ANNEX 3: THE INTEGRATED MAP OF MENTAL HEALTH SERVICES IN THE ST VINCENT'S HEALTH NETWORK (SVHN)

A nested subsystem in the Central Eastern Sydney Primary Health Network region (CESPHN)

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ABBREVIATIONS

ABS Australian Bureau of Statistics
ADC Acute Day Care
ARIA Accessibility/Remoteness Index of Australia
ATAPS Access to Allied Psychological Services
BSIC Basic Stable Inputs of Care
CALD Culturally and Linguistically Diverse
CBA Community Based Activity Program (Buckingham House)
CCM Clinical Case Manager
CESPHN Central and Eastern Sydney PHN
D2DL Day2Day Living
DESDE- LTC Description and Evaluation of Services and Directories in Europe for long-term care
ES Eastern Sydney
FACS Family and Community Services
GIS Geographical Information System
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
LTC Long Term Care
mhGAP Mental Health Gap Action Program
MHN Mental Health Nurse
MHSRRA Mental Health Services in Rural and Remote Areas
MTC Main Type of Care
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
PHN Primary health network
PIR Partners in recovery
PW Peer Worker
SA1 Statistical area 1
SES South Eastern Sydney
SESLHD South Eastern Sydney LHD

SF Support Facilitator
SLA Statistical Local Area
SLHD Sydney Local Health District
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, may seem to be very hospital-centric and even archaic for advanced community-based mental health services which are recovery-oriented and highly devolved. However, these categories are employed for comparability with standardized categories which have been used for some years in European mental health service mapping studies and the resulting Atlases [this standard classification system is 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 (1).

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* (2) 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.

While the SVHN is a nested subsystem within the CESPHN, the service mapping of mental health services within the network aligns with these recommendations. From this inventory of available services specifically targeted for people with a lived experience of mental illness, 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 mostneeded.

It is a tool for evidence-informed planning that critically analyses the pattern of mental health care provided within the SVHN. We used a standard classification system, the "*Description and Evaluation of Services and Directories in Europe for long-term care"* model (DESDE-LTC) (3), to describe and classify the services; as well as geographical information systems to geo-locate theservices.

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 some gaps in the provision of mental health care in the SVHN. These are a lack of:

- Non-hospital acute and sub-acute care
- Lack of medium or long-term accommodation for people with a lived experience of mentalillness
- Acute health care day-related

Taken together, the information in this Atlas highlights key areas for consideration for future planning for the provision of mental health services in the SVHN. 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, and characterised by fragmentation and inefficient provision of care (4). The Integrated Mental Health Atlas of the CESPHN region, of which this report is an annex, provides a detailed discussion of the Australian mental health context, outlining governmental priority in 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.

This report describes St Vincent's Health Network (SVHN), a specialised care network within metropolitan Sydney that operates mainly, but not only, as a "nested subsystem" within the CESPHN region (it also extends to Western Sydney). It has its own affiliate network and also specific connections with care provision organisations operating in Greater Sydney, although SVHN is mainly connected with SESLHD. This network functions in a highly urbanised area, and as such, the provision of mental health care in the SVHN represents specific challenges that influence the urban planning strategies (5-7) in Greater Sydney.

In this context, it is crucial to provide decision makers at the different levels of the care system (SVHN, LHDs, PHN, NSW Health) with the basic service delivery information to improve informed choices about future investments and resource allocation in urban mental health care. A key component for achieving this objective is identifying the services that currently exist in the SVHN, and noting how these services link within and across areas.

However, it would be misleading to provide an Atlas of SVHN separate to those of SESLHD and SLHD as it could lead to double counting of the care provision system in the CESPHN region. Whilst SESLHD and SLHD are official health jurisdictions operating within the CESPHN region and can be described as "meso-level" health areas with their own administrative geographical characteristics, St. Vincent's has different roles and definitions within the PHN.

SVHN can be defined as: a) a macro-organisation (a hospital corporation- St Vincent's Hospital Sydney Limited) that operates within a meso-level area (CESPHN region); b) A network officially registered "for the purposes of the National Health Reform Agreement in respect of three recognised establishments: St Vincent's Hospital, Darlinghurst; Sacred Heart Health Service, Darlinghurst and; St Joseph's Hospital, Auburn"; c) the registered network SVHN plus the affiliated services and other organisations with established collaborative arrangements in the provision system of the inner city SLA; and d) the broader network of SVHN and the partner organisations in Greater Sydney (mainly in SESLHD, SLHD and WSLHD).

According to these characteristics, SVHN cannot be defined as a health area such as the SESLHD; however, it is also different from other macro-organisations such as Prince of Wales Hospital or Sutherland Hospital in SESLHD. For these reasons, it has been defined as a nested subsystem.

In this report we define SVHN as the provision subsystem of the network in postcode areas (c). We have included the geographical mapping of SVHN in the area in which St. Vincent's is geographically located (SESLHD). We provide in this annex complementary information on the characteristics of the delivery subsystem provided by St. Vincent's Hospital, and the organisations affiliated or closely connected to this macro-organisation. The geographical maps and the visual representation of the social and demographic characteristics of the Inner City SLA area is described in Annex 2 (SESLHD). The organisational analysis

of the nested system of SVHN is a first look at the operations of the network, and will support the development of integrated planning and service delivery at the regional level.

1.1 WHAT IS INTEGRATED MENTAL HEALTH SERVICE MAPPING?

Integrated mental health service mapping identifies the number of mental health services in a designated area or organisation, and describes what these services are doing, and where they are located; as well as identification of data on service availability and care capacity. This mapping analysis allows comparison between small health areas and/or organisations, highlighting variations of care, and detecting gaps in the system. This information can be merged into a geographical atlas of mental health care as shown in the main report (*The Integrated Mental Health Atlas of the Central and Eastern Sydney PHN Region)*, or it can be displayed independently to improve evidence-informed planning.

1.2 HOW WAS THE INTEGRATED MENTAL HEALTH MAP OF THE SVHN ASSEMBLED?

A detailed description of the coding and mapping process can be found in the CESPHN main document. A brief description is provided below to assist readers who are reading the SVHN Annex as a stand-alone document.

This map was developed using the "Description and Evaluation of Services and Directories in Europe for long-term care" (DESDE-LTC) (3). 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. They have time stability (typically they have been funded for more than three years) and structural stability. Structural stability means that they have administrative support, their own space, their own finances (for instance a specific cost centre) and their own forms of documentation (i.e. they produce their own report by the end of the year) (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 BSICs in the SVHN using these criteria, 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, main report) depicts the different types of care used in our system.

There are six main types of care (3):

- **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 (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 (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 (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 (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 (Figure 7, p. 25, mainreport).
- **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) (Figure 8, p.26, mainreport).

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 region for a detailed description of the process or methodology.

2. DESCRIPTION OF THE NESTED SUBSYSTEM: BOUNDARIES AND INDICATORS

In developing this subsystem map, the main governance units of analysis to define boundaries in the main CESPHN report (LGAs and SLAs) bore a low correspondence to the reported areas of coverage of the SVHN. 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 region as part of the network. Finally, in collaboration with the LHDs and the network, it was resolved that the SVHN was a "nested subsystem" within the CESPHN region[1]. As such, an organisational analysis would be most appropriate for the SVHN, and the geographical analysis of the CESPHN region would be taken as the geographical reference. The catchment area the SVHN was identified based on expert knowledge as the population living in the following postcode areas: 2000, 2010, 2011, 2021, 2025, and 2027. However, it has been estimated that 35% of the persons to whom the SVHN provides care live outside this catchment area.

Figure 1. Catchment area of SVHN's Caritas.

[1] See discussion for a more detailed explanation of nested systems

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 SVHN come from data collected to build the CESPHN integrated atlas. The list of services identified in the CESPHN catchment area was submitted to the director of Inner City Health/ Clinical Director Mental & Homeless Health Service of the St Vincent's Health Network (Sydney) on the 1st of June, who selected those taking part in the SVHN. This list was revised by the Mental Health Atlas of South Eastern Sydney (SES), steering committee. This analysis includes services for adults only. Services for children and adolescents are included in the SESLHD annex.

We found a total of 62 BSICs (or teams), corresponding to 71 MTCs for people with a lived experience of mental illness or psychosocial problems. Eight functional teams had more than one main type of care or MTC. We did not include services where the primary presentation is not for mental health, for example, alcohol and other drugs, intellectual disability or homelessness.

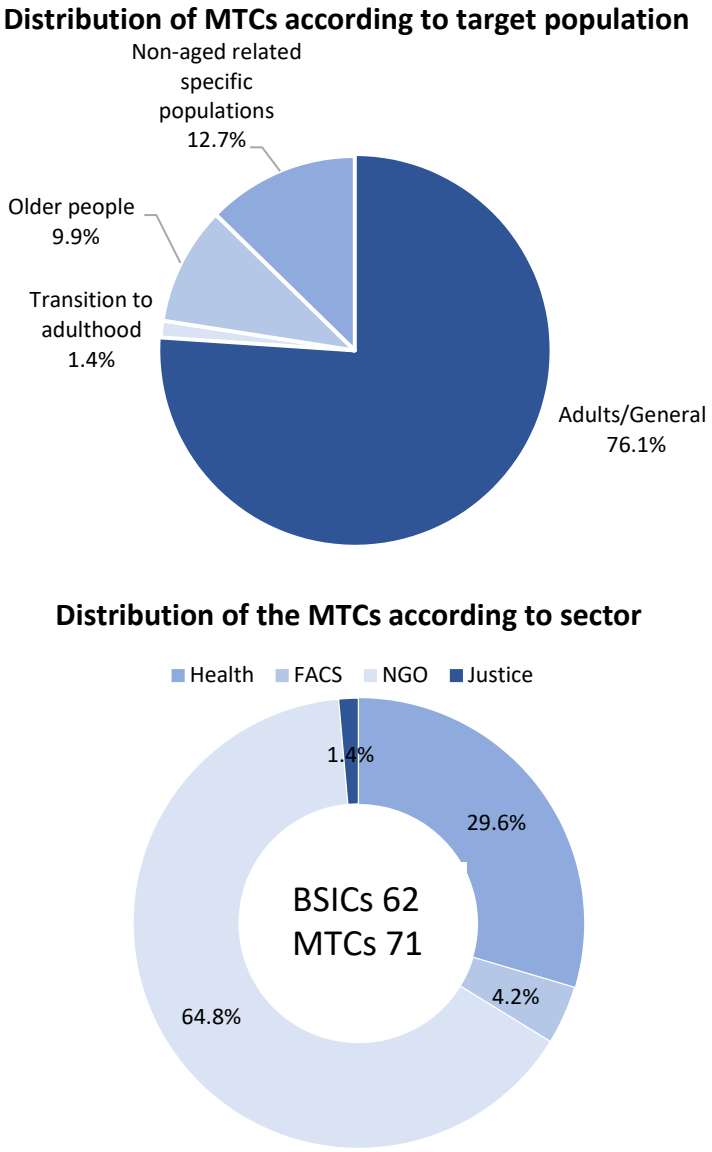
With regards to the age distribution of consumers provided for, 76% of the care provided is for adults without any target on specific populations, and 1.4% and 9.9% of the MTCs are specific to the transition to adulthood, and the older age populations respectively. 12.7% of the MTCs provided care dedicated to non-age related specific populations including carers of people with mental illness, Aboriginal and Torres Strait Islander peoples population, culturally and linguistically diverse (CALD) population, parents with a lived experience of mental illness (MD) and services that are gender-specific. Four or fewer services were identified for each of those sub-populations.

