THE INTEGRATED MENTAL HEALTH ATLAS OF SOUTH WESTERN SYDNEY

THE UNIVERSITY OF SYDNEY

WESTERN SYDNEY UNIVERSITY

UNIVERSITY OF WOLLONGONG AUSTRALIA

PARTNERS IN RECOVERY SOUTH WESTERN SYDNEY

An Australian Government Initiative

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ABBREVIATIONS

ATAPS Access to Allied Psychological Services

BSIC Basic Stable Input of Care

DESDE- LTC Description and Evaluation of Services and Directories in Europe for long-term care

FaCS Family and Community Services

GIS Geographical Information System

HASI House and Accommodation Support Initiative

LHD Local Health District

MTC Main Type of Care

NGO Non-Governmental Organization

NDIS National Disability Insurance Scheme

NSW New South Wales

PIR Partners in Recovery

SWS South Western Sydney

WHO World Health Organization

A NOTE ON THE LANGUAGE

The language used in some of the service categories mapped in this report eg outpatient-clinical, outpatient-social, day hospital may seem to be very hospital-centric and even archaic for advanced community –based mental health services which are already 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 Atlas [this standard classification system is the "Description and Evaluation of Services and Directories in Europe for long-term care" model (DESDE-LTC)].

EXECUTIVE SUMMARY

"Without a map we will not know where we are coming from or where we are going.
We can neither describe the journey to others nor interpret their directions"
(HealthKnowledge,2011)

The recent *National Review of Mental Health Programmes and Services* by the National Mental Health Commission has drawn attention to the need of 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 calls for responsiveness to the diverse local needs of different communities across Australia.

The Integrated Mental Health Atlas of South Western Sydney aligns with this recommendation. It is a tool for evidence-informed planning that critically analyses the pattern of mental health care provided within the boundaries of South Western Sydney Local Health District. We used a standard classification system, the "*Description and Evaluation of Services and Directories in Europe for long-term care*" model (DESDE-LTC), to describe and classify the services; as well as geographical information systems to geolocate the services.

Use of the DESDE-LTC, widely used in Europe, has enabled a more robust understanding of what services actually provide and will enable planners to make comparisons across areas and regions, once this methodology is more widely available.

The Atlas revealed major differences in the provision of mental health care in South Western Sydney, when compared to other regions and countries. These are:

1) a lack of acute and sub-acute community residential care;
2) a comparative lack of services providing acute day care and non-acute day care (i.e. day centres providing structured activities to promote health and social inclusion);
3) lower availability of specific employment services for people with a lived experience of mental ill-health;
4) uneven distribution of the Access to Allied Psychological Services (ATAPS) providers;
5) lower availability of supported accommodation initiatives

These results mirror the needs analysis of Partners in Recovery (PIR) clients in South Western Sydney. An analysis of unmet needs amongst PIR clients found the highest areas of need were: psychological distress; daytime activities; company (social life); physical health; employment and volunteering; and accommodation.

In spite of this, the main strength of the Mental Health System of South Western Sydney is the relatively good geolocation of the services. Services are in the areas with higher needs and the overall geographical accessibility is good. The availability of specific services for carers is another asset.

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

Policy makers and service providers can use the information presented in this Atlas to develop service plans which are better informed by local-evidence and to reform the pattern of adult mental health care in South Western Sydney LHD.

1. FRAMEWORK

The philosophy of mental health care reform has been built on key principles of community psychiatry, with four linked areas of action[1]:

i) deinstitutionalisation and the end of the old model of incarceration in mental hospitals;
ii) development of alternative community services and programs;
iii) integration with other health services; and
iv) Integration with social and community services.

More recently this has also included a focus on recovery orientation and person-centred care.

Australia started this journey of reform in 1983, with David Richmond's report on care for people experiencing mental ill-health and intellectual disabilities in NSW: *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled*. But it took 10 years to establish the first National Mental Health Strategy[2]. Since then, there have been considerable systemic changes made, including the closure or downsizing of many large psychiatric hospitals and the development of the community mental health movement[3].

However, this journey has not been completed and application of reform has been patchy. For example, the Australian mental health system still has high rates of readmission to acute care, with at least 46% of patients hospitalized being readmitted during the year following the admission [4]; we have high rates of compulsory community treatment orders, ranging from 30.2 per 100,000 population in Tasmania to 98.8 per 100,000 population in Victoria[5]; and high rates of seclusion with 10.6 seclusion events per 1,000 bed days in 2011-12[6]. These features are associated with a system characterised by fragmented, hospital-based, inefficient provision of care[2]. It has been argued that we lack a clear service model, that reform has not been informed by evidence, and that quality and access to care is a lottery dependent on postcode[2].

The situation in South Western Sydney is no better than in the rest of Australia. There is no publicly available data on readmission rates, compulsory treatment orders, or rates of seclusion. Yet according to data from the 45 and Up Study[7], it is an area of New South Wales with high risk of psychological distress.

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

This Atlas is an ideal tool to help them in this process.

1.1. What are Integrated Mental Health Atlases?

The WHO Mental Health Gap Action Program (mhGAP) [8] has highlighted the need for a comprehensive and systematic description of all the mental health resources available and the utilisation of these resources. It is not only important to know the **numbers** of services in each health area, but also to describe **what** they are doing and **where** they are located. This information also enables an understanding of the context of health-related interventions which are essential for the development of evidence-informed policy.

Evidence-informed policy is an approach to policy decisions that is intended to ensure that the decision making process is well-informed by the best available research evidence. Evidence refers to facts intended for use in support of a conclusion. It is important to highlight that evidence alone does not make decision, as this evidence has to be also valued and filtered by the policy makers. However, evidence-informed policy tries to do this process more transparent, so others can examine it. Evidence-informed policy combines 'global evidence' available from around the world, with 'local evidence', from the specific setting in which decisions and actions will be taken. This includes a detailed analysis of the area, taking into account the prevalence of mental health problem and other demand driven indicators, together with the availability of resources[9].

In depth understanding of the local context is crucial to implement any new strategy. There is not an agreed definition of context; however, it can be defined as all those variables that can be related with both the new strategy that we want to implement and the outcome that we want to achieve. In other words, it makes references to "the where" the process is happening, including organisational and divisional structures and cultures; group norms; leadership; political processes; and broader economic, social and political trends and events[10].

The 'integrated care model' [11] has challenged the way health-related care should be assessed and planned. It enables us to identify new routes for linked-up, consumer-centred approaches to care. Greater integration relies on a global picture of all the services available, regardless of which sector is funding them (i.e. Health, Social Welfare and Family, Employment, Criminal Justice). Such 'systems thinking' enables policy planners to capture the complexity of service provision holistically. It offers a comprehensive way of anticipating synergies and mitigating problems and barriers, with direct relevance for creating policies that integrate the different systems of care [12, 13]. This is particularly important in the mental healthcare sector, which is characterised by increasing personalisation of services and care coordination programs such as Partners in Recovery (PIR) or the National Disability Insurance Scheme (NDIS).

Within this context, Integrated Atlases of Mental Health are essential tools for decision making and quality assessment. These Integrated Atlases include detailed information on social and demographic characteristics and health-related needs, as well as data on service availability and care capacity. Integrated Atlases of Mental Health allow comparison between small health areas, highlighting variations of care, and detecting gaps in the system. The holistic service maps produced through an

Integrated Atlas of Mental Health also allows policy planners and decision makers to build bridges between the different sectors and to better allocate services [14].

Integrated Atlases of Health include maps and graphics as a main form of presenting the data. As a visual form of communicating health information, they crucially bridge the gap between complex epidemiological presentations of statistics and the varied educational backgrounds represented by policymakers, other decision makers and consumers [15]. Policy makers and health planners may use the information presented in the Atlas as a visual reference point from which to quickly present and structure their ideas. In addition, the new knowledge presented in an Atlas will quickly increase a planner's self-efficacy and personal mastery of the field. Consequently, policy makers and health planners will be more willing to make informed decisions bolstered by solid evidence. In parallel, as Atlases are integrated (i.e. they include all funding providers) they may increase collaboration across services as they can act as a shared reference point from which to discuss the system. Consequently, it is expected that the Integrated Mental Health Atlas of South Western Sydney will change the culture of planning and, from this, the provision of care through facilitating the integration and coordination of services. This will be reflected in the quality of care provided and, in the longer term, better health outcomes for people with a lived experience of mental illness[16].

The Integrated Mental Health Atlas of South Western Sydney aligns with some key recommendations made by the *National Review of Mental Health Programmes and Services* by the National Mental Health Commission[3] The report draws attention to the local level of MH planning in Australia and the relevance of a bottom-up approach to understanding "services available locally [in] the development of national policy". It also calls for responsiveness to the diverse local needs of different communities across Australia: "Mental Health Networks, in partnership with Local Health Networks, should conduct comprehensive mapping of mental health services, programmes and supports available in regional, rural and remote areas through Commonwealth, state and territory and local governments, private and not-for-profit sectors".

The NSW Commission plan[17] indicates that the current mental health system is highly fragmented, difficult to navigate and characterised by disjointed policy, financing and service delivery systems at national and state levels. Furthermore, there is a mismatch between top-down policies developed centrally at national and state levels and the local need for efficient resource allocation. The lack of a comprehensive mapping of the available services constitutes an additional barrier to the accessibility of mental health services in this disjointed system.

The Integrated Mental Health Atlas of South Western Sydney can help us to understand the current scenario in the prevision on mental health care.

1.2. How was the Integrated Atlas of Mental Health assembled?

Typically, general Atlases of health are formed through lists or directories of services and inclusion of services is based on their official or everyday titles. This is particularly problematic for several reasons [18]:

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

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

In order to overcome these limitations, we have used the "*Description and Evaluation of Services and Directories in Europe for long-term care*" (DESDE-LTC)[19] . 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. This classification of services based on the actual activity of the service therefore reflects the real provision of care in the territory.

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

1.2.1. 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 group of people. They have time stability (that is, they have been funded for more than 3 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 produced their own report by the end of the year) (See Box 1, below).

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.
Criterion C: Time continuity (more than 3 years)
Criterion D: Organizational stability
Criterion D.1: The service is registered as an independent legal organization (with its own company tax code or an official register). This register is separate and the organization does not exist as part of a meso-organization (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 fulfils **3** 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-organization (e.g. specific end of the year reports).

We identified the BSICs using these criteria and then labelled them. The typology of care provided by the BSIC (or service) is broken down into a smaller unit of analysis that identifies the "Main Type(s) of Care" (MTC) offered by the BSIC. Each service is described using one or more MTC codes based on the main care structure and activity offered by the service. For instance, the same service might include a principal structure or activity (for example a 'residential' code) and an additional one (for example, a 'day care' code). Figure 1 depicts the different types of care used in our system.

There are 6 main types of care[19]:

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 clients do not make use of such services simply because they are homeless or unable to reach home. Residential care can be divided in Acute and Non-Acute branches, and each one of this in subsequent branches. Figure 2 depicts the Residential Care branch.

Day Care: The day care branch is used to classify facilities which (i) are normally available to several clients 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 clients to stay at the facility beyond the periods during which they have face to face contact with staff. Figure 3, below, depicts the day care coding branch.

Outpatient Care: The outpatient care branch is used to code facilities which (i) involve contact between staff and clients 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 4 depicts the outpatient care branch.

Accessibility to Care: The accessibility branch classifies facilities whose main aim is to facilitate accessibility to care for clients with long term care needs. These services, however, do not provide any therapeutic care. Figure 5 depicts the specific codes under this branch.

Information for Care: These codes are used for facilities that provide clients 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 6 depicts the information care branch.

Self-help and Voluntary Care: These codes are used for facilities which aim to provide clients 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 7 depicts the self-help and volunteer care branch.

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

Figure 1. Main Type of Care: core codes

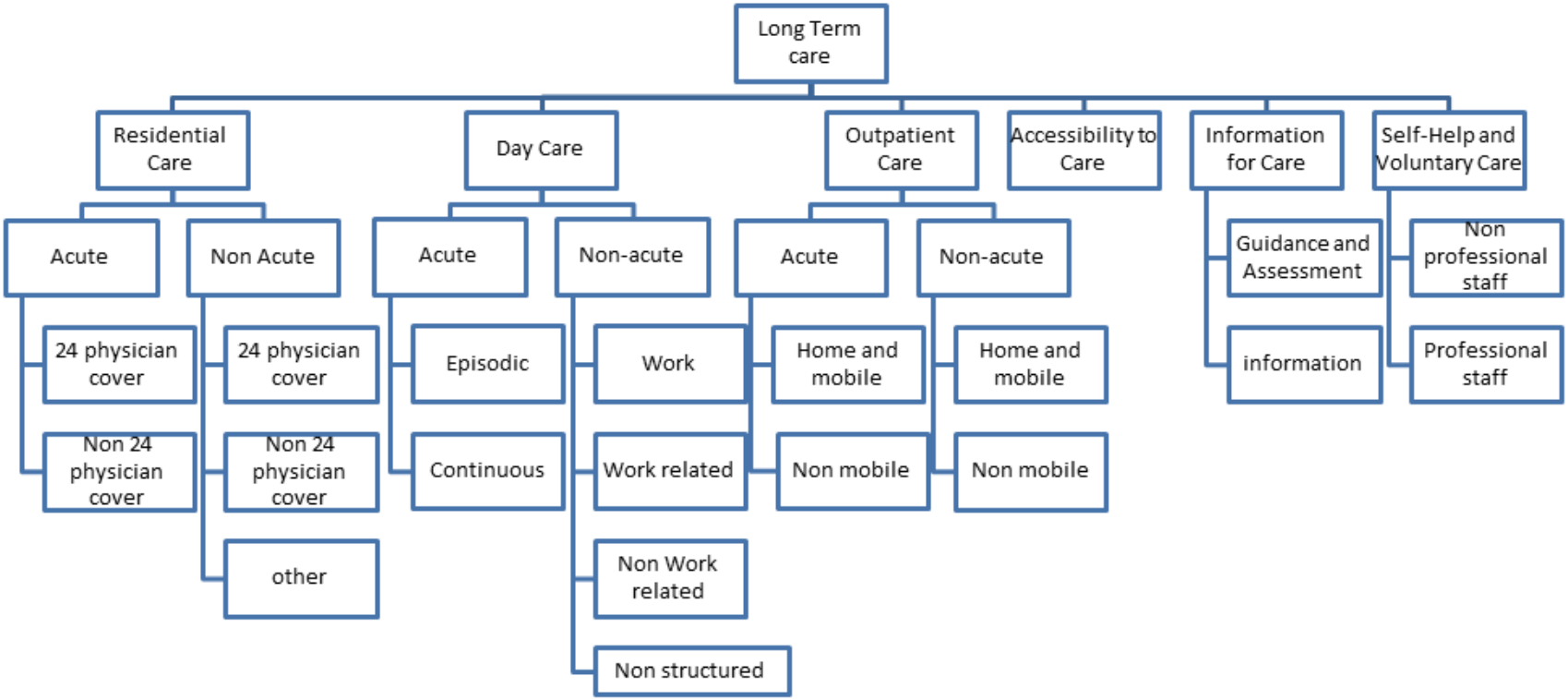


Figure 2. Residential care coding branch

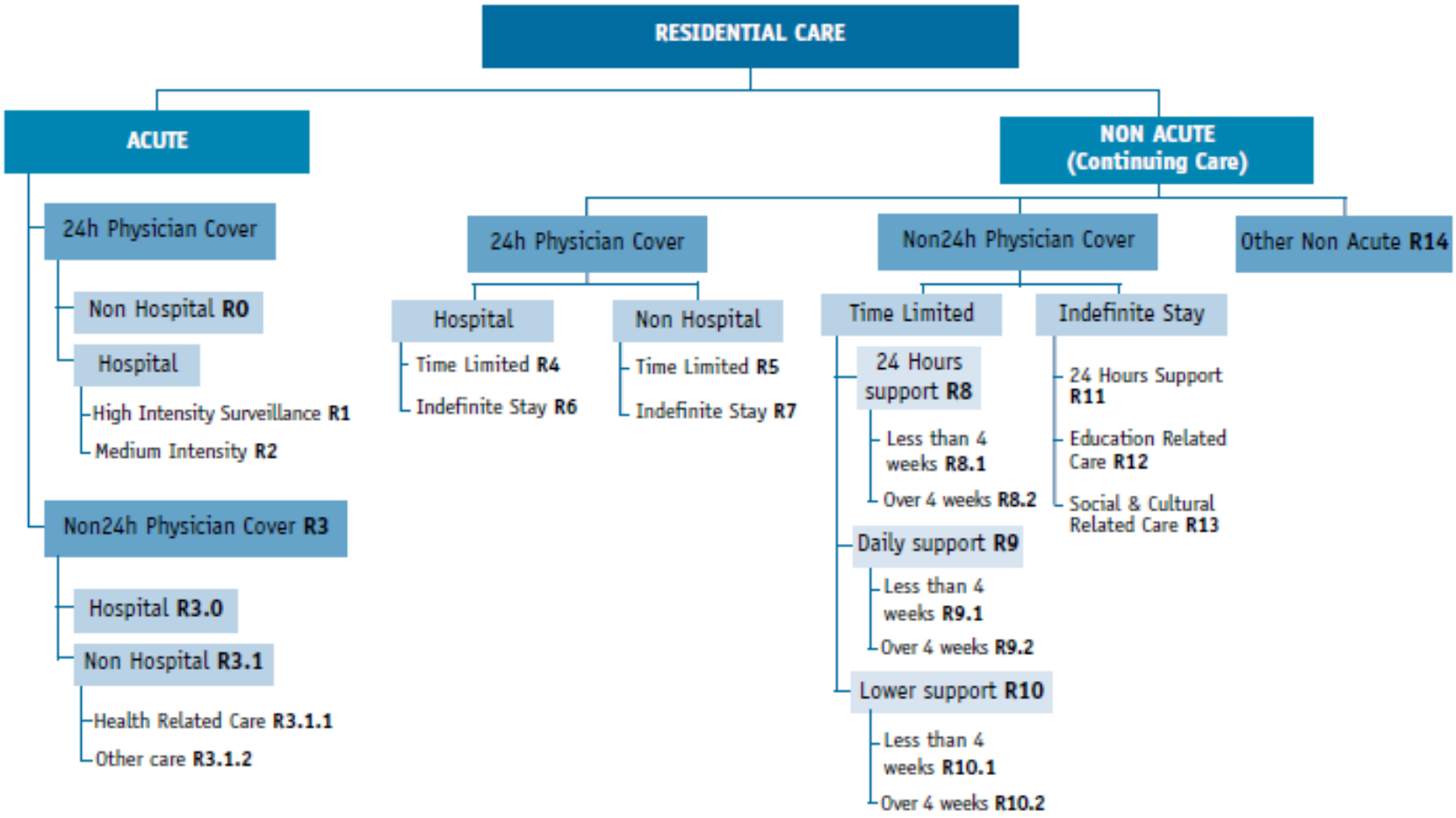


Figure 3. Day care coding branch

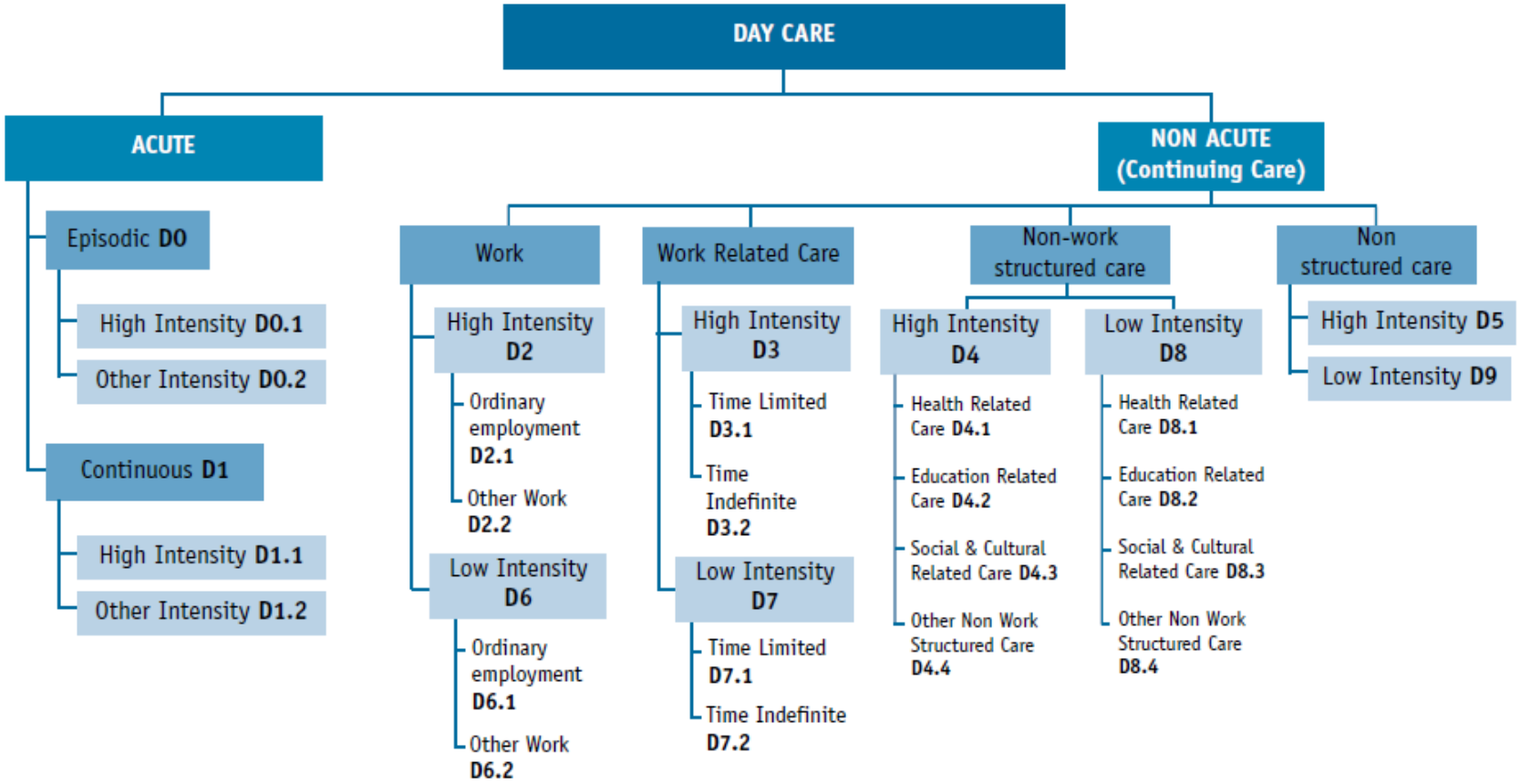


Figure 4. Outpatient care coding branch

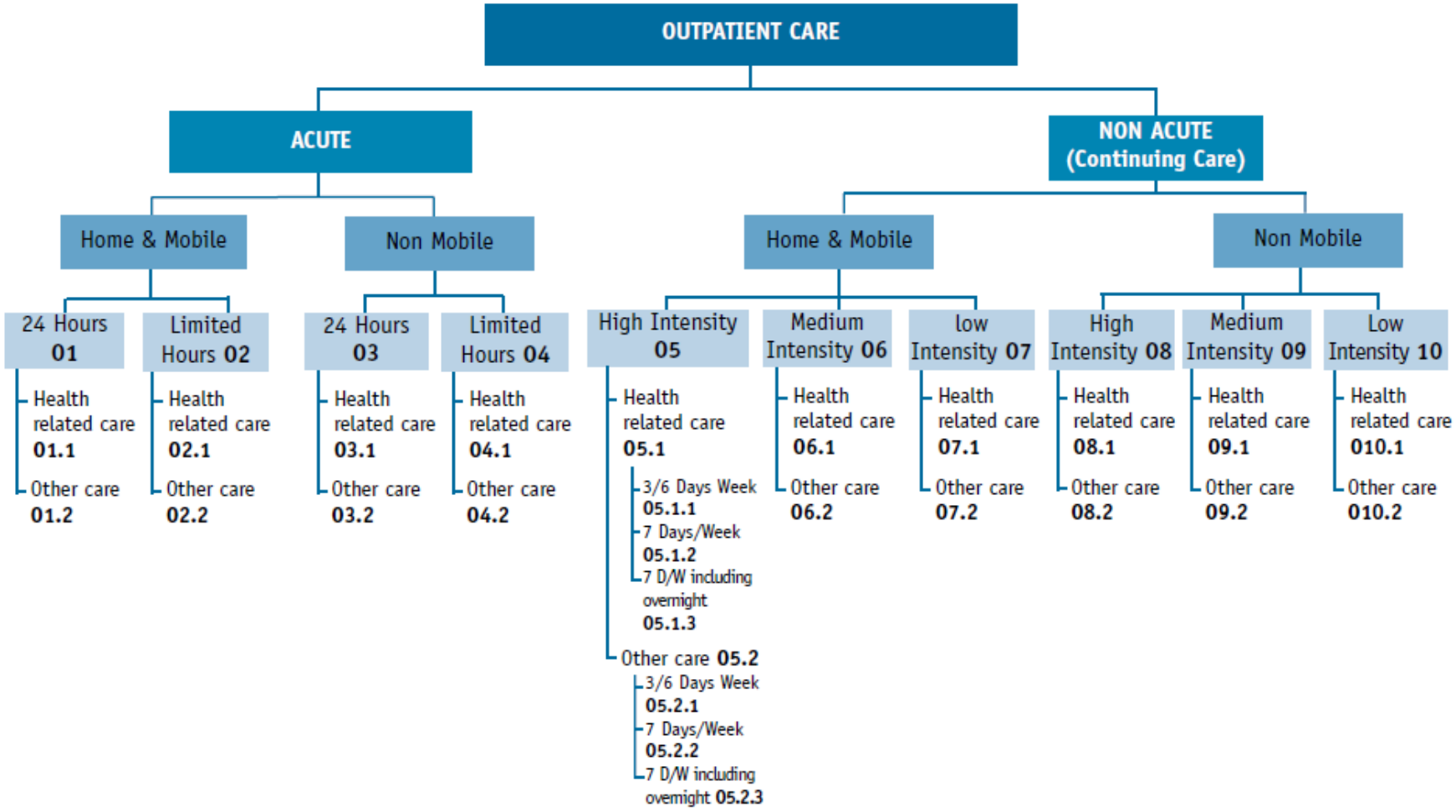


Figure 5. Accessibility to care coding branch

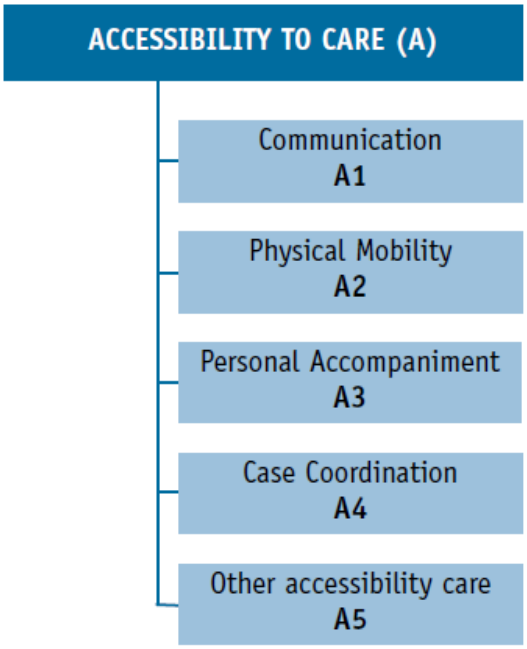


Figure 6. Information for care coding branch

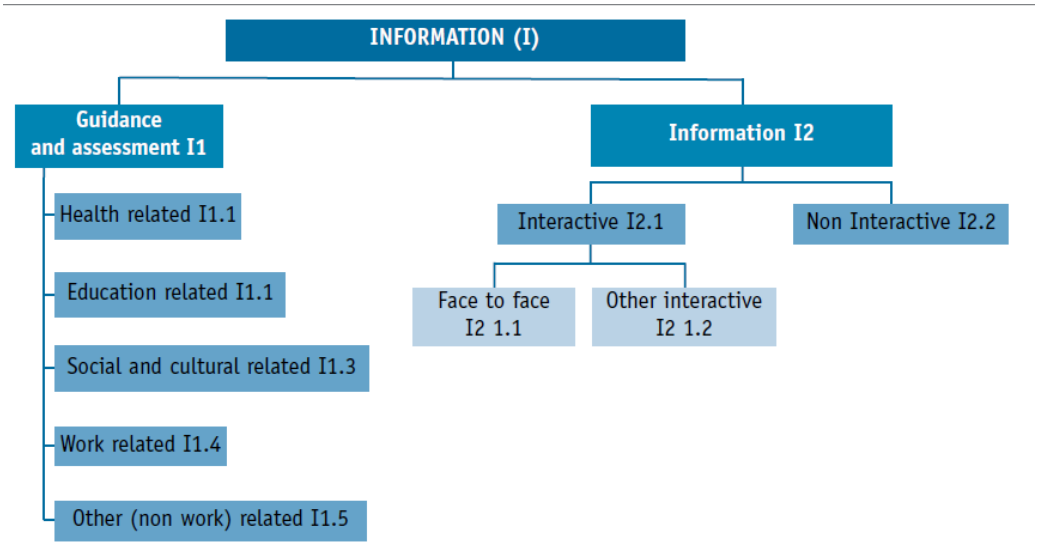
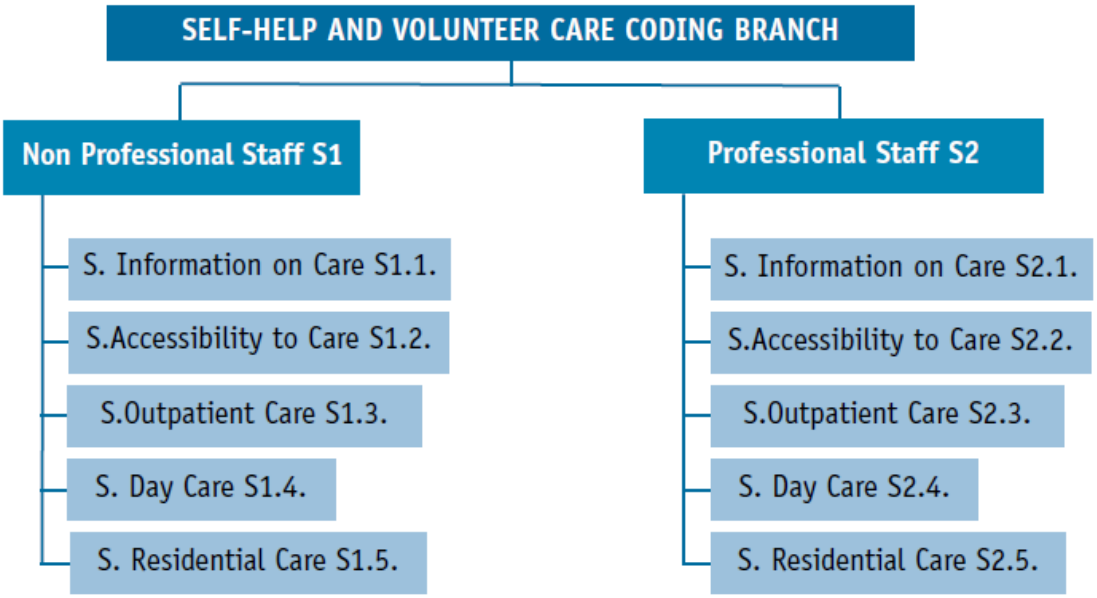


Figure 7. Self-help and volunteer care coding branch



1.2.2. Inclusion Criteria

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

1) **The service targets people living with mental illness**: The inclusion of services that are generic, and lack staff with the specialised training and experience to treat people with a lived experience of mental ill-health, may lead to bias which obscures the availability of services providing the specialised focus and expertise needed in mental health.

2) **The service is publicly funded**: The study focuses on services that are universally accessible. Access to most private mental health services in Australia requires an individual to have private health insurance coverage, high income or savings. Inclusion of private providers would give a misleading picture of the resources available to most people living with mental ill-health and obscures the data for evidence informed planning of the public health system. Most private services have some level of public funding, for example Medicare subsidies of private hospitals or community-based psychiatric specialist services. It would be useful in future mapping exercises to include an additional layer of private service mapping to inform those who can afford private health care and for planning in the private sector. However as a baseline the importance of establishing the nature of universal and equitably accessible health care necessitates that these maps remain distinct.

3) **The service has received funding for more than 3 years:** The inclusion of stable services (rather than those provided through short term grants) guarantees that we are mapping the robustness of the system. If we include services with less than three years of funding it will jeopardize the use of the Atlas for evidence informed planning.

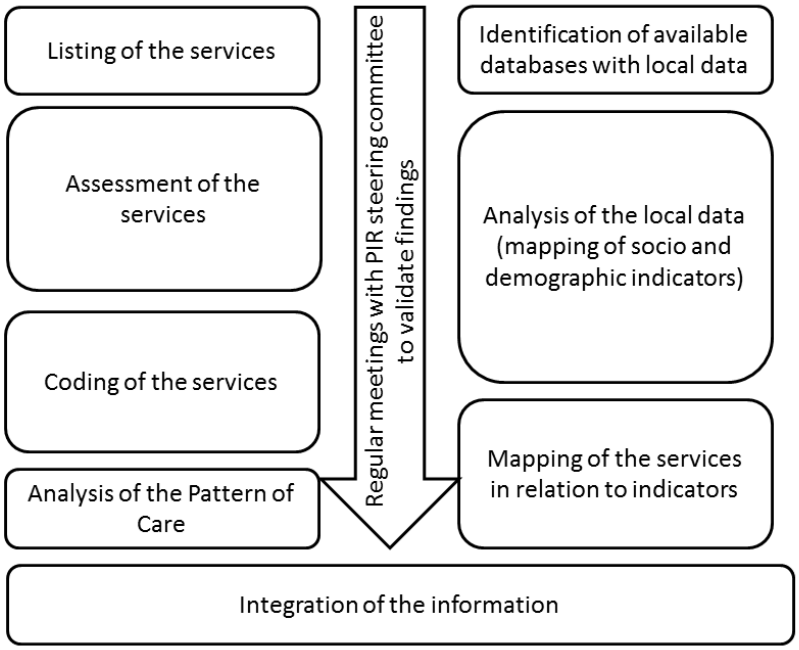
4) **The service is within the boundaries of South Western Sydney LHD:** The inclusion of services that are within the boundaries of Western Sydney LHD is essential to have a clear picture of the local availability of resources.

5) **The service provides direct care or support to clients:** We excluded services that were only concerned with the coordination of other services or system improvement, without any type of contact with people with a lived experience of mental ill-health

1.3. WHAT PROCESS WAS FOLLOWED IN SOUTH WESTERN SYDNEY?

There were four distinct steps in the creation of the Integrated Mental Health Atlas of South Western Sydney. Figure 8 summarises the process followed in the development of the Atlas. These steps are explained below.

Figure 8. Steps followed in the development of the Integrated Mental Health Atlas of South Western Sydney



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

Step 2 - Codification of the services followed criteria defined in DESDE-LTC, according to their MTC (not the official name).

The codes can be split into four different components:

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

GX All age groups
NX None/undetermined
CX Child & Adolescents (0-17 years old)
AX Adult (>17 years old)
OX Old > 64
Cc Only children (0-12 years old)
Ca Only adolescent (12-17 years old)
TC Period from child to adolescent (8-12 years old)
TA Period from adolescent to adult (16-25 years old)
TO Period from Adult to old (60- 70 years old)

b) Diagnostic group: ICD-10 codes in brackets after the age group code but before DESDE-LTC code were used to describe the main diagnostic group covered by the service. In the majority of the services we have used the code [F0-F99], which means that the service includes all types of mental disorders or does not specify any. If the service is not targeting mental ill-health, but psychosocial problems (for instance with some child and adolescent services) we have used the code [Z56-Z65]. If the client of the service is a child, but the professional is working with the family, we have included the code [e310] (immediate family), from the International Classification of Functioning (ICF).

c) DESDE-LTC code: The third component of the code is the core DESDE-LTC code which is the MTC. As we have explained before (pages 13-21) the services are classified according to their main type of care. This care can be related to: a) residential care (codes starting with R); b) day care (codes starting with D); c) outpatient care (codes starting with O); d) Accessibility to care (codes starting

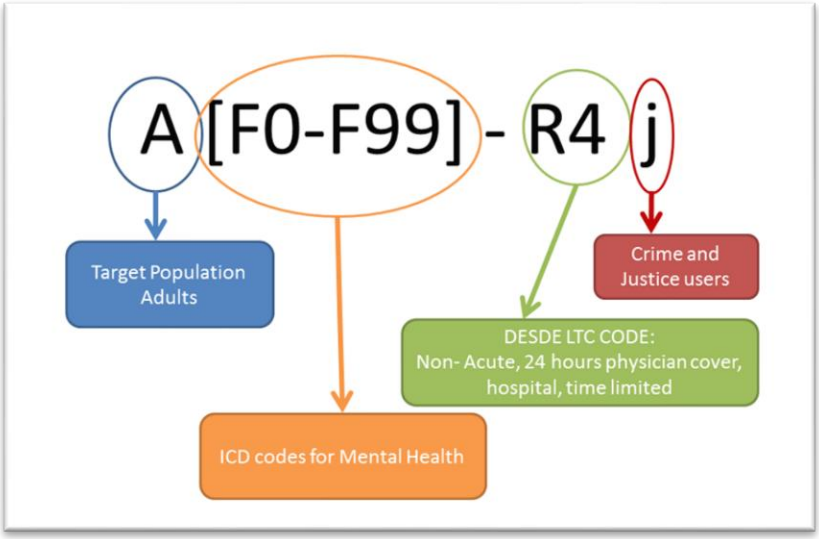
with A); e) Information for care (codes starting with I); and f) Self-Help and Voluntary care (codes starting with S).

d) Qualifiers: In some cases, a 4th component may be incorporated to facilitate a quick appraisal of those characteristics of the services which may be relevant to local policy. The qualifiers used in these Atlas are:

- **"b" based-care:** This additional code typifies outpatient/ambulatory services that do not provide any care outside their own premises
- **"d" mobile-care:** This additional code is used in those non-mobile services, which have between 20% and 49% mobile contacts.
- **"j" Justice care:** This additional code describes BSICs whose main aim is to provide care to individuals in contact with crime and justice services.
- **"l" Liaison care:** This additional code describes liaison BSICs where specific consultation for a subgroup of clients is provided to other area (e.g. outpatient consultation on intellectual disabilities to a general medical service, or consultation on mental ill-health for the general medical services of a hospital).
- **"s" Specialised care:** This additional code describes BSICs for a specific subgroup within the target population of the catchment area (e.g. services for Elderly people with Alzheimer's disease within the "E" group, or services for Eating Disorders within the "MD" group).
- **"u" Unique:** This additional code describes single-handed BSICs where care is delivered by a health care professional (psychiatrist, psychologist, nurse).

Example: A sub-acute forensic unit in a hospital for adults with lived experience of mental illness will receive the following code presented in Figure 9:

Figure 9. Components of the code- an example of a sub-acute forensic unit based in a hospital.



Step 3 Mapping the BSICs:

A series of chloropleth maps (maps that uses different colours inside defined geographical areas) were visualised in the GIS to illustrate the distributions and small-area variations in each of the demand-related variables, including:

- Density Index: Population/ Km^2
- Dependency Ratio: Population between 0-15 + >64 years old/ Population 16-64*100
- Aging Ratio: Population >64 years old/ Population 0-15*100
- Percentage of people born overseas: Population born overseas/ total population*100
- Percentage of people living alone: Number of homes with just 1 person/ Total Population)*100
- Percentage of Unemployment People: Number of unemployed people/ population 16-64 years old*100
- Percentage of people with psychological distress: Number of people with different levels of psychological distress according to the Kessler-10/total population*100
- Percentage of people providing assistance (caregivers) to another person : Number of people providing assistance/ population 16-64 years old*100
- SEIFA index

A second set of maps was then constructed to visualise the locations of all mental health services, and selected BSICs, South Western Sydney and in relation to some of these demand-related indicators. These maps enhanced with the derivation of a spatial accessibility metric, classifying all areas within the LHD jurisdiction by their distance to the mental health services being presented.

Step 4 Description of the pattern of care: service availability and capacity

We have analysed the availability of services, by MTC as well as the capacity.

- **Availability:** Defined as the presence, location and readiness for use of services or other organizational units in a care organization or a catchment area at a given time. A service is available when it is operable or usable upon demand to perform its designated or required function. The calculated availability rates of an MTC is calculated by 100,000 residents.

- **Placement Capacity**: Maximum number of beds in residential care and of places in day care in a care delivery organization or a catchment area at a given time. Rates have been calculated by 100,000 residents.

This analysis allows us to compare the availability and capacity rates with other areas and to estimate if the provision is adequate with regard to the populations needs. We have compared the area of South Western Sydney with other local areas from England, Finland, France, Italy, Norway and Spain. The information on the European Countries has been developed as part of the Refinement Project[20], funded by the European Commission.

2. Mapping South Western Sydney: Socio and Economic Indicators

South Western Sydney Local Health District (SWSLHD) is the largest district in metropolitan Sydney, with a population of over 820,000 people. It is expected that by 2021 the population of SWS will have increased to more than 1 million people, and that the number of people who are older than 65 years old will increase by 48%.

