around staff without health professional qualifications, with a lack of clear distinction between some titles such as “Support Worker”, “Mental Health Worker”, and “Support Facilitator”.

7. DISCUSSION

7.1. GEOGRAPHIC AND SOCIO-ECONOMIC INDICATORS IN THE ACT PHN REGION.

The ACT PHN region comprises two different remoteness area classifications: RA1 (major cities) and RA2 (inner regional Australia). Population density in the ACT is lower than Sydney and Melbourne, and similar to Brisbane, Adelaide and Perth (Australian Bureau of Statistics (ABS), 2010). Population is concentrated in the urban area in the north east. The eastern section of this area has a risk of psychological distress equal to or greater than the national average (Australian Bureau of Statistics (ABS), 2008). The importance of urban design, including walkability and green spaces on psychological distress has been emphasised (Astell-Burt, Mitchell, & Hartig, 2014; Hartig & Kahn, 2016). Research into the health impacts of urban design,has found associated increased rates of death by cardiac arrest (Drennan et al., 2016), and of suicide by jumping from a high place (Panczak, Galobardes, Spoerri, Zwahlen, & Egger, 2013).

Social and demographic indicators vary across the region. At the SA2 level, the lowest incomes, lowest levels of education attainment, and highest unemployment rates are found in the north and east of the urban area, while the areas of North Canberra and South Canberra have the highest incomes, highest rates of people with Year 12 equivalent and above, and the lowest rates of lone parents. In all areas, unemployment is lower than the national average (Australian Bureau of Statistics, 2017a). Although social and demographic diversity within the ACT is not as great as in, for example, the CESPHN, nevertheless, the diversity within the region requires focussed localised planning.

7.2. HEALTH CARE PROVISION IN THE ACT PHN REGION

The ACT Blueprint describes a vision of person-centred and integrated care embraced and adopted by all parts of the health and social system,with a focus on system integration, the enabling of health pathways and inter professional collaboration (Capital Health Network, 2015). Goals of the ACT PHN strategic plan include collaboration for aligned, collective results, and channeling and leveraging resources for maximum benefit.

The social and economic diversity of the region is reflected in the use of health services. In 2014-15, life expectancy and rates of childhood immunization were higher than the national average, and rates of smoking and of potentially preventable hospitalisations lower. The ACT PHN region had the equal fourth highest rate of people stating they had excellent, very good, or good health, and age standardised GP attendances in the ACT PHN, at 4.7 %, were lower than the national average of 5.7%. However, the ACT PHN region also had the equal third highest rate in the nation of people who delayed or did not see a GP in the previous 12 months due to cost (7%), and equal sixth highest of people unable to fill a prescription due to cost (7%); 25% of people felt the waiting time to see a

GP was unacceptable, and 57.9% of GP attendances were bulk billed, compared to the national average of 84.3%. The rate of specialist attendance was equal second highest in the country at 39% of adults, and the rate of hospital admission in the previous 12 months was equal third highest of all PHNs (MyHealthyCommunities, 2017).

7.3. MENTAL HEALTH CARE PROVISION IN THE ACT PHN REGION, 2016

The ACT has the highest percentage of population with mental health problems of all states and territories (15.5%, compared to 13.4% for Australia) (ACT Health, 2014). The ACT PHN is one of the ten PHN lead sites chosen to take a lead role in developing and delivering new models of primary mental health care, and new approaches to regional planning, integration and stepped care.

Key functions of lead sites will be:

- "Establishing models for the development of regional community mental health and suicide prevention plans in collaboration with Local Hospital Networks, non-government organisations, National Disability Insurance Scheme providers, and other related services and organisations.
- Demonstrating models of stepped care, including coordinated clinical care for people with severe mental illness who are managed in primary care; and models of early intervention low intensity mental health care, such as 'coaching' services" (Mental Health PHN Consultative Forum, 2016)

In 2011-12, the proportion of expenditure on community mental health services, in relation to public mental health services, in the ACT was the highest of the states and territories, and the proportion of expenditure on grants to NGOs was also the highest. The ACT had the highest rate of community mental health care contacts, the third lowest rate of residential mental health care episodes, the lowest rate of mental health nurses, but the highest rate of registered psychologists. Expenditure on public hospitals was the lowest in the nation, with the number of public sector specialised mental health beds per 100,000 population also the lowest, and the rate of overnight hospitalisations for mental health needs lower than the national average (MyHealthyCommunities, 2017). The rate of people followed up by community mental health care in the seven days following hospital discharge was the highest in Australia. In addition, expenditure on PBS subsidised mental health medications was the second lowest in the nation (National Mental Health Commission, 2014) (vol 4, paper 3). Taken together, these figures suggest that in the ACT, there may be a greater availability of mental health care in the community than in other states and territories.

However, the ACT PHN Baseline Needs Assessment (Capital Health Network, 2016b) identified key priority issues as including: early intervention care; services for moderate to severe illness presentations; better management of physical issues; the need for a systems approach to suicide prevention; issues surrounding the NDIS transition; and

service provision for vulnerable populations such as transgender population and refugees. Transitions of care between acute/sub-acute/primary health care, and preventable hospitalisations were also identified as areas of concern, indicating "lack of knowledge and awareness of community based support services; need for better access to outpatient services; lack of consistency in discharge planning processes and poor communication between different parts of health system". In addition**,** limited services are reported as being available during the after-hours period for people with mental health and behavioural problems (Capital Health Network, 2016b; Government-Health, 2017), and the number of hospital separations for ACT residents with a primary diagnosis of mental or behavioural disorder has also continued to increase, from 2009-10 to 2011-12 (2,935 to 2,970 respectively).

The Integrated Mental Health Atlas of the ACT PHN Region has revealed some important systemic gaps and differences between the ACT and other locations in the world regarding the main components of the secondary care subsystem of mental health. These gaps are mainly related to:

- a lack of acute and sub-acute community residential care;
- a comparative lack of services providing acute day care and non-acute day care/programs (i.e. day centres providing structured activities to promote health and social inclusion);
- a lack of employment related services; and
- a lack of Culturally and Linguistically Diverse(CALD) services.

Other differences include:

- more highly specialised services for specific groups –particularly gender specific, and youth carers and gender specific;
- relatively high rate of supported residential services; and
- relatively high rate of accessibility services.

The first two gaps identified are similar to those found in some areas in metropolitan Sydney (i.e. Western Sydney and South Western Sydney), suggesting systemic structural gaps in the organisation of mental health care delivery system in NSW and ACT. These findings support the main recommendations pointed out by *National Review of Mental Health Programmes and Services* by the National Mental Health Commission (National Mental Health Commission, 2014), namely the lack of alternatives to hospitalisations, and the need for strengthening the community mental health care subsystem.

The following sections of the Atlas provide discussion on areas of commonality and difference in the ACT PHN, when compared to local and international jurisdictions. The discussion is framed within the stepped care model, concentrating on secondary and tertiary care services. The section concludes by considering the implications of these commonalities and differences to mental health care planning in the ACT.

Although the stepped care model has been used to structure the Atlas discussion, adscription of non-health services into this model may cause some confusion. In the stepped care model adopted by the Fifth Mental Health Plan, a clear distinction is made between psychological services for those with mild mental illness; clinical services in primary care backed by psychiatrists for those with moderate mental illness; and clinical care for those who experience severe mental illness provided by GP care, psychiatrists, mental health nurses and allied health. This distinction, in the absence of a fully implemented integrated care system, could produce further fragmentation instead of preventing it. Social support services such as education and employment supports are included in the 2016 PHN guidelines for the broader primary care of child and adolescent services (Department of Health, 2016b). From these guidelines it is not clear, however, to what extent, for example, Headspace should be considered a primary care service (according to the population assisted) or a secondary care service (with regards to its staff capacity). A further example of blurred delineation within the stepped care model is that of Health In Mind mental health nurses and individual practices of psychologists, which are counted as part of the primary care network in some reports.

