ANNEX 1: THE INTEGRATED MENTAL HEALTH ATLAS OF THE SYDNEY LOCAL HEALTH DISTRICT

THE UNIVERSITY OF SYDNEY

PARTNERS IN RECOVERY
INNER WEST SYDNEY
connecting communities for a healthy and meaningful life

phn
CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

UNIVERSIDAD LOYOLA ANDALUCÍA

AUTHORS:

UNIVERSITY OF SYDNEY

PROF. LUIS SALVADOR-CARULLA (CHIEF INVESTIGATOR-HEAD OF THE PROJECT)
MS. KATHERINE HOPMAN (ASSOCIATE RESEARCHER)
MS. CAILIN MAAS (SERVICE ASSESSMENT; GEOGRAPHICAL INFORMATION SYSTEMS)
DR. ANA FERNANDEZ (COORDINATOR. ASSESSMENT OF THE SERVICES)
DR. TIANXI XU (RESEARCH ASSISTANT)
MS. MARYANNE COURTENAY FURST (RESEARCH ASSISTANT)

UNIVERSIDAD LOYOLA ANDALUCÍA (SPAIN)

DR. JAVIER ALVAREZ-GALVEZ (VISITING RESEARCHER)
DR. JOSE A. SALINAS-PEREZ (GEOGRAPHICAL INFORMATION SYSTEMS)

FRENCH NATIONAL INSTITUTE OF HEALTH AND MEDICAL RESEARCH (INSERM), PARIS UNIVERSITY HOSPITALS (AP-HP)

DR. AMÉLIE PRIGENT (RESEARCH ASSISTANT)
MS. CORALIE GANDRÉ (RESEARCH ASSISTANT)

DOI:

ISBN: 978-1-74210-411-9

ACKNOWLEDGEMENTS

We are grateful to all the service providers who participated in this study. We would like to thank all the Steering Committee members who have helped us to contact the services and understand the territory:
Victor Storm, John Downie, Zoe Benjamin, Paul Clenaghan, Andrew McDonald, Karen Frost and Kerri Scott. We would like to acknowledge the international collaboration of the Psicost Scientific Association and Universidad Loyola Andalucia (Spain); and the French National Institute of Health and Medical Research (INSERM), Paris University Hospitals (AP-HP).

SUGGESTED CITATION

Furst, M.C.; Salinas-Perez, J.A.; Hopman, K.; Maas, C.; Fernandez, A.; Xu, T.; Alvarez-Galvez, J.; Prigent, A.; Gandré, C.; Salvador-Carulla, L. (2016). The Integrated Mental Health Atlas of the Central and Eastern Sydney PHN Region. Annex 1: Sydney Local Health District. Mental Health Policy Unit. Brain and Mind Centre. Faculty of Health Sciences. University of Sydney. 30 December 2016

CONTENTS

Abbreviations 6

EXECUTIVE SUMMARY 8

1. FRAMEWORK 9

1.1 WHAT ARE INTEGRATED MENTAL HEALTH ATLASES? 10

1.2 HOW WAS THE INTEGRATED ATLAS OF MENTAL HEALTH ASSEMBLED? 10

1.3 WHAT ARE BASIC STABLE INPUTS OF CARE (BSIC)? 10

2. MAPPING THE AREA: SOCIO AND ECONOMIC INDICATORS 12

2.1 THE BOUNDARIES AND JURISDICTION 12

2.2 SOCIOECONOMIC INDICATORS 13

3. DESCRIBING THE SERVICES PROVIDING CARE FOR PEOPLE WITH A LIVED EXPERIENCE OF MENTAL ILLNESS 26

3.1 GENERAL DESCRIPTION 26

3.2 ADULTS 36

3.2.1 RESIDENTIAL CARE 36

3.2.2 DAY CARE 46

3.2.3 OUTPATIENT CARE 49

3.2.4 ACCESSIBILITY SERVICES 62

3.2.5 INFORMATION AND GUIDANCE 65

3.2.6 SELF AND VOLUNTARY SUPPORT 66

3.3 AGE SPECIFIC POPULATIONS 67

3.3.1 TRANSITION TO ADULTHOOD 67

3.3.2 SERVICES FOR OLDER PEOPLE 68

3.4 NON-AGE RELATED SPECIFIC POPULATIONS 69

3.4.1 GENDER SPECIFIC SERVICES 69

3.4.2 SERVICES FOR CARERS 69

3.4.3 MULTICULTURAL SERVICES 70

3.4.4 SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES 71

3.4.5 HOMELESSNESS SERVICES 71

3.4.6 ALCOHOL AND OTHER DRUGS 72

4 MAPPING THE MENTAL HEALTH SERVICES 72

5 DESCRIPTION OF THE PATTERN OF CARE IN THE AREA 77

6 INTERNATIONAL COMPARISONS 85

6.1 NORTHERN EUROPE COMMUNITY MENTAL CARE MODEL 86

6.2 SOUTHERN EUROPE MODEL OF MENTAL HEALTH CARE 89

6.3 ENGLISH SYSTEM 92
6.4 PLACEMENT CAPACITY- CROSS-NATIONAL COMPARISONS 94
6.4.1 RESIDENTIAL CARE 94
6.4.2 DAY CARE 94
7 DISCUSSION 95
7.1 BOUNDARIES AND SOCIAL AND DEMOGRAPHIC CHARACTERISTICS OF THE SLHD 95
7.2 KEY CHARACTERISTICS OF THE MENTAL HEALTH SYSTEM IN THE SLHD 96
7.2.1 RESIDENTIAL CARE (INCLUDING HOSPITAL CARE) 97
7.2.2 NON RESIDENTIAL CARE 100
7.2.3 SERVICES FOR SPECIFIC POPULATION GROUPS 106
7.3 MAIN GAPS IN SERVICE AVAILABILITY AND UNMET NEEDS 107
7.4 IMPLICATIONS OF THE MAIN GAPS FOR THE LOCAL MENTAL HEALTH SYSTEM 108
7.5 STUDY LIMITATIONS 110
7.6 FUTURE STEPS 111
7.7 CONCLUSION 113
8. REFERENCES 114

TABLE OF FIGURES

Figure 1. Population density 15
Figure 2. High risk of psychological distress 16
Figure 3. Distribution of lone parents 17
Figure 4. Distribution of people living alone 18
Figure 5. Distribution of unemployment 19
Figure 6. Distribution of households without internet 20
Figure 7. Distribution of aboriginal and Torres Strait islander peoples 21
Figure 8. Distribution of areas of low English proficiency 22
Figure 9. Ageing index 23
Figure 10. Dependency index 24
Figure 11. Comparison of the MTC identified in SLHD and SESLHD according to target population, type of care and sector of care 27
Figure 12. Geographical distribution of high risk of psychological distress and residential services 73
Figure 13. Geographical distribution of population density and day program services 74
Figure 14. Geographical distribution of high risk of pyschological distres and outpatient non mobile services 75
Figure 15. Geographical distribution of population density and outpatient mobile services 76
Figure 16. Pattern of availability of MTCs for adult population in SLHD with lived experience if mental illness. Availability of MTCs per 100,000 residents 78
Figure 17.Description of the workforce by sector in SLHD and SESLHD 80
Figure 18. Number of beds per 100,000 residents in SLHD, SESLHD, SWS & WS (adults) 81
Figure 19. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD & SESLHD in metropolitan Sydney. Availability of MTC per 100,000 residents 82
Figure 20. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD & SWSLHD in metropolitan Sydney. Availability of MTC per 100,000 residents 83
Figure 21. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD & WSLHD in metropolitan Sydney. Availability of MTC per 100,000 residents 84
Figure 22. Pattern of availability of MTC in local mental health systems for the adult population with a lived experience of mental illness. Comparison between SLHD and Sor-Trondelag-Norway. Availability of MTC per 100,000 residents 87
Figure 23. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD and Helsinki & Uusimaa-Finland. Availability of MTC per 100,000 residents .. 88
Figure 24. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD & Verona-Italy. Availability of MTC per 100,000 residents 90
Figure 25. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD and Girona-Spain. Availability of MTC per 100,000 residents 91
Figure 26. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD and Hampshire-England. Availability of MTC per 100,000 residents 93

LIST OF TABLES.

Table 1. Description of the socio and economic characteristics of the area (2011) 25
Table 2. Description of the MTC per type of population and sector 29
Table 3. Acute inpatient services: availability and placement capacity 36
Table 4. Acute inpatient unit: workforce capacity 38
Table 5. Non-acute inpatient services: availability and placement capacity 39
Table 6. Non- acute inpatient services: workforce capacity 40
Table 7. BSICs related to public housing: availability and workforce capacity 42
Table 8. Residential care provided by NGOs: availability, capacity and workforce capacity 45
Table 9. Day care provided by the public health sector: availability 47
Table 10. Day care provided by the public health sector: workforce capacity 47
Table 11. Work-related day care provided by NGOs: availability and workforce capacity 49
Table 12. Acute mobile outpatient care provided by the public health sector: availability 49
Table 13. Acute mobile outpatient care provided by the public health sector: workforce capacity 50
Table 14. Acute non-mobile outpatient care provided by the public health sector: availability 51
Table 15. Acute non-mobile outpatient care provided by the public health sector: workforce capacity 51
Table 16. Non-acute mobile outpatient care provided by the public health sector: availability 52
Table 17. Non-acute mobile outpatient BSIC provided by the public health sector: workforce capacity 53
Table 18. Non-acute non-mobile outpatient care provided by the public health sector: availability 54
Table 19. Non-acute non-mobile outpatient care provided by the public health sector: workforce capacity 55
Table 20. ATAPS: workforce capacity 56
Table 21. Non-acute mobile outpatient care provided by NGOs: availability 57
Table 22. Non-acute mobile outpatient BSIC provided by NGOs: workforce capacity 59
Table 23. Non-acute non-mobile outpatient care provided by NGOs: availability 61
Table 24. Non-acute non-mobile outpatient BSIC provided by NGOs: workforce capacity 61
Table 25. Accessibility services provided by NGOs: availability 62
Table 26. Accessibility services provided by NGOs: workforce capacity 63
Table 27. PIR programs: availability and workforce capacity 65
Table 28. Information and guidance services provided by NGOs: availability 66
Table 29. Self and voluntary support provided by NGOs: availability 66
Table 30. Outpatient care for transition to adulthood in the public health sector: availability and workforce capacity 67
Table 31. Outpatient care provided for transition to adulthood by NGOs: availability and workforce capacity 68
Table 32. Services providing care for older people: availability, placement and workforce capacities 68
Table 33. Services for carers: availability and workforce capacity 69
Table 34. Multicultural services: availability and workforce capacity 70
Table 35. Services for Aboriginal and Torres Strait Islander peoples: availability and workforce capacity 71
Table 36. Socio-demographic indicators in 5 local areas of mental health care in Countries with different models of care 85
Table 37. Cross-national comparisons- Placement capacity- beds per 100,000 residents according to type of residential care.. 94
Table 38. Cross-national comparisons- Placement capacity- places per 100,000 residents according to type of day care 95

ABBREVIATIONS

ABS Australian Bureau of Statistics
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
CBA Community Based Activity Program (Buckingham House)
CCG Clinical Commission Groups
CCM Clinical Case Manager
CCMH Concord Centre for Mental Health
CESPHN Central and Eastern Sydney PHN
D2DL Day2Day Living
DESDE- LTC Description and Evaluation of Services and Directories in Europe for long-term care
DSA Disability Services Australia
ES Eastern Sydney
FACS Family and Community Services
GIS Geographical Information System
HASA Health and Safety Assistant
HASI Housing and Accommodation Support Initiative
ICF International Classification of Functioning
IWS Inner West Sydney
IRSD Index of Relative Socio-Economic Disadvantage
LGA Local Government Area
LHD Local Health District
LOTE Language Other Than English
LTC Long Term Care
MB Professor Marie Bashir Centre
MBE Medicare Benefits Expenditure
mhGAP Mental Health Gap Action Program
MHEC Mental Health Emergency Care
MHN Mental Health Nurse
MHNIP Mental Health Nurse Incentive Program=
MHSRRA Mental Health Services in Rural and Remote Areas
MTC Main Type of Care
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
SCHN Sydney Children's Hospital Network
SES South Eastern Sydney
SESLHD South Eastern Sydney LHD
SF Support Facilitator
SLA Statistical Local Area
SLHD Sydney Local Health District
SMHSOP Specialist Mental Health Services for Older People
SSI Settlement Services International
SVHN St Vincent's Hospital Network
SWS South Western Sydney
SW Social Worker
TAMHSS Transforming Australia's Mental Health Service Systems
WHA World Health Assembly
WHO World Health Organisation
WS Western Sydney

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 the relevance of a bottom-up approach to understanding "services available locally [in] the development of national policy". It also called for responsiveness to the diverse local needs of different communities across Australia.

The findings from the National Review were in line with the recommendations presented by the New South Wales (NSW) Mental Health Commission in the report *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024. Living Well* identified that Local Health Districts (LHD) and primary care organisations such as Medicare Locals and their replacement Primary Health Networks (PHN) should implement strategies to ensure that scarce clinical skills are employed to the best effect, and the need to harness new technology to support clinicians and service providers with new tools to improve care, data collection and information sharing.

The Integrated Mental Health Atlas of the Sydney Local Health District (SLHD) aligns with these recommendations. 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 other regions of NSW. This will inform services planning and the allocation of resources where they are most needed.
It is a tool for evidence-informed planning that critically analyses the pattern of mental health care provided within the boundaries of the SLHD. We used a standard classification system, the "*Description and Evaluation of Services and Directories in Europe for long-term care"* model (DESDE-LTC), 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, once this methodology is more widely available.
The Atlas revealed major differences in the provision of mental health care in the SLHD, when compared to other regions and countries. These are a lack of:

- Non-hospital acute and sub-acute care
- Medium or long-term accommodation for people with mental illnesses
- Acute and non-acute health-related day care

Strengths include:

- Good availability of inpatient residential care
- Good availability of non- acute social outpatient care
- Good availability of accessibility services

Taken together, the information in this Atlas highlights key areas for consideration for future planning for the provision of mental health services in the SLHD. The findings reflect some of the recommendations in the recent report of the National Review of Mental Health Programmes and Services made by the National Mental Health Commission.

1. FRAMEWORK

Although guided by changing philosophies of psychiatric care which favour a more community orientated, integrated, and person centred approach, the process of mental health care reform in recent decades in Australia has been variable, resulting in a system still largely hospital based, characterised by fragmentation and inefficient provision of care (1). The Integrated Mental Health Atlas of the CESPHN, of which this report is an annex, provides a detailed discussion of the Australian mental health context, outlining the government's priority on developing an integrated, person centred system of services for people with a lived experience of mental illness. For detail on the context of mental health reform and on the methods followed to produce this Annex, please refer to the main document.

In the SLHD, as in the rest of Australia or NSW, there is a lack of publicly available data on readmission rates, compulsory treatment orders, or rates of seclusion, and in some areas covered by the SLHD, the risk of psychological distress is higher than the average for the whole of New South Wales (2). A number of relevant initiatives have been undertaken in SLHD within the framework of the Healthy, Strong Communities program (formerly the Service Delivery Reform in Central Sydney) to facilitate the implementation of integrated care projects to help people who experience difficulties as a result of mental illness, live in stable homes and inclusive communities at an early stage.

The SLHD is, additionally, characterised by one of the highest levels of urbanisation in Australia. Although it has a high accessibility of services according to the Accessibility/Remoteness Index of Australia (ARIA) (3), the provision of mental health care in the SLHD represents specific challenges that require tailored planning, as mental illnesses are particularly prevalent in urban Australia, calling for specific urban planning strategies (4-6).

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. A key component for achieving this objective is identifying the services that currently exist, and noting how these services link within and across areas. The organisational analysis of the SLHD is a first look at the operations of the local health district, and will support the development of integrated planning and service delivery at the regional level. This Atlas of the SLHD is an ideal tool to support this process.

1.1 WHAT ARE INTEGRATED MENTAL HEALTH ATLASES?

Integrated Mental Health Atlases identify the number of mental health services in a designated area, and describe what these services are doing, and where they are located. They also include detailed information on socio-economic and demographic characteristics of the population, as well as identification of health-related needs, and 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 allow policy planners and decision makers to build bridges between the different sectors, and to better allocate services.

1.2 HOW WAS THE INTEGRATED ATLAS OF MENTAL HEALTH ASSEMBLED?

A detailed description of the Integrated Mental Health Atlas development process can be found in the CESPHN Framework document. A brief description is provided below to assist readers who are selecting to read the SLHD Annex as a stand-alone document. In SLHD, we have not included child and adolescent services. These services are included for the SESLHD in the SESLHD annex. It is important to note that an international standardised terminology for those professionals without formal health or allied health qualifications, such as “support worker”, “community worker”, or “mental health worker”, is lacking. This poses challenges for understanding, and differentiating between, the precise roles played by the professionals described by these terms in comparisons across jurisdictions.

This Integrated Mental Health Atlas was developed using the "Description and Evaluation of Services and Directories in Europe for long-term care" (DESDE-LTC) (7). This is an open-access, validated, international instrument for the standardised description and classification of services for Long Term Care (LTC). It includes a taxonomy tree and coding system that allows the classification of services in a defined catchment area according to the main care structure/activity offered, as well as the level of availability and utilisation. It is based on the activities, not the name, of the service provider. The classification of services based on the actual activity of the service therefore reflects the real provision of care in a defined catchment area. The DESDE-LTC is focused on the evaluation of the minimal service organisation units or Basic Stable Inputs of Care (BSIC).

1.3 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 on a routine basis. They have time stability (typically they have been funded for more than three years) and structural stability. Structural stability means that they typically 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) (See Box 1).

Box 1. Basic Stable Input of Care: criteria

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)
G3.3. Separated documentation when in a meso-organisation (e.g. specific end of the year reports).

We identified the BSIC in the SLHD 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, p.21 in the main report *The Integrated Mental Health Atlas of the Central and Eastern Sydney PHN)* depicts the different types of care used in our system.

There are six main types of care (7):

- **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 3, p.22, main report).
- **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 4, p.23, main report). 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 5, p.24, main report).
- **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 6, p.25, main report).
- **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 7, p.25, main report).
- **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 8, p.26, main report).

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

Please refer to the Integrated Mental Health Atlas of the CESPHN for a detailed description of the process or methodology.

2. MAPPING THE AREA: SOCIO AND ECONOMIC INDICATORS

2.1 THE BOUNDARIES AND JURISDICTION

The Sydney Local Health District (SLHD) is centrally located in the Greater Sydney area. The SLHD is bounded by Western Sydney LHD and South Western Sydney LHD to the west, South Eastern Sydney LHD to the south and east, and Northern Sydney LHD across the Parramatta River (59). The Central Eastern Sydney Primary Health Network (CESPHN) was established in 2015 to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes. More than 1.4 million individuals reside in the PHN (8). The region covered by the CESPHN includes three former Medicare Locals (ES, IWS and SES). Its boundaries include the SLHD and SESLHD. The SVHN and Sydney Children's Hospital Networks (9) are also nested within the boundaries of the PHN.

A note on boundaries in the SLHD

The SLA is the most appropriate unit of analysis when considering the subcomponents of the CESPHN. In the most recent realignment of the district boundaries in 2011, the boundaries between the two LHDs were defined using SLA, instead of LGA, with approximately half of the City of Sydney LGA being part of the SLHD, and the other half part of the SESLHD (10-12).

In the SLHD, the LGA boundaries correspond to SLA boundaries for all SLAs, except for Sydney West and South, which are both part of the Sydney LGA, and Canterbury Concord and Canterbury Drummoyne, which are both part of the Canterbury LGA. Therefore, overall, the SLHD includes the SLAs of Ashfield, Burwood, Canada Bay, Canterbury, City of Sydney (Sydney South and West SLAs only), Leichhardt, Marrickville, and Strathfield.

We used LGAs in the overall analysis of social and demographic indicators in the report of the CESPHN. However we preferred to use SLAs for the specific analysis of the two local health districts (SLHD and SESLHD) due to the division of the Sydney LGA in two parts managed each of one managed by a different LHD.

A note on the St Vincent's Health Network (SVHN) annex

In developing the atlas, LGAs and SLAs were used to define boundaries, which are the main governance units of analysis in the LHDs. However, these geographical units bore a low correspondence to the reported areas of coverage of the network. In lieu of using these units or designing a new geographical unit, the team was given the catchment area for the SVHN's CARITAS defined at the postcode level. However, the SVHN reported that the area of operation was far greater than this catchment area and identified services that were located across the whole CESPHN as part of the Network, including SLHD. Finally, in collaboration with the LHDs and the network it was resolved that the SVHN was a nested system within the CESPHN. As such an organisational analysis would be most appropriate for the SVHN and the geographical analysis of the CESPHN would be taken as the geographical reference.

2.2 SOCIOECONOMIC INDICATORS

The SLHD covers a population of 548,632 inhabitants. It is expected that by 2025 the population of this LHD will have increased by 22% (13). More than one quarter of the population is living in Canterbury. Table 1 summarises the main socio and economic indicators in the SLHD.

The figures below allow visualisation of some selected indicators using choropleth maps. Overall, these SLAs are characterised by a high density index, and a low dependency index, in comparison to all NSW and Australia - suggesting a relatively limited pressure on productive population - and a high percentage of people who completed Year 12 of high school or equivalent. These SLAs also have a low percentage of Aboriginal and Torres Straight Islanders

(0.9% on average vs. 2.5% both for NSW and Australia as a whole), but a high multicultural community, with an average of 49% for the whole LHD (vs. 31% and 30% for NSW, and Australia, respectively), as well as a high percentage of people with low English proficiency (9.2% for the SLHD vs. 4.1% for NSW, and 3.2% for Australia, respectively).

Canterbury appears as a particularly socially and economically disadvantaged area (indicated by the low IRSD decile), and is also the zone with the highest percentage of individuals unemployed and with a low income, as well as the highest percentage of lone parents, the highest percentage of people with low English proficiency, and the lowest percentage of people who completed Year 12 of high school or equivalent. The percentage of dwellings with no internet connection was also the highest in this area, and was greater than both the State and national average, which may be problematic for eHealth initiative strategies prioritized by the NSW state health plan towards 2021 (14). In addition, Canterbury was the SLA with the highest percentage of the population with high, or very high, psychological distress, and this percentage was also greater than both the state and the national average. The Canada Bay (both Concord and Drummoyne) and Leichhardt areas were the least socially and economically disadvantaged areas, as indicated by their high IRSD decile.

The most densely populated areas, Sydney West and South, also have the lowest dependency index, and the highest percentage of people living alone, and those not married or in a de facto relationship. They were also among the areas with the lowest proportion of residents requiring assistance with core activities.

Finally, Marrickville and Sydney South were the areas with the highest percentage of Aboriginal and Torres Strait Islander peoples.