SWSLHD covers seven local government areas (LGAs): Bankstown, Liverpool, Fairfield, Campbelltown, Camden, Wollondilly and Wingecarribee. These LGAs areas are highly diverse, including the urban areas in the North (Bankstowns and Fairfield), semi-urban in the center (Camden, Campbelltown and Liverpool) and the rural areas of Wollondilly and Wingecarribee, in the south of the region. Wingecarribee stood out as being high on dependency, ageing population and lone person household. However, this area is less disadvantage than Fairfield, Bankstown and Campbelltown, which present high rates of unemployment and a high population density (i.e. people per km^2). Furthermore, these areas are characterized by a high multicultural community, with almost half of the population being born overseas. This highly contrasts with the situation in Wingecarribee and Wollondilly. Figure 10 and 11 shows the distribution of the risk of psychological distress in different LHDs, using Kessler scores and data from the 45 and Up study[7]. It can be observed that the higher risk of psychological distress is concentrated around the boundaries between Western Sydney and South Western Sydney, in areas also characterized by high deprivation (lower SEIFA deciles). These areas can be considered "hot spots" for mental health care provision. The rest of figures (12-19) depict the distribution of key socio and economic indicators related to mental health care. Table 1 summarises this information by LGA.

Table 1. Description of the LGA of South Western Sydney

LGA	People per km^2	Dependency index	Percent ≥64y(%)	Unemployment rate (%)	Overseas born (%)	Lone person household (%)	SEIFA Decile	Risk of psychological distress *
Bankstown	2518	54.9	13.7	7.6	43.8	6.3	2	Above average
Camden	282	51.5	9.7	4.0	19.8	4.6	8	Average
Campbelltown	468	45.5	9.3	7.4	34.0	6.1	2	Above average
Fairfield	1945	47.9	12.0	9.7	57.6	4.7	1	Above average
Liverpool	590	48.4	9.2	7.0	46.2	4.8	3	Above average
Wingecarribee	17	69.6	21.6	4.2	19.9	9.7	7	Below average
Wollondilly	18	51.2	10.8	4.2	16.9	5.2	7	Below average
New South Wales	9	51.5	14.7	5.9	31.4	8.7		

Figure 10. Risk of psychological distress[7].

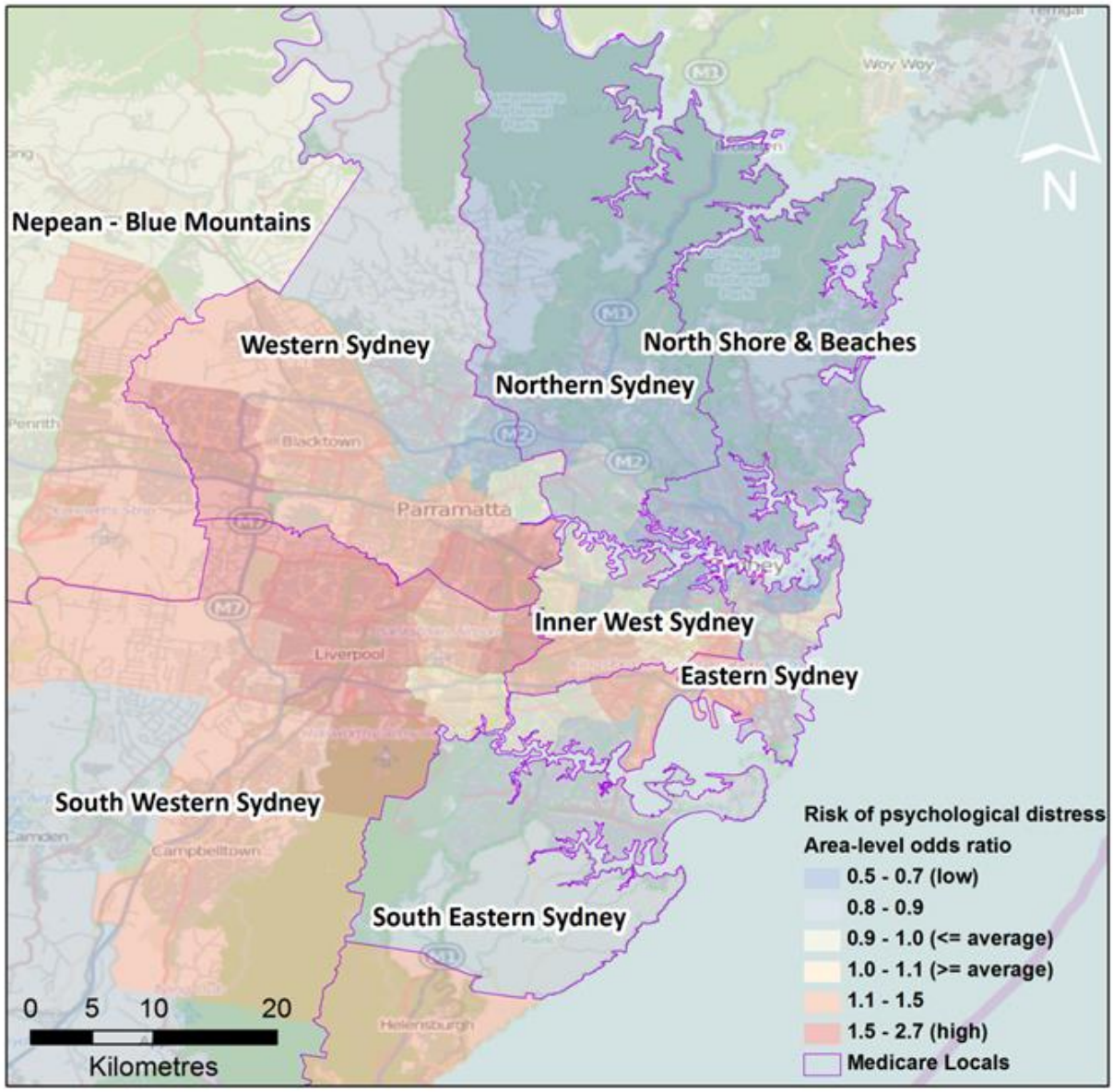


Figure 11. Risk of Psychological Distress in South Western Sydney.

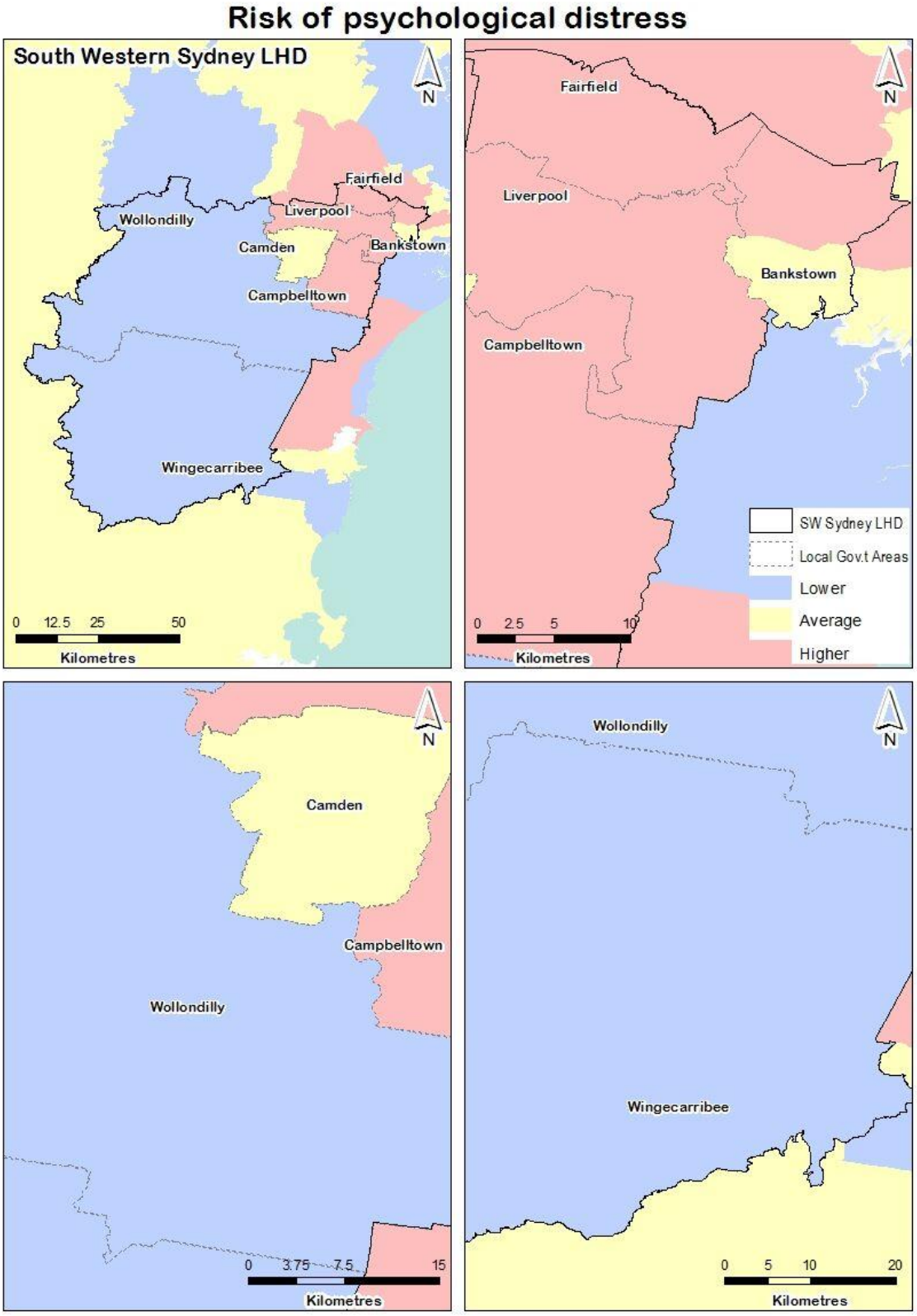


Figure 12. Population Density in South Western Sydney

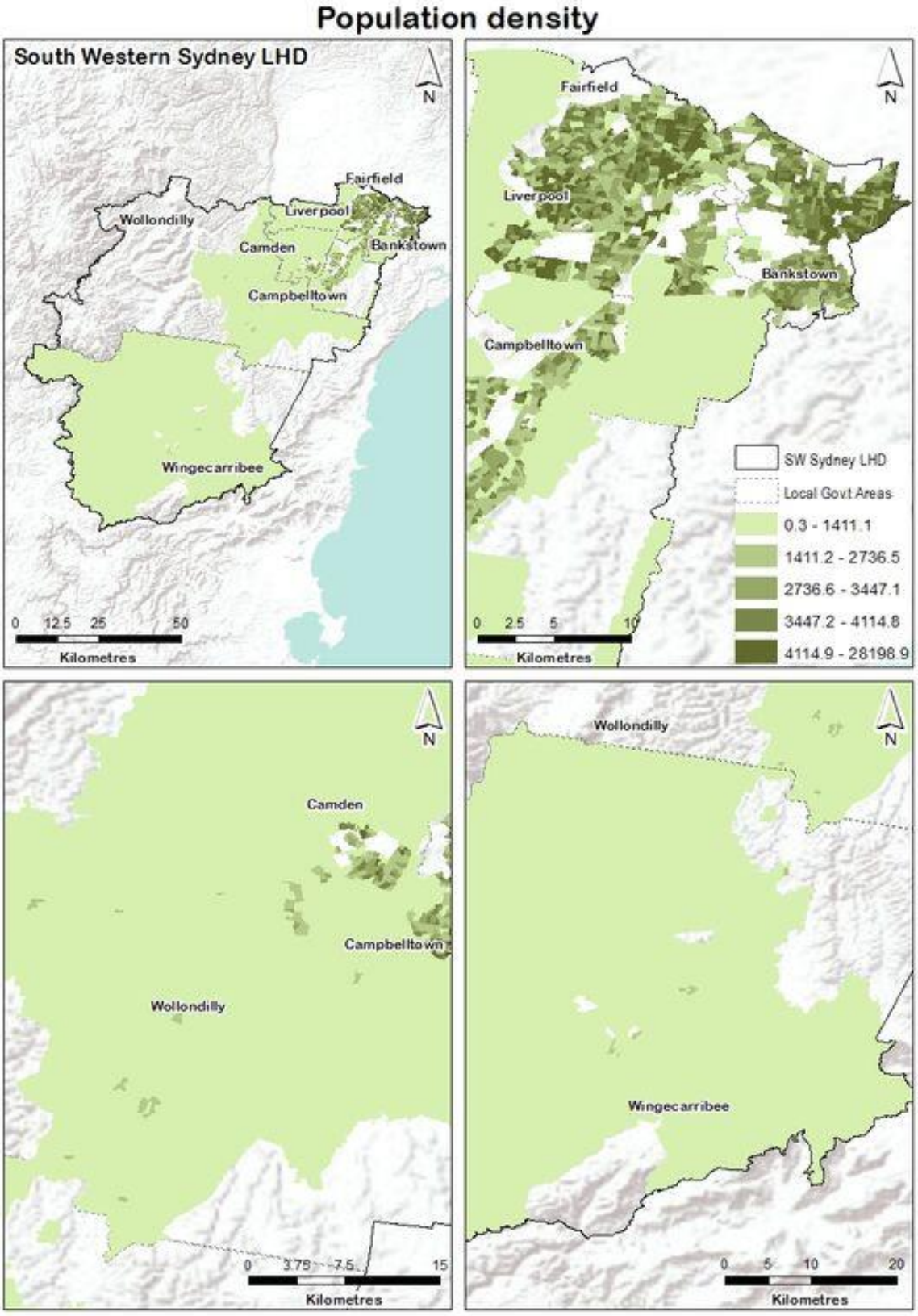


Figure 13. Dependency Index in South Western Sydney

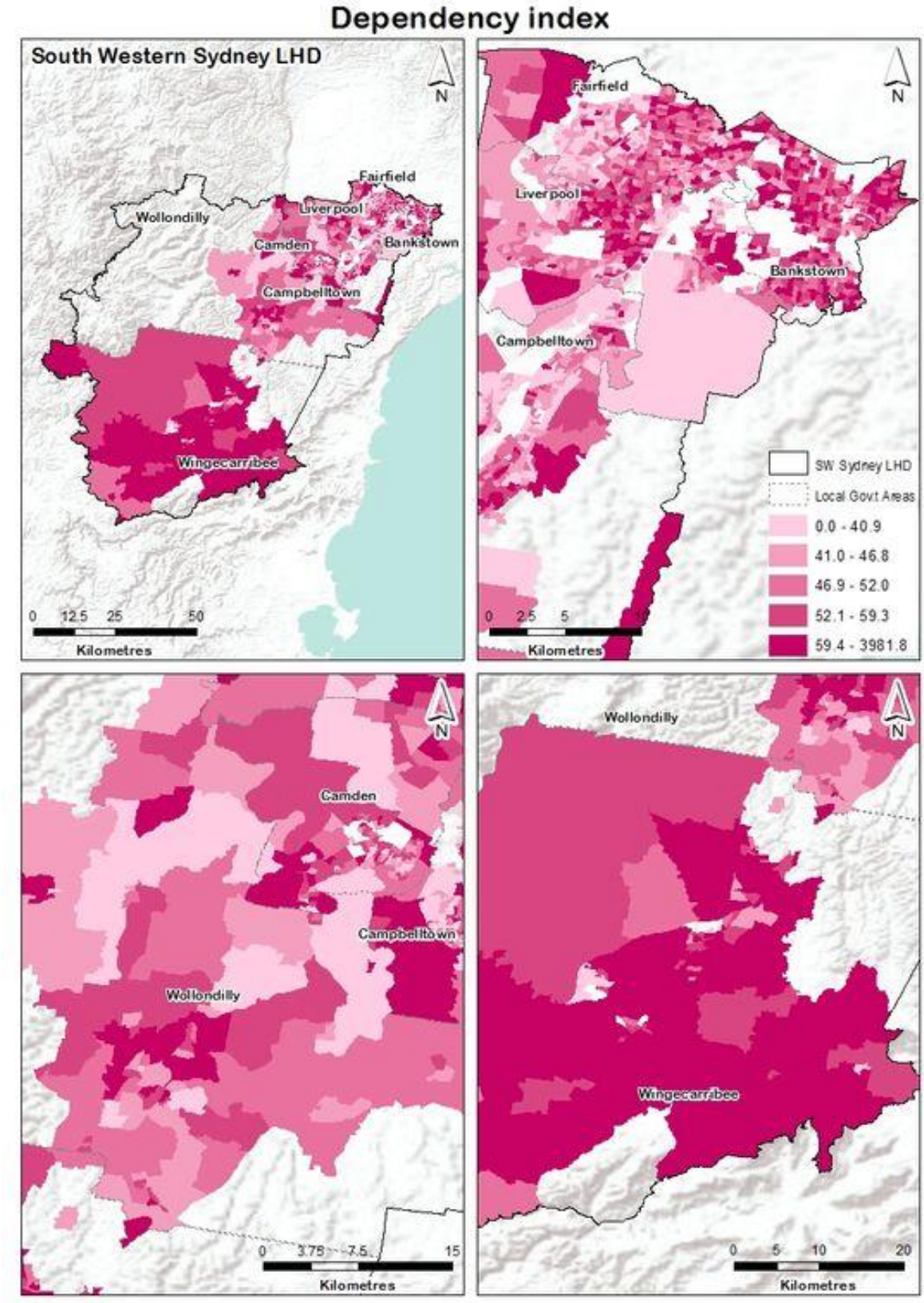


Figure 14. Distribution of people aged more than 64 years old in South Western Sydney

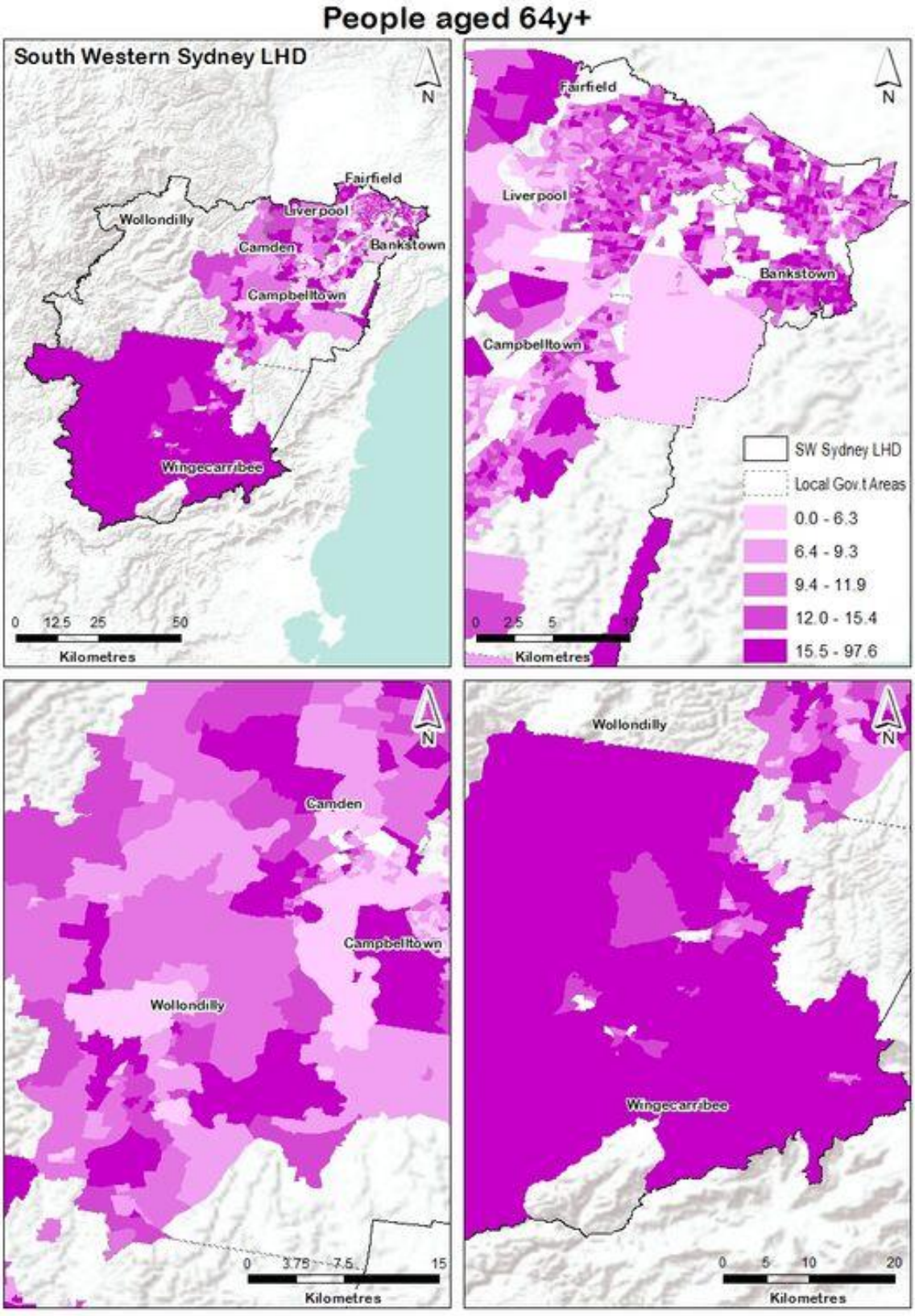


Figure 15. Distribution of unemployment in South Western Sydney

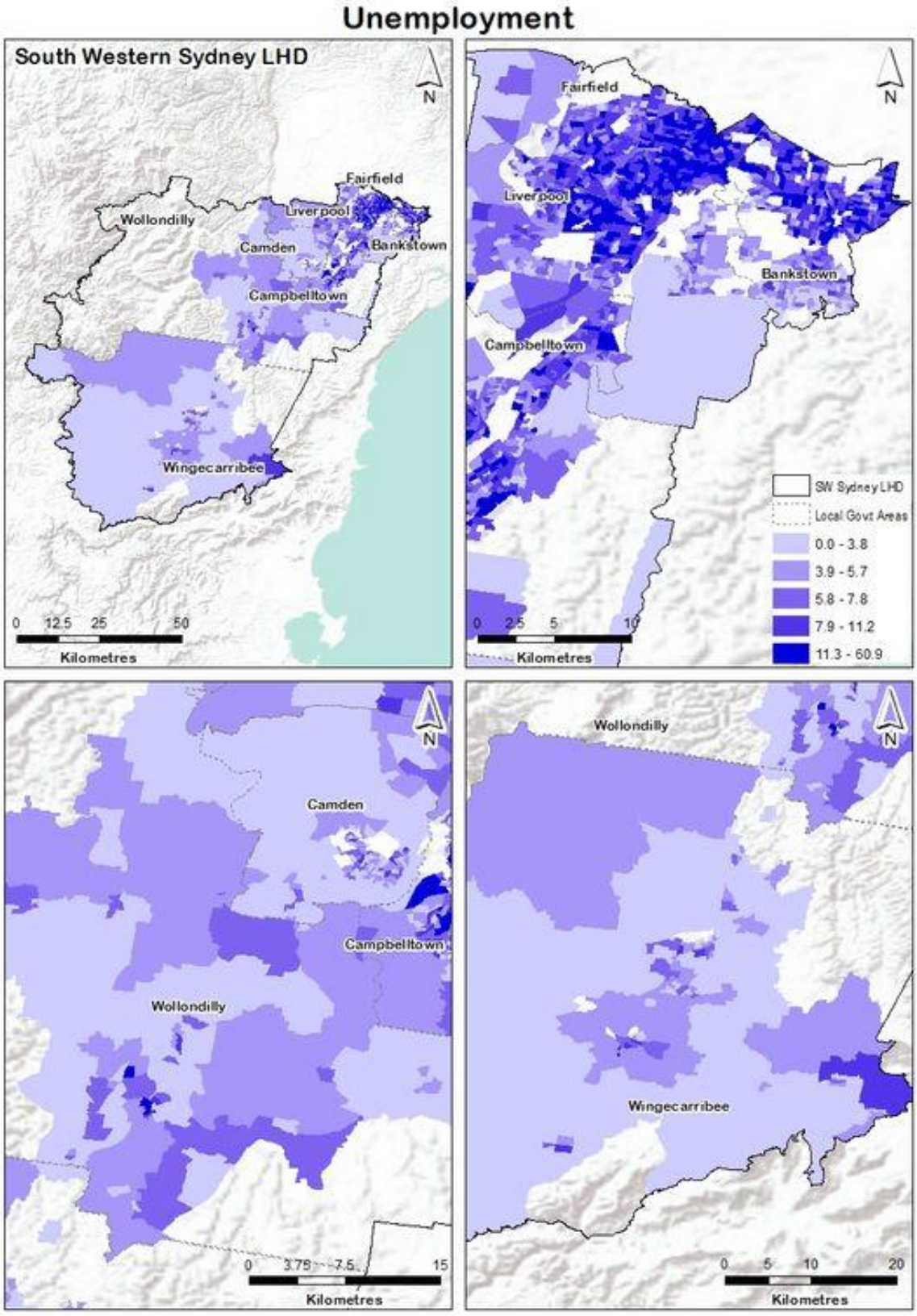


Figure 16. Distribution of People Born Overseas in South Western Sydney

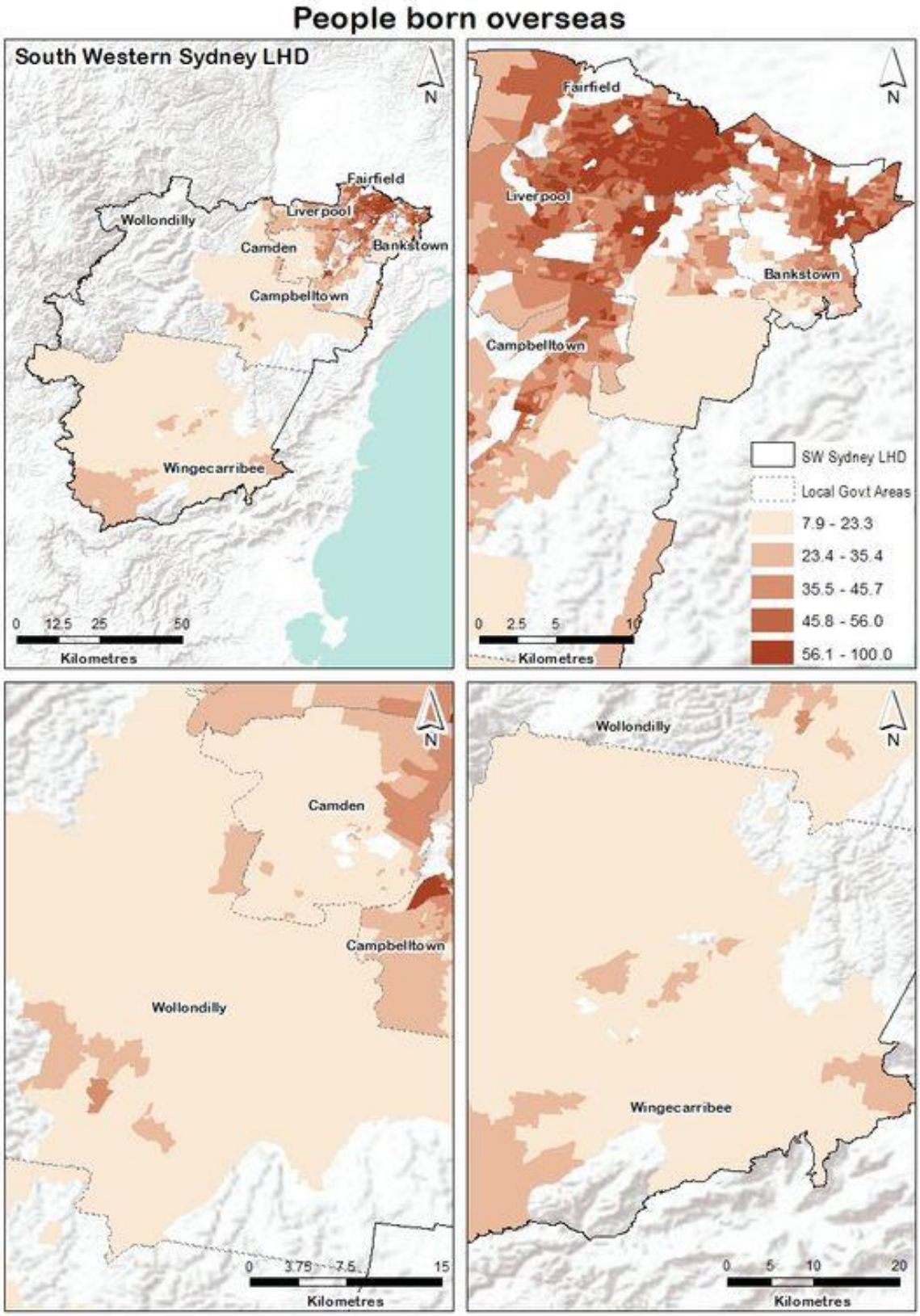


Figure 17. Distribution of people living alone in South Western Sydney

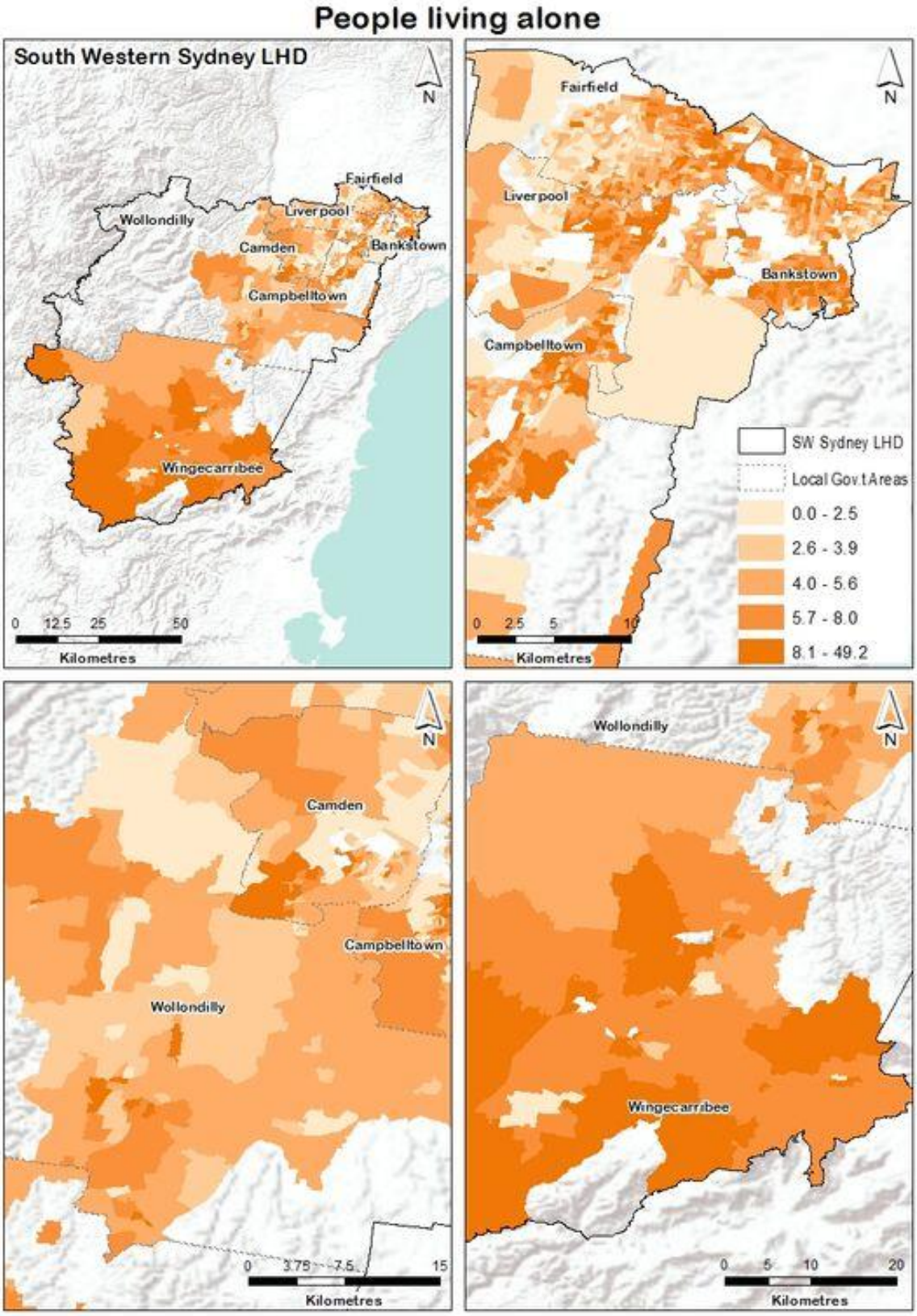


Figure 18. Number of people who care for another person with a disability in South Western Sydney

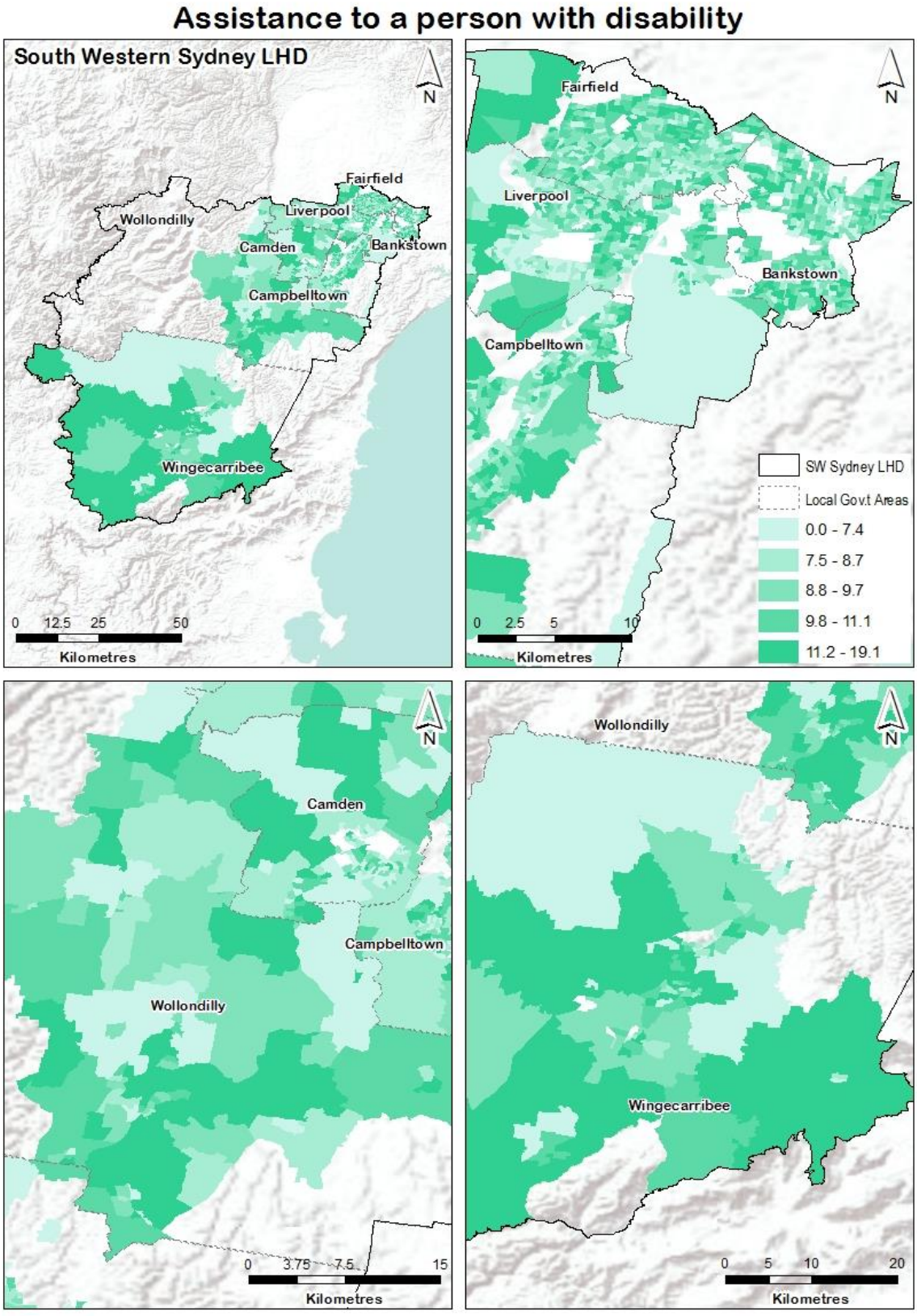
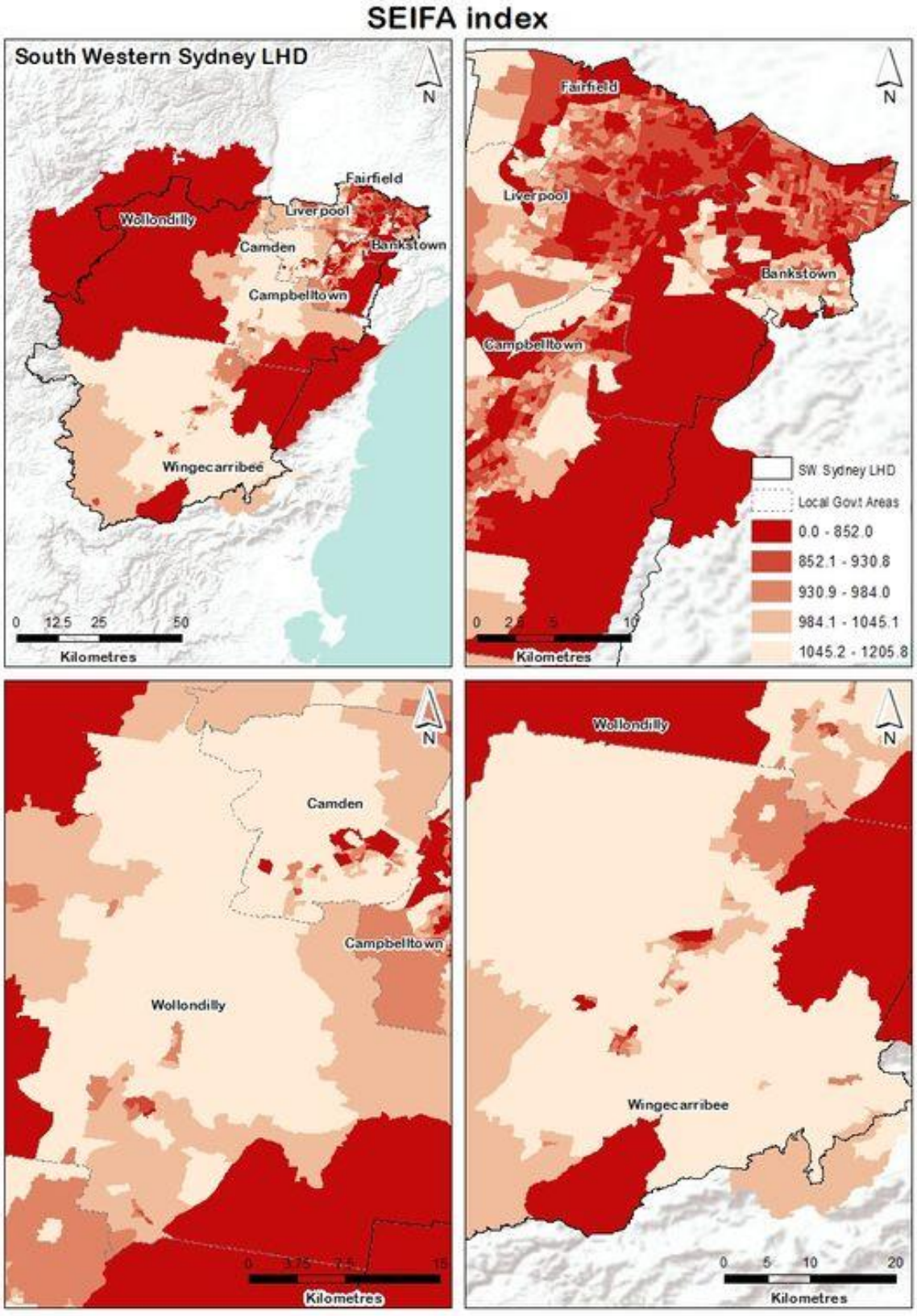


Figure 19. Distribution of the SEIFA Index in South Western Sydney



3. DESCRIBING THE SERVICES PROVIDING CARE FOR PEOPLE WITH A LIVED EXPERIENCE OF MENTAL ILL-HEALTH IN SOUTH WESTERN SYDNEY

3.1. General Description

Data on services providing care for people with a lived experience of mental ill-health in South Western Sydney was collected from 7th January 2015 to 29th May 2015. We received 50 on-line responses complemented with 17 face to face interviews with large mental health provider organizations. The Mental Health Atlas of South Western Sydney was publicly presented on the 5th November to an audience of over 120 representatives from different organizations. The document was then opened for public comments. After this period we only received three requests to add 3 new services. In addition, the Partners in Recovery (PIR) program was extended for three additional years. Consequently, we have included the information related to PIR in this new version. Finally, we have also included a short paragraph related to the Ability Links program.

We found a total of 126 BSICs (or services) for people with a lived experience of mental health ill-health or psychosocial problems. About 95% of these BSICs (or services) received only one MTC code. The total number of MTC codes found was 135. In addition, we have included in the description 104 ATAPs providers, information about two Aboriginal services, and the Transcultural Mental Health Service (which is located in Western Sydney LHD). We are not including services targeting Alcohol and Other Drugs, Intellectual Disability or homelessness.

Table 2 depicts the distribution of the MTC by sector and population group.

Figure 20 briefly describes the MTCs identified.

With regard to the age distribution of clients provided for, 69% of the care provided is for adults and 8% for Child and Adolescents.5% of the services were devoted to young people (i.e. 16 to 25 years old) and 5% to older people. 7% are offering services for carers, families and friends and 6% are targeting people with non-English background.

Almost 44% of the care for people with mental health problems is provided by the health sector. The NGO sector also contributes with 47% of the MTCs, while the remaining 9% is provided by FaCS However, as will be explained below, services provided by FaCS are not specifically targeting people with experiencing mental ill-health. All this information will be described in detail in the sections below.