7.3.1 NON-RESIDENTIAL MENTAL HEALTH CARE

HEALTH IN MIND (FORMERLY KNOWN AS ATAPS)

Health in Mind (formerly ATAPS) is funded by the Commonwealth Department of Health through the ACT PHN. This program provides access to effective treatment for people with diagnosed mild to moderate mental health conditions, with financial barriers to gaining treatment, and who can respond well to focussed psychological strategies (Capital Health Network, 2016a). Health in Mind is a free initiative, which provides services for 'hard to reach' groups such as culturally and linguistically diverse communities, and people who are homeless or at risk of homelessness. Like ATAPS, it could be conceptualised as a primary care or secondary care service. To determine whether there is an equitable access to Health In Mind services in the ACT PHN region it may be important to conduct a spatial analysis of Health In Mind referrals, and a corresponding analysis of the distribution of professionals. Such an analysis is important to determine if Health In Mind reflects the findings of recent analyses of the Medicare '*Better Access*' initiative that found major disparities in the use of mental health services across Australia, with greater use among more advantaged communities (Meadows, Enticott, Inder, Russell, & Gurr, 2015). This finding points out the need to also revise the access and use of the Better Access program in this region, as well as other programs included in the Medicare Benefits Schedule (MBS), and the Mental Health Nurse Incentive Program (MHNIP).

OUTPATIENT SERVICES

The pattern of Outpatient health related care in the ACT PHN region is broadly similar to that in the areas in NSW we have mapped, as well as those in both northern and southern European countries, in that there is generally a higher availability of non-acute services, particularly non-acute, non-mobile care

ACUTE HEALTH RELATED OUTPATIENT SERVICES

In ACT, as in CES and WS and SWS, acute health related Outpatient care is provided exclusively by the public health sector. Acute mobile health related Outpatient care, such as that provided by Crisis and Assessment Teams, is more available in the ACT than in than in SWS, but less available than in CES and WS. Acute non-mobile health related Outpatient care is less available in the ACT than in CES and SWS. Consultation Liaison services were the only service of this type available in the ACT PHN region. While in other regions, Emergency Departments have included specialised teams providing this type of care, in ACT specialised acute mental health care in the Emergency Department is available at Canberra Hospital in the Mental Health Short Stay Unit which provides short term (up to 48 hour accommodation for assessment) and so has been coded in Residential care.

In international comparisons, the ACT PHN region's rate of acute health related mobile Outpatient care is similar to Norway, and higher than Finland, while it has lower availability of acute non-mobile health care than either Finland or Norway. Finland also provides more health related daycare and more alternatives to hospitalisation. In comparison to southern European countries, ACT has slightly less acute health related Outpatient care than Italy, but slightly more than Spain. However, in both these countries, other community based healthcare such as heath related daycare, or alternatives to hospitalisation, are more available.

NON-ACUTE HEALTH RELATED OUTPATIENT SERVICES

Non-acute Outpatient care is coded in DESDE-LTC as low-mobile (O8-O10) or mobile care (O5-O7), depending on the frequency of care provided outside the service premises (if less than 50% of the care is provided outside the centre is coded as low-mobile).

The ACT PHN region has slightly higher availability of non-acute mobile health care (such as the Mobile Intensive Treatment Team and the Woden Transition to Recovery service) than WS, SWS and the CESPHN. This is even though community mental health teams, which in CESPHN were coded as non-acute mobile, are not included in the ACT PHN atlas as mobile: rather, they have been coded as non-mobile, as they do not reach the 50% threshold required, but with a "q" qualifier to indicate that nevertheless, a substantial amount (20-49%) of care is provided as mobile. It is important to note that one of the teams coded as non-acute mobile health care in the ACT PHN region is the

CAMHS Early Intervention Team (14-25 years). It has been included in the adults section, but only includes young adults. Notably, in the ACT, CAMHS provides services to adults, albeit young adults in this case, but also to a general population in the case of the Eating Disorders program. This raises questions as to the best use of resources, and to whether CAMHS is stepping in to provide services in areas of unmet need for adults. The Mobile Intensive Treatment Team is based in the Northside of the ACT, with no equivalent service on the Southside. So, while the availability appears to be higher, it is also more limited in its scope. Additionally, the individual Health In Mind providers are included in this analysis: while numerous, these ten individual practitioners provide an average of just 0.2 FTE care each.

Nevertheless, the rate of availability of non-acute Outpatient health care is relatively high in the ACT PHN region, This can be considered in relation to the use of mental health services cited above, showing that the ACT has the highest rate of community mental health contacts in the nation, and a lower than average rate of overnight mental health related hospitalisations.

SOCIAL/CULTURAL RELATED OUTPATIENT SERVICES

The pattern of social Outpatient care is similar in the ACT to that in WS, SWS, and CES. The greatest availability is in the area of non-acute, mobile social Outpatient care, such as PHAMS. Unlike the other atlases in NSW, which have frequently coded PIR services as Outpatient, in the ACT PHN atlas they are, with one exception, coded as Accessibility. This might lead one to expect that the ACT PHN region would have a lower availability of Outpatient care than in NSW, particularly as there are also more Outpatient services such as HASI in NSW, coded as such because they provide support to people in their homes. However, except in SWS, this is not the case. This may be because the ACT PHN region has a wider range of teams providing care in this classification, including PHAMS, the Detention Exit program provided by Wellways, CatholicCare's Home Care Support, and St.Vincent de Paul's Mental Health Services Team. However, it should be noted that the four PHAMS teams have been given the "v" qualifier, indicating that they do not have ongoing funding.

DAY SERVICES

Day care for people with a lived experience of mental illness has been considered a key component of psychiatric reform since the early 60s (Marshall, Crowther, Sledge, Rathbone, & Soares-Weiser, 2011; Vazquez-Bourgon et al., 2012). "Day Care" (including partial hospitalisation) refers to all services where the consumer stays for part of the day but not overnight, or just for a single face-to-face contact. There is a whole array of different types of day care services according to the phase and the severity of the mental illness: from acute care (i.e. day hospitals/partial hospitalisation), to non-acute care (i.e. day programs/centres) and recovery oriented programs (i.e. peer support, respite, social clubs, or work-related approaches), just to mention a few. These services should

be integrated in a local acute care subsystem that also incorporates mobile care alternatives for crisis intervention at home (crisis resolution teams, medical homes), together with non-mobile emergency services and high-intensity co-ordination/case-management as in Assertive Community Treatment (Vazquez-Bourgon et al., 2012).

ACUTE HEALTH RELATED DAY CARE

There are no acute health related Day services in the ACT. Acute Day services can provide a less restrictive alternative to admission to an acute ward admission for people in crisis. High intensity acute day care or day hospitals can be a cost effective alternative to hospitalisation. They provide the same high level of care by specialised mental health professionals as inpatient wards, while allowing people to maintain their contacts and relationships in the community, and reducing the risk of institutionalization and the stigma associated with it. They comprise part of the Thornicroft and Tansella balanced care model as alternatives to acute inpatient care. Acute day care has been included in NICE recommendations for the prevention and management of psychosis and schizophrenia (NICE, 2014). However, research into the efficiency and effectiveness of acute day care alternatives is limited and inconclusive, one study suggesting that they may be more effective for female, educated patients with moderate to severe symptoms than the most severely unwell people who benefit from acute inpatient admission (Priebe, Watzke, Hansson, & Burns, 2008), and another that while they are suitable options in situations where demand for inpatient care is high and facilities exist that can be converted to these uses, they are a less attractive option in situations where the demand for inpatient care is low and can be covered by other options (Marshall et al., 2011).

NON-ACUTE HEALTH RELATED DAYCARE

Non-acute high-intensity Day care ("day centres") is a key component of a community mental health system missing in the ACT PHN region. Day programs staffed with at least 20% highly skilled mental health professionals, such as psychologists, neuropsychologists or mental health nurses (D4.1 and D8.1), can provide more intensive rehabilitation and recovery oriented program activities in a highly specialised environment than day centres staffed with non-health professionals (D2 to D10 services). This workforce capacity allows these centres to provide a better focus on tertiary prevention and clinical improvement (e.g. by better training in daily living, problem solving, stress management, social skills or cognitive rehabilitation). This type of centre can improve socialisation and assist individuals to learn new skills according to their needs. They also include occupational therapy tailored to the patient's needs. They should be provided in a recovery oriented format that promotes peer-support. Day centres allow people with mental illness to have structured, more intensive rehabilitation programs including educational, vocational and health activities provided in the same location. These type of centres can provide recovery-oriented practices for community living, one of the key components of care, according to the THAMSS report (Department of Health and

Ageing, 2013).