29.6% of the care for people with a lived experience of mental illness is provided by the public health sector, while 64.8% is provided by NGOs, 4.2% by family and community services, and 1.4% by the justice system.

With regard to the distribution by MTC, the services provided by the public health sector were mostly coded as Outpatient (76.2%) and Residential (19%). 4.8% were coded as Guidance and Information. In the non-health sector (i.e. NGOs, FACS and others), Outpatient care was also the most common (54%) followed by Day Care (20%) and Accessibility (14%). Residential care was much less developed than in the public health sector (2%), while Self-help and Voluntary care represented 4% of the care provided in the non-health sector.

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

Figure 2. Description of the MTCs identified



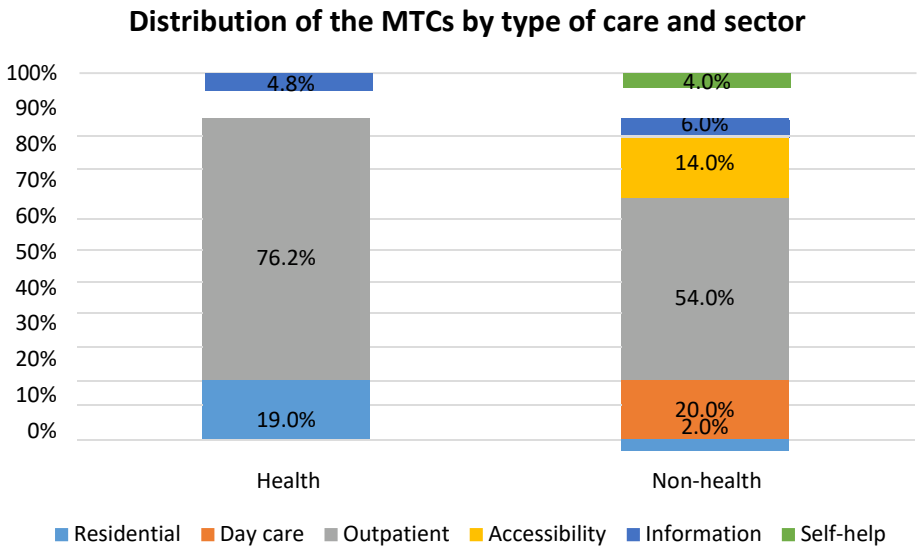

Distribution of the MTCs by type of care and sector
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
4.8%
76.2%
19.0%
4.0%
6.0%
14.0%
54.0%
20.0%
2.0%
Health
Non-health
Residential
Day care
Outpatient
Accessibility
Information
Self-help

Table 1. Description of the MTCs 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	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
R2	Acute, 24 hours physician cover, hospital, medium intensity	2	0	0	0	2	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	3	0	0	0	3
R8.2	Non-acute, non-24 physician cover, time limited, 24 hours support, over 4 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0	1
TOTAL R		**3**	**0**	**0**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**4**	**0**	**1**	**0**	**5**

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																										
D2.2	Non-acute, work, high intensity, other work	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
D5	Non-acute, non structured care, high intensity	0	0	4	0	4	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	5	0	5
D7.1	Non-acute, work related care, low intensity, time limited	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
D8.3	Non-acute, non-work structured care, low intensity, social and cultural related care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0	1
D10	Other non-acute day care not classified anywhere else	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	TOT AL	H	FACs	NGO	J	TOT AL	H	FACs	NGO	J	TOT AL	H	FACs	NGO	J	TOT AL	H	FACs	NGO	J	TOT
TOT AL D		0	0	8	0	8	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	0	10	0	10

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT AL	H	FACs	NGO	J	TOT AL	H	FACs	NGO	J	TOT AL	H	FACs	NGO	J	TOT AL	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																										
O2.1	Acute, home and mobile, limited hours, 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
O3.1	Acute, non-mobile, 24h, 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
O5.1	Non-Acute, Home & Mobile, High Intensity	1	0	0	0	1	1	0	0	0	1	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	12	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12	0	12

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
O6.1	Non-Acute, Home & Mobile, Medium Intensity	0	0	1	0	1	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	1	0	1	0	2
O6.2	Non-Acute, Home & Mobile, Medium Intensity, other care	0	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	0	5	0	5
O7.2	Non-Acute, Home & Mobile, low Intensity, other care	0	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	2
O8.1	Non-Acute, non-mobile, High intensity , health related care	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
O9.1	Non-Acute, non-mobile, Medium intensity , health related care	6	0	1	0	7	0	0	0	0	0	5	0	0	0	5	0	0	1	0	1	11	0	2	0	13

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
O9.2	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	1	1	2	0	0	2	1	3
O10.2	Non-Acute, Home & Mobile, Medium Intensity, other care	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 O		9	2	20	0	31	1	0	0	0	1	6	0	0	0	6	0	0	4	1	5	16	2	24	1	43

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	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	4	0	4
A5.3	Other accessibility care: health related: social and cultural services	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
A5.5	Other accessibility care: health related: housing related	0	1	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	2
TOTAL A		**0**	**1**	**5**	**0**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**1**	**6**	**0**	**7**
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																										
I1.1	Professional assessment and guidance related to health 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
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		**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**
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	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
TOTALS		**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**
TOTAL		**13**	**3**	**38**	**0**	**54**	**1**	**0**	**0**	**0**	**1**	**7**	**0**	**0**	**0**	**7**	**0**	**0**	**8**	**1**	**9**	**21**	**3**	**46**	**1**	**71**

3.2 ADULTS

In this section we describe the availability and placement capacity (number of places or beds available in every functional team) of the BSICs/services providing care for adults (>17 years old) with a lived experience of mental illness, by sector. Specific age related services for the transition from adolescence to adulthood, and 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 separately.

3.2.1 RESIDENTIAL CARE

3.2.1.1 RESIDENTIAL CARE PROVIDED BY THE PUBLIC HEALTH SECTOR

ACUTE INPATIENT SERVICES

A total of two BSICs/services, corresponding to three MTCs providing acute inpatient care in the SVHN were identified. One of the three MTCs is considered high intensity (code R1), while the other two are medium intensity (R2).

The number of BSICs provided by the public health sector providing acute care is 2, or 2.29 per 100,000 residents. The number of acute beds provided by the public health sector is 33, or 37.76 per 100,000 residents.

Table 2. Acute inpatient services: availability and placement capacity

Provider	Name	Main DESDE Code	Other DESDE code(s)	Beds/Places	Town / Suburb	Area of Coverage
St Vincent's Mental Health Service	Acute Inpatient Unit	AX[F00-F99]-R2	AX[F00-F99]-R1	21 / 6	Darlinghurst	SV
St Vincent's Mental Health Service	Psychiatric Emergency Care Centre	AX[F00-F99]-R2	AX[F00-F99]-O3.1	6	Darlinghurst	SV
Total	2			33		
Rate per 100,000 residents (>17 years old)	2.29			37.76		

The next table shows the workforce capacity related to adult acute inpatient services in the area covered by the SVHN. The total number of FTEs related to adult acute inpatient services is 68.1, or 77.92 per 100,000 residents. Psychiatrists and mental health nurses, as expected, account for the greatest proportion of the workforce.

Table 3. Acute inpatient unit: workforce capacity

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT
St Vincent's Mental Health Service	Acute Inpatient Unit	43.7	3.8	0.5	36.6	2.3	0.5
St Vincent's Mental Health Service	Psychiatric Emergency Care Centre	24.4	2		21.8	0.6	
Total		68.1					
Rate per 100,000 residents (>17 years old)		77.92					

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

We did not identify any non-acute inpatient and residential services in the SVHN.

OTHER RESIDENTIAL CARE PROVIDED BY THE PUBLIC SECTOR (SOCIAL AND COMMUNITY HOUSING)

SOCIAL HOUSING

Family and Community Services (FACS) provides public in-home care for vulnerable people including the following groups:

- Aboriginal and Torres Strait Islander people
- Children and young people
- Families
- People who are in need of housing
- People with a disability, their families and carers
- Women
- Lesbian, gay, bisexual, transgender, intersex or queer youth and
- Older people

According to the report published by FACS NSW (8), as of the 30th of June 2013, there were a total of 110,059 households living in public housing: 25,973 living in community housing and 4,469 living in Aboriginal Housing. FACS manages 149,972 properties in NSW, comprising 117,798 public housing dwellings, 27,450 properties in the community housing sector and 4,724 Aboriginal Housing properties.

However, the DESDE-LTC codification of public housing (and the NGOs) is difficult for several reasons. Firstly, it is not possible to know how many of the properties are specifically devoted to people with a lived experience of mental illness. Secondly, 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 thirdly, properties are not restricted to specified districts (i.e. a person living in Redfern may be relocated out of the district area if there is a property available there). The separation of property, management and care provision, together with case complexity and comorbidity provided additional obstacles for coding these services. As a matter of fact, social 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 organisations that provide people with 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 illness is provided is more accurately conceptualised as a financing mechanism than a service providing care. Therefore, we have included FACS services as ambulatory mobile care (O code) and accessibility (A code: assisting consumers to access social housing through assessment and eligibility).

We found three BSIC/services delivered by FACS providing direct care related to housing in the SVHN. Although this is not specifically for people with a lived experience of mental illness, most of their consumers experience mental illness. Two of the three 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 therefore are coded as "Outpatient" care (O). The other BSIC is focused on helping the client to access social housing (through assessment and eligibility), and is coded as "Accessibility" (A).