Lastly, the distribution of the different types of care by sector is quite similar. Outpatient is the type of care most frequently provided, followed by residential care.

Figure 20. Description of the MTC provided

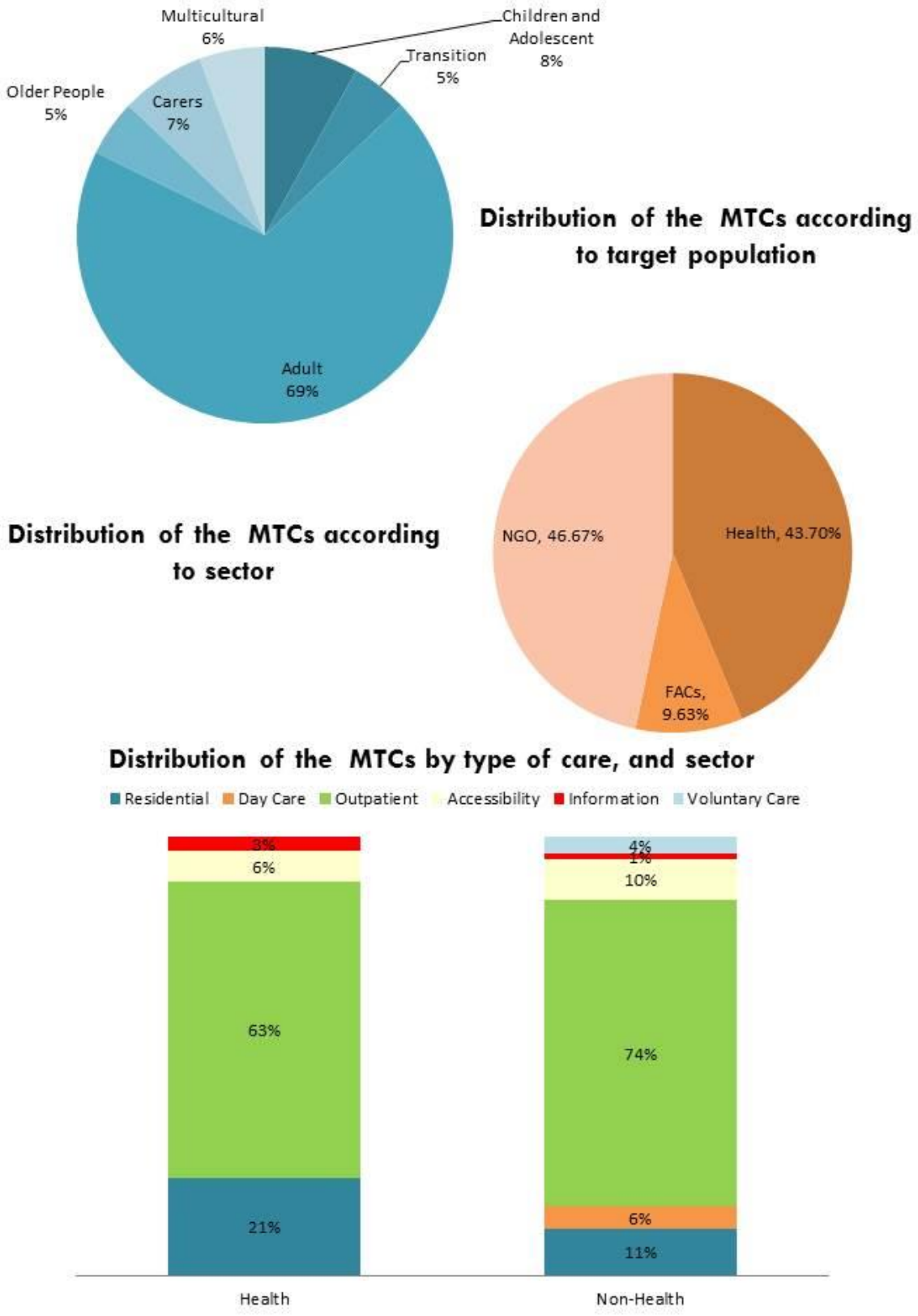


Table 2. Description of the MTCs per age group and sector

		Adults				Children and Adolescents				Older People				Specific Populations				Total			
MTC	**Definition**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**
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			1				0				0				0	1	0	0	1
R2	Acute, 24 hours physician cover, hospital, medium intensity *	6			6	2			2				0				0	8	0	2	8
R4	Non- Acute, 24 hours physician cover, hospital, time limited	2			2				0	2			2				0	2	0	0	4
R9.2	Non-acute, non-24 hours physician cover, time limited, daily support, over 4 weeks			4	4				0				0				0	0	0	4	4
R11	Indefinite stay 24 hours support			4	4				0				0				0	0	0	4	4
DAY CARE: Facilities that are normally available to several users at a time, provide some combination of treatment/support/care for problems related to long-term care needs; have regular opening hours, and expect service users to stay at the facility beyond periods druing which they have face-to-face contact with staff																					
D2.2	non-acute, work, high intensity, work related			1	1				0				0				0	0	0	1	1
D4.3.	non-acute, non-work structured care, high intensity, social and cultural related care			3	3				0				0				0	0	0	3	3
OUTPATIENT: Facilities that involve contact between staff and users for some purpose related to management of their condition and its associated clinical and social dificulties																					
O3.1	Acute, non-mobile, 24-h, health related care*	3			3				0				0				0	3	0	0	3
O4.1.	acute, non-mobile, time limited, health related care	6			6				0				0				0	6	0	0	6
O6.1	Non-Acute, Home & Mobile, Medium Intensity, health related care			3						1			1					1	0	3	4
O8.1	Non-Acute, non-mobile, High intensity , health related care	13		1	14	8	1	1	10	3			3	1			1	25	1	2	28

		Adults				Children and Adolescents				Older People				Specific Populations				Total			
MTC	**Definition**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**
O9.1	Non-Acute, non-mobile, Medium intensity , health related care	2		3	5			3	3				0			1	1	2	0	7	9
O10.1	Non-acute, non-mobile, low intensity, health related care	1			1				0				0	1			1	2	0	0	2
O5.2	Non-Acute, Home & Mobile, High Intensity, other care			13	13				0				0				0	0	0	13	13
o6.2	Non-Acute, Home & Mobile, Medium Intensity, other care			4	4				0				0			2	2	0	0	6	6
O7.2	Non-Acute, Home & Mobile, low Intensity, other care		9	1	10				0				0			4	4	0	9	5	14
O8.2	Non-Acute, non-mobile, High intensity , other care			1	1			1	1				0			2	2	0	0	4	4
O9.2	Non-Acute, non-mobile, Medium intensity , other care				0				0				0			3	3	0	0	3	3
O10.2	Non-Acute, non-mobile, Low intensity , other care				0				0				0	1			1	1	0	0	1
ACCESSIBILITY: Facilities which main iam is to provide accesibility aids for users wiwth long term care needs																					
A3	Personal Accompaniment by non-care professionals.	2			2				0				0				0	2	0	0	2
A4	Case Coordination	2			2				0				0				0	2	0	0	2
A5.4	Access to Employment			4	4				0				0				0	0	0	4	4
A5.5	Access to Housing		3		3				0				0				0	0	3	0	3
INFORMATION AND GUIDANCE: Facilities which main aim is to provide users with information and or assessm,ent of their needs. This service does not entail subsequent follow-up or direct care provision																					
I1.1	Information, interactive, face to face				0				0				0	1			1	1	0	0	1
I2.2	Information, non-interactive				0				0				0	1			1	1	0	0	1
I1.5	Professional assessment and guidance related to legal issues			1	1				0				0				0	0	0	1	1

		Adults				Children and Adolescents				Older People				Specific Populations				Total			
MTC	**Definition**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**	**H**	**FACS**	**NGO**	**TOTAL**
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 above), but the staff is non-paid																					
S1.2	Non-professional staff accessibility to care			1					0				0				0			1	1
S1.3	Non-professional staff outpatient care			2	2				0				0				0	0	0	2	2
TOTAL		38	12	46	91	10	1	5	16	6	0	0	6	5	0	12	17	59	13	63	130

3.2. Adults

In this section we describe the availability and placement capacity of the BSICs (or services) providing care for adults (> 18 years olds) experiencing mental ill-health by sector. Specific care related to the transition from adolescence to adulthood is included in the section on Child and Adolescent Care. Similarly, specific care for older people experiencing mental health problems is presented in an independent section.

3.2.1. Residential Care

3.2.1.1. Residential Care Provided by the Public Health Sector

Acute Inpatient Services

A total of 7 BSICs (or services) were identified which provide acute inpatient care in the South Western Sydney LHD. The units in Bankstown (Banks House), Campbelltown (DEM PECC) and Liverpool (PECC) also provide ambulatory emergency care. The 2 units attached to the Psychiatric Emergency Care Centre (PECC) at Liverpool and Campbelltown are short stay mental health unity (up to 3 days) for patients with lower risk. It provides an opportunity to assess and stabilize them in a short period of time. The acute inpatient team at Campbelltown, Bankstown and Liverpool also provide 24-hours emergency care.

The number of acute beds per 100,000 residents is 18.95. The number of BSICs providing acute care per 100,000 residents is 1.08

Table 3. Acute inpatient services: Availability and Placement Capacity

Provider	Name	Main Desde code	Secondary Desde code	Beds	Suburb	Coverage Area
Mental Health Services SWS LHD	Banks House	Ax[F0-F99]-R2	ax[f0-f99]-o3	30	Bankstown	South Western Sydney
	DEM PECC	Ax[F0-F99]-R2	ax[f0-f99]-o3	6	Campbelltown	South Western Sydney
	Waratah House	Ax[F0-F99]-R2		30	Campbelltown	South Western Sydney
	Liverpool PECC	Ax[F0-F99]-R2	ax[f0-f99]-o3	6	Liverpool	South Western Sydney
	MHU East	Ax[F0-F99]-R2		20	Liverpool	South Western Sydney
	MHU West	Ax[F0-F99]-R2		20	Liverpool	South Western Sydney
	MHU HDU	Ax[F0-F99]-R1		10	Liverpool	South Western Sydney

The next table show the workforce capacity related to adult acute inpatient services in the area of South Western Sydney. Psychiatrists and Mental health nurses, as expected, account for the higher percentage of the workforce. The number of psychologists is low, although at Liverpool Hospital is available on a referral basis.

Table 4. Acute Inpatient unit: Workforce Capacity.

Provider	Name	Psych	Psychol	MH Nurse	OT	SW	Total
Mental Health Services SWS LHD	Banks House	4.5	1	39.81	2	2	49.31
	DEM PECC	2	0	17.94	0	1	20.94
	Waratah House	5	0	39.81	2	0	46.81
	Liverpool PECC	2	*	18.19	0	0.5	20.69
	MHU East	3.2	*	26.87	1	1	32.07
	MHU West	3	*	26.87	1	1	31.87
	MHU HDU	3	*	26.87	1	1	31.87
	Total	22.7	1	196.36	7	6.5	233.56
	Rate per 100,000 inh	3.53	0.16	30.51	1.09	1.01	36.29

PSYCH: PSYCHIATRIST (INCLUDING REGISTRARS); PSYCHOL: PSYCHOLOGIST; OT: OCCUPATIONAL THERAPIST; SW: SOCIAL WORKER; DT: DIVERSIONAL THERAPIST; * ON A REFERRAL BASIS.

SUB-ACUTE INPATIENT SERVICES

A total of 2 BSICs were identified as providing sub-acute inpatient care in the area of the South Western Sydney LHD. All of them are located at Liverpool Hospital. The length of stay of the Mental Health Unit South is up to three months, while the length of stay in the North unit is from three to six months. The patient mix of the North Unit is characterized by severe cognitive impairment.

The number of sub-acute beds per 100,000 residents is 5.28. The number of services providing sub-acute care per 100,000 residents is 0.31

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

Provider	Name	Main Desde Code	Beds	Suburb	Coverage Area
Mental Health Services SWS LHD	DEGN MHU North	Ax[F0-F99]-R4	14	Liverpool	South Western Sydney
	MHU Subacute South	Ax[F0-F99]-R4	20	Liverpool	South Western Sydney

Table 6 describes the workforce capacity in sub-acute care in South Western Sydney. As in the case of acute care, mental health nurses and psychiatrists are the professionals with the highest representation.

Table 6. Sub-acute inpatient services: workforce capacity

Provider	Name	Psych	Psychol	MH Nurse	OT	SW	DT	Total
Mental Health Services SWS LHD	DEGN MHU North	1	*	17.94	1	0.5	0	20.44
	MHU Subacute South	3	1	25.96	1	1.5	1	33.46
	Total	**4**	**1**	**43.9**	**2**	**2**	**1**	**53.9**
	Rate per 100,000 residents	0.62	0.16	6.82	0.31	0.31	0.16	8.37

PSYCH: PSYCHIATRIST (INCLUDING REGISTERS); PSYCHOL: PSYCHOLOGIST; OT: OCCUPATIONAL THERAPIST; SW: SOCIAL WORKER; DT: DIVERSIONAL THERAPIST; * ON A REFERRAL BASIS.

3.2.1.2. Residential Care provided by Family and Community Services (FaCS)- Social and Community Housing

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

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

FaCS aims to improve the lives of vulnerable people and to support their participation in social and economic life. People with mental health problems use the services provided by FaCS, but FaCS does not provide specific care for people with mental health problems. Concerns have been raised about the appropriateness of including FaCS in the Mental Health Atlas as it could bias the picture by implying that there are significantly more services targeting people with mental health problems than there are. On the other hand, people with mental health problems are one of the main client groups in some of these areas, such as Public Housing. Excluding some of these services also distorts the picture.

The fact remains that there is no specific BSIC (service or team) in Family and Community services that specialises in care for people with mental health problems. This contrasts significantly to other counties, where equivalents to Family and Community services include a specific division related to Mental Health. In spite of this, we think that it is important to mention the services for the general population that relate to Public Housing and Child Protection.

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

Social Housing

According to the last report published by FaCS NSW [21], as at 30 June 2013 there were a total of 110,059 households living in public housing; 25,973 living in community housing and 4469 living in Aboriginal Housing. FaCS manages 149,972 properties in all NSW, comprising 117,798 public housing dwellings, 27,450 properties in the community housing sector and 4724 Aboriginal Housing properties.

We have identified three main obstacles for evidence informed local planning related to mental health care in social housing: 1) it is not possible to know how many of the properties are specifically devoted to people with a lived experience of mental ill-health; 2) it is not possible to know how many people with a lived experience of mental ill-health were using the properties (data on mental health status is not collected); and 3) properties are not restricted to specified districts (i.e. a person living in South Western Sydney may be relocated in Northern NSW if there is a property available there).

An additional problem is that public housing may or may not include direct support. People with a lived experience of mental ill-health who need support at home receive this type of care through the House

and Accommodation Support Initiative (HASI). HASI is a partnership between NSW Health, Housing NSW and an array of non-government organizations (NGOs) that provides people with mental health problems 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 health problems is provided is more accurately conceptualised as a financing mechanism than a service providing care.

In spite of the above limitations we codified the FaCS services. We found 13 BSIC/services delivered by FaCS providing direct care related to housing. Although this is not specifically for people with mental health problems, most of their clients experience mental health issues. Nine out of the 13 services are providing tenancy support, that is, non-acute, mobile, outpatient care of low intensity (contact with the client is lower than once a month). The other five BSICs are focused on helping the client to access social housing (through assessment and eligibility).

It is important to recognize that although these BSICs/services are mainly providing care for people within the boundaries of South Western Sydney LHD, they also provide support to people from throughout the state if needed.

The total number of BSICs (or services) providing tenancy support (non-acute, mobile, outpatient care, low intensity) in South Western Sydney is 1.39 per 100,000 residents. The total number of case workers providing this type of care is 99, with a rate of 15.38 per 100,000 residents.

The number of BSICs (or services) providing assessment and eligibility care (accessibility to social housing) in South Western Sydney is 0.46per 100,000 residents, with a rate of 7.76 per 100,000 residents.

However, as we have already said, this is not a specific service for people with a lived experience of mental illness.

Table 7. Availability and workforce capacity of BSICs related to public housing

Provider	Name	Main DESDE Code	Suburb	Coverage Area	Workforce Capacity
Family & Community Services	Tenancy support	AX[Z55-Z65]-O7.2	Bankstown	South Western Sydney	11
	Tenancy support	AX[Z55-Z65]-O7.2	Bankstown	South Western Sydney	11
	Tenancy support	AX[Z55-Z65]-O7.2	Bankstown	South Western Sydney	6
	Tenancy support	AX[Z55-Z65]-O7.2	Campbelltown	South Western Sydney	12
	Tenancy support	AX[Z55-Z65]-O7.2	Campbelltown	South Western Sydney	12
	Tenancy Support	AX[Z55-Z65]-O7.2	Fairfield	South Western Sydney	13
	Tenancy Support	AX[Z55-Z65]-O7.2	Fairfield	South Western Sydney	9
	Tenancy Support	AX[Z55-Z65]-O7.2	Liverpool	South Western Sydney	12
	Tenancy Support	AX[Z55-Z65]-O7.2	Miller	South Western Sydney	13
	Subtotal				**99**

	case workers				
	Rate per 100,000 inh				**15.38**
	Assessment and Eligibility	AX[Z55-Z65]-A5.5.	Campbelltown	South Western Sydney	17
	Assessment and Eligibility	AX[Z55-Z65]-A5.5.	Fairfield	South Western Sydney	16
	Assessment and Eligibility	AX[Z55-Z65]-A5.5.	Liverpool	South Western Sydney	17
	Subtotal case workers				**50**
	Rate per 100,000 inh				**7.77**

The same limitations that have been discussed in the FaCS section also apply to community housing: organizations such as Hume, Argyle, St George, among others, only provide the property, while the support is provided by other NGOs. So, this type of service is a "financial mechanism" (help to access housing) rather than a service providing direct support for people with mental health problems. As mentioned in the FaCS section, although the property is located in South Western Sydney, it is utilized by the whole state. In addition, it is difficult to know how many of these properties are devoted to people with mental health problems, as they are accessible to all vulnerable groups in the general population. Despite this, it is possible to estimate how many residents in the properties are participating in the HASI, or similar, targeting people with a lived experience of mental illness.

The number of HASI properties in the community housing sector in South Western Sydney is 5 per 100,000 residents.

Table 8 summarises this information as a proxy of availability of housing for people with mental health problems, when this information was reported by the providers.

Table 8. Community Housing Providers in South Western Sydney Region

	No Properties in the area (WS and SWS)	No of properties with a client under the HASI program or similar
Evolve Housing	2234	-
Argyle Community Housing	1994	13 HASI properties and 4 transitional properties
Community Housing Limited	1248	-
Ecclesia Housing	302	-
Hume Community Housing	1400	14 HASI properties and 2 aboriginal HASI (managed by NEAMI and NEW Horizons) 12 Transitional Housing Programs (managed by NEAMI and NEW Horizons) 7 long term customers (NEAMI and NEW Horizons) 3 transitional properties
MA Housing	961	-
St George	4069	5 HASI properties
Wentworth Community Housing	1942	-

3.2.1.3. Residential Care provided by NGOs

We have identified 8 residential services provided by NGOs, 4 out of them are time limited while 4 allow for indefinite stay.

Time Limited Residential Care

NEAMI, in partnership with the Macarthur Rehabilitation Team, provide 4 residential units for people with a lived experience of mental illness. These residential units are step-down facilities to ease the transition to community. The clients have daily support and can live in the facility for more than 4 weeks, up to 6 months.

The number of BSICs providing time-limited residential care in South Western Sydney per 100,000 residents is 0.62; with 1.24 beds per 100,000 residents.

Table 9. Time limited residential care in the NGO sector: availability

Meso-organization (i)	Name	Desde1	Beds	Suburb	Area of Coverage
NEAMI & McArthur Rehab Team	Stepdown 1	Ax[F00-F99]-R9.2	2	Campbelltown	South Western Sydney
	Stepdown 2	Ax[F00-F99]-R9.2	2	Campbelltown	South Western Sydney
	Stepdown 3	Ax[F00-F99]-R9.2	2	Campbelltown	South Western Sydney
	Stepdown 4	Ax[F00-F99]-R9.2	2	Campbelltown	South Western Sydney

Indefinite Residential Care

We have identified 4 BSICs providing indefinite residential care for people with a lived experience of mental illness in South Western Sydney. The service provided by Grow is for people with coexisting mental health and drug and alcohol problems or mental health problems alone. It is indefinite because it does not have a maximum period of stay.

The boarding houses provided by New Horizons are targeting men with long time schizophrenia and complex needs.

The number of indefinite residential care per 100,000 residents is 0.62. The number of indefinite residential beds is 3.88 per 100,000 residents.

Table 10. Indefinite residential care in the NGO sector: availability

Provider	Name	Desde1	Beds	Suburb	Area of Coverage
Grow	Grow Residential Rehabilitation Program	Ax[F10-F19]-R11o	17	West Hoxton	South Western Sydney
New Horizons	Boarding House	Ax[F00-F99]-R11	4	Bass Hill	South Western Sydney
	Boarding House	Ax[F00-F99]-R11	4	Campbelltown	South Western Sydney
	Boarding House	Ax[F00-F99]-R11	4	Minto	South Western Sydney

With regard to the workforce capacity, all of them are staffed with mental health workers that provide 24 hours support. Medical and Psychiatric care is available on-call.

Table 11. Indefinite residential care in the NGO sector: workforce capacity

Provider	Name	MHW	Vol	Total
Grow	Grow Residential Rehabilitation Program	9.2	2	11.2
New Horizons	Boarding House	4		
	Boarding House	4		
	Boarding House	4		
Total		17.2	2	19.2
Rate per 100,000 Residents		**2.67**		

MHW: MENTAL HEALTH WORKER

3.2.2. DAY CARE

3.2.2.1. DAY CARE PROVIDED BY THE PUBLIC HEALTH SECTOR

We have not located any service providing Day Care in the Public Health Sector.

3.2.2.2. DAY CARE PROVIDED BY NGOS.

SOCIAL AND CULTURAL RELATED

We have identified 3 BSICs (or services) providing social and cultural related day care for people with mental health problems. These are centres that enable social contacts in a structured way and that provide workshops that aim to train people in basic life skills.Although the activities are structured, the clients choose when to attend, and there is not an individual plan attached. The three services identified (RichmondPRA and Schizophrenia Fellowship) are high intensity, meaning that they can be used more than the equivalent of four half days per week. The Day to day Living Program by RichmondPRA has around 118 clients per year.

The total number of BSICs (or services) providing cultural and social related day care in South Western Sydney is 0.47 per 100,000 residents.

Table 12. Day Care –social and cultural related: availability

Provider	Name	Desde 1	Suburb	Coverage Area
RichmondPRA	Flowerdale Cottage-Day to Day Living	Ax[F0-F99]-D5	Liverpool	South Western Sydney
Schizophrenia Fellowship	Sunflowers seed day to day living centre	AX[F0-F99]-D5	Bowral	South Western Sydney
	Harmony House Day to Day living Centre	AX[F0-F99]-D5	Campbelltown	South Western Sydney

In regards to the **workforce capacity**, we only have information from RichmondPRA. The Day to Day living program has 2.3 full time equivalents (mental health workers). This equals to 0.35 mental health workers per 100,000 residents.

WORK RELATED

Only one BSIC (or service) providing work-related day care for people with experiencing mental ill-health was identified within the boundaries of South Western Sydney LHD. This day-care facility provides clients with the opportunity to work for pay. In this case, employees are paid at least 50% of the minimum wage for this form of work. This service has 33 places.

The total number of BSICs (or services) providing work related day care in South Western Sydney is 0.16 per 100,000 residents, with a total of 5.13 places per 100,000 residents.

Table 13. Day Care- Work Related: availability

Provider	Name	Desde 1	Places	Suburb	Coverage Area
RichmondPRA	Enterpraise	Ax[F0-F99]-D2.2	33	Warrick Farm	South Western Sydney

The number of **full time equivalents** is 5.4 or 0.84 per 100,000 residents.

3.2.3. OUTPATIENT CARE

3.2.3.1. OUTPATIENT CARE PROVIDED BY THE PUBLIC MENTAL HEALTH SECTOR

ACUTE OUTPATIENT CARE (EMERGENCY CARE)

We identified a total of 6 BSICs (or services) providing emergency care for adults with mental health problems. Three of these teams liaise with other services at hospitals to provide psychiatric care and the other three provide acute outpatient care during business hours. It should be noted that none of these teams provide 24 hours psychiatric emergency care. This care is provided by the acute inpatient team (see residential care section)

The numbers of services providing acute outpatient care per 100,000 residents is 0.93.

Table 14. Acute Outpatient Care: availability

Provider	Name	Desde1	Suburb	Coverage Area
Mental Health Services SWS LHD	Consultation liasion Fairfield	Ax[ICD][F0-F99]-04.1l	Carramar	South Western Sydney
	Consultation Liason campbelltown	Ax[ICD][F0-F99]-O4.1l	Campbelltown	South Western Sydney
	Consultation liason Liverpool	Ax[ICD][F0-F99]-O4.1l	Liverpool	South Western Sydney
	Community Mental Health Emergency Team (CoMHET)	Gx[F0-F99]-O4.1	Liverpool	South Western Sydney
	Community Mental Health Emergency Team (CoMHET)	Gx[F0-F99]-O4.1d	Bankstown	South Western Sydney
	Community Mental Health Emergency Team (CoMHET)	Gx[F0-F99]-O4.1d	Campbelltown	South Western Sydney

Table 16 summarized the workforce providing acute outpatient care in South Western Sydney. As expected, the number of clinical health professionals is higher than the number of allied health professionals.

Table 15. Acute Outpatient Care: workforce capacity

Provider	Name	Psych	Psychol	Nur	OT	SW
Mental Health Services SWS LHD	Consultation liasion Fairfield			1		
	Consultation Liason campbelltown	2		1		
	Consultation liason Liverpool	3.2	2	1		
	COMHET-Liverpool	2	3	13.6		5
	COMHET- Bankstown	1.6	1.63	9.12	0.53	2
	COMHET-Campbelltown	1.8	6	10.8		1
TOTAL		10.6	12.63	36.52	0.53	8
Rate per 100,000 residents		1.65	1.96	5.67	0.08	1.24

PSYCH: PSYCHIATRIST; PYSCHOL: PSYCHOLOGIST; NUR: NURSES; OT: OCCUPATIONAL THERAPISTS; SW: SOCIAL WORKERS

NON-ACUTE MOBILE OUTPATIENT CARE

We have not found any non-acute mobile outpatient care service in South Western Sydney. It has to be kept in mind that to be classified as a mobile more than 50% of the activity should be done outside the centre. In South Western Sydney the teams do not reach this threshold, although they have high mobility.

Non-Acute Non-Mobile Outpatient Care

We identified 13 BSICs (or services) providing non-acute, non-mobile outpatient care. These teams provide face to face services to people with mental health problems living in the different areas of South Western Sydney LHD:

- There are 6 Community Mental Health Team (Bankstown, Bowral, Campbelltown, Fairfield, Liverpool and Wollondilly) that are highly mobile (they have the capacity to see people in their home or other place in the community, and around 20% - 49% of their activity is outside the office) and have the capacity to see clients according to their needs (i.e. on a weekly basis if needed). We have added the qualifier “d” to these codes to highlight this fact. The team that sits in Bowral also provides care for children and adolescents.
- There are 3 BSICs that are more focused on rehabilitation and recovery (in Bankstown, Campbelltown and Liverpool).
- In addition to that, there is one adult psychology team, which is office based and sits in Campbelltown.
- There is a Day Program service in Carramar. In spite of its name, our system does not classify it as a day care service, as it provides group face to face contact during a limit period of time, but people cannot stay at the facility when the contact has finished. The frequency of the contact is at least fortnightly.
- There is also an anxiety clinic in Bankstown, run by the SWSLHD.

- The Bankstown GP initiative also has a non-mobile non-acute outpatient service provided by nurses. It has a very low intensity with a monthly frequency of contact.

The numbers of BSICs (or services) providing non- acute outpatient care per 100,000 residents is 2.02.

Table 16. Non-acute non-mobile outpatient care: availability

Provider	Name	Desde1	Desde 2	Suburb	Coverage Area
Mental Health Services SWS LHD	Day program	Ax[F0-F99]-O9.1		Carramar	South Western Sydney
	Outpatient service-Adult psychology team	Ax[F0-F99]-O8.1b		Campbelltown	South Western Sydney
	Outpatient Service-Bankstown team	Ax[F0-F99]-O8.1d		Bankstown	South Western Sydney
	Outpatient Service - Bowral Team	Ax[F0-F99]-O8.1d	cx[f0-f99]-O8.1x	Bowral	South Western Sydney
	Outpatient Service-Wollondylee Team	Ax[F0-F99]-O8.1d		Campbelltown	South Western Sydney
	Outpatient service-Campbelltown Team	Ax[F0-F99]-O8.1d		Campbelltown	South Western Sydney
	Outpatient service-Fairfield team	Ax[F0-F99]-O8.1d		Fairfield	South Western Sydney
	Outpatient service-Liverpool team	Ax[F0-F99]-O8.1d		Liverpool	South Western Sydney
	Rehabilitation team	Ax[F0-F99]-O8.1d		Campbelltown	South Western Sydney
	Therapy and Recovery services	Ax[F0-F99]-O8.1d		Liverpool	South Western Sydney
	Assertive Outreach Team	Gx[F0-F99]-O8.1d		Bankstown	South Western Sydney
	Anxiety Clinic	Gx[40-48]-O8.1		Bankstown	South Western Sydney
Bankstown GP Division Inc	Mental Health Nurse Incentive Program (MHNIP)	Ax[F0-F99]-O10.1		Bankstown	South Western Sydney

Table 17 shows the workforce providing non-acute non-mobile care related to health needs. The most common professional was the mental health nurse, followed by the psychologists and the occupational therapists.

Table 17. Non-acute non-mobile outpatient care: workforce capacity

Provider	Name	Suburb	Psych	Pyshcol	MHN	OT	SW	MHW	CCM	NCCM	HE
Mental Health Services SWS LHD	Day program	Carramar									
	Outpatient service-Adult psychology team	Campbelltown		4.9							
	Outpatient Service-Bankstown team	Bankstown	1	3.48	5.6	4	5.6				1
	Outpatient Service - Bowral Team	Bowral	3	3	13		1	2	3		
	Outpatient Service-Wollondylee Team	Campbelltown	0.175	0.5	3.6	0	0			0.4	
	Outpatient service-Campbelltown Team	Campbelltown	1.5	3	10.4	0	3	1		2	
	Outpatient service-Carramar team	Fairfield	1.3	4.4	10	1.8	3	1.2	19	0	0
	Outpatient service-Liverpool team	Liverpool	1.4	3.4	3.4	2	1				
	Rehabilitation team	Campbelltown	0.2	1.6	0.6	7	1				
	Therapy and Recovery services	Liverpool		5	1	10					6
	Assertive Outreach Team	Bankstown	0.3	1	1.6	3	1.6	1			
	Anxiety Clinic	Bankstown			**3**						
Bankstown GP Division Inc	Mental Health Nurse Incentive Program (MHNIP)	Bankstown			2						1
TOTAL			**8.575**	**29.28**	**52.6**	**24.8**	**16.2**	**5.2**	**22**	**2.4**	**8**
Rate per 100,000 residents			**1.33**	**4.55**	**8.17**	**3.85**	**2.52**	**0.81**	**3.42**	**0.37**	**1.24**

Access to Allied Psychological Services (ATAPs)

In addition, there are around 104 private providers under the ATAPs program in the area of South Western Sydney. The numbers of ATAPs providers providing non- acute outpatient care per 100,000 residents is 12 in all the area, ranging from 7.56 in Fairfield, to 40.38 in Wingecarribee. According to the DESDE LTC system, the ATAPs program will receive the code **Gx[F00-F99]-O9.1.**

Table 18. Rate of ATAPS providers per LGA

	Pop	Number of ATAPs providers	rate per 100,000 residents
Bankstown	193,398	16	8.27
Camden	56720	9	15.87
Campbelltown	145,967	20	13.70
Fairfield	198,381	15	7.56
Liverpool	180,143	19	10.55
Wingecarribee	47,054	19	40.38
Wollondilly	46,295	6	12.96
TOTAL	867,958	104	11.98

On the other hand, Disability Services Australia (DSA) provides psychological services through the Better Access plan, under Medicare. The client needs to get a referral from his/her GP. This service is free. Although it is a mobile service, as more than 50% of the visits are made outside the office, DSA has three offices in South Western Sydney covering all the region. The team is staffed by psychologists.

Table 19. Psychological Services provided by DSA thought the Better Access Plan.

Provider	Name	Desde1	Suburb	Area (i)
Disability Services Australia	Psychological Services	Ax[F0-F99]-O6.1	Bankstown	South Western Sydney
Disability Services Australia	Psychological Services	Ax[F0-F99]-O6.1	Campbelltown	South Western Sydney
Disability Services Australia	Psychological Services	Ax[F0-F99]-O6.1	Moss Vale	South Western Sydney

The total number of Full Time Equivalent professionals from DSA providing psychological services is 2.50, 0.25 FTE in Bankstown; 2 FTE in Campbelltown; and 0.25 in Moss Vale.

Perinatal Services

We have identified 2 additional BSIC (or services) providing perinatal related care.

The first one sits in Liverpool Hospital. It is staffed with 1 psychiatrist, 4.3 psychologists, 3 Mental health nurses, and 1.7 occupational therapists.

The second one, is provided by Karitane, an affiliated Health Organization (AHO) funded through Mental Health in SWSLHD. The service is called **Jade House**, and is a specialist outpatient mental health service providing early intervention and treatment of mental illness in parents, infants and young children during the perinatal and early childhood periods. There is a particular focus on supporting the quality of the developing attachment relationship between the parents and the infant. Interventions provided can include parent-infant therapy, individual therapy for parent(s), evidence based psychological therapies, psychiatric intervention- prescription of medication and review, Child and Family Health Nurse consultation, family sessions, psycho-education, group programs, referral to other services in the community and systemic coordination and support of other involved services. It is staffed with 1.9 FTE Clinical Psychologist, 0.21 FTE social worker, 0.84 registered nurse with mental health training, 0.21 FTE consultant child and infant psychiatrist, 1 FTE clinical manager. It sits in Carramar, although they also have a satellite ain Camden Hospital.

Outpatient Care Provided by NGOs

Mobile Outpatient Care

We identified 13 BSICs (or services) providing non-acute mobile outpatient care for people with mental health problems. Six of them are related to the HASI program. Affordable housing is delivered by social housing providers, clinical care by the Mental Health Services, and accommodation support by the

NGOs. In the area of South Western Sydney LHD, accommodation support is provided by New Horizons and NEAMI. New Horizons also provides a HASI service specific to Aboriginal and Torres Strait Islanders people.

Catholic Care, MaCcarthur Disability Services, and The Benevolent Society have the Personal Helpers and Mentors Program. This service provides practical assistance to people with severe mental illness to help them to achieve their goals, develop better social relationships and manage their day-to-day activities. Similarly, Care Connect has a case manager services that also provides care related to the social needs of people with a lived experience of mental health illness. NEAMI also provides the Recovery and Resources Services Program which is a service to support people with a lived experience of mental illness by providing improved access to community based activities. It has a recovery approach, which means that they take into account the social needs of the clients and support them to meet these needs.

The Disability Trust Support has a Mental Health Accommodation Support services that support people with mid to moderate mental illness who live independently in the community. They cover the Wingecarribee, Wollondilly and Macarthur areas

Finally, the Consumers Activity Network provides support to people who are discharged from the hospital to home, in the areas of Liverpool and Campbelltown. This service is run by consumers/peers.

The total number of BSICs (or services) from the NGO sector providing mobile outpatient care (non-acute) in South Western Sydney 2.17 per 100,000 residents (0.93 account the HASI program alone).

Table 20. Non-acute mobile outpatient care in the NGO sector: availability

Provider	Name	Desde1	Suburb	Area (i)
Catholic Care	Personal Helpers and Mentors	Ax[F00-F99]-O5.2	Liverpool	South Western Sydney
Benevolent Society	Personal Helpers and Mentors	Ax[F00-F99]-O6.2	Liverpool	South Western Sydney
Macarthur Disability Services	Personal Helpers and Mentors	Ax[F00-F99]-O6.2	Campbelltown	South Western Sydney
CareConnect	Case Manager	Gx[F0-F99]-O7.2	Bellavista	South Western Sydney
Consumers Activity Network-CAN Mental Health	From Hospital to Home	Ax[F00-F99]-O5.2	Liverpool	South Western Sydney
New Horizons	HASI	Ax[F00-F99]-O5.2	Liverpool	South Western Sydney
	HASI	Ax[F00-F99]-O5.2	Bankstown	South Western Sydney
	HASI-Aboriginal	Ax[F00-F99][1102]-O5.2	Campbelltown	South Western Sydney
NEAMI	HASI	Ax[F00-F99]-O5.2	Smithfields	South Western Sydney
	HASI	Ax[F00-F99]-O5.2	Bankstown	South Western Sydney
	HASI	Ax[F00-F99]-O5.2	Campbelltown	South Western Sydney
NEAMI	Resource and Recovery	Ax[F00-F99]-O6.2	Bankstown	South Western Sydney
The Disability Trust Support (MHAS)	Mental Health Accommodation	Ax[F00-F99]-O6.2	Mittagong	South Western Sydney

Table 21 describes the workforce providing non-acute mobile outpatient care in the NGO sector. There is some information missing, so data should be interpreted with caution. The most common professional was the mental health worker.

Table 21. Non-acute mobile outpatient care in the NGO sector: Workforce Capacity

Provider	Name	MHW	peers
Catholic Care	PHAMS		
CareConnect	Case Manager	4	
Consumers Activity Network-CAN Mental Health	From Hospital to Home		4
Benevolent Society	Personal Help and Mentors	5	
New Horizons	Personal Helpers and Mentors-asylum seekers	4	
New Horizons	HASI	7	
New Horizons	HASI	7	
New Horizons	HASI-Aboriginal	4	
NEAMI	HASI		
NEAMI	HASI		
NEAMI	HASI		
NEAMI	Resource and Recovery		
The Disabilirt Trust Support (MHAS)	Mental Health Accommodation	1.5	
Total		32.5	4
Rate per 100,000 residents		5.04	0.62

Partners in Recovery

Partners in Recovery in South Western Sydney is managed by Schizophrenia Fellowship. They contract other organizations to provide the support. 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, these providers are not just focused on the accessibility, but take a more holistic approach, providing also some of counselling or coaching. Theoretically, the code of the PIR program should be an A4, but it seems that they are providing more intensive direct day care. They can meet accordingly to the needs of the patient, with the capacity of meeting them on a daily basis, if needed in the first stage of the program. The program started in 2012, and it has been recently extended for 3 additional years (until 2018).

Table 22. Partners in Recovery

Provider	Name	Desde1	Suburb	Coverage Area	FTE support facilitators
RichmondPRA+ Care Connect	Partners in Recovery	A [F0-F99]-O5.2	Bankstown	South Western Sydney/Bankstown LGA	3
AfterCare + Gandangarra Health Service	Partners in Recovery	A [F0-F99]-O5.2	Liverpool	South Western Sydney/Liverpool LGA	3 (AfterCare) + 4 (Gandangarra)

The Benevolent Society	Partners in Recovery	A [F0-F99]-O5.2	Liverpool	South Western Sydney/ Fairfield	r
	Partners in Recovery	A [F0-F99]-O5.2	Campbelltown	South Western Sydney/Wollondilly and Wingecarribee	5
MaCarthur Disability	Partners in Recovery	A [F0-F99]-O5.2	Campbelltown	South Western Sydney/Campbelltown/ Camden	7

NON-MOBILE OUTPATIENT CARE

We have found four BSICs (or services) providing non-mobile outpatient care. Mission Australia has a counselling service in Miller, which can be used by any age group. Similarly, the Salvation Army provides counselling for a different range of common mental disorders, such as anxiety and depression. The University of Western Sydney has a Psychology clinic in Narellan which can be used by anyone and it has no cost. Lastly, Uniting Care has a counselling program focused on financial problems

The total number of BSICs (or services) from the NGO sector providing non-mobile outpatient care (non-acute) in South Western Sydney is 0.62 per 100,000 residents.

Table 23. Non-acute non-mobile outpatient care in the NGO sector: Availability

Provider	Name	Desde1	Suburb	Area (i)
Mission Australia	Counselling	Gx[Z55-Z65]-O9.1	Miller	South Western Sydney
Salvation Army	Counselling	Ax[Z55-Z65]-O9.1	Leumeah	South Western Sydney
University of Western Sydney Psychology Clinic (located in Life Line Macarthur)	University of Western Sydney Psychology Clinic	Gx[F0-F99]-O9.1b	Narellan	South Western Sydney
Uniting Care	Counselling Program (financial)	Ax[z56-z56][d860-d879]-O8.2b	Fairfield	South Western Sydney
	Southern Highlands Bereavement Care Service	Gx[Z63.4]-O8.1	Bowral	South Western Sydney

Table 24 shows the workforce of the outpatient non-mobile care provided by the NGO sector. The most common professional is the psychologist, explained by the presence of the Psychology Clinic at the University of Western Sydney

Table 24. Non-acute non-mobile outpatient care in the NGO sector: Workforce Capacity

Provider	Name	Counsellors	Psych	Social Worker
Mission Australia	Counseling		1	
University of Western Sydney Psychology Clinic (located in Life Line Macarthur)	University of Western Sydney Psychology Clinic		6	

Provider	Name	Counsellors	Psych	Social Worker
Uniting Care	Counselling Program (financial)	2		
	Southern Highlands Bereavement Care Service		0.2	0.4
Total		2	7.2	0.4
Rate per 100,000 residents		0.32	1.12	0.06

3.2.4. Accessibility Services

3.2.4.1. Accessibility Services Provided by the Health Sector

We have identified 4 services/BSICs providing accessibility to care in the health sector: two of them aim to facilitate the accessibility to services by Aboriginal and Torres Strait Islanders Peoples and the other two are related to personal accompaniment/advocacy provided by peers/ consumers with a lived experience of mental illness. They sit in Bankstown and Liverpool.