In the ACT we have identified only one non-acute health related Day centre with high intensity (equivalent to day hospitals): an eating disorders program. It is important to note that non-acute high intensity Day services were lacking in all other PHN regions previously mapped in metropolitan Sydney. The eating disorders program we identified is a specialised service which we have also found in two other regions. These three regions share close proximity to universities, and a high concentration of population, which may facilitate the delivery of highly specialised care. Of note, the eating disorder program is another service for other age groups besides children and adolescents provided by CAMHS.

The lack of day care in the local system may be attributed to several reasons. First, mental health funding has moved from services provided in the public sector - including the more institutional modes provided by the LHDs - to community-based services provided by the NGO sector. This shift has been a significant aspect of de-institutionalisation, emerging hand in hand with the closure of psychiatric hospitals across the system. Day Hospitals and health-staffed day centres have been unintended victims of this necessary shift in the model of care. NGO-run services have been focused on the less clinical (and less expensive) end of day care, focusing on cultural or respite services. Reduced budgets mean the staff that can be contracted are lower skilled, or lack the specific skills needed for more intensive services. Although these types of services (D2-D10) are absolutely necessary, we must not neglect more intensive health related day services (D1, D4.1 and D8.1). Indeed, at least in Greater Sydney, health-related day centres for mental health can be found in the private health sector, suggesting that there may be equity problems in access to this type of care, adding to findings on inequity of the operation of the "Better Access Program" in Australia (Meadows et al., 2015):

The disappearance of day hospitals and day centres in the public sector could also be attributed to the shift to individualisation of care and tailored programs of daily activities. Individual care, based on individual preferences and choices, tends to prioritise face-to-face programs and home-based treatments, rather than day care interventions. Crisis resolution or home treatment teams are an effective community intervention to manage psychiatric crises, but they should not be seen as the only alternative to acute inpatient care. A recent systematic review (Wheeler et al., 2015) did not find a significant effect in hospitalisation rates for the implementation of crisis resolution services; and observational studies have shown disparate effects in Norway (Hasselberg, Grawe, Johnson, & Ruud, 2011) and in England (Johnson & Bindman, 2008). It has been suggested that a strategy that combines "crisis resolution/ home treatment" and "day hospitals" is a good option to treat patients in the community (Vazquez-Bourgon et al., 2012).

We may also keep in mind that models which prioritise individual care may have unintended adverse effects if critical services in a community care model are missing from the local system. Likewise, and although this requires further evaluation, the value

of choice in recovery oriented systems may be limited by the availability of core services in the system. In order to make useful choices to meet an individual's needs, a whole array of service alternatives should be available in the local care system. Strikingly, the lack of high-intensity Day care (eg Day Hospitals and Day Centres related to health) has not been mentioned as a critical system gap in previous policy documents. Other authors have documented the dismantling of the Australian community mental health system in recent years, but without specific mention of the disappearance of day care (Rosen, Gurr, & Fanning, 2010; Rosen, Gurr, Fanning, & Owen, 2012).

The reduction or disappearance of day care staffed with health professionals has also been observed in other health systems in the process of shifting to a competitive market based on personalisation, such as that in the United Kingdom. Although this shift has been described in the disability sector (Barnes, 2011; Duffy, 2011; Ferguson, 2012), an understanding of the impact of this reform in the overall efficiency of the care system is still missing. Therefore, there is an urgent need to assess the effects of this silent reform on key performance indicators of the system, and on the outcomes. This need is made particularly urgent in the context of the transition to the National Disability Insurance Scheme (NDIS), which has a strong emphasis on individualisation and care planning driven by demand.

SOCIAL/CULTURAL RELATED DAY CARE/PROGRAMS

Three Day care BSICs were identified, offering participants opportunities to develop skills across a range of areas including computer skills, arts based skills, practical skills such as furniture restoration, and work related skills such as computer skills or barista training. However, two of these do not have guaranteed funding for three years. This means that the ongoing availability of the already limited day centre options which does exist in the ACT is precarious.

EMPLOYMENT RELATED DAY CARE/PROGRAMS

While the above services provide some work related skills training, we found no service in the ACT providing employment alternatives for people with mental health needs. ACT is the only area in Australia we have mapped in which we found no services of this type.

Services providing employment can play a critical role in promoting recovery (Walsh & Tickle, 2013). Supported employment and supported education are key rehabilitation interventions for people with psycho-social disability (WARP, 2016). An example is Individual Placement and Support in particular, found by one systematic review to be relatively effective in leading to competitive employment when compared with traditional vocational rehabilitation services (Modini et al., 2016). While Richmond Fellowship has a worker engaged as an Employment Support Worker, this is part of the PHAMS program, which is being phased out with the introduction of the NDIS. Competitive employment must be the final goal of any employment intervention in mental health.

However, it is necessary to have a broad availability of different employment alternatives for people with mental illness in addition to supported employment. These alternatives can be relevant to people transitioning to competitive employment, as well as for those for whom competitive employment is not an option. Some of these alternative services may be classified as 'social firms' which are market-oriented businesses that employ people with disabilities; or 'social enterprises' which are primarily focused on training and rehabilitation (Grove, 1999). The recently published NICE clinical guideline for Psychosis and Schizophrenia in adults recommends to: "Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work (but also to…) consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment" (NICE, 2014). Specialised services for increasing access to employment, such as the Individual Placement and Support model, in addition to vocational rehabilitation are a part of the Thornicroft and Tansella model for balanced care (Thornicroft & Tansella, 2013).

ACCESSIBILITY SERVICES

The ACT has a significantly higher rate of Accessibility services than the other areas we have mapped. A significant contributing factor is that PIR in the ACT is coded most commonly as Accessibility, whereas in other areas, PIR teams have provided more of an Outpatient service. The main objective of the PIR program is to increase accessibility to a range of services for people with a lived experience of mental illness. However, in other mapped areas, many PIR are in fact providing more intensive direct care, meaning that they have been coded as O (Outpatient) rather than A(Accessibility). This could indicate that in these other areas, a gap in availability of community outpatient care is being filled by PIR, and that this gap in community outpatient care is not present in the ACT. The higher contact with community mental health services noted above, as well as the highest rate of registered psychologists in the ACT (MyHealthyCommunities, 2017) could suggest that this is the case. On the other hand, it may be that there is a greater need for assistance with system navigation in the ACT, due to the high number of NGO services available, a pattern of care which increases the complexity of the system. As this atlas was being collated at a time of transition to the NDIS, it may also be that a lack of clarity over service availability and eligibility has contributed to a need for the higher use of PIR as Accessibility services.

In other areas we have mapped, most Accessibility services are employment related, assisting people to access employment skills and opportunities, however, this type of accessibility and case co-ordination was not identified in the ACT. One service in this category provides care co-ordination for people discharged from acute care following a suicide attempt. This speaks to key areas in the Fifth Mental Health Plan and to the ACT PHN Baseline Needs Assessment (Capital Health Network, 2016b) identifying suicide prevention in the community as a priority, including more support post discharge following a suicide attempt.

Care co-ordination is a key component of integrated care and personalised care, as well as of the stepped care approach, assisting vulnerable people to access available supports according to their needs. However, the majority of services in this category, including the PIRs, do not have definite funding for three years.

7.3.2 RESIDENTIAL SERVICES

In the stepped care approach, inpatient hospital care provides support primarily for those at the severe end of the spectrum, estimated to be 3.2% of the population, while services provided in the community should cater for the majority of people experiencing mild and moderate to severe mental illness. Availability of acute care is an important component of an integrated system. However, alternatives to acute hospitalisation, and alternative forms of long-stay community residential care, are also components of the balanced care model. Currently in Australia, the system is still skewed towards hospital care, a "downstream" focus on care for people once they have reached crisis point, with expenditure on psychiatric wards the only area of a significant increase in funding (Australian Institute of & Welfare, 2016). Additionally, the ACT PHN Baseline Needs Assessment has identified the need for more prevention and early intervention services to reduce the need for hospitalisation and inpatient facilities (Capital Health Network, 2016b). Although the National Mental Health Commission Review recommended the reallocation of a minimum of $1 billion in Commonwealth acute hospital funding into more community-based psychosocial, primary and community mental health services, the governmental response did not question the current unbalance to hospital provision. There is an on-going debate in the Australian literature on the need to invest in community beds at the expense of hospital beds (Allison, Bastiampillai, & Goldney, 2014).