Figure 1. Population density

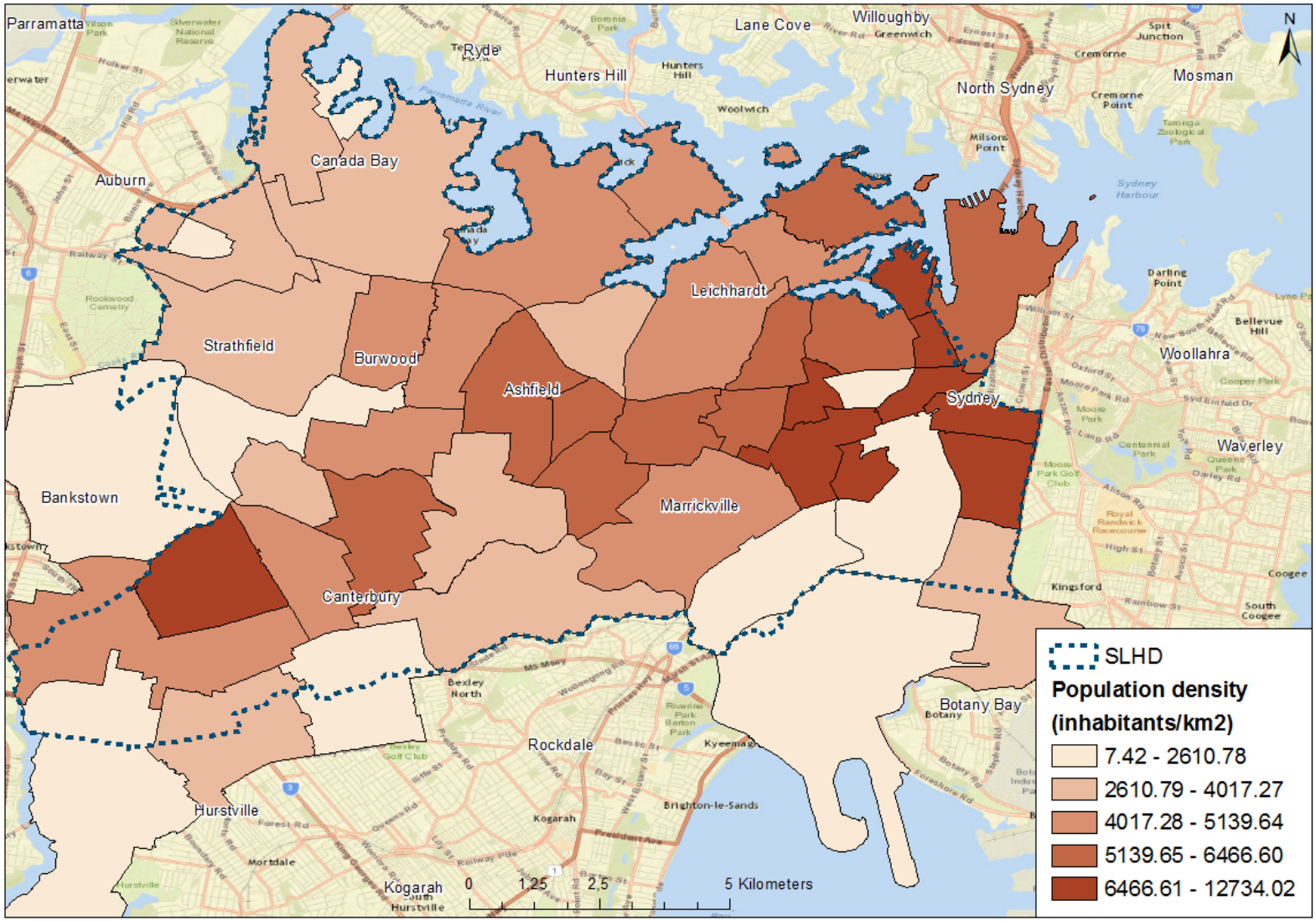


Figure 2. High risk of psychological distress

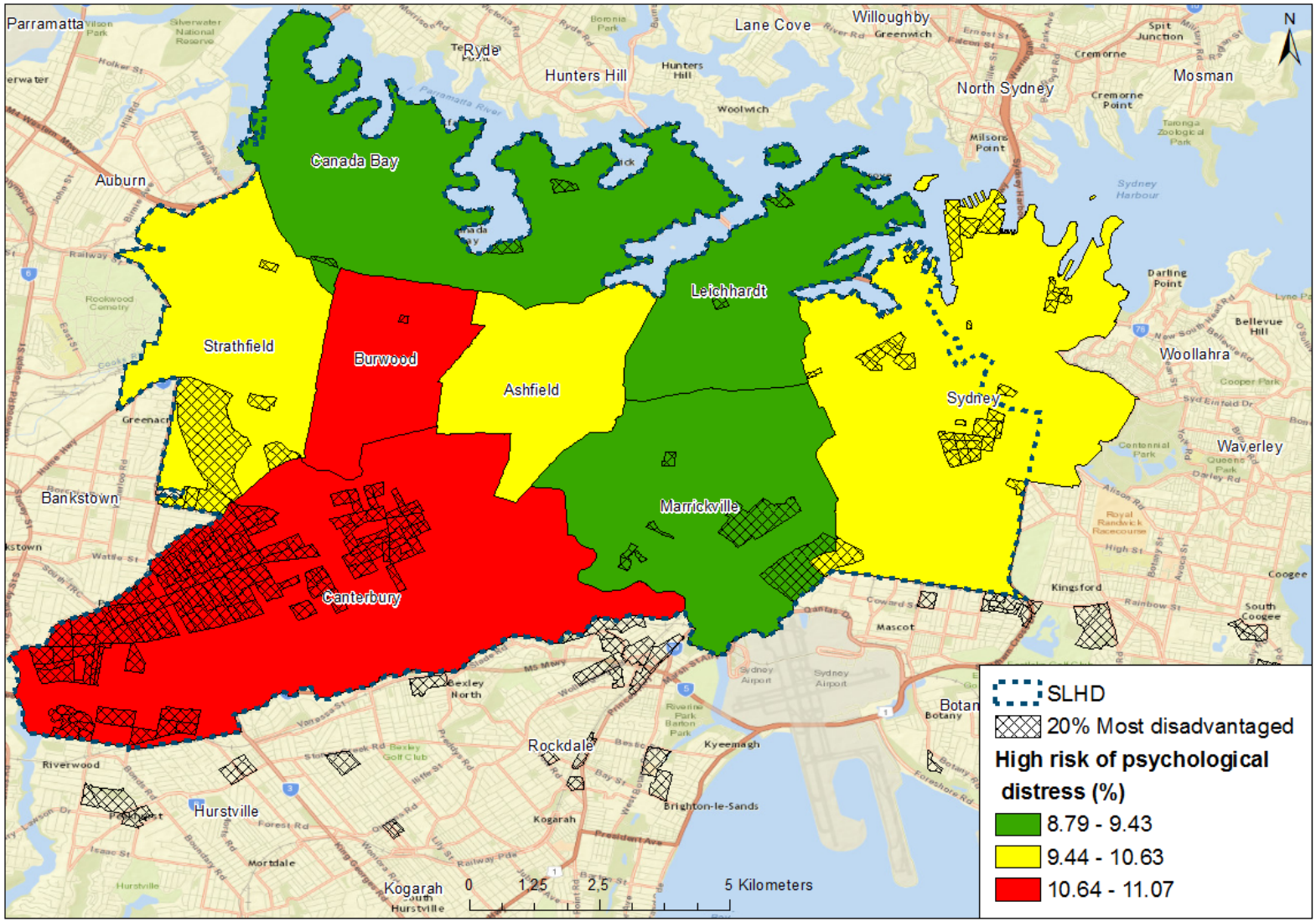


Figure 3. Distribution of lone parents

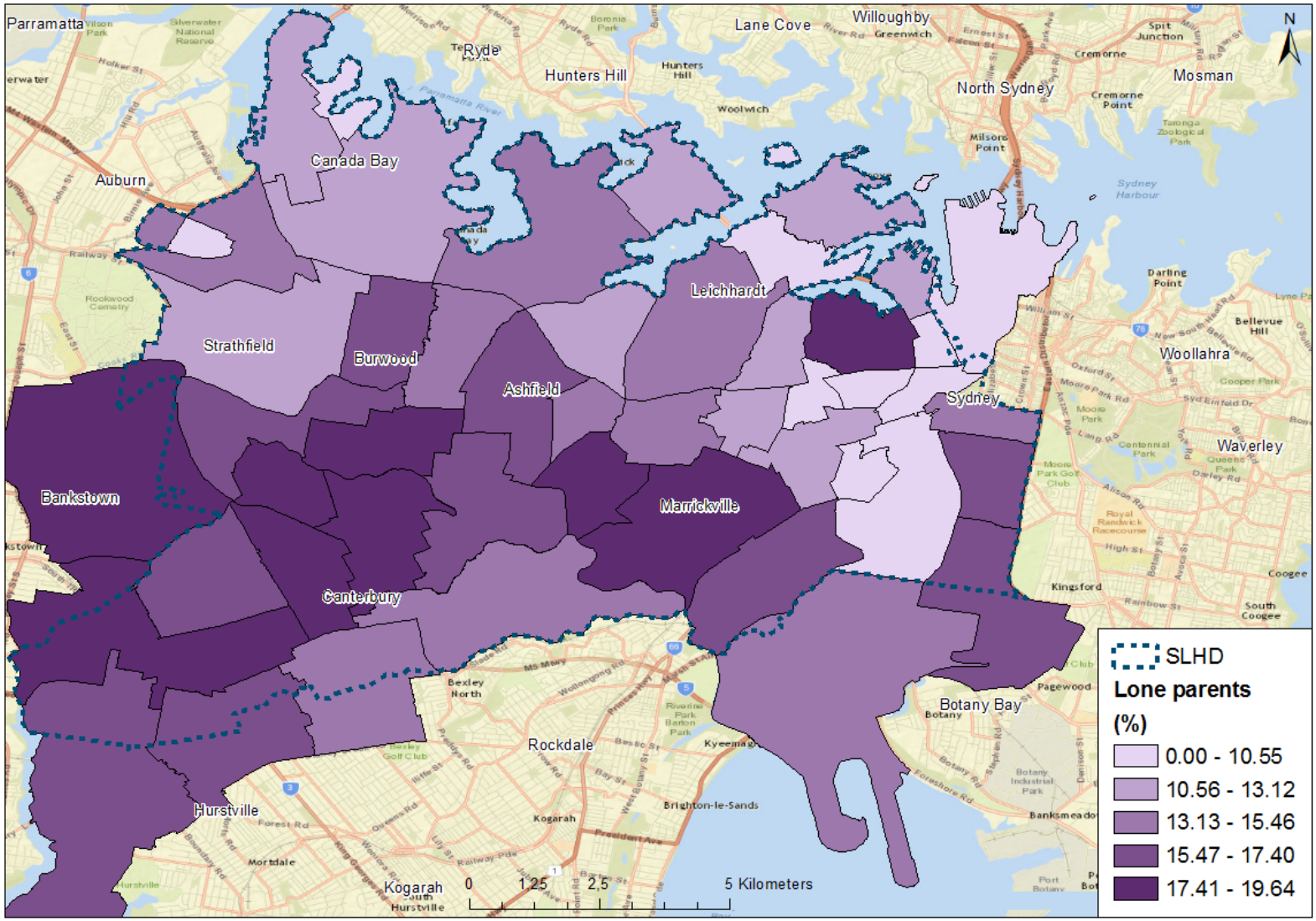


Figure 4. Distribution of people living alone

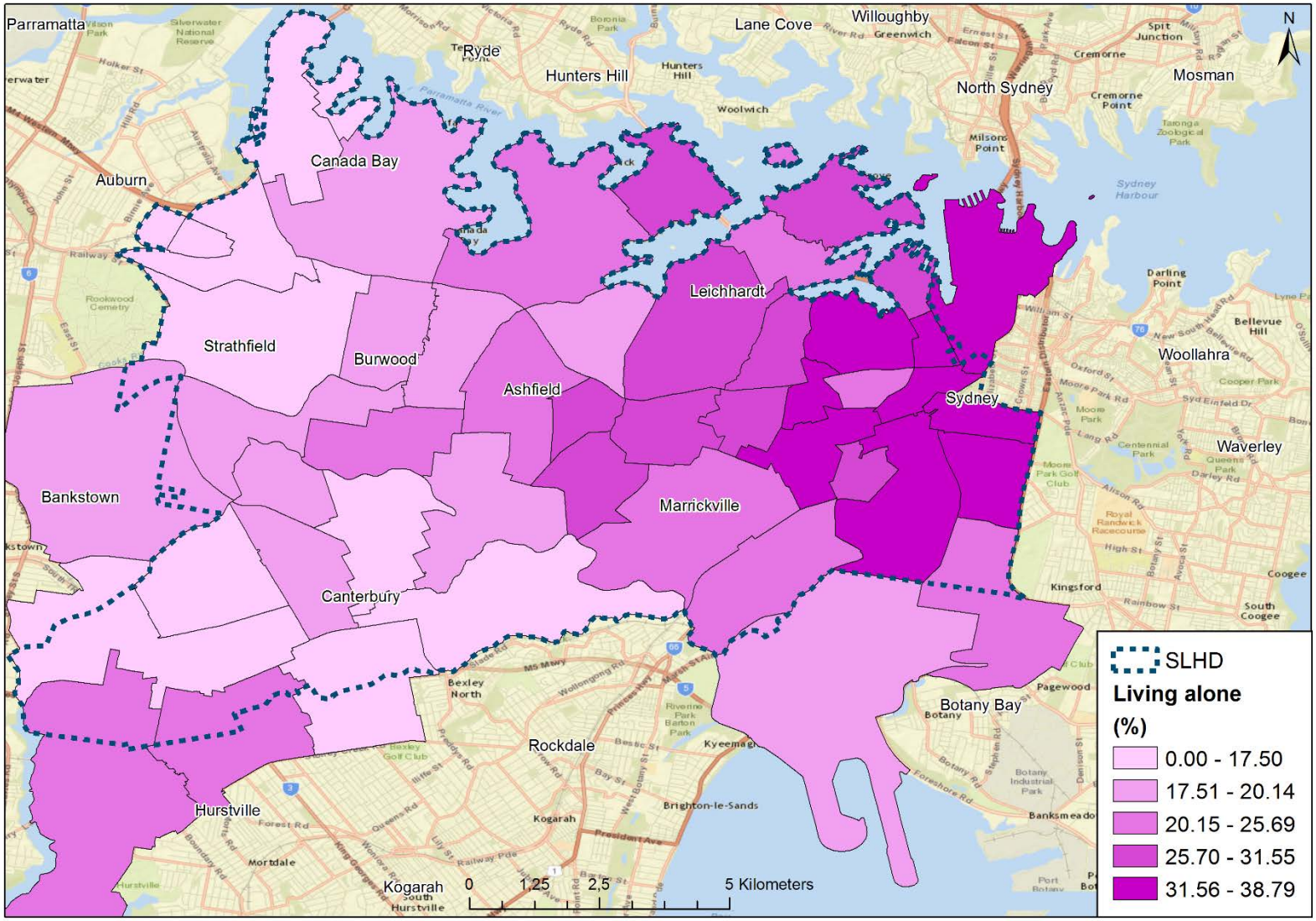


Figure 5. Distribution of unemployment

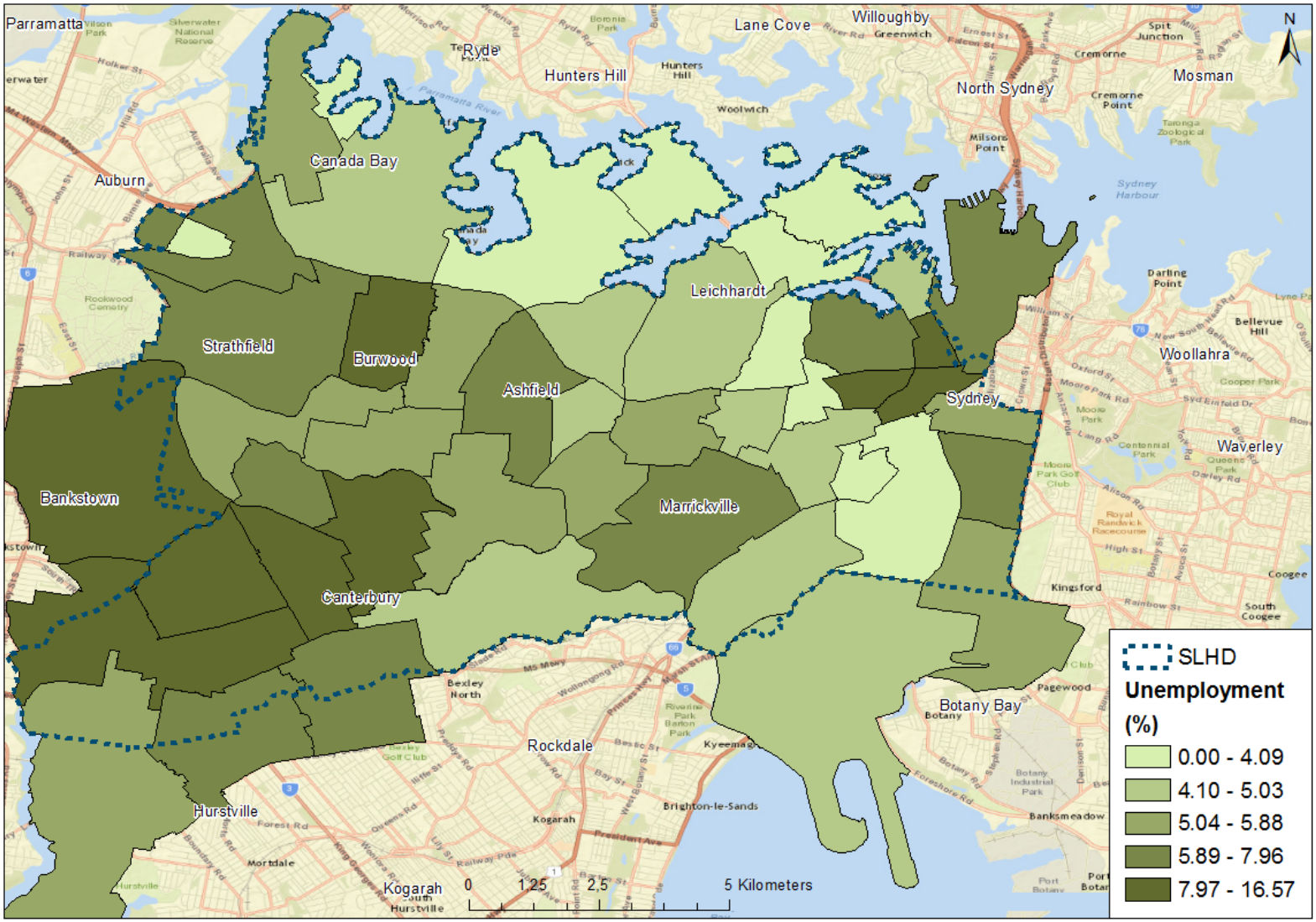


Figure 6. Distribution of households without internet

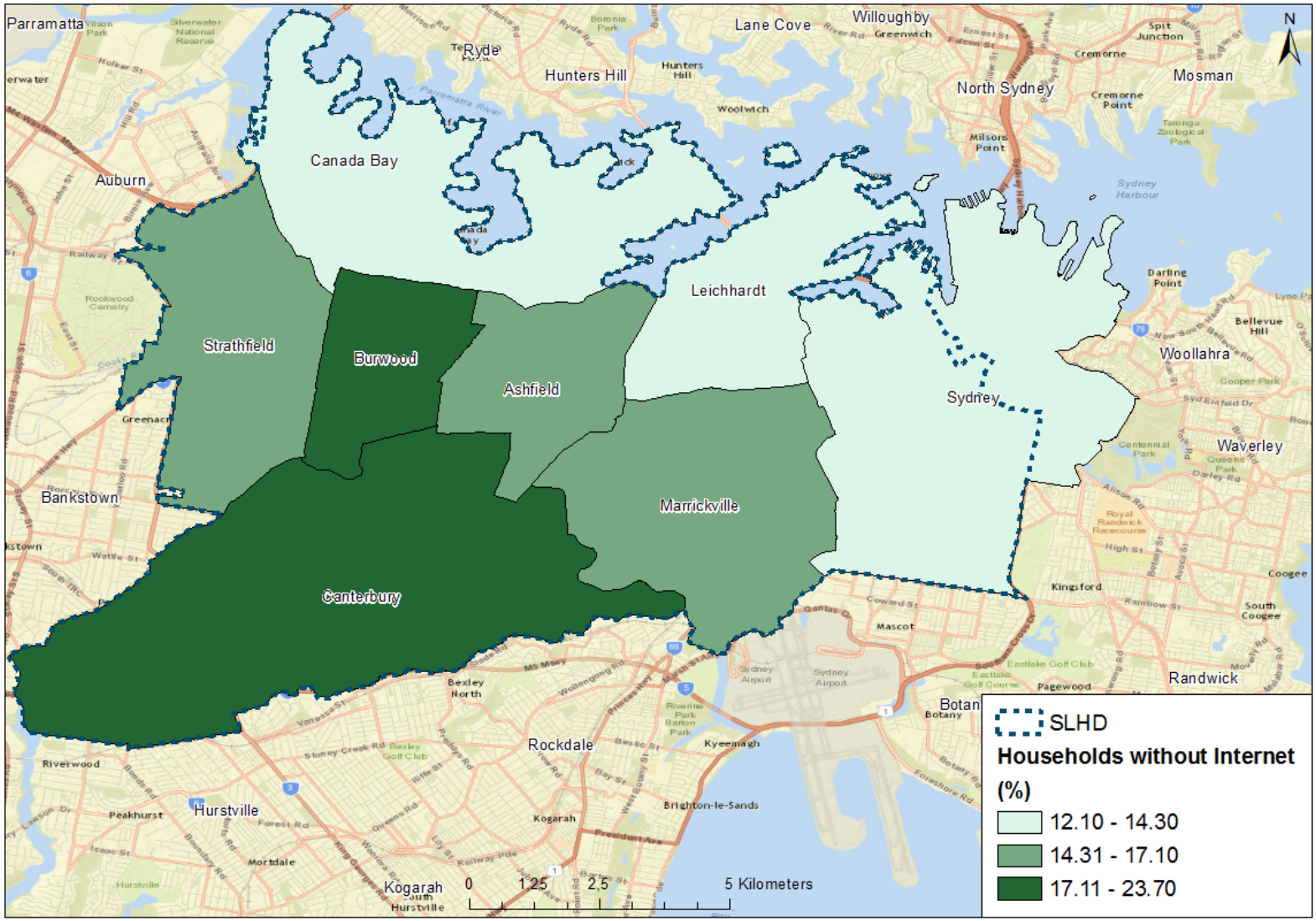


Figure 7. Distribution of aboriginal and Torres Strait islander peoples

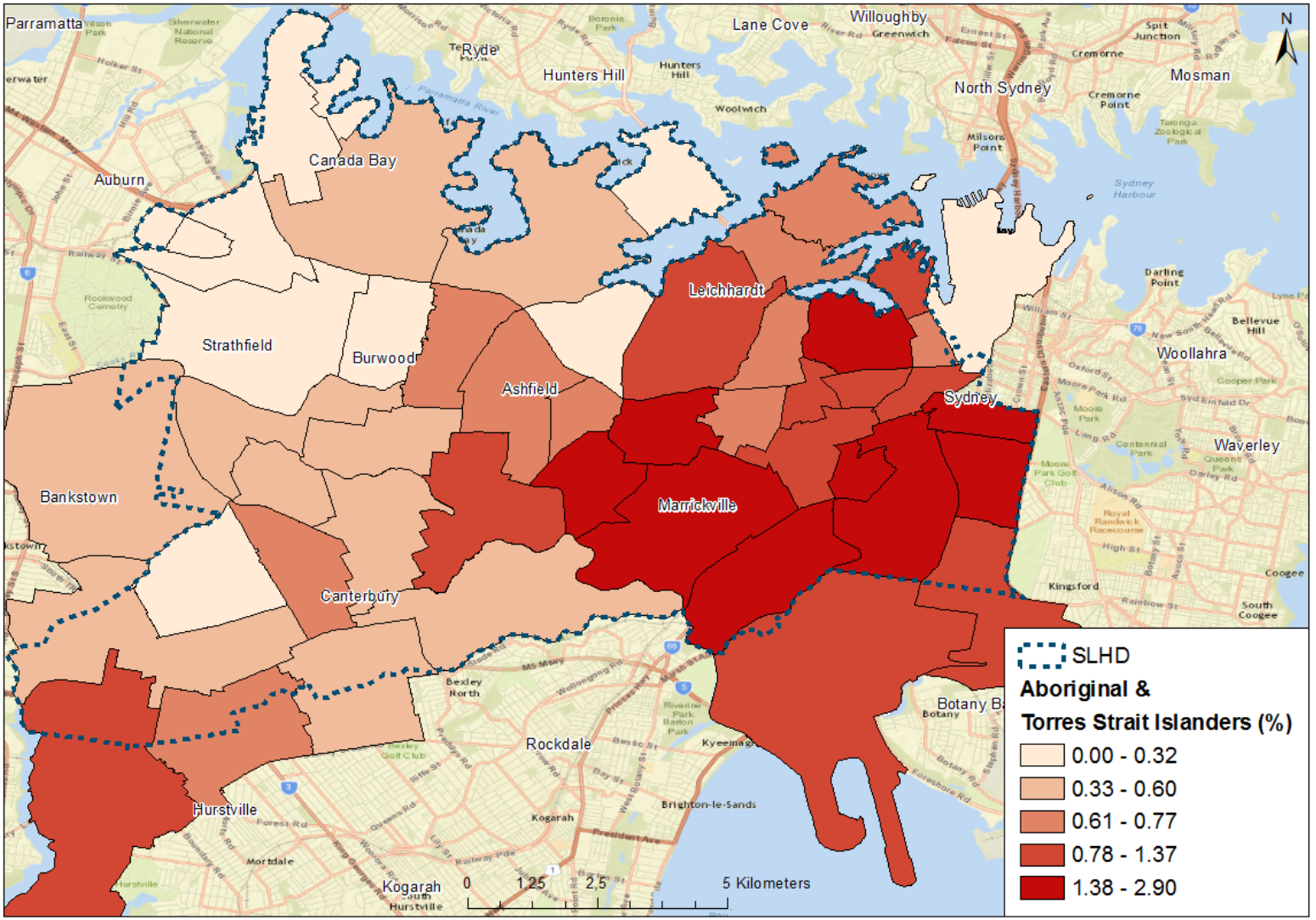


Figure 8. Distribution of areas of low English proficiency

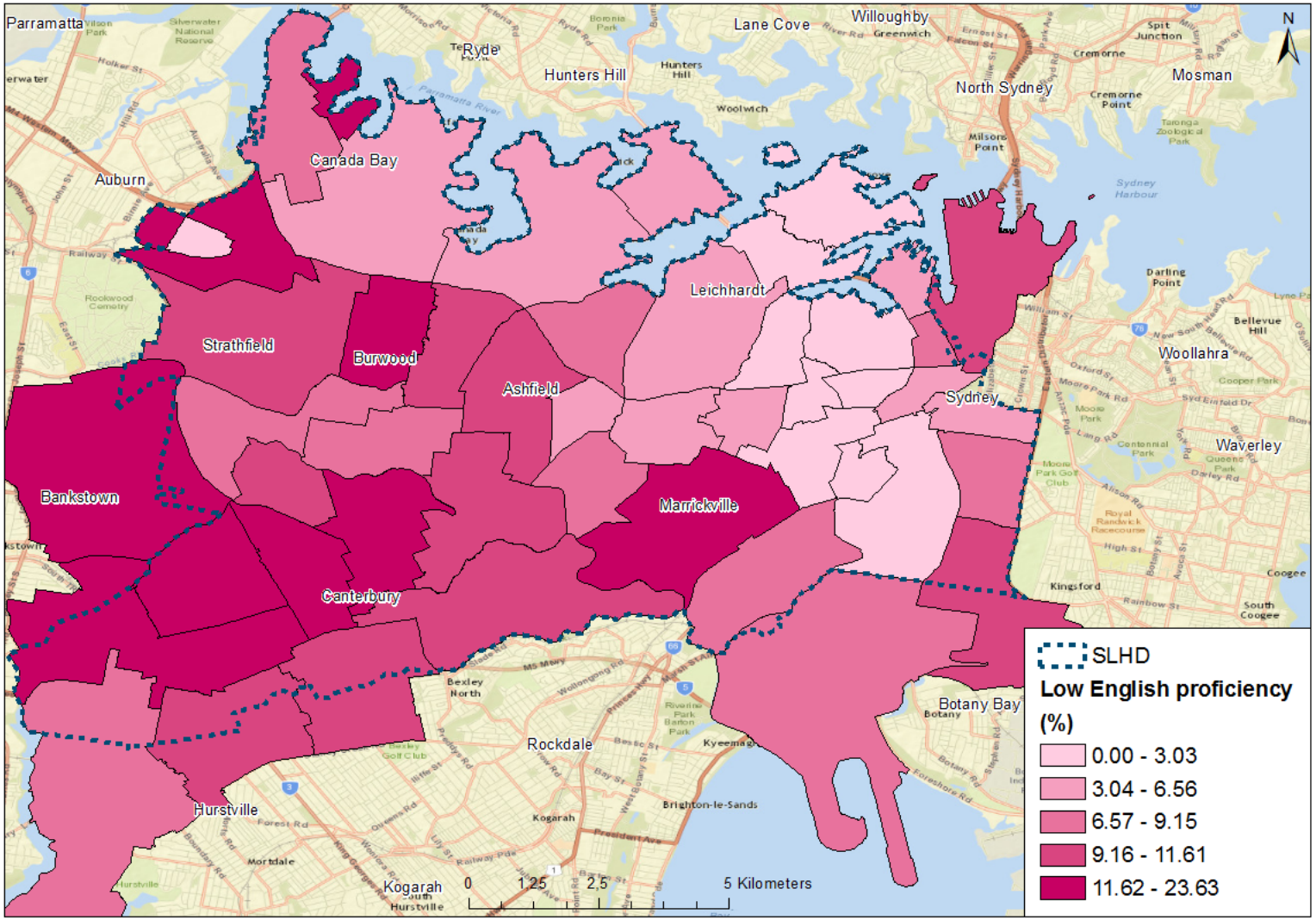


Figure 9. Ageing index

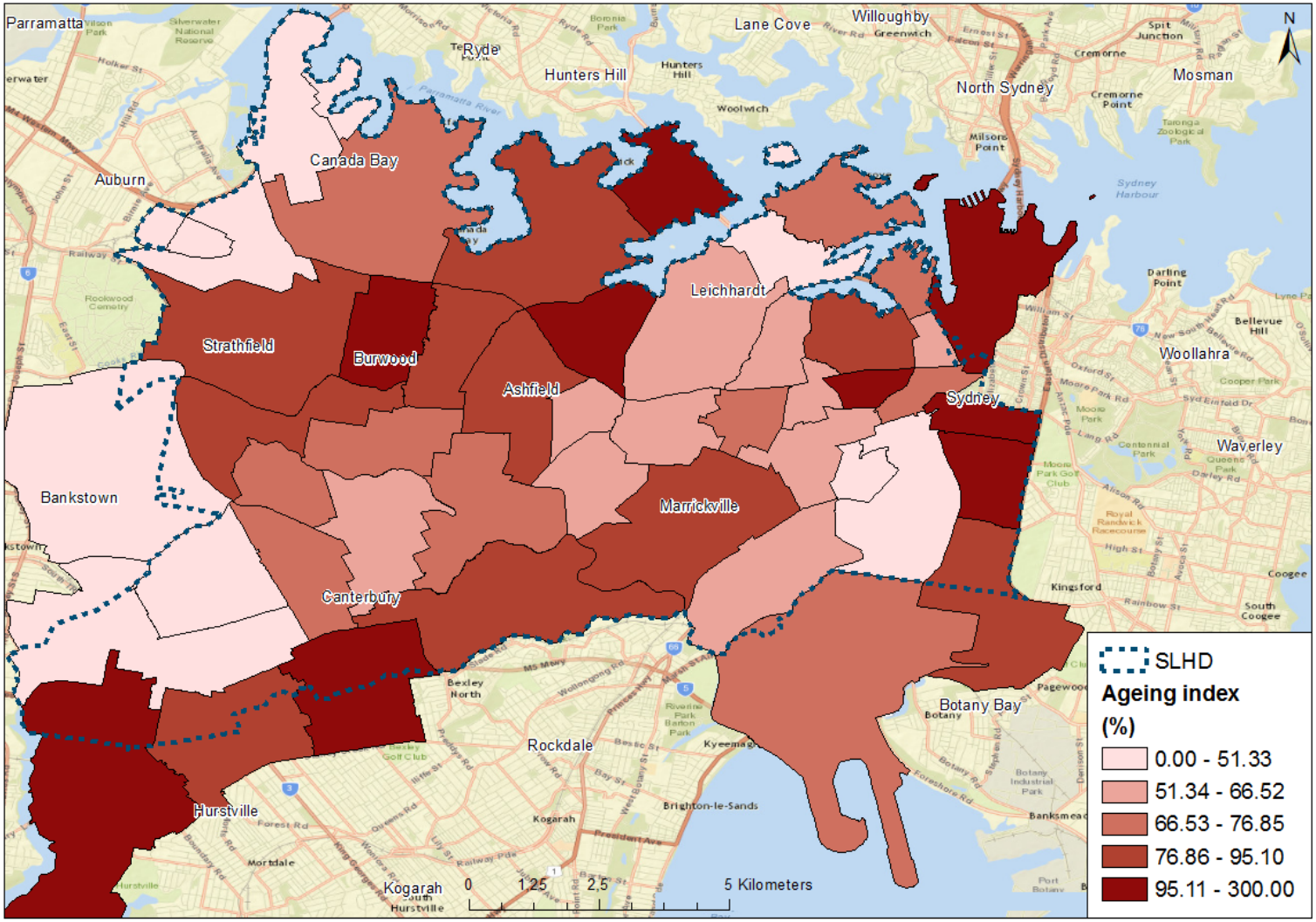


Figure 10. Dependency index

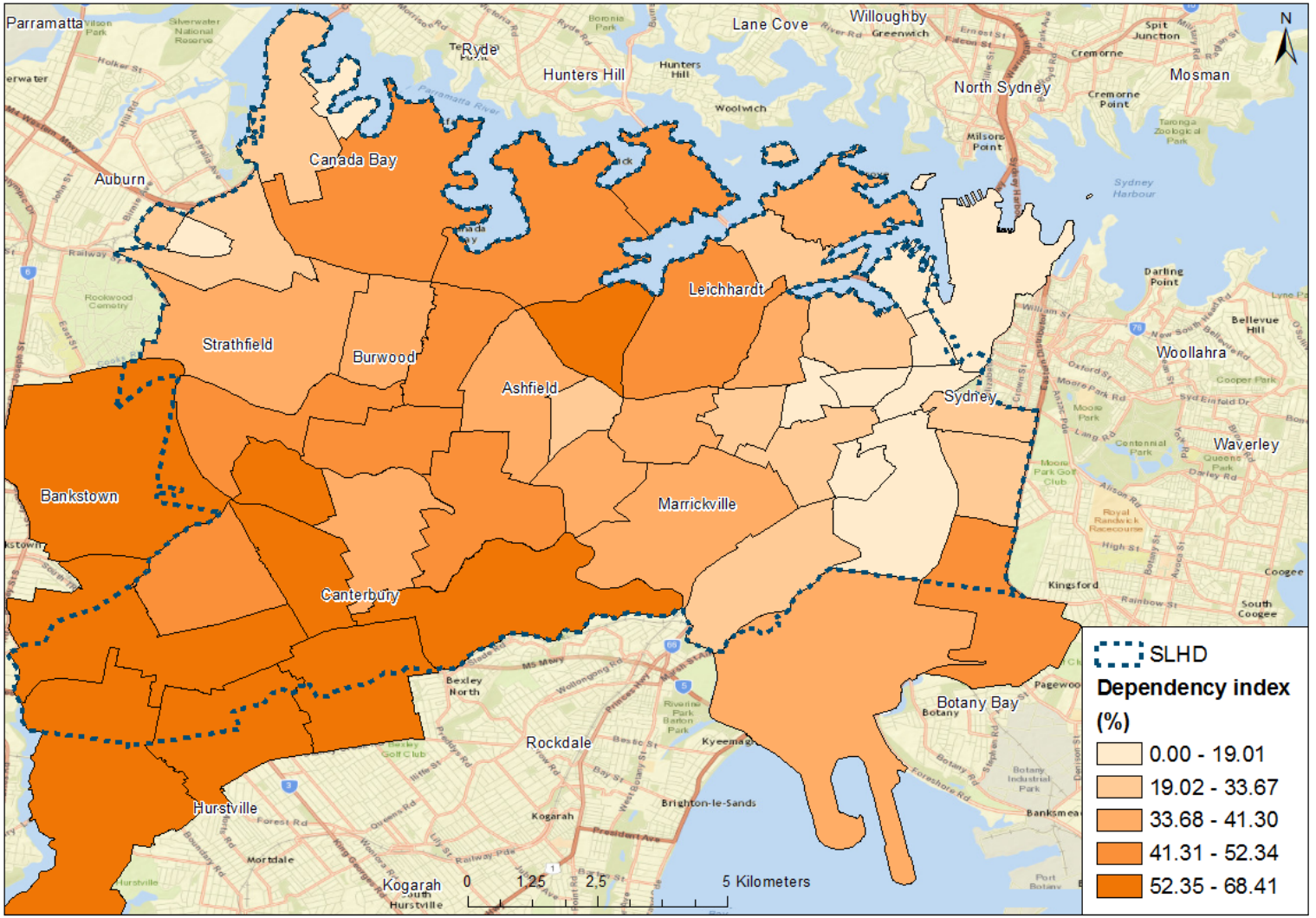


Table 1. Description of the socio and economic characteristics of the area (2011)

SLA	Ashfield	Burwood	Canada Bay Concord	Canada Bay Drummoyne	Canterbury	Leichhardt	Marrickville	Strathfield	Sydney South	Sydney West	Total LHD	NSW	Australia
Population (% of LHD)	41,213 (7.5)	32,424 (5.9)	39,203 (7.1)	36,560 (6.7)	137,453 (25.1)	52,198 (9.5)	76,502 (13.9)	35,187 (6.4)	56,614 (10.3)	41,278 (7.5)	548,632	6,917,656	21,507,719
Density index	4965.4	4566.8	3409.0	4404.8	4090.9	4971.2	4636.5	2531.4	5242.0	7241.8	4347.3	8.6	2.8
Women (%)	51.4	50.9	50.7	52.2	50.0	52.6	50.5	49.8	47.2	49.9	50.4	50.7	50.6
Ageing index	90.3	91.2	65.5	92.3	63.8	59.4	68.3	68.2	87.6	79.3	71.9	71.7	68.1
Dependency index	43.7	43.4	42.2	50.5	53.0	38.3	34.7	42.2	22.0	17.5	39.3	54.5	54.5
Unemployment rate (%)	6.1	6.8	5.0	3.6	8.2	4.0	5.3	6.4	5.3	6.6	5.9	5.9	5.6
Lone parent (%)	3.7	3.9	3.3	3.4	4.6	3.2	3.9	3.7	2.8	2.6	3.7	4.3	4.2
Living alone (%)	10.1	6.8	6.6	10.6	7.1	12.1	11.5	6.1	15.5	15.3	10.0	8.7	8.8
Not married or in a de facto relationship (%)	45.9	48.7	40.0	40.3	43.9	41.9	48.6	45.0	54.7	55.0	46.3	41.7	41.3
Needs assistance for core activities (%)	6.4	5.5	3.6	4.7	5.7	3.4	4.6	4.3	3.4	2.5	4.6	5.2	4.9
IRSD decile of disadvantage (1 = high; 10 = low)	6	5	9	9	2	9	7	7	6	7	-	-	-
Aboriginal and Torres Strait Islander peoples (%)	0.6	0.4	0.4	0.4	0.6	1.0	1.5	0.3	2.0	1.4	0.9	2.5	2.5
Overseas born (%)	50.7	58.3	48.6	34.9	55.3	34.7	41.7	60.2	49.5	55.4	49.2	27.3	26.0
Low English proficiency (%)	9.3	12.6	7.4	4.5	15.7	2.3	7.6	11.8	5.7	5.1	9.2	4.1	3.2
Year 12 of high school or equivalent completed (%)	63.6	64.2	64.1	60.7	53.4	70.7	64.2	67.1	68.7	72.4	63.3	47.6	47.6
Income<$600 wk (%)	48.6	56.4	44.8	38.8	60.8	31.9	41.3	52.2	37.3	41.3	46.8	52.4	51.4
Dwellings with no internet connection (%)*	17.1	17.6	14.3	14.3	23.7	12.1	15.8	14.6	12.6	12.6	-	20.1	19.7
Population with psychological distress (%)*	10.6	10.8	9.4	9.4	11.1	8.8	9.4	10.5	10.3	10.3	-	10.5	10.8

* *For those indicators, data were only available at the LGA level. LGA boundaries correspond to SLA boundaries for all SLAs, except for Sydney West and South, which are both part of the Sydney LGA, as well as for Canterbury Concord and Canterbury Drummoyne, which are both part of the Canterbury LGA. For those SLAs, the two indicators were therefore allocated the same value as the LGA in which they are included.*

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 SLHD was collected from the 1st of August, 2015 to the 23rd of February, 2016. We received seven on-line responses, complemented with 27 face-to-face or telephone interviews with mental health provider organisations.

