ANNEX 2: THE INTEGRATED MENTAL HEALTH ATLAS OF THE SOUTH EASTERN SYDNEY LOCAL HEALTH DISTRICT

THE UNIVERSITY OF SYDNEY

Eastern Sydney Partners in Recovery

PiiR

SOUTH EASTERN SYDNEY PARTNERS IN RECOVERY

phn CENTRAL AND EASTERN SYDNEY

An Australian Government Initiative

AUTHORS

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

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

FRENCH NATIONAL INSTITUTE OF HEALTH AND MEDICAL RESEARCH (INSERM), PARIS UNIVERSITY HOSPITALS (AP-HP)
DR. AMÉLIE PRIGENT (RESEARCH ASSISTANT)
MS. CORALIE GANDRÉ (RESEARCH ASSISTANT)

DOI:

ISBN:

ACKNOWLEDGMENTS

We are grateful to all the service providers who participated in this study. We want to thank all the Steering Committee members who have helped us to contact the services and understand the territory: in South Eastern Sydney: Catherine Goodwin, Alex Carson, Peter McGeorge, Victoria Civils-Wood, Terry Cayley, Amanda Kupronow, and Jennifer Montgomery. We would like to acknowledge the international collaboration of the Psicost Scientific Association and Universidad Loyola Andalucia (Spain); and the French National Institute of Health and Medical Research (INSERM), Paris University Hospitals (AP-HP).

SUGGESTED CITATION

Furst, M.C.; Salinas-Perez, J.A.; Hopman. K.; Maas. C.; Fernandez. A.; Xu T.; Alvarez-Galvez, J.; Prigent A.; Gandré C.; Salvador-Carulla, L. (2016). The Integrated Mental Health Atlas of the Central and Eastern Sydney PHN. Annex 2: South Eastern Sydney Local Health District. Mental Health Policy Unit. Brain and Mind Centre. Faculty of Health Sciences. University of Sydney. 30 December 2016.

CONTENTS

INDEX OF FIGURES

INDEX OF TABLES

ABBREVIATIONS

ABS Australian Bureau of Statistics
ADC Acute Day Care
ARIA Accessibility/Remoteness Index of Australia
ATAPS Access to Allied Psychological Services
AW Aboriginal Worker
BSIC Basic Stable Inputs of Care
CALD Culturally and Linguistically Diverse
CBA Community Based Activity Program (Buckingham House)
CCG Clinical Commission Groups
CCM Clinical Case Manager
CESPHN Central and Eastern Sydney PHN
D2DL Day2Day Living
DESDE- LTC Description and Evaluation of Services and Directories in Europe for long-term care
ES Eastern Sydney
FACS Family and Community Services
GIS Geographical Information System
HASI Housing and Accommodation Support Initiative
IWS Inner West Sydney
IRSD Index of Relative Socio-Economic Disadvantage
LGA Local Government Area
LHD Local Health District
LOTE Language Other Than English
LTC Long Term Care
MBE Medicare Benefits Expenditure
mhGAP Mental Health Gap Action Program
MHN Mental Health Nurse
MHNIP Mental Health Nurse Incentive Program
MHSRRA Mental Health Services in Rural and Remote Areas
MTC Main Type of Care
NGO Non-Governmental Organisation
NDIS National Disability Insurance Scheme
NHSD National Health Services Directory
NICE National Institute for Health and Care Excellence
NSW New South Wales
OT Occupational Therapist
PARC Prevention and Recovery Care
PC Primary Care
PHN Primary health network
PIR Partners in recovery
PW Peer Worker

SA1 Statistical area 1
SCHN Sydney Children's Hospital Network
SES South Eastern Sydney
SESLHD South Eastern Sydney LHD
SF Support Facilitator
SLA Statistical Local Area
SLHD Sydney Local Health District
SMHSOP Specialist Mental Health Services for Older People
SVHN St Vincent's Hospital Network
SWS South Western Sydney
SW Social Worker
TAMHSS Transforming Australia's Mental Health Service Systems
WHA World Health Assembly
WHO World Health Organisation
WS Western Sydney

A note on the language

The language used in some of the service categories mapped in this report e.g. outpatient-clinical, outpatient-social may seem hospital-centric and even archaic for advanced community-based mental health services which are recovery-oriented and highly devolved. However, these categories are employed for comparability with standardized categories which have been used for some years in European mental health service mapping studies and the resulting Atlas [this standard classification system is the "Description and Evaluation of Services and Directories in Europe for long-term care" model (DESDE-LTC)]. We have made once exception to the DESDE terminology and have substituted the term Day Program for Day Hospital as this is more reflective of the terminology adopted by services in Australia.

EXECUTIVE SUMMARY

The 2014 *National Review of Mental Health Programmes and Services* by the National Mental Health Commission drew attention to the need for local planning of care for people with a lived experience of mental illness in Australia, and the relevance of a bottom-up approach to understanding "services available locally [in] the development of national policy". It also called for responsiveness to the diverse local needs of different communities across Australia (1).