Although acute beds within hospitals are a key component of an integrated care system, it is also important to implement residential alternatives in the community. Step Up care ,including supervised respite and CATT team home management, is one alternative, and is additional to Step Down care, which appears more developed in the ACT. The existing alternatives and structure of home and community care in the ACT are outlined below. However, more studies are needed on the efficiency of these type of services. Some authors suggest that acute residential care in the community may be more cost-effective than hospital admission (Thornicroft & Tansella, 2013). In the French setting, a negative correlation was found between length of stay in fulltime hospitalisation for patients with mental illness, and the development of alternatives to fulltime hospitalisation in the local context (Gandré et al., 2017). A recent quasi-experimental study carried out in Brisbane evaluating "crisis houses" showed that this community alternative provides a cost-saving for mental health services (Siskind et al., 2013). A similar study completed in Canada demonstrated that scattered housing with intensive case management support increased housing stability for people with a lived experience of mental illness who had been experiencing homelessness (Stergiopoulos et al., 2015). Other initiatives in Australia that fit in this model is the Prevention and Recovery Care Model (PARC) in Victoria

(Department of Health, 2010). These services can also function as a 'step-down' from a period of acute psychiatric hospitalisation, to facilitate transition from hospital. The key characteristic of these services is that they are staffed with highly-skilled mental health professionals.

The pattern of residential care in the ACT PHN region has some interesting differences with those of the NSW regions we have mapped, which show greater availability of acute hospital beds than non-acute hospital and community accommodation. The availability of acute care in the ACT PHN is similar to all areas in NSW, Finland and Norway, but lower than that in Spain and Italy. However, the high availability of non-hospital residential care, and of this type of service in relation to acute hospital inpatient services, is in inverse proportion to the NSW regions, and closer to that of Finland, which has a high availability across a range of types of services, and to Spain and Italy, where care delivery is characterised by a strong emphasis on community care. Italy, however, and to a lesser extent Finland and Norway, also have services which provide residential alternatives to hospitalisation. Residential alternatives to acute hospitalisation, such as crisis houses, are not present in the ACT but are more closely aligned with the philosophy of care in the community, as well as being a key part of the balanced care model.

While residential acute care is provided exclusively in a public hospital setting, and is broadly similar in availability to other mapped areas in NSW, availability of medium to long term residential care is higher in the ACT PHN region than in NSW, with the balance between these types of care and acute hospital care availability being closer to that of Finland. However, European countries have a greater range and availability of residential alternatives. Norway and Finland have similar acute hospital availability to the ACT but more non-acute beds. Finland has a higher availability of non-acute hospital residential care, and a more diverse range of non-hospital residential care; and Spain and Italy, while having lower availability of acute hospital care, have more alternatives to acute hospitalization.

The ACT PHN region has a higher proportion of NGOs to public sector services than other mapped areas in NSW, except SWS. This is reflected in the balance of hospital to community care, with significantly more residential care in the community in the ACT than in other areas. This aligns with a balanced care model, and with the prevailing philosophy of care provided mostly in the community. However, the lack of guaranteed funding for several NGO provided services means that the higher number of NGOS in the ACT leads to greater system instability.

The ACT PHN region also provides a higher proportion of residential rehabilitation care. While there is no evidence for the best model of care, supported housing may provide greater cost effectiveness than other models. Studies in Canada on "Housing First", a rehabilitative model which provides supported housing to people with a lived experience of mental illness who are homeless, suggest that the immediate provision of short to medium term- one to three years-housing, along with appropriate, and if needed,

intensive, clinical and social support, assists in promoting recovery, and housing stability (Tim Aubry et al., 2016). The higher rate of residential services in ACT means that initiatives in residential care for people with a mental illness could be implemented in the territory, as the necessary infrastructure would be better developed than in other areas.

7.3.3 SERVICES FOR SPECIFIC POPULATIONS

SERVICES FOR CHILDREN AND ADOLESCENTS

Services for children and adolescents are a key part of the provision of preventative and early intervention care. The six priority areas highlighted for primary mental health commissioning includes youth mental health. The ACT PHN region has a higher rate of services for young people than other areas we have mapped, including specific preventative and early intervention services, such as a service specifically for children at risk due to exposure to trauma. However, as previously mentioned, CAMHS also provides services outside this specific age group, the implications of which may require further examination. Services for children are mostly health related, although there is no acute Residential care for children and adolescents.

The National Review (National Mental Health Commission, 2014) found that at a national level, there are high rates of 16-25 year olds with mental health issues not in education or employment. This may be better addressed in the ACT PHN region, which provides a broader range of types of support for those in the transition to adulthood age group than we have found in other areas. This includes services targeting young carers of people with mental illness, and young males, both populations with particular vulnerability. However, the services providing social and educational related care also have the least stability of funding. Additionally, there is no employment related service.

SERVICES FOR OLDER ADULTS

The ACT PHN region, like the other areas we have mapped, provides some support specifically for older people with mental illness, with an acute inpatient ward and a community care team. The physical health of people with mental health issues has been highlighted as a concern, and this becomes more pressing as people age, due to the effects of long term use of psychotropic medications and/or of other lifestyle factors, such as lower rates of physical exercise, higher rates of drug and alcohol problems, and homelessness. Although the life expectancy of people with mental illness is lower than the general population, with the continuing development of medications with fewer side effects, and potentially better preventative health care for this population, the need for services to support older people with mental illness may increase, including the need for more long term, as well as acute, care.

GENDER SPECIFIC SERVICES

The provision of gender specific care mental health care in the ACT is notable for its high availability, particularly gender specific services for males. This is the only atlas in which we have identified gender specific services for males. The reason for this difference is unclear. One of these services, through its outreach to workplaces, is particularly focussed on identification of, and early intervention for, mental health problems. Two of the three gender specific services for women are related to the perinatal period.

OTHER SPECIFIC POPULATIONS

Other specific groups targeted by mental health services include Aboriginal and Torres Strait Islander peoples, veterans, parents with mental illness, offenders, and carers, as well as a service providing psychological care specifically to the deaf and deaf/blind population. The importance of mental health services for Aboriginal and Torres Strait Islander people is documented in the ACT PHN Work Activity Plan (ACT PHN, 2016), and is also one of the six key areas for primary mental health commissioning. The rate of availability of services for this population is better than in other areas we have mapped, although it is provided by just one organisation. In 2015-2016, 96,000 ACT residents, or approximately 25% of the population, were born overseas, of whom approximately 40,000 were born in non- English speaking countries (Australian Bureau of Statistics, 2017b). However, we were unable to identify any mental health services for the CALD population.

7.4. MAIN SERVICE GAPS AND UNMET NEEDS

In other regions, PIR consumers have identified daytime activities, employment and volunteering opportunities, social life, psychological distress, physical health and accommodation as top unmet needs (South Eastern Sydney Partners in Recovery, 2015). The main gaps identified in this atlas relate to: (i) daycare and support to provide opportunities for social activities, and educational opportunities; (ii) alternatives to acute hospitalisation; and (iii) employment related services, and suggest that there may be similar unmet needs in these areas in the ACT.

The ACT PHN Baseline Needs Assessment identified the following: (i) need for more appropriate, evidence-based early intervention and prevention based services for people experiencing mental ill health; (ii) need to increase services focusing on psychological interventions for people with moderate to severe presentations; and (iii) need to improve integration between primary mental health care services and tertiary services and increase community based support services for people discharged from hospital following a suicide attempt

We have identified that ACT has a relatively good availability of non-acute residential care and accessibility services when compared to other areas. Accommodation in the

community is an integral part of a balanced system, important in aiding recovery and reducing the need for acute and crisis care by identifying and supporting people before crises are reached. An important caveat here is that several of these services do not have guaranteed funding for a period of three years, so their continued presence in the system is not guaranteed. The high rate of accessibility services is largely due to PIR services, which face similar funding issues. This is particularly relevant in view of the ACT PHN Needs Assessment which identified care co-ordination for those who do not transition to the NDIS as an area of need.