The total number of BSICs (or services) from the health sector providing care management (accessibility to services) for Indigenous people in South Western Sydney is 0.31 per 100,000 residents. On the other hand, the total number of BSIC (or services) providing peer support (personal accompaniment/ advocacy) is 0.31 per 100,000 residents.

Table 25. Accessibility related services in the health sector: Availability

Provider	Name	Desde1	Suburb	Area (i)
Mental Health Services SWS LHD	Care management ABORIGINAL PEOPLE	Ax[F00-F99]-A4s	Liverpool	South Western Sydney
	Care management ABORIGINAL PEOPLE	Ax[F00-F99]-A4s	Bankstown	South Western Sydney
	Peer Support	Ax[F00-F99]-A3	Liverpool	South Western Sydney
	Peer Support	Ax[F00-F99]-A3	Bankstown	South Western Sydney

In regards to the workforce, there are a total of 2 health educators engaging with indigenous population. The peer support program is staffed with 1.2 peers, 0.42 health educators and 0.8 volunteers.

3.2.4.2. Accessibility Services Provided by NGOs

We have found 4 BSICs or services facilitating access specifically to employment in South Western Sydney for people with mental health illness. There are other organizations such as AFFORD, Wise Employment or Max Employment, among others, that also offer employment services for people with disability, including people with psychosocial disabilities, but they are not specific for people with mental illness.

The total number of BSICs (or services) from the NGO sector providing accessibility to employment is 0.62 per 100,000 residents.

Table 26. Accessibility to care related services in the NGO sector: Availability

Provider	Name	Desde1	Suburb	Area (i)
RichmondPRA	Disability employment services	Ax[F00-F99]-A5.4	Liverpool	South Western Sydney
Catholic Care	PHAMS Employment	Ax[F00-F99]-A5.4	Liverpool	South Western Sydney
New Horizons	PHAMS employment	Ax[F00-F99]-A5.4	Bankstown	South Western Sydney
Schizophrenia Fellowship	PHAMS employment	Ax[F00-F99]-A5.4	Campbelltown	South Western Sydney

Table 27 describes the workforce providing accessibility to employment. The specific services for people with a lived experience of mental health problems have a total workforce of 1.86 mental health workers per 100,000 residents.

Table 27. Accessibility to care related service in the NGO sector: Workforce capacity

Provider	Name	MHW
RichmondPRA	Disability employment services	3
New Horizons	PHAMS employment	4
Schizophrenia Fellowship	PHAMS employment	5
Total		**12**
Rate per 100,000 residents		**1.55**

Ability Links

Ability Links is a program funded by FACs that 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, they deal with people with mental health issues. They have estimated that at least 70% of their clients will have mental health needs. St Vincent de Paul Society in partnership with Settlement Services International are the providers of the Ability Links in Western Sydney. Settlement Services International has offices in Campsie, Bakstown, Fairfield and Liverpool; while St Vincent de Paul Society has teams in Narellan and Bowral. They provide care for people from 9 to 65 years old.

3.2.5. Information and Guidance

3.2.5.1. Information and Guidance Services provided by NGOs

We have identified 1 BSIC (or services) providing legal information for people with a lived experience of mental illness. This service is Legal Aid NSW Civil Law Division and it is located in Fairfield.

3.2.6. Self and Voluntary Support

3.2.6.1. Self and Voluntary Support provided by NGOs.

We have found three BSICs/services based on volunteer staff providing care for people with mental health problems: the Mental Health Association, which provides Anxiety Support Groups on a monthly basis in different locations around South Western Sydney (Bankstown, Fairfield, and Moss Vale); Hearing Voices Network NSW that also provides support groups on a monthly basis in different locations (Bowral and Campbelltown); and the Compeer friendship program, runs by St Vincent de Paul Society, which aim to improve the quality of life of adults with a mental illness through one-to-one friendship with a caring volunteer.

Table 28. Self-help groups: Availability

Provider	Name	Desde1	Suburb	Area
Mental Health Association	Anxiety Support Groups	Ax[F40-F48]-S1.3	Different Locations	South Western Sydney
Hearing Voices Network NSW	Support Groups	Ax[F20-F29]-S1.3	Different Locations	South Western Sydney
St Vincent de Paul Society	Compeer	Ax[F00-F99]-S1.2	Different Locations	South Western Sydney

3.2.7. Specific Services for Carers

3.2.7.1. NGO sector

Disability Trust, Macarthur Disability, BCD Community care, Anglicare and Community Links Wollondilly provide community respite services through the Heaven Project. This is a service that supports carers of people with mental health illness. The focus is on wellness and social activities as a way of improving their capacity to provide care, by avoiding carer fatigue and burnout.

Carer Assist, by Schizophrenia Fellowship, and the Carer Support, by Uniting care, support the family members, friend and carer of people with all type of mental illness by providing information, workshops to enhance their skills, and help to access respite.

Lastly, it is worth mentioning that Commonwealth Respite and Carelink Program also provides information about respite options and other support services in their local areas. It is a generic service but it does include mental health information.

Table 29. Services providing support for carers

Provider	Name	Desde1	Suburb	Area (i)
Anglicare	The Haven Project-Community Respite Service	Gx [e310][F0-F99]-O7.2	Bellavista	South Western Sydney
Disability Trust	The Haven Project-Community Respite Service	Gx [e310][F0-F99]-O7.2	Mittagong	South Western Sydney
Community Links Wollondilly	Wingecarribee Family Support Service inc- Haven Project	Gx [e310][F0-F99]-O6.2	Bowral	South Western Sydney
Macarthur Disability	The Haven Project-Community Respite Service	Gx [e310][F0-F99]-O7.2	Campbelltown	South Western Sydney
BCD Community Care	The Haven Project-Community Respite Service	Gx [e310][F0-F99]-O7.2	Mittagong	South Western Sydney
Schizophrenia Fellowship	Carer Assist	Gx [e310][F0-F99]-O8.2d	Moss Vale	South Western Sydney
	Carer Assist	Gx [e310][F0-F99]-O8.2d	Campbelltown	South Western Sydney
	Carer Assist	Gx [e310][F0-F99]-O9.2d	Bankstown	South Western Sydney
Uniting Care	Carer Support	Gx [e310][F0-F99]-O9.2d	Smithfield	South Western Sydney

Table 30 describes the workforce providing respite services. Data should be taken with caution as we lack information for a number of services. In spite of this, at least 1.35 workers providing support to the carers of people with a mental illness.

Table 30. Services providing support for carers: workforce

Provider	Name	SW	MHW	Psych	Vol
Community Links Wollondilly	Wingecarribee Family Support Service inc.	0.8	1.5	0.1	0.3
Anglicare	The Haven Project-Community Respite Service		16		
Disability Trust	The Haven Project-Community Respite Service	1			
Schizophrenia Fellowship	Carer Assist (global)		3.4		
Total Services		1.8	6.5	0.1	0.3
Rate per 100,000 residents		0.29	1.01	0.02	0.05

3.3. Children and Adolescents

In this section we describe the availability and placement capacity of the BSICs (or services) providing care for children and adolescents with mental health problems. Specific care related to transition from adolescence to adulthood is also included in this section.

3.3.1. Residential Care

3.3.1.1. Residential Care provided by the Public Health Sector

A total of two BSICs (or services) providing care for children and adolescents experiencing mental health problems were identified, the two of them at Campbelltown Hospital. The Gna Ka Luns is an acute mental health unit providing care for children and adolescents with behavioural problems. A total of 10 places are available. It is a unit that provides care for all the state. The Birunji unit is an acute inpatient unit for young people with mental health problems (16-25 years old). This service covers the South Western Sydney LHD and has 20 beds.

The total number of BSICs (or services) providing inpatient acute care for children and adolescent[1] experiencing mental health problems in South Western Sydney is 0.60. The number of beds per 100,000 residents is 5.99. However, it has to be kept in mind that this service covers all the state.

The total number of BSICs (or services) providing inpatient acute care for young people (16 to 25 years old)[2] is 0.83 per 100,000 residents. The number of beds per 100,000 residents is 16.74.

Table 31. Acute residential care- children and adolescents: availability and placement capacity

Provider	Name	Desde1	Beds	Suburb	Coverage Area
Mental Health Services SWS LHD	Gna Ka Lun (Child and Adolescent)	Ca[F0-F99]-R2	10	Campbelltown	State Level
	Birunji	TA[F0-F99]-R2	20	Campbelltown	South Western Sydney

Table 32 depicts the workforce providing inpatient acute care for children and adolescents and young people. The most common professional is the mental health nurse, followed by the psychiatrist and the social worker.

[1] The total number of people between 5 and 17 years in South Western Sydney (Census 2011) was 166,842.
[2] The total number of people between 16 and 25 years old in South Western Sydney (Census 2011) was 119,427

Table 32. Acute residential care- children and adolescents: workforce capacity

Provider	Name	Psych	Psychol	MHN	OT	SW	DT
Mental Health Services SWS LHD	Gna Ka Lun (Child and Adolescent)	2.9	1	26.87	1	2	1
Rate per 100,000 child and adolescent		**1.74**	**0.60**	**16.11**	**0.60**	**1.20**	**0.60**
Mental Health Services SWS LHD	Birunji	1.8	1.6	22.51	1	1.6	1
Rate per 100,000 young people		**1.51**	**1.34**	**18.85**	**0.84**	**1.34**	**0.84**

3.3.2. Day Care

We have not found any services providing day care for children and adolescents.

3.3.3. Outpatient Care

3.3.3.1. Outpatient Care provided by the Public Health Sector

A total of 7 BSICs (or services) providing outpatient care for children and adolescents were found. Four of them are services for children and adolescents (Infant, child and adolescents team in Bankstown, Campbelltown, Carramar and Liverpool), while the other three (early intervention program in Bankstown and Liverpool and youth team in Campbelltown) are services targeting young people (16-25 years). The Community Mental Health team that sits in Bowral also provide care for children and adolescents with mental illness (see the adult section).

All the BSICs (or services) identified are non-mobile and non-acute. However, the three services for young people have some mobility.

The total number of BSICs (or services) providing non-mobile non-acute outpatient care for children and adolescent experiencing mental health problems in South Western Sydney is 2.39.

The total number of BSICs (or services) providing non-mobile non-acute outpatient care for young people (16 to 25 years old) is 3.35 per 100,000 residents.

Table 33. Non-mobile non-acute care provided at the health sector for child and adolescents: availability

Provider	Name	Desde1	Suburb	Coverage Area
Mental Health Services SWS LHD	Infant, child and adolescent team	Cx[F0-F99]-O8.1b	Bankstown	South Western Sydney
	Outpatient services-children psychology team	Cx[F0-F99]-O8.1b	Campbelltown	South Western Sydney
	Infant, child and adolescent team	Cx[F0-F99]-O8.1b	Carramar	South Western Sydney
	Infant, child and adolescent team	Cx[F0-F99]-O8.1b	Liverpool	South Western Sydney
	Early Intervention Program	TA[F0-F99]-O8.1d	Bankstown	South Western Sydney
	Outpatient Service-youth team	TA[F0-F99]-O8.1d	Campbelltown	South Western Sydney
	Early Intervention Program	TA[F0-F99]-O8.1d	Liverpool	South Western Sydney

Table 34 depicts the staff providing outpatient non-acute non-mobile care for children, adolescents and young people. The most common professional in the two age groups is the psychologists.

Table 34. Non-mobile non-acute care provided at the health sector for child and adolescents: workforce capacity

Provider	Name	Psych	Psychol	MHN	OT	SW	NCCM
Mental Health Services SWS LHD	Infant, child and adolescent team	0.3	2	1			
	Outpatient services-children psychology team	1.5	0.8	1	3	2	
	Infant, child and adolescent team						
	Infant, child and adolescent team	2.7	14.5		1	2	
Total		**4.5**	**17.3**	**2**	**4**	**4**	
Rate per 100,000 child and adolescent		**2.70**	**10.37**	**1.20**	**2.40**	**2.40**	
Mental Health Services SWS LHD	Early Intervention Program	0.6	2.84	1	1	3	
	Outpatient Service-youth team	3.5	7	1.6			
	Early Intervention Program	0.4	3.7	3	1.7		1
Total		**4.5**	**13.54**	**5.6**	**2.7**	**3**	**1**
Rate per 100,000 young people		**3.77**	**11.34**	**4.69**	**2.26**	**2.51**	**0.84**

3.3.3.2. Outpatient Care provided by FaCS

We identified one service that provides care for children and their families in a vulnerable situation, with a special focus on the mental health needs of both children and their parents. It is a non-mobile, non-acute, high intensity, outpatient service. This BSIC or service is composed by a team of 7 psychologists who, in addition to the face-to-face contact with the families, also provide clinical advice to other community services and training for case workers. The direct care they provide consists of behavioural assessment and parenting education aimed at providing them with skills to address their children's behavioural problems. Although the client is the child, they always have direct contact with the parents and/or carers. It is characterised as a preventive and early intervention service, rather than a service focused on treatment. These 7 psychologists sit in different places (1 in Bankstown, 1 in Liverpool, 1 in Fairfield, 1 in Ingleburn, and 3 in Campbelltown) but they are not restricted by the geographical area (i.e.a person in Bankstown can be visitied by the psychologist who sits in Liverpool).

Table 35. Availability of non-acute non-mobile outpatient care- child and adolescents (FaCS)

Provider	Name	Desde 1	Suburb	Coverage Area
Family & Community Services-	Child protection	Cx[e310][Z55-Z65]-O8.1	Fairfield	South Western Sydney

3.3.3.3. Outpatient Care provided by NGOs

Non-Mobile Outpatient Services

There are four services providing non-mobile outpatient support for young people with mental health problems. Three of them are focused on the heath related needs (Headspace managed by RichmondPRA

in Bankstown; the Brain and Mind Centre in Campbelltown; and the Benevolent Society in Liverpool). The other two, Miller Pathways, by Mission Australia, and the Break Thru Family Mental Health Support Service, aims to prevent the mental/behavioural problems of children with psychosocial difficulties. They work with the child and the family. Miller Pathways-Happy Healthy Minds is more focused on the health needs (including the social ones) while Break Thru targets the social needs. Miller Pathways-Happy Healthy Minds also provides information related to mental health issues.

The total number of BSICs (or services) providing non-mobile non-acute outpatient care for children and adolescent experiencing mental health problems in South Western Sydney is 1.20 per 100,000 residents.

The total number of BSICs (or services) providing non-mobile non-acute outpatient care for young people (16 to 25 years old) with a lived experience of mental illness is 1.67 per 100,000 residents in South Western Sydney.

Table 36. Non-acute non-mobile outpatient care provided by the NGO sector for child and adolescents: availability.

Provider	Name	Desde 1	Suburb	Coverage Area
Benevolent Society	Headspace	TA[F0-F99]-O9.1b	Liverpool	South Western Sydney
RichmondPRA	Headspace	TA[F0-F99]-O9.1b	Bankstown	South Western Sydney
Brain and Mind Centre-University of Sydney	Headspace	TA[F0-F99]-O9.1b	Campbelltown	South Western Sydney
Mission Australia	Miller Pathways-Happy Healthy Minds	Cx[Z55-Z65]-O8.1d	Miller	South Western Sydney
Break Thru Family Mental Health Support Service	Break Thru Family Mental Health Support Service	Cx[Z55-Z65]-O8.2d	Bankstown	South Western Sydney

Table 37 depicts the information related to the workforce. We only have information on the workforce of Miller Pathways-Happy Healthy Minds and Break Thru Family Mental Health Support Service. Having said that, Headspaces are staffed by a multidisciplinary team of psychologists, GPs and social workers, among others.

Table 37. Non-acute non-mobile outpatient care provided by the NGO sector for child and adolescents: workforce capacity.

Provider	Name	MHW	Psych
Mission Australia	Miller Pathways-Happy Healthy Minds		2
Break Thru Family Mental Health Support Service	Break Thru Family Mental Health Support Service	6	
Total		6	2
Rate per 100,000 residents		3.60	1.20

3.4. Older People

In this section we summarise the specific services providing care for people older than 65 years old with a lived experience of mental illness. All the services identified are provided by the Public Health Sector

3.4.1 Residential Care provided by the Public Health Sector

We have identified 2 residential units providing mental health care for people older than 65 years old. The Braeside sub –acute unit is managed by HammondCare and the Bankstown-Lidcombe Hospital Unit is managed by Aged Care. The Braeside sub-acute unit has 16 beds for people with mental health problems including dementia with severe behavioural disturbances or other mental health issues. The Bankstown unit is more focused on neurodegenerative illness, such as Parkinson and other types of Dementia, and it is not mental health specific, but a medical unit. In spite of this, it is included due to the close relation between neurodegenerative illness and mental health.

The total number of BSICs (or services) providing residential care for older people[3] with a lived experience of mental illness is 2.04 per 100,000 residents in South Western Sydney.

Table 38. Residential care for older people: availability

Provider	Name	Desde 1	Suburb	Coverage Area
HammondCare	Sub-Acute Unit	Ox[F0-F99]-R4	Fairfield	South Western Sydney
Aged Care SWSLHD	Hospital Unit	Ox [F0-F99]-R4	Bankstown	South Western Sydney

3.4.2 Day Care provided by the Public Health Sector

We have not identified any specific service providing day care for older people with mental illness.

3.4.3 Outpatient Care provided by the Public Health Sector

We have identified 4 teams providing outpatient care for older people with mental illness. Three of them are managed by the Mental Health Services at the LHD , while the other is managed by HammondCare.

The three services provided by the Mental Health Services at the LHD are non-mobile, but had high mobility, with almost 50% of their activity being outside the office. On the other hand, the service provided by HammondCare has been classified as a mobile as between 50-70% of their activity is made at the home of the client or in the place the client resides. The services provided by the Mental Health Services have the capacity to visit people 3 times per week, if required. The frequency of the contact in the HammondCare service is weekly.

[3] The total number of people older than 65 years old in South Western Sydney (Census 2011) was 98,089.

The total number of BSICs (or services) providing outpatient care for older people with a lived experience of mental illness is 4.08 per 100,000 residents in South Western Sydney.

Table 39. Outpatient care for older people: availability

Provider	Name	Desde 1	Suburb	Coverage Area
Mental Health Services SWS LHD	Community MH Team	Ox [F0-F99]-O8.1d	Bankstown	South Western Sydney
	Community MH Team	Ox [F0-F99]-O8.1d	Camden	South Western Sydney
	Community MH Team	Ox [F0-F99]-O8.1d	Bowral	South Western Sydney
HammondCare	Community MH Team	Ox[F0-F99]-O6.1	Fairfield	South Western Sydney

Table 40 summarises the workforce capacity. The most common professional was the mental health nurse, followed by the psychologist and the social worker.

Table 40. Outpatient care for older people: workforce

Provider	Name	Psych	Psychol	MHR	OT	SW	CNC
Mental Health Services SWS LHD	SMHSOP Community Team Bankstown	0.5	0.5	2		1	
	SMHSOP Community Team Macarthur Camden	1	0.4	2.6			
	SMHSOP Community Team Wingecarribee	0.45	1	0.4			
HammondCare	SMHSOP Community Team Braeside	0	0.6	2.5	0.5	1	0.5
	Total	1.95	2.5	7.5	0.5	2	0.5
	Rate per 100,000 residents	1.99	2.55	7.65	0.51	2.04	0.51

3.5. Other Specific Populations

3.5.1. Multicultural Services provided by the public Health Sector

We have found two services providing multicultural care by the public health sector.

One is the Transcultural MH Service. Although it is located at Westmead, inside Cumberland Hospital, it is worth including it here as it covers all the state. This service can be divided into 3 BSICs. The first one is focused on prevention and early intervention. It provides monthly outpatient care for migrants and their families. It provides outpatient non-mobile, high intensity, non-acute care for people with mental health problems from different cultural backgrounds. This BSIC also incorporates a team that translates and elaborates mental health information for individuals from different cultural and linguistic backgrounds. They are also responsible for translating clinical instruments (such as questionnaires) and for guaranteeing respectful cultural practices. The second BSIC targets people with gambling problems who come from different cultural and linguistic backgrounds. They provide high intensity, non-mobile, non-acute care. The third BSIC mainly provides information related to mental health to people with mental health issues coming from different cultures. This BSIC is not involved in follow-up with the client. It has to be kept in mind that this service provides support to the entire state.

In addition to the services provided by the Transcultural MH team, we have identified another BSIC (or service) providing care for the Vietnamise community in Cabramatta. It is part of the Community Health Centre and they provide outpatient non-mobile non-acute care (i.e. support groups in a monthly basis).

Lastly, the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) is located in Carramar, It helps refugees deal with their past experience and build new connections in Australia. The service includes counselling, psychotherapy (individual and group) both for children and adult people.

Table 41. Multicultural Services (Health)

Provider	Name	Desde 1	Desde 2	Suburb	Coverage Area
Transcultural MH Services	Prevention and Early Intervention- Carers Programs	Gx[F0-F99][Z59.0][e310] - O10.1s	gx[f0-f99][z59.0]-I2.2s	Westmead	State Level
	Multicultural Gambling	Ax[F63.0][Z59.0]-O8.1s		Westmead	State Level
	Clinical Services	Gx [F0-F99][Z59.0]-I1.1s		Westmead	State Level
Community Health Centre	Mental Health Support Groups	Gx[F0-F99]-O10.2s		Cabramatta	South Western Sydney
	Treatment And Rehabilitation Of Torture And Trauma Survivors (STARTTS)	Gx[F00-F99]-O9.1		Carramar	South Western Sydney

3.5.2. Multicultural Services provided by NGOs

We have only identified 1 additional BSIC (or service) providing care for people with psychosocial problems from diverse cultural and linguistic backgrounds. It is a gambling help counselling service provided by the Arab Council Australia. It is staffed with one social worker and one mental health worker.

Table 42. Multicultural Services provided by NGOs.

Provider	Name	Desde 1	Suburb	Coverage Area
Arab Council Australia	Gambling Help Counselling	Ax[F63.0]-O9.2s	Bankstown	South Western Sydney
New Horizons	Personal Helpers and Mentors-asylum seekers	Ax[Z55-Z65]-O6.2s	Liverpool	South Western Sydney

3.5.3 Specific Services for Aboriginal and Torres Strait Islanders

We have contacted with 2 Aboriginal Services in South Western Sydney: Gandangara Health Services and Tharawal Aboriginal Corporation.

Gandangara Health Services does not have any specific program for people with a lived experience of mental illness.

Tharawal Aboriginal Coorporation, on the other hand, has a mental health worker who works full time and supports clients by intensive care planning and link those clients into GP services and other programs based on clients' needs.

3.6. Other Services

3.6.1. Alcohol and Other Drugs

Although Alcohol and Other Drugs can be considered a mental health problem, its complexity requires a detailed and separate analysis. Having said that, it is worth mentioning two organizations that are supporting people with alcohol and other drugs related problems taking also special care of the mental health needs of their clients.

The Odyssey House McGrath Foundation has 2 residential units providing 24 hours support over 4 weeks, for people with problems related to drug abuse, who also have mental health problems. One of the units is in Eaglevale (50 beds) and the other in Minto (54 beds). Although the main target is the drug problem, they provide holistic care with a special focus on the psychological problems. It also has an outpatient center in Cambelltown where they provide non-acute non-mobile care according to the needs of the person.

St Vincent de Paul Society runs a Day Care Centre, the Mayfields Day Recovery Centre, in Campbelltown. This is a service whose primary target population is people with Alcohol and Other Drugs problems. However, more than 20% of their clients also had a comorbid mental health problem.

The main type of care is health related, but less than 20% of its staff are health professionals (1 social worker, 1 counsellor and 2 support workers). This service has 18 places.

3.6.2. Homeless Services

Similarly to the case of AOD, the complexity of homelessness requires a detailed analysis. We acknowledge that most of the people who are homeless have an addition mental health problem. However, the main objective of this Atlas is to describe the services which target mental illness/mental health. If we include the services for homeless people in the analysis we will bias the picture.

In spite of this, it may be worth mentioning that the partnership between NEAMI & Macarthur Rehab Team also provides residential care for people who are homeless (the accommodation access program). Although most of the clients under this program have additional mental health problems, the primary criteria to access the program is being homeless; They have 2 crisis units, where people can stay up to 3 months and they receive daily support; and 5 transitional units, with a length of stay up to 18 months and lower support.

4. MAPPING OF THE MENTAL HEALTH SERVICES

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

Figures from 21 to 27 show the distribution of the population and demand indicators with respect to geographic access to residential adult services. Figure 28 analyses access to adult residential services in South Western Sydney

Similarly, figures 29 to 36 display the distribution of indicators with respect to the location of adult day care services. Figure 37 shows the accessibility to these services.

Figures 38 to 45 depict the same results but by adult outpatient services. Finally, figures from 46 to 49 illustrate of services for child and adolescent in relation with some of the indicators.

Overall, the maps show that the public funded services are located in the most populous areas of the LHD jurisdiction, particularly around Liverpool, Campbelltown and Bankstown. These are also the communities identified as being at a greater risk of psychological distress and socioeconomic disadvantage. Communities in the southern area of the LHD are shown to have poorer geographic access to inpatient services; however levels of disadvantage and risk of psychological distress are also lower in this part of the LHD, and specially in Wingecarribee there is good accessibility to community mental health services and psychological services.

Figure 21. Location of the services taking into account population density

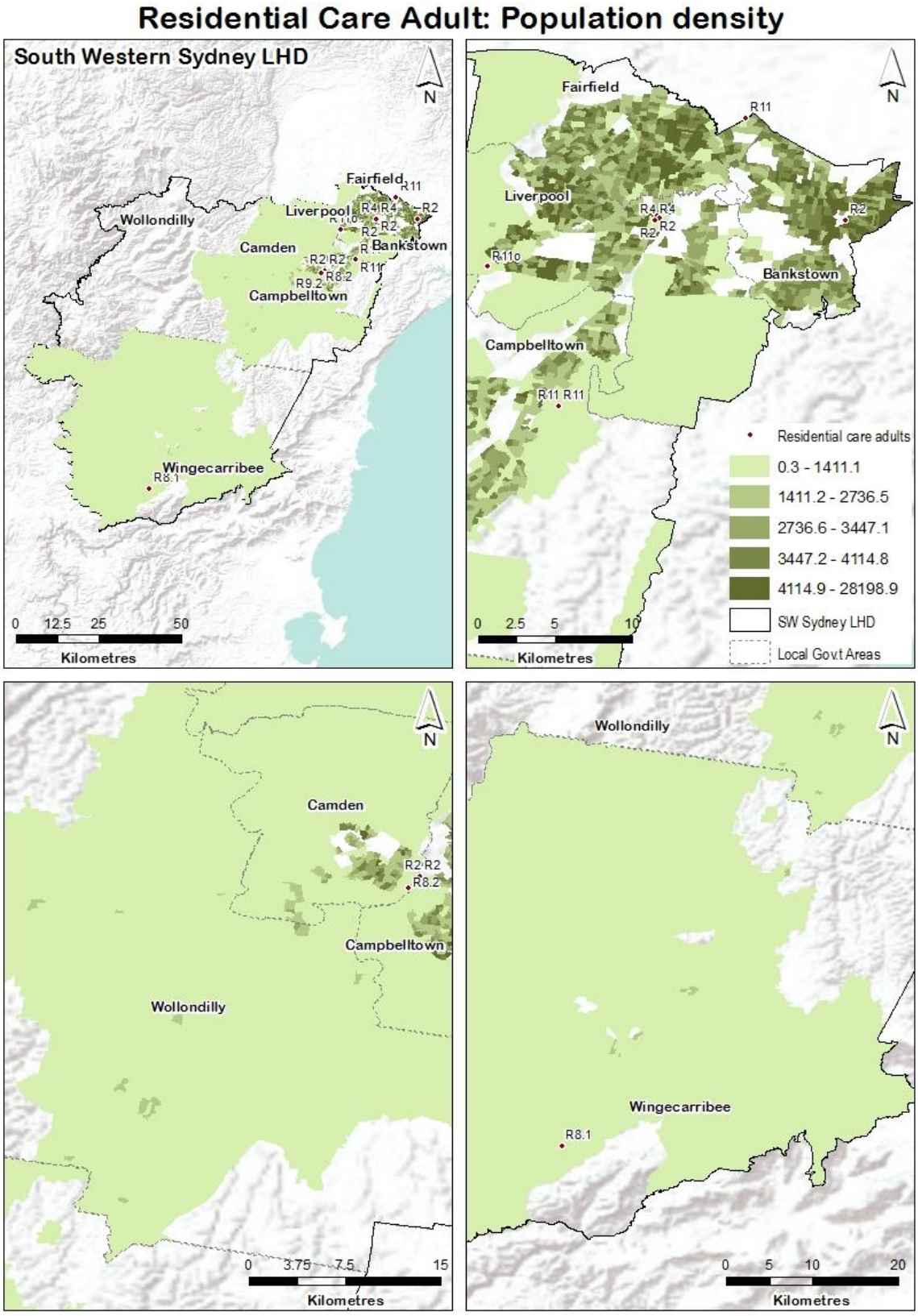


Figure 22. Location of services providing residential care, by percentage of people who provide informal care to a person with a disability.

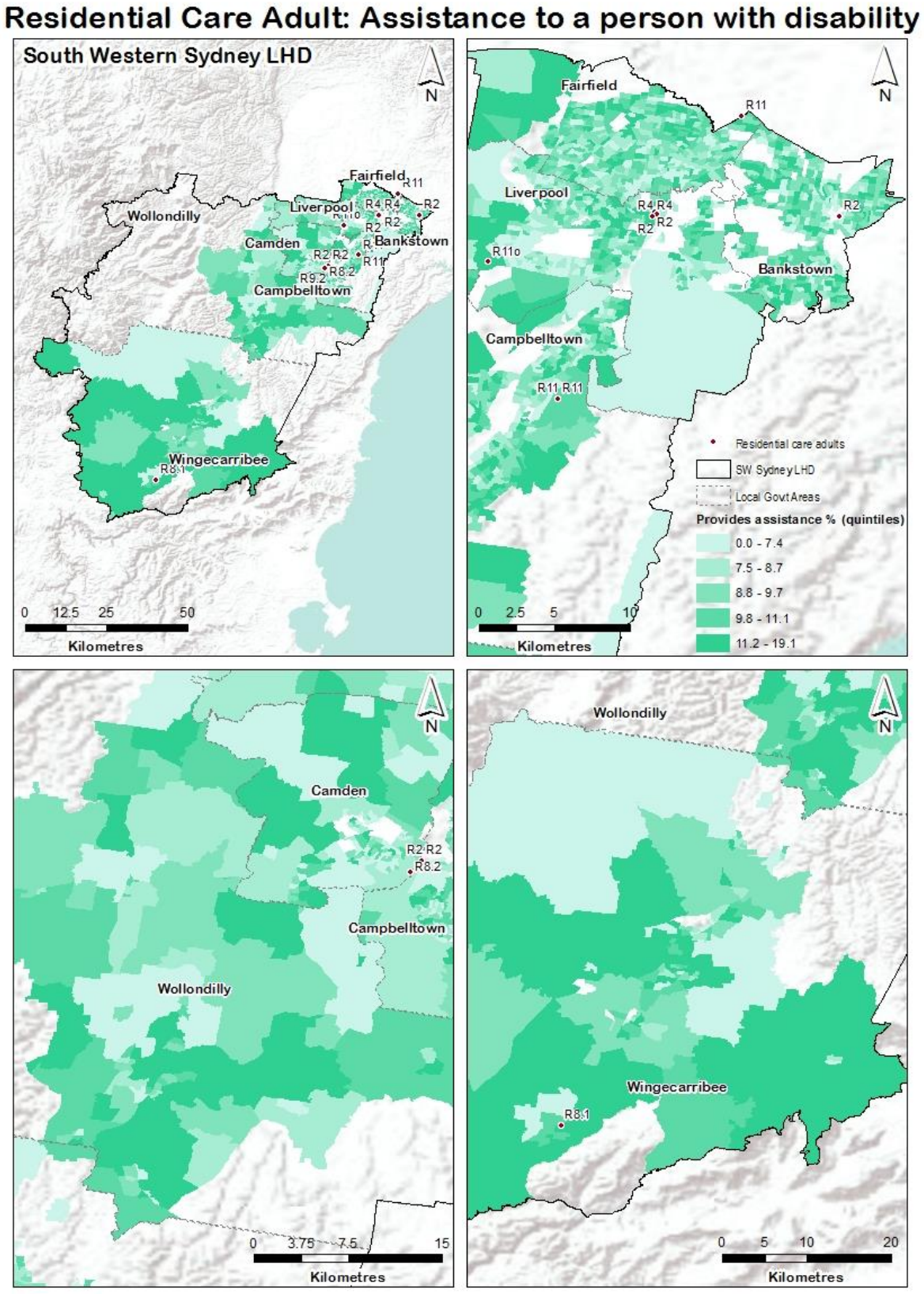


Figure 23. Location of services providing residential care, by dependency index distribution

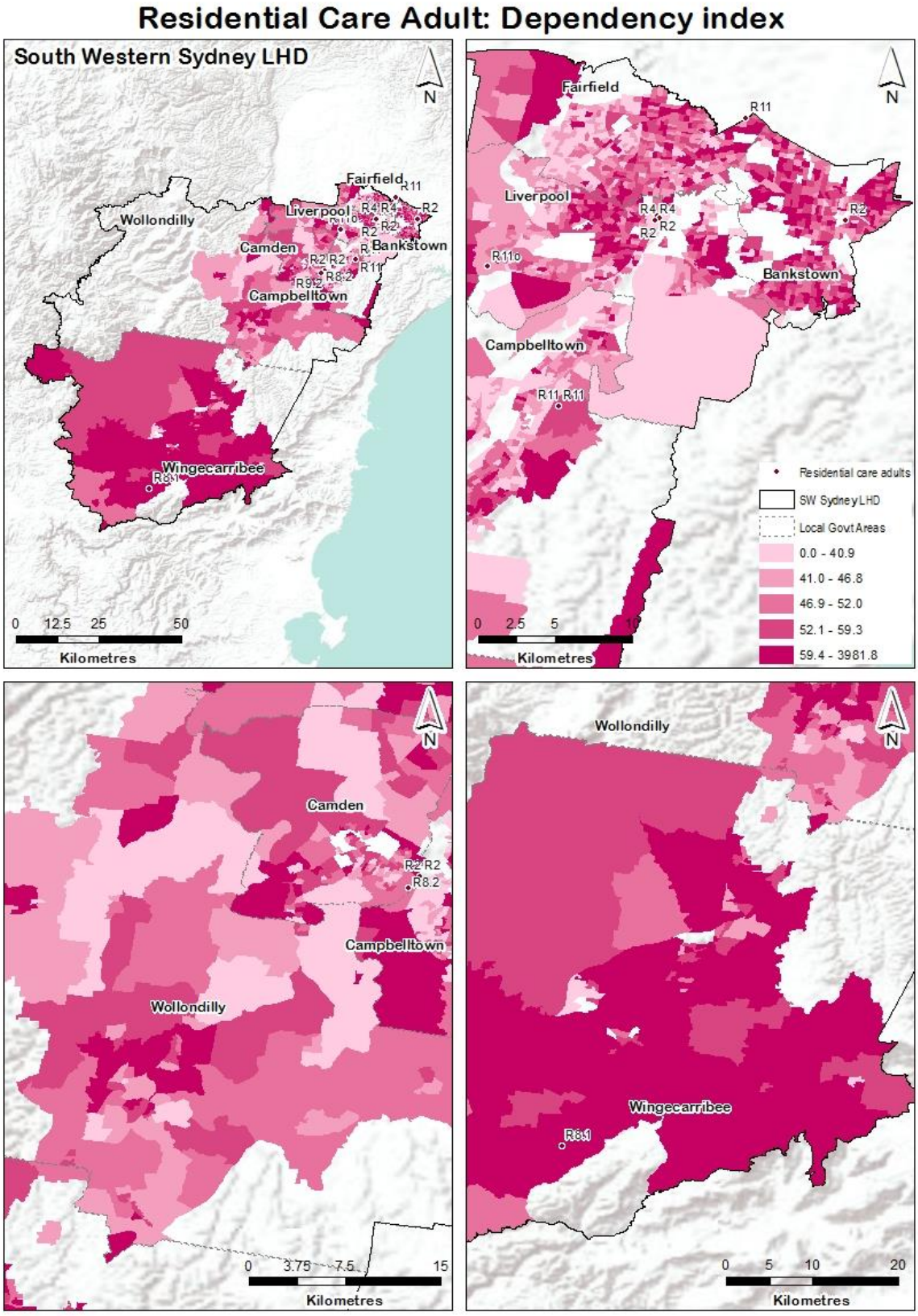


FIGURE 24. Location of services providing residential care by percentage of people living alone

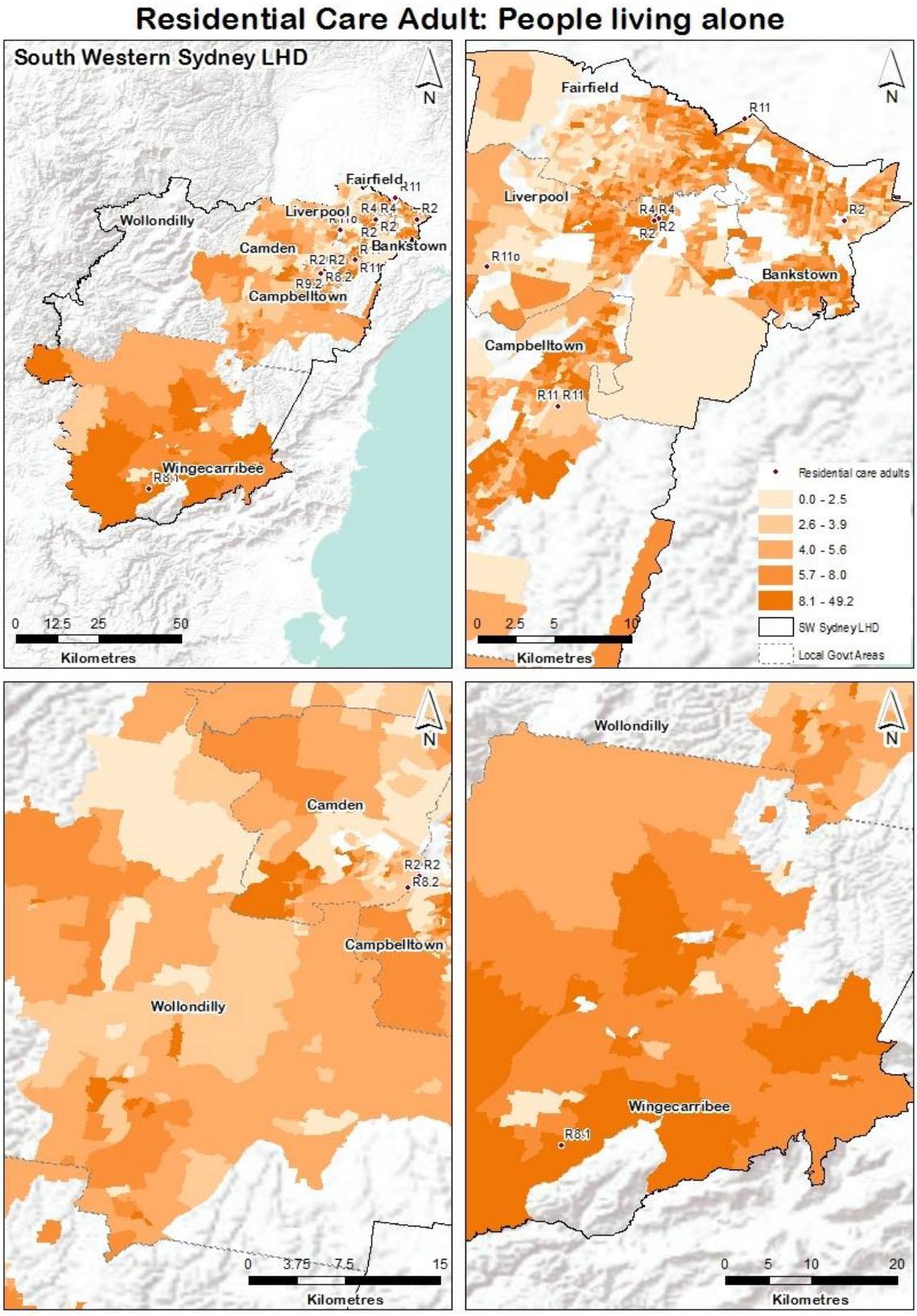


Figure 25. Location of services providing residential care by percentage of people living alone.