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

The total number of BSICs/services from FACS providing tenancy support (non-acute, mobile, outpatient care, low intensity) in the SVHN is 2, or 2.29 per 100,000 residents. The total number of FTEs of case workers providing this type of care is 17, with a rate of 19.45 per 100,000 residents.

The number of BSICs/services from FACS providing assessment and eligibility care (accessibility to social housing) in the SVHN area is 1.14 per 100,000 residents, with a rate of 32.04 FTEs 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 4. BSICs related to social housing: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
FACS	Tenancy Support*	AX[Z55-65]-O7.2	7	Strawberry Hills	ES
FACS	Tenancy Support*	AX[Z55-65]-O7.2	10.0	Waterloo	IWS
Total	2		17		
Rate per 100,000 residents (>17 years old)	2.29		19.45		

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
FACS	Eligibility and Assessment*	AX[Z55-65]-A5.5	28	Strawberry Hills	ES
Total	1		28		
Rate per 100,000 residents (>17 years old)	1.14		32.04		

Please note FACS BSICs are also counted in Outpatient mobile and Accessibility sections below

3.2.1.2 COMMUNITY HOUSING

For consistency, the same coding principles adopted for Social Housing have been applied to the Community Housing sector. That is, services which provide both accommodation and in-home support to people with a lived experience of mental illness are coded as residential care, and services which provide in-home support only, are coded as outpatient care. Following these principles, there were no general adult community housing organisations that were coded as providing residential care to people with a lived experience of mental illness in the SVHN.

There was, however, a gender specific community residential service, B Miles, identified, managing properties which have been specifically designated for people with a lived experience of mental illness. B Miles is a specific service for women who experience mental illness who are at risk of being homeless, or are already homeless. B Miles' primary objectives are to resolve and prevent homelessness by providing flexible service delivery comprised of: a) Crisis accommodation; b) Transitional housing; c) Outreach support. Although they are located in the area covered by St Vincent's Hospital (SESLHD), it is worth noting that they have 4 transitional houses for women with mental illness in the area of IWS (1 in Petersham, 1 in Camperdown, 1 Ashfield, 1 in Marrickville) and 10 in ES (3 in Randwick, 2 in Kensington, 3 in Potts Point, 1 in Surry Hills, and 1 in Rushcutters Bay). They also provide low intensity support to the women living in these properties, if needed. This service was mapped as a gender specific service (See section 3.4.1).

Ecclesia Housing has 6 transitional properties in the area of St Vincent's (SESLHD), where Neami National provide the support (Neami Help Housing Recovery). These 6 transitional properties may host a total of 20 people up to 19 months. This service is coded in Outpatient mobile section below.

3.2.1.3 RESIDENTIAL CARE PROVIDED BY NGOS

A number of NGOs provide in-home support for people with disabilities in the greater CESPHN region. Codification of these services is complicated, as some 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 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 service was identified providing in-home support to people with a lived experience of mental illness in the SVHN. This is described here but coded in the outpatient mobile service section. Ashfield Biala is run by Aftercare, and provides supported residential accommodation for adults aged between 18 and 40 who are recovering from a serious 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.

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

3.2.2 DAY CARE

3.2.2.1 DAY CARE PROVIDED BY THE PUBLIC HEALTH SECTOR

We did not identify any day care provided by the public health sector in the SVHN.

3.2.2.2 DAY CARE PROVIDED BY NGOS

SOCIAL AND CULTURE RELATED

We identified six NGO funded, BSIC/services, incorporating seven MTCs, providing day programs which offer social and/or cultural activities for people with a lived experience of mental illness in the SVHN. The first service, Buckingham House (RichmondPRA), is located within the SVHN, but is open to residents of the whole CESPHN region. 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 region. 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 place; 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.

The Wayside Chapel (Uniting Care) also run a D2DL program in Potts Point. This program provides structured activities five days a week, and runs from a drop in centre which is open seven days a week, from 9am to 8pm. The D2DL program was originally funded to support consumers living within Sydney City. Extension of this area of coverage has however occurred. The Wayside Chapel D2DL program also has a satellite service, Chapel by the Sea, at Bondi.

The remaining two BSICs/services provide a mix of structured and unstructured activities. The Recreational Program run by Aftercare aims to increase the social activities of people with a lived experience of mental illness and runs groups in the community, and Holdsworth House in Woollahra runs the Holdsworth House Club Program.

An additional day program not specifically for people with a lived experience of mental illness was also identified in the mapping process, but is not coded. The St Vincent de Paul Society manages a Men's Shed (St Mary MacKillop), which welcomes people with a lived experience of mental illness, but is not specifically for them.

The total number of BSICs/services from the NGO sector providing social and culture-related day care within the boundaries of the SVHN is 6, or 6.87 per 100,000 residents. The total number of FTEs for those services is 25.2, or 28.83 per 100,000 residents.

Table 5. Social and culture-related day care provided by NGOs: availability and workforce capacity

Provider	Name	Main DESDE Code	Other DESDE code(s)	FTE	Town / Suburb	Area of Coverage
Aftercare	Recreational Program	AX[F00-F99]-D10		3	Randwick	ES
Holdsworth Club Program	Holdsworth Club Program	AX[F00-F99]-D5		15	Woollahra	ES
RichmondPRA	Buckingham House – D2DL	AX[F00-F99]-D5		2.7	Surry Hills	SV-ES
RichmondPRA	Buckingham House-CBA program	AX[F00-F99]-D10		1	Surry Hills	SV-ES
Uniting Church	The Wayside Chapel/Chapel by the Sea (satellite)	AX[F00-F99]-D5t		NA	Bondi Beach	ES
Uniting Church	Wayside Chapel - D2DL	AX[F00-F99]-D5	AX[F00-F99]-D2.2	3.5	Kings Cross	SES
Total	6			25.2		
Rate per 100,000 residents (>17 years old)	6.87			28.83		

FTE: Full-Time Equivalents.

WORK-RELATED

There is one BSIC (or service) providing work-related day care for people with a lived experience of mental illness in the SVHN. Although this BSIC is located in the area of SLHD, its consumers can come from all of Greater Sydney.

Table 6. Work-related day care provided by NGOs: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
RichmondPRA	Pre-Employ Institute	AX[F00-F99]-D7.1	0.8	Surry Hills	Greater Sydney Area
Total	1		0.8		
Rate per 100,000 residents (>17 years old)	1.14		0.92		

The total number of BSICs/services from the NGO sector providing work-related day care is 1, or 1.14 per 100,000 residents. The number of full time equivalents is 0.8, or 0.92 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 one BSIC (or service) providing acute mobile outpatient care for adults with a lived experience of mental illness. It provides acute care, home & mobile, on limited hours.

The total number of BSICs/services from the public health sector providing acute mobile outpatient care is 1, or 1.14 per 100,000 residents.

Table 7. Acute mobile outpatient care provided by the public health sector: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
St Vincent's Mental Health Service	Acute Care Team	AX[F00-F99]-O2.1	Darlinghurst	SV
Total	1			
Rate per 100,000 residents (>17 years old)	1.14			

There are a total of 9.60 FTEs of professionals providing acute and mobile care, or 10.98 per 100,000 residents. Clinical Case Managers are the largest professional group.

Table 8. Acute mobile outpatient care provided by the public health sector: workforce capacity

Provider	Name	Total FTE	Psych/reg	SW	OT	CCM	Edu
St Vincent's Mental Health Service	Acute Care Team	9.6	1.5	1	0.5	5.6	1
Total		9.6					
Rate per 100,000 residents (>17 years old)		10.98					

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-register; SW: Social worker; OT: Occupational therapist; CCM: Clinical case manager; Edu: Educator.

ACUTE NON-MOBILE OUTPATIENT CARE

The Psychiatric Emergency Care Centre (PEEC) of the St Vincent's Hospital, which mainly provides acute residential care (see the corresponding section), also provides non-mobile outpatient care (DESDE 2 = O3.1).

The number of MTCs from the public health sector providing acute non-mobile outpatient care per 100,000 residents is 0.85.

NON ACUTE MOBILE OUTPATIENT CARE

We found one BSIC (or service) providing non-acute mobile outpatient care within the boundaries of the SVHN, a case management team that provides medium intensity care (i.e. contacts are made at least on a fortnightly basis).

The number of services from the public health sector providing non-acute mobile outpatient care per 100,000 residents is 1, or 1.14 per 100,000 residents.

Table 9. Non-acute mobile outpatient care provided by the public health sector: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
St Vincent's Mental Health Service	Case Management Team	AX[F00-F99]-O5.1	Darlinghurst	SV
Total	1			
Rate per 100,000 residents (>17 years old)	1.14			

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 21.5, or 24.6 per 100,000 residents.

Table 10. Non-acute mobile outpatient BSICS provided by the public health sector: workforce capacity

Provider	Name	Total FTE	Psych/reg	Psychol	CCM
St Vincent's Mental Health Service	Case Management Team	21.5	2	0.5	19

Total	21.5
Rate per 100,000 residents (>17 years old)	24.6

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; CCM: Clinical case manager.

NON-ACUTE NON-MOBILE OUTPATIENT CARE

We have identified five BSICs/services, incorporating six MTCs, providing non-acute, non-mobile outpatient care within the boundaries of the SVHNS.

Some of these services are specialised services targeting personality disorders, affective disorders and people with a lived experience of mental illness and HIV/AIDs.

Table 11. Non-acute non-mobile outpatient care provided by the public health sector: availability

Provider	Name	Main DESDE Code	Other DESDE code(s)	Town / Suburb	Area of Coverage
St Vincent's Mental Health Service	Anxiety Disorders Clinical	AX[F40-48]-O9.1		Darlinghurst	SV
St Vincent's Mental Health Service	Borderline Group-Day Care	AX[F60.3]-O9.1		Darlinghurst	SV
St Vincent's Mental Health Service	Community Rehab Team	AX[F00-F99]-O9.1		Darlinghurst	SV
St Vincent's Mental Health Service	Consultation Liaison Team	AX[F00-F99]-O9.1ll	AX[F10-F19]-O9.1l	Darlinghurst	SV
St Vincent's Mental Health Service	HTH/HIV Team	AX[F00-F99]-O9.1l		Darlinghurst	SV
Total	5				
Rate per 100,000 residents (>17 years old)	5.72				

The number of BSICs/services from the public health sector providing non-acute non-mobile outpatient care is 5, or 5.72 per 100,000 residents.