IMPLICATIONS OF THE MAIN GAPS FOR THE LOCAL MENTAL HEALTH SYSTEM

Fragility of the system: "v" qualifiers.

An additional issue that emerged in this study was related to the lack of robustness, or the fragility of the system, brought about by short term programs lacking recurrent funding bases. We found that around a third of services did not have stability of funding. In other atlases, we have not included these services due to their instability, but we have included them here as they represent a significant proportion of care. We have used the "v" qualifier to indicate these services. It is important to note that data was collected for this atlas during a period of acute transition, particularly in relation to the transition to the NDIS, adding to uncertainty for immediate planning for many services, and changes in service delivery in some cases during, and since, the period of our data collection. The higher rates of NGOs in ACT PHN region increases the balance of community care in the ACT, but also the system fragility, as it is this sector that is most affected by funding instability. This is particularly so in those areas specifically highlighted by territory and national planning, and in which the ACT PHN region has at present relatively good availability: such as non-acute residential, youth social and educational support, suicide prevention, and accessibility services, but also in general adult outpatient social support, such as the PHAMS program. The "v" qualifier was assigned to services in all branches, particularly Outpatient care. At the time of data collection, two of the three Day services had a "v" qualifier, indicating that this branch of care, already fragile, is threatened. Indeed, since that time, the Mental Health Foundation has been unable to continue funding The Rainbow Psychosocial Rehabilitation program, and it closed in December 2016. As mentioned previously, the good availability of residential care in the community is potentially also at risk, as seven of these services do not have funding stability. It is important to also note that while most services with a "v " qualifier are NGOs, Brian Hennessy Rehabilitation Centre provided by ACT Health is also shortly to close, with the introduction in 2018 of the University of Canberra Public Hospital, a purpose built hospital for people rehabilitating from surgery, injury or mental health issues.

Additionally, even the common three year time frame is an insufficient period to test the benefits of new services. This type of problem is typical of high income countries where decision makers/policy planners (the advocates for a new service) take a 'component view' rather than a public health orientation, which takes a 'system thinking perspective'

of the whole pattern of care at the local level and how the different components are related (Thornicroft & Tansella, 2013). The problem with the component approach is that it results in a highly inefficient use of scarce resources, as investment is made in new services, whilst the core services are absent, or not appropriately resourced. This leads to a "reactive", rather than a "proactive" system, based on long term planning informed by local evidence. In addition, all of these programs are community based, which means that the community mental health system in ACT PHN region is very fragile. This lack of robustness is particularly relevant in the current situation, where major changes are occurring due to the transition of many mental health services to the NDIS, and to the current changes in organisation and governance related to the commissioning role of the PHNs, and their relationship with other components of the system, such as LHDs and the hospital networks.

Integration of the mental health care system

According to the government response to the mental health commission report, "regional integration" is a systems-based approach that seeks to better coordinate and plan regional services to improve system and health outcomes (Australian Government Department of Health, 2015). Regional integration works to integrate pathways and services around the needs of consumers, while also striving for the best possible use and targeting of available resources to address individual and community needs. The emphasis on a system-based approach is critical to generate new informed evidence for policy and planning. As previously stated, the specific priorities for regional service integration and delivery led by PHNs include: "development of evidence-based regional mental health plans based on comprehensive needs assessment, and service mapping designed to identify gaps and opportunities for better use of services to reduce duplication and remove inefficiencies". The Government has committed itself to build the capacity of PHNs to lead mental health planning and integration at a regional level in partnership with LHDs, non-government organisations, local NDIS providers, alcohol and other drug services, Indigenous organisations, general practices and other regional stakeholders.

This mapping has provided a description of the service availability and capacity but it has not analysed the level of integration of the mental health care system. However, analysis of the integration of care cannot be carried out without a prior knowledge of what services are available in the local area; therefore the information provided here is a necessary precursor to understanding the integration of the care system. In addition, the lack of major components of a fully developed community mental health care system identified in the gap analysis has clear implications for the integration of care, as a system cannot be fully integrated when major components of the system are missing. This has implications for the stepped care model, which assumes an integrated system, without major gaps in health pathways. The large number of NGOs and their independence of each other in the ACT PHN region increases the complexity of the system, and the ability to provide system co-ordination. Additionally, Calvary Hospital, operated by the Sisters of the Little Company of Mary, but within the public health system, could be seen as a

"nested subsystem", similar to St. Vincent's in Central and Eastern Sydney (Salvador-Carulla et al, 2016). The difficulties for informed public policy and planning of geographic and substantive boundaries of subsystems nested in broader systems have been pointed out previously (Weible & Sabatier, 2007). Problems may arise in such systems in relation to the territorial scope, the substantive scope (e.g. local mental health policy), the agents or participant organisations operating in the general systems and in the nested system, and the population perspectives with regards to social, demographic and epidemiological indicators. On the other hand, and from a systems thinking perspective, a nested subsystem can increase flexibility and capacity of self-adaptation to changes in the environment of the broader system.

While this atlas is aimed at planners, a map of the system designed to aid consumers and clinicians in navigating the system, may be particularly relevant in the ACT. In any case, the need and the number of co-ordination services, whose activities are not part of the routine activities of direct care, may indicate the lack of continuity of care in the system. The transition to NDIS of many non-health services may potentially increase the level of fragmentation. So too, the reliance of the system on NGOS could increase fragmentation, make co-ordination of the balance of care more difficult, and decrease the stability of the system.

We have found that one characteristic of the mental health care system in the ACT PHN region is the fragmentation of funding across functional teams, so that different professionals working within the same team may have different funding. An example of this is the part time provision of a CAMHS funded mental health nurse to a NGO funded residential service. This indicates a need for a complementary mapping of the financing flows in the system.

The ACT PHN region has a higher rate of service availability than other areas and a greater range of specialist services. The complexity of the system created by the number and variety of services and by the high rate of NGOs, suggests that more service integration is a greater need than more services. However, despite a high number of services, concerns were expressed by many services about their ability to meet need. Some services found they needed to implement strategies to address this demand for service, such as the "Active Hold" strategy employed by the New Horizons service operated by Marymead; or by running groups to maintain contact with people waiting for more intensive support. However, when comparing the ACT to areas such as those in Greater Sydney, the relative isolation of the ACT should be remembered: that is, while in Sydney, a service not provided in one LHD may be provided in an adjacent region, in the ACT, this is of course not the case. This should be taken into account when comparing number and range of services available.

An additional finding was a discrepancy in some cases between the service description described on services' websites, and their current availability at time of interview. Some services were providing more care than that described on their websites, while some

services which were no longer available remained on others' websites. The ability of other service providers, health professionals and service users themselves to understand and navigate the system is reduced if publicly available information lacks currency.

Implications for moderate to severe patients

All of the problems described in this discussion are related to the concept of the "missing middle" of care, which has been also highlighted in the review made by the National Mental Health Commission (National Mental Health Commission, 2014). In its response to the National Review, the government has committed to giving " priority to resolving the fragmentation of service delivery for people with severe and complex mental illness who are being managed in primary care" (Australian Government Department of Health, 2015), however the lack of Day care and Residential alternatives in the community (despite the ACT's greater availability of Residential care) makes this difficult to achieve. When analysing the information, the type of services provided in the ACT PHN region may cover the needs of the two extremes of the lived experience of mental illness: on the one hand, those people with mental health problems who are relatively well, have good support, and only need low-level support, and on the other hand, those who are in a severe crisis situation who require acute care in a hospital setting. In the middle, we have a significant proportion of people with a lived experience of chronic and moderate to severe mental illness who need more community-based options. In this sense, a balanced care system requires the active implication of the health sector in the provision of community care, together with the social sector.