We found a total of 94 BSICs (or teams), corresponding to 96 MTC for people with a lived experience of mental illness or psychosocial conditions. We did not include services where the primary presentation is not mental health, for example: alcohol and other drugs, intellectual disability or homelessness.

Regarding the distribution of services according to age group targeted, 86% of care provided is for adults, 4% for people transitioning to adulthood and 2% is for for people aged 65 years and over.

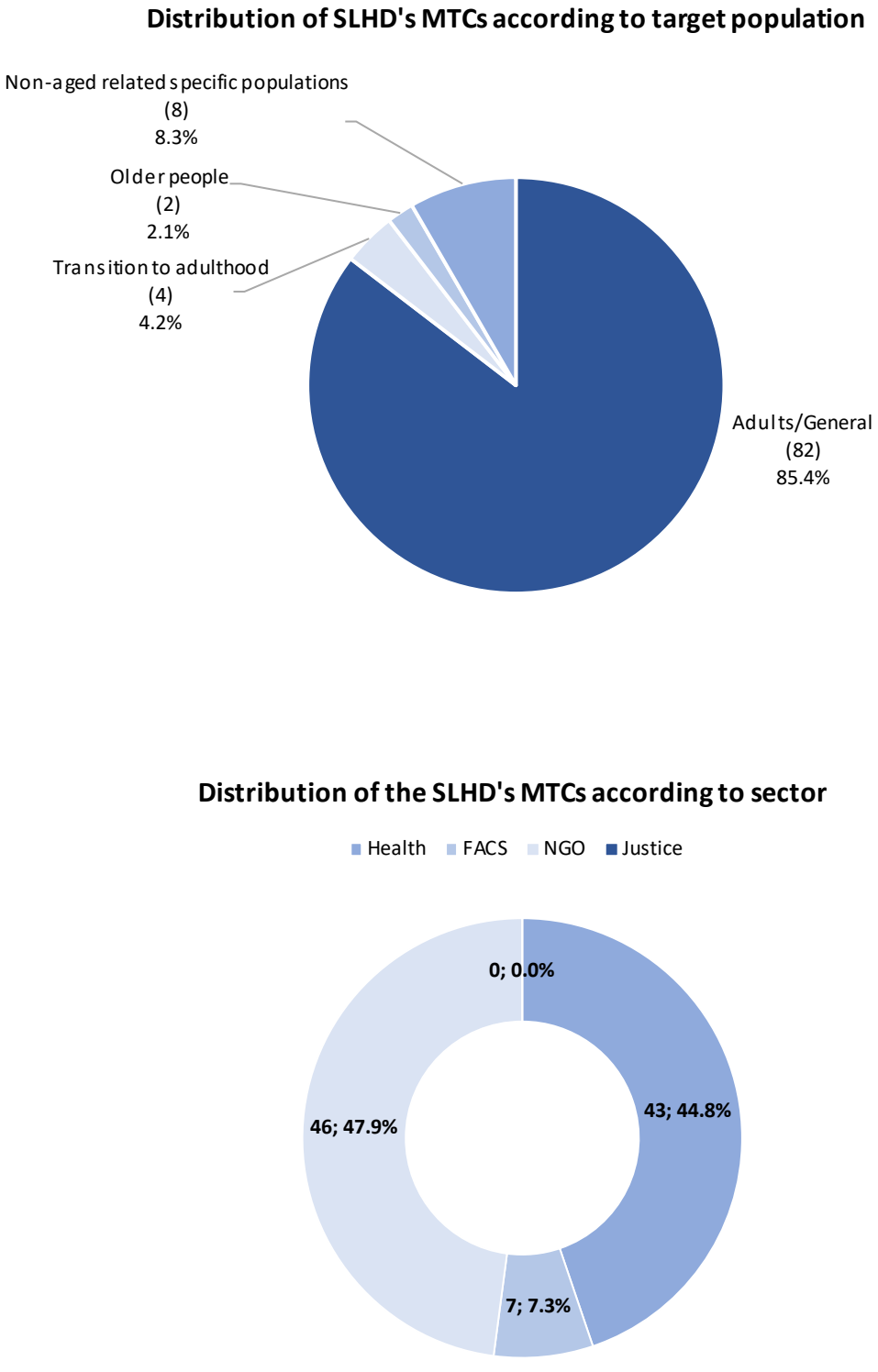
8% of the care provided was for non-age related specific populations, including carers of people with mental illness, Aboriginal and Torres Strait Islander peoples, and culturally and linguistically diverse (CALD) population. Five or fewer services were identified for each of these sub-populations.

44.8% of care for people with a lived experience of mental illness is provided by the public health sector, while 47.9% is provided by non-government organisations (NGOs), and 7.3% by FACS (Family and Community Services).

Regarding distribution by MTC, the services provided by the public health sector were mostly classified into outpatient (65.1%), and residential (32.6%), with only 2.3% providing day care. In the non-health sector (i.e. NGOs and FACS), outpatient care was also the most common (49.1%) followed by accessibility (18.9%) and self-help (13.2%). Residential care was much less developed than in the public health sector (7.5%).

A detailed description of the MTC identified is provided in the figures below.

Figure 11. Comparison of the MTC identified in SLHD and SESLHD according to target population, type of care and sector of care



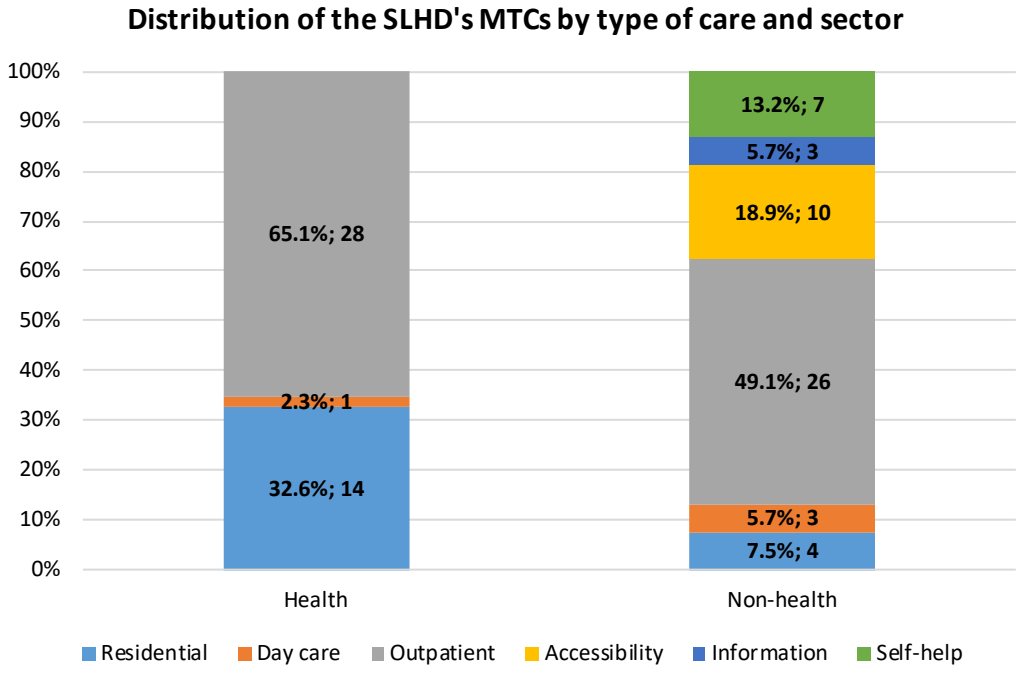

Distribution of the SLHD's MTCs by type of care and sector
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
65.1%; 28
2.3%; 1
32.6%; 14
13.2%; 7
5.7%; 3
18.9%; 10
49.1%; 26
5.7%; 3
7.5%; 4
Health
Non-health
Residential
Day care
Outpatient
Accessibility
Information
Self-help

Table 2. Description of the MTC per type of population and sector

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
RESIDENTIAL: Facilities that provide beds overnight for purposes related to the clinical and social management of their long term care																										
R1	Acute, 24 hours physician cover, hospital, high intensity	5	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	5
R2	Acute, 24 hours physician cover, hospital, medium intensity	6	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	6
R4	Non-acute, 24 hours physician cover, hospital, time limited	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
R6	Non-acute, 24 hours physician cover, hospital, indefinite stay	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
R9.2	Non-acute, non-24 physician cover, time limited, daily support, over 4 weeks	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
R11	Non-acute, non-24 physician cover, indefinite stay, 24 hours support	0	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3
R13	Non-acute, non-24 physician cover, indefinite stay, lower support	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
TOTAL R		**14**	**0**	**4**	**0**	**18**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**0**	**4**	**0**	**18**

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
DAY CARE: Facilities that involve contact between staff and users for some purpose related to management of their condition and its associated clinical and social dificulties																										
D2.1	Non-acute, work, high intensity, ordinary employment	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
D2.2	Non-acute, work, high intensity, other work	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
D4.1	Non-acute, non-work structured care, high intensity, health related care	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
TOTAL D		1	0	3	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	3	0	4

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
OUTPATIENT: Facilities that involve contact between staff and users for some purpose related to management of their condition and its associated clinical and social difficulties																										
O1.1	Acute, mobile, 24h, health related care	3	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	3
O3.1	Acute, non-mobile, 24h, health related care	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
O4.1	acute, non-mobile, time limited, health related care	3	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	3

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
O5.1.1	Non-Acute, Home & Mobile, High Intensity, 3 to 6 days a week care	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
O5.2	Non-Acute, Home & Mobile, High Intensity, other care	0	0	8	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	8
O6.1	Non-Acute, Home & Mobile, Medium Intensity	5	0	0	0	5	2	0	0	0	2	2	0	0	0	2	1	0	0	0	1	10	0	0	0	10
O6.2	Non-Acute, Home & Mobile, Medium Intensity, other care	0	0	4	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	4
O7.2	Non-Acute, Home & Mobile, low Intensity, other care	0	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	6
O8.1	Non-Acute, non-mobile, High intensity, health related care	4	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	4

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
O9.1	Non-Acute, non-mobile, Medium intensity , health related care	3	0	3	0	6	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	3	0	5	0	8
O9.2	Non-Acute, non-mobile, Medium intensity , other care	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	0	3	0	3
O10.1	Non-acute, non-mobile, low intensity, health related care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0	0	0	1
TOTAL O		**22**	**6**	**16**	**0**	**44**	**2**	**0**	**2**	**0**	**4**	**2**	**0**	**0**	**0**	**2**	**2**	**0**	**2**	**0**	**4**	**28**	**6**	**20**	**0**	**54**

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
ACCESSIBILITY: Facilities which main iam is to provide accesibility aids for users wiwth long term care needs																										
A4	Case Coordination	0	0	5	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	5
A5.3	Other accessibility care: health related: social and cultural services	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
A5.4	Other accessibility care: health related: work related	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
A5.5	Other accessibility care: health related: housing related	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
TOTAL A		**0**	**1**	**9**	**0**	**10**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**9**	**0**	**10**
INFORMATION AND GUIDANCE: Facilities which main aim is to provide users with information and or assessment of their needs. This service does not entail subsequent follow-up or direct care provision																										
I2.1.1	Information, interactive, face to face	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
I2.1.2	Information, interactive, other	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
I2.2	Information, non interactive	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
TOTAL I		**0**	**0**	**3**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**3**
VOLUNTARY CARE: Facilities which main aim is to provide users with long term care needs with support, self-help or contact with un-pain staff that offers accessibility, information, day, outpatient and residential care (as described avobe), but the staff is non-paid																										
S1.2	Volunteers providing access (personal accompaniment)	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
S1.3	Non-professional staff outpatient care	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	4	0	4	0	0	6	0	6
TOTAL S		**0**	**0**	**3**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**	**4**	**0**	**0**	**7**	**0**	**7**
TOTAL		**37**	**7**	**38**	**0**	**82**	**2**	**0**	**2**	**0**	**4**	**2**	**0**	**0**	**0**	**2**	**2**	**0**	**6**	**0**	**8**	**43**	**7**	**46**	**0**	**96**

*Note: Not funded for mapping child and adolescent services in SLHD so excluded here.

3.2 ADULTS

In this section, we describe the availability and placement capacity of the BSIC/services providing care for adults (> 17 years old) with a lived experience of mental illness, by type of care, and by sector. Specific care services related to transition from adolescence to adulthood, for older people with a lived experience of mental illness, as well as for non-age related specific services (e.g. services for carers and Aboriginal and Torres Strait Islander peoples) are described in a separate section.

3.2.1 RESIDENTIAL CARE

3.2.1.1 RESIDENTIAL CARE PROVIDED BY THE PUBLIC SECTOR

ACUTE INPATIENT SERVICES

A total of 11 BSIC/services were identified which provide acute inpatient care in the SLHD. Two of these BSIC are specifically for people with eating disorders. Five of the remaining nine MTC are considered high intensity units (code R1), while the other four MTCs are medium intensity (R2).

The Manning acute unit specialises in caring for people with a first episode of mental illness, while Norton is for people with recurrent and more established illnesses. The short stay unit at the Marie Bashir centre also admits people with substance abuse/dependence related conditions, suffering an acute episode, for 72 hours.

The number of acute beds from the public health sector per 100,000 residents, excluding the 26 specialised beds for people with eating disorders, is 132, or 29.41 per 100,000 residents. The number of BSICs from the public health sector providing acute care per is 9, or 2.01 per 100,000 (excluding the two specific services for people with eating disorders).

Table 3. Acute inpatient services: availability and placement capacity

Provider	Name	Main DESDE Code	Beds/Places	Town / Suburb	Area of Coverage
SLHD Mental Health Service	Female High Dependency unit-CCMH	AX[F00-F99]-R1	12	Concord	IWS
SLHD Mental Health Service	Female High Dependency unit-MB	AX[F00-F99]-R1	8	Camperdown	IWS
SLHD Mental Health Service	Intensive Psychiatric Unit-CCMH	AX[F00-F99]-R1	10	Concord	IWS
SLHD Mental Health Service	Jara unit-CCMH	AX[F00-F99]-R2	30	Concord	IWS
SLHD Mental Health Service	Male High Dependency unit-CCMH	AX[F00-F99]-R1	10	Concord	IWS

SLHD Mental Health Service	Male High Dependency unit-MB	AX[F00-F99]-R1	8	Camperdown	IWS
SLHD Mental Health Service	Manning Acute Unit	AX[F00-F99]-R2	24	Concord	IWS
SLHD Mental Health Service	Norton Acute Unit	AX[F00-F99]-R2	24	Concord	IWS
SLHD Mental Health Service	Short-stay unit MB	AX[F00-F99]-R2	6	Camperdown	IWS
Total	9		132		
Rate per 100,000 residents (>17 years old)	2.01		29.41		
SLHD Mental Health Service	Acute Unit - Eating Disorders	AX[F50]-R2	6	Camperdown	State
SLHD Mental Health Service	Acute Unit-MB	AX[F50]-R2	20	Camperdown	IWS
Total	2		26		
Rate per 100,000 residents (>17 years old)	0.45		5.79		

The next table shows the workforce capacity related to adult acute inpatient services in the area covered by the SLHD. The total number of FTEs in adult acute inpatient services is 246.7, or 54.96 per 100,000 residents, excluding units for people with eating disorders. Psychiatrists and mental health nurses, as expected, account for the greater percentage of the workforce. In addition, the Female High Dependency Unit at CCMH, the Manning Acute Unit (CCMH), the Norton Acute Unit (CCMH) and Jara (CCMH), share the following professionals with the subacute units at the CCMH: 0.68 dietitian, 0.23 speech pathologist, 0.38 physiotherapist and 0.63 music therapist. In the Marie Bashir Centre, the Male and Female High Dependency Unit share 0.97 welfare officer.

Table 4. Acute inpatient unit: workforce capacity

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT	Others
SLHD Mental Health Service	Female High Dependency unit-CCMH	23.6	2.9	0.6	18.6	1.0	0.5	
SLHD Mental Health Service	Female High Dependency unit-MB	25.8	2.5	0.3	20.2	1.3	1.0	0.5
SLHD Mental Health Service	Intensive Psychiatric Unit-CCMH	20.7	1.6		18.2	0.5	0.4	
SLHD Mental Health Service	Jara unit-CCMH	37.3	6.5	1.0	27.0	1.8	1.0	
SLHD Mental Health Service	Male High Dependency unit-CCMH	20.7	1.6		18.2	0.5	0.4	
SLHD Mental Health Service	Male High Dependency unit-MB	25.8	2.5	0.3	20.2	1.3	1.0	0.5
SLHD Mental Health Service	Manning Acute Unit	34.8	4.9	0.7	24.3	3.0	2.0	
SLHD Mental Health Service	Norton Acute Unit	37.9	4.8	0.6	28.5	2.0	2.0	
SLHD Mental Health Service	Short-stay unit MB	20.0	1.6		17.9	0.5		
Total		246.7						
Rate per 100,000 residents (>17 years old)		54.96						
SLHD Mental Health Service	Acute Unit - Eating Disorders	21.0	1.3	1.4	17.5		0.8	
SLHD Mental Health Service	Acute Unit-MB	40.4	4.6		32.4	2.4	1.0	
Total		61.4						
Rate per 100,000 residents (>17 years old)		13.68						

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

NON-ACUTE INPATIENT AND RESIDENTIAL SERVICES

A total of 3 BSIC providing non-acute inpatient and residential care in the SLHD were identified. Kirkbride provides non-acute care time limited (up to three months), and is located at CCMH. Broughton is also located at CCMH, and provides more long term care (12 months or more-no time limit) for people with a lived experience of mental illness. The 35 beds are distributed as follows: 5 forensic beds (for people with mental illness waiting for trial); 9 disability beds (for people who experience chronic and long term mental illness); and 21 rehabilitation beds, to ease the transition from the hospital to the community. The Broughton Unit is currently being transformed into a rehabilitation unit.

Mental Health Services in the SLHD, in partnership with Schizophrenia Fellowship, provide a community-based respite service (Eurella, also known as Burwood Respite Facility) for people who are diagnosed with a mental illness. This provides individualised care plans to assist consumers to achieve their planned goals.

Table 5. Non-acute inpatient services: availability and placement capacity

Provider	Name	Main DESDE Code	Beds/Places	Town / Suburb	Area of Coverage
SLHD + Schizophrenia Fellowship	Respite-Eurella	AX[F00-F99]-R9.2	9	Burwood	IWS
SLHD Mental Health Service	Broughton unit CCMH	AX[F00-F99]-R6	35	Concord	IWS
SLHD Mental Health Service	Kirkbride unit CCMH	AX[F00-F99]-R4	15	Concord	IWS
Total	3		59		
Rate per 100,000 residents (>17 years old)	0.67		13.14		

The number of non-acute beds provided by the public health sector per 100,000 residents is 59, or 13.14 per 100,000 residents: 11.14 in the hospital setting, and 2.01 in the community. The number of services from the public health sector providing non-acute care is 3, or 0.67 per 100,000 residents.

The table below describes the workforce capacity providing non-acute inpatient care in the SLHD. As was the case of acute care, mental health nurses and psychiatrists are the largest group of professionals. As commented above, Kirkbride and Broughton share several professionals with some of the acute units at the CCMH. Eurella is staffed with 2 FTE (mental health nurses) who

work during business hours from Monday to Friday, providing some support to the residents. The total number of FTEs for non-acute inpatient services is 56.2, or 12.52 per 10,000 residents.

Table 6. Non- acute inpatient services: workforce capacity

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT	MHW	Edu
SLHD + Schizophrenia Fellowship	Respite-Eurella	2.0						2.0	
SLHD Mental Health Service	Broughton unit CCMH	31.7	2.8	0.7	24.0	2.2	2.0		
SLHD Mental Health Service	Kirkbride unit CCMH	22.5	1.6	0.4	17.5	2.0	1.0		
Total		56.2							
Rate per 100,000 residents (>17 years old)		12.52							

FTE: Full Time Equivalents; Psych/reg: Psychiatrists-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist; MHW: mental health workers; Edu: Educator.

OTHER RESIDENTIAL CARE

We have not identified any supported accommodation residential services in the community provided by the public sector. This was also the case in South Western Sydney, although not in Western Sydney. See FACS below for services from the public sector which provide care in the home without owning the housing stock.

CARE PROVIDED BY FAMILY AND COMMUNITY SERVICES (FACS)-SOCIAL AND COMMUNITY HOUSING IN THE HOME

Family and Community Services (FACS) provides services related to:

- Aboriginal and Torres Strait Islander peoples,
- Children and young people,
- Families,
- People who are in need of housing,
- People with a disability, their families and carers,
- Women, and
- Older People.

FACS aims to improve the lives of vulnerable people, and to support their participation in social and economic life. People with a lived experience of mental illness use the services provided by FACS, but are not specifically the target group. As FACS services are generic (i.e. they are not specific to persons experiencing mental illness), concerns have been raised about the appropriateness of including FACS in the Mental Health Atlas, as the picture could be biased by the implication that there are significantly more services targeting people with a lived experience of mental illness than actually exist. On the other hand, people with a lived experience of mental illness are one of the main client groups in some of these areas, such as public housing. Thus, excluding some of these services also distorts the picture.

The fact remains that there is no specific BSIC (service or team) in FACS specialising in care for people with a lived experience of mental illness. This contrasts significantly with other countries, where equivalents to FACS include a specific division related to mental health. In spite of this, we think that it is important to mention services for the general population which relate to public housing and child protection.

We have excluded from this analysis services providing care for people with intellectual disabilities.

SOCIAL HOUSING

According to the last report published by FACS NSW (15), as of the 30th of June 2013, there were a total of 110,059 households living in public housing: 25,973 in community housing and 4,469 in Aboriginal Housing. FACS manages 149,972 properties in all NSW, comprising 117,798 public housing dwellings: 27,450 properties in the community housing sector, and 4,724 Aboriginal Housing properties.

We have identified three main obstacles for evidence informed local planning regarding mental health care in social housing in NSW, which could also be applied to SLHD: 1) it is not possible to know how many of the properties are specifically devoted to people with a lived experience of mental illness; 2) it is not possible to know how many people with a lived experience of mental illness were using the properties (data on mental health status is not collected); and 3) properties are not restricted to specified districts (i.e. a person living in Redfern may be relocated in Campbelltown if there is a property available there). These obstacles are compounded if the person with a lived experience additionally has a dual diagnosis, or high complexity.

An additional challenge is that public housing may or may not include direct support. People with a lived experience of mental illness who need support at home receive this type of care through the Housing and Accommodation Support Initiative (HASI). HASI is a partnership between NSW Health, Housing NSW, and an array of non-government organisations (NGOs) which provide people with a lived experience of mental illness with access to stable housing, linked to clinical and psychosocial rehabilitation services. HASI can be delivered at an individual's privately owned or rented property, or through social housing. Consequently, it could be argued that the way housing for people with mental illnesses is provided is more accurately conceptualised as a financing mechanism, than a service providing care.

In spite of the above limitations, we coded the FACS services which could be related to mental health care. We found 7 BSIC/services delivered by FACS providing direct care related to housing. Although this care is not specifically for people with a lived experience of mental illness, most of their consumers would fit into this category. 6 out of the 7 services provide tenancy support, that is, non-acute, mobile, outpatient care of low intensity (contact with the client is lower than once a month,) and are therefore are coded as "Outpatient" care (O) in the DESDE-LTC system. One of the services is composed of specialists providing tenancy support to more complex consumers, and covers the entire district. The other BSIC is focused on helping clients to access social housing (through assessment and eligibility), and is coded as "Accessibility" ("A").

It is important to recognize that although these BSIC/services mainly provide care for people within the boundaries of the SLHD, they also provide support to people from throughout the state, if needed.

The total number of BSIC/services from the FACS providing tenancy support (non-acute, mobile, outpatient care, low intensity) in the SLHD is 6, or 1.34 per 100,000 residents. The total number of FTEs support workers providing this type of care is 58, with a rate of 12.92 per 100,000 residents.

The number of BSIC/services from the FACS providing assessment and eligibility care (accessibility to social housing) in the SLHD is 1, or 0.22 per 100,000 residents, with 17 support workers or a rate of 3.79 support workers per 100,000 residents. However, as we have already said, this is not a specific service for people with a lived experience of mental illness.

Table 7. BSICs related to public housing: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
FACS	Balmain/Leichhardt/Marrickville Tenancy Team*	AX[Z55-65]-O7.2	10.0	Ashfield	Balmain, Leichhardt, Marrickville
FACS	Burwood/Glebe Tenancy Team*	AX[Z55-65]-O7.2	10.0	Burwood	Burwood, Glebe
FACS	Redfern Tenancy Team*	AX[Z55-65]-O7.2	10.0	Redfern	Redfern
FACS	Riverwood/Canterbury Tenancy Team*	AX[Z55-65]-O7.2	10.0	Riverwood	Riverwood, Canterbury
FACS	Specialists across the district*	AX[Z55-65]-O7.2	8.0	Ashfield	IWS
FACS	Waterloo Tenancy Team*	AX[Z55-65]-O7.2	10.0	Waterloo	Waterloo

Total	6		58		
Rate per 100,000 residents (>17 years old)	1.34		12.92		
FACS	Sydney District Access & Demand Team*	AX[Z55-65]-A5.5	17.0	Ashfield	IWS
Total	1		17		
Rate per 100,000 residents (>17 years old)	0.22		3.79		

FTE: Full Time Equivalents

**Please note FACS BSICs are also coded in the relevant Outpatient and Accessibility sections*

The same limitations which were discussed in the FACS section also apply to community housing: organisations such as St George Community Housing (which gives particular priority to Aboriginal and Torres Strait Islander peoples), Hume Housing, and Argyle only provide the property, while the psychosocial support is provided by other NGOs. So, this type of service is a "financial mechanism" (help to access housing), rather than a service providing direct support for people with mental illness, so it should be included in a map of the financing flows, rather than in the map of service provision. As mentioned above in the discussion on FACS, although the property is located in the SLHD, it is utilised by the whole state. It is difficult to know how many of these properties are devoted to people with a lived experience of mental illness, as they are accessible to all vulnerable groups in the general population. Despite this, it is possible to estimate how many residents in the properties are participating in the HASI program, or similar, targeting people with a lived experience of mental illness.