The total number of FTEs of professionals providing non-acute non-mobile outpatient care in the public health sector is 16.4, or 18.76 per 100,000 residents.

Table 12. Non-acute non-mobile outpatient care provided by the public health sector: workforce capacity

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT
St Vincent's Mental Health Service	Anxiety Disorders Clinical	4.5	2.2	2.3			
St Vincent's Mental Health Service	Borderline Group-Day Care	1			1		
St Vincent's Mental Health Service	Community Rehab Team	2.6	0.2	0.4		1	1

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT
St Vincent's Mental Health Service	Consultation Liaison Team	6.3	3.5	1.6	1.2		
St Vincent's Mental Health Service	HTH/HIV Team	2	0.2	1.2	0.6		
Total		16.4					
Rate per 100,000 residents (>17 years old)		18.76					

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

3.2.3.2 OUTPATIENT CARE PROVIDED BY NGOS AND NON HEALTH SECTOR SERVICES

ACUTE MOBILE OUTPATIENT CARE

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

ACUTE NON-MOBILE OUTPATIENT CARE

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

NON-ACUTE MOBILE OUTPATIENT CARE

We found 18 BSICs providing non-acute mobile outpatient care within the boundaries of the SVHN. Aftercare, Mission Australia and Neami National provide the support component of the HASI program. This program has been described in the residential section of this report.

Anglicare and Aftercare 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 is considered high-intensity, as they have the capacity to see their consumers at least three days per week if needed. The PHaMs programs by Anglicare have the capacity to see consumers at least weekly.

Brown Nurses is a service providing in-home care to socially and economically disadvantaged individuals with complex needs, especially, but not exclusively, with a lived experience of mental illness.Their area of coverage is Greater Sydney, although they have a special focus on the SLHD and SVHN catchment regions.

NEAMI, in partnership with Ecclesia, provide the support to people with a lived experience who live in the transitional properties (Help Housing Recovery).

The number of BSICs/services from the NGO sector providing non-acute mobile outpatient care is 18, or 20.6 per 100,000 residents. This includes Partners in Recovery (PIR) programs providing those type of services. (See specific PIR section for further information abot PIR services).

Table 13. 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	Lilyfield	IWS
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	Alexandria	SES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	Randwick	ES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	Randwick	ES
Aftercare	Personal Helpers and Mentors	AX[F00-F99]-O5.2	Sylvania Waters	SES
Aftercare	PHaMs Canada Bay	AX[F00-F99]-O5.2	Auburn	Canada Bay, Leichhardt, Auburn, Ashfield, Bankstown
Aftercare	PHaMs Rozelle	AX[F00-F99]-O5.2	Lilyfield	Balmain, Rozelle, Lilyfield
Aftercare	Transitional Housing Program-Biala (METRO)	AX[F00-F99]-O6.2	Ashfield	IWS
Anglicare	PHaMs	AX[F00-F99]-O6.2	Bondi Beach	ES
Brown Nurses	Brown Nurses	AX[F00-F99]-O6.1	Glebe	SV
FACS	Tenancy Support*	AX[Z55-65]-O7.2	Strawberry Hills	ES
FACS	Waterloo Tenancy Team*	AX[Z55-65]-O7.2	Waterloo	Waterloo
Mission Australia	HASI	AX[F00-F99]-O5.2	Waterloo	ES-SV
Neami National	HASI - City	AX[F00-F99]-O5.2	Darlinghurst	SV
Neami National	HASI - Eastern	AX[F00-F99]-O5.2	Darlinghurst	SV
Neami National	Help Housing Recovery	AX[F00-F99]-O6.2	Darlinghurst	SV
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	Pagewood	ES
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	Darlinghurst	SV
Total	18			
Rate per 100,000 residents (>17 years old)	20.6			

** Please note FACS and PIR BSICs are also described and counted in FACs table in specific FACS and PIR sections of report*

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 107.5, or 123 per 100,000 residents.**

Table 14. Non-acute mobile outpatient BSICS provided by NGOs: workforce capacity

Provider	Name	Total FTE	MHN	SW	nCCM	MHW	SF	SupW	Others
Aftercare	HASI central	9						9	
Aftercare	Partners in Recovery*	3					3		
Aftercare	Partners in Recovery*	5					5		
Aftercare	Partners in Recovery*	6					6		
Aftercare	Personal Helpers and Mentors	5						5	
Aftercare	PHaMs Canada Bay	5						5	
Aftercare	PHaMs Rozelle	5						5	
Aftercare	Transitional Housing Program-Biala (METRO)	3						3	
Anglicare	PHaMs	12		4	6	2			
Brown Nurses	Brown Nurses	5	5						
FACS	Tenancy Support	7							7
FACS	Waterloo Tenancy Team	10						10	
Mission Australia	HASI	4					4		
Neami National	HASI - City	6					6		
Neami National	HASI - Eastern	4					4		
Neami National	Help Housing Recovery	3					3		
Neami National	Partners in Recovery*	10.5					10.5		
Neami National	Partners in Recovery	5					5		
Total		107.5							
Rate per 100,000 residents (>17 years old)		123							

** Please note FACS and PIR BSICs are also described and counted in FACs table in specific FACS and PIR sections of report*

FTE: Full-Time Equivalents; Psych/reg: Psychiatrist-registrar; MHN: Mental health nurse; SW: Social worker; nCCM: Non-Clinical Case Manager; MHW: Mental health worker; SF: Support facilitator; SupW: Support worker/community worker.

NON-ACUTE NON-MOBILE OUTPATIENT CARE

We have identified four BSIC/services providing non-acute non-mobile outpatient care.

Wesley Mission has a financial counselling service and a psychological service in Sydney (City, Pitt Street) which can be used by people from all the Greater Sydney Area. It also supports people across17 properties in Surry Hills with a lived experience of mental illness who arehomeless.

The Haymarket Foundation aims to support socio-economically disadvantaged people in Sydney, providing

medical assistance and crisis accommodation. Although it mainly works with people who are homeless, it

also provides psychological services for people with a lived experience of mental illness who are vulnerable (they do not need to be homeless).

The number of BSIC/services from the NGO sector providing non-acute non-mobile outpatient care is 4, or 4.58 per 100,000 residents.

Table 15. Non-acute non-mobile outpatient care provided by NGOs: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Haymarket Foundation	Psychological Services	AX[F00-F99]-O8.1	East Sydney	Greater Sydney
Wesley Mission	Financial Counselling/Gambling	AX[Z55-65]-O9.2	Sydney	Greater Sydney Area
Wesley Mission	Homelessness support for people with MH issues	AX[F00-F99]-O10.2	Surry Hills	SV-ES-SES
Wesley Mission	Psychological Services	AX[F00-F99]-O9.1	Sydney	Greater Sydney Area
Total	4			
Rate per 100,000 residents (>17 years old)	4.58			

The table below shows the workforce providing non-acute non-mobile care related to health needs. The number of FTE is 16, or 18.31 per 100,000 residents.

Table 16. Non-acute non-mobile outpatient BSIC provided by NGOs: workforce capacity

Provider	Name	Total FTE	Psychol	nCCM
Haymarket Foundation	Psychological Services	1	1	
Wesley Mission	Financial Counselling/Gambling	8		8
Wesley Mission	Homelessness support for people with MH issues	6		6
Wesley Mission	Psychological Services	1	1	
Total		16		
Rate per 100,000 residents (>17 years old)		18.31		

FTE: Full-Time Equivalents; Psych/reg: Psychiatrist-registrar; MHN: Mental health nurse; nCCM: Non-clinical case manager..

3.2.4 ACCESSIBILITY SERVICES

3.2.4.1 ACCESSIBILITY SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR

We have not found any public health sector BSIC providing accessibility services.

3.2.4.2 ACCESSIBILITY SERVICES PROVIDED BY NGOS AND NON HEALTH SECTOR SERVICES

One BSIC provides accessibility support related to cultural and leisure activities, through the Active Link Initiative.

Two BSICs/services provide accessibility services relating to housing. Way2Home provides accessibility support related to finding secure, affordable and safe housing, and the Community Options programs of the Benevolent Society support individuals with complex care needs (including mental illness), to remain living independently in the community.

The other three accessibility services are provided by Partners in Recovery (see separate description of PIR) and FACS.

The total number of BSIC/services from the NGO sector providing accessibility services is 6, or 6.87 per 100,000 residents, including Partners in Recovery (PIR) programs providing those type of services. Not including PIR, the rate of services providing accessibility to housing is 1.14 per 100,000 residents, and 1.14 for accessibility to cultural activities.

Table 17. 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	Eligibility and Assessment*	AX[Z55-65]-A5.5	Strawberry Hills	ES
Mission Australia	Partners in Recovery*	AX[F00-F99]-A4	Waterloo	IWS
Neami National	Way2Home	AX[F00-F99]-A5.5	Darlinghurst	SV
The Benevolent Society	Community Options Program	AX[F00-F99]-A4	Rosebery	ES
Total	6			
Rate per 100,000 residents (>17 years old)	6.87			

** Please note FACS and PIR BSIC is also described and counted in specific FACS section in Residential care above*

Accessibility services for people with a lived experience of mental illness have a total workforce of 63.3, or 72.43 FTEs per 100,000 residents. This includes PIR, discussed below.

Table 18. Accessibility services provided by NGOs: workforce capacity

Provider	Name	Total FTE	nCCM	SF	SupW	Others
Aftercare	Active Linking Initiative	5			5	
Aftercare	Partners in Recovery*	4		4		
FACS	Eligibility and Assessment*	28				28

Provider	Name	Total FTE	nCCM	SF	SupW	Others
Mission Australia	Partners in Recovery*	4		4		
Neami National	Way2Home	18.3			18.3	
The Benevolent Society	Community Options Program	4	4			
Total		63.3				
Rate per 100,000 residents (>17 years old)		72.43				

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

** Please note FACS and PIR BSIC is also described and counted in specific FACS section in Residential care above*

PARTNERS IN RECOVERY

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 just focused on accessibility, but take a more holistic approach, providing also 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, daily 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 7 PIR in the SVHNS. The total number of PIR per 100,000 residents is 8.01 *Note that, in this report, 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 19. 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]-O5.2	3	8.00%	Alexandria	SES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	5	13.33%	Randwick	ES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	6	16.00%	Randwick	ES
Aftercare	Partners in Recovery*	AX[F00-F99]-A4	4	10.67%	Alexandria	IWS
Mission Australia	Partners in Recovery*	AX[F00-F99]-A4	4	10.67%	Waterloo	IWS
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	10.5	28.00%	Pagewood	ES
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	5	13.33%	Darlinghurst	SV
Total	7		37.5	100%		
Rate per 100,000 residents (>17 years old)	8.01		42.91			

FTE: Full-Time Equivalents

**Please note PIR BSICs are also described and counted in the relevant Outpatient and Accessibility sections of the report*

ABILITY LINKS

Ability Links is a program funded by FACS which 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 not a specific service for people with psychosocial disabilities, it deals with people with a lived experience of 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 partnership with Settlement Services International (SSI). It provides care for people from 9 to 65 yearsold.