It is important to note that gaps in the care provision for moderate disorders have been identified as a major problem in other countries with highly advanced community care systems such as Norway (OECD, 2014). However the gap in other OECD countries is mainly related to the mild-moderate target group treated in primary care and by community nurses, and not to clients experiencing moderate- severe mental illness treated in specialised care, as identified in this analysis. Models of care such as those in the UK, featuring specialist rehabilitation services and care pathways which include inpatient and supported accommodation services have been shown to reduce the need for acute care in people with complex psychosis (Killaspy et al., 2016). The care pattern for mild-moderate mental ill-health in primary care in ACT PHN region is an area that requires further investigation. The gap in high intensity Day care, including in employment related services, may hinder tertiary prevention or rehabilitation.

7.5. STUDY LIMITATIONS

There are several limitations that need to be acknowledged.

First, some services may be missing because we did not reach them. However, we presented and discussed services included and coded in the study to the Steering

Committee of the Atlas project and, after different iterative reviews, it was agreed that the majority of the services have been included and coded. A small number of services did not provide information on FTEs. Additionally, the generic services that are not specific to mental health, but that are used by people with mental illness, have not been coded and registered in this atlas.

Some services providing care for people with disabilities and homelessness expressed their interest in the Atlas, but they did not want to be included as their target population was not mental health. This is an issue which has also been identified in other PHN regions. The focus on individual care based on a person's level of functioning, without any consideration for the target population group may have implications in the care delivery system, which should be explored in the future. Questions arise as to whether a service which does not provide a mental health component in its provision system can adequately attend to and meet the specific needs of this population group.

Second, we have not included private providers, as this atlas is focused on services with a minimum level of universal accessibility. The inclusion of private providers in the mapping of publicly available services may increase noise, hamper the interpretation of the results and misrepresents the universality of access to services. Private services should be included as an additional map in future analysis.

Third, we have included services that have time-limited funding of less than three years. The inclusion of care programs that are time-limited could distort the analysis.

Fourth, the assessment of the services was made through interviews with the managers of the services. Some information may not be accurate and should be objectively confirmed (e.g. the percentage of activities made outside the office in order to be classified as a mobile service).

Finally, we have only included services within the boundaries of the ACT PHN region. We acknowledge that some services outside the area, such as in Goulburn and Queanbeyan, may also be used by people in the ACT PHN region. However, we did not include these, as they did not include any services with explicit service agreements to serve the population of the ACT PHN region.

Integrated Atlases of Mental Health are considered key tools for evidence-informed policy and planning. In this Atlas we have mapped in a comprehensive way the stable services providing care for people with lived experience of mental illness. However, to have a complete picture of the situation, the results of this Atlas should be completed by mapping the:

- **Needs of the primary care physicians related to the provision of mental health:** General practitioners or family physicians are usually the first contact with the

health system and they can play a key role in the prevention of mental illness and the treatment of common mental illness. It is therefore crucial to understand and meet the needs of these professionals.

- **Analysis of professional profiles by main types of care.** Substantial differences have been identified in the professional profiles of the workforce in comparison with similar main types of care in Europe, particularly in the non-health / NGO sector. This would require a detailed analysis in the future.
- **Rates of utilisation of the services**, by MTC, using the information provided in the administrative databases: the analysis of service utilisation will detect hot and cold spots and areas of improvement. The information collected in the local Integrated Atlas of Mental Health Care can be combined with utilisation and outcome data to produce decision support tools that may help with the analysis of benchmarking and relative efficiency, as well as to redesign and improve available services. The DESDE-LTC system has been previously used for this purpose in other countries (Torres-Jiménez, García-Alonso, Salvador-Carulla, & Vicente Fernández-Rodríguez, 2015).
- **Care Packages:** The information presented in this Atlas may be complemented with an analysis on care packages: set of services and interventions that are provided to a consumer at a single time period (complex or collaborative interventions).
- **Pathways to care:** understanding how people with a lived experience of mental illness navigate the system is a key area of knowledge needed for creating systems which increase accessibility and efficiency. This will allow a continuity of care analysis.
- **Financing mechanisms and financing flows**: This will allow us to delve into important areas such as the *Better Access Program* and housing, as well as service complexity issues.
- **Level of integration of the services providing mental health care and the philosophy of care of the services:** a collateral finding that emerges, but that should be included, related to integration is the different philosophy of care of the services. It is important to know the view of the different providers on the public mental health system and their role in it.
- **Analysis of services *for specific target population groups,*** mainly: child and adolescent care, homelessness services, fully private services not accessible through public funding, and alcohol and other drug services, with a particular focus on care for comorbid patients.

The information provided in this Atlas is particularly useful for the following areas of navigation, management and planning:

- **Case and care coordinators:** The data in this Atlas could facilitate a better understanding of the landscape in which they work and the services that are available to their consumers.

- **Managers and Planners:** The information gathered in this Atlas is useful for the development of bottom up system indicators that can be used to monitor the evolution of the system. The production of different Atlases based on the DESDE system every 4 or 5 years can assist in the monitoring of the changes and the evaluation of policies (Fernandez et al., 2014). This can be easily done by introducing the classification system (DESDE) into an on-line program that automatizes the codification of the services. The Department of Social Welfare of Andalusia, in the South of Spain, has incorporated the DESDE into their web page, so services receive the code after answering some questions. It will be also important to evaluate the impact of this Atlas, as a visual tool to increase the capacity and efficacy of managers and planners in evidence-informed decision making and in system thinking.
- **Consumers:** A user-friendly version of the Atlas may support consumers' to navigate the system, location of services and increase their local knowledge on service availability and capacity. For instance, the results of the Integrated Mental Health Atlas of Western Sydney have been used by Carers NSW in a submission to a NSW Parliament Inquiry into service co-ordination in communities with high social needs.

8. CONCLUSION

This Atlas contributes to the development of evidence-based regional mental health plans. It provides a service mapping to assist in identifying gaps and opportunities for better use of services to reduce duplication and remove inefficiencies. This type of information has been prioritised by the Federal Government to the PHNs to implement the mental health reform (Mental Health PHN Consultative Forum., 2016). Our observations are in line with the report in the National Mental Health Commission's National Review of Mental Health Programmes and Services. This review recommended, amongst others: 1) the development of more community-based psychosocial, primary and community mental health services, as alternatives to acute hospital care; and 2) boosting of the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services.

Mapping the service landscape is a vital prerequisite for understanding the components within it and for providing system co-ordination. Accountability in mental health should incorporate assessment of not just health, but also other sectors, such as housing and employment (Rosenberg & Salvador-Carulla, 2017). Over time, service mapping can enable monitoring of the behaviour of the system and how system components interact with, and affect, each other and the system as a whole. The mental health system of the ACT PHN region is characterised by a high level of complexity, due to the relatively high availability of services, the number of NGO providers, the range of types of care, the presence of a nested subsystem in Calvary Hospital, and the funding instability of around one third of services. This is reflected in the high rate of Accessibility services needed to navigate the system. Yet features of the existing system structure, such as the relatively high number of community residential services, lend themselves to the ACT PHN region becoming an appropriate place for the development of new models of care. This is a unique moment for ACT PHN to creatively develop new partnerships and services that are community based, promote recovery and empower consumers. We firmly believe that the use of this Atlas may assist in the planning and improvement of the care provided for people with a lived experience of mental illness.

9. REFERENCES

ACT Health. (2014). Australian Capital Territory Chief Health Officer's Report 2014. Canberra: ACT Government.

ACT PHN. (2016). Primary Health Network: Annual Mental Health Activity Work Plan 2016-2017: Department of Health- Australian Government.

Allison, S., Bastiampillai, T., & Goldney, R. (2014). Acute versus sub-acute care beds: Should Australia invest in community beds at the expense of hospital beds? *Australian & New Zealand Journal of Psychiatry, 48*(10), 952-954. doi: 10.1177/0004867414538106

Andrews, G., & Slade, T. (2001). Interpreting scores on the Kessler Psychological Distress Scale (K10). *Australian and New Zealand Journal of Public Health, 25*(6), 494-497. doi: DOI 10.1111/j.1467-842X.2001.tb00310.x

Aslanyan, G., Benoit, F., Bourgeault, I. L., Edwards, N., Hancock, T., King, A., . . . Timmings, C. (2010). The inevitable health system(s) reform: an opportune time to reflect on systems thinking in public health in Canada. *Can J Public Health, 101*(6), 499.