We have contacted the following community housing providers:

- St George Community Housing
- Bridge Housing
- Metro Housing
- Women Community Housing
- Hume Community Housing Association
- Argyle
- B-Miles Women´s Foundation
- Ecclesia Housing

Only St George Community Housing (SGCH) has properties devoted to the HASI program. At the time of the interview (October 2015), SGCH had a total of 10 properties in the area of IWS (one in Burwood, 2two in Canterbury, six in Ashfield and one in Strathfield).

In spite of this, both Metro and B-Miles manage properties that are specific for people with a lived experience of mental illness.

Metro Housing is a generic specialist housing provider, with a particular focus on psychosocial disabilities. It primarily covers the area of IWS. It has 12 transitional properties managed in partnership with the LHD, and another additional 20 transitional properties in partnership with Aftercare.

B Miles is a specific service for women with a lived experience of mental illness who are at risk of being, or already are, homeless. B Miles' primary objectives are to resolve and prevent homelessness by providing flexible service delivery comprised of: a) Crisis accommodation; b) Transitional housing; and c) Outreach support. Although they are located in the area covered by St Vincent's Hospital (SESLHD), it is worth noting that they have four transitional houses for women with a lived experience of mental illness in the area of IWS (one in Petersham, one in Camperdown, one in Ashfield, and one in Marrickville). They also provide low intensity support to the women living in these properties, if needed.

The other housing services providers contacted did not have any specific programs for people with a lived experience of mental illness living in the SLHD. However, most of them recognise that a high percentage of their consumers have a psychosocial disability.

3.2.1.2 RESIDENTIAL CARE PROVIDED BY NGOS

A number of NGOs provide in-home support for people with disabilities in the CESPHN. Unfortunately, the DESDE-LTC codification of these services has similar problems to those identified in social and community housing. A number of services provide accommodation and support, while others are reliant on community housing organisations to provide the accommodation, and provide in-home support separately. In addition, some services are not specifically designated for people with a lived experience of mental illness (although people with a lived experience of mental illness are often their main consumers). Representatives from several public agencies and NGOs within the CESPHN met to discuss how best to code NGO funded, in-home support services. The following agreement was made:

1) Services which provide both accommodation and individual support to people with a lived experience of mental illness would be coded as residential care.
2) Services which provide in-home support to public or community housing residents with a lived experience of mental illness would be coded as outpatient care.

One NGO funded BSIC was identified as providing non-acute residential care to people with a lived experience of mental illness in the CESPHN. This service, Casa Venegas, is managed by St John of God and provides 43 beds, spread across 16 sites in Sydney's Inner West and West (3 within the SLHD, in Belfield, Burwood and Concord). Casa Venegas has a mix of houses and bedsit accommodation, some of which are privately leased, some which are owned by the

Department of Housing, and one which is managed by Metro Housing. The service has been coded as a single BSIC with a number of satellites representing the different accommodation sites. Approximately 71% of the population serviced by Casa Venegas have a diagnosis of schizophrenia, and a further 15% have a diagnosis of schizo affective disorder. Casa Venegas provides both high and low supported accommodation which is non-time limited. The low support accommodation service has a goal of assisting consumers to transition to community housing.

Residents of Casa Venegas' high support accommodation receive daily assistance (Monday to Friday) and have 24 hour on-call support (non-medical) during the week. Residents within the high support accommodation pay rent, which includes an additional fee for utilities and a shopping service. Residents of the lower level supported accommodation receive support one to two times a week, pay a subsidised rent, and are required to pay their own utility bills.

Table 8. Residential care provided by NGOs: availability, capacity and workforce capacity

Provider	Name	Main DESDE Code	Other DESDE code(s)	Beds/Places	FTE	Town / Suburb	Area of Coverage
St John of God	Casa Venegas	AX[F00-F99]-R11		4	8.4	Burwood	IWS
St John of God	Casa Venegas (satellite)	AX[F00-F99]-R11t		3	NA	Concord	IWS
St John of God	Casa Venegas (satellite)	AX[F00-F99]-R11t	AX[F00-F99]-R13t	4 4	NA	Belfield	IWS
Total	3			15	8.4		
Rate per 100,000 residents (>17 years old)	0.27			1.37	0.77		

FTE: Full-Time Equivalents

Seven services were identified within the CESPHN providing in-home support to people with a lived experience of mental illness. These services are described below but coded in the outpatient mobile service section. These services include:

- Ashfield Biala: This service is run by Aftercare and provides supported residential accommodation for adults aged between 18 and 40 who are recovering from a serious episode of mental illness. The service is a transitional service which operates five days a week, and clients of the service can stay for up to two years. The service can accommodate up to 24 clients (21 beds within the CESPHN and three located in North Parramatta). The housing is provided through the Metro Community Housing Co-op.

- Camperdown Units Program: provides 12 units for people diagnosed with a mental illness. Care for these units is provided by the Community Mental Health Service Team.
- Sydney Residential Outreach Team: This service is run by RichmondPRA (now known as flourish) and provides 32 packages of outpatient care for people with severe mental illness. The intensity of support ranges from low (one to two visits per week) to high (two to three visits per day up to a total of up to 10 hours per week).

There are also Assisted Boarding Houses providing approximately 152 beds across the CESPHN. These beds have not been coded in the CESPHN atlas, as they are not specifically designated for people with a lived experience of mental illness.

The Camperdown project, also known as Common Ground, provides housing for people who have been homeless for a long period. It also provides tailored support to assist consumers make the transition into permanent accommodation. This service is specifically for people who are experiencing homelessness, and does not provide clinical care for people with a mental illness.

The Independent Community Living Australia Limited (ICLA) also leases accommodation in the Inner West and Eastern areas of Sydney from various community housing providers. Funding for ICLA is provided by Ageing, Disability and Home Care (ADHC) and NSW Health. ICLA provides long term secure and affordable supported accommodation for people with a lived experience of mental illness and for people with other mental disability (for example, intellectual disability). Unfortunately data from this service was not available by the time of completion of data collection.

The Atlas mapping process has highlighted that there are limited residential care services available for people with a lived experience of mental illness in the CESPHN. The SLHD has been working towards addressing this need, and has developed a strategic residential care plan. This plan proposed that the respite beds (see Eurella) will convert to a 24 hour residential support program offering step up, step down care. Additional NGO services are also proposed for the Camperdown Units Program, to provide 24 hour supervision and support.

3.2.2 DAY CARE

3.2.2.1 DAY CARE PROVIDED BY THE PUBLIC SECTOR

We have only identified 1 BSIC (service) providing day care in the public health sector. This service is specifically for people with an eating disorder diagnosis. It is located at the Marie Bashir Centre and provides care to the whole State.

Table 9. Day care provided by the public health sector: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
SLHD Mental Health Service	Day Program-Eating Disorders	AX[F50]-D4.1	Camperdown	State
Total	1			
Rate per 100,000 residents (>17 years old)	0.22			

The day program for people with eating disorders is staffed with a multidisciplinary team of professionals, including psychiatrists, psychologists, mental health nurses, occupational therapists, and dietitians. Psychologists and dietitians are the largest group in this service.

The number of day care services provided by the public health sector is 1, or 0.22 per 100,000 residents. The workforce capacity is 3.4 FTEs, or 0.76 per 100,000 residents.

Table 10. Day care provided by the public health sector: workforce capacity

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	OT	Edu	Others
SLHD Mental Health Service	Day Program-Eating Disorders	3.4	0.1	1.0	0.3	0.5		1.4
Total		3.4						
Rate per 100,000 residents (>17 years old)		0.76						

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registar; Psychol: Psychologist; MHN: Mental health nurse; OT: Occupational therapist; Edu: Educator

3.2.2.2 DAY CARE PROVIDED BY NGOS

SOCIAL AND CULTURAL ACTIVITY RELATED DAY CARE/PROGRAMS

We have not identified any day care service providing social and/or cultural activities specifically for people with a lived experience of mental illness, within the boundaries of the SLHD. St Vincent de Paul Society manage a Men's Shed (St Mary MacKillop) which welcomes people with a lived experience of mental illness, but it is not specifically a mental health related service.

However, there are a number of services located within St Vincent's Hospital area (SESLHD) that are also open to residents of the Inner West. These services are:

- Lou's Place (The Marmalade Foundation): although the service is for women who are homeless or at risk, it has a particular focus on psychosocial disabilities.
- Buckingham House (RichmondPRA), is located within the SESLHD, but is open to residents of the whole CESPHN. Two different programs operate from Buckingham House: the Community Based Activity Program (CBA) targeting people with psychosocial disabilities living in boarding houses, and the Day to Day Living Program (D2DL), targeting people with a lived experience of mental illness living within independent, inpatient or supported accommodation in the CESPHN. Transport services operate from the Prince of Wales, Royal Prince Alfred and Concord Hospital's mental health inpatient units to enable consumers to attend the D2DL program at Buckingham House. Transport services also collect consumers from Independent Community Living Accommodation (Bondi) and other community organisations. The Buckingham House D2DL program has 76 designated places; however there are more than 150 people registered as attendees. People can drop in to this service without any obligation to maintain regular contact. The program offers a series of structured activities which range from cooking to painting classes to relaxation and programs to quit smoking. The service also organises social and leisure activities (e.g. cinema, barbecues or bowling). Some of these activities may include a small fee.

  The CBA team at Buckingham House provides transport for consumers from boarding houses to the day program. The program has a combination of individual sessions and group sessions. The main objective is to avoid social isolation and to promote physical and social activities. Sometimes consumers share program activities with the D2DL participants.

WORK-RELATED DAY CARE/PROGRAMS

There are 3 BSIC (or services) providing work-related day care for people experiencing mental illness within the boundaries of the SLHD. Although these BSIC are located in the area of the SLHD, their consumers may come from across Greater Sydney.

In 2 of these facilities (Prestige Packing and Scanning and Document Destruction) employees are paid at least 50% of the minimum wage for this form of work. In the other BSIC (Courier and Warehousing) people are paid at least the official minimum wage, and the organisation follows standard work regulations in the open market.

Table 11. Work-related day care provided by NGOs: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
RichmondPRA	Prestige Packing	AX[F00-F99]-D2.2	3.0	Marrickville	IWS
RichmondPRA	Social Enterprise: Courier and warehousing	AX[F00-F99]-D2.1	3.5	Marrickville	IWS
RichmondPRA	Social Enterprise: Scanning and Document Destruction	AX[F00-F99]-D2.2	0.5	Marrickville	IWS
Total	3		7		
Rate per 100,000 residents (>17 years old)	0.67		1.56		

The total number of BSIC/MTC (or services) from the NGO sector providing work-related day care within the boundaries of the SLHD is 3, or 0.67 per 100,000 residents.
The number of full time equivalents is 7, or 1.56 per 100,000 residents.

3.2.3 OUTPATIENT CARE

3.2.3.1 OUTPATIENT CARE PROVIDED BY THE PUBLIC HEALTH SECTOR

ACUTE MOBILE OUTPATIENT CARE

We identified 3 BSIC/services providing acute mobile outpatient care for adults with a lived experience of mental illness. They provide care 24 hours a day. Staff are on duty for 14 hours, and from 22:30 to 08:30 are available on-call.

The total number of BSIC/services from the public health sector providing acute mobile outpatient care within the boundaries of the SLHD is 3, or 0.67 per 100,000 residents.

Table 12. Acute mobile outpatient care provided by the public health sector: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
SLHD Mental Health Service	Acute Care Service - Camperdown	AX[F00-F99]-O1.1	Camperdown	Camperdown, Redfern, Marrickville

SLHD Mental Health Service	Acute Care Service - Canterbury	AX[F00-F99]-O1.1	Campsie	IWS
SLHD Mental Health Service	Acute Care Service-Croydon	AX[F00-F99]-O1.1	Croydon	IWS
Total	3			
Rate per 100,000 residents (>17 years old)	0.67			

There are a total of 40.8 FTEs of professionals providing acute and mobile care, or 9.09 per 100,000 residents within the boundaries of the SLHD. Mental health nurses are the largest group of professionals employed.

Table 13. Acute mobile outpatient care provided by the public health sector: workforce capacity

Provider	Name	Total FTE	Psych/reg	MHN	SW
SLHD Mental Health Service	Acute Care Service - Camperdown	20.2	2.0	15.7	2.5
SLHD Mental Health Service	Acute Care Service - Canterbury	11.0	2.0	8.0	1.0
SLHD Mental Health Service	Acute Care Service-Croydon	9.6	1.2	7.4	1.0
Total		40.8			
Rate per 100,000 residents (>17 years old)		9.09			

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-register; Psycho: Psychologist; MHN: Mental health nurse; SW: Social worker.

ACUTE NON-MOBILE OUTPATIENT CARE

We identified 5 non mobile acute care BSICs (services).

The services are located in the CCMH, the Marie Bashir Centre, and in Emergency Departments. The Psychiatric Admission Unit at the CCMH and the Assessment Unit at the Marie Bashir Centre provide 24 hour coverage. The emergency department nursing team at the Emergency Department operates during business hours.

The number of MTC from the public health sector providing acute non-mobile outpatient care is 5, or 1.11 per 100,000 residents.

Table 14. Acute non-mobile outpatient care provided by the public health sector: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
SLHD Mental Health Service	Assessment Unit- MB	AX[F00-F99]-O3.1	Camperdown	IWS
SLHD Mental Health Service	Emergency Department Nursing team Canterbury	AX[F00-F99]-O4.1	Campsie	IWS
SLHD Mental Health Service	Emergency Department Nursing team Concord	AX[F00-F99]-O4.1	Concord	IWS
SLHD Mental Health Service	Emergency Department Nursing team RPAH	AX[F00-F99]-O4.1	Camperdown	IWS
SLHD Mental Health Service	Psychiatric Admission Unit-CCMH	AX[F00-F99]-O3.1	Concord	IWS
Total	5			
Rate per 100,000 residents (>17 years old)	1.11			

The table below shows the workforce providing acute-non mobile care within the boundaries of the SLHD. As with the mobile team, mental health nurses comprise the largest group of professionals. The total number of FTEs of professionals providing acute non-mobile outpatient care in the public health sector is 17.6, or 3.92 per 100,000 residents in the SLHD.

Table 15. Acute non-mobile outpatient care provided by the public health sector: workforce capacity

Provider	Name	Total FTE	Psychol	MHN
SLHD Mental Health Service	Assessment Unit- MB	6.7	0.7	6.0
SLHD Mental Health Service	Emergency Department Nursing team Canterbury	0.5		0.5
SLHD Mental Health Service	Emergency Department Nursing team Concord	0.5		0.5
SLHD Mental Health Service	Emergency Department Nursing team RPAH	3.9		3.9

Provider	Name	Total FTE	Psychol	MHN
SLHD Mental Health Service	Psychiatric Admission Unit-CCMH	6.0		6.0
Total		17.6		
Rate per 100,000 residents (>17 years old)		3.92		

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

NON ACUTE MOBILE OUTPATIENT CARE

We have identified 5 community mental health teams providing outpatient care. There is a medium level of frequency of contact with consumers (at least fortnightly). These teams provide the core care, around which specialist services operate (i.e. early intervention, assertive outreach team, inpatient services, etc.). The other 2 BSICs are specialist services providing high intensity care (i.e. mobile assessment and treatment team and Assertive Outreach Team).

The number of services from the public health sector providing non-acute mobile outpatient care is 7, or 1.56 per 100,000 residents.

Table 16. Non-acute mobile outpatient care provided by the public health sector: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
SLHD Mental Health Service	Assertive Outreach Team- Croydon	AX[F00-F99]-O5.1.1	Croydon	IWS
SLHD Mental Health Service	Community mental health service- Camperdown	AX[F00-F99]-O6.1	Camperdown	IWS
SLHD Mental Health Service	Community mental health service- Canterbury	AX[F00-F99]-O6.1	Campsie	IWS
SLHD Mental Health Service	Community mental health service- Croydon	AX[F00-F99]-O6.1	Croydon	IWS
SLHD Mental Health Service	Community mental health service- Marrickville	AX[F00-F99]-O6.1	Marrickville	IWS
SLHD Mental Health Service	Community mental health service- Redfern	AX[F00-F99]-O6.1	Redfern	IWS
SLHD Mental Health Service	Mobile Assessment and Treatment Team	AX[F00-F99]-O5.1.1	Camperdown	IWS

Total	7
Rate per 100,000 residents (>17 years old)	1.56

The table below shows the workforce providing non-acute mobile outpatient care related to health needs. The total number of full-time equivalents workers is 98.5, or 21.72 per 100,000 residents. The teams providing non-acute mobile outpatient care are multidisciplinary, but composed mostly of mental health nurses. Core teams at Marrickville, Croydon, and Canterbury, have three additional multilingual workers, one clozapine coordinator, and one GP, (shared with other teams), respectively.

Table 17. Non-acute mobile outpatient BSIC provided by the public health sector: workforce capacity

Provider	Name	Total FTE	Psych /reg	Psychol	GP	MHN	SW	OT	Sup W	Edu	Peer	Others
SLHD Mental Health Service	Assertive Outreach Team-Croydon	12.4	1.4	2.0		4.0	2.0			1.0	2.0	
SLHD Mental Health Service	Community mental health service-Camperdown	12.6	1.7	1.5		6.0		1.4			2.0	
SLHD Mental Health Service	Community mental health service-Canterbury	20.6	2.0	2.6	1	4.6	3.4	1.0	3.0		2.0	1.0
SLHD Mental Health Service	Community mental health service-Croydon	16.4	1.2	2.0	1.1	6.3	2.8	1.0	1.0			1.0
SLHD Mental Health Service	Community mental health service-Marrickville	17.3	1.8	1.4	0.1	7.2	2.8	1.0				3.0
SLHD Mental Health Service	Community mental health service-Redfern	8.7	1.5	0.6	0.1	4.9	1.0	0.6				
SLHD Mental Health Service	Mobile Assessment and	10.6	0.9	1.0		5.1	1.6	1.0			1.0	

	Treatment Team	
Total		98.5
Rate per 100,000 residents (>17 years old)		21.72

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; GP: General practitioner; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist; SupW: Support worker/community worker; Edu: Educator; Peer: Peer worker.

NON-ACUTE NON-MOBILE OUTPATIENT CARE

We have identified 7 BSIC/services providing non-acute non-mobile outpatient care within the boundaries of the SLHD.

Two of those services are metabolic clinics, located at Concord Hospital and Prince Alfred Hospital (Camperdown). The main objective of these clinics is to monitor the physical health of people with a lived experience of severe mental illness, especially with regard to the risk of metabolic syndrome. The metabolic clinics are open once per week. The SLHD also has a Physical Health Unit in Marrickville, staffed with one FTE exercise physiologist, and one FTE dietitian. It is an office-based service with low intensity of contact (fortnightly-monthly). Additionally, there are four consultation-liaison services.

Table 18. Non-acute non-mobile outpatient care provided by the public health sector: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
SLHD Mental Health Service	Ambulatory clinic-Eating Disorders	AX[F50]-O9.1	Camperdown	State
SLHD Mental Health Service	Consultation Liaison Canterbury	AX[F00-F99]-O8.1	Campsie	IWS
SLHD Mental Health Service	Consultation Liaison Concord	AX[F00-F99]-O8.1	Concord	IWS
SLHD Mental Health Service	Consultation Liaison RPAH	AX[F00-F99]-O8.1	Camperdown	IWS
SLHD Mental Health Service	Consultation Liaison-CNC	AX[F00-F99]-O8.1	Camperdown	IWS
SLHD Mental Health Service	Metabolic Clinic I	AX[F00-F99]-O9.1	Camperdown	IWS

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
SLHD Mental Health Service	Metabolic Clinic II	AX[F00-F99]-O9.1	Concord	IWS
Total	7			
Rate per 100,000 residents (>17 years old)	1.56			

The number of BSIC/services from the public health sector providing non-acute non-mobile outpatient care is 7, or 1.56 per 100,000 residents.

The table below shows the workforce providing non-acute non-mobile care related to health needs.

The total number of FTEs of professionals providing non-acute non-mobile outpatient care in the public health sector amounts to 4.41 per 100,000 residents.

Table 19. Non-acute non-mobile outpatient care provided by the public health sector: workforce capacity

Provider	Name	Total FTE	Psych/reg	Psychol	MHN
SLHD Mental Health Service	Ambulatory clinic-Eating Disorders	0.1	0.1		
SLHD Mental Health Service	Consultation Liaison Canterbury	0.5			0.5
SLHD Mental Health Service	Consultation Liaison Concord	0.5			0.5
SLHD Mental Health Service	Consultation Liaison RPAH	12.1	10.6	1.0	0.5
SLHD Mental Health Service	Consultation Liaison-CNC	6.6	5.6		1.0
SLHD Mental Health Service	Metabolic Clinic I	NA			
SLHD Mental Health Service	Metabolic Clinic II	NA			
Total		19.8			

Rate per 100,000 residents (>17 years old)	4.41

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

ACCESS TO ALLIED PSYCHOLOGICAL SERVICES (ATAPS)

In addition, there are 84 private providers under the ATAPS program in the SLHD. The numbers of ATAPS providers providing non- acute outpatient care per 100,000 residents is 16.27 in the entire area, ranging from 7.61 in Canterbury, to 37.67 in Burwood. According to the DESDE LTC system, the ATAPS program receive the code **Gx[F00-F99]-O9.1.**

Table 20. ATAPS: workforce capacity

	Clin Psych	MHN	Psych	SW	SW (MHA)	OT	Grand Total	Total population over 17	Rate per 100,000 residents
Ashfield	2.0	2.0	1.0	0.0	0.0	0.0	5.0	33,849	14.8
Burwood	4.0	1.0	4.0	0.0	1.0	0.0	10.0	26,545	37.7
Canada Bay	2.0	0.0	7.0	0.0	0.0	0.0	9.0	60,888	14.8
Canterbury	0.0	1.0	7.0	0.0	0.0	0.0	8.0	105,137	7.6
Leichhardt	0.0	2.0	10.0	0.0	2.0	0.0	14.0	42,514	32.9
Marrickville	2.0	0.0	4.0	0.0	3.0	0.0	9.0	63,730	14.1
Strathfield	1.0	0.0	3.0	0.0	0.0	0.0	4.0	28,045	14.3
Sydney	9.0	0.0	13.0	3.0	0.0	0.0	25.0	155,615	16.1
Total							84.0	516,323	16.3

Clin Psych: Clinical psychologist; MHN: Mental health nurse; Psych: Psychologist; SW: Social worker; SW(MHA): Social worker mental health accredited; OT: Occupational therapist.

We received a response from one Better Access provider during the data gathering process for the Atlas. Disability Services Australia (DSA) provides psychological services through the Better Access Initiative under Medicare. The client requires a referral from his/her GP. This service is free. The main office is in Redfern. They have one FTE psychologist. The main DESDE code of this BSIC is O9.1. It is included in the availability section of non-acute non-mobile outpatient care services.

3.2.3.2 OUTPATIENT CARE PROVIDED BY NGOS

ACUTE MOBILE OUTPATIENT CARE

We have not found any BSIC/services providing acute mobile outpatient care provided by NGOs within the boundaries of the SLHD.

ACUTE NON-MOBILE OUTPATIENT CARE

We did not identify any BSIC/services providing acute non-mobile outpatient care provided by NGOs within the boundaries of the SLHD.

NON-ACUTE MOBILE OUTPATIENT CARE

We found 18 BSIC providing non-acute mobile outpatient care within the boundaries of the SLHD. Aftercare, New Horizons, Mission Australia and Neami National provide the support component of the HASI program. These teams have been described in the residential section of the Atlas.

Anglicare, Aftercare, New Horizons and Neami National also support people with a lived experience of mental illness though the Personal Helpers and Mentors Program (PHaMs), which aims to provide increased opportunities for recovery for people aged 16 years and over, whose lives are severely affected by mental illness. The program focuses on helping consumers to overcome social isolation, and increase their connections to the community. People are supported through a recovery focused and strengths based approach which recognises recovery as a personal journey driven by the participant. The PHaMs program offered by Aftercare and Neami National are considered high-intensity, as they have the capacity to see their consumers at least three days per week if needed. The PHaMs programs by New Horizons and Anglicare have the capacity to see consumers at least weekly.

Aftercare also provides support for people living in Biala, a supported residential service for adults aged between 18 and 40 years recovering from an episode of serious mental illness. Aftercare provides the support at home, five days a week, and the properties are managed by Metro Community Housing.

The number of BSICs/services from the NGO sector providing non-acute mobile outpatient care is 18, or 4.01 per 100,000 residents, including Partners in Recovery (PIR) programs providing those type of services – see specific section dedicated to PIR.

Table 21. Non-acute mobile outpatient care provided by NGOs: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage

Aftercare	HASI central	AX[F00-F99]-O5.2	Lylifield	IWS
Aftercare	PHaMs Canada Bay	AX[F00-F99]-O5.2	Auburn	Canada Bay, Leichardt, Auburn, Ashfield, Bankstown
Aftercare	PHaMs Rozelle	AX[F00-F99]-O5.2	Lylifield	Balmain, Rozelle, Lilyfield
Aftercare	Transitional Housing Program-Biala (METRO)	AX[F00-F99]-O6.2	Ashfield	IWS
FACS	Balmain/Leichhardt/Marrickville Tenancy Team*	AX[Z55-65]-O7.2	Ashfield	Balmain, Leichhardt, Marrickville
FACS	Burwood/Glebe Tenancy Team*	AX[Z55-65]-O7.2	Burwood	Burwood, Glebe
FACS	Redfern Tenancy Team*	AX[Z55-65]-O7.2	Redfern	Redfern
FACS	Riverwood/Canterbury Tenancy Team*	AX[Z55-65]-O7.2	Riverwood	Riverwood, Canterbury
FACS	Specialists across the district*	AX[Z55-65]-O7.2	Ashfield	IWS
FACS	Waterloo Tenancy Team*	AX[Z55-65]-O7.2	Waterloo	Waterloo
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	Ashfield	IWS
Neami National	PHaMs	AX[F00-F99]-O5.2	Ashfield	IWS
New Horizons	HASI	AX[F00-F99]-O5.2	Marrickville	IWS
New Horizons	PHaMs Croydon-Bankstown	AX[F00-F99]-O6.2	Marrickville	IWS
New Horizons	PHaMs Redfern-Waterloo-City	AX[F00-F99]-O6.2	Marrickville	IWS
New Horizons	PHaMs Redfern-Waterloo-City	AX[F00-F99]-O6.2	Marrickville	IWS
RichmondPRA	HASI-Boarding House	AX[F00-F99]-O5.2	Five Dock	IWS
RichmondPRA	Sydney Residential Outreach Team	AX[F00-F99]-O5.2	Five Dock	IWS

Total	18
Rate per 100,000 residents (>17 years old)	4.01

*Please note PIR and FACS BSICs are also coded in separate dedicated sections

The table below shows the workforce providing non-acute mobile outpatient care related to health needs. The total number of FTEs workers is 131.9, or 29.39 per 100,000 residents.

Table 22. Non-acute mobile outpatient BSIC provided by NGOs: workforce capacity

Provider	Name	Total FTE	MHW	SF	SupW	Peer	Others
Aftercare	HASI central	9.0			9.0		
Aftercare	PHaMs Canada Bay	5.0			5.0		
Aftercare	PHaMs Rozelle	5.0			5.0		
Aftercare	Transitional Housing Program-Biala (METRO)	3.0			3.0		
FACS	Balmain/Leichhardt/Marrickville Tenancy Team*	10.0			10.0		
FACS	Burwood/Glebe Tenancy Team*	10.0			10.0		
FACS	Redfern Tenancy Team*	10.0			10.0		
FACS	Riverwood/Canterbury Tenancy Team*	10.0			10.0		
FACS	Specialists across the district*	8.0			8.0		
FACS	Waterloo Tenancy Team*	10.0			10.0		
Neami National	Partners in Recovery*	4.0		4.0			
Neami National	PHaMs	4.4			4.4		

New Horizons	HASI	10.5		10.5		
New Horizons	PHaMs Croydon-Bankstown	9.0		9.0		
New Horizons	PHaMs Redfern-Waterloo-City	5.0		5.0		
New Horizons	PHaMs Redfern-Waterloo-City	1.0		1.0		
RichmondPRA	HASI-Boarding House	11.0		11.0		
RichmondPRA	Sydney Residential Outreach Team	7.0	4.0		2.0	1.0
Total		131.9				
Rate per 100,000 residents (>17 years old)		29.39				

FTE: Full-Time Equivalents; Psych/reg: Psychiatrist-registrar; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist; Edu: Educator; NCCM: Non-Clinical Case Manager; SF: Support facilitator; SupW/CommunityW: Support worker/community worker.

**Please note PIR and FACS BSICs are also coded in separate dedicated sections*

NON-ACUTE NON-MOBILE OUTPATIENT CARE

We have identified 3 BSIC/services providing non-acute, non-mobile, outpatient care within the boundaries of the SLHD.

Wesley Mission provides financial counselling and support to people with gambling problems from their office in Ashfield. Wesley Mission has another financial counselling service and a psychological service in Sydney (City, Pitt Street) which can be used by people from the Greater Sydney Area. It also provides support to 17 properties (which it manages) in Surry Hills specifically for people with a lived experience of mental illness who are homeless.

Schizophrenia Fellowship provides health related care in the Sunflower Health Service (in Burwood). They also operate a specific program together with the LHD and the Canterbury Leagues Club NSW: people with a lived experience of mental illness can use the club gym facilities during specific hours for free, under the supervision of a nurse and/or a social worker.

In addition, Exodus Foundation operate a service providing social care for people who are homeless, (so it was not included in the calculations of rates nor in the tables), but with a particular focus on their mental health needs.

The number of BSIC/services from the NGO sector providing non-acute non-mobile outpatient care is 3, or 0.67 per 100,000 residents.

Table 23. Non-acute non-mobile outpatient care provided by NGOs: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Schizophrenia Fellowship	Sunflower Health Services	AX[F00-F99]-O9.1	Burwood	IWS
Schizophrenia Fellowship + LHD + Bulldog NSW	Physical Activity	AX[F00-F99]-O9.1	Belmore	Greater Sydney
Wesley Mission	Financial Counselling/Gambling	AX[Z55-65]-O9.2	Ashfield	Greater Sydney
Total	3			
Rate per 100,000 residents (>17 years old)	0.67			

The table below shows the workforce providing non-acute non-mobile care. The number of FTE is 0.3, or 0.07 per 100,000 residents. We have to keep in mind, though, that the Sunflower Health Service is staffed with casual providers (i.e. psychologist and dietitians) who are hired in a casual position according to need.