3.2.5 INFORMATION AND GUIDANCE

3.2.5.1 INFORMATION AND GUIDANCE SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR

We have identified one BSIC (or service) providing exclusively information and guidance for people with a lived experience of mental illness. **The total number of BSIC or services from the health sector providing information and guidance for people with a lived experience of mental illness is 1, or 1.14 per 100,000 residents.**

Table 20. Information and guidance services provided by the public health sector: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
St Vincent's Mental Health Service	Triage Service	GX[F00-F99]-I1.1	Darlinghurst	SV
Total	1			
Rate per 100,000 residents (>17 years old)	1.14			

The table below describes the workforce providing information and guidance. **The specific services for people with a lived experience of mental illness have a total workforce of 2, or 2.29 FTEs per 100,000 residents.**

Table 21. Information and guidance services provided by the public health sector: workforce capacity

Provider	Name	Total FTE	CCM
St Vincent's Mental Health Service	Triage Service	2	2
Total		2	
Rate per 100,000 residents (>17 years old)		2.29	

FTE: Full-Time Equivalents; CCM: Clinical case manager.

3.2.5.2 INFORMATION AND GUIDANCE SERVICES PROVIDED BY NGOS AND NON HEALTH SECTOR SERVICES

We have identified two BSIC/services, corresponding to three MTCs, providing information for people with a lived experience of mental illness. One 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 2.29 per 100,000 residents.

Table 22. 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	Woolloomooloo	STATE
Total	2				
Rate per 100,000 residents (>17 years old)	2.29				

3.2.6 SELF AND VOLUNTARY SUPPORT

3.2.6.1 SELF AND VOLUNTARY SUPPORT PROVIDED BY NGOS

We have found two BSIC/services based on volunteer staff providing care for people with a lived experience of mental illness. They are: the Compeer friendship program, operated by the St Vincent de Paul Society, which aims to improve the quality of life of adults with a mental illness through one-to-one friendship with a caring volunteer; and Schizophrenia Fellowship, which has a Support Group in Bondi Junction.

The total number of BSIC/services from the NGO sector providing self and voluntary support services in the SVHNS is 2, or 2.29 per 100,000 residents.

Table 23. Self and voluntary support provided by NGOs: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Schizophrenia Fellowship	Support Group	AX[F00-F99]-S1.3	Bondi Junction	ES
St Vincent de Paul	Compeer	GX[F00-F99]-S1.2	Different locations	SES and SLHD
Total	2			
Rate per 100,000 residents (>17 years old)	2.29			

3.3 AGE SPECIFIC POPULATIONS

3.3.1 TRANSITION TO ADULTHOOD

We identified 1 BSIC (or service) providing specific care for people with a lived experience of mental illness transitioning to adulthood. The total number of such BSIC per 100,000 residents aged 18 and below, is 13.28. The total number of FTEs of professionals providing care for transition to adulthood is 4.8, or 63.75 per 100,000 residents.

Table 24. Outpatient care for transition to adulthood in the public health sector: availability & workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
St Vincent's Mental Health Service	Early Psychosis team	TA[F20-29]-O5.1	4.8	Darlinghurst	SV
Total	1		4.8		
Rate per 100,000 residents (<18 years old)	13.28		63.75		

FTE: Full Time Equivalents

3.3.2 SERVICES FOR OLDER PEOPLE

We identified one BSIC/ service, corresponding to seven MTCs, and including four satellites, providing specific care for older people with a lived experience of mental illness. **The rate of MTCs per 100,000 residents over 64 years was 49.31 (standardised per 100,000 residents aged over 64 years to maintain comparability). The total number of FTEs of professionals providing mental health care for older people amounts to 151.39 per 100,000 residents.**

Table 25. Services providing care for older people: availability, placement and workforce capacities

Provider	Name	Main DESDE Code	Other DESDE code(s)	FTE	Town / Suburb	Area of Coverage
St Vincent's Mental Health Service	Psychogeriatric team - Elisabeth Lodge aged care facility (satellite)	OX[F00-F99]-O9.1t		NA	Rushcutters Bay	SV
St Vincent's Mental Health Service	Psychogeriatric team - Gertrude Abbott aged care facility (satellite)	OX[F00-F99]-O9.1t		NA	Surry Hills	SV
St Vincent's Mental Health Service	Psychogeriatric team - Lulworth aged care facility (satellite)	OX[F00-F99]-O9.1t		NA	Elizabeth Bay	SV
St Vincent's Mental Health Service	Psychogeriatric team - Presbyterian aged care facility (satellite)	OX[F00-F99]-O9.1t		NA	Paddington	SV

Provider	Name	Main DESDE Code	Other DESDE code(s)	FTE	Town / Suburb	Area of Coverage
St Vincent's Mental Health Service	Psychogeriatric team- Community Home Visit	OX[F00-F99]-O6.1	OX[F00-F99]-R2 OX[F00-F99]-O9.1	11.4	Darlinghurst	SV
Total	5			NA		
Rate per 100,000 residents (>64 years old)	49.31			NA		

FTE: Full Time Equivalents. NA: not available.

3.4 NON-AGE RELATED SPECIFIC POPULATIONS

3.4.1 GENDER SPECIFIC SERVICES

We identified three BSIC/services, corresponding to four MTCs, providing specific care based on gender.

3.4.1.1 GENDER SPECIFIC RESIDENTIAL CARE PROVIDED BY NGOS

B Miles Women's Foundation is a specialist homelessness service, supporting those with a lived experience of mental illness who are also experiencing or at risk of homelessness.

Table 26. Residential care provided by NGOs: availability, capacity and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
B Miles Women's Foundation	Refuge in Darlinghurst	AXF[F00-F99]-R8.2s	9	Darlinghurst	SV
Total	1		9		
Rate per 100,000 women(>17 years old)	2.41		21.73		

FTE: Full Time Equivalents

3.4.1.2 GENDER SPECIFIC DAY CARE PROVIDED BY NGOS

One service located within St Vincent's Hospital is open to women residents of Greater Sydney. This service is Lou´s Place (The Marmalade Foundation): although the service is for women who are homeless or at risk of homelessness, it has a particular focus on psychosocial disabilities.

Table 27. Day care provided by NGOs: availability and workforce capacity

Provider	Name	Main DESDE Code	Beds/Places	FTE	Town / Suburb	Area of Coverage
The Marmalade Foundation Limited	Lou's Place	AXF[F00-F99]-D5	30	2	Potts Point	Greater Sydney, Central Coast, Illawarra
Total	1		30	2		
Rate per 100,000 women(>17 years old)	2.41		72.45	4.83		

FTE: Full Time Equivalents

3.4.1.3 GENDER SPECIFIC OUTPATIENT CARE PROVIDED BY NGOS

The B-Miles Outreach Support Services 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. They provide support in-home or wherever the client prefers. They can meet the client on a weekly basis if needed (DESDE-LTC code: Ax[F00-F99]-O6.2). They are staffed with 3 FTE (non-clinical case managers).

Table 28. Outpatient care provided by NGOs: availability and workforce capacity

Provider	Name	Main DESDE Code	Other DESDE code(s)	FTE	Town / Suburb	Area of Coverage
B Miles Women's Foundation	Outreach Support Services in Housing	AXF[F00-F99]-O6.2s	AXF[F00-F99]-O9.2	3	Edgecliffe	Ashfield, Leichhardt, Marrickville City of Sydney
Total	1			3		
Rate per 100,000 women(>17 years old)	2.41			7.24		

FTE: Full Time Equivalents

3.4.2 SERVICES FOR CARERS

We have identified one BSIC/or service providing care for carers of people with a lived experience of mental illness. It is provided by NGOs.

Table 29. Services for carers: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
Aftercare	Family and Carers (FACES)	AX[e310][F00-F99]-O6.2	4	Sylvania Waters	SES-ES-SV
Total	1		4		
Rate per 100,000 residents (>17 years old)	1.14		4.58		

FTE: Full Time Equivalents

3.4.3 SERVICES FOR OFFENDERS

Within NSW, services delivering health care to adults and young people in contact with the forensic mental health and criminal justice system are provided by a state-wide, specialised network called Justice Health and Forensic Mental Health Network. This network provides services across community, inpatient and custodial settings. Please refer to the main document for details of the statewideservice.

We found only one service providing specific care for offenders in the SVHN region: this statewide service provides non-acute non-mobile outpatient care. It provides 1 FTEpsychologist.

Table 30. Services for offenders: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
Justice system	Justice-Co-existing Disorders Project	AX[F00-F99]-O9.2ms	1(psychol)	Sydney	SES-ES-SV
Total	1		1		
Rate per 100,000 residents (>17 years old)	1.14		1.14		

FTE: Full Time Equivalents

3.4.4 MULTICULTURAL SERVICES

We identified two multicultural BSIC/services providing care for people from cultural and linguistically diverse backgrounds with a lived experience of mental illness within the SVHN boundaries.

JewishCare runs a Mental Health and Wellbeing Program which provides two MTC to consumers with a lived experience of mental illness. The MTC include an accessibility service, and a day program. The program is based in Woollahra, however staff from JewishCare can travel to meet with individuals in the community. They provide services in a satellite office on the North Shore, and in Headspace at Bondi Junction. The Mental Health and Wellbeing Program provides short and long term care coordination for adult consumers with a lived experience of mental illness. Care coordination can involve individual assessments, referrals and linkages to appropriate services, assistance with developing independent living skills, advocacy and provision of information. In addition to individual support, the team also works with families, groups and the community as a whole. Social inclusion groups run from the Woollahra centre and

in the local community on a weekly basis. Anyone can be referred to JewishCare's Mental Health and Wellbeing Team. The majority of consumers however have an affiliation with the Jewish faith.

The second BSIC is provided by Jewish House. Jewish House is located in Bondi. The service runs a 24 hour crisis line which is open to all members of the public and an individual psychiatry and psychology service.