Astell-Burt, T., Mitchell, R., & Hartig, T. (2014). The association between green space and mental health varies across the lifecourse. A longitudinal study. *Journal of Epidemiology and Community Health, 68*(6), 578-583. doi: 10.1136/jech-2013-203767

Australian Bureau of Statistics. (2017a). Labour Force, Australia, Mar 2017. *Australian Bureau of Statistics*.

Australian Bureau of Statistics. (2017b). Migration, Australia, 2015-16.

Australian Bureau of Statistics (ABS). (2008). National Survey of Mental Health and Wellbeing: Summary of Results, 2007. . Retrieved 21 April, 2016, from http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Main%20Features32007?opendocument&tabname=Summary&prodno=4326.0&issue=2007&num=&view=

Australian Bureau of Statistics (ABS). (2009) National Health Survey: Summary of Results 2007-2008. *cat. no. 4364.0*. Canberra: ABS.

Australian Bureau of Statistics (ABS). (2010). Australian Statistical Geography Standard (ASGS): Volume 1 - Main Structure and Greater Capital City Statistical Areas, July 2011. Retrieved 21 April, 2016, from http://www.abs.gov.au/ausstats/abs@.nsf/0/7CAFD05E79EB6F81CA257801000C64CD?opendocument

Australian Bureau of Statistics (ABS). (2014). Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure, July 2011. from http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.005July%202011?OpenDocument

Australian Government Department of Health. (2015). Australian government response to contributing lives, thriving communities - Review of mental health programmes and services. Retrieved 21 April, 2016, from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response

Australian Institute of, H., & Welfare. (2016). Specialised mental health care facilities.

Australian Institute of Health and Welfare. (2015). Mental health services - in brief 2015 (Vol. Cat. no. HSE 141.). Canberra: the Author.

Barnes, M. (2011). Abandoning Care? A Critical Perspective on Personalisation from an Ethic of Care. *Ethics and Social Welfare, 5*(2), 153-167. doi: 10.1080/17496535.2010.484265

Caldwell, T. M., Jorm, A. F., & Dear, K. B. (2004). Suicide and mental health in rural, remote and metropolitan areas in Australia. *Med J Aust, 181*(7 Suppl), S10-14.

Capital Health Network. (2015). A Blueprint for Capital Health Network Related Content. Retrieved 11/05/2017, from https://www.chnact.org.au/blueprint

Capital Health Network. (2016a). ACT PHN Annual Report 2015/2016. Canberra: Capital Health Network.

Capital Health Network. (2016b). Baseline Needs Assessment 2016. Canberra.

Department of Health. (2010). Adult prevention and recovery care (PARC) services framework and operational guidelines 2010. Victoria.
Department of Health. (2016a). Annexure A1 - Primary Mental Health Care. from http://www.health.gov.au/internet/main/publishing.nsf/Content/F4F85B97E22A94CACA257F86007C7D1F/$File/Annexure%20A1%20-%20Primary%20Mental%20Health%20Care.pdf
Department of Health. (2016b). PHN programme guidelines. Retrieved 30 June, 2016, from http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines
Department of Health. (2016c). Primary health networks: Grant programme guidelines February 2016 - Version 1.2. from http://www.health.gov.au/internet/main/publishing.nsf/Content/F4F85B97E22A94CACA257F86007C7D1F/$File/Primary%20Health%20Network%20Grant%20Programme%20Guidelines%20-%20V1.2%20February%202016.pdf
Department of Health and Ageing. (2013). *National Mental Health Report 2013*. Canberra: Department of Health and Ageing.
Drennan, I. R., Strum, R. P., Byers, A., Buick, J. E., Lin, S., Cheskes, S., . . . Investigators, R. (2016). Out-of-hospital cardiac arrest in high-rise buildings: delays to patient care and effect on survival. *Canadian Medical Association Journal, 188*(6), 413-419. doi: 10.1503/cmaj.150544
Duffy, S. (2011). A fair society and the limits of personalisation. *The Centre for Welfare Reform, Sheffield*.
Ferguson, I. (2012). Personalisation, social justice and social work: a reply to Simon Duffy. *Journal of Social Work Practice, 26*(1), 55-73. doi: 10.1080/02650533.2011.623771
Fernandez, A., Salinas-Perez, J. A., Gutierrez-Colosia, M. R., Prat-Pubill, B., Serrano-Blanco, A., Molina, C., . . . Salvador-Carulla, L. (2014). Use of an integrated Atlas of Mental Health Care for evidence informed policy in Catalonia (Spain). *Epidemiol Psychiatr Sci*, 1-13. doi: 10.1017/S2045796014000511
Foundation, H. (2014). *Perspectives on Context. A selection of essays considering the role of context in successful quality improvement.* London: Health Foundation.
Gandré, C., Gervaix, J., Thillard, J., Macé, J.-M., Roelandt, J.-L., & Chevreul, K. (2017). The development of psychiatric services providing an alternative to full-time hospitalization is associated with shorter length of stay in French public psychiatry. *International Journal of Environmental Research and Public Health, 14*(3), 325.
Goodwin, N. (2013). Understanding integrated care: a complex process, a fundamental principle. *International Journal of Integrated Care, 13*.
Government-Health, A. C. T. (2017). Walk-in Centre. *Walk-in Centre*.
Grove, B. (1999). Mental health and employment: Shaping a new agenda. *Journal of Mental Health, 8*(2), 131-140. doi: 10.1080/09638239917508
Hartig, T., & Kahn, P. H. (2016). Living in cities, naturally. *Science, 352*(6288), 938-940. doi: 10.1126/science.aaf3759
Hasselberg, N., Grawe, R. W., Johnson, S., & Ruud, T. (2011). An implementation study of the crisis resolution team model in Norway: are the crisis resolution teams fulfilling their role? *BMC Health Serv Res, 11*.
Health, A. G. D. o. (2017). Fifth National Mental Health and Suicide Prevention Plan: Department of Health. Australian Government
Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Evans, M., . . . Harvey, C. (2000). Psychotic disorders in urban areas: an overview of the Study on Low Prevalence Disorders. *Australian and New Zealand Journal of Psychiatry, 34*(2), 221-236. doi: DOI 10.1080/j.1440-1614.2000.00728.x
Johnson, S., & Bindman, J. (2008). Recent research on crisis resolution teams: findings and limitations. In S. Johnson, J. Needle, J. Bindman & G. Thornicroft (Eds.), *Crisis Resolution and Home Treatment in Mental Health*. Cambridge: Cambridge University Press.
Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L. T., . . .

Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine, 32*(6), 959-976. doi: 10.1017/S0033291702006074

Killaspy, H., Marston, L., Green, N., Harrison, I., Lean, M., Holloway, F., . . . Koeser, L. (2016). Clinical outcomes and costs for people with complex psychosis; a naturalistic prospective cohort study of mental health rehabilitation service users in England. *BMC Psychiatry, 16*(1), 95.

Light, E., Kerridge, I., Ryan, C., & Robertson, M. (2012). Community treatment orders in Australia: rates and patterns of use. *Australasian Psychiatry, 20*(6), 478-482. doi: Doi 10.1177/1039856212466159

Marshall, M., Crowther, R., Sledge, W. H., Rathbone, J., & Soares-Weiser, K. (2011). Day hospital versus admission for acute psychiatric disorders. *The Cochrane database of systematic reviews*(12), CD004026-CD004026. doi: 10.1002/14651858.CD004026.pub2

Meadows, G. N., Enticott, J. C., Inder, B., Russell, G. M., & Gurr, R. (2015). Better access to mental health care and the failure of the Medicare principle of universality. *Med J Aust, 202*(4), 190-194. doi: 10.5694/mja14.00330

Mendoza, J., Bresnan, A., Rosenberg, S., Elson, A., Gilbert, Y., Long, P., Wilson, K., & Hopkins, J. (2013). Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future. *Summary Report*. Caloundra, QLD: ConNectica.

Mental Health PHN Consultative Forum. (2016). Mental Health PHN Circular 1 - 12 January 2016. *Department of Health*.