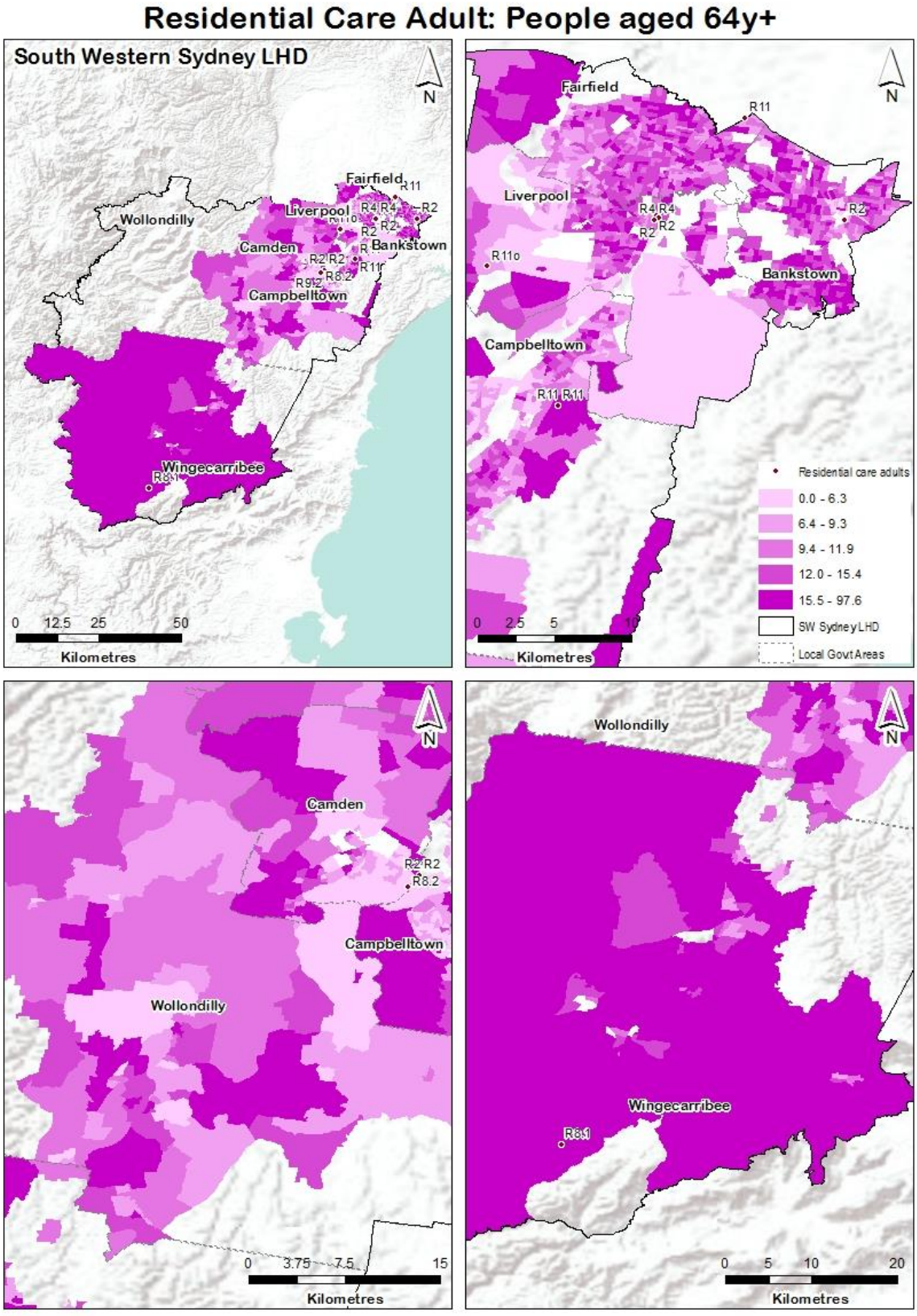


Figure 26. location fo services providing residential care, by risk of psychological distress

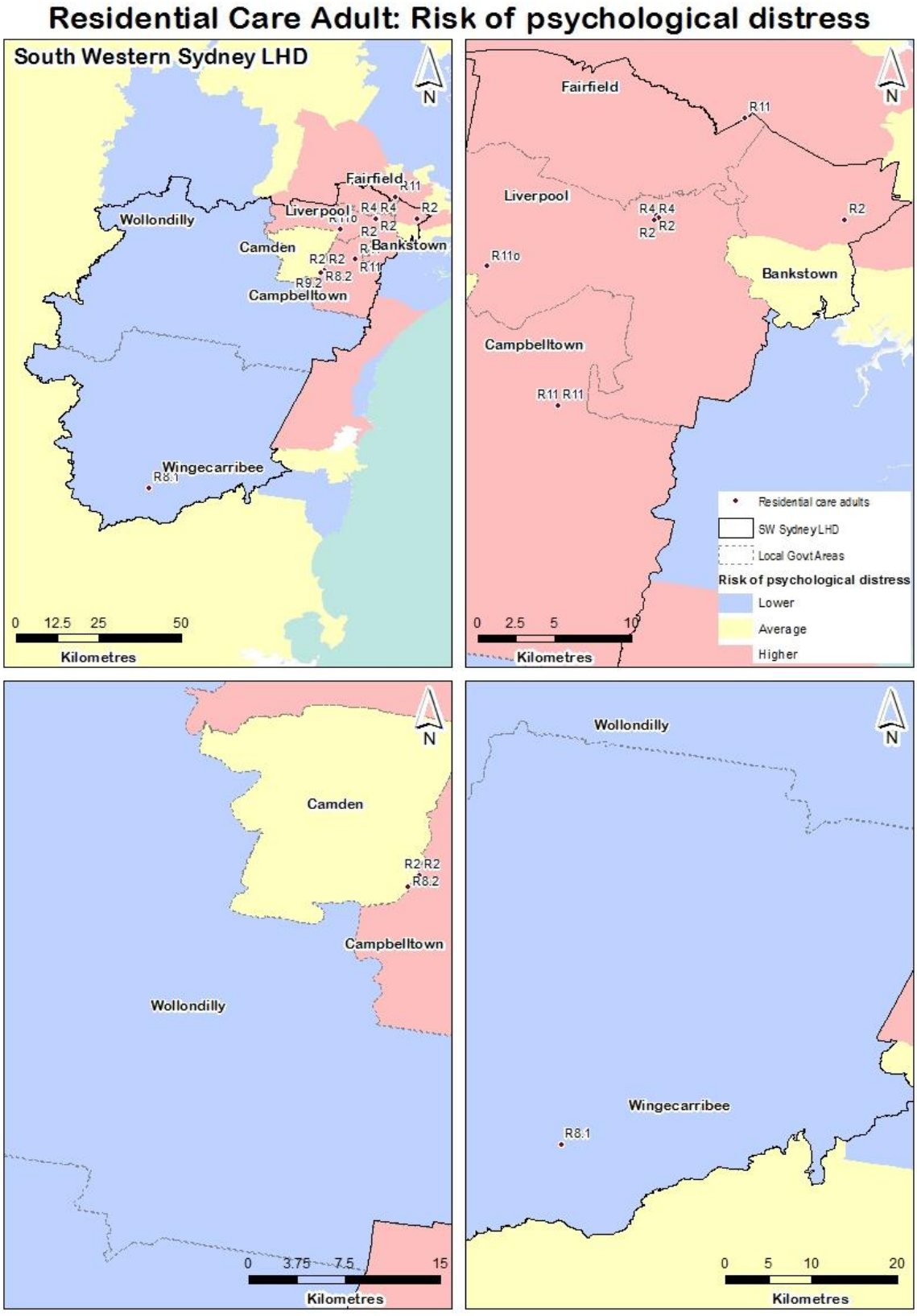


Figure 27. Location of residential services, by SEIFA index.

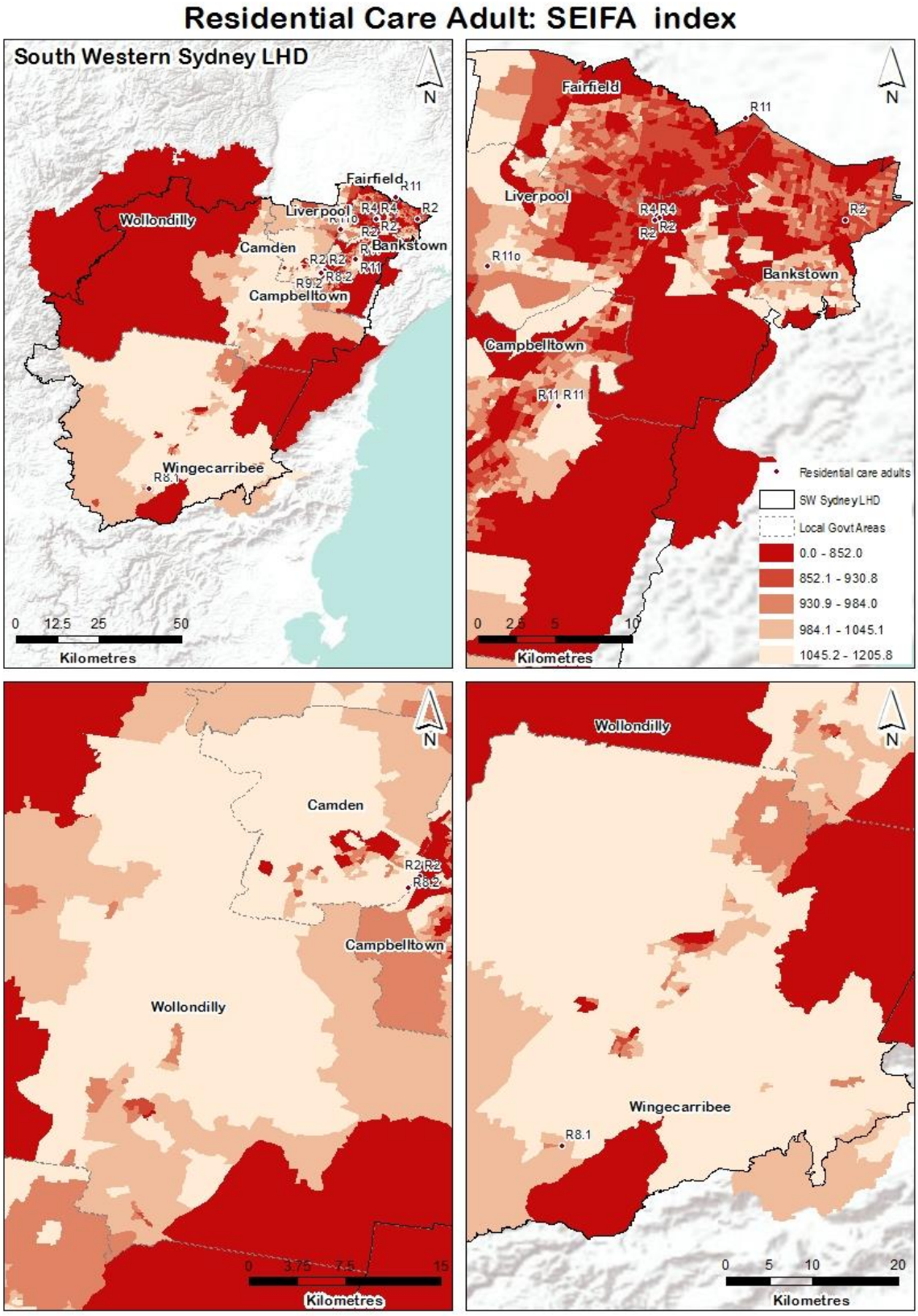


Figure 28. Accessibility to services providing residential care

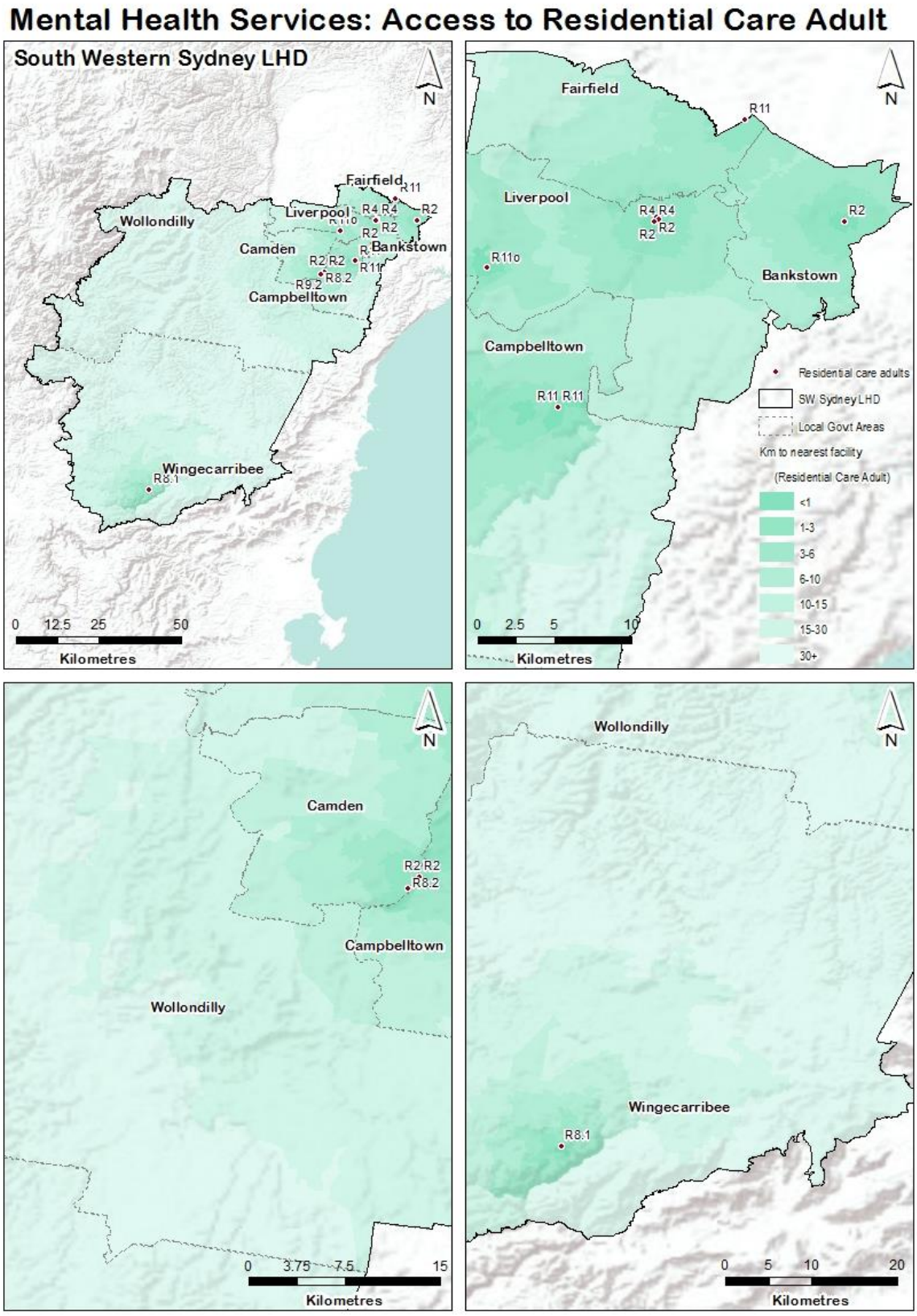


Figure 29. Location of services providing day care, by population density.

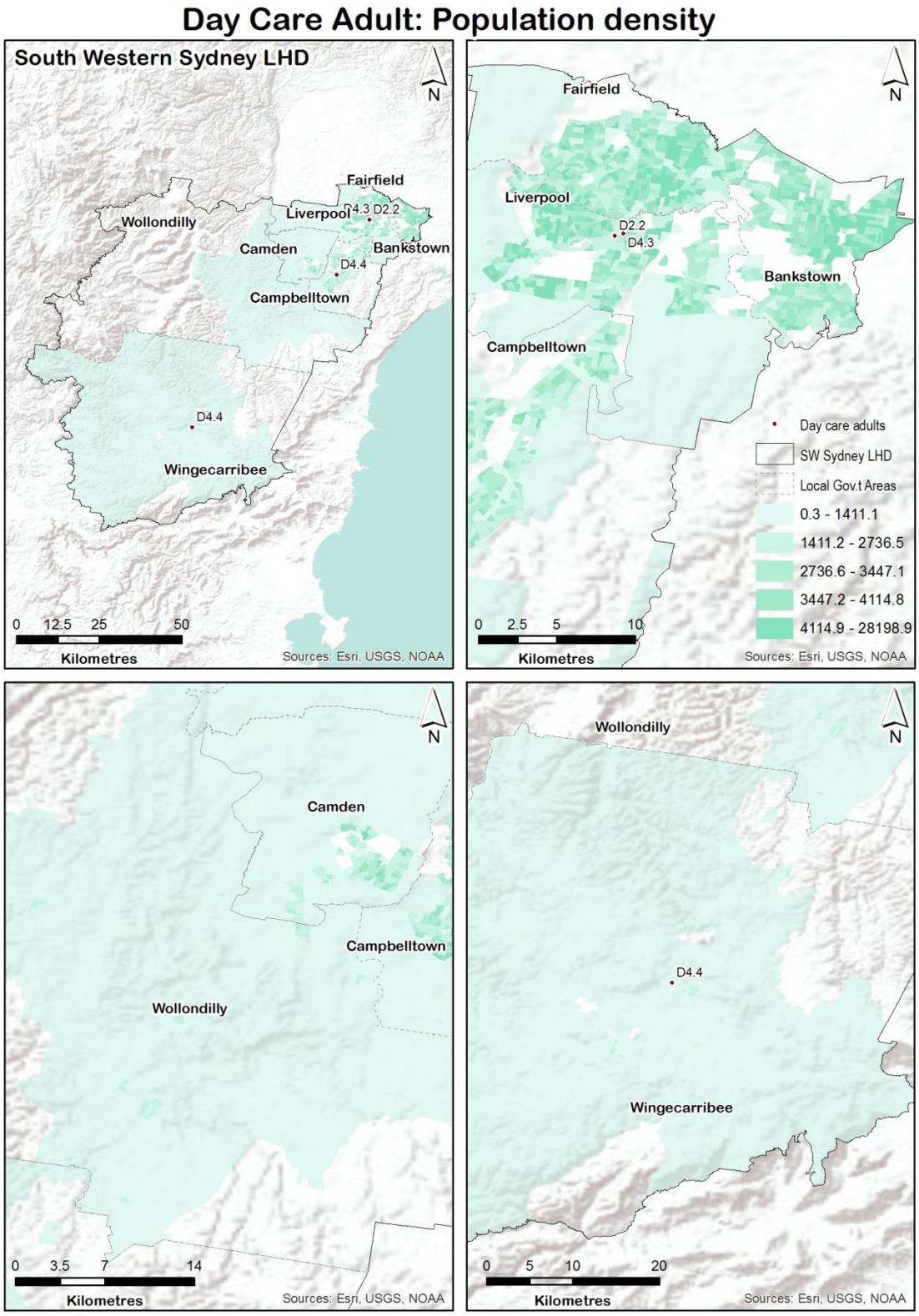


Figure 30. Location of services providing day care, by dependency index.

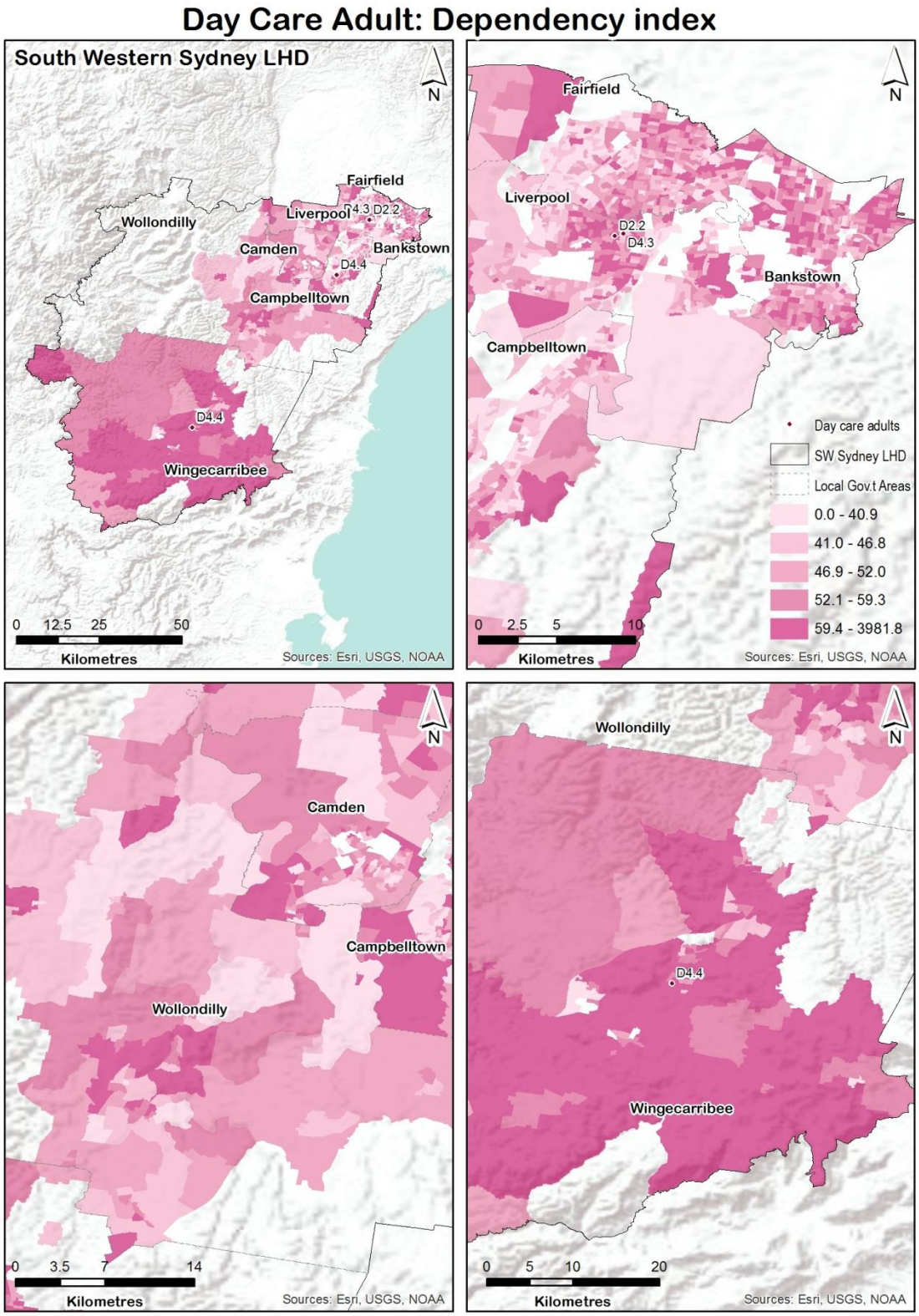


Figure 31. Location of services providing day care by percentage of people living alone.

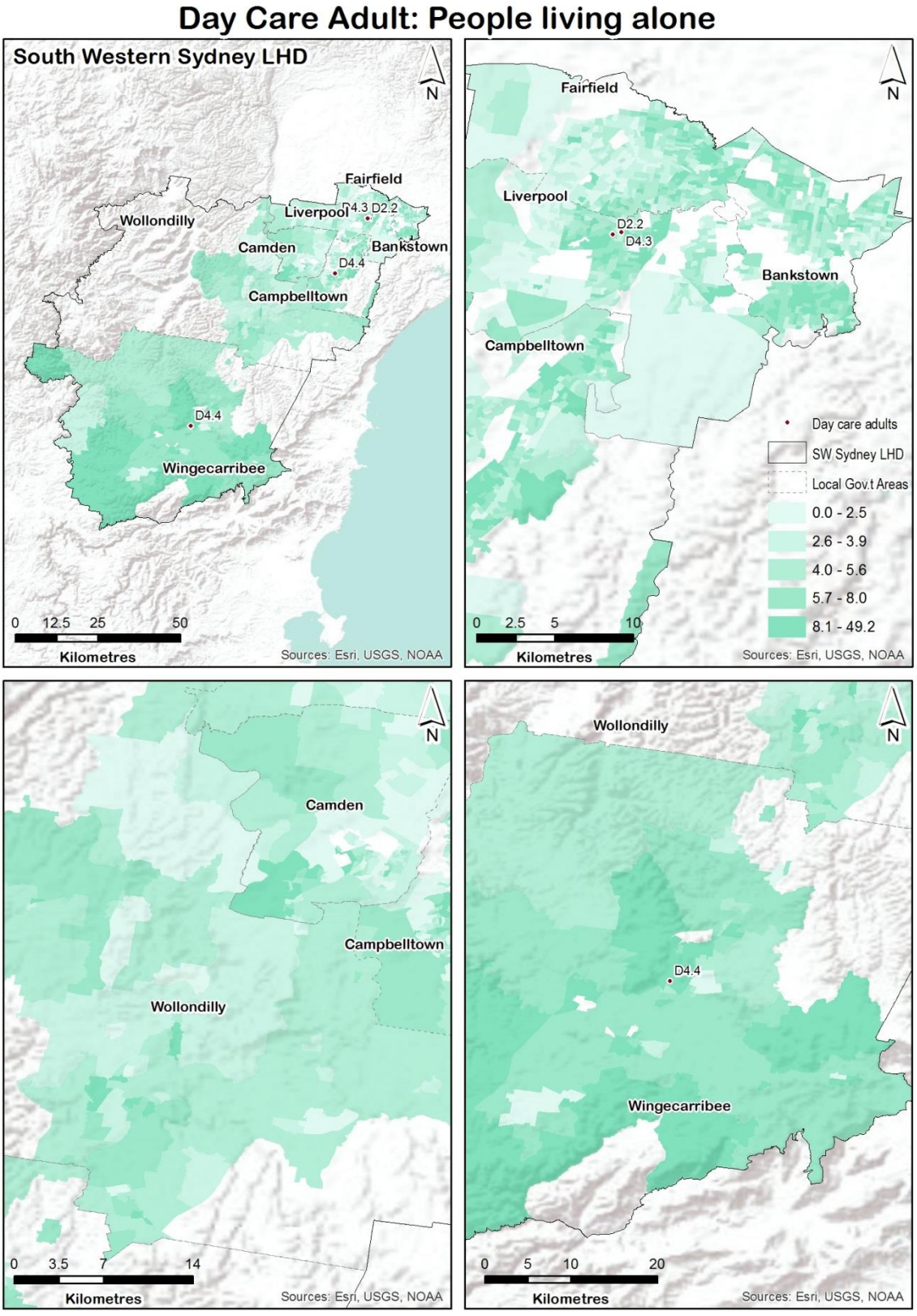


Figure 32. Location of services providing day care, by percentage of people older than 64 years old

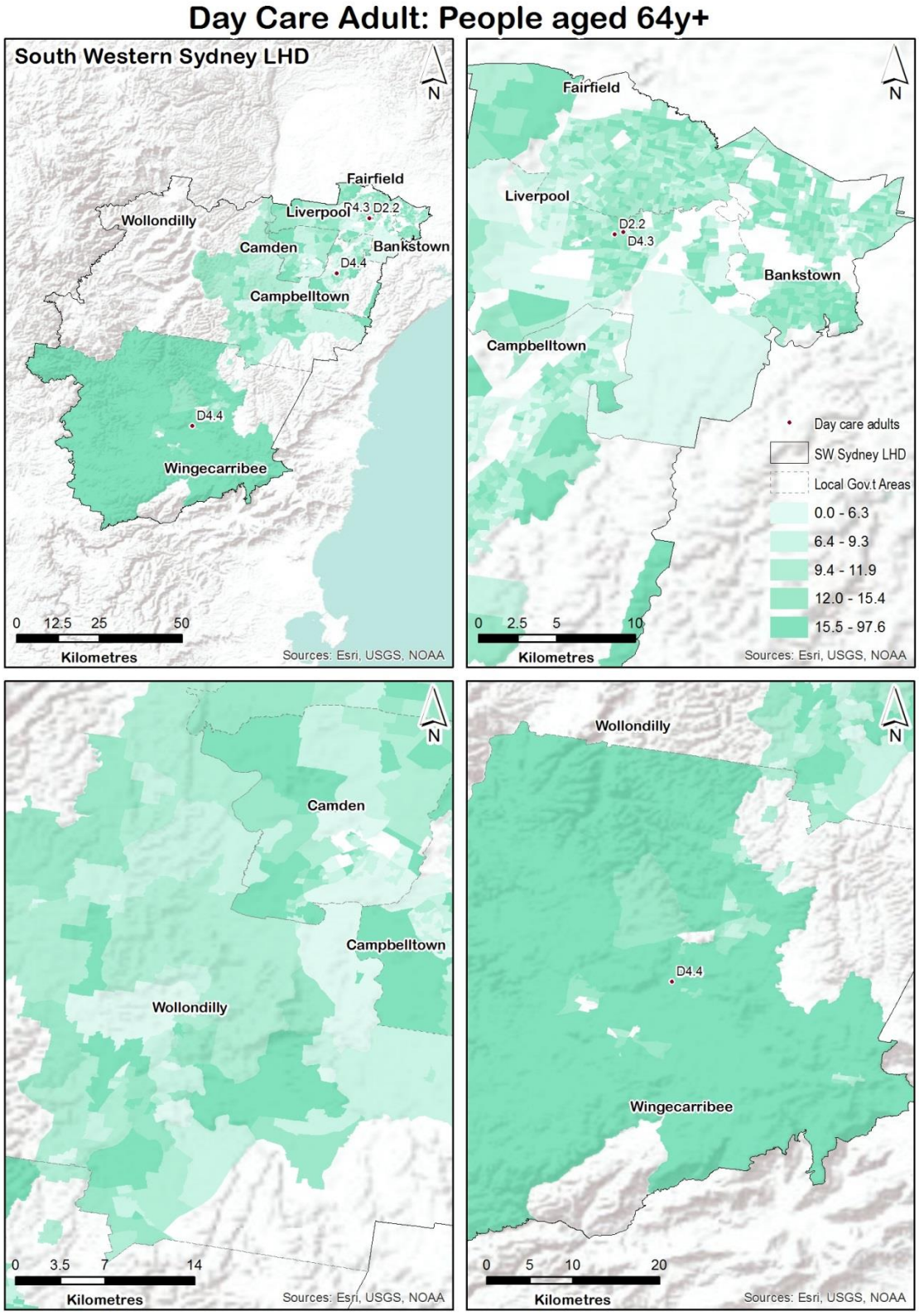


Figure 33. Location of services providing day care, by risk of psychological distress

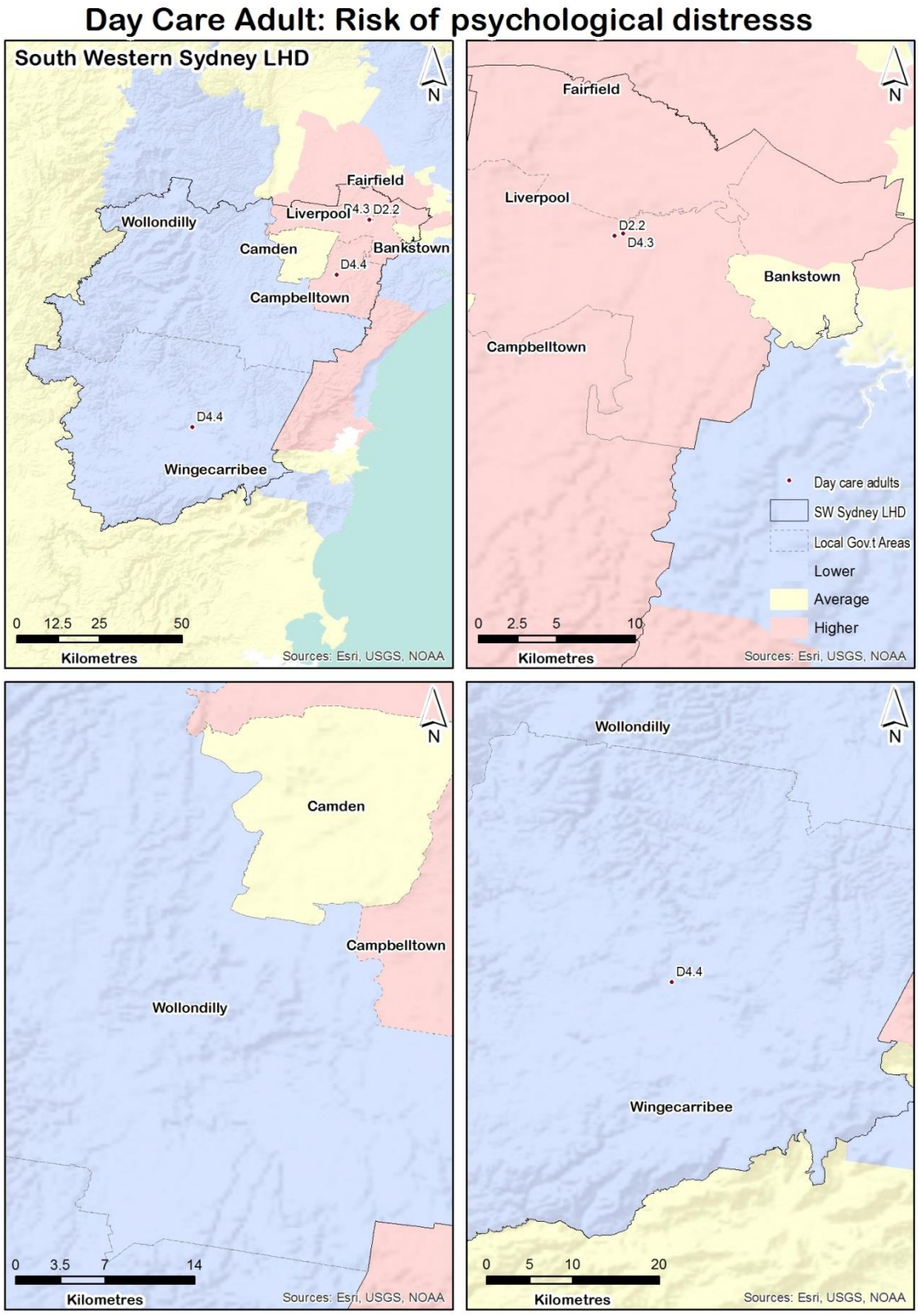


Figure 34. Location of services providing day care, by SEIFA index.

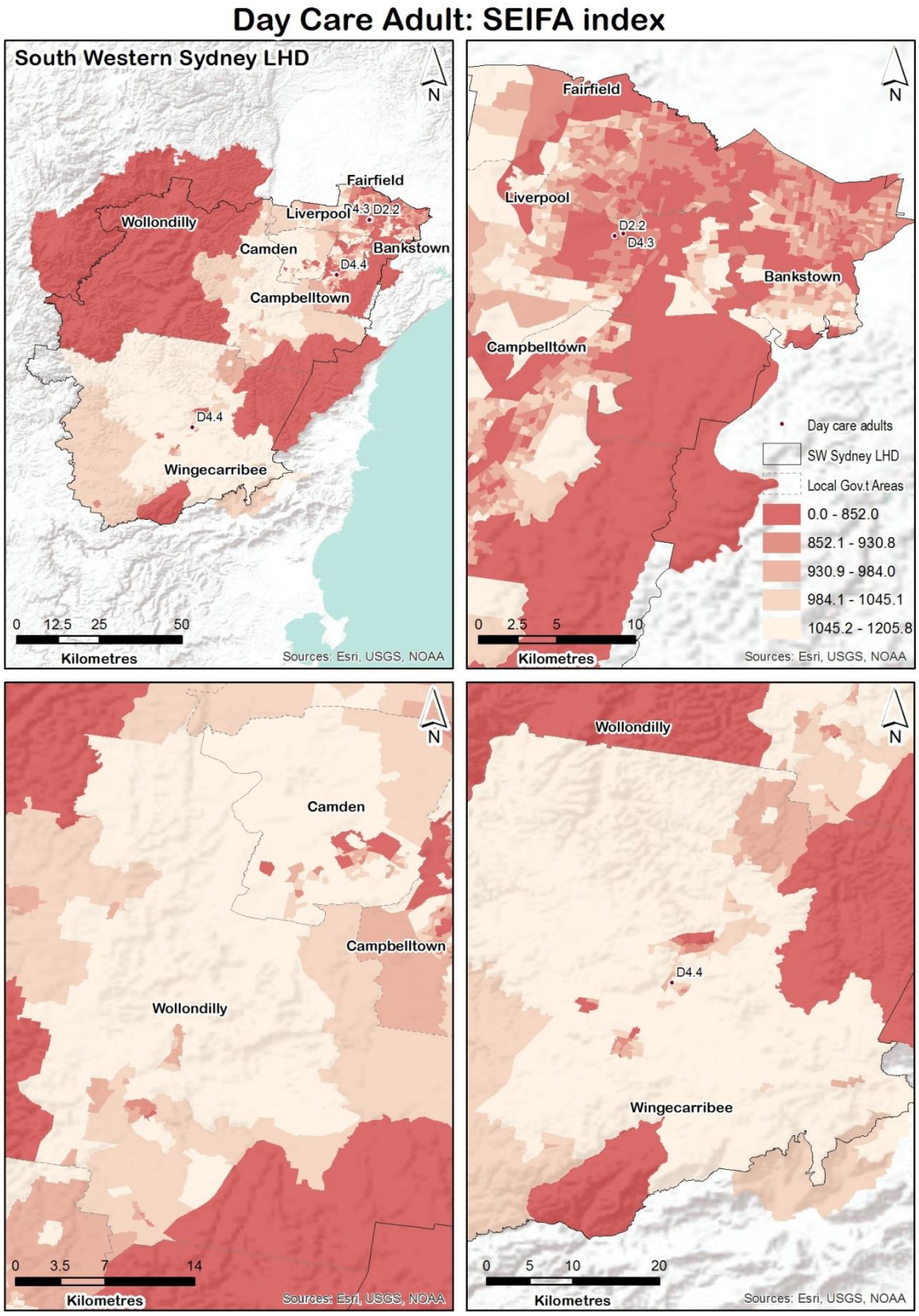


Figure 35. Location of services providing day care, by percentage of unemployed people

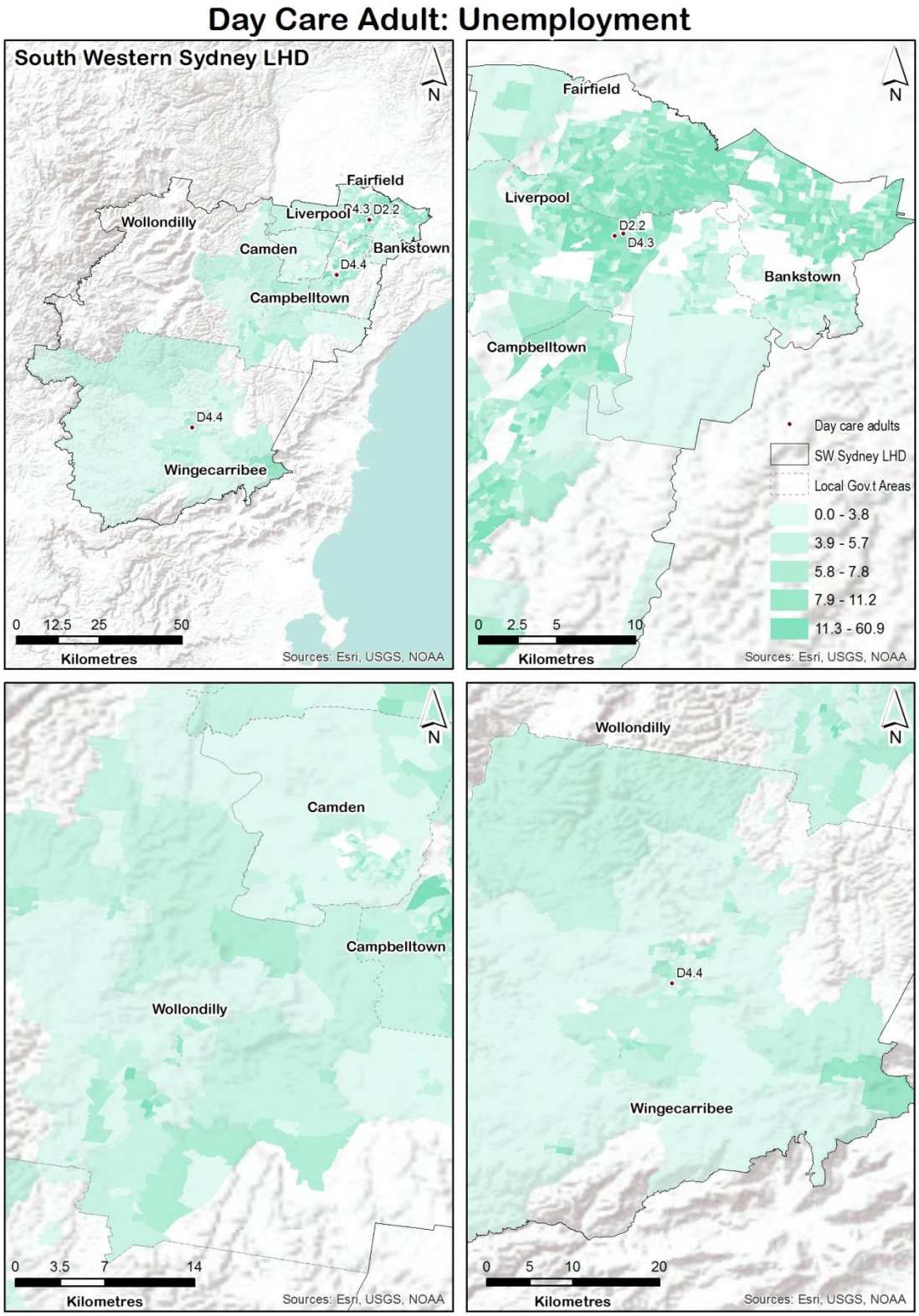


Figure 36. Location of services providing day care, by percentage of people providing informal care to a person with disability.