In addition to the above BSIC, there are two state-wide services which provide outreach mental health services to people from culturally and linguistically diverse backgrounds. 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 31 Multicultural services: availability and workforce capacity

Provider	Name	Main DESDE Code	Other DESDE code(s)	FTE	Town / Suburb	Area of Coverage
Jewish Care	Mental health and wellbeing	AX[F00-F99]-A4	AX[F00-F99]-D8.3	7	Woollahra	ES
Jewish House	Psychological Services	AX[F00-F99]-O9.1		2	Bondi	ES
Total	2			9		
Rate per 100,000 residents (>17 years old)	2.29			10.26		

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

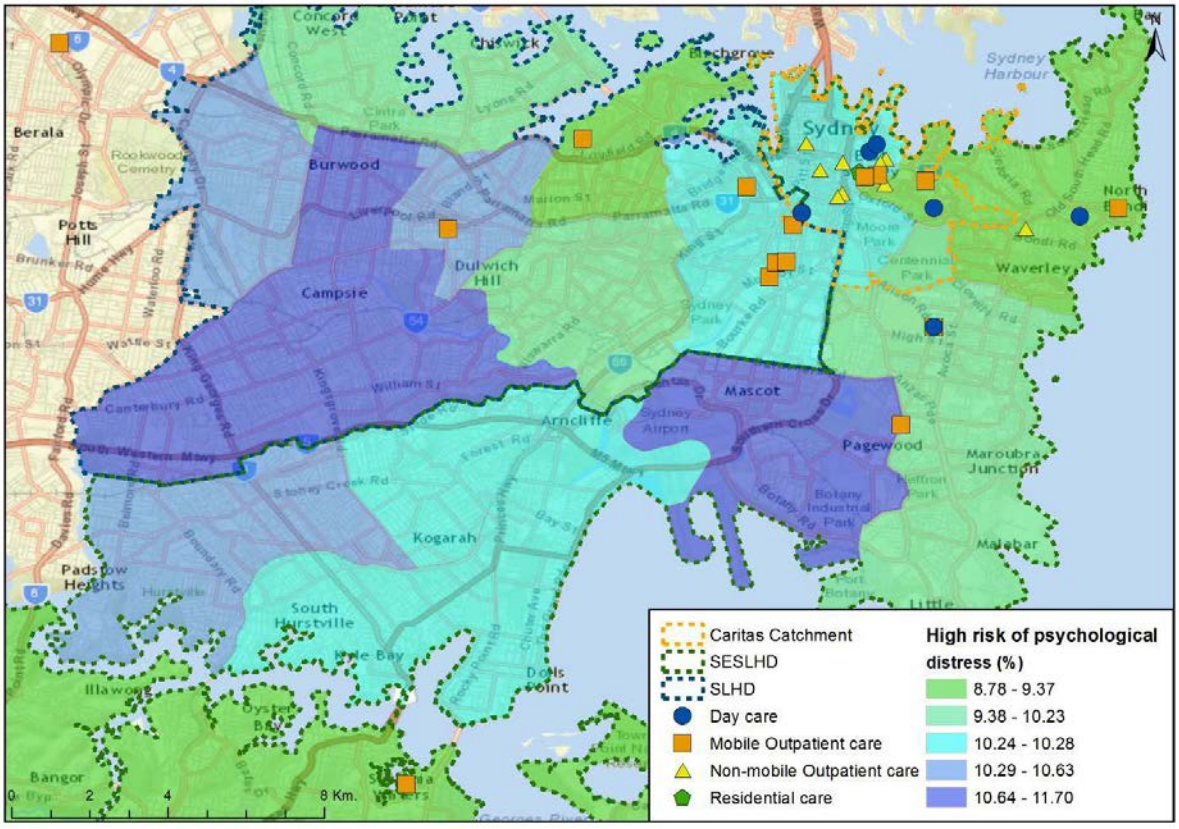
3.4.6 ALCOHOL AND OTHER DRUGS

Alcohol and Other Drugs (AOD) services have not been mapped in this report. A separate coding and mapping of these services is required to fully understand the mental health delivery system of the region. Although it can be considered a mental health issue, its complexity requires a detailed and separate analysis.

4. MAPPING THE MENTAL HEALTH SERVICES

As the SVHN spans the CESPHN, please see the CESPHN Atlas and the detailed descriptions of the areas in the SESLHD and SLHD Annexes for Geographical Information System Data (the geographical maps of service locations) of the areas covered by the network. Below a general map of SVHN area is provided.

Figure 3. Map of mental health services in SVHN's Caritas catchment area.



5. DESCRIPTION OF THE PATTERN OF CARE IN THE AREA

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

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 a lived experience of mentalillness
- Acute health care day-related

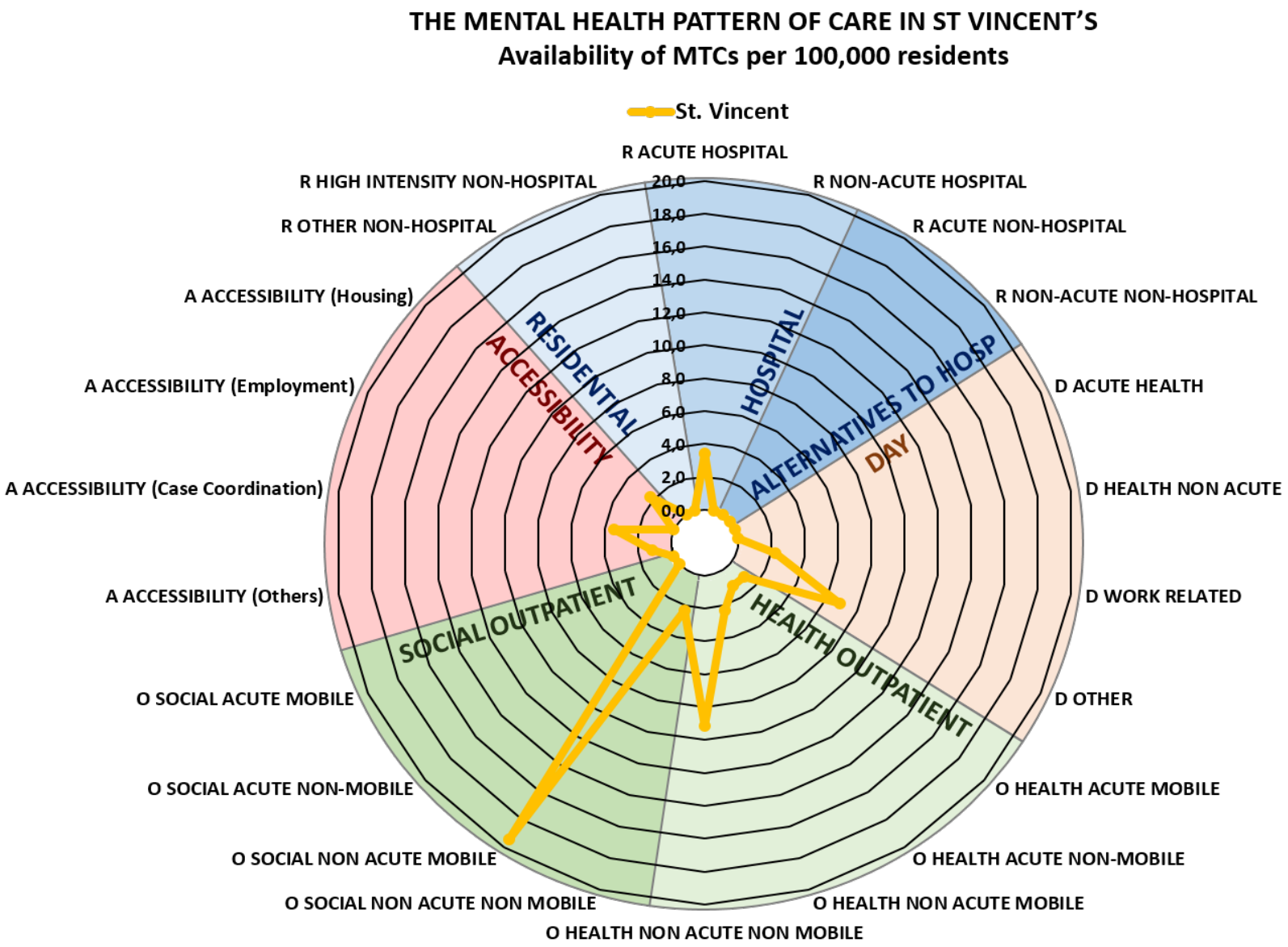
The most notable gap is related to an absence of services staffed with psychiatrists, psychologists and nurses, who provide care for people with a lived experience of mental illness experiencing a crisis. These services provide the same type of care as the hospital (in an inpatient unit), but are embedded into the community. These are predominantly small units, with a strong focus on recovery (e.g. crisis homes). This gap is also evident in the CESPHN, SESLHD and SLHD.

The second gap is related to the lack of supported accommodation for people with a lived experience of mental illness.

The third gap refers to a lack of acute health-related day programs. Acute health-related day care includes services which provide an alternative to hospitalisation. In these services, people experiencing a mental health crisis are not admitted into a hospital, but are treated in the community. They spend all day at the facility, but they sleep at home. In comparison, non-acute day care includes day care centres staffed with a minimum of 20% of highly skilled mental health professionals. In this type of service people with lived experience of mental illness can spend the day, socialising and participating in structured activities related to health, such as cognitive training. However, while in the SVHN there is a lack of acute day care services, there is a number of social and cultural related day care services provided by Aftercare, RichmondPRA, the Holdsworth Club and Uniting Church.

Within the SVHN there is a significant number of mobile services, specifically social non-acute teams. There is also a number of non-acute, non-mobile health related services.

Figure 4. The pattern of mental health care in the area.