Table 24. Non-acute non-mobile outpatient BSIC provided by NGOs: workforce capacity

Provider	Name	Total FTE	Psych/reg	Psychol	CCM	nCCM	Others
Schizophrenia Fellowship	Sunflower Health Services	NA					
Schizophrenia Fellowship + LHD + Bulldog NSW	Physical Activity	NA					
Wesley Mission	Financial Counselling/Gambling	0.3				0.3	

Total	0.3
Rate per 100,000 residents (>17 years old)	0.07

*FTE: Full-Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; CCM: Clinical case manager; nCCM: Non-clinical case manager; NA: Not available at the time of completion of the study. *Including Disability Services Australia.*

3.2.4 ACCESSIBILITY SERVICES

3.2.4.1 ACCESSIBILITY SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR

We have not found any service in the public health sector providing accessibility care in the SLHD.

3.2.4.2 ACCESSIBILITY SERVICES PROVIDED BY NGOs

We have identified 10 BSICs/services providing accessibility services. Two of these facilitate access to employment in the SLHD for people with a lived experience of mental illness: RichmondPRA - in partnership with Ostara ; and Schizophrenia Fellowship. Two BSIC or services provide accessibility support related to cultural and leisure activities through the Active Link Initiative. Five accessibility services are Partners in Recovery services, and FACS provides the Sydney District Access and Demand service.

The total number of BSICs/services from the NGO sector providing accessibility services is 10, or 2.23 per 100,000 residents, including Partners in Recovery (PIR) programs providing those type of services – see specific section dedicated to PIR. Not including PIR, the rate of services is 1.11 per 100,000 residents both for accessibility to employment and for cultural activities.

Table 25. Accessibility services provided by NGOs: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Aftercare	Active Linking Initiative	AX[F00-F99]-A5.3	Five Dock	IWS
Aftercare	Partners in Recovery*	AX[F00-F99]-A4	Alexandria	IWS
FACS	Sydney District Access & Demand Team*	AX[Z55-65]-A5.5	Ashfield	IWS

Mission Australia	Partners in Recovery*	AX[F00-F99]-A4	Waterloo	IWS
New Horizons	Partners in Recovery*	AX[F00-F99]-A4	Marrickville	IWS
Newtown Community Center	Active Linking Initiative	AX[F00-F99]-A5.3	Newtown	IWS
RichmondPRA	Partners in Recovery*	AX[F00-F99]-A4	Five Dock	IWS
RichmondPRA + Ostara	Disability Employment Service	AX[F00-F99]-A5.4	Redfern	Redfern
Schizophrenia Fellowship	Disability Employment Service	AX[F00-F99]-A5.4	Burwood	IWS
Schizophrenia Fellowship	Partners in Recovery*	AX[F00-F99]-A4	Burwood	IWS
Total	10			
Rate per 100,000 residents (>17 years old)	2.23			

**Please note PIR and FACS BSICs are also coded in separate dedicated sections*

The table below describes the workforce providing accessibility services.

The specific services for people with a lived experience of mental illnesses have a total workforce of 51.6, or 11.5 workers per 100,000 residents.

Table 26. Accessibility services provided by NGOs: workforce capacity

Provider	Name	Total FTE	SF	SupW
Aftercare	Active Linking Initiative	5.0		5.0
Aftercare	Partners in Recovery	4.0	4.0	
FACS	Sydney District Access & Demand Team*	17.0		17.0
Mission Australia	Partners in Recovery*	4.0	4.0	

New Horizons	Partners in Recovery*	4.0	4.0	
Newtown Community Centre	Active Linking Initiative	2.0		2.0
RichmondPRA	Partners in Recovery*	6.6	6.6	
RichmondPRA + Ostara	Disability Employment Service	2.0		2.0
Schizophrenia Fellowship	Disability Employment Service	2.0		2.0
Schizophrenia Fellowship	Partners in Recovery*	5.0	5.0	
Total		51.6		
Rate per 100,000 residents (>17 years old)		11.5		

FTE: Full-Time Equivalents; NCCM: Non-clinical case manager; SupW/CommunityW: Support worker/Community worker; MHW: Mental health worker.

**Please note PIR and FACS BSICs are also coded in separate dedicated sections*

PARTNERS IN RECOVERY

Partners in Recovery in the SLHD is managed by New Horizons. 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. Interestingly, though, these providers are not only focused on accessibility, but also take a more holistic approach, providing some counselling or coaching. Theoretically, the code of the PIR program should be an A4 (accessibility/care manager), but some organisations report that they are providing more intensive direct day care, so they received an outpatient code (O5.2). They can meet according to the needs of the consumer, with the capacity to meet them on a daily basis if needed in the first stage of the program. The program started in 2012, and it has been recently extended for 3 additional years (until 2018).

We identified 6 PIR BSICs in the SLHD. The total number of PIR BSICs per 100,000 residents is 1.34.

Note that, in this Atlas, PIR were also taken into account in the rates of services providing accessibility and outpatient services when applicable (based on their main DESDE code) as they recently obtained stable funding (at least three years). However, it was not the case at the time of completion of the previous integrated atlases of mental healthcare developed in Australia.

Table 27. PIR programs: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	%FTE	Town / Suburb	Area of Coverage
Aftercare	Partners in Recovery*	AX[F00-F99]-A4	4.0	14.5%	Alexandria	IWS
Mission Australia	Partners in Recovery*	AX[F00-F99]-A4	4.0	14.5%	Waterloo	IWS
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	4.0	14.5%	Ashfield	IWS
New Horizons	Partners in Recovery*	AX[F00-F99]-A4	4.0	14.5%	Marrickville	IWS
RichmondPRA	Partners in Recovery*	AX[F00-F99]-A4	6.6	23.9%	Five Dock	IWS
Schizophrenia Fellowship	Partners in Recovery*	AX[F00-F99]-A4	5.0	18.1%	Burwood	IWS
Total	6		27.6	100%		
Rate per 100,000 residents (>17 years old)	1.34		6.15			

FTE: Full-Time Equivalents

**Please note that PIR BSICs are also coded separately in the relevant Outpatient and Accessibility sections*

ABILITY LINKS

Ability Links is a program funded by FACS, but not specific to people with a lived experience of mental illness. It aims to support people with disability, their families and carers. It supports people to access supports and services in their local communities. Although it is specifically for them, it often works with people with mental illness. It has estimated that at least 70% of its consumers will have mental health needs. St Vincent de Paul Society is the provider of the Ability Links Program in the CESPHN, in partnership with Settlement Services International (SSI). It provides care for people from 9 to 65 years old.

3.2.5 INFORMATION AND GUIDANCE

3.2.5.1 INFORMATION AND GUIDANCE SERVICES PROVIDED BY THE PUBLIC SECTOR

We have not identified any BSICS/services providing exclusively information and guidance for people with a lived experience of mental illness in the public health sector.

3.2.5.2 INFORMATION AND GUIDANCE SERVICES PROVIDED BY NGOs

We have identified 2 BSICS/services, corresponding to 3 MTC, providing information for people with a lived experience of mental illness.

One of them is provided by the Mental Health Association, while the other is provided by the Inner Sydney Regional Council.

The number of BSICs from the NGO sector providing information and guidance for people with a lived experience of mental illness is 2, or 0.45 per 100,000 residents in the SLHD.

Table 28. Information and guidance services provided by NGOs: availability

Provider	Name	Main DESDE Code	Other DESDE code(s)	Town / Suburb	Area of Coverage
Inner Sydney Regional Council	Information Services/ Tenant	AX[Z55-65]-I2.1.1		Waterloo	City of Sydney
Mental Health Association	Information Services	GX[F00-F99]-I2.2	GX[F00-F99]-I2.1.2	Wooloomooloo	STATE
Total	2				
Rate per 100,000 residents (>17 years old)	0.45				

3.2.6 SELF AND VOLUNTARY SUPPORT

3.2.6.1 SELF AND VOLUNTARY SUPPORT PROVIDED BY NGOS

We have found 3 BSIC/services based on volunteer staff providing care for people with mental illnesses.

They are: Hearing Voices Network NSW, which provides support groups on a monthly basis in Newtown, Chatswood, Woolloomooloo, Sutherland, Penrith, Newcastle, Campbelltown, Dapto, Bathurst, Goulburn, Queanbeyan, Taree, Deniliquin, Wollongong, and Ulladulla, of which Newtown is in the SLHD. The Compeer friendship program, runs 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; and Newtown Community Centre provides free counselling to people with psychosocial conditions (a service run by volunteers).

The total number of BSICS/services from the NGO sector providing self and voluntary support services in the SLHD is 3, or 0.67 per 100,000 residents.

Table 29. Self and voluntary support provided by NGOs: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Hearing Voices	Groups	AX[F00-F99]-S1.3	Different locations	IWS and SES
Newtown Community Center	Counselling	AX[Z55-65]-S1.3	Newtown	IWS
St Vincent de Paul	Compeer	GX[F00-F99]-S1.2	Different locations	SES and SLHD
Total	3			
Rate per 100,000 residents (>17 years old)	0.67			

3.3 AGE SPECIFIC POPULATIONS

3.3.1 TRANSITION TO ADULTHOOD

3.3.1.1 OUTPATIENT CARE PROVIDED BY THE PUBLIC SECTOR

We identified 2 public health sector BSIC/services providing specific care for people with a lived experience of mental illness who are transitioning to adulthood. **The total number of such BSIC per 100,000 residents (above 18) in the whole PHN amounts to 0.45. The total number of FTEs of professionals providing care for transition to adulthood in the SLHD is 3.45 per 100,000 residents.**

Table 30. Outpatient care for transition to adulthood in the public health sector: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
SLHD Mental Health Service	Early Intervention Psychosis - Camperdown	TA[F20-29]-O6.1	4.9	Camperdown	IWS
SLHD Mental Health Service	Early Intervention Psychosis - Croydon	TA[F20-29]-O6.1	10.6	Croydon	IWS
Total	2		15.5		

Rate per 100,000 residents (<18 years old)	0.45		3.45		

FTE: Full Time Equivalents

3.3.1.2 OUTPATIENT CARE PROVIDED BY NGOS

We identified 2 outpatient BSIC/services providing care to people transitioning to adulthood with a lived experience of mental illness, or a rate of 0.45 per 100,000 residents under the age of 18 years.

Table 31. Outpatient care provided for transition to adulthood by NGOs: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
New Horizons	Headspace Ashfield	TA[F00-F99]-O9.1	7.6	Ashfield	IWS
University of Sydney	Headspace Camperdown	TA[F00-F99]-O9.1	3.5	Camperdown	STATE
Total	2		11.1		
Rate per 100,000 residents (<18 years old)	0.45		2.47		

FTE: Full Time Equivalents

3.3.2 SERVICES FOR OLDER PEOPLE

We identified 2 BSICs/services providing care specifically for people aged 65 years and over, with a lived experience of mental illness. **The total number of such MTC per 100,000 residents in the whole SLHD was 0.45 (standardised per 100,000 residents aged over 64 to maintain comparability).**

The two services identified are specialist mental health services for older people (SMHSOP), provided by the community mental health services of the SLHD: one in the Canterbury team and the other in Camperdown. They provide outpatient (community) non-acute mobile care.

Table 32. Services providing care for older people: availability, placement and workforce capacities

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
SLHD Mental Health Service	SMHOP Canterbury	OX[F00-F99]-O6.1	NA	Campsie	IWS
SLHD Mental Health Service	SMHSOP Camperdown	OX[F00-F99]-O6.1	NA	Camperdown	IWS
Total	2				
Rate per 100,000 residents (>64 years old)	0.45				

FTE: Full Time Equivalents; NA: Not available at the time of completion of the study

3.4 NON-AGE RELATED SPECIFIC POPULATIONS

3.4.1 GENDER SPECIFIC SERVICES

We did not identify any gender specific services within the boundaries of the SLHD, but the B-Miles Outreach Support Services in Edgecliff also covers the area of Greater Sydney. It supports women who are already housed and require tenancy support, assistance to access resources and support to maintain their living arrangements. It provides support in-home, or wherever the client prefers. The service can meet with the client on a weekly basis if needed (DESDE-LTC code: Ax[F00-F99]-O6.2). It is staffed with 3 FTE (non-clinical case managers).

3.4.2 SERVICES FOR CARERS

We have identified 5 BSIC/services, or 1.11 per 100,000 residents, providing support for carers of people with a lived experience of mental illness. They are all provided by Schizophrenia Fellowship: two provide non-mobile non-acute outpatient support related to social needs, while the other three are support groups run by volunteers in different locations across the SLHD. Carer Assist, one of the non-mobile non-acute outpatient services, has its main office in Bankstown, although it may use the office in Burwood if needed. To avoid problems related to geographical accessibility, it relies on telephone visits and e-mail communication.

Table 33. Services for carers: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
Schizophrenia Fellowship	Carer Assist	AX[e310][F00-F99]-O9.2e	2.0	Bankstown	Greater Sydney

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
Schizophrenia Fellowship	Educational groups	AX[e310][F00-F99]-O9.2	0.6	Gladesville	Greater Sydney
Schizophrenia Fellowship	Support Group	AX[F00-F99]-S1.3	NA	Balmain	IWS
Schizophrenia Fellowship	Support Group	AX[e310][F00-F99]-S1.3	NA	Burwood	IWS
Schizophrenia Fellowship	Support Group	AX[e310][F00-F99]-S1.3	NA	Inner West	IWS
Total	5		2.6		
Rate per 100,000 residents (>17 years old)	1.11		0.58		

FTE: Full Time Equivalents

3.4.3 MULTICULTURAL SERVICES

We identified 1 BSIC (or service), or 0.22 per 100,000 residents, providing mental health care for people from a multicultural and linguistically diverse background. This is a support group in Newtown for people with a Greek background, provided by Schizophrenia Fellowship.

In addition to local services, it is important to note that there are two state-wide services which provide outreach mental health services to people from culturally and linguistically diverse backgrounds within SESLH, for the whole state. The Transcultural Mental Health Centre (TMHC) provides non-acute short-term assessment and counselling, and cultural consultancy services to other mental health service providers. The second state-wide service is the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). This service provides short and long term counselling for people from refugee and refugee-like backgrounds who have experienced torture or trauma; as well as a range of community development activities.

Table 34. Multicultural services: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
Schizophrenia Fellowship	Greek-speaking group Mental Health Support	AX[F00-F99]-S1.3	NA	Newtown	IWS
Total	1				

Rate per 100,000 residents (>17 years old)	0.22				

FTE: Full Time Equivalents

3.4.4 SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

We have identified 1 BSIC/service, with a satellite, specifically for Aboriginal and Torres Strait Islander peoples with a lived experience of mental illness.

This service is managed by the SLHD and provides outpatient (community), non-acute, mobile care. It is located in Camperdown and staffed with 0.5 FTE psychiatrist, one FTE mental health nurse, and one Aboriginal worker.

Table 35. Services for Aboriginal and Torres Strait Islander peoples: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
AMS & SLHD Community Mental Health Service	Psychiatric clinical supervision	GX[IN][F00-F99]-O6.1	0.2	Redfern	SLHD
SLHD Mental Health Service	Aboriginal mental health unit (satellite)	GX[IN][F00-F99]-O10.1t	3.2	Redfern	Camperdown, Redfern
Total	2		3.4		
Rate per 100,000 residents (>17 years old)	0.45		0.76		

FTE: Full Time Equivalents

3.4.5 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.

In spite of this, it may be worth mentioning “Common Ground” (Mission Australia, Camperdown). This is a crisis accommodation facility with approximately 104 units. It is also known as The Camperdown Project, and it provides 24/7 support for people with a high risk of becoming

homeless and who have previously experienced homelessness, rather than specifically for people with a lived experience of mental illness. There is no time restriction to length of stay. Overnight security is provided. Professionals from the Community Mental Health Team at the SLHD visit some of the residents on a regular basis (please refer to the Pathways to Housing Project for more information).

3.4.6 ALCOHOL AND OTHER DRUGS

Although the use of 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 can be considered a mental health issue, its complexity requires a detailed and separate analysis.

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 12. Geographical distribution of high risk of psychological distress and residential services

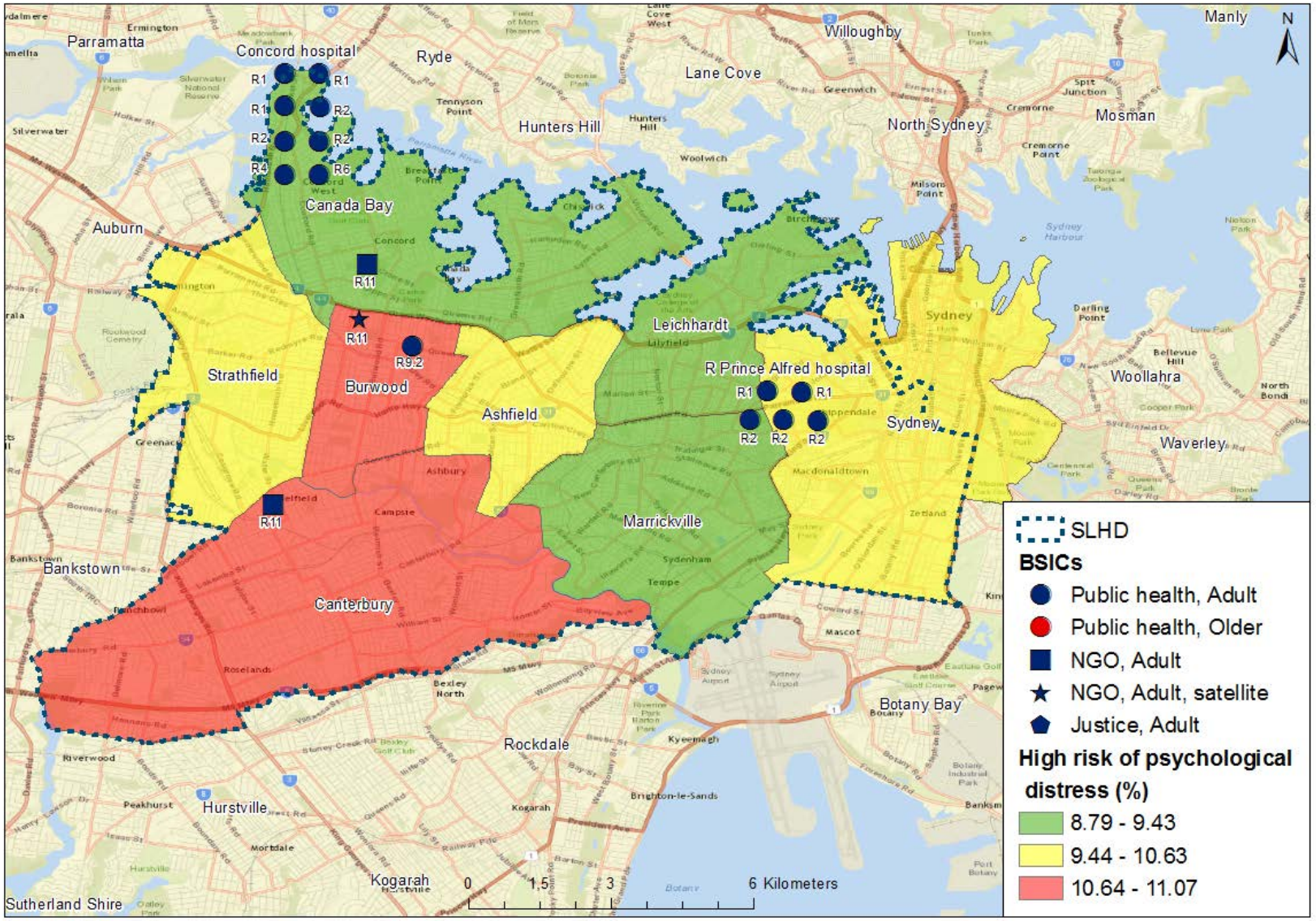


Figure 13. Geographical distribution of population density and day program services

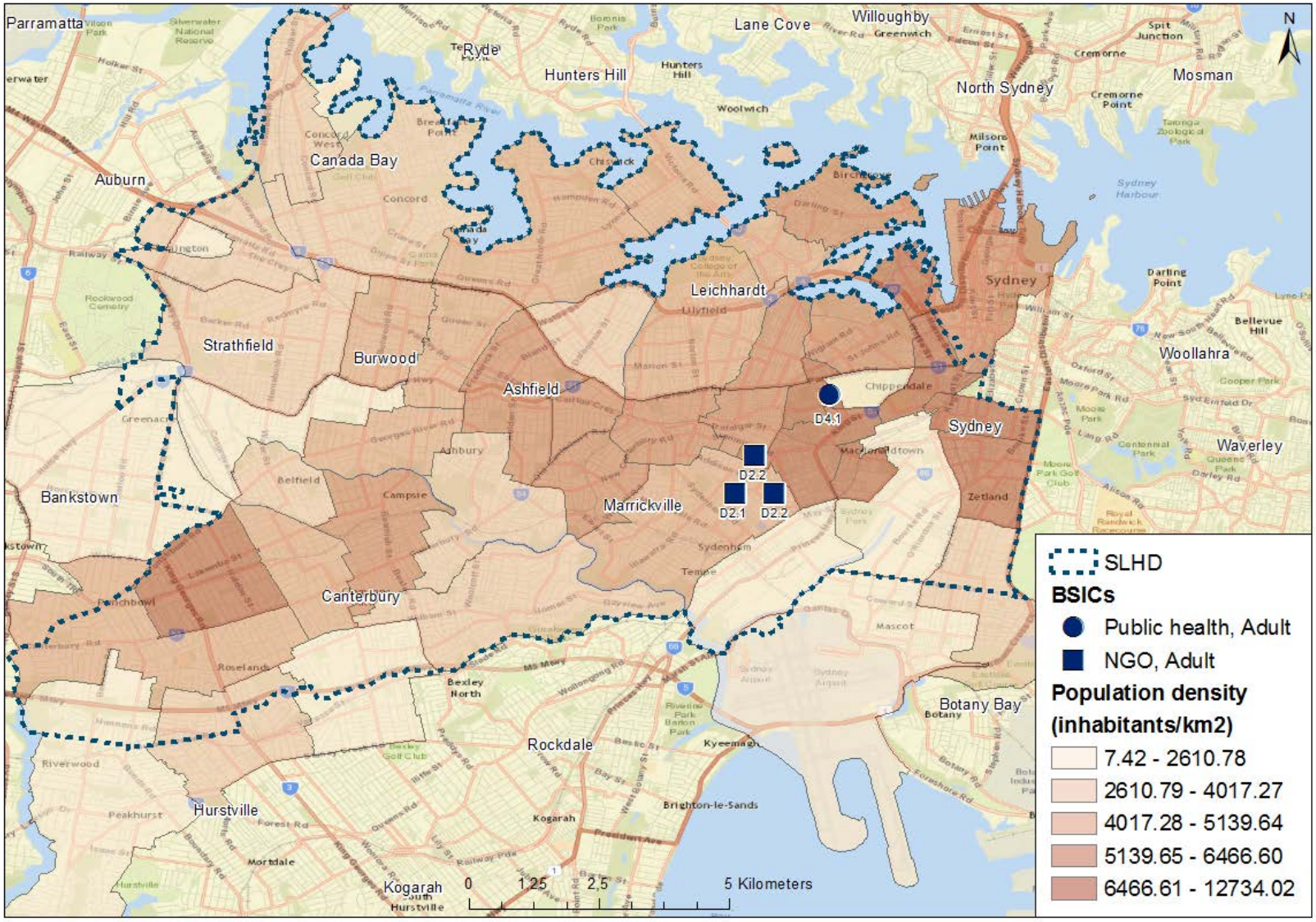


Figure 14. Geographical distribution of high risk of pyschological distres and outpatient non mobile services

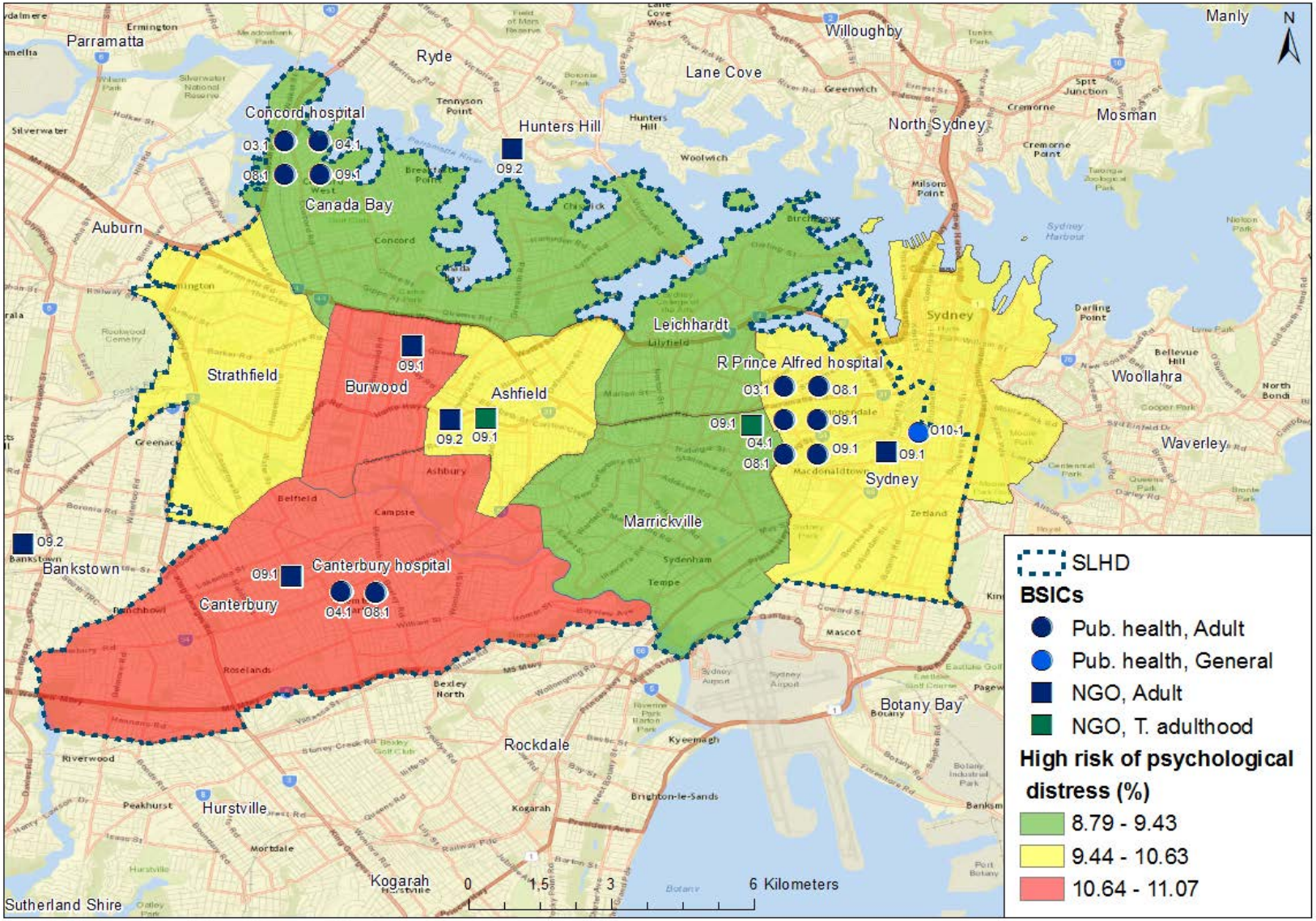
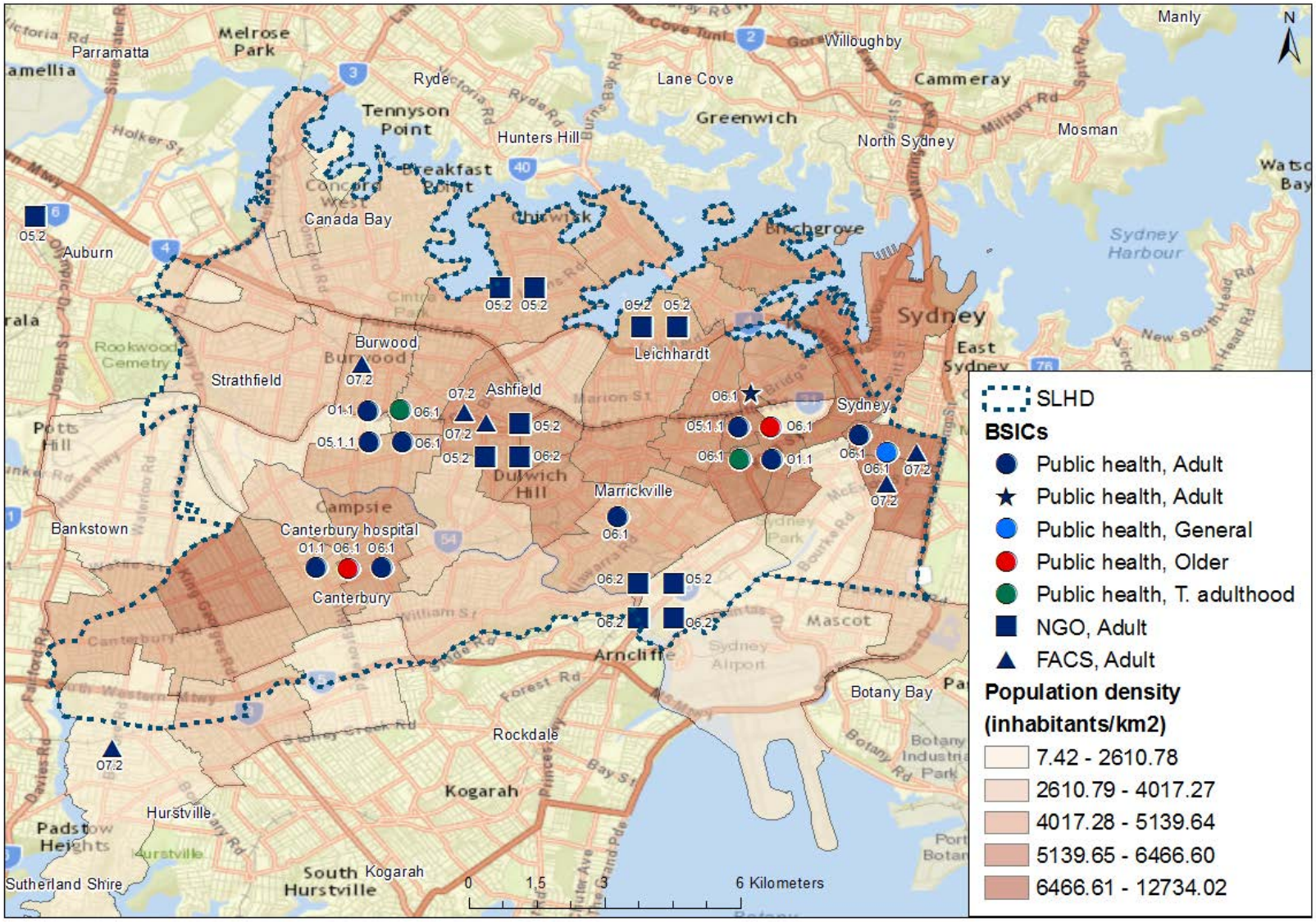


Figure 15. Geographical distribution of population density and outpatient mobile services



5 DESCRIPTION OF THE PATTERN OF CARE IN THE AREA

The figures below depict the pattern of adult mental health care in the SLHD. For this analysis, and to facilitate comparisons across jurisdictions, we focus on services for adults with a lived experience of mental illness (typically 18-64 years old).