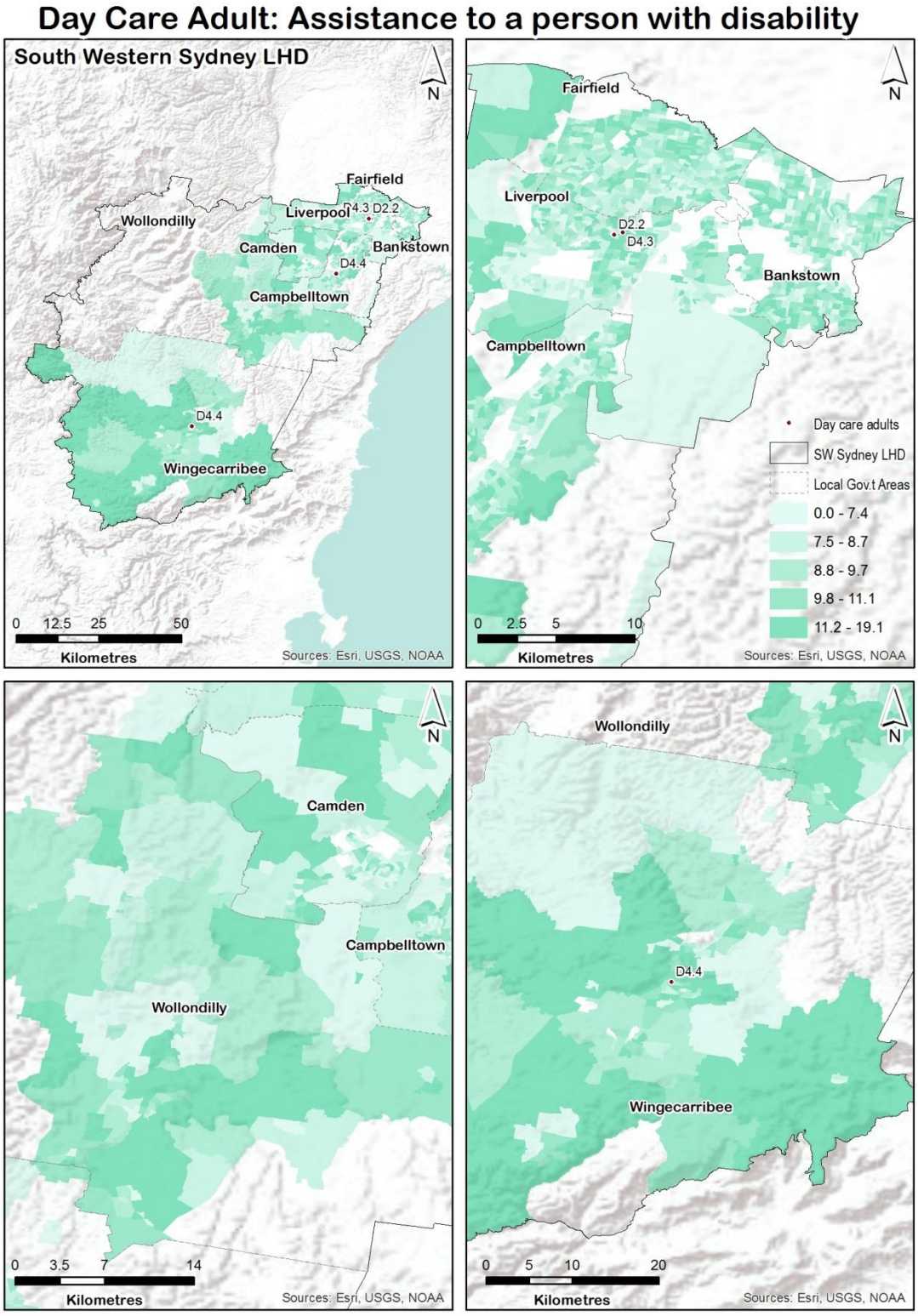


Figure 37. Accessibility to services providing day care

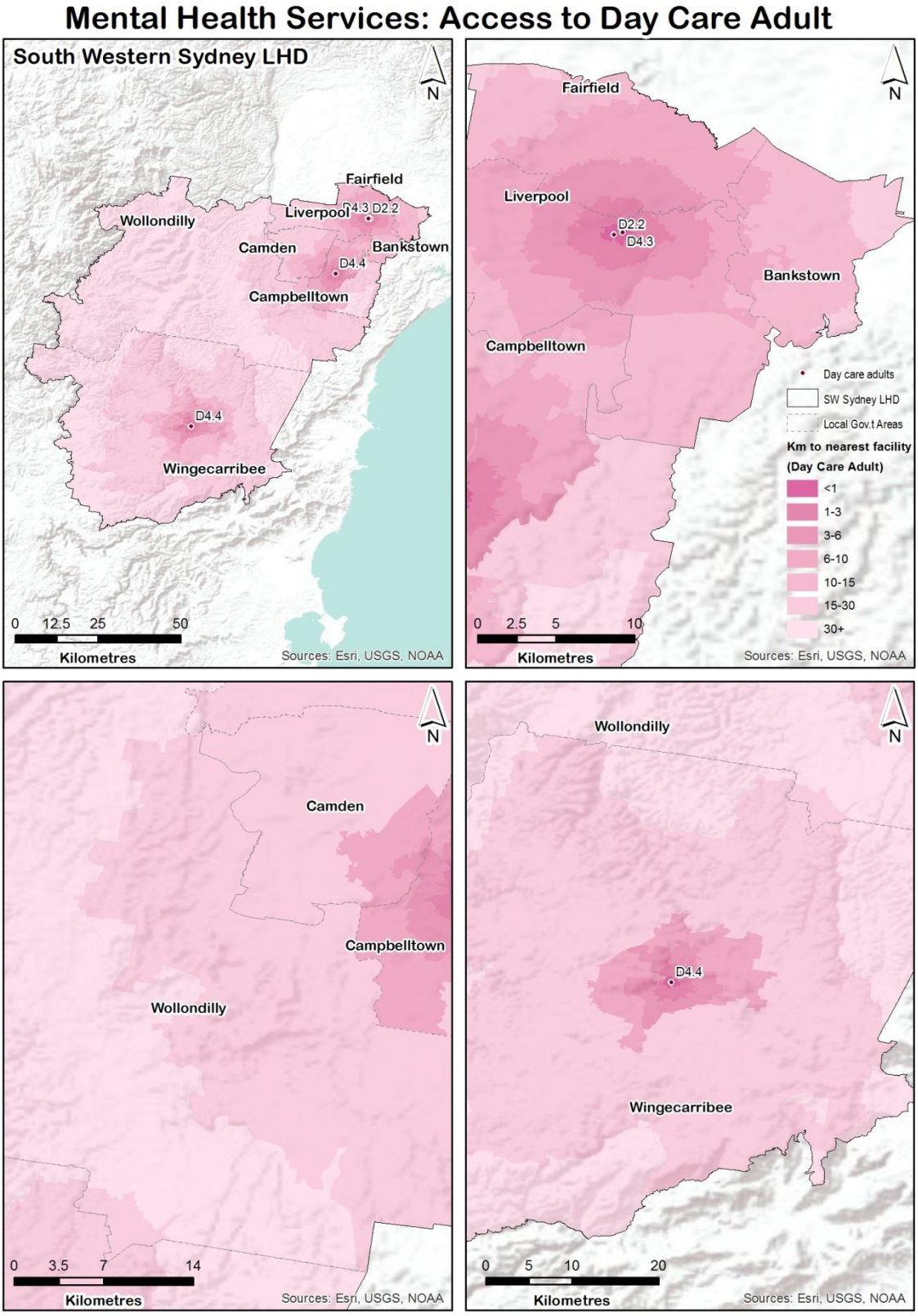


Figure 38. Location of services providing outpatient care, by population density

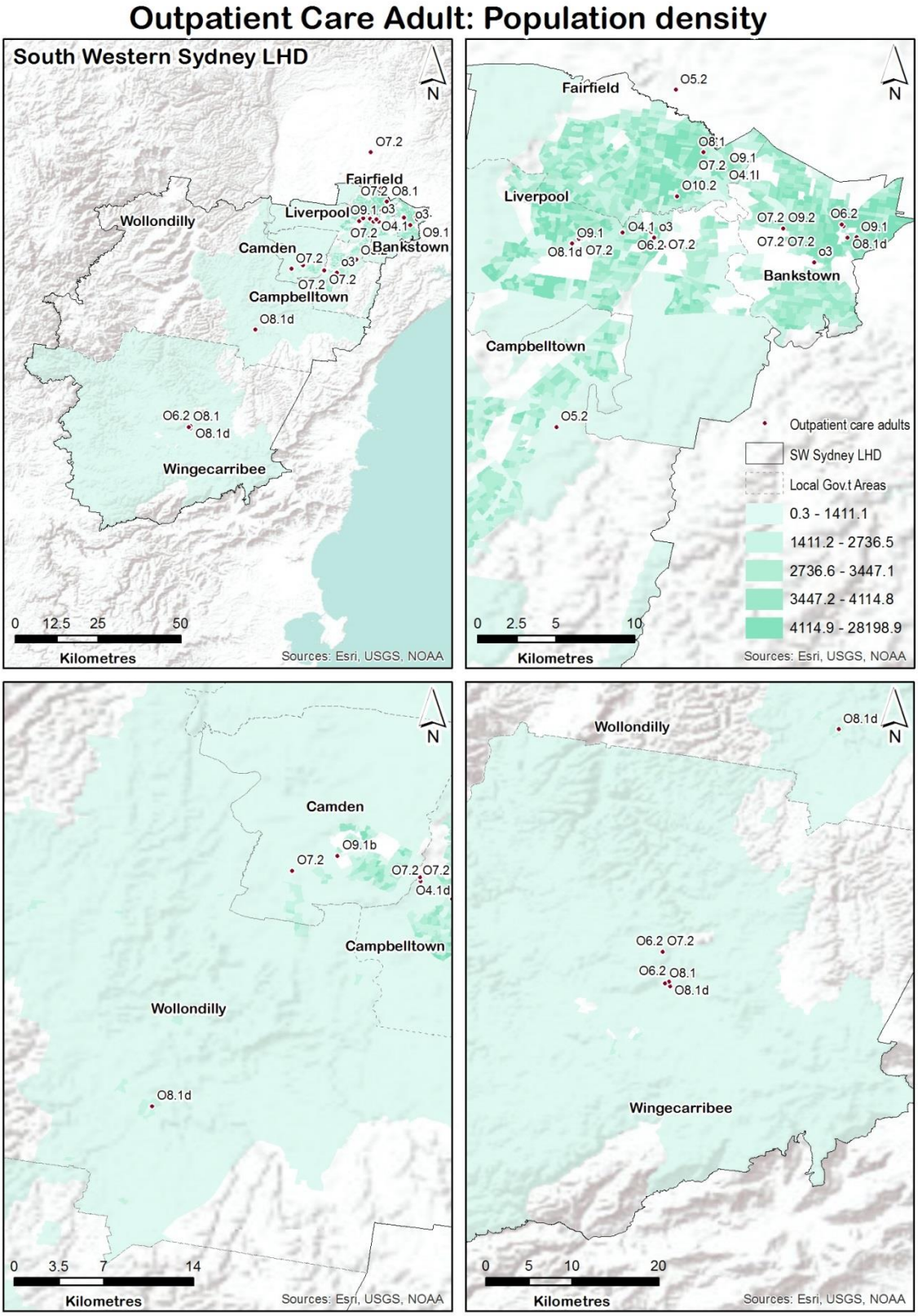


Figure 39. Location of services providing outpatient care, by dependency index.

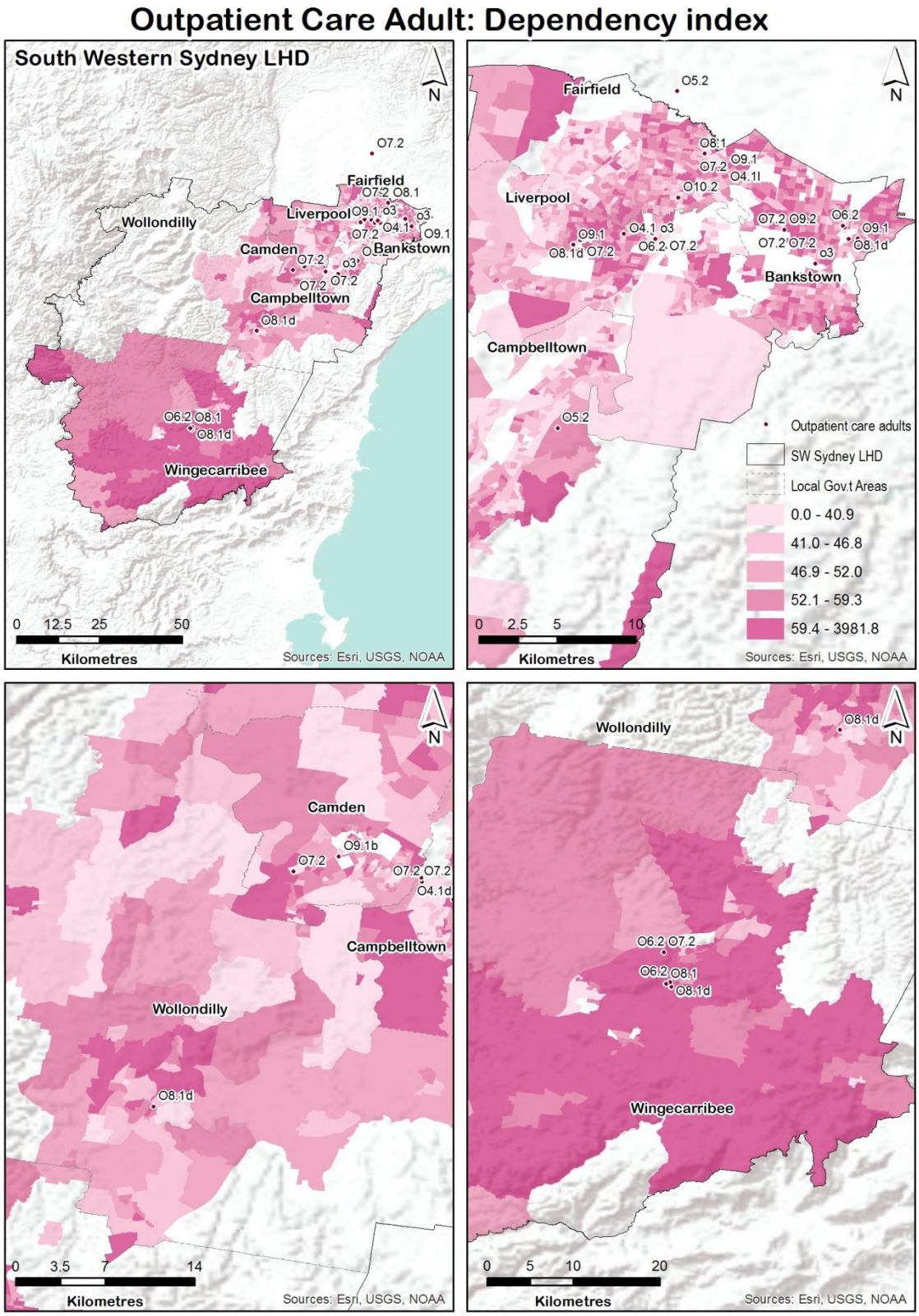


Figure 40. Location of services providing outpatient care, by percentage of people living alone.

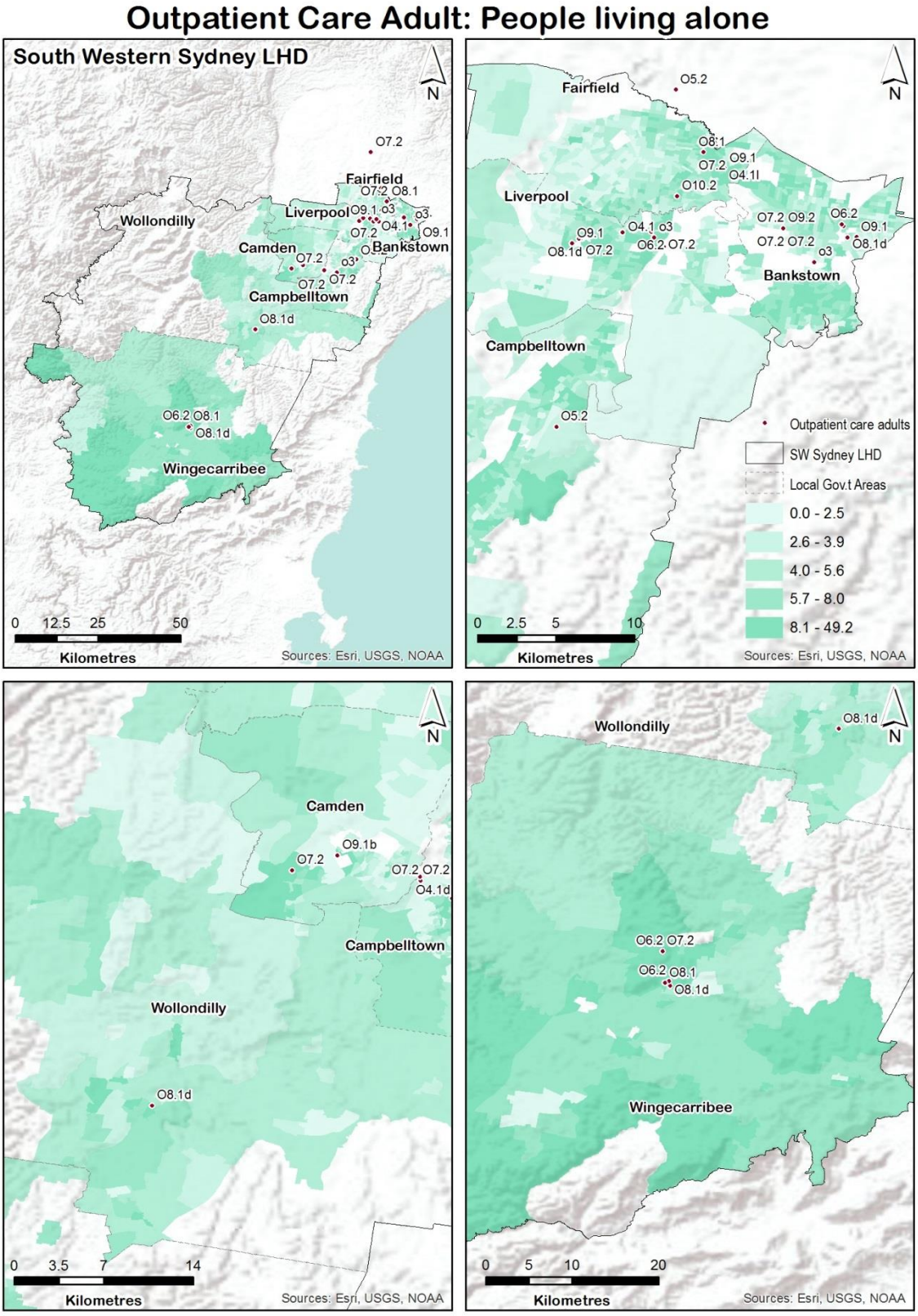


Figure 41. Location of services providing outpatient care, by percentage of people older than 64 years old.

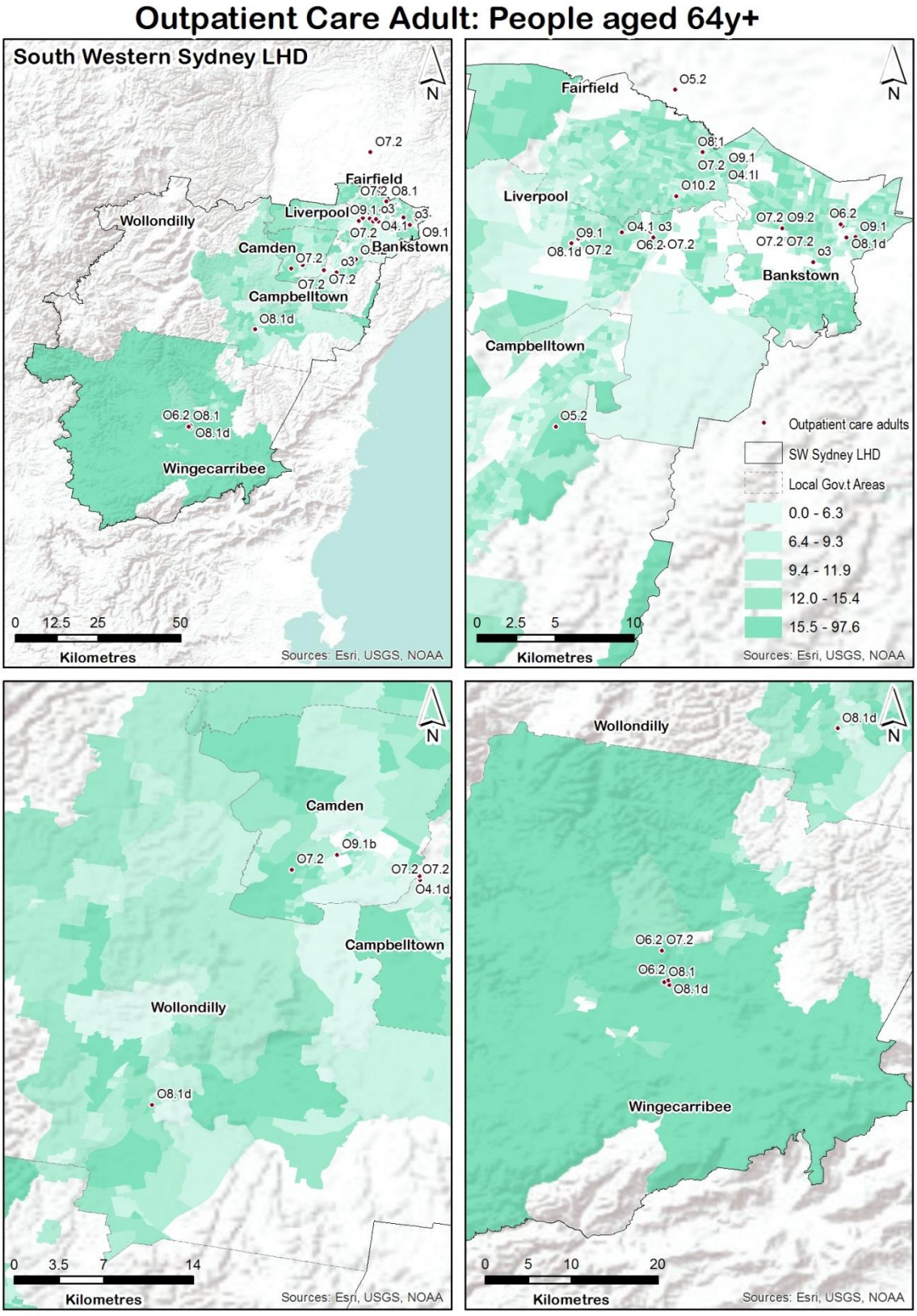


Figure 42. Location of services providing outpatient care, by risk of psychological distress.

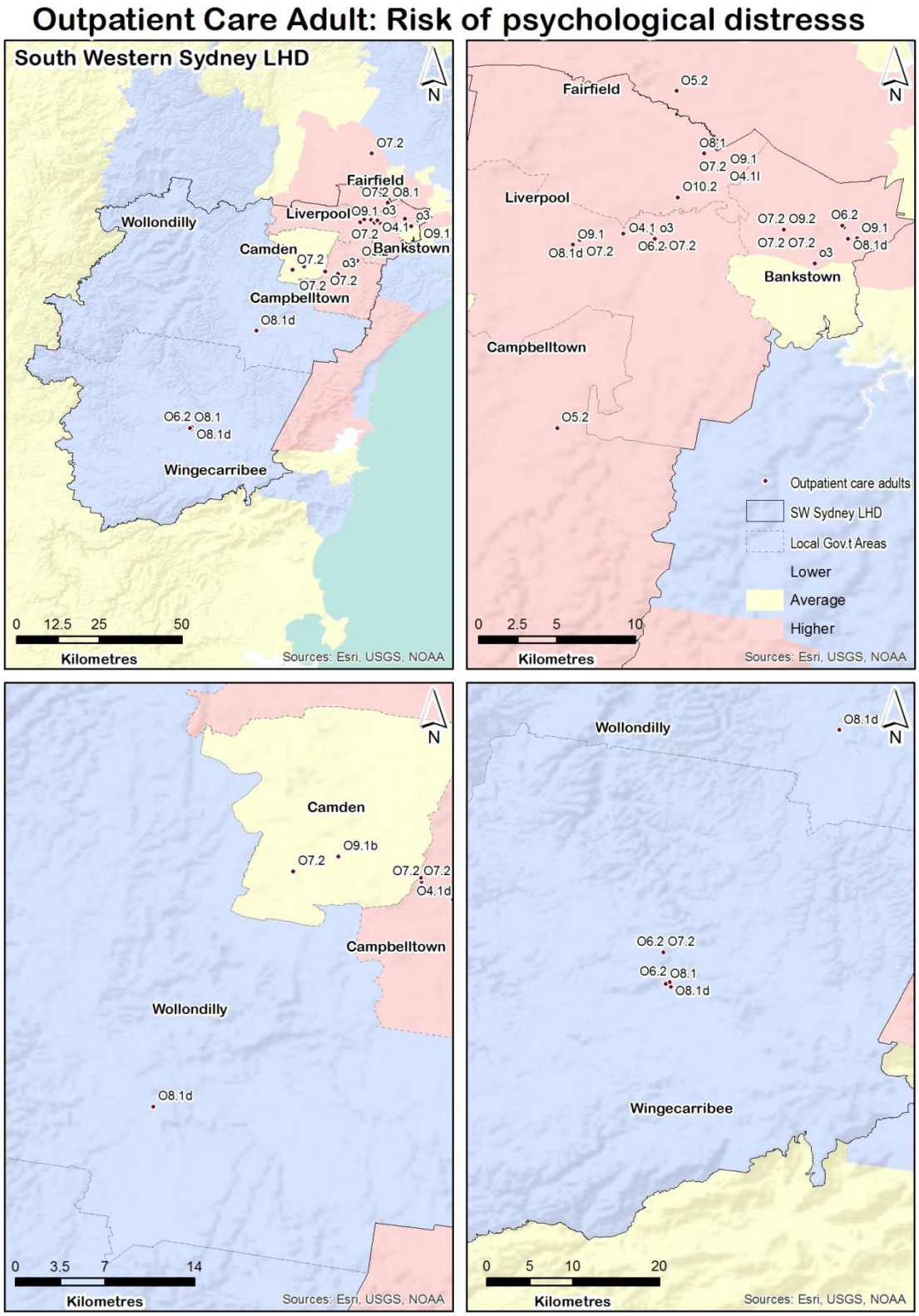


Figure 43. Location of services providing outpatient care, by SEIFA index

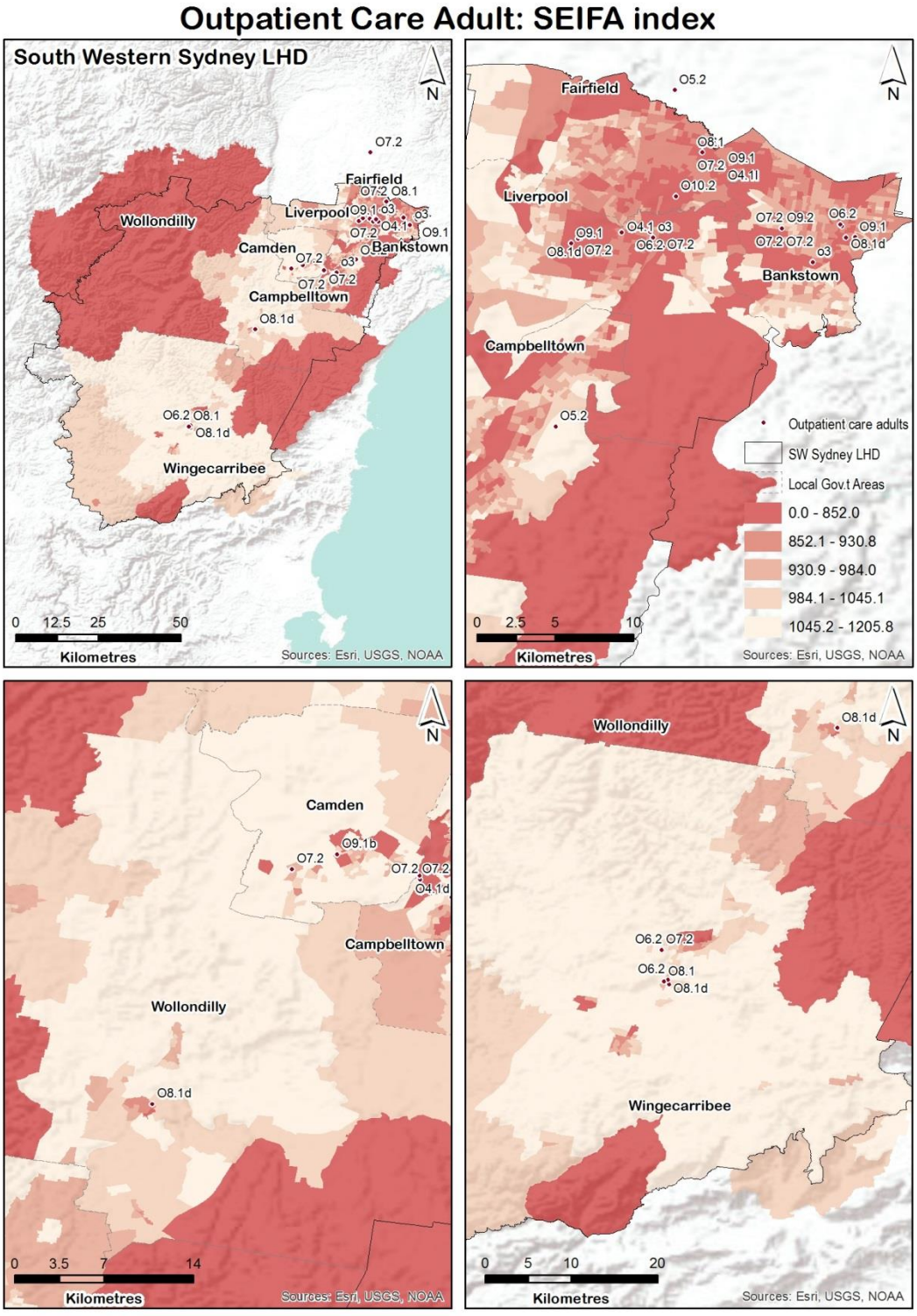


Figure 44. Location of services providing outpatient care, by percentage of people providing informal care to a person with a disability.

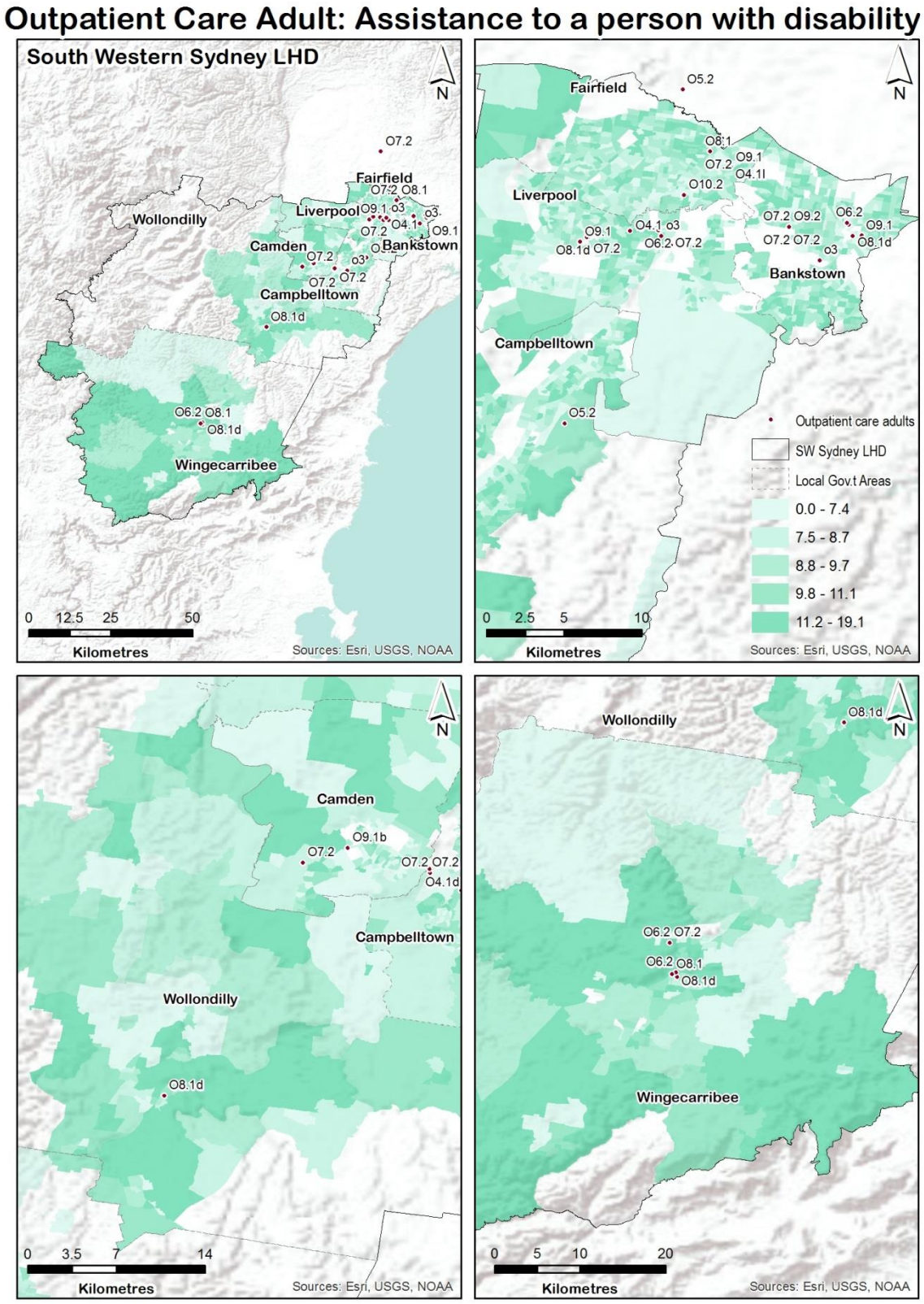


Figure 45. Accessibility or residential services providing outpatient care.

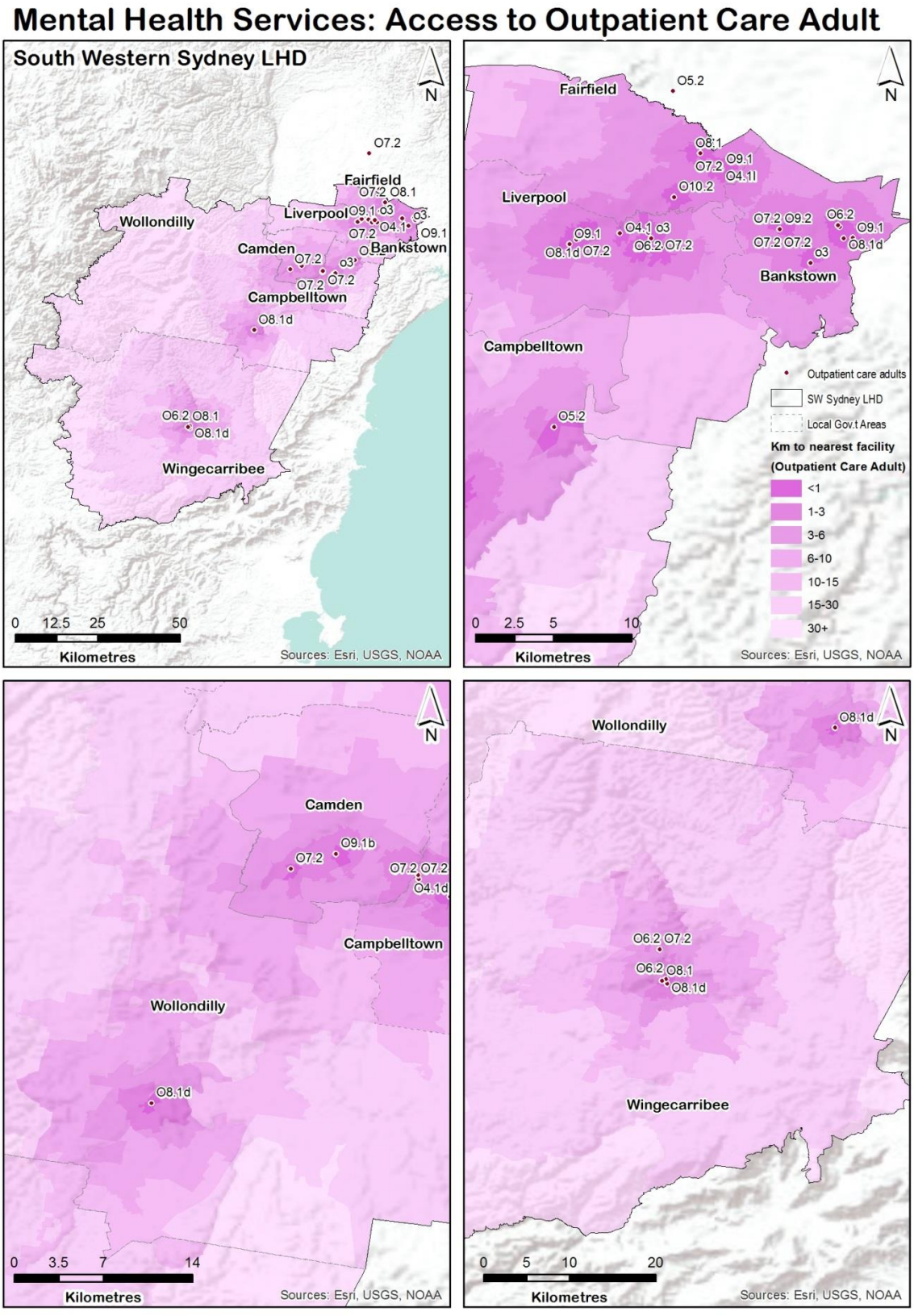


Figure 46. Location of services providing care for children and adolescents with behavioural problems, by population density.

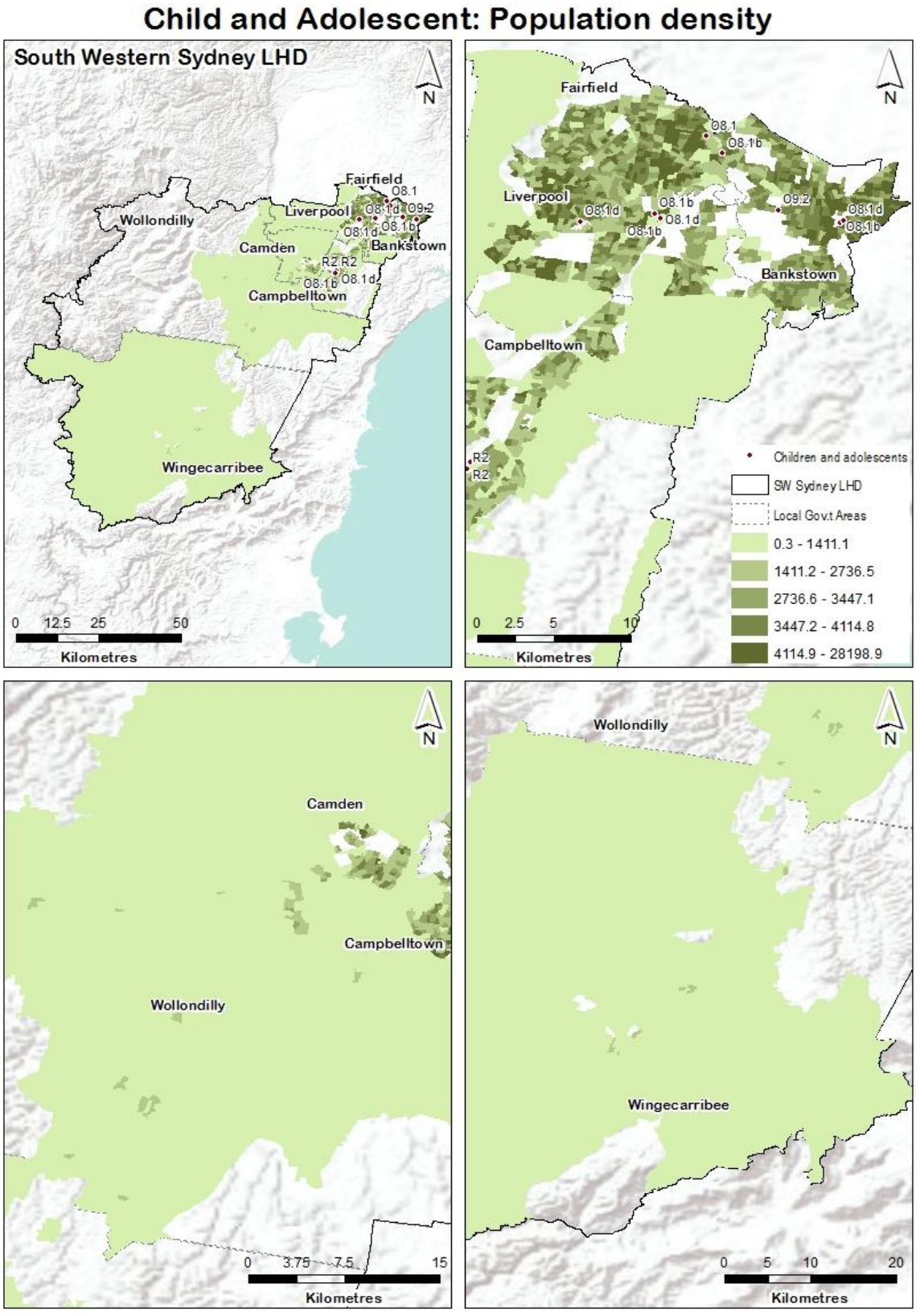


Figure 47. Location of services providing care for children and adolescents with behavioural problems, by dependency index.