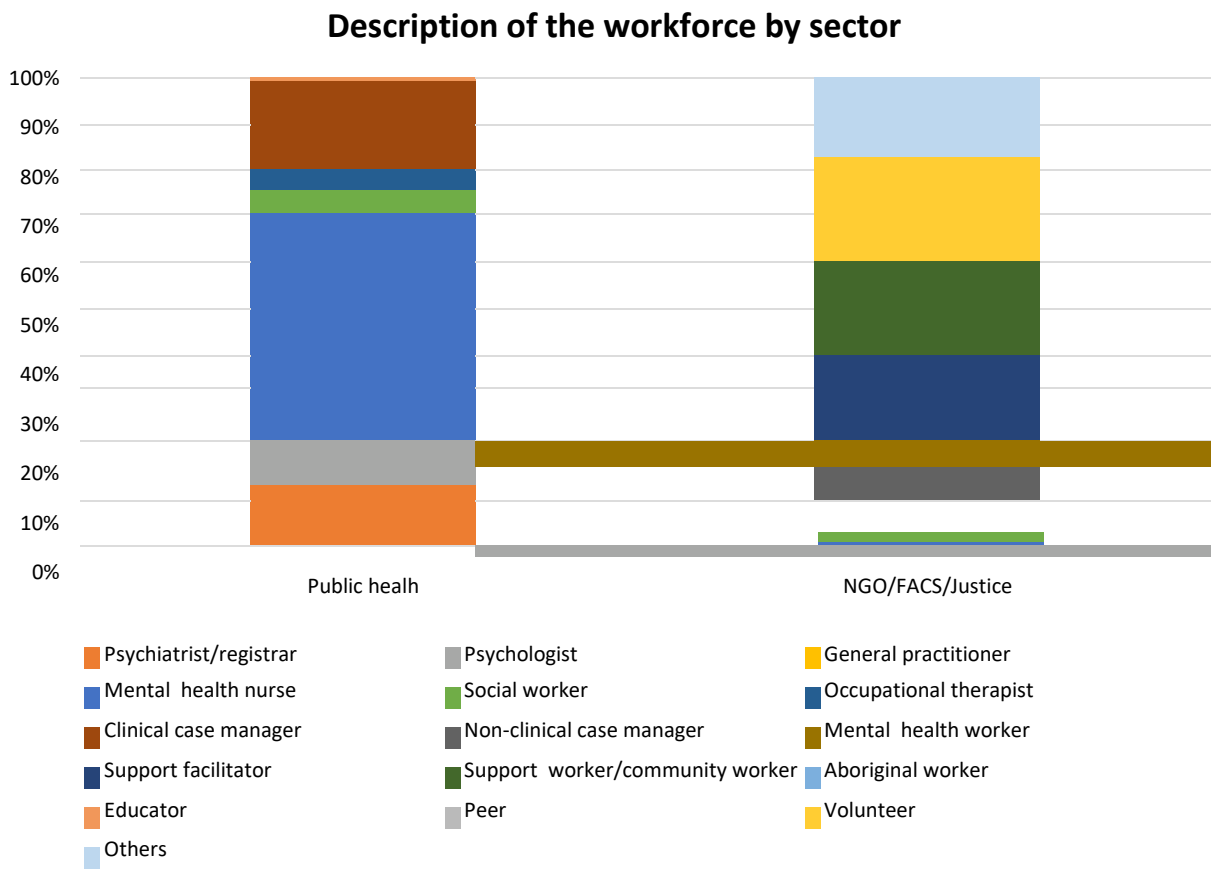


In this section, we present an overview of the workforce capacity in the SVHN. This data should be interpreted with caution, as we did not get a response from all service providers. In addition, the different terminology used by the providers complicates the analysis (e.g. support facilitator, non-clinical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

The rate of professionals in the public mental health sector providing care for people with a lived experience of mental illness per 100,000 residents in the SVHN is around 10.56 per 100,000 residents. The rate of professionals working in NGOs providing care for people with a lived experience of mental illness per 100,000 residents of the SVHNS amounts to 20.49.

The profile of professionals in the health sector and the NGO sector is very different (see figure below). In the health sector, the largest group of professionals are mental health nurses, followed by clinical case managers and psychiatrists. In the NGO sector, there are very few clinical professionals. This may reduce their capacity to provide more intensive care, although some organisations may hire them on a casual position, according to need.

Figure 5. Description of the workforce by sector



6. DISCUSSION

This organisational analysis of the nested system of SVHN, which spans the CESPHN, is a first look at the operations of the network. The Integrated atlas of the CESPHN, and this associated annex, provide a standardised identification of existing services, types of care provided and service capacities. Together, these sources of information can support decision makers and planners to refine and improve the provision of mental health services across the area. This is particularly relevant in the context of the on-going mental health reform, particularly the transition to NDIS and the new funding role of the PHNs. The federal government has outlined a series of key objectives with an end point 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 the existing services.

The St Vincent's Health Network (Sydney) is considered an affiliated health organisation within the organisational chart of NSW Health. It sits apart from the state-wide health services, the shared services and the core structure of LHDs and specialty networks (9). Therefore, St Vincent's is a special case, operating mainly as a nested subsystem within the Central and Eastern Sydney PHN (CESPHN). Although the Network operates across the jurisdictional boundaries of the SLHD and the SESLHD, the governance relationship between the network, the LHDs and the PHN is unclear (9). Collaborative arrangements with the LHDs in which it is located ensure provision of clinical services to these communities.

The difficulties for informed public policy and planning of geographic and substantive boundaries of subsystems nested in broader systems have been pointed out previously (10). Problems arise in relation to the territorial scope, the substantive scope (e.g., local mental health policy), the agents or participant organisations, and the population perspectives with regards to social, demographic and epidemiological indicators. On the other hand, and from a systems thinking perspective, a nested subsystem can increase flexibility and capacity of self-adaptation to changes in the environment of a system.

6.1 KEY CHARACTERISTICS OF THE MENTAL HEALTH SYSTEM IN THE SVHN

The SVHN Annex has revealed some important differences between the SVHN and other local and international jurisdictions. These differences can be used to focus discussions on the planning of an equitable, sustainable and effective mental health care system.

The SVHN Annex has highlighted major strengths and areas for improvement in the pattern of mental health care in the network. Strengths include:

- good availability of acute hospital inpatient care
- good availability of non-acute social outpatient care
- good availability of non-acute health related outpatient care
- good availability of services for older people

Areas for improvement include:

- a lack of alternatives to hospitalisation for people with moderate to severe mentalillness
- a lack of residential care in the community
- a lack of acute health related day care

Some of these results are similar to those found in other areas in metropolitan Sydney (i.e. Western Sydney South Western Sydney, Sydney LHD and South East Sydney LHD), suggesting systemic organisational structural gaps in the mental health care delivery system in NSW. 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* (5), and the *National Review of Mental Health Programmes and Services* by the National Mental Health Commission (2), particularly 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*, indicating that NSW has the lowest residential community care in Australia, and the highest expenditure onhospitals.

The following sections of the mapping analysis provide discussion on the commonalities and differences observed in numbers of BSIC and MTC identified in the SVHN, 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 mapping was to identify and to describe all specific services available for persons experiencing mental health issues in the SVHN. 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 to complement these results.

Although the stepped care model has been used to structure the 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 (11), 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 the clinical care using a combination of GP care, psychiatrists, mental health nurses and allied health which should be provided for those experiencing 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 (12). From these guidelines, for example, 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 staffcapacity).

6.1.1 RESIDENTIAL CARE

As in other areas of greater Sydney, there is a good rate of acute hospital care, but no acute or non- acute alternatives to hospitalisation. There is a lack of non- acute hospital care. The dominance of acute inpatient hospital care should be viewed within the context of a low rate of acute outpatient health care, and a lack of health related day care, although the SVHN has a higher rate of health related non acute outpatient care than other areas we have mapped 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 (13).

Although acute beds within hospitals are a key component of an integrated care system, it is also important to implement residential alternatives in the community. 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 (14). 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 (15). Other initiatives in Australia that fit in this model is the Prevention and Recovery Care Model (PARC) in Victoria (16). 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 SVHN could fill a gap in the provision of mental health careservices.

There are significant differences in the provision of community residential care in the CESPHN. In the SVHN, we identified no general adult services in this category, and one gender specific service. In SESLHD, also, no organisation providing residential care in the community has responded to the CESPHN Atlas project. 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 SVHN provide accommodation support to a wide range of consumers. They are, however, distinctly different from equivalent services in other countries. The equivalent services 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-LTCconsortium.

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 provide specific care for people with a lived experience of mental illness. 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 countries (see main report). The Pathways to Housing project run by Inner West Sydney Partners in Recovery provides a crucial closer look at this issue that may have implications for SVHN.

A previous evaluation of the Housing and Accommodation Support Initiative (HASI), 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 the 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.

6.1.2 OUTPATIENT CARE

HEALTH RELATED OUTPATIENT CARE

The pattern of health related Outpatient care is similar in SVHN to that in the other areas of metropolitan Sydney. There is a higher availability of non-acute than acute outpatient services, but generally low mobility of services. More services, such as the existing Case Management Teams could be beneficial in this area. There is a high degree of specialisation of non-acute non-mobile outpatient care, with several services for specific groups, i.e. HIV/AIDS; Borderline Personality Disorder; and Anxietydisorders.

NON-HEALTH RELATED OUTPATIENT CARE (SOCIAL OUTREACH SERVICES)

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, although the rates of availability in the SVHN are higher. The main difference in the pattern of outpatient care in the SVHN is the significantly higher number of social outpatient non acute mobile services. This is largely due to the number of HASI, PHaMs, and PIR services in this category in SVHN in relation to other outpatient categories. It is important to note that PHaMS programs are being phased out with the transition to the NDIS. As discussed earlier, HASI services are providing in-home care to people who may be living either in their own home or in social housing. Also discussed earlier is the PIR program, BSICs of which may be coded either as Outpatient or Accessibility, depending on the particular service and the local needs for which it is providing, but which are in this region coded mainly as Outpatient. The balance of social to health outpatient care is similar to SLHD, WS and SWS, with social related outpatient care being more highly available than health related outpatient care. This is the reverse of the situation in SESLHD, where there is a higher number and range of health related outpatient services.

6.1.3 DAY CARE/STRUCTURED PROGRAMS

Day care for people with a lived experience of mental illness has been considered a key component of psychiatric reform since the early 60s (13, 14). “Day Care” (including partial hospitalisation) refers to all services where the consumer stays for part of the day, but not overnight, or just for a single face-to-face contact. There is a whole array of different types of day care services according to the phase and the severity of the mental illness: from acute care (i.e. day hospitals/partial hospitalisation), to non-acute care (i.e. day programs/centres), and recovery oriented programs (i.e. peer support, respite, social clubs, or work-related approaches), just to mention a few. These services should be integrated in a local acute care subsystem 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(13).

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 SVHN.

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 (17). 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 (18) and by the US Agency for Healthcare Research and Quality (AHRQ) (19). 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 (18). 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 vs day hospital) without taking into account their overall impact on the system.