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

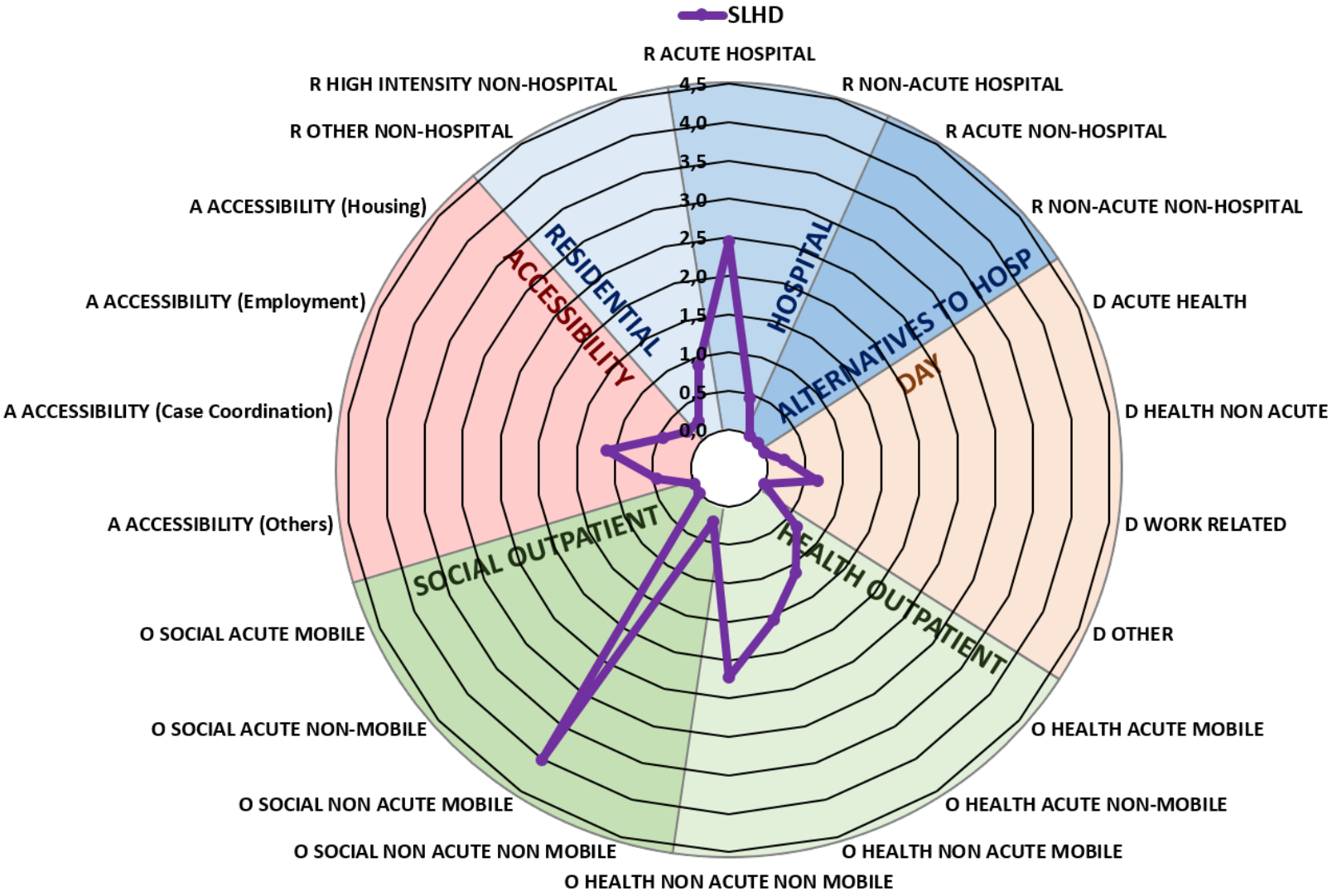
Similar to our findings in other areas, we have found three major gaps in the provision of services:

- Non-hospital acute and sub-acute care
- Lack of medium or long-term accommodation for people with mental illnesses
- Acute and non-acute health care day-related

The first gap is related to an absence of services staffed with psychiatrists, psychologists and nurses, who provide care for people with a lived experience of mental illness 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). The second gap is related to the lack of supported accommodation for people with a lived experience of mental illness. This has already been pointed out by other Atlases, and is one of the major strategic areas for PIR in IWS. The third gap refers to a lack of day care related to health. Acute day care related to health provides an alternative to hospitalisation. People experiencing a mental health crisis are not admitted to hospital, but treated in the community. They spend all day at the facility, but sleep at home. Non-acute day care includes day care centres staffed with at least 20% of highly skilled mental health professionals. In this type of service, people with a lived experience of mental illness can spend the day, socialising and participating in structured health related activities, such as cognitive training. There is also a lack of day care related to cultural and leisure activities; however, this is partially met by the “Active Linking Initiative” and the presence of Buckingham House and Lou`s Place in the boundaries between SESLHD and the SLHD.

On the other hand, there is good development of mobile services, both acute and non-acute, managed by the SLHD. We have also identified new services specifically targeting physical health, such as the metabolic clinics provided by the public sector, or the Sunflower Health services provided by Schizophrenia Fellowship.

Figure 16. Pattern of availability of MTCs for adult population in SLHD with lived experience if mental illness. Availability of MTCs per 100,000 residents

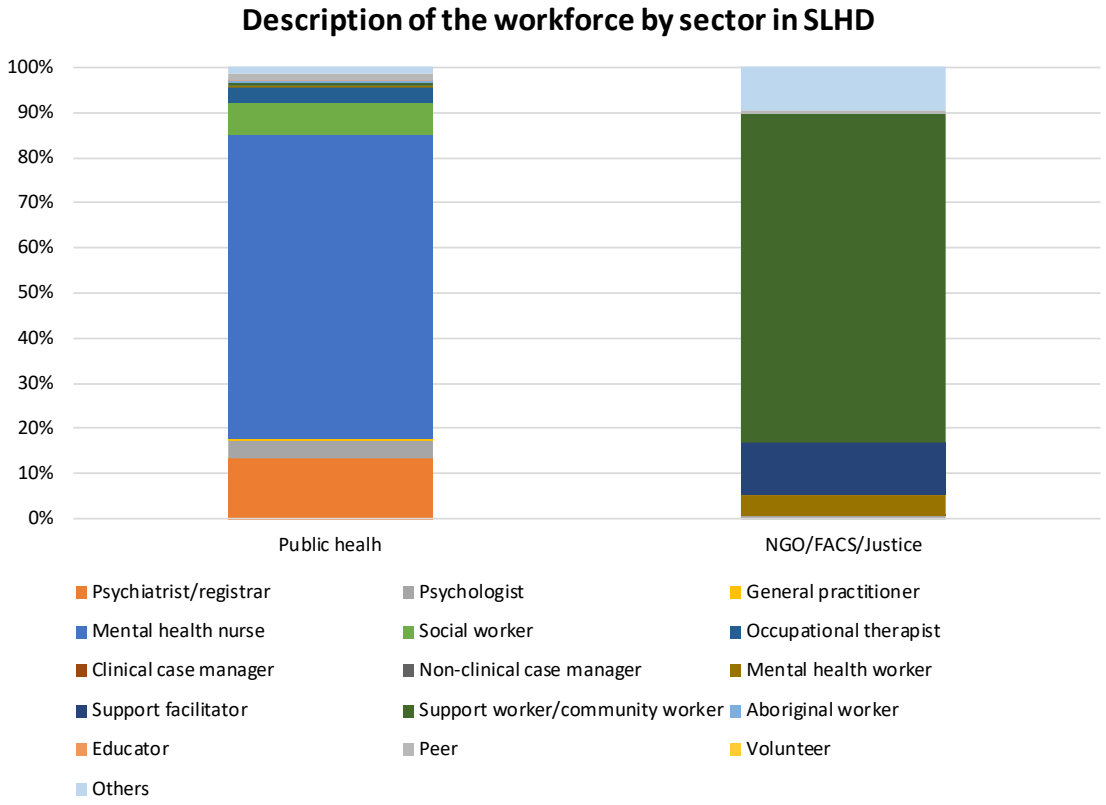


In this section, we present an overview of the workforce capacity in the SLHD. This data needs to be interpreted with caution, as we did not get any response from a small number of service providers. In addition, the different terminology used by the providers complicates the analysis (e.g. support facilitator, 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.

There are 100.3 professionals in the public sector per 100,000 residents providing care for people with a lived experience of mental illness in the SLHD (excluding private providers under ATAPS or the Better Access Program). In the NGO sector, there are 44.51 professionals per 100,000 residents providing care for people with a lived experience of mental illness in the SLHD.

Differences in the profile of professionals in the health sector and the NGO sector are represented in the figure below. In the health sector, the largest group of professionals are mental health nurses, followed by psychiatrists, and social workers. In the NGO sector, there are very few clinical professionals. This may reduce the capacity of this sector to provide more intensive care, although some organisations may hire them on a casual position, according to needs.

Figure 17.Description of the workforce by sector in SLHD and SESLHD



The figures below compare the pattern of mental health care between the SLHD and SESLHD, the SLHD and South Western Sydney LHD, and between the SLHD and Western Sydney LHD area.

The SLHD area has a larger availability of acute inpatient care, when compared to SELHD, South Western Sydney and Western Sydney. When looked at in detail, the acute units in the SLHD are smaller, but the number of beds per 100,000 residents is higher, than in the other areas. This may be explained by the higher number of patients coming from outside the IWS area.

The SLHD has more services devoted to employment, but it lacks some services providing day care related to cultural and social needs. However, in the SLHD there is a day health care centre, specifically for people with eating disorders.

Outpatient/community services (acute and non-acute) in the SLHD have a higher mobility than in South Western Sydney and Western Sydney, which are more office and telephone based. SLHD has a higher rate of mobility in both social and health non acute outpatient care than SESLHD, but a lower rate of mobility in acute health care, and a lower rate of non- acute, non-mobile health services. In addition, the SLHD has innovative services targeting the physical health needs of

people with a lived experience, which were not found in Western Sydney and South Western Sydney.

With regard to accessibility-related services, the main difference is related to coding issues: in the SLHD, PIR was coded as an accessibility-related service, while in SESLHD, Western Sydney and South Western Sydney it was coded as an outpatient/community service. The differences in how the different organisations (and even within the organisations) conceptualise the main activities of PIR requires further analysis.

Lastly, the availability of residential care in the community for people with a lived experience of mental illness is higher in South Western Sydney and Western Sydney than in the SLHD. This is mainly explained by the presence of the CHIP Hostel on the grounds of Cumberland Hospital (Western Sydney) and the presence of limited time facilities in South Western Sydney provided by Neami National. However, the availability of this type of care is higher in SLHD than in SESLHD.

Figure 18. Number of beds per 100,000 residents in SLHD, SESLHD, SWS & WS (adults)

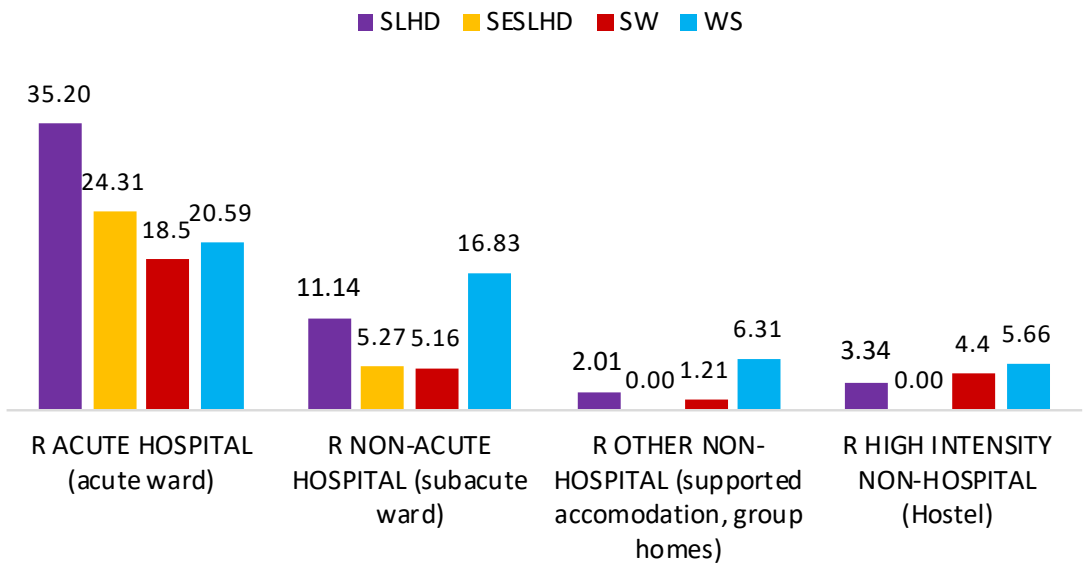


Figure 19. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD & SESLHD in metropolitan Sydney. Availability of MTC per 100,000 residents

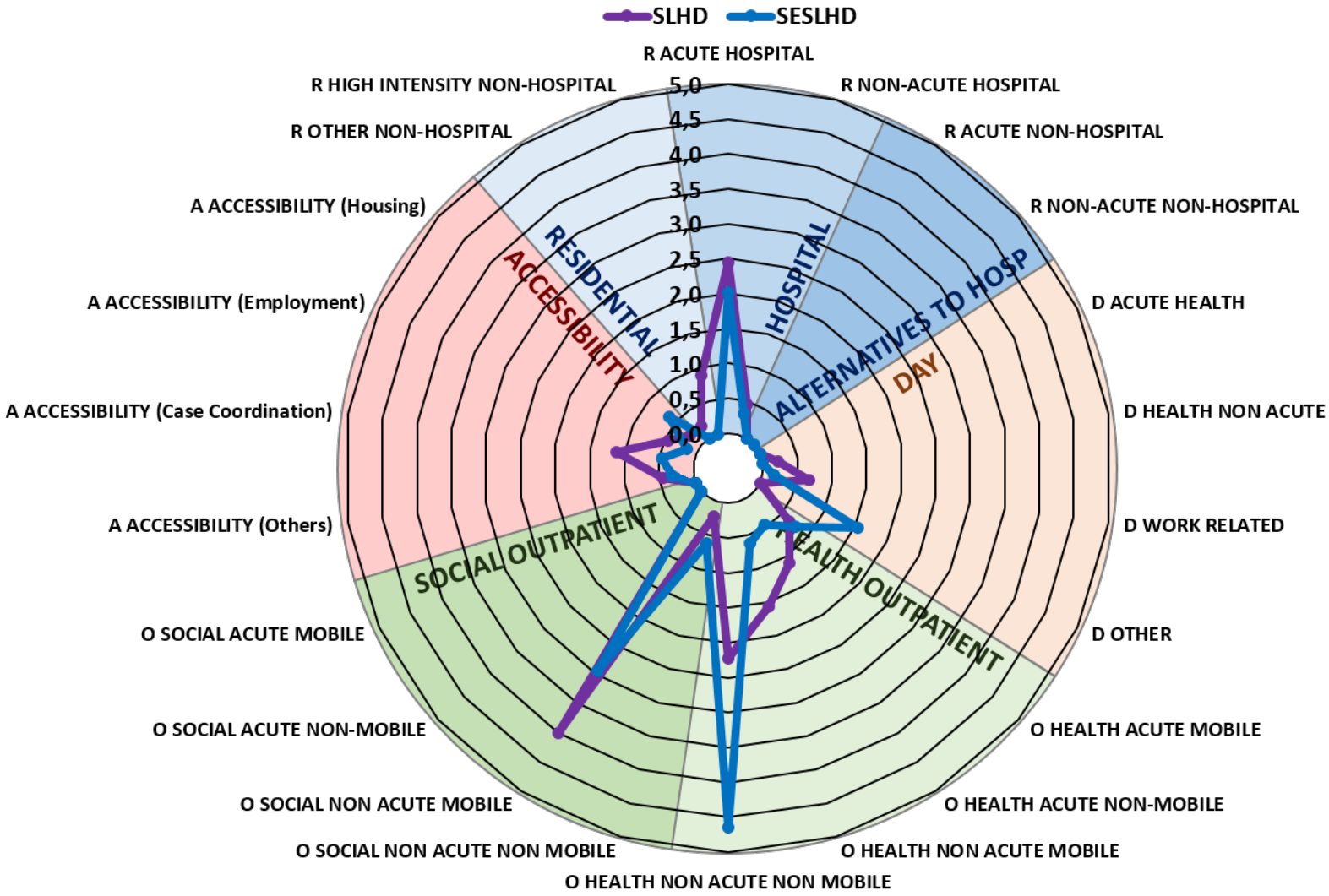


Figure 20. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD & SWSLHD in metropolitan Sydney. Availability of MTC per 100,000 residents

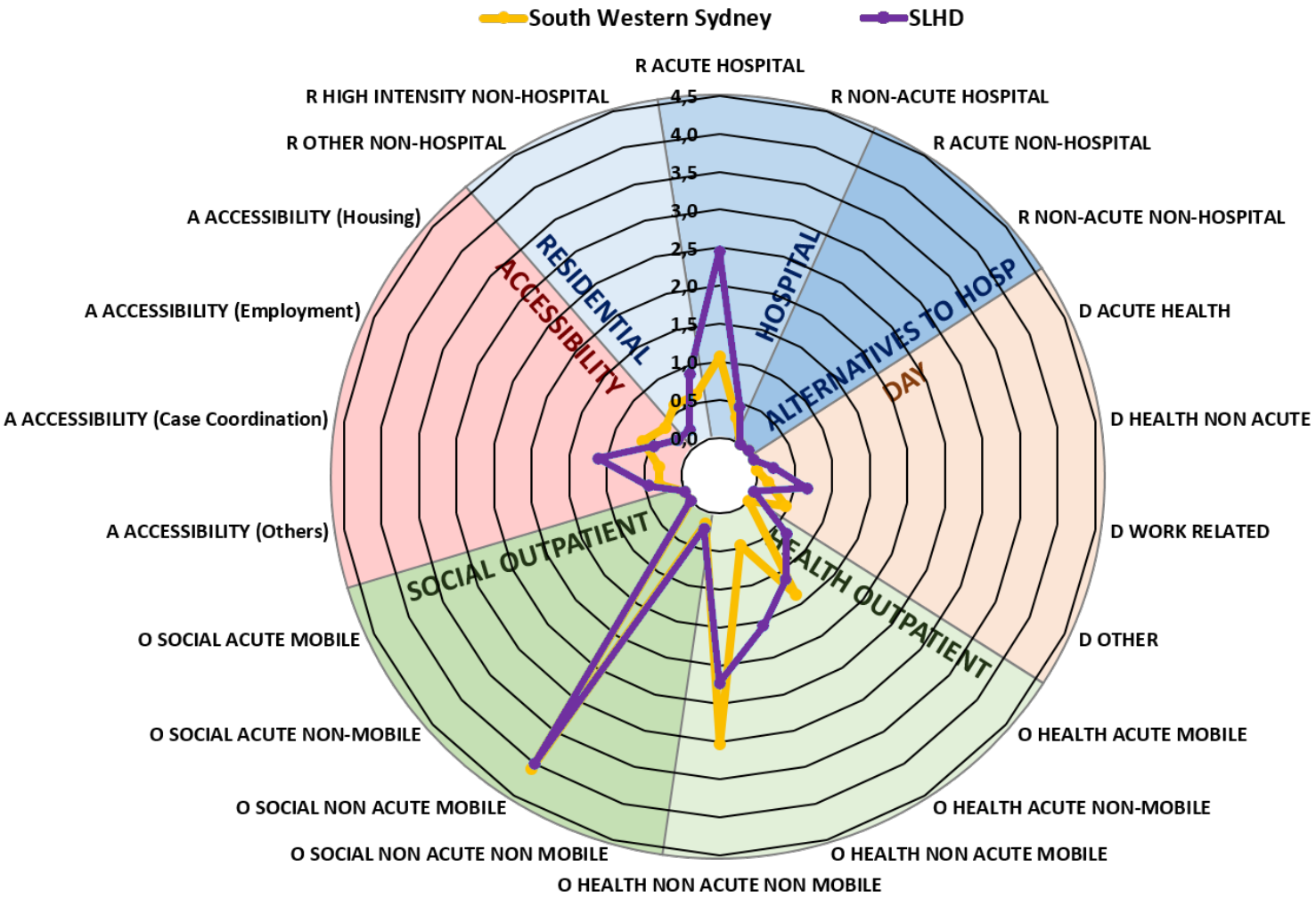
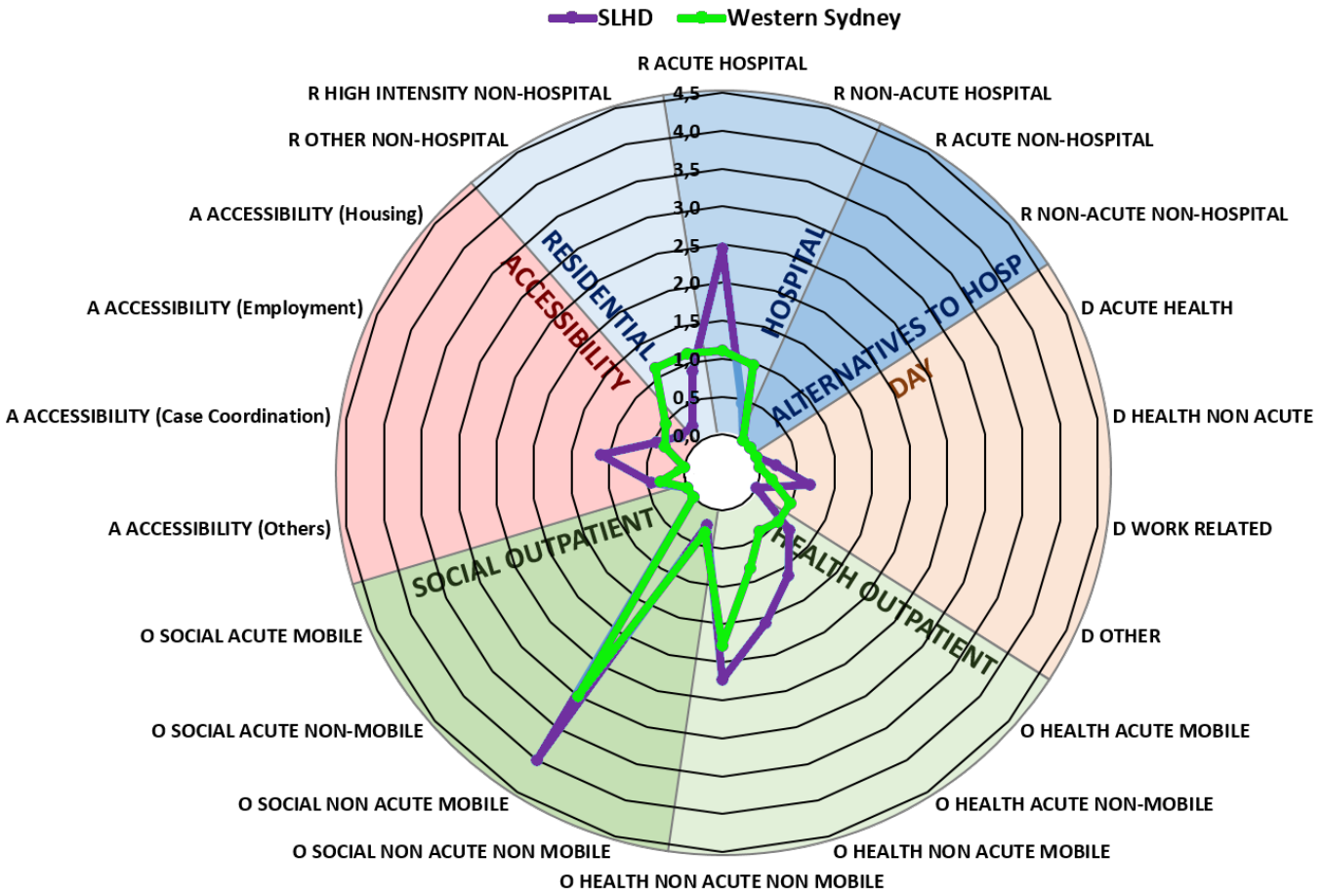


Figure 21. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD & WSLHD in metropolitan Sydney. Availability of MTC per 100,000 residents



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(16). 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.

However, in order 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 SLHD 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 (17). The following table describes the areas selected.

Table 36. 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	€4156	€ 2504	€ 2282	€ 2345	€2626

[1] Including Portsmouth and Southampton Unitary Authorities.

capita Purchasing Power Parity (in Euros) (2010)					
Total health care expenditure as a share of GDP	9.4%	8.9%	9.3%	9.6%	9.6%

6.1 NORTHERN EUROPE COMMUNITY MENTAL CARE MODEL

The figures below compare the SLHD with an area in Norway (Sør-Trøndelag), and 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 per capita. 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.

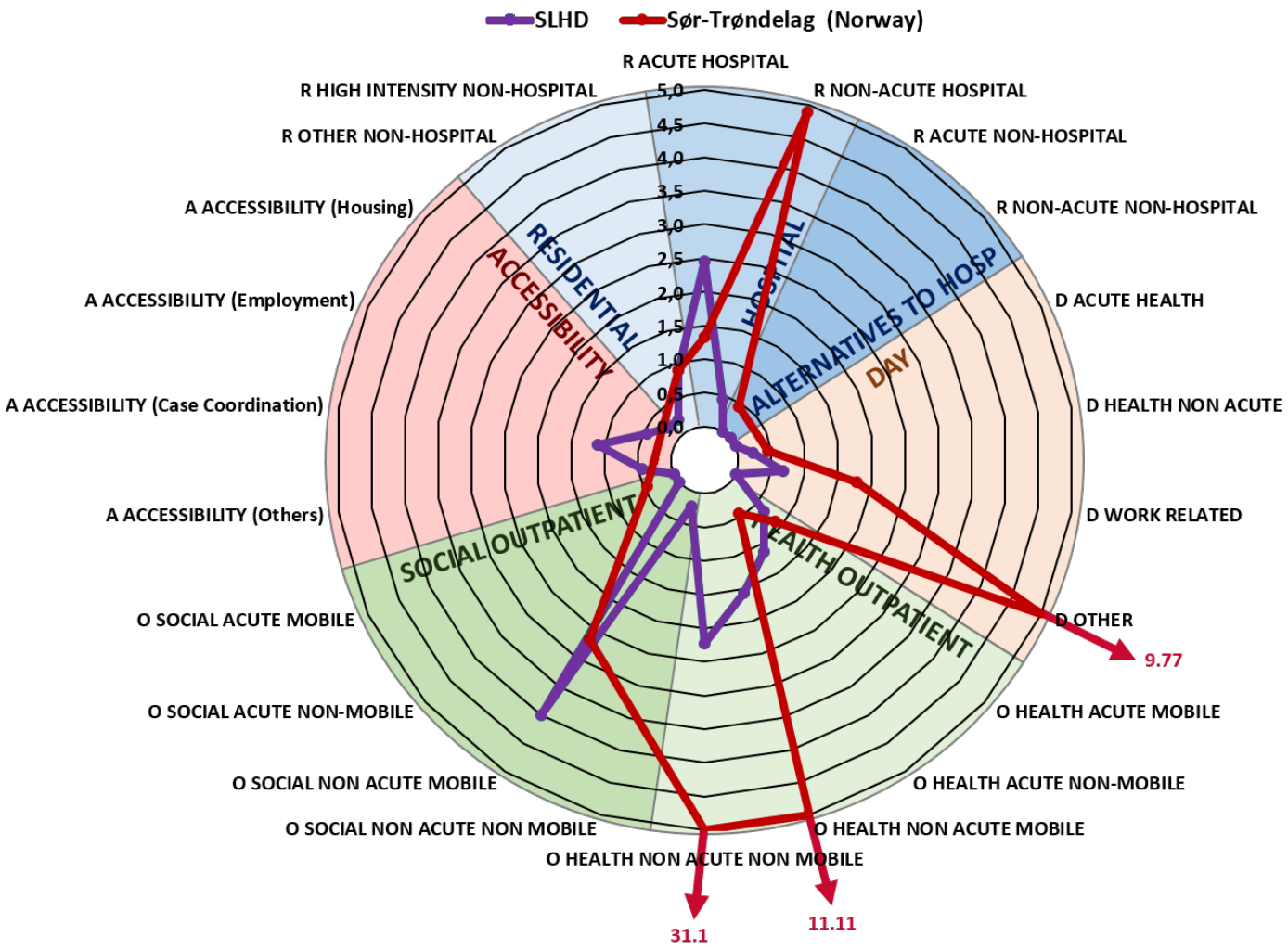
The main difference with the SLHD is its high availability of non-acute care at the hospital, day care related to employment and social and cultural issues, and outpatient non-acute care, both mobile and non-mobile. The addition of the ATAPS providers to the SLHD figures would, however, reduce the amount of difference in 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 public 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 illnesses 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.