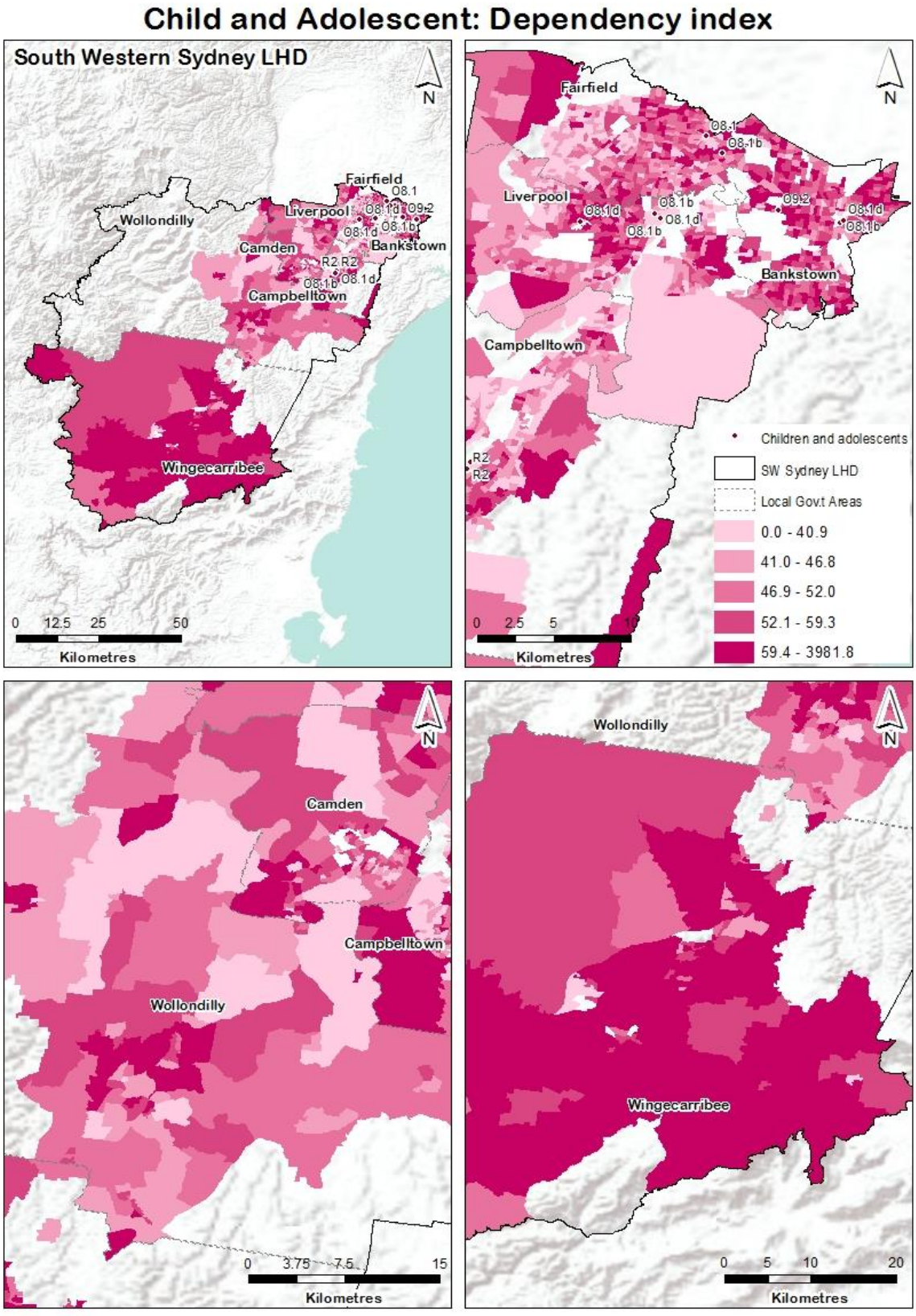


Figure 48. Location of services providing care for children and adolescents with behavioural problems, by SEIFA

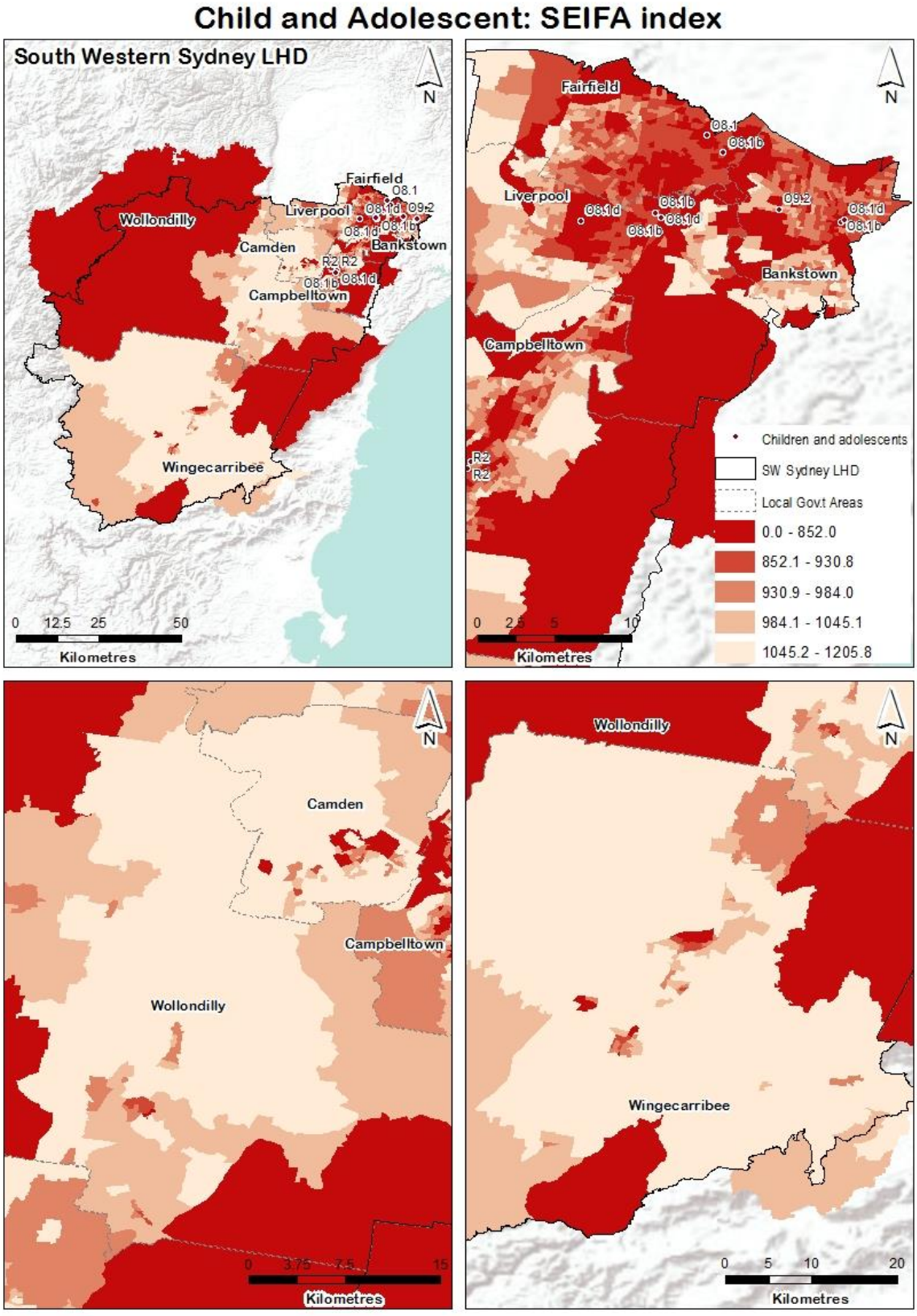
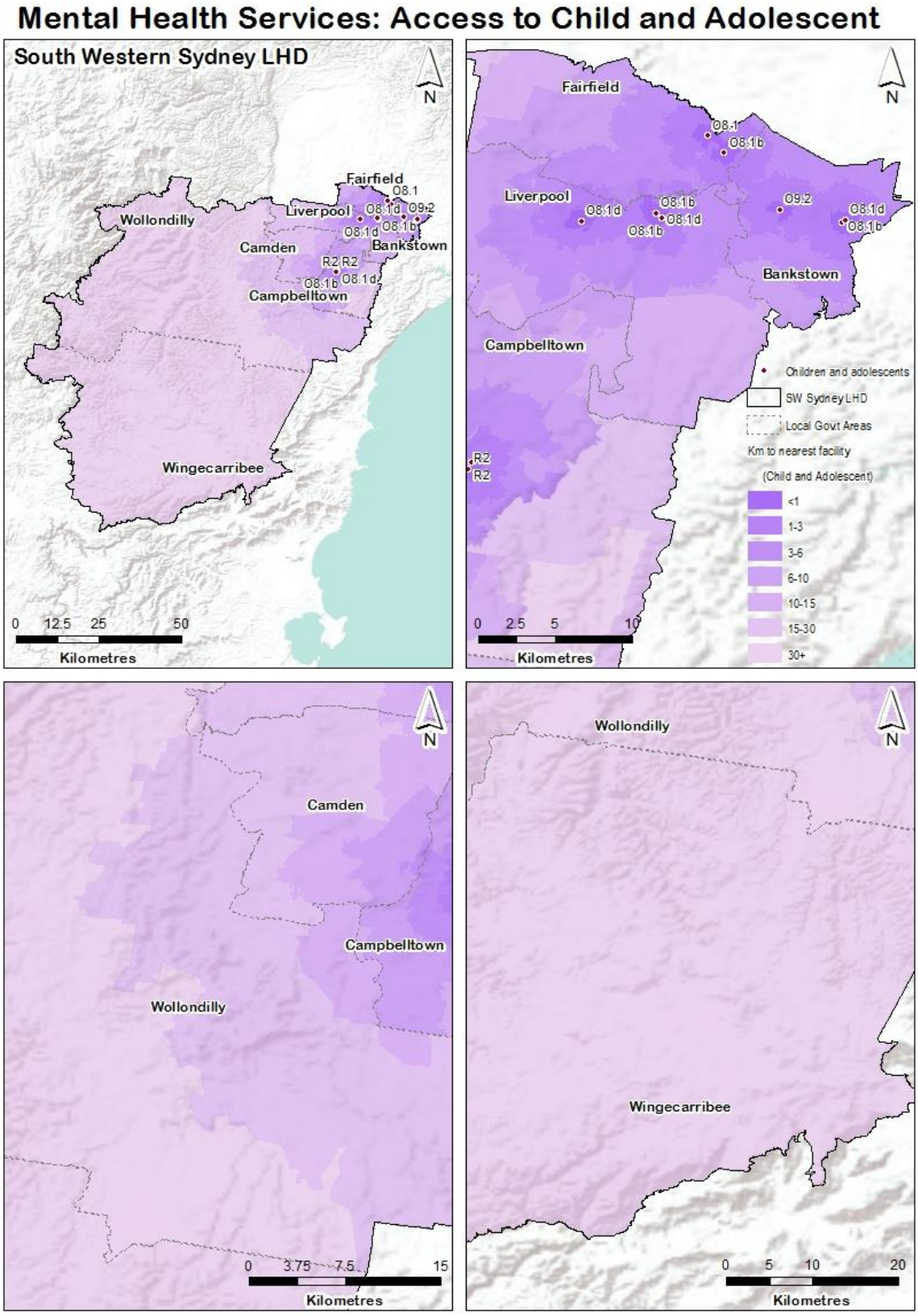


Figure 49. Accessibility to services providing care for children and adolescents with a behavioural problem.



5. DESCRIPTION OF THE PATTERN OF CARE IN SOUTH WESTERN SYDNEY

Figure 50 depicts the pattern of adult mental health care in South Western Sydney LHD. To allow comparisons with other areas, we are only including the services for adult people (i.e. specific services for children, adolescent and younger people; older people; carers and multicultural population are not included).

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

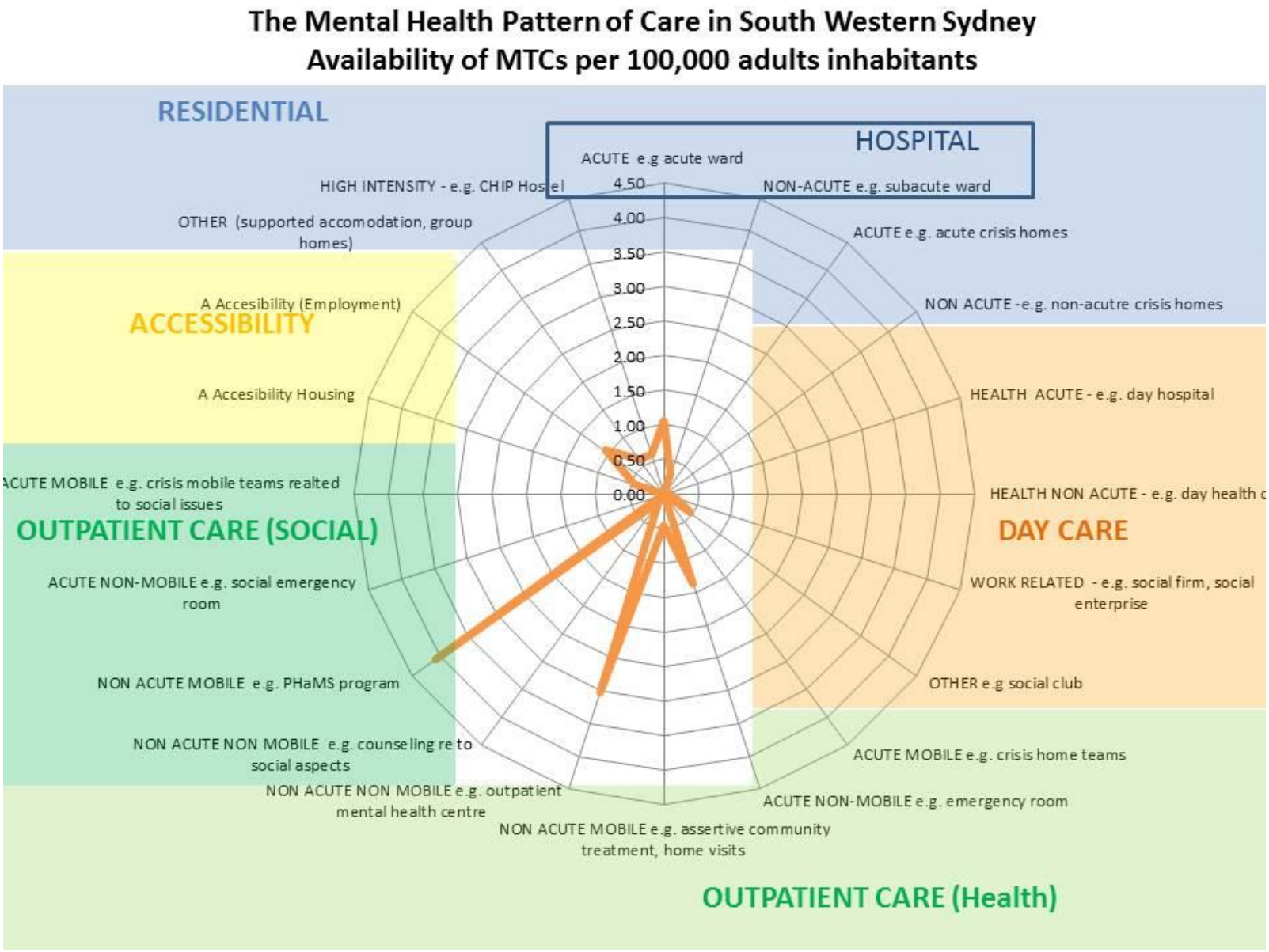
We have found 4 major gaps in the provision of services:

1) Non-hospital acute and sub-acute care
2) Lack of medium or long term accommodation for people with mental health problems
3) Acute and non-acute health care day-related
4) Low availability of specific services related to employment for people with mental illness.

The first gap is related to an absence of services staffed with psychiatrists, psychologists, and nurses, who provide care for people with lived experience of mental illness who are experiencing a crisis. They provide the same type of care as the hospital (in an inpatient unit) but are embedded into the community. There are small units, with a strong focus on recovery (e.g. home crisis). The second gap is related to the lack of supported accommodation for people with mental health problems. The third gap refers to a lack of day care related to health. Acute day care related to health includes which provide an alternative to hospitalisation. People living a mental health crisis are not admitted in a hospital, but treated in the community. They spend all the day at the facility, but they sleep at home. On the other hand, non-acute day care includes day care centres staffed with at least 20% of mental health high skill professionals. In these types of centres people with lived experience of mental illness can spend the day, socialising and participating in structured activities related to health, such as cognitive training. Lastly, we have found a low availability of day care centres providing care related to work (e.g social firms/enterprises where people with lived experience of mental illness work and are paid).

Another issue that appears is the lack of outpatient mobile services related to health needs. To be classified as a mobile, the service has to do more than 50% of their activity outside the centre. Although the outpatient non-mobile services identified are doing between 20%-49% of their activity outside the centre, at that moment they are not passing the 50% cut-off.

Figure 50. The Pattern of Mental Health Care in South Western Sydney



In this section we present an overview of the workforce capacity in South Western Sydney. These data has to be interpreted with caution as we did not get any response from some service providers. In addition, the different terminology used by the providers difficult the analysis. More research is needed in order to understand this. 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 South Western Sydney is around 70 per 100,000 residents (including children and adolescents). If we add the staff at the NGOs this rate is increase to more than 100 staff per 100,000 residents.

As it can be observed the profile of professionals in the health sector and the NGO sector is very different (figure 51). In the health sector the most common professional is the mental health nurse followed by the psychologist and the psychiatrist, The number of clinical professionals at the NGO sector is small (less than 10%), which may reduce their capacity to provide more intensive care.

Figure 51. Workforce capacity in South Western Sydney- Adult

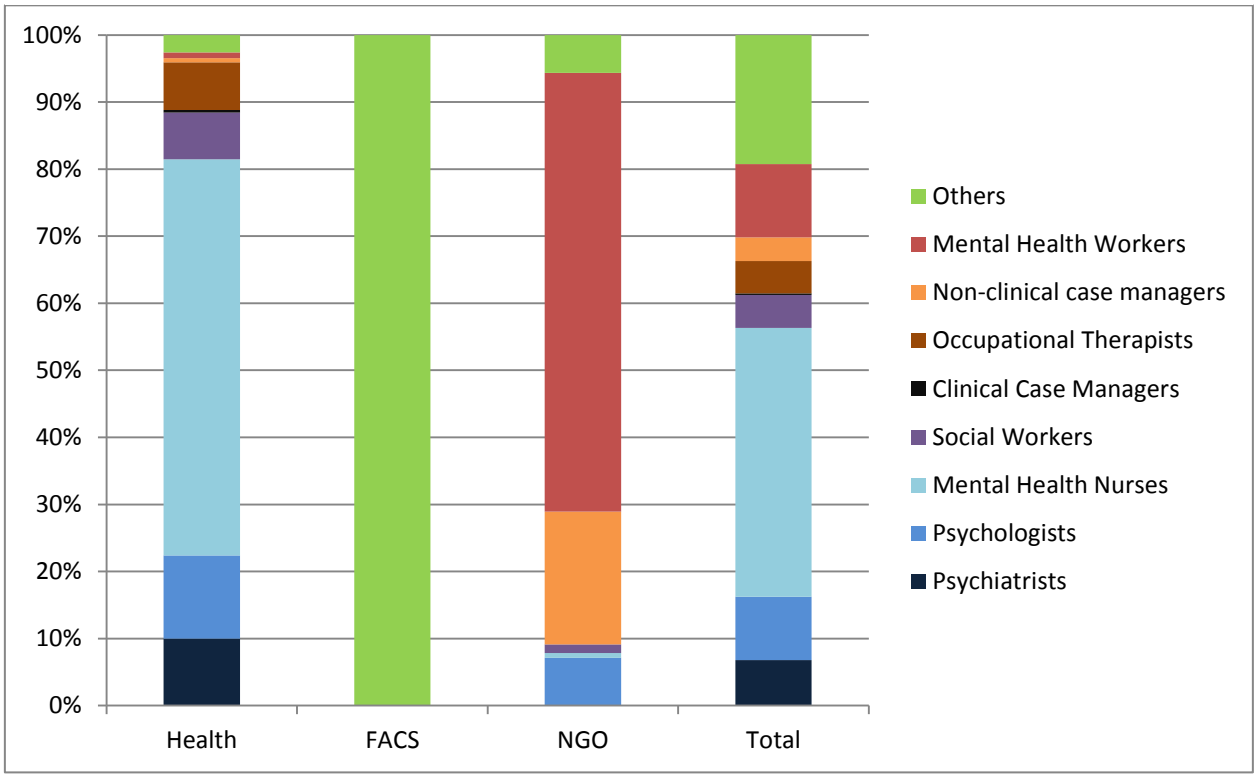


Figure 53 compares the mental health pattern of care between South Western Sydney and Western Sydney.

South Western Sydney provides less mobile outpatient care related to health needs than Western Sydney. However, it has to be kept in mind that the outpatient services in South Western Sydney have a high mobility, and it is possible than in one year time their code change to mobile services. On the other hand, South Western Sydney has more organizations providing mobile non-acute outpatient care related to the social needs of people with a lived experience of mental illness. This can be explained by the presence of NGOs in South Western Sydney that are not in Western Sydney, such as New Horizons or NEAMI.

With regard to inpatient care, the presence of the Cumberland Hospital in Western Sydney may explain the high availability of non-acute teams in Western Sydney, when compared with South Western Sydney, as well as the higher capacity. However, the provision of non-acute beds in Western Sydney may be an outlier, and should not be considered as the benchmark in NSW.

The availability of residential care in the community for people with a lived experience of mental illness is higher in Western Sydney than in South Western Sydney. This is mainly explained by the presence of the CHIP Hostel on the grounds of Cumberland Hospital, a large inpatient public psychiatric hospital (figure 52)

Figure 52. Rate of beds per 100,000 adults: South Western Sydney vs Western Sydney

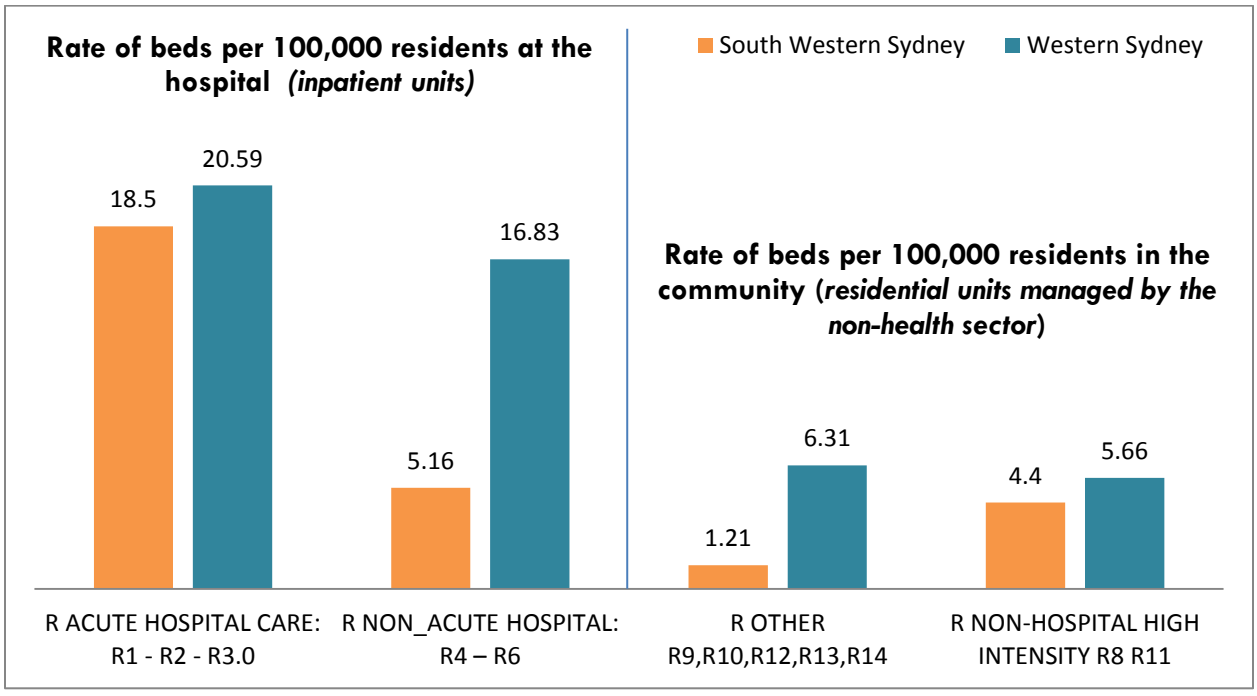
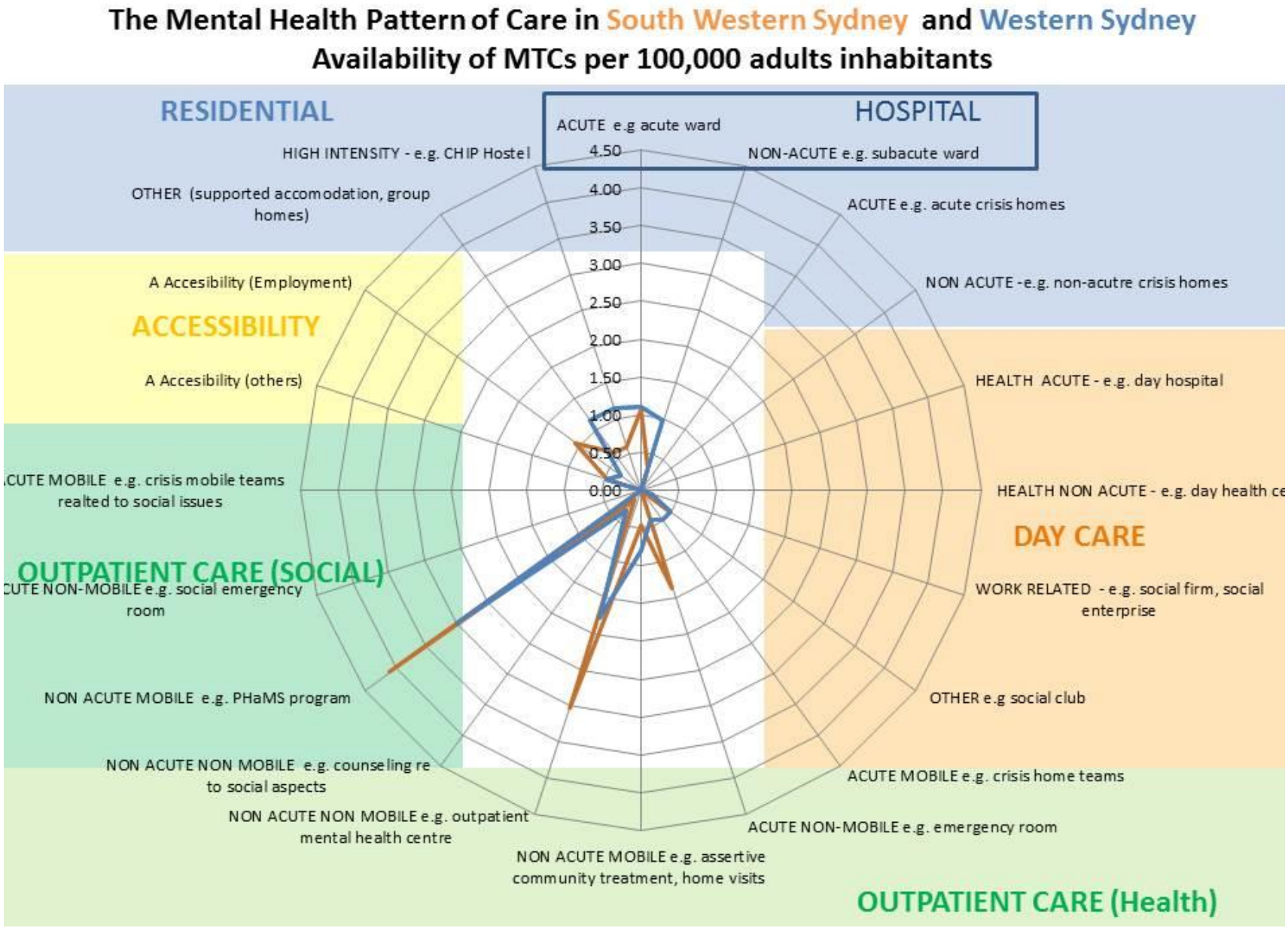


Figure 53. Availability of MTCs: South Western Sydney vs Western Sydney



6. INTERNATIONAL COMPARISONS

International comparisons are useful for: 1) learning about national systems and policies; 2) learning why those systems take the forms they do; and 3) learning lessons from other countries for application elsewhere[22]. In the absence of a gold standard for planning the provision of mental health services, international comparisons may be also useful for ask questions that are given by granted.

However, in order to conduct meaningful comparisons, it is important to use a standardised tool that goes beyond terminological variability. We have mapped the pattern of Mental Health in different European areas using the DESDE-LTC. The use of a common language allows us to compare South Western Sydney with different community care models in Europe. The information on the European Countries has been presented as part of the The Refinement Research Project [20] funded by the European Commission. Table 42 describes the areas selected.

Table 43. Description of the areas

	Sør-Trøndelag (NORWAY)	Helsinki and Uusimaa Hospital District (FINLAND)	ULSS20 - Verona (ITALY)	Girona (SPAIN)	Hampshire[4] (ENGLAND)
Population (>18 years old)	225,081 (2010)	1,206,446 (2010)	393,402 (2010)	599,473 (2010)	1,364,799 (2010)
Land Area (km²)	18,856	8,751	1,061	5,585	3,769
Population density (inhb./ km²)	15.60 (2011)	176.56 (2011-12)	416.85 (2001)	132.61 (2010)	459.45 (2010)
Ageing Index (>65/<15x100)	81.42 (2012)	82.17 (2010)	144.10 (2010)	98.29 (2010)	100.66 (2011)
Dependency ratio (<15 & >65/15-4x100)	49.55 (2012)	44.82 (2010)	53.51 (2010)	46.20 (2010)	52.43 (2011)
People living alone (%)	40.78 (2011)	41.37 (2011)	29.16 (2001)	17.94 (2007)	27.73 (2001)
Average of people per household	2.21 (2011)	2.07 (2011)	2.44 (2001)	2.62 (2007)	2.37 (2011)
Immigrants (%)	6.64 (2012)	6.14 (2011)	12.24 (2010)	21.60 (2010)	-
Unemployment rate (%)	2.79 (2010)	7.35 (2010)	4.21 (2001)	18.28 (2010)	5.8 (2011)
Total health care expenditure per capite Purchasing Power Parity (in Euros) (2010)	€4156	€ 2504	€ 2282	€ 2345	€2626
Total health care expenditure as a share of GDP	9.4%	8.9%	9.3%	9.6%	9.6%

[4] Including Portsmouth and Southampton Unitary Authorities.

6.1. Northern Europe Community Mental Care Model

Figure 54 compares South Western Sydney with an area in Norway (Sør-Trøndelag) while Figure 55 compares South Western Sydney with an area in Finland (Helsinki and Uusimaa).

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

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

With regard to socio and economic characteristics, Sør-Trøndelag las a low population density (15. 60 inh/km^2). It also has a very low unemployment index.

The main different with South Western Sydney is related to the high availability of non-acute care at the hospital, outpatient mobile services related to health care and day care related to employment and social and cultural issues.

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

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

When comparing South Western Sydney and the Finnish area the main contrast is the high number of residential and day care in Finland.

Figure 54. Pattern of Mental Health Care in South Western Sydney (orange line) and Sør-Trøndelag –Norway (red line).

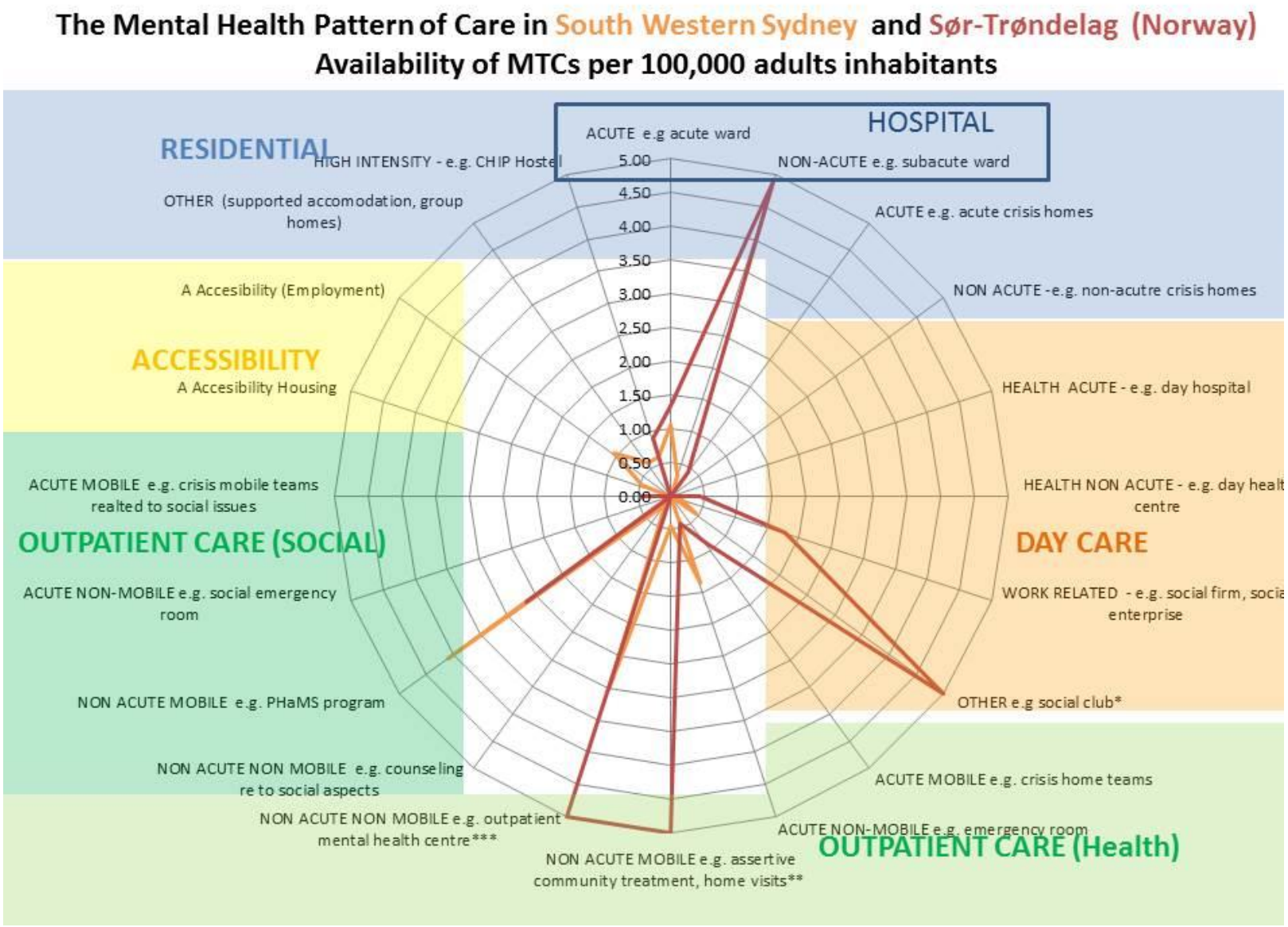
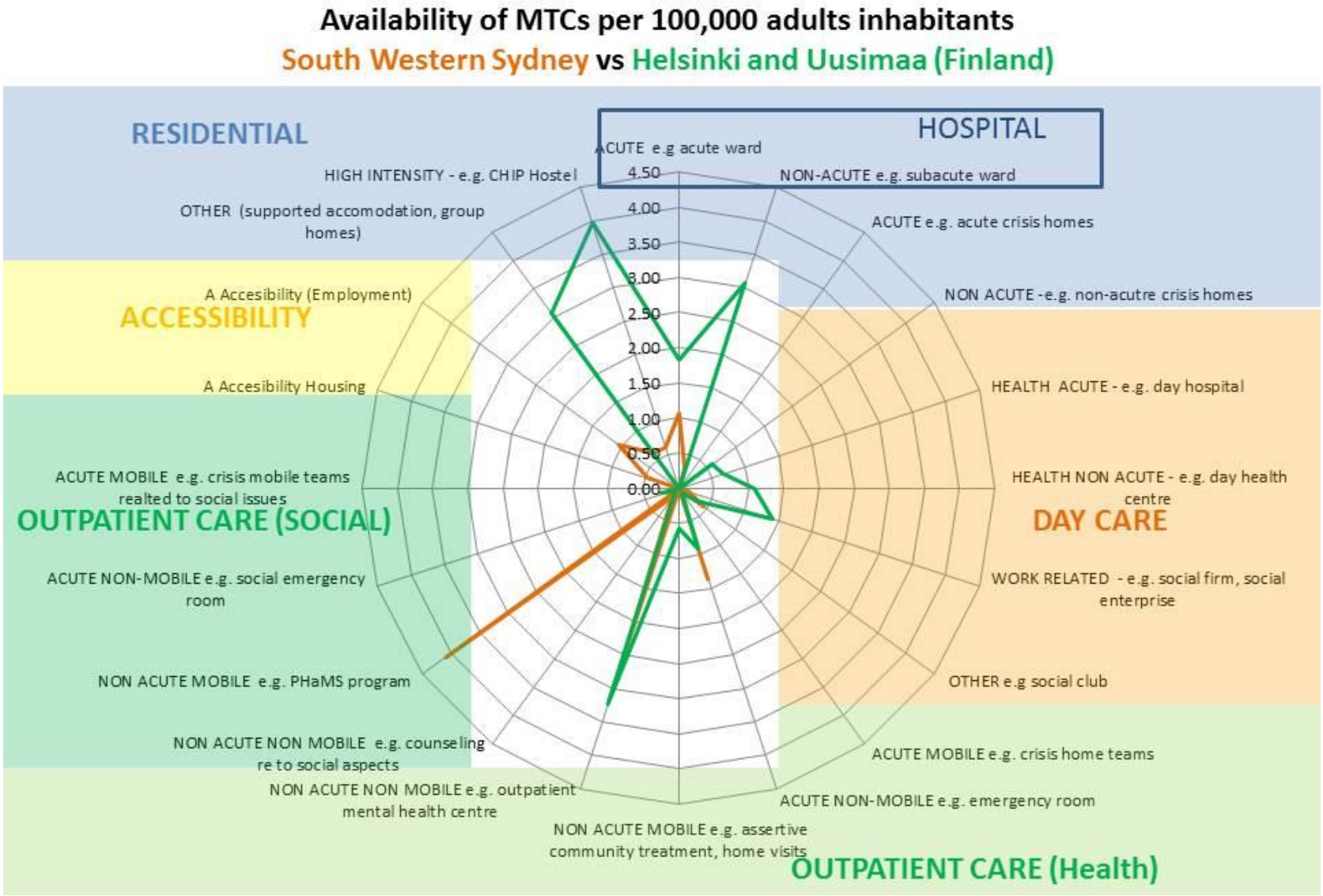


Figure 55. Pattern of Mental Health Care in South Western Sydney (orange line) and Helsinki and Uusimaa – Finland (green line)



6.2. Southern Europe Model of Mental health Care

Figure 56 compares South Western Sydney with Italy (Veneto Region) and figure 57 compares South Western Sydney with Spain (Girona). Mental Health in Southern Europe is characterized by a strong emphasis on community care, and low availability of psychiatric hospitals. As in the case of Northern Europe, the public health sector is funded from general taxes.

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

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

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

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

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

Figure 56. Pattern of Mental Health Care in South Western Sydney (orange line) and Veneto- Italy (brown line).