The US AHRQ (19) 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) (20). 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 highest levels 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 (21): *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 that is missing in the CESPHN region as a whole. Day programs staffed with at least 20% highly skilled mental health professionals, such as psychologists, neuropsychologists or mental health nurses (D4.1 and D8.1), can provide more intensive rehabilitation and recovery oriented program activities in a highly specialised environment than day centres staffed with non-health professionals (D2 to D10 services). This workforce capacity allows these centres to provide a better focus on tertiary prevention and clinical

improvement (e.g. by better training in daily living, problem solving, stress management, social skills or cognitive rehabilitation). This type of centre can improve socialisation and assist individuals to learn new skills according to their needs. They can also include occupational therapy tailored to the patient's needs. They should be provided in a recovery oriented format which promotes peer-support. Day centres allow people with mental illness to have structured, more intensive rehabilitation program through 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 (22).

In the SVHN, we have identified no non-acute health related day care centre with high intensity (equivalent to day hospitals). It is important to note that these services were lacking in all other regions previously mapped in metropolitan Sydney.

The lack of acute 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 (20).

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 (23) 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 (24) and in England (25). 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 (17).

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 systems may be limited by the availability of core services in the system. In order to make useful choices to meet an individual's needs, a whole array of service alternatives should be available 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 (26, 27).

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 (28-30), an understanding of the impact of this reform in the overall efficiency of the care system is still missing. Therefore, there is an urgent need to assess the effects of this silent reform on key performance indicators of the system and on the outcomes. This need is made particularly urgent in the transition to the National Disability Insurance Scheme (NDIS), which has a strong emphasis on individualisation and care planning driven bydemand.

SOCIAL DAY CARE

We have identified six BSICs providing social and cultural day care activities to the general adult population within the SVHN. These are located in Eastern and South Eastern Sydney and are also coded in the South East Sydney LHD (Annex 2). They include two Day to Day Living programs. This is a program which has been extended for three years, but which will be transitioning to the NDIS[2]. 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 needs and course of recovery. Typically, these services are coded as O5 (low mobile) or O6 (mobile and home) in the classification system, and 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 other abilities who may require more support than that needed in supported employment. Some of these alternative services may be classified as 'social firms' which are market-oriented businesses employing people with disabilities; or 'social enterprises' which are primarily focused on training and rehabilitation (31). The recently published NICE clinical guideline for Psychosis and Schizophrenia in adults recommends to (21): "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. There is one BSIC (or service) providing work-related day care for people with a lived experience of mental illness in the SVHN. Although this BSIC is located in the area of SLHD, its consumers can come from all of Greater Sydney. 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

[2] See http://www.health.gov.au/internet/main/publishing.nsf/content/mental-d2dl

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.

Work related day programs are an area of contrast between the Greater Sydney jurisdictions with European mental health systems, where there is a greater availability. This could be an area for development in the SVHN.

6.1.4 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 (32). 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. An Atlas or service mapping study 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 related to the SVHN, 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 the accessibility to a different range of services of people with a lived experience of mental illness. Interestingly though, a significant number of these PIR providers are not just focused on the accessibility, but take a more holistic approach, also providing some type of direct care, such as counselling or intensive coaching. As such, only two out of seven services providing PIR in the SVHN have been coded as Accessibility (A4 – Care coordination) while the rest have been coded as non-health related outpatient care (O5.2). 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 were coded as O5.2 (33). This was also the case in Western Sydney where the 5 teams have all been coded as O5.2 (34). Interestingly, in the SLHD geographical region, five of the six PIR were coded as Accessibility, while in the SESLHD geographical region, the pattern was closer to SVHN, with all nine PIR coded as Outpatient. The transfer to NDIS of these services will imply 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 the one identified in other regions in Greater Sydney, except for teams providing accessibility to employment, which is larger 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.

6.1.5 SERVICES FOR SPECIFIC POPULATION GROUPS

6.1.5.1 SERVICES FOR TRANSITION TO ADULTHOOD

There is a considerable number of transition services from adolescence to adulthood in the CESPHN as a whole. In the SVHN there is one MTC providing transitional care while we identified four BSICs in SLHD, ten in SESLHD, five teams providing this type of care 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 in 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 region, in comparison to the overall availability of services for children and adolescents. This may indicate a problem in the continuity of care in the core outpatient services for adolescent and foradults.

6.1.5.2 SERVICES FOR OLDER PEOPLE EXPERIENCING MENTAL ILLNESS

One BSIC providing seven MTCs providing care for older people with mental illness is available in the area. With the exception of one residential MTC, all services for this population are coded as Outpatient, non-acute, non-mobile care. These are satellite psychogeriatric teams provided by the St.Vincent's Mental Health Service. The rate of residential care for this population is lower in SVHN than in SWS and WS, but the provision of Outpatient care is much higher. Availability of services for older people is higher in the SESLHD, but this region is inclusive of the SVHN services as well as those of eastern suburbs' mental health services. In contrast, the SLHD has a much lower rate of this type of service, with no residential care.

6.1.5.3 SERVICES FOR OTHER POPULATION GROUPS EXPERIENCING MENTAL ILLNESS

Most services providing care for specific groups in the SVHN are services providing care for a wider area, for example the statewide justice service. The exception to this are the two multicultural services, providing care primarily, but not exclusively, for a specific cultural group.

6.2 MAIN GAPS IN SERVICE AVAILABILITY AND UNMET NEEDS

The service mapping analysis of SVHN indicates similar gaps to those identified in other regions in Greater Sydney (SWS,WS. SELHD and SLHD). 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 (14, 35). They also match the unmet needs reported by PIR consumers in the PIR needs assessments complete in IW, SES and ES. The top 6 unmet needs tend to be focused on daytime activities, employment and volunteering opportunities, social life, psychological distress, physical health and accommodation (36).

Table 32. Top 5 unmet needs identified in the Partners in Recovery program in the three PIR areas of the CESPHN region (data provided by IWS, SES and ES PIRS)

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

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

6.3.1.1 FRAGILITY (LACK OF ROBUSTNESS OF THE CARE DELIVERY SYSTEM)

A particular issue emerging in the survey was the lack of robustness, or the fragility of the system brought 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, due to the policy of funding services and programs for limited periods of time of up to three years, with separate organisational structures than those already available stable services. 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' of the whole pattern of care at the local level and how the different components are related (14). The problem of the component approach is that it results in an inefficient use of scarce resources, as investment is made in new services, whilst the 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 informed by local evidence. In addition, the skills and experience acquired by the workforce could be lost when the program is ended. The reliance on time-limited programs, mainly community based, means that the mental health system in the SVHN region is "fragile". This lack of robustness is particularly relevant under the current situation, where major changes are occurring due to the transition of many mental health services to the NDIS and due to the current changes in organisation and governance related to the commissioning role of the PHNs and their relationship with other components of the system such as LHDs and the Hospitalnetworks.

6.3.1.2 INTEGRATION OF THE MENTAL HEALTH CARE SYSTEM

According to the government response to the mental health commission report, "Regional integration" isa systems-based approach which seeks to better coordinate and plan regional services to improve system and health outcomes (37). Regional integration works to integrate pathways and services around the needs of consumers, while also striving for the best possible use and targeting of available resources to address individual and community. The emphasis on a system-based approach is critical to generate new informed evidence for policy and planning.

This mapping has provided a description of the service availability and capacity but it has not analysed the level of integration of the mental health care system. However, the analysis of the integration of care cannot be carried out without a prior knowledge of what services are available in the local area, and therefore 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, as a system cannot be fully integrated when major components of the system are missing. In any case the need and the number of coordination services that are not part of the routine activities performed in the 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.

6.4 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 that 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 (2), 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 SVHN 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 that require acute care in a hospital setting. For example, acute hospital based residential care is available, but subacute hospital care and non-hospital and community residential care providing medium to high level support, is lacking, as is acute health related day support. 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 (14).

The care pattern for mild-moderate mental illness in primary care in the SVHN is an area that requires further investigation.

These gaps also have implications for a 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 and 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) (38), and in specific conditions (e.g., anxiety and depression) (39, 40). 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) (41) 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 different steps of the care system if the care delivery system and the workforce responsibilities and caseload are divided by levels of severity and staging without a full map of the

availability of services and the pathways of care as well as a better understanding of the pathways that may ensure care continuity.

7. 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 mental illness, may be absent. Some services providing care for people with disabilities and homelessness specific services expressed their interest in the project, but they did not want to be included as their target was not mental health. This is an issue which has also been identified in otherregions.

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 report 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 futureanalysis.

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 this analysis 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 mobileservice).

Fifth, we have only included services within SVHN even though some of the residents in this area may use services from other regions. The limitations of nested systems as described above also apply here. 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 (42), benchmark analysis and modelling of relative or technical efficiency at local level (43) as has already been carried out in other metropolitan areas(44).

Sixth, the SVHN boundaries are not officially designated as in the case of SLHD and SESLHD. The real population served by the network extends beyond its boundaries to include an additional population 35% greater than that living within its boundaries. This makes comparisons between this report and other annexes more difficult.

8. FUTURE STEPS

Integrated Atlases of Mental Health are considered key tools for evidence- informed policy and planning. In this report 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 report 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 thefuture.
- **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 this report 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 (43).
- **Care Packages:** The information presented in this report 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 careanalysis.
- **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 views 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 comorbidpatients.

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

- **Case and care coordinators:** The data in this study 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 study is useful for the development of bottom up system indicators that can be used to monitor the evolution of the system. The production of different Atlases based on the DESDE system every 4 or 5 years can assist in the monitoring of the changes and the evaluation of policies (44). 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 its web page, so services receive the code after answering some questions. It will be also important to evaluate the impact of this analysis, as a visual tool to increase the capacity and efficacy of managers and planners in evidence-informed decision making and in systemthinking.
- **Consumers:** A user-friendly version of the report may support consumers' to navigate the system, location of services and increase their local knowledge on service availability and capacity. For instance, the results of the Integrated Mental Health Atlas of Western Sydney have been used by Carers NSW in a submission to a NSW Parliament Inquiry into service coordination in communities with high social needs.

9. CONCLUSION

This mapping analysis of a nested subsystem of mental health care provision provides a unique contribution to evidence-informed mental health planning (45). 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 SVHN to creatively develop new partnerships and services that are community based, promote recovery and empower consumers. We firmly believe that the use of the CESPHN Atlas and the related annexes may assist in the planning and improvement of the care provided for people with a lived experience of mental illness.

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