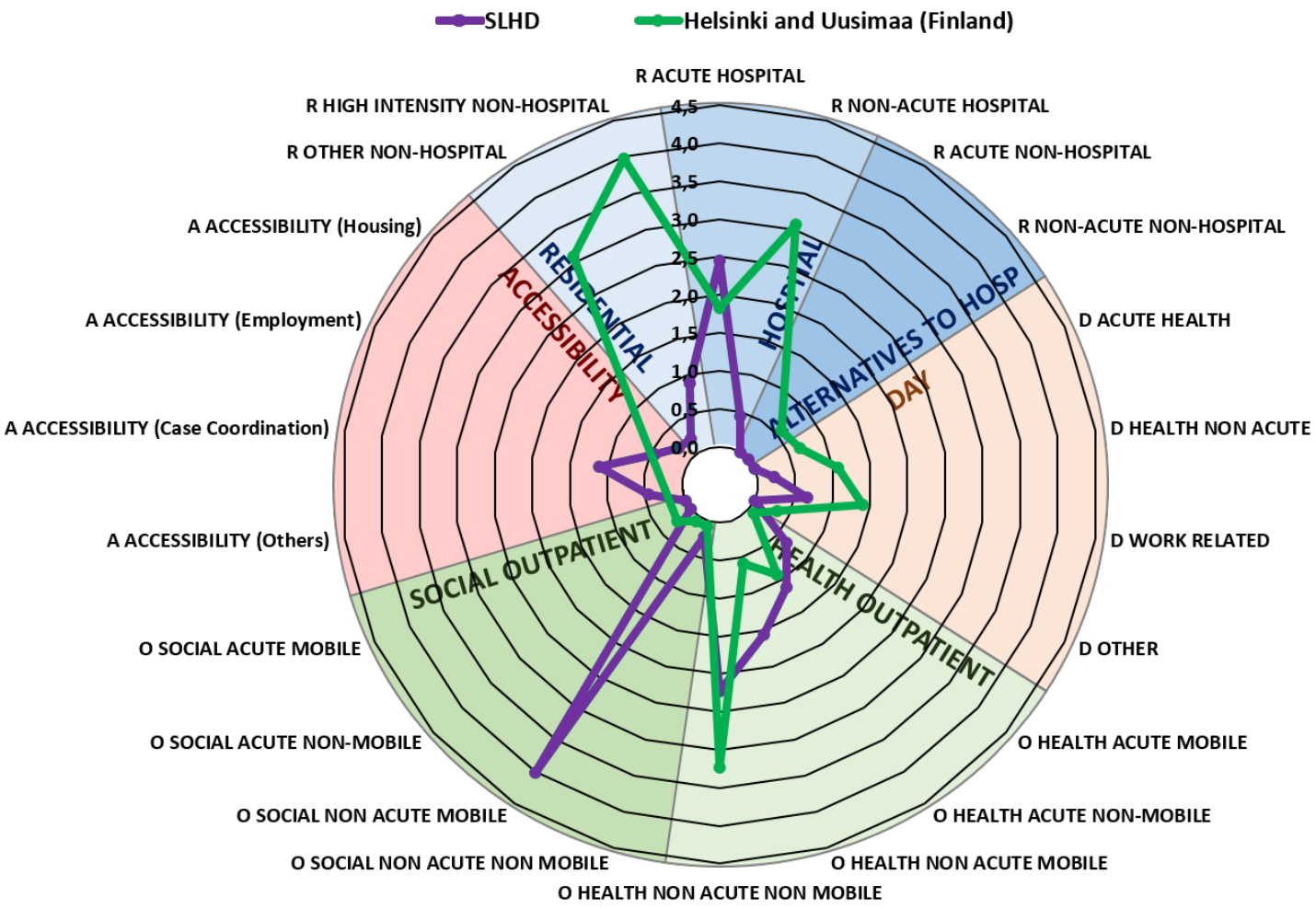
When comparing the SLHD and the Finnish area, the main difference is the high rate of residential and day care in Finland, as well as the high availability of non-acute inpatient care.

Figure 22. Pattern of availability of MTC in local mental health systems for the adult population with a lived experience of mental illness. Comparison between SLHD and Sor-Trondelag-Norway. Availability of MTC per 100,000 residents



Accessibility MTCs were not collected in Norway.

Figure 23. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD and Helsinki & Uusimaa-Finland. Availability of MTC per 100,000 residents



Accessibility MTCs were not collected in Finland.

6.2 SOUTHERN EUROPE MODEL OF MENTAL HEALTH CARE

The figures below compare the SLHD with Italy (Veneto Region), and with Spain (Girona). Mental health 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.

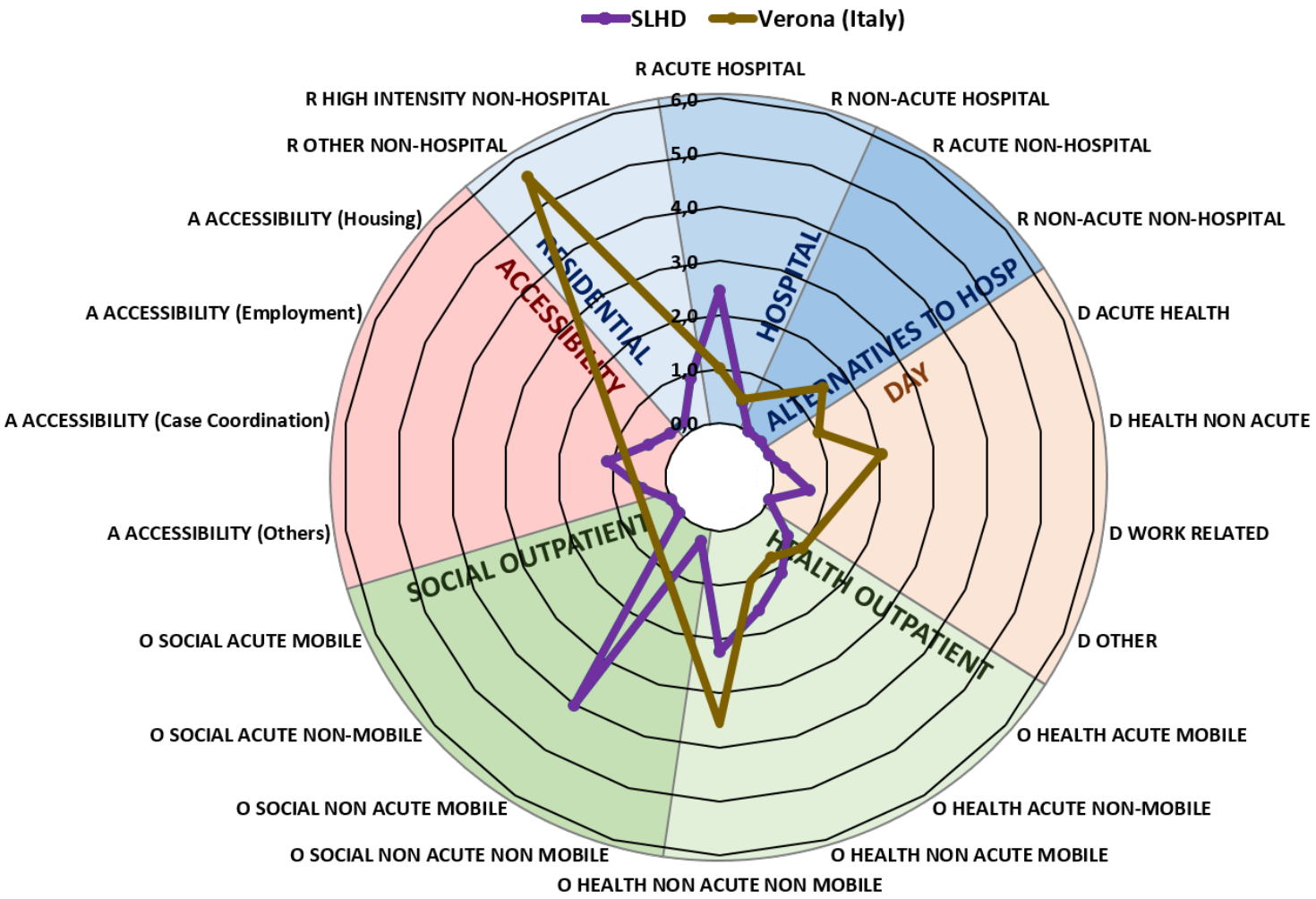
Socio and economic indicators from the area are derived from data from 2001, which would have changed. However, this area registers a high ageing index and population density.

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, Hospitalization and Community Care. Hospitalization 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, including an Adult Mental Health Centre and other specific services. Mental health patients enter the system through primary care (PC) that fulfills a gatekeeping function.

The area depicts high levels of unemployment, as well as high immigration rates.

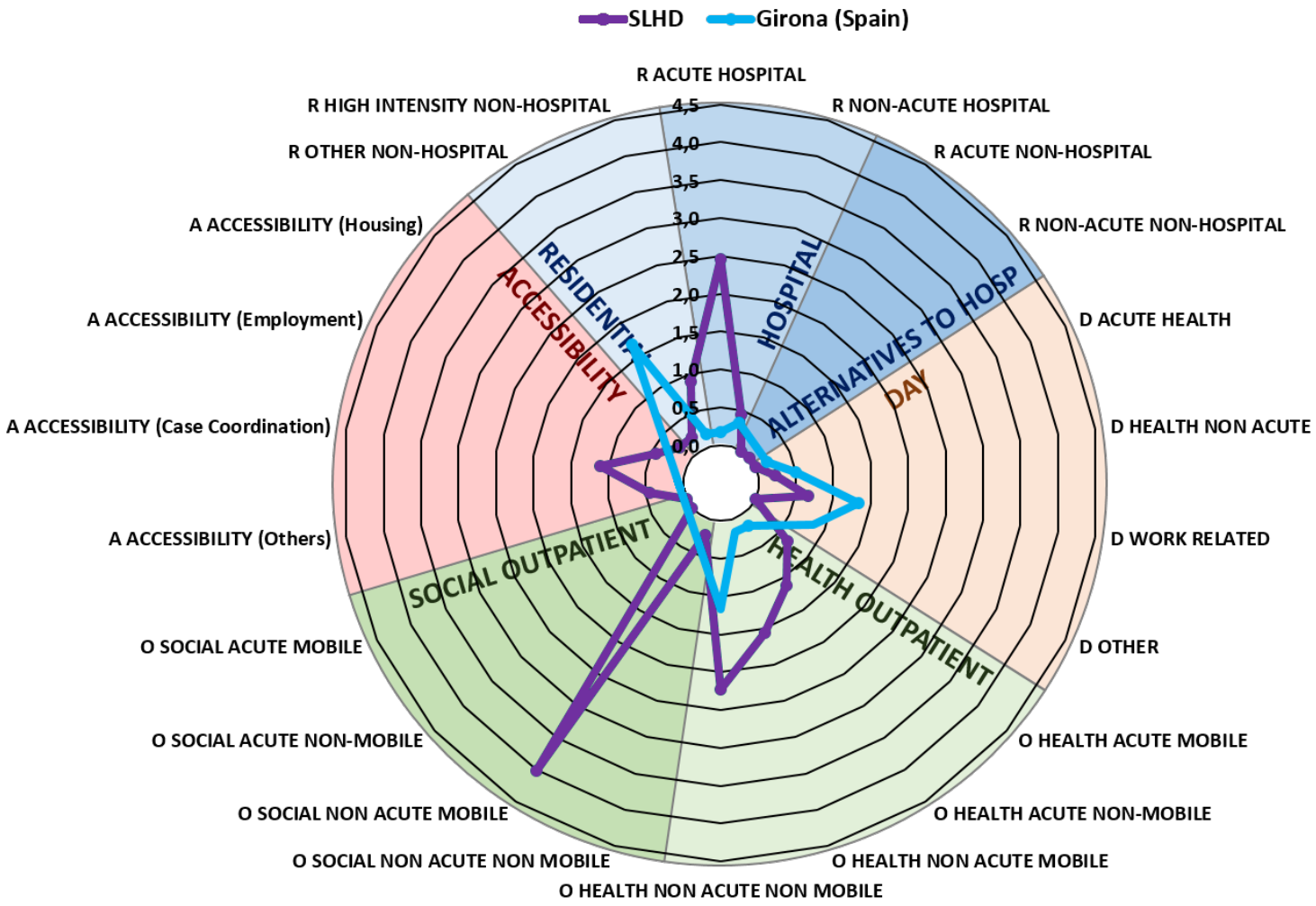
Both in Italy and Spain, the availability of acute hospital care is lower than in the SLHD (especially in Spain), while the non-acute hospital care is higher. On the other hand, the availability of day care, specifically health related day care, is higher and so is specific public housing for people with a lived experience of mental illness.

Figure 24. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD & Verona-Italy. Availability of MTC per 100,000 residents



Accessibility MTCs were not collected in Italy.

Figure 25. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD and Girona-Spain. Availability of MTC per 100,000 residents



Accessibility MTCs were not collected in Spain.

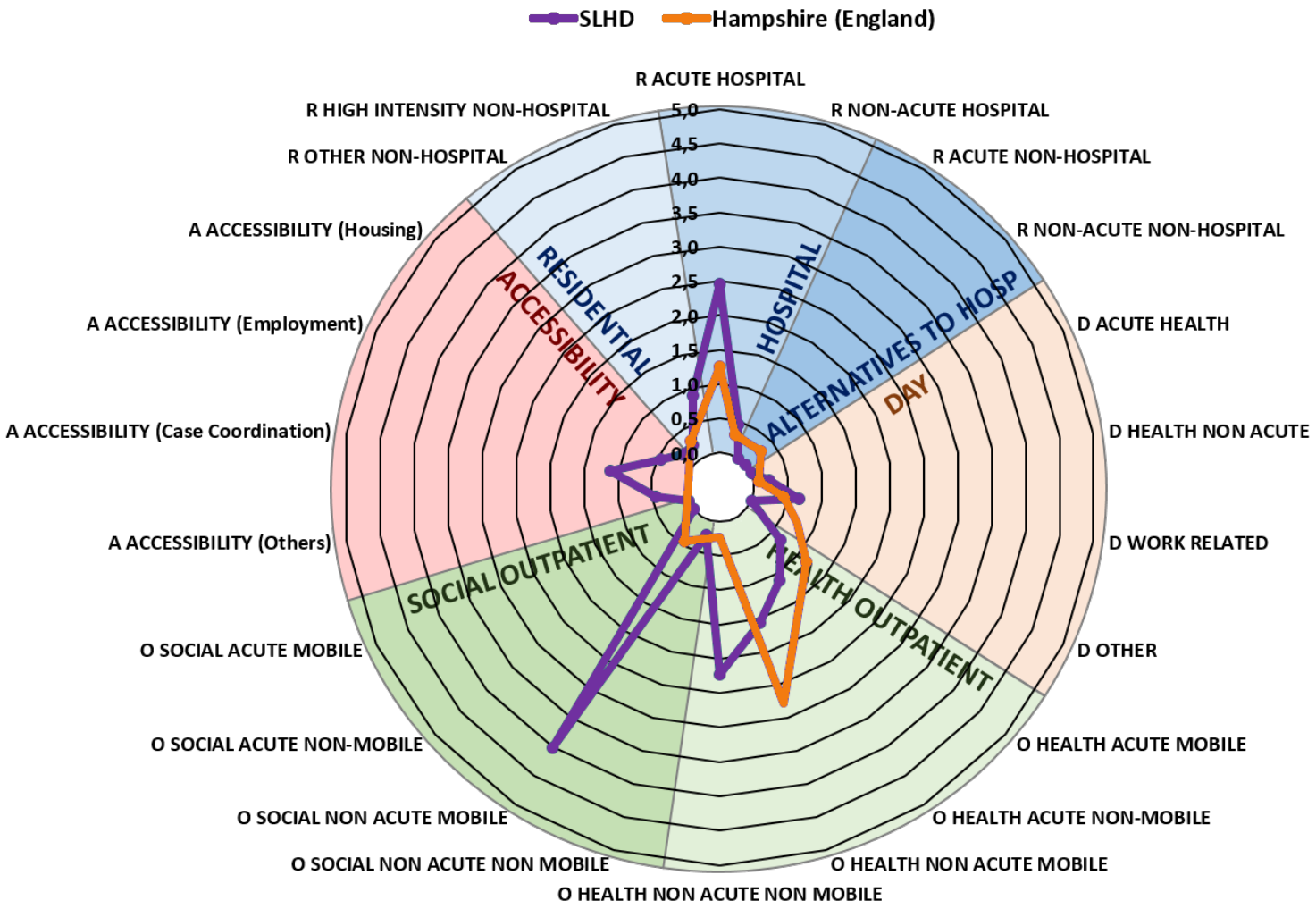
6.3 ENGLISH SYSTEM

The figure below compares the SLHD 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 socioeconomic 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 high availability of mobile care related to health, and the lack of day care related to health and non-acute care in the hospital, similar to our findings in the SLHD.

Figure 26. Pattern of availability of MTC in local mental health care systems for the adult population with a lived experience of mental illness. Comparison between SLHD and Hampshire-England. Availability of MTC per 100,000 residents



Accessibility MTCs were not collected in Spain.

6.4 PLACEMENT CAPACITY- CROSS-NATIONAL COMPARISONS

6.4.1 RESIDENTIAL CARE

There are large differences across countries related to bed availability per 100,000 residents. These rates mirror the different models of mental health care. The SLHD has a higher rate of acute hospital beds than well-known community-based mental health models, such as the Italian and the Spanish models, but also more than the Scandinavian countries. This may be explained by the fact that the SLHD also treats people from outside their boundaries (i.e. people who work but do not live there, and tourists and backpackers). The rate of non-acute hospital beds is similar to Spain and Italy, higher than in UK, but lower than in the Scandinavian countries. The absence of alternatives to hospitalizations in the community, especially step-down facilities and health related day care centres, is one of the major gaps of the system.

Table 37. Cross-national comparisons- Placement capacity- beds per 100,000 residents according to type of residential care

Groups	SLHD	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	29.4	28.4	26.9	14.0	7.0	26.4
R Non-acute hospital: R4 – R6	11.1	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	2.0	0.0	58.6	35.8	12.0	7.5
R non-hospital high intensity R8 R11	2.9	8.9	113.6	0.0	9.7	0.0

6.4.2 DAY CARE

Some of the most advanced models, such as the Finnish model, 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 the SLHD (and New South Wales). This scenario is very similar to the English one, where day care has been substituted by individual care. It is important to

highlight that the lack of structured activities is an important unmet need perceived by PIR consumers. Day care is important as it provides structured activities related to a range of life areas. 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. In the SLHD, we have found one day health care centre; however, it is specific for people with eating disorders and covers all the State.

Table 38. Cross-national comparisons- Placement capacity- places per 100,000 residents according to type of day care

Groups	SLHD	Sør-Trøndelag (Norway)	Helsinki and Uusimaa (Finland)	Verona (Italy)	Girona (Spain)	Hampshire (England)
D Health acute	0	0	9.62	3.05	4.17	0
D Health non-acute	0*(a)	n.a.	17.99	40.67	12.51	n.a.
D Work-related	n.a	8* (b)	18.15	0	32.53	n.a.
D Other	0	0	12.35	0	27.52	n.a.

**(a) SLHD has specific Eating Disorders Clinic which covers whole state *(b)One group not available in Norway*

7 DISCUSSION

Mental health care in Australia is undergoing significant reform. The federal government has outlined a series of key objectives with the aim of developing an integrated model of care with a person-centred approach. To be successful, this approach requires clear knowledge of the current structure of mental health care, and the potential of existing services.

The Integrated atlas of the CESPHN, and its associated annexes, provide a standardised identification of existing services, types of care provided and service capacities. This information, when combined with local data, provide additional information on how the integrated care policy is followed in this area. Together these sources of information can support decision makers and planners to refine and improve the provision of mental health services across the area.

7.1 BOUNDARIES AND SOCIAL AND DEMOGRAPHIC CHARACTERISTICS OF THE SLHD

Please refer to main document for social and demographic characteristics of the region.

7.2 KEY CHARACTERISTICS OF THE MENTAL HEALTH SYSTEM IN THE SLHD

The SLHD annex has highlighted strengths and areas for improvement in the pattern of mental health acre in the region. Strengths include:

- Good availability of inpatient residential care
- Good availability of non acute social outpatient care
- Good availability of accessibility services

Areas for improvement include:

- Non-hospital acute and sub-acute care
- Lack of medium or long-term accommodation for people with mental illnesses
- Acute and non-acute health care day-related

These results are similar to those found in other areas previously mapped in metropolitan Sydney (i.e. Western Sydney and South Western Sydney LHD/PHN) suggesting systemic organisational structural gaps in the mental health care delivery system in NSW. In general, the pattern of care of SLHD and SESLHD show commonalities, and a better availability than other regions such as SWS and WS. The SLHD care profile shows differences mainly in health-related outpatient care and in day care. This is discussed below.

These findings support the main recommendations pointed out by the NSW Commission Plan *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* (18) and the *National Review of Mental Health Programmes and Services* by the National Mental Health Commission (19), mainly the lack of alternatives to hospitalisations; and the need for strengthening the community mental health care subsystem. Misalignments in investment and financing have also been pointed out by the *National Mental Health Review* (19) which indicates that NSW has the lowest residential community care in Australia and the highest expenditure on hospitals.

The following sections of the Atlas provide discussion on the commonalities and differences observed in numbers of BSIC and MTC identified in the SLHD, compared to local and international jurisdictions. The discussion is framed within the stepped care model, concentrating on secondary and tertiary care services. The purpose of this Atlas was to map all specific services available for persons experiencing mental health issues in the SLHD. Therefore, we have not included the primary care generic services which also provide mental health care.

Further research should analyse the adequacy of mental health treatment provided in primary care, drug and alcohol services, and social areas relevant to mental health, such as homelessness, to complement these results. We have included information on the ATAPS program. We have discussed above the conceptual problems of classification of bridging or borderline programs such as ATAPS. This program can be regarded as a secondary care program for patients experiencing mild mental illness. We have included information on the ATAPS program as part of the secondary care system.

Although the stepped care model has been used to structure the Atlas discussion, it is noted that adscription of non-health services into this model may cause some confusion. In the stepped care model adopted in the 2015 government response (20), 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 using a combination of GP care, Psychiatrists, mental health nurses and Allied Health for those who experience severe mental illness. This distinction in the absence of a fully implemented integrated care system could produce further fragmentation instead of preventing it. For example, the 2016 PHN guidelines include in the broader primary care of child and adolescent services, social support services such as education and employment supports (21). From these guidelines it is not clear to what extent 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 ATAPS mental health nurse,s and individual practices of psychiatrists, which are counted as part of the primary care network in some reports.

7.2.1 RESIDENTIAL CARE (INCLUDING HOSPITAL CARE)

While SESLHD and SLHD provide a similar number of acute hospital MTCs, SLHD has a higher acute bed capacity, more closely resembling that identified in Western and South Western Sydney. It is important to note that there are historical agreements related to care sharing between SLHD and SESLHD, and other PHNs and LHDs. This may generate an over-estimate of the bed capacity ratio to the residents of this catchment area. This information should be completed with service utilisation data in the future.

As in other areas of Greater Sydney, there is a good rate of acute hospital care, but limited non acute hospital care, and no acute or non- acute alternatives to hospitalisation in SLHD. This suggests a structural organisational gap in the care provision system of greater metropolitan Sydney, which has also been found in other areas of NSW. The dominance of acute inpatient hospital care should be considered in the context of a lack of sufficient alternatives to hospitalisation, and a lack of health related day care, although the SLHD has a higher rate of community residential care, and health related acute outpatient care than other areas in NSW.

It is important to note that the balance of care of the Australian mental health system is skewed towards hospital care. 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(22).

Although acute beds in hospitals are a key component of an integrated care system, it is also important to provide residential alternatives in the community. 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 (23). 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 (24). Other initiatives in Australia that fit in this model is the Prevention and Recovery Care Model (PARC) in Victoria (25). These services can also function as a 'step-down' from a period of acute psychiatric hospitalization, to facilitate transition from hospital. The key characteristic of these services is that they are staffed with highly-skilled mental health professionals. The development of these types of services in the SLHD could fill a gap in the provision of mental health care services.

There are significant differences in the provision of community residential care in the two LHDs of the CESPHN. In SESLHD, no organisation providing residential care in the community has responded to the Atlas project, and as such the number of beds that are known by the care system to be occupied by people with a lived experience of mental illness is unclear. In comparison, within the SLHD, Casa Venegas (St John of God) provides 13 supported accommodation beds for people with a lived experience of mental illness. In addition, 78 beds are known by the SLHD care system and have specific packages of social support provided by RichmondPRA, Biala (Ashfield), Aftercare and the Camperdown Unit Program with health care provided by the public outpatient teams.

FACS in SLHD provide accommodation support to a wide range of consumers. They are, however, distinctly different from equivalent services in other countries. The equivalent services in other countries often have specific divisions related to mental health and are coded as residential care providers in the integrated mental health atlases following the international recommendations established by the DESDE-LTC consortium.

As previously stated, social housing may or may not include direct support. Although people with a lived experience of mental illness are a significant component of the users of FACS in NSW, FACS does not specifically provide care for this population. People with a lived experience of mental illness in community housing who need support at home, receive this type of care through the HASI program. It could be argued that the way housing for people with mental illness is provided in Australia is more accurately conceptualised as a financing mechanism, than a service providing care. This has resulted in most providers who deliver support in the home, being coded as outreach/Outpatient services (mainly codes O5.2 and O6.2). This organisational arrangement of supported housing may present an obstacle to the provision of integrated care in supported housing, unlike that described in European areas, such as in Verona (Italy), and Girona (Spain), in Southern

Europe, or Helsinki in Finland, where the support and housing is provided by more integrated services, coded as Residential BSIC. The Pathways to Housing project run by Inner West Sydney Partners in Recovery provides a crucial closer look at this issue.

A previous evaluation of the Housing and Accommodation Support Initiative (HASI)(26), the only specific social housing initiative for people with a lived experience of mental illness, also pointed out these problems. HASI consumers who require social housing apply through Housing Pathways for public or community housing. They are prioritised according to need. They are housed in existing social housing stock, when a property becomes available, and this varies depending on location and needs, ranging up to many months. Although the evaluation report implicitly acknowledges geographical variability in the implementation and outcomes of the program, it does not present any data by LHD. This is crucial in order to develop a plan to promote stable housing tailored to the area, with specific guidance on the number of places needed.

If we compare the pattern of care in SLHD to that in Scandinavian countries, there are important differences to note. In Norway, a lower rate of acute hospital care than the SLHD is balanced by higher rates of other types of care, particularly non acute hospital care, day care ,and non-acute mobile health care, but also high intensity non hospital care, alternatives to hospitalisation, and work related daycare. In Finland, which has a similar rate of acute hospital care as the SLHD, there is nevertheless also higher rates of non-hospital residential care, non-acute hospital care, and work related day care. Finland, however, provides a lower rate of social outpatient care. These countries have high per capita health expenditure, and while they provide similar rates of acute hospital care to SLHD, they do not demonstrate the strong skewing of care towards acute hospital care that is evident in SLHD, and in other areas we have mapped in Australia.

If we compare the SLHD to Southern European community models, such as those developed in Italy and Spain, we can see that the balance of residential care moves away from acute hospital care, and strongly towards residential care in the community. Verona (Italy) also provides a higher rate of alternatives to hospitalisation, and of health related day care, while Girona in Spain provides less health related non acute outpatient care, but more work related day care. These countries provide lower rates of acute hospital care, but more types of other residential care, particularly in the community, and more day care services.

Differences in availability of residential care types and placement capacity indicate variability across jurisdictions, rather than differences in quality of care. In order to derive organisational learning, it is necessary to complement this information with data on service utilisation, and quality indicators. In any case, it is relevant to show that benchmark areas in Europe such as Girona, Verona and Helsinki show a very different pattern of service delivery. The gaps and challenges identified in residential care in SLHD reinforce the relevance of the priority topics selected by the Healthy, Strong Communities program in this LHD.

7.2.2 NON RESIDENTIAL CARE

HEALTH RELATED OUTPATIENT CARE

The pattern of outpatient and outreach services according to their Main Types of Care (MTCs) is similar to that found in other areas of Greater Sydney. It is worth noting that the range of services available in health related outpatient care is higher than in other areas of Greater Sydney, such as SESLHD and SWSLHD. This includes a balanced distribution of acute and non-acute non-mobile services, and non-acute mobile services. There are few teams providing non-acute mobile teams. SESLHD has a higher availability of teams providing non-acute non-mobile care. The relative efficiency of the different models of balance of care (e.g. mobile versus non-mobile teams, acute versus non acute) has not been tested, and a proper analysis will require the incorporation of utilisation data. In any case, the differences identified in the number of teams providing non-mobile outpatient care in the two districts of CESPHN deserve further investigation.

NON-HEALTH RELATED OUTPATIENT CARE (SOCIAL OUTREACH SERVICES)

The pattern of outpatient and outreach services according to their Main Types of Care (MTCs) in the social sector is even more similar to other LHDs of Greater Sydney. Many of the outreach services provide home/residential support or replace on-site day care. These characteristics have been discussed in the day care and the residential care sections of this report.

DAY CARE

Day care for people with a lived experience of mental illness has been considered a key component of psychiatric reform since the early 60s (7). "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 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 which also incorporates mobile care alternatives for crisis intervention at home (crisis resolution teams, medical homes), together with non-mobile emergency services and high-intensity coordination/case-management as in Assertive Community Treatment (7).

ACUTE HEALTH RELATED DAY CARE

Due to the high demand for beds in the region, and the lack of alternatives for people experiencing moderate-severe mental illness under crisis, acute day care centres could be a beneficial addition to services in the SLHD.

Acute day care (ADC) provided by qualified mental health professionals (eg psychiatrists, nurses and psychologists) is a less restrictive alternative to inpatient admission for people who are experiencing acute and severe mental illness. Its objective is to deliver personalised, intensive and

structured health care interventions in non-residential service locations (7). Day hospitals or partial hospitalisation services combine the close supervision of a standard inpatient unit, with the maintenance of patients in the community. They also follow a multidisciplinary and multimodal approach.