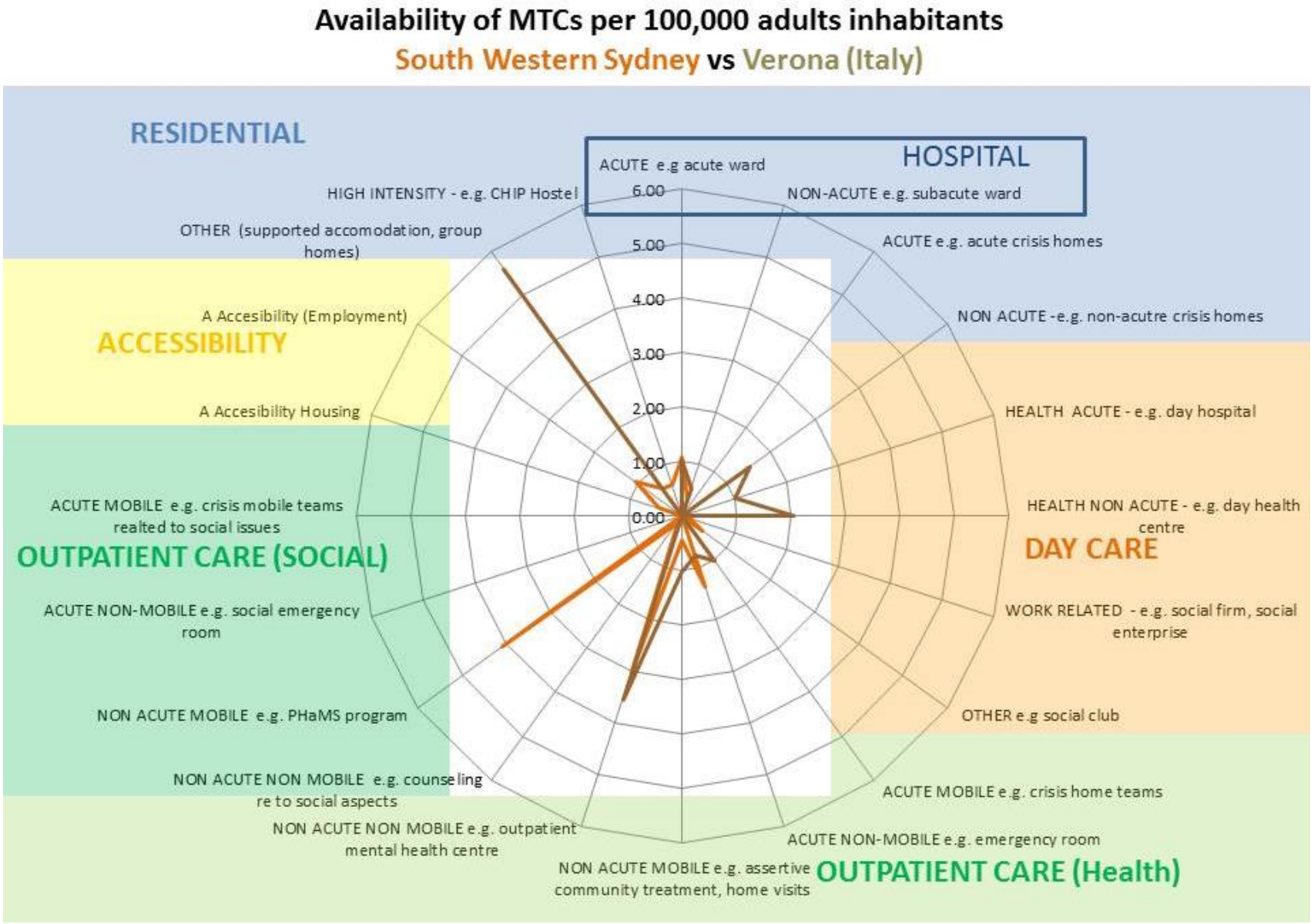
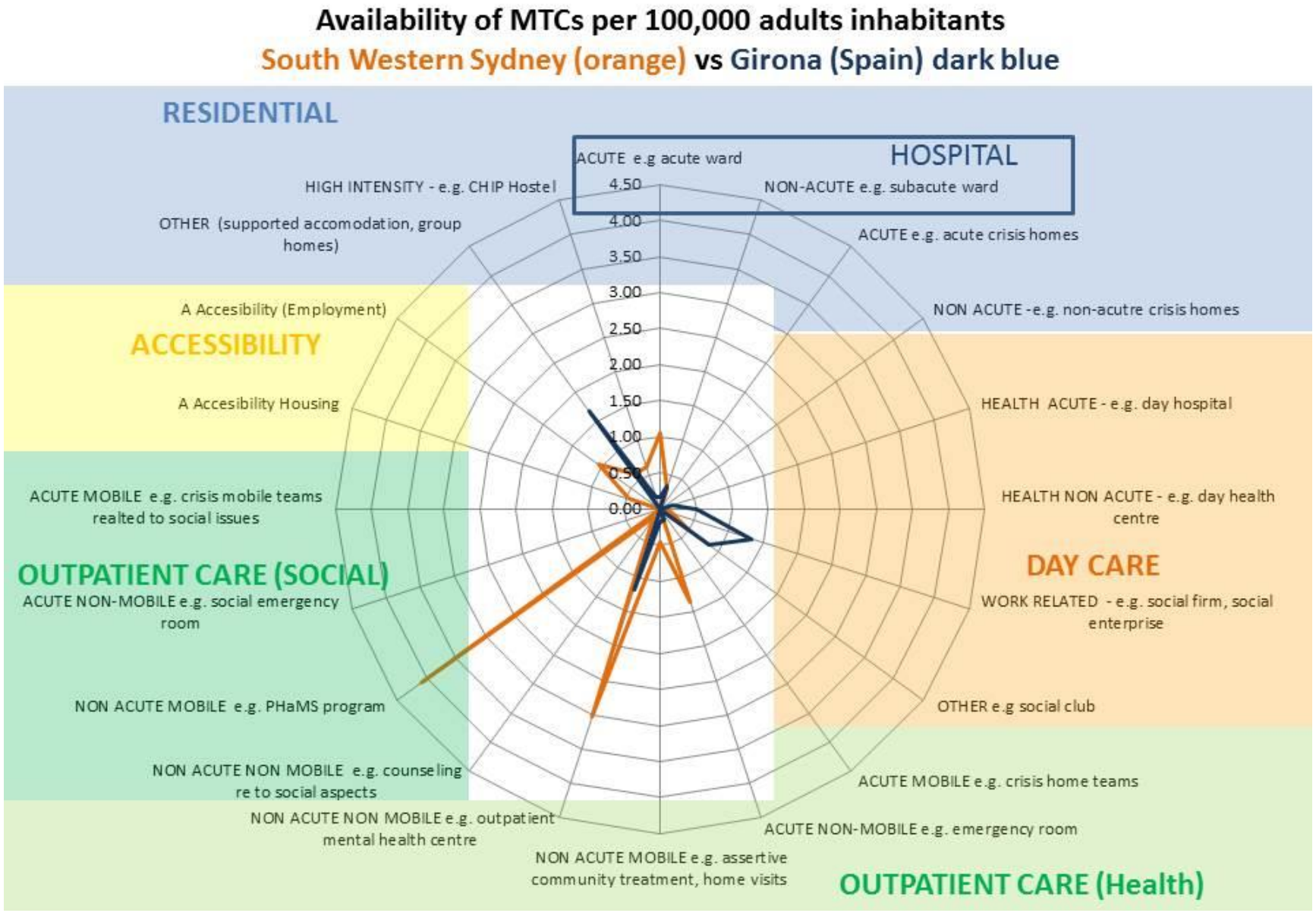


Figure 57. Pattern of Mental Health Care in South Western Sydney (orange) and Girona –Spain (dark blue).



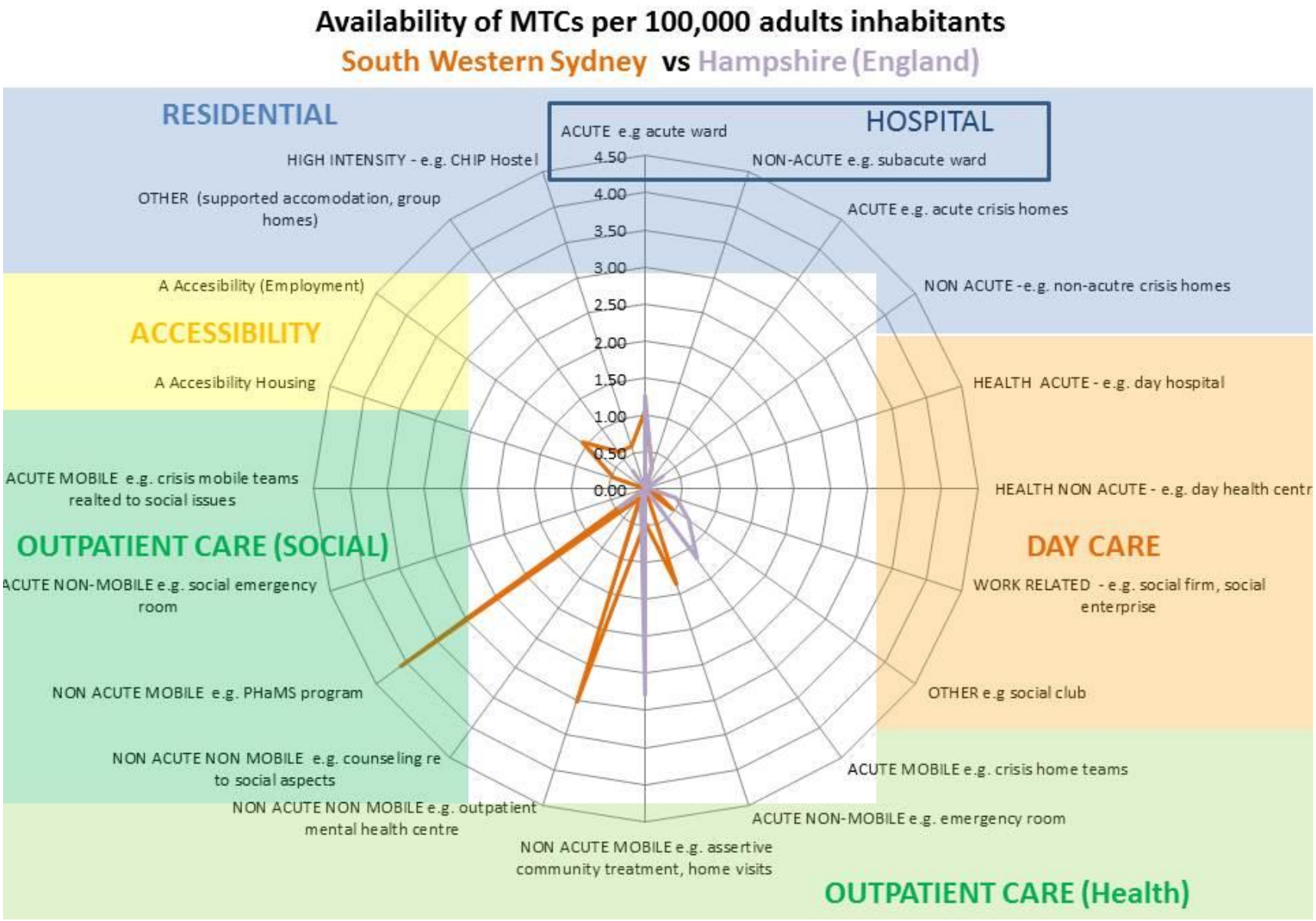
6.3 ENGLISH SYSTEM

Figure 58 compares South Western Sydney with an area in England (Hampshire). England raises funds mainly form general taxes. There is one purchaser organization for most health care services. Since 2013 this function is held by the Clinical Commission Groups (CCGs). Local Health authorities are involved in funding social care services, in addition to local authorities and the state. CCGs tend to contract one local Mental Health Trust, an organization that will be responsible for providing most mental health services for a locality. These Trusts may also subcontract to others.

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

One of the main characteristics of the English model is the high availability of mobile care related to health, and the lack of day care related to health and non-acute care in the hospital, similarly to what we have found in South Western Sydney.

Figure 58. Pattern of Mental Health Care in South Western Sydney (orange line) and Hampshire- England (violet line).



6.4. Placement Capacity- Cross-national comparisons

6.4.1. Residential Care

There are large differences across countries related to the availability of beds per 100,000 residents. These rates mirror the different models of mental health care. South Western Sydney has a higher rate of acute hospital beds than well-known community-based mental health models such as the Italian and the Spanish one, however it has less when compared with the English and the Scandinavian model. The rate of non-acute beds in the hospital is quite similar to the rate found in Hampshire (England) but lower than in the other countries. In the absence of alternatives to hospitalizations in the community, especially step-down facilities and health related day care centres, the low number of non-acute beds may be a problem

Table 44. Cross-national comparisons- Placement capacity- beds per 100,000 residents according to type of residential care

GROUPS	South Western Sydney (Australia)	Sør-Trøndelag (Norway)	Helsinki and Uusimaa (Finland)	Verona (Italy)	Girona (Spain)	Hampshire (England)
RATE OF BEDS PER 100,000 RESIDENTS IN INPATIENT CARE (HOSPITAL)						
R ACUTE HOSPITAL CARE: R1 - R2 - R3.0	18.50	28.43	26.86	13.98	7.01	26.38
R NON_ACUTE HOSPITAL: R4 – R6	5.16	75.08	52.22	11.95	15.35	4.84
RATE OF BEDS PER 100,000 RESIDENTS IN THE COMMUNITY						
R ACUTE NON-HOSPITAL: R0 R3.1.1	0	64.42	0	0	0	0
R NON ACUTE NON-HOSPITAL: R5 - R7	0	0	12.27	16.52	0	2.49
R OTHER R9,R10,R12,R13,R14	1.21	0	58.6	35.84	12.01	7.47
R NON-HOSPITAL HIGH INTENSITY R8 R11	4.40	8.89	113.64	0	9.68	0

6.4.2. Day Care

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

Table 45. Cross-national comparisons- Placement capacity- beds per 100,000 residents according to type of day care

GROUPS	South Western Sydney (Australia)	Sør-Trøndelag (Norway)	Helsinki and Uusimaa (Finland)	Verona (Italy)	Girona (Spain)	Hampshire (England)
D HEALTH ACUTE	0	0	9.62	3.05	4.17	0
D HEALTH NON ACUTE	0	0	17.99	40.67	12.51	0
D WORK RELATED	5	8	18.15	0	32.53	0
D OTHER	No data	0	12.35	0	27.52	0

7. DISCUSSION

The Integrated Mental Health Atlas of South Western Sydney has revealed some important differences between South Western Sydney and other locations. These observations can be used to focus discussion on the planning of an equitable, sustainable and effective mental health system within the boundaries of South Western Sydney LHD. These differences are mainly related to:

1) a lack of acute and sub-acute community residential care;
2) a comparative lack of services providing acute day care and non-acute day care (i.e. day centres providing structured activities to promote health and social inclusion);
3) lower availability of specific employment services for people with a lived experience of mental ill-health;
4) lower availability of supported accommodation initiatives

These results are very similar to the ones found in Western Sydney, suggesting systemic gaps in NSW, and support the main findings pointed out by the NSW Commission Plan *Living Well: a strategic Plan for Mental Health in NSW 2014-2024"* NSW [17] and the *National Review of Mental Health Programmes and Services* by the National Mental Health Commission[3], named the lack of alternatives to hospitalizations.

Misalignments in investment and financing have also been pointed out by the *National Mental Health Review* [3] which indicates that NSW has the lowest residential community care in Australia and the highest expenditure on hospitals (NMHC, 2014, Paper 3).

There is a consensus on the need to base the mental health care of high income countries on a strong primary mental health sub-system together with a core tertiary care for severe acute cases. However there are some relevant information gaps concerning the constitution of secondary care in community-oriented specialised mental health services. According to a number international models[23], including that most recently promoted by Thornicroft and Tansella (2014)[24, 25], specialised mental health services should include the following:

(i) Specialised outpatient/ambulatory clinics;
(ii) Assertive community treatment teams;
(iii) Early intervention teams;
(iv) Alternatives to acute in-patient care, such as high intensity day care, crisis homes; and other alternatives to acute hospitalisation
(v) Alternative types of long-stay community residential care; and
(vi) Specialised forms of work and occupation.

Strong Primary Care System

We have not included information related to the number of general practitioners and nurses practitioners under the Mental Health Incentive Program. Further research should analyse what is the adequacy of mental health treatment provided in primary care to complement these results. However,

we have included information on the Access to Allied Psychological Services (ATAPs) program. ATAPS enables GPs to refers clients with mental health problems to ATAPS mental health professionals[26]. ATAPS mental health professionals include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islanders Health Workers with specific mental health qualifications. Clients are eligible for a maximum of 12 sessions per calendar year. Our results pointed out that there is an inequity in the distribution of these professionals, with a higher rate in the more affluent areas. This mirrors the recent analyses of the Medicare 'Better Access' initiative that found major disparities in the use of mental health services across Australia, with greater use among more advantaged communities[27].

In addition, psychological distress is the most frequently reported unmet need of PIR clients. The relatively low availability of Psychological Services may be related to this fact.

Tertiary Mental Health System

The rate of acute beds in South Western Sydney is slightly lower than the rate in Western Sydney. However, the number of sub-acute beds is lower than in Western Sydney and in the majority of the countries analysed (except England). The scarcity of subacute beds together with the lack of alternatives to hospitalisation is one of the major differences observed in South Western Sydney.

Specialised outpatient/ambulatory clinics

These types of services are coded as outpatient non-mobile care (as less than 50% of the care is provided outside the centre). These services are well developed in SWSLHD. A good example can be the Anxiety Clinic.

Assertive community treatment (ACT)

ACT is coded as mobile non-acute outpatient. We have only found one team that can be related to this model in South Western Sydney. However, the fidelity of this service to the original ACT model was low. There is good quality evidence on the effectiveness of ACT [28], consequently there is a need to promote the development of these services in South Western Sydney. The recent "Transforming Australia's Mental Health System" (TAMHSS)[29] report also highlights the need of these services.

Early Intervention Teams

We found that nearly 5% of the services were devoted to transition to adulthood populations. This is mainly related to the development of the Headspaces centres. However, a review of Headspace pointed out that 53% of their clients have low or medium psychological distress, and that only 47% have higher psychological distress or risk. This data raised concerns on the efficient of the service[30]. On the other hand, he SWS LHD also provides early intervention though a specialized team. Indeed, early interventions teams have been proposed as a core element of the Australian system[29].

Alternatives to acute in-patient care

The two major differences we located in SWS LHD were in residential acute and non-acute care outside the hospital (i.e. in the community), and acute day care.

1. Lack of acute and sub-acute community residential care

Even though the National Mental Health Commission Review has 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, there is still a debate in the Australian literature on the need to invest in community beds at the expense of hospital beds[31] .

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. 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 [24]. 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 [32]. Other initiatives in Australia that fit in this model is the Prevention and Recovery Services Model (PARC) in Victoria[33]. 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 if that they are staffed with highly-skilled mental health professionals.

The development of these types of services in South Western Sydney LHD will fill a gap in the provision of mental health care services

2. Absence of services providing acute day care by high skilled professionals

Acute day care (ADC) is a less restrictive alternative to inpatient admission for people who are acutely and severely mentally ill. Its objective is to deliver personalised, intensive and structured health care interventions in non-residential service locations[1]. 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[34] and by the US Agency for Healthcare Research and Quality (AHRQ)[35]. The Cochrane review concluded that ADC is at least as effective as traditional methods, and they are suitable options in situations where demand for inpatient care is high and facilities exist that can be converted to these uses. However, they are a less attractive option in situations where the demand for inpatient care is low and can be covered by other options [34]. 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[35] 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)[36]. 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 which 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[37]: *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.*

Due to the high demand for beds in South Western Sydney LHD, the lack of alternatives for moderate-severe patients under crisis, acute Day Care Centres could be a beneficial addition to South Western Sydney services.

Lack of comprehensive information about long term accommodation

Supported housing is another key component of a community mental health system. However it has not been possible to obtain comprehensive information on the Public and Community Housing properties assigned to people with a lived experience of mental ill-health. It seems that there is no *a priori* planning based on an analysis of population level needs (e.g. 20% of the properties are dedicated for people experiencing mental health issues). The lack of information on supportive accommodation jeopardises evidence-informed policy and planning. A long waiting list for housing and an increase in the number of people with a lived experience of mental ill-health who become homeless points to a major gap in this type of care provision in NSW.

A previous evaluation of the Housing and Accommodation Support Initiative (HASI)[38], 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.

As in so many areas of mental health, poor reporting of basic statistics makes it difficult to take this question much further. As a proxy of availability, one option might be to count the number of people with mental health problems using properties provided through social housing programs. Unfortunately, this information is not recorded. The only alternative is to know how many clients of social and community housing are also under the HASI program or another program targeting mental ill-health. Although this information is not readily available we have estimated that there are around 32 community housing properties with a HASI clients. We have not been able to ascertain how many properties with HASI clients does SWS have managed by the public housing sector. Consequently, the availability of community based residential services presented in this Atlas should be interpreted with caution and is likely to be underrepresented. In addition, the way this type of care is arranged (i.e. a partnership between the public health sector, which provides the clinical care; the NGOs, which provide the support at home and Housing providers, that own the facilities), complicates the codification of these services, as housing providers are not delivering direct care. Housing providers are better conceptualised as financing mechanisms. This can also create confusion and tension within the partners, and between providers and clients if the aims of the program and the roles of the providers are not clearly specified[38]. Another problem related to the way the HASI initiative is arranged that has emerged though the interviews we have made is the need to share a minimum set of data between the partners. In addition, HASI is only available to Mental Health Consumers involved with Community Mental Health, so many consumers cannot even access this service. The analysis of the unmet need of South Western Sydney PIR clients revealed that accommodation is an unmet need for 35% of them.

Employment-related services

It is also worthwhile highlighting the low diversity of services providing employment which plays a critical role in promoting recovery [39]. We identified some organizations which aim to support people with a lived experience of mental ill-health to work in jobs that pay competitive wages in integrated settings in the community. Unfortunately, these are short-term programs that lack stability and have therefore not been included in our Atlas. There is a need to fund more long-term specific services supporting employment for people with lived experience of mental illness.

RichmondPRA, New Horizons, Catholic Care and Schizophrenia Fellowship support people with mental health problems to find a competitive job in the open market. This is an effective approach to incorporate people with a lived experience of mental illness into the workforce, if a series of conditions are met: 1) supported employment is integrated with the mental health treatment (i.e. supported employment specialists works in collaboration with the clinical mental health team); and 2) Follow up supports are non-time limited

Although we absolutely agree that competitive employment must be the final goal, as with other areas of day care, it is important to have a broad availability of different employment alternatives for people with mental health problems in addition to supported employment. The number of people with a lived experience of mental ill-health in ordinary employment is very low and it may be the case that ordinary employment cannot be provided to all persons with a mental problem. The opportunity costs of promoting ordinary employment for all the population with a severe mental problem may not be feasible and it could be the case that not all of the people would be able to work in the ordinary employment, but they have still the right to work. For instance, employment rank fifth in the list of unmet needs of SWS PIR clients, with 36% of them expressing that employment is an unmet need. Therefore it is important to guarantee that there are other options available for people that may have other abilities and may require more support. Some of these alternative services may be classified as 'social firms' which are market-oriented businesses that employ people with disabilities; or 'social enterprises' which are primarily focused on training and rehabilitation[40]. The availability of these other options may also allow a smoother transition to ordinary employment.

Indeed, the recently published NICE clinical guideline for Psychosis and Schizophrenia in adults recommends to [37]: *"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"*

Further findings

Additional issues that have emerged in this Atlas are related to:

- Disappearance of the day sector as a whole
- Geographic access to mental health services
- Fragility of the mental health system

1. Disappearance of the day care sector

Day care for people with a lived experience of mental ill-health has been considered a key component of psychiatric reform since the early 60s[1, 41]. "Day care" (or 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 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 centres) and recovery oriented programs (i.e. peer support, respite, social clubs, or work-related approaches), just to mention a few. These services should be integrated in a local acute care subsystem that also incorporates mobile care alternatives for crisis intervention at home (crisis resolution teams, medical homes), together with non-mobile emergency services and high-intensity coordination/case-management as in Assertive Community Treatment[1].

In South Western Sydney we identified some public services which provide recovery oriented social day care, but none related to acute or non-acute health-related care which are usually staffed with highly skilled mental health clinicians, such as psychiatrists, clinical psychologists or mental health nurses.

We have already commented on the lack of acute day care services related to health, but, what is the importance of non-acute health day care centres?

Non-acute high-intensity day care ("day centres") is a key component of a community mental health system that is missing in South Western Sydney. Day centres staffed with at least 20% highly skilled mental health professionals, such as psychologists, neuropsychologists or mental health nurses, can provide a more intensive treatment than day centres staffed with non-health professionals and therefore provide a better focus on tertiary prevention and clinical improvement (e.g. by better training in daily living, problem solving, stress management, social skills or cognitive rehabilitation). This type of centre can improve socialisation and assist individuals to learn new skills according to their needs. They also include occupational therapy tailored to the patient's needs. They should be provided in a recovery oriented format that promotes peer-support. Day Care centres allow people with mental health problems to have structured day activities in a highly specialized environment. Educational, Vocational and Health activities are provided in the same place allowing for a more intensive rehabilitation program. These type of centres can provide recovery-oriented practices for community living, one ofe the key components of care, according to the THAMSS report[29].

A lack of these services is particularly relevant in the context of Partners in Recovery in South Western Sydney. An analysis of the needs carried out in 764 of their clients identifies *daytime activities* and *company* (social life) as significant unmet needs, reported by 47% and 45% of the PIR clients. These activities, especially daytime activities and social life, could be provided by these services. While these services may have been missed from analyses conducted at a service and policy level their lack is being strongly felt amongst consumers. This also aligns with the recommendation of developing more recovery-oriented practices for community living.

It is important to note that day hospitals and day care centres were available in South Western Sydney LHD some years ago. The reasons for their disappearance are complex and an analysis of these factors goes beyond the objective of this report. However, policy remedies must be built of an understanding of how this occurred. It could be the case that the absence of high-intensity day care in South Western Sydney is partly a by-product of a shift in the service model from acute to community care and from a provision-guided system to a more choice-oriented system which focuses on personalisation.

Public funding mental health services have moved from services provided in the public sector - including the more institutional modes provided by the LHD - to community-based services provided by the NGO sector. This shift has been a significant aspect of deinstitutionalization, emerging hand in hand with the closure of psychiatric hospitals across the system. Day Hospitals and 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 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 are absolutely necessary, we must not neglect more intensive health related day services. Indeed, day hospitals and day centres for mental health can be found in the private health sector, suggesting that there may be equity problems in the access to this type of care, adding to findings on outpatient care with respect to the operation of the *Better Access Program* in Australia[27]:

> "*people living in more disadvantaged and rural areas receive a service model in response to mental health needs that is characterised by lower volumes of services, provided possibly by less highly trained providers"*

The disappearance of day hospitals and day centres in the public sector could also be attributed to the shift to individualisation of care. Individual care based on individual preferences and choices, tends to prioritise individual face-to-face programs and home-based treatments rather than group 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 [42]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[43] and in England[44]. 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 [1].

We may also keep in mind that models that 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 take 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 [45, 46].

A central lesson of this mapping model is that mental health care needs to be treated as a system. Services providing intensive day care-such as day hospitals or day centres - as well as other components of the system should be included in a system when they are necessary. We need to create a system which fits with community needs, not policy trends or institutional imperatives.

The reduction or disappearance of health staffed day care 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[47-49] , an understanding the impact of this reform in the overall efficiency of the care system is still missing. Therefore it is an urgent need to assess the effects of this silent reform on key performance indicators of the system and on the outcomes. This need is made particularly urgent in the context of National Disability Insurance Scheme (NDIS), which has a strong emphasis on individualisation.

2. Geographic access to mental health services

The analysis of the accessibility to mental health services in regards to demand driven indicators suggested that higher dependency and % ≥64y with greater distance to mental health services, whereas increasing proximity was associated with unemployment, higher percentage of migrants and lone person households. This indicates that public mental health services are located in the areas that are more in social need, but that may be a problem in the southern areas related to the ageing population. More research is needed to understand the implications of these findings.

This is related to the fact that South Western Sydney can be divided in two different areas: the north, mainly urban; and the south, which has rural-related characteristic. Two different plans may be needed to the LHD.

3. Fragility of the system

An additional issue that emerged in this study was related to 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 is an insufficient period to test their benefits. This type of problem is typical of high income countries where decision makers/policy planners (the advocates for a new service) take a 'component view' rather than a public health orientation, which takes a 'system thinking perspective' of the whole pattern of care at the local level and how the different components are related [24]. The problem of the component approach is that it results in a highly inefficient use of scarce resources, as investment is made in new services, whilst the core services are absent or not appropriately resourced. This leads to a "reactive" system, rather than a "proactive" system based on long term planning informed by local evidence. In addition, most of these programs are community based, which means that the community mental health system in South Western Sydney is very "fragile".

All of the problems described in this discussion are related to the concept of the "missing middle" of care, that has been also highlighted in the review made by the National Mental Health Commission[3]. When analysing the information, the type of services provided in South Western Sydney may cover the needs of the two extremes of the lived experience of mental illness: on the one hand, those people with mental health problems who are relatively well, have good support, and only need low-level support, and on the other hand, those who are in a severe crisis situation that require acute care in a hospital setting. In the middle we have a significant proportion of people with a lived experience of chronic and moderate to severe mental illness who need more community-based options. In this sense, a balanced care system requires the active implication of the health sector in the provision of community care, together with the social sector[24].

It is important to note that gaps in the care provision for moderate disorders have been identified as a major problem in other countries with highly advanced community care systems such as Norway[50]. However the gap in other OECD countries is mainly related to the mild-moderate target group treated in primary care and by community nurses and not to clients experiencing moderate-severe mental ill-

health treated in specialised care as identified in this analysis. The care pattern for mild-moderate mental ill-health in primary care in Western Sydney is an area that requires further investigation.

The gap in high intensity day care may hinder tertiary prevention or rehabilitation. As the National Mental Health Commission has also pointed out in its report, it is a system that responds too late[3].

The availability and placement capacity of the care subsystem for specific target population groups deserves further analysis. Unfortunately we cannot provide extensive comparison with other local districts in other OECD countries as the Refinement Study in Europe was limited to mental health services for adult populations. Specific services for child and adolescent populations show an unbalance towards transition services. Although a number of transition services are required at any local level to ensure the transition of clients with complex needs, it seems that many resources are devoted to transition services in South Western Sydney 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 for adults.

In spite of this, the main strength of the Mental Health System of South Western Sydney is the relatively good geolocation of the services. Services are in the areas with higher needs and the overall geographical accessibility is good. Even in WIngecarrebee there is good access to community mental health services. The availability of specific services for carers is strength.

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. Nonetheless, some services that are not specific to mental health, but that are used by people with mental health problems, may be absent. Some services providing care for people with disabilities expressed their interest in the Atlas, but they did not want to be included as their target was not mental health. Second, we have not included private providers. The inclusion of private providers in the mapping of publicly available services may increase noise, hamper the interpretation of the results and misrepresents the universality of access to services. Private services should be included as an additional map in future analysis. Third, we have only mapped services that do not have time-limited funding (or that are confident are going to be refunded). The inclusion of care programs that are time-limited would also have distorted the analysis, and would have decreased the utility of the Atlas for evidence-informed planning. Fourth, the assessment of the services was made through interviews with the managers of the services. Some information may not be accurate and should be objectively confirmed (e.g. the percentage of activities made outside the office in order to be classifies as a mobile service). Fifth, it has to been taken into account that there are some areas with sparse population. The chloropleths maps can be misleading, to overcome this problem we are using the smallest geographical scale data available. Finally, we have only included services within the boundaries of SWS LHD. We acknowledge that some of the residents in this area may use services

from other LHD, such a South Eastern Sydney. A complete Atlas of NSW would eventually solve this problem.

Future Steps

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

(i) **Needs of the primary care physicians related to the provision of mental health:** General practitioners or family physicians are usually the first contact with the health system and they can play a key role in the prevention of mental illness and the treatment of common mental health problems. It is therefore crucial to understand and meet the needs of these professionals.

(ii) **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.

(iii) **Care Packages:** The information presented in this Atlas may be complemented with an analysis on care packages: set of services and interventions that are provided to a consumer at a single time period (complex or collaborative interventions)

(iv) **Pathways to care:** understanding how people with a lived experience of mental ill-health navigate the system is a key area of knowledge needed for creating systems which increase accessibility and efficiency.

(v) **Financing mechanisms and financing flows**: This will allow us to delve into important areas such as the *Better Access Program* and housing.

(vi) **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 what is the view of the different providers on the public mental health system and their role in it.

(vii) **Detailed analysis of rural areas**

Recent analysis of interviews with 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 clients' needs [51]. One of the challenges to their work was the time taken in interpreting and sharing of knowledge about the system in which they work – a system whose boundaries, relationships and key features are difficult to interpret as an outsider.

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

Staff of PIR: The data in this Atlas could facilitate a better understanding of the landscape in which they work and the services that are available to their clients.

Managers and Planners: The information gathered in this Atlas is useful for the development of bottom up system indicators that can be used to monitor the evolution of the system. The production of different Atlases based on the DESDE system every 4 or 5 years can assist in the monitoring of the changes and the evaluation of policies [16]. This can be easily done by introducing the classification system (DESDE) into an on-line program that automatizes the codification of the services. The Department of Social Welfare of Andalusia, in the South of Spain, has incorporated the DESDE into their web page, so services receive the code after answering some questions. It will be also important to evaluate the impact of this Atlas, as a visual tool to increase the capacity and efficacy of managers and planners in evidence-informed decision making and in system thinking.

Consumers: A user-friendly version of the Atlas may facilitate to consumers system navigation, 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.

8. CONCLUSION

Our observations are in line with the recent 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 services providers to provide more comprehensive, integrated and higher-level mental health services.*

This is an unique moment for South Western Sydney to creatively develop new partnerships and services that are community based, promote recovery and empower consumers. We firmly believe that the use of this Atlas may assist in the planning and improvement of the care provided for our fellows with a lived experience of mental illness.

REFERENCES

1. Vazquez-Bourgon J, Salvador-Carulla L and Vazquez-Barquero JL. Community alternatives to acute inpatient care for severe psychiatric patients. *Actas Esp Psiquiatri*. 2012; 40: 323-32.
2. Mendoza J, Bresnan, A., Rosenberg, S., Elson, A., Gilbert, Y., Long, P., Wilson, K., & Hopkins, J. Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future. . *Summary Report*. Caloundra, QLD: ConNectica, 2013.
3. National Mental Health Commission. The National Review of Mental health Programmes and Services. Sydney: NMHC, 2014.
4. Zhang JY, Harvey C and Andrew C. Factors associated with length of stay and the risk of readmission in an acute psychiatric inpatient facility: a retrospective study. *Aust Nz J Psychiat*. 2011; 45: 578-85.
5. Light E, Kerridge I, Ryan C and Robertson M. Community treatment orders in Australia: rates and patterns of use. *Australas Psychiatry*. 2012; 20: 478-82.
6. Australian Institute of Health and Welfare. Mental health services—in brief 2013. Canberra: AIHW, 2013.
7. Astell-Burt T and Feng X. Investigating 'place effects' on mental health: implications for population-based studies in psychiatry. *Epidemiology and psychiatric sciences*. 2015; 24: 27-37.
8. World Health Organization. Scaling up care for mental, neurological, and substance use disorders: Mental Health Gap Action Programme (mhGAP). In: World Health Organization, (ed.). Geneve2008.
9. Oxman AD, Lavis JN, Lewin S and Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP) 1: What is evidence-informed policymaking? *Health research policy and systems / BioMed Central*. 2009; 7 Suppl 1: S1.
10. Health Foundation. *Perspectives on Context. A selection of essays considering the role of context in successful quality improvement.* London: Health Foundation, 2014.
11. Goodwin N. Understanding integrated care: a complex process, a fundamental principle. *Int J Integr Care*. 2013; 13.
12. Savigny DA, T. *Sytems Thinking for Health Systems Strengthening.* Geneve: World Health Organization, 2009.
13. Aslanyan G, Benoit F, Bourgeault IL, et al. The inevitable health system(s) reform: an opportune time to reflect on systems thinking in public health in Canada. *Canadian journal of public health = Revue canadienne de sante publique*. 2010; 101: 499.
14. Bickenbach J, Bigby C, Salvador-Carulla L, et al. The Toronto declaration on bridging knowledge, policy and practice in aging and disability: Toronto, Canada, March 30, 2012. *International journal of integrated care*. 2012; 12: e205.
15. Parrott R, Hopfer S, Ghetian C and Lengerich E. Mapping as a visual health communication tool: promises and dilemmas. *Health communication*. 2007; 22: 13-24.
16. Fernandez A, Salinas-Perez JA, Gutierrez-Colosia MR, et al. Use of an integrated Atlas of Mental Health Care for evidence informed policy in Catalonia (Spain). *Epidemiology and psychiatric sciences*. 2014: 1-13.
17. The Mental Health Commission of New South Wales. “Living Well: strategic Plan for Mental Health in NSW” . The Mental Health Commission of New South Wales 2014.
18. Salvador-Carulla L, Romero, C., Weber, G., Dimitrov,H., Sprah, L., Venner, B., McDaid, D., for the DESDE-LTC group. Classification, assessment and comparison of European LTC services. Development of an integrated system. *Eurohealth*. 2011; 17.
19. Salvador-Carulla L, Alvarez-Galvez J, Romero C, et al. Evaluation of an integrated system for classification, assessment and comparison of services for long-term care in Europe: the eDESDE-LTC study. *Bmc Health Serv Res*. 2013; 13: 218.
20. The Refinement Project: http://www.refinementproject.eu/
21. New South Wales Government. Family and Community Services | Annual Report 2012–13. 2014.
22. Cacace M, Ettelt S, Mays N and Nolte E. Assessing quality in cross-country comparisons of health systems and policies: Towards a set of generic quality criteria. *Health Policy*. 2013; 112: 156-62.
23. Department of Health. National Service Framework for Mental Health. London: Department of Health, 1999.

24. Thornicroft G and Tansella M. The balanced care model for global mental health. *Psychological medicine*. 2013; 43: 849-63.
25. Thornicroft G and Tansella M. Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence. *The British journal of psychiatry : the journal of mental science*. 2004; 185: 283-90.
26. Department of Health. Access to Allied Psychological services (ATAPS). 2015. Accessible in: http://www.health.gov.au/internet/main/publishing.nsf/content/mental-boimhc-ataps
27. Meadows GN, Enticott JC, Inder B, Russell GM and Gurr R. Better access to mental health care and the failure of the Medicare principle of universality. *The Medical journal of Australia*. 2015; 202: 190-4.
28. Marshall M and Lockwood A. Assertive community treatment for people with severe mental disorders. *The Cochrane database of systematic reviews*. 2000: CD001089.
29. Transforming Australia's Mental Health Service System,(TAMHSS) inc., 2015, Essential Components of Care [ECC] Framework to complement the National Guidance for Jurisdictional or Regional Flexible Action Plans, in response to Recommendations of the National Mental Health Strategy Report, Oct 2014.
30. Muir K, Powell A, Patulny R, et al. Headspace Evaluation Report. In: Centre SPR, (ed.). New South Wales: University of New South Wales, 2009.
31. Allison S, Bstaiampillai T and Goldney R. Acute versus sub-acute beds: should Asutralia onvest in community beds at the expense of hospital beds. *Australian & New Zealand Journal of Psychiatry*. 2014; 48.
32. Siskind D, Harris M, Kisely S, et al. A retrospective quasi-experimental study of a community crisis house for patients with severe and persistent mental illness. *Australian & New Zealand Journal of Psychiatry*. 2013; 47: 667-75.
33. Department of Health. Adult Prevention and Recovery Care (PARC) services framework and operational guidelines. Victoria: Department of Health, 2010. Accessible in: http://www.health.vic.gov.au/mentalhealthservices/parc.pdf
34. Marshall M, Crowther R, Sledge WH, Rathbone J and Soares-Weiser K. Day hospital versus admission for acute psychiatric disorders. *The Cochrane database of systematic reviews*. 2011: CD004026.
35. Agency for Healthcare Research and Quality. Management Strategies to reduce Psychiatric Admissions. Draft technical brief. Rockville, MD.: Agency for Healthcare Research and Quality. , 2014.
36. Priebe S, McCabe R, Schutzwohl M, et al. Patient Characteristics Predicting Better Treatment Outcomes in Day Hospitals Compared With Inpatient Wards. *Psychiat Serv*. 2011; 62: 278-84.
37. National Institute for Health and Care Excellence. Psychosis and shizophrenia in adults: prevention and management. In: NICE, (ed.). *NICE Guidlines*. UK: National Institute for Health and Care Excellence, 2014.
38. Bruce J, McDermott S, Ramia I, Bullen J and Fisher KR. Evaluation of the Housing and Accommodation Support Initiatives (HASI) Final Report for NSW Health and Housing NSW. Sydney: Social Policy Research Centre Report, 2012.
39. Walsh FP and Tickle AC. Working Towards Recovery: The Role of Employment in Recovery From Serious Mental Health Problems: A Qualitative Meta-synthesis. *International Journal of Psychosocial Rehabilitation*. 2013; 17: 35-49.
40. Grove B. Mental Health and Employment: Shaping a new agenda. *Journal of Mental Health*. 1999; 8: 131-40.
41. Duncan DF. The Prevention of Primary Prevention, 1960-1994: Notes Toward a Case Study. *J Prim Prev* 1994; 15: 73-9.
42. Wheeler C, Lloyd-Evans B, Churchard A, et al. Implementation of the Crisis Resolution Team model in adult mental health settings: a systematic review. *BMC psychiatry*. 2015; 15: 74.
43. Hasselberg N, Grawe RW, Johnson S and Ruud T. An implementation study of the crisis resolution team model in Norway: Are the crisis resolution teams fulfilling their role? *Bmc Health Serv Res*. 2011; 11.
44. Johnson S. Crisis resolution and Home treatment in England: where are we now? In: Economics IoH, (ed.). *Consensus Statement on Improving Mental health Transitions - November 4-6, 2014*. Edmonton, Alberta2014.
45. Rosen A, Gurr R and Fanning P. The future of community-centred health services in Australia: lessons from the mental health sector. *Australian health review : a publication of the Australian Hospital Association*. 2010; 34: 106-15.

46. Rosen A, Gurr R, Fanning P and Owen A. The future of community-centred health services in Australia: 'When too many beds are not enough'. *Australian health review : a publication of the Australian Hospital Association*. 2012; 36: 239-43.
47. Ferguson I. Personalisation, social justice and social work: a reply to Simon Duffy. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community,*. 2012; 26: 55-73.
48. Duffy S. A Fair Society and the Limits of Personalisation.Disussion Paper. *The Centre for Welfare Reform First Presented at the Tizard Memorial Lecture, 4th March 2011*. 2011.
49. Barnes M. Abandoning Care? A Critical Perspective on Personalisation from an Ethic of Care. *Ethcis and Social Welfare*. 2011; 5: 153-67.
50. OECD. OECD Reviews of Health Care Quality: Norway 2014 Rasing Standards. OECD, 2014.
51. Smith-Merry J, Gillespier J, Hancock N and Yen I. Doing Mental Health Care Integration: A Qualitative Study of a New Work Role. Unpublished Working Paper. 2015.