Mental Health PHN Consultative Forum. (2016). Mental Health Reform Implementation Circular 1/2016 - Questions and Answers for Primary Health Networks (PHNs). from http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Circular1

Minister for Health. (2015). A new blueprint for mental health services. from http://www.health.gov.au/internet/ministers/publishing.nsf/Content/11DEF2F4DEA3E2E9CA257F0900098986/$File/A-new-blueprint-for-mental-health-services.pdf

Modini, M., Tan, L., Brinchmann, B., Wang, M.-J., Killackey, E., Glozier, N., . . . Harvey, S. B. (2016). Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence. *The British Journal of Psychiatry*, bjp. bp. 115.165092.

MyHealthyCommunities. (2017). Primary Health Network area: Australian Capital Territory. *MyHealthyCommunities*.

National Mental Health Commission. (2014). *Report of the National Review of Mental Health Programmes and Services*. Canberra: Australian Government.

NICE. (2014). Psychosis and shizophrenia in adults: prevention and management. UK.

OECD. (2014). *OECD Reviews of Health Care Quality: Norway 2014*: OECD Publishing.

Oxman, A. D., Lavis, J. N., Lewin, S., & Fretheim, A. (2009). SUPPORT Tools for evidence-informed health Policymaking (STP) 1: What is evidence-informed policymaking? *Health Res Policy Syst, 7 Suppl 1*, S1. doi: 10.1186/1478-4505-7-S1-S1

Panczak, R., Galobardes, B., Spoerri, A., Zwahlen, M., & Egger, M. (2013). High life in the sky? Mortality by floor of residence in Switzerland. *Eur J Epidemiol, 28*(6), 453-462. doi: 10.1007/s10654-013-9809-8

Parrott, R., Hopfer, S., Ghetian, C., & Lengerich, E. (2007). Mapping as a visual health communication tool: promises and dilemmas. *Health Commun, 22*(1), 13-24. doi: 10.1080/10410230701310265

Priebe, S., Watzke, S., Hansson, L., & Burns, T. (2008). Objective social outcomes index (SIX): a method to summarise objective indicators of social outcomes in mental health care. *Acta Psychiatr Scand, 118*(1), 57-63. doi: 10.1111/j.1600-0447.2008.01217.x

QHS. (2015). Health Care Services Plan 2015-2019 (pp. 46). Queanbeyan: Queanbeyan Health Service

Rosen, A., Gurr, R., & Fanning, P. (2010). The future of community-centred health services in Australia: lessons from the mental health sector<xref ref-type="fn"

rid="FN1">A</xref>. *Australian Health Review, 34*(1), 106-115. doi: https://doi.org/10.1071/AH09741
Rosen, A., Gurr, R., Fanning, P., & Owen, A. (2012). The future of community-centred health services in Australia: 'When too many beds are not enough'. *Australian Health Review, 36*(3), 239-243. doi: https://doi.org/10.1071/AHv36n3_RE
Rosenberg, S., & Salvador-Carulla, L. (2017). PERSPECTIVES: Accountability for Mental Health: The Australian Experience. *J Ment Health Policy Econ, 20*(1), 37.
Salinas-Pérez, J. A., García-Alonso, C. R., Molina-Parrilla, C., Jordà-Sampietro, E., & Salvador-Carulla, L. (2012). Identification and location of hot and cold spots of treated prevalence of depression in Catalonia (Spain). *International Journal of Health Geographics, 11*(36), 1-10.
Salvador-Carulla, L., Alvarez-Galvez, J., Romero, C., Gutierrez-Colosia, M. R., Weber, G., McDaid, D., . . . Johnson, S. (2013). Evaluation of an integrated system for classification, assessment and comparison of services for long-term care in Europe: the eDESDE-LTC study. *BMC Health Serv Res, 13*, 218. doi: 10.1186/1472-6963-13-218
Salvador-Carulla, L., Amaddeo, F., Gutiérrez-Colosía, M., Salazzari, D., Gonzalez-Caballero, J. L., Montagni, I., . . . Kalseth, J. (2015). Developing a tool for mapping adult mental health care provision in Europe: the REMAST research protocol and its contribution to better integrated care. *International Journal of Integrated Care, 15*(4).
Salvador-Carulla. L., Fernandez. A., Maas. C., Prigent A, Gandré C. & Xu T, (2016). *The Integrated Mental Health Atlas of the Central and Eastern Sydney Primary Health Network*. Mental Health Policy Unit. Brain and Mind Centre. Faculty of Health Sciences. University of Sydney
Savigny, D. A., T. (2009). *Sytems Thinking for Health Systems Strengthening.* Geneve: World Health Organization.
Siskind, D., Harris, M., Kisely, S., Brogan, J., Pirkis, J., Crompton, D., & Whiteford, H. (2013). A retrospective quasi-experimental study of a community crisis house for patients with severe and persistent mental illness. *Australian & New Zealand Journal of Psychiatry, 47*(7), 667-675. doi: 10.1177/0004867413484369
SNSWLHD. (2013). Southern NSW Local Health District Health Care Services Plan 2013-2018 (pp. 84). Queanbeyan: Southern NSW Local Health District.
South Eastern Sydney Partners in Recovery. (2015). South Eastern Sydney Partners in Recovery: Two year anniversary. from http://www.sespir.com.au/PDFs/SESPIR-final-two-year-anniversary-report.pdf
Stergiopoulos, V., Hwang, S. W., Gozdzik, A., Nisenbaum, R., Latimer, E., Rabouin, D., . . . Frankish, J. (2015). Effect of scattered-site housing using rent supplements and intensive case management on housing stability among homeless adults with mental illness: a randomized trial. *Jama, 313*(9), 905-915.
Tansella, M., & Thornicroft, G. (1998). A conceptual framework for mental health services: the matrix model. *Psychological Medicine, 28*(03), 503-508.
The Refinement Project Research Consortium. (2013). The Refinement Project. . 2013, from http://www.refinementproject.eu/
Thornicroft, G., & Tansella, M. (2013). The balanced care model for global mental health. *Psychol Med, 43*(4), 849-863. doi: 10.1017/S0033291712001420
Tim Aubry, Paula Goering, Scott Veldhuizen, Carol E. Adair, Jimmy Bourque, Jino Distasio, . . . Sam Tsemberis. (2016). A Multiple-City RCT of Housing First With Assertive Community Treatment for Homeless Canadians With Serious Mental Illness. *Psychiatric Services, 67*(3), 275-281. doi: 10.1176/appi.ps.201400587
Torres-Jiménez, M., García-Alonso, C. R., Salvador-Carulla, L., & Vicente Fernández-Rodríguez. (2015). Evaluation of system efficiency using the Monte Carlo DEA: The case of small health areas. *European Journal of Operational Research, 22*(2), 525-535.
Vazquez-Bourgon, J., Salvador-Carulla, L., & Vazquez-Barquero, J. L. (2012). Community alternatives to acute inpatient care for severe psychiatric patients. *Actas Espanolas De Psiquiatria, 40*(6), 323-332.
Walsh, F. P., & Tickle, A. C. (2013). Working towards recovery: the role of employment in

recovery from serious mental health problems: a qualitative meta-synthesis. *International Journal of Psychosocial Rehabilitation, 17*(2), 35-49.
WARP. (2016). World Association for Psychosocial Rehabilitation.

Weible CM, Sabatier PA. A guide to the advocacy coalition framework. In: Fischer F, Miller GJ, editors. Handbook of public policy analysis: Theory, politics, and methods. Boca Raton, FL: CRC Press; 2007. p. 123-36.

Wheeler, C., Lloyd-Evans, B., Churchard, A., Fitzgerald, C., Fullarton, K., Mosse, L., . . . Johnson, S. (2015). Implementation of the Crisis Resolution Team model in adult mental health settings: a systematic review. *BMC Psychiatry, 15*(1), 74. doi: 10.1186/s12888-015-0441-x
WHO. (2008). Scaling up care for mental, neurological, and substance use disorders: Mental Health Gap Action Programme (mhGAP). . from http://www.who.int/mental_health/mhgap_final_english.pdf
Zhang, J. Y., Harvey, C., & Andrew, C. (2011). Factors associated with length of stay and the risk of readmission in an acute psychiatric inpatient facility: a retrospective study. *Australian and New Zealand Journal of Psychiatry, 45*(7), 578-585. doi: Doi 10.3109/00048674.2011.585452