Recent systematic reviews on the efficiency of acute day care alternatives to hospitalisation include the reviews made by the Cochrane Library(27) and by the US Agency for Healthcare Research and Quality (AHRQ)(28). The Cochrane review concluded that ADC is at least as effective as traditional methods, and provide suitable options in situations where demand for inpatient care is high, and facilities exist that can be converted to this use. However, they are a less attractive option in situations where the demand for inpatient care is low and can be covered by other options (27). The two major advantages of day hospitals are that they: 1) strengthen the patient's autonomy and links with the community; and 2) reduce the risk of institutionalization and the stigma associated with it. In addition, it is estimated that day hospitals can save around 5% of the cost of acute psychiatric inpatient care. However, these systematic reviews also indicate that studies on ADC do not follow a systematic approach and are limited to only two components of the local system (i.e. acute hospital versus day hospital) without taking into account their overall impact on the system.

The US AHRQ(28) draft acknowledges that a decrease in number of psychiatric admissions is a key priority for providers and insurers, and provides an analysis of alternatives to psychiatric hospitalization (e.g., day hospital, short-term crisis unit, various forms of supported housing, assertive community treatment services). This review calls for more research into ADC.

Another relevant source of information is the European Day Hospital Evaluation Study in Europe (EDEN)(29). This is a multicentre randomized controlled trial, comparing acute treatment in day hospitals and conventional wards in five European cities with different models of community care: Prague (Czech Republic); Dresden (Germany); Wroclaw (Poland); Michalovce (Slovakia); and London (UK). The study indicated that day hospitals are an extended care type in Europe which is more useful for female, educated, patients with moderate to severe symptoms, rather than those with the highest degree of severity, who may benefit from acute hospital care. Despite the results of these studies, the overall number of studies on ADC is surprisingly low, and we lack comparisons of the relative efficiency of local systems with, and without, day hospitals. Acute day care has been included in the recommendations made by NICE for the prevention and management of psychosis and schizophrenia(30): *Crisis houses or acute day facilities may be considered in addition to crisis resolution and home treatment teams depending on the person's preference and need.*

NON-ACUTE HEALTH-RELATED DAY CARE/PROGRAMS

Non-acute high-intensity day care ("day centres") is a key component of a community mental health system missing in the CESPHN. 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), provide a higher level of service delivery, due to their ability to 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). The capacity of this workforce 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 can also include occupational therapy tailored to need. 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 program on 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 (31).

In the SLHD, we have identified one non-acute health related day care centre with high intensity (equivalent to day hospitals), however this is only for people with eating disorders. It is important to note that these services were lacking in all other regions previously mapped in the public sector of metropolitan Sydney.

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 deinstitutionalisation, emerging hand in hand with the closure of psychiatric hospitals across the system. Day Hospitals as 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, health-related day centres for mental health can be found in the private health sector in Greater Sydney, suggesting that there may be equity problems in the access to this type of care, adding to findings on inequity of the operation of the *Better Access Program* in Australia (32).

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 (33) 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(34) and in England(35). 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 (7).

We may also keep in mind that models which prioritize 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 services may be limited by the availability of core services in the system. In order to make useful choices to meet an individual's need, a whole array of service alternatives should be available at 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 (36,37).

The reduction or disappearance of day care staffed with health professionals has also been observed in other health systems that are shifting to a competitive market based on personalisation, such as England. Although this shift has been described in the disability sector (38-40), an understanding of the impact of this reform in the overall efficiency of the care system is still missing. Therefore, it 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 transition to the National Disability Insurance Scheme (NDIS), which has a strong emphasis on individualisation and care planning driven by demand.

SOCIAL DAY CARE

We have not identified any services providing social and cultural day care activities within the boundaries of the SLHD. However, many NGOs, particularly RichmondPRA, and Lou's Place in St Vincent's Health Network, cater for people within the SLHD. Therefore, these services could be considered as part of the CESPHN, rather than part of a single LHD.

In other PHNs (eg Western Sydney) previously available day care centres were progressively replaced by a complex program of day activities offered on an hourly basis, to groups of participants without a similar condition, level of need or course of recovery. Typically, these services are coded as O5 (low mobile) or O6 (mobile and home)in the classification system. They may offer a broad array of daily activities, but do not allow for a full planning of structured rehabilitation.

EMPLOYMENT RELATED SERVICES

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. This is very relevant in the transition process to ordinary employment for those who experience severe mental illness, and for those people who are not able, or are not willing, to work in ordinary employment. It is important to guarantee that there are other options available for people with diverse abilities, and who may require more support than that provided in supported employment. 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 (41). The recently published NICE clinical guideline for Psychosis and Schizophrenia in adults recommends to (42): "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".

The availability of specific employment services is a positive component of mental health provision. In the SLHD, we have found three employment-related services, and two services providing accessibility to employment. Specific employment services are an effective approach to incorporate people with a lived experience of mental illness into the workforce, if two conditions are met: 1) supported employment is integrated with the mental health treatment (i.e. supported employment specialists works in collaboration with the clinical mental health team); and 2) Follow up supports are non-time limited.

Differences in the availability of this type of care provision are clear with Girona (Spain) and Helsinki-Usimaa in Finland, but they are particularly relevant in comparison with Norway. This may indicate the need to develop more alternatives to employment and supported employment services in the area. Employment ranks fifth in the list of unmet needs of SES and IWS PIR consumers, while it came in third in ES (see Figure 49).

In any case, the availability of health-related day care for eating disorders, and the higher provision of work-related day care, may indicate that SLHD is well placed to pilot and implement new strategies in day care provision in NSW.

CARE COORDINATION AND INFORMATION

Recent analysis of interviews with Partners In Recovery (PIR) support facilitators and team leaders has identified that the main component of these roles is to identify and make contact with services, in order to meet their consumers' needs (43). One of the challenges to their work was the time taken to interpret and share knowledge about the system in which they work – a system whose boundaries, relationships and key features are difficult to interpret as an outsider. The Atlas can

provide a useful tool for navigation and individual care planning for case managers, navigators and coordinators.

The availability of coordination services is particularly relevant in the context of PIR in the CESPHN, although there is an apparent lack of a consistency in the actual model of care PIR utilises. The main objective of the PIR program is to increase accessibility to a different range of services of people with a lived experience of mental illness. Interestingly though, in the CESPHN, a significant number of these PIR providers are not just focused on accessibility, taking a more holistic approach by also providing some type of direct care, such as counselling, or intensive coaching. In SLHD, this is not as pronounced, with 5 out of 6 services in SLHD providing PIR coded as Accessibility (A4 – Care coordination) whilst the sixth has been coded as non-health related outpatient care (O5.2) rather than accessibility. It is possible that PIR teams have been filling gaps that have been identified in care provision, namely poor access to psychosocial services. This is the situation identified in South Western Sydney, where all the teams providing PIR where coded as O5.2 (44). This was also the case in Western Sydney, where the five teams have all been coded as O5.2 (45). The transfer to NDIS of these services implies changes in the organisation of care in this system that may have some consequences in the delivery system in some districts, particularly in areas of high psychological distress. It may also complicate performance assessment of PIR programs, when the activities do not fully match the original objective of the delivery program.

The availability of services providing accessibility to care is similar to that identified in other regions in Greater Sydney, except for teams providing accessibility to employment, of whichthere are fewer than in South Western Sydney. The lack of these services in the maps of the local areas in Europe is due to the fact that accessibility and information services were not included in the local mapping in the European regions.

ATAPS

The ATAPS program can be conceptualised as a primary care or secondary care service. It provides universal access to psychological care for those experiencing mild to moderate mental illness. The ATAPS program was introduced by the Australian government to provide individualised, evidence-based mental health care by trained allied mental health professionals on a free or low fee basis at point of use. To determine whether there is equitable access to ATAPS services in the SESLHD, it may be important to conduct a spatial analysis of ATAPS referrals, and a corresponding analysis of the distribution of ATAPS professionals. Such an analysis is important to determine if ATAPS 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 (46). This finding indicates 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).

7.2.3 SERVICES FOR SPECIFIC POPULATION GROUPS

7.2.3.1 SERVICES FOR CHILDREN AND ADOLESCENTS

Child and adolescent services were only coded for the SESLHD, and are therefore unable to be compared here.

7.2.3.2 SERVICES FOR TRANSITION TO ADULTHOOD

There is a considerable number of transition services from adolescence to adulthood. In the SLHD there are four MTCs providing transitional care, while we identified ten teams in SESLHD, five teams in Western Sydney, and six in South Western Sydney. A number of transition services are required at any local level to ensure the transition of consumers with complex needs. At least from the SESLHD where both transitional and child and adolescent services have been mapped, it seems that many resources are devoted to transition services in the CESPHN, in comparison to the overall availability of services for children and adolescents. This may indicate a problem in the continuity of care in core outpatient services for adolescent and for adults.

7.2.3.3. SERVICES FOR OLDER PEOPLE WITH A LIVED EXPERIENCE OF MENTAL ILLNESS

Services providing care for people aged 65 years and over with a lived experience of mental illness are available in the area, with significant differences across the two LHDs. SLHD has two BSICs for this age group, both outpatient non acute mobile, while the SESLHD provides ten, including residential and outpatient non mobile care. The variety and availability of the service provision system in the CESPHN is better than in the other PHNs mapped to date, as we have identified a broad range of residential, outpatient mobile and non-mobile services in both the public health sector and in NGOs.

7.2.3.4 SERVICES FOR OTHER POPULATION GROUPS EXPERIENCING MENTAL ILLNESS

The availability of services for other population groups in SLHD is remarkable. The three gender specific services identified in the survey provide residential, day and outpatient low-mobile care for women and cover the broad area of Greater Sydney. These services cover critical areas of delivery such as 24-hour support community residential care and day care in the community and when they are added to the general delivery system of mental health care reduce the gaps identified in this area.

It is important to note the availability of services for carers, homelessness, multicultural services and services for Aboriginal and Torres Strait Islander populations in the SLHD district.

7.3 MAIN GAPS IN SERVICE AVAILABILITY AND UNMET NEEDS

The Integrated Mental Health Atlas of SLHD identifies similar gaps to those identified in other areas in Greater Sydney (SWSLHD and WSLHD, and SESLHD). As previously stated, these gaps are mainly related to lack of residential alternatives to hospitalisation in the community (e.g. crisis homes, and high intensity rehabilitation support homes); lack of day care (both health related and social day care); and lack of residential support homes and residences with integrated care provision. These areas of care encompass three of the six major delivery areas recommended by Thornicroft and Tansella in their community and mental health model (23, 48). They also match the unmet needs reported by PIR consumers in the PIR needs assessments complete in IW, SES and ES. The top six unmet needs tend to be focused on daytime activities, employment and volunteering opportunities, social life, psychological distress, physical health and accommodation (49).

Table 39. Top 5 unmet needs identified in the Partner in Recovery program in the three PIR areas of the CESPHN (data provided by IWS, SES and ES PIRs).

IWS (PIR)	SES (PIR)	ES (PIR)
1. Daytime activities	1. Meaningful activities	1. Daytime Activities
2. Company (social life)	2. Psychological distress	2. Company
3. Psychological distress	3. Company	3. Employment & Volunteering
4. Physical health	4. Physical health	4. Accommodation
5. Employment & volunteering	5. Employment & volunteering	5. Psychological distress

It is important to note that psychological distress is one of the most frequently reported unmet needs of PIR consumers. This program aims to assist people with severe and persistent mental illness. The relatively low availability of psychological services may be related to this fact, although the ATAPS program, which targets aimed at mild/moderate illness, is an attempt to fill this gap, it targets quite distinct populations. An analysis of the needs of the PIR consumers identifies *daytime activities* and *company* (social life) as significant unmet needs, reported by the PIR consumers. These activities, especially daytime activities and social life, could be provided by day care services. While these services may have been missed from analyses conducted at a service and policy level their related unmet needs are being strongly felt amongst consumers. This also aligns with the recommendation of developing more recovery-oriented practices for community living.

7.4 IMPLICATIONS OF THE MAIN GAPS FOR THE LOCAL MENTAL HEALTH SYSTEM

FRAGILITY (LACK OF ROBUSTNESS OF THE CARE DELIVERY SYSTEM)

A particular issue emerging from the survey was the lack of robustness or the fragility of the system, brought about by short term programs lacking recurrent funding bases. The common three-year time frame provided by DESDE-LTC which clearly identified stable services and the robustness of the care delivery system in Western Europe, in comparison to the one available in some Eastern European countries, showed problems in mapping the service delivery system in Greater Sydney. This was due to the policy of funding services and programs, with separate organisational structures than the existing stable services, for limited periods of time of up to three years. Three years may be the minimum period to test the benefits of a new program, and it is clearly insufficient for testing the implementation of innovative strategies.

This type of problem occurs in high income countries where decision makers and policy planners (the advocates for a new service) take a 'component view' rather than a public health orientation, which takes a 'system thinking perspective', considering relationships between different elements of the system, and the whole pattern of care at the local level (23). The problem of the component approach is that it results in an inefficient use of scarce resources. Investment is made in new services while core services are absent, or not appropriately resourced and sustained. This leads to a "reactive" system, rather than a "proactive" system based on long term planning,and informed by local evidence. In addition, the skills and experience acquired by the workforce can be lost when short term programs end. The reliance on time-limited programs, mainly community based, means that the mental health system in the SLHD and in the CESPHN is "fragile". This lack of robustness is particularly relevant in the current situation, with major changes occurring due to the transition of many mental health services to the NDIS, and current changes in organisation and governance related to the commissioning role of the PHN, and its relationship with other components of the system, such as LHDs and 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 (20). Regional integration works to integrate pathways and services around the needs of consumers, while also striving for the best possible targeting and use of available resources, for both individual and community benefit. The emphasis on a system-based approach is critical to generate new informed evidence for policy and planning. 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 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 which services are available in the local area. Thus, the information provided here is necessary to carry out, and to understand, 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. This is because a system cannot be fully integrated when major components of the system are missing. In any case, the need and number of coordination services, which are not a part of routine activity performed in direct care services, 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.

PROBLEMS IN THE CARE DELIVERY SUBSYSTEM FOR MODERATE TO SEVERE PATIENTS

Many of the gaps identified in this report have a particular impact on the "missing middle", that is, the population with moderate to severe levels of mental illness, which is not receiving adequate care. The gaps in the care system for this group were highlighted in the review made by the National Mental Health Commission (18), which described the system as one that responds too late. In particular, the gap in high intensity day care may hinder tertiary prevention or rehabilitation.

When analysing the information, the type of services provided in the SLHD may better cover the needs of the two extremes of the lived experience of mental illness: on the one hand, those people with mental illness 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 (23).

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 (47). 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 consumers experiencing moderate-severe mental illness treated in specialised care, as identified in this analysis. The care pattern for mild-moderate mental illness in primary care in the SLHD is an area that requires further investigation.

These gaps also have implications for reform based on the stepped care model. From a policy perspective, there is tension between a policy planning strategy aimed at developing an integrated care system, and another strategy targeting specific areas of improvement such as suicide prevention, specific population groups or specific systems of care delivery. This tension is particularly relevant in the context of a stepped care model in a system characterised by significant fragmentation. It is important to note, the link between the stepped care model and the integrated care model have not been sufficiently explored, and the evidence available on the implementation of the stepped care model is mainly available on specific interventions within the service delivery system (e.g., psychotherapy) (50), and in specific conditions (e.g., anxiety and depression) (51,52). A major question is whether the stepped care model implemented in regional areas following an integrated care approach even when in an activity based system such as Germany (e.g., Aachen or Hamburg , Germany), (53) can be extrapolated to regions that are characterised by an activity based system which is highly fragmented, as in Australia. There is a risk of developing further silos and fragmentation in the implementation of a stepped care model if the care delivery system, workforce responsibilities and caseload are divided by levels of severity, without a full map of service availability, and knowledge and understanding of care pathways, and how they may ensure care continuity.

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, some services that are not specific to mental health, but that are used by people with lived experience of mental illness, may be absent. Some services providing care for people with disabilities and homelessness specific services expressed their interest in the Atlas, but did not want to be included as their target was not mental health. This is an issue which has also been identified in other PHNs.

The focus on individual care based on level of functioning without any consideration of the target population group, may have implications for 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. The CESPHN concentrates a considerable number of private health services into its jurisdiction with the highest number of specialists' attendances per person in Australia; and the costs of a specialised visit are the second highest in Australia after North Sydney.

Third, we have only mapped services that do not have time-limited funding (or that are confident they will continue to receive funding for at least three years). The inclusion of care programs that are time-limited would also have distorted the analysis, and would have decreased the utility of the Atlas for evidence-informed planning.

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 classifies as a mobile service).

Fifth, we have only included services within the boundaries of the SLHD, even though some of the residents in this area may use services from other regions, such as SESLHD, South Western Sydney, Western Sydney or Northern Sydney. A complete Atlas of Greater Sydney would solve this problem and allow a full understanding of the pattern of service availability and capacity in relation to service utilisation and patients flows. This information will eventually facilitate hot-spot analysis (54), benchmark analysis and modelling of relative or technical efficiency at local level (55) as has already been carried out in other metropolitan areas (56).

7.6 FUTURE STEPS

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 complimented by addressing the following issues:

- **Services at the Primary Care Level.** 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 Atlas of Mental Health Care can be combined with utilisation and outcome data to produce decision support tools that may help

decision for 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 (57).

- **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.
- **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. Cultural and linguistic diversity and Aboriginal and Torres Strait Islander mental health care should be a special focus of attention for the CESPHN, particularly SLHD, whilst care in inner regional areas closer to a main city (Sutherland Shire) and very remote Australia (Lord Howe Island) should be regarded as a relevant topic for SESLHD (16).

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 which 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 (56). 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, identify 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 coordination in communities with high social needs.

7.7 CONCLUSION

This Atlas contributes to the development of evidence-based regional mental health plans based on (i) comprehensive needs assessment; and (ii) identification of gaps and opportunities for better use of services through service mapping. Reducing duplication and removing inefficiencies is a requirement of PHNs–by the Federal Government as part of mental health reform (58). Our observations are in line with the report of the National Mental Health Commission's National Review of Mental Health Programmes and Services, which 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.

This is a unique moment for SLHD 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.

This mapping has provided a description of 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 knowledge of which services are available in the local area, so the information provided here is necessary to carry out and to understand integration of the care system. 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. The need, and the number, of coordination services, may also indicate a lack of continuity of care in the system. The transition to NDIS of many non-health services may potentially increase the level of fragmentation.

8. REFERENCES

1. Mendoza J, Bresnan, A., Rosenberg, S., Elson, A., Gilbert, Y., Long, P., Wilson, K., & Hopkins, J. Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future. . Caloundra, QLD: ConNectica, 2013
2. Astell-Burt T, Feng X. Investigating 'place effects' on mental health: implications for population-based studies in psychiatry. Epidemiology and Psychiatric Sciences. 2015;24(1):27-37.
3. Australian Bureau of Statistics. Australian Statistical Geography Standard (ASGS) 2013 [cited 2016, 30 June]. Available from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.005July%202011?OpenDocument.
4. Australian Bureau of Statistics (ABS). National Survey of Mental Health and Wellbeing: Summary of Results, 2007 2008 [Available from: http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Main%20Features32007?opendocument&tabname=Summary&prodno=4326.0&issue=2007&num=&view=.
5. Caldwell TM, Jorm AF, Dear KBG. Suicide and mental health in rural, remote and metropolitan areas in Australia. Medical Journal of Australia. 2004;181(7):S10-S4.
6. Jablensky A, McGrath J, Herrman H, Castle D, Gureje O, Evans M, et al. Psychotic disorders in urban areas: an overview of the Study on Low Prevalence Disorders. Australian and New Zealand Journal of Psychiatry. 2000;34(2):221-36.
7. Salvador-Carulla L, Alvarez-Galvez J, Romero C, Gutierrez-Colosia MR, Weber G, McDaid D, et al. Evaluation of an integrated system for classification, assessment and comparison of services for long-term care in Europe: the eDESDE-LTC study. BMC health services research. 2013;13:218.
8. Department of Health. Central and Eastern Sydney PHN factsheet 2016 [cited 2016, 28 July]. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/503C7D0F1A39C1D5CA257F1500041405/$File/PHN%20Infographic%20-%20Central%20and%20Eastern%20Sydney.pdf.
9. Central and Eastern Sydney Primary Health Networks. About Central and Eastern Sydney PHN. 2016 [cited 2016 21 April]. Available from: https://www.cesphn.org.au/about/about-cesphn.
10. NSW South Eastern Sydney Local Health District. South Eastern Sydney Local Health District: Our Population. Available from: http://www.seslhd.health.nsw.gov.au/about_us/documents/FactSheet_SESLHD_Our_Population.pdf.
11. Sydney Local Health District (SLHD). Our local health district boundary. 2013 [cited 2016 21 April]. Available from: https://www.slhd.nsw.gov.au/planning/pdf/SLHD%20_Boundary.pdf.
12. South Eastern Sydney Local Health District. South Eastern Sydney Local Health District: Our Boundary 2013. Available from: http://www.seslhd.health.nsw.gov.au/about_us/documents/FactSheet_SESLHD_Our_New_Boundary.pdf
13. NSW Government Ministry of Health. Sydney West Statistical Local Area Health Profile 2013 [Available from:

http://www.phcris.org.au/phplib/filedownload.php?file=/organisation/ml_cna/pdf/102/IWSML_Sydney_West_Combined_sub-regional_profile_v1_2.pdf.

14. NSW Government Ministry of Health. NSW State Health Plan: Towards 2021 2014 [Available from: http://www.health.nsw.gov.au/statehealthplan/Publications/NSW-State-Health-Plan-Towards-2021.pdf.
15. Family and Community Services. Family and Community Services Annual Report 2013-14: Volume 1: Performance and activities report 2014 [cited 2016, 25 August]. Available from: https://www.facs.nsw.gov.au/__data/assets/file/0008/303002/FACS-AR-13_14_Vol-1-Performance.pdf.
16. Cacace M, Ettelt S, Mays N, Nolte E. Assessing quality in cross-country comparisons of health systems and policies: Towards a set of generic quality criteria. Health Policy. 2013;112(1-2):156-62.
17. Salvador-Carulla L, Amaddeo F, Gutierrez-Colosia MR, Salazzari D, Gonzalez-Caballero JL, Montagni I, et al. 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. 2015;15:e042.
18. NSW Commission. "Living Well: a strategic Plan for Mental Health in NSW 2014-2014" 2014.
19. National Mental Health Commission. The National Review of Mental Health Programmes and Services. Sydney: NMHC; 2014 2014.
20. Australian government Department of Health. Australian government response to contributing lives, thriving communities - Review of mental health programmes and services. 2015 [Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response.
21. Department of Health. PHN programme guidelines 2016 [Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines.
22. Allison S, Bstaiampillai T, Goldney R. Acute versus sub-acute beds: should Asutralia onvest in community beds at the expense of hospital beds. Australian & New Zealand Journal of Psychiatry. 2014;48(10).
23. Thornicroft G, Tansella M. The balanced care model for global mental health. Psychological medicine. 2013;43(4):849-63.
24. Siskind D, Harris M, Kisely S, Brogan J, Pirkis J, Crompton D, et al. A retrospective quasi-experimental study of a community crisis house for patients with severe and persistent mental illness. Australian & New Zealand Journal of Psychiatry. 2013;47(7):667-75.
25. Health Do. Adult Prevention and Recovery Care (PARC) services framework and operational guidelines Victoria: Department of Health; 2010 [cited 2015 2 November]. Available from: http://www.health.vic.gov.au/mentalhealthservices/parc.pdf.
26. Bruce J, McDermott S, Ramia I, Bullen J, Fisher KR. Evaluation of the Housing and Accommodation Support Initiatives (HASI) Final Report for NSW Health and Housing NSW. Sydney: Social Policy Research Centre Report, 2012.
27. Marshall M, Crowther R, Sledge WH, Rathbone J, Soares-Weiser K. Day hospital versus admission for acute psychiatric disorders. The Cochrane database of systematic reviews. 2011(12):CD004026.
28. Quality. AfHRa. Management Strategies to reduce Psychiatric Admissions. Draft technical brief. Rockville, MD.: Agency for Healthcare Research and Quality. , 2014.

29. Priebe S, McCabe R, Schutzwohl M, Kiejna A, Nawka P, Raboch J, et al. Patient Characteristics Predicting Better Treatment Outcomes in Day Hospitals Compared With Inpatient Wards. Psychiat Serv. 2011;62(3):278-84.
30. NICE. Psychosis and schizophrenia in adults: prevention and management. UK: National Institute for Health and Care Excellence, 2014.
31. Department of Health and Ageing. National Mental Health Report 2013. Canberra: Department of Health and Ageing; 2013
32. Meadows GN, Enticott JC, Inder B, Russell GM, Gurr R. Better access to mental health care and the failure of the Medicare principle of universality. The Medical journal of Australia. 2015;202(4):190-4.
33. Wheeler C, Lloyd-Evans B, Churchard A, Fitzgerald C, Fullarton K, Mosse L, et al. Implementation of the Crisis Resolution Team model in adult mental health settings: a systematic review. BMC psychiatry. 2015;15:74.
34. Hasselberg N, Grawe RW, Johnson S, Ruud T. An implementation study of the crisis resolution team model in Norway: Are the crisis resolution teams fulfilling their role? Bmc Health Serv Res. 2011;11.
35. Johnson S. Crisis resolution and Home treatment in England: where are we now? In: Economics IoH, editor. Consensus Statement on Improving Mental health Transitions - November 4-6, 2014; Edmonton, Alberta2014.
36. Rosen A, Gurr R, Fanning P. The future of community-centred health services in Australia: lessons from the mental health sector. Australian health review : a publication of the Australian Hospital Association. 2010;34(1):106-15.
37. Rosen A, Gurr R, Fanning P, Owen A. The future of community-centred health services in Australia: 'When too many beds are not enough'. Australian health review : a publication of the Australian Hospital Association. 2012;36(3):239-43.
38. Ferguson I. Personalisation, social justice and social work: a reply to Simon Duffy. Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community,. 2012;26(1):55-73.
39. Duffy S, editor A Fair Society and the Limits of Personalisation.Disussion Paper. The Centre for Welfare Reform First Presented at the Tizard Memorial Lecture, 4th March 2011; 2011.
40. Barnes M. Abandoning Care? A Critical Perspective on Personalisation from an Ethic of Care. Ethcis and Social Welfare. 2011;5(2):153-67.
41. Grove B. Mental Health and Employment: Shaping a new agenda. Journal of Mental Health. 1999;8(2):131-40.
42. NICE. Psychosis and schizophrenia in adults: prevention and management. UK: National Institute for Health and Care Excellence, 2014.
43. Smith-Merry J, Gillespier J, Hancock N, Yen I. Doing Mental Health Care Integration: A Qualitative Study of a New Work Role. Unpublished Working Paper. 2015.
44. Salvador-Carulla L, Fernandez A, Feng X, Astell-Burt T, Maas C. The Integrated Mental Health Atlas of South Western Sydney. Sydney: Mental Health Policy Unit, Brain and Mind Centre, Faculty of Health Sciences, University of Sydney. South Western Sydney Partners in Recovery, Sydney. ; 2016.
45. Salvador-Carulla L, Fernandez A, Feng X, Astell-Burt T, Maas C, Smith-Merry J, et al. The Integrated Mental Health Atlas of Western Sydney. Sydney: Mental Health Policy Unit, Brain and Mind Centre, Faculty of Health Sciences, University of Sydney. Western Sydney Partners in Recovery, Sydney. ; 2016.

46. Meadows GN, Enticott JC, Inder B, Russell GM, Gurr R. Better access to mental health care and the failure of the Medicare principle of universality. The Medical journal of Australia. 2015;202(4):190-4.
47. OECD. OECD Reviews of Health Care Quality: Norway 2014 Rasing Standards. OECD, 2014.
48. Thornicroft G, Tansella M. Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence. The British journal of psychiatry : the journal of mental science. 2004;185:283-90.
49. South Eastern Sydney Partners in Recovery. South Eastern Sydney Partners in Recovery: Two year anniversary 2015 [cited 2016 29 June]. Available from: http://www.sespir.com.au/PDFs/SESPIR-final-two-year-anniversary-report.pdf
50. McQueen D, Smith PS. NICE recommendations for psychotherapy in depression: Of limited clinical utility. Psychiatriki. 2015;26(3):188-97.
51. . Heddaeus D, Steinmann M, Liebherz S, Harter M, Watzke B. [psychenet - The Hamburg Network for Mental Health: Evaluation of the Health Network Depression from the Perspective of Participating General Practitioners, Psychotherapists and Psychiatrists]. Psychiatr Prax. 2015;42 Suppl 1:S54-9.
52. Ho FY, Yeung WF, Ng TH, Chan CS. The Efficacy and Cost-Effectiveness of Stepped Care Prevention and Treatment for Depressive and/or Anxiety Disorders: A Systematic Review and Meta-Analysis. Sci Rep. 2016;6:29281.
53. Brocheler A, Bergmann F, Schneider F. Models of mental health care in psychiatry across sectoral borders. Eur Arch Psychiatry Clin Neurosci. 2009;259 Suppl 2:S227-32.
54. Salinas-Pérez JA, García-Alonso CR, Molina-Parrilla C, Jordà-Sampietro E, Salvador-Carulla L. Identification and location of hot and cold spots of treated prevalence of depression in Catalonia (Spain). International Journal of Health Geographics. 2012;11(36):1-10.
55. Torres-Jiménez M, García-Alonso CR, Salvador-Carulla L, Vicente Fernández-Rodríguez. Evaluation of system efficiency using the Monte Carlo DEA: The case of small health areas. European Journal of Operational Research. 2015;22(2):525-35.
56. Fernandez A, Salinas-Perez JA, Gutierrez-Colosia MR, Prat-Pubill B, Serrano-Blanco A, Molina C, et al. Use of an integrated Atlas of Mental Health Care for evidence informed policy in Catalonia (Spain). Epidemiology and psychiatric sciences. 2014:1-13.
57. Torres-Jiménez M, García-Alonso CR, Salvador-Carulla L, Vicente Fernández-Rodríguez. Evaluation of system efficiency using the Monte Carlo DEA: The case of small health areas. European Journal of Operational Research. 2015;22(2):525-35.
58. Australian Government Department of Health. Implementation Circular 2/2016 2016 [Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Circular2_Mental.
59. Sydney Local Health District (2015). A Picture of Health Sydney Local Health District Health Profile. SLHD Planning Unit (Dr P Garrett) NSW Government Health, SLHD.