The findings from the National Review were in line with the recommendations presented by the New South Wales (NSW) Mental Health Commission in the report *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024. Living Well* (2) identified that Local Health Districts (LHD) and primary care organisations such as Medicare Locals and their replacement Primary Health Networks (PHN) should implement strategies to ensure that scarce clinical skills are employed to the best effect, and the need to harness new technology to support clinicians and service providers with new tools to improve care, data collection and information sharing.

The Integrated Mental Health Atlas of South Eastern Sydney Local Health District (SESLHD) aligns with these recommendations. The Atlas is the region's first inventory of available services specifically targeted for people with a lived experience of mental illness, from which it will be possible to derive benchmarks and comparisons with other regions of NSW. This will inform services planning and the allocation of resources where they are most needed.
It is a tool for evidence-informed planning that critically analyses the pattern of mental health care provided within the boundaries of the SESLHD. We used a standard classification system, the "*Description and Evaluation of Services and Directories in Europe for long-term care"* model (DESDE-LTC), to describe and classify the services; as well as geographical information systems to geo-locate the services.

Utilisation of the DESDE-LTC tool, a system widely used in Europe, has enabled a more robust understanding of what services actually provide and will enable planners to make comparisons across areas and regions, once this methodology is more widely available.
The Atlas revealed major differences in the provision of mental health care in the SESLHD, when compared to other regions and countries. These are a lack of:

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

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

1. FRAMEWORK

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

Despite a lack of data available to precisely describe quality and access to care in South Eastern Sydney (SES), there are indications that the situation in this area is no better than in the rest of Australia. The mental health inpatient readmission rate within 28 days widely varied among hospitals. At Prince of Wales Hospital (located in the northern part of the district), this rate increased from almost 9% to 14% between 2005 and 2010, whereas at Sutherland Hospital (located in the southern part of the district) (2) it decreased from almost 10% to 5% over the same period of time. There was also considerable variability in the percentage of mental health patients followed up after inpatient discharge; follow up post-discharge being considered as essential to ensure continuity of care, and to reduce inpatient readmissions. The percentage of patients contacted by a Community Mental Health Service team within 7 days was 75% at St George and Sutherland Hospitals, but only 50% at the Prince of Wales Hospital. The wide heterogeneity of the area covered by the SESLHD, which encompasses both highly urbanised areas and rural territories (e.g., Lord Howe and Norfolk Islands), may accentuate the variability in quality and access to care.

At the local level, several initiatives have been undertaken within the South Eastern Sydney Local Health District (SESLHD) to promote integrated care. In particular, the CESPHN, one of the 31 Primary Health Networks (PHN) developed in Australia, has been established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes. It also aims to improve coordination of care to ensure patients receive the right care, in the right place, at the right time. The CESPHN is involved in a range of programs aimed at delivering integrated care including Aboriginal health, aged care, mental health, population health, child and maternal health, alcohol and other drugs and digital health in partnership both with those LHDs and hospital networks (3).

The areas covered by the SESLHD are mainly urban, and characterised by a high accessibility of services according to the Accessibility/Remoteness Index of Australia (ARIA) (4). The ARIA is a continuous index developed by the Australian Bureau of Statistics (ABS) to assess remoteness of Australian areas based on road distances between localities and services, such as education and health. It allows for classification of areas within five groups from "Major cities of Australia" (high

accessibility) to "Very remote Australia" (high remoteness) (5,6). The provision of mental health care in urban areas represents specific challenges that require tailored planning as mental illnesses are particularly prevalent in urban Australia (7-9).

The majority of the SESLHD is considered as "Major cities of Australia", except for the areas corresponding to the Royal National Park which are considered as "Inner Regional Australia" (quite high accessibility), and for Lord Howe Island and Norfolk Island, which are classified as "Very remote Australia" (4). Lord Howe Island is located 700 km from the mainland, and is populated by a small and isolated community.
The provision of mental health care in remote areas poses challenges for Primary Health Networks, particularly in ensuring availability and accessibility of services. Remote populations are also less likely to seek professional help (10), and more likely to suffer from stigma than urban populations.The "Mental Health Services in Rural and Remote Areas" (MHSRRA) program funded by the Department of Health, provides funding to Non-Governmental Organisations (NGOs) such as Primary Health Networks (PHN) and the Royal Flying Doctor Service to deliver mental health services in rural and remote communities.

In this context, it is crucial to provide policy and service decision makers with every tool and opportunity to make better, more informed choices about future investments in urban mental health care, including which services are needed, and where and how they can be most effectively delivered. In other words, they need a map that will guide them through the mental health reform journey in urban areas. A key component for achieving this objective is identifying the services that currently exist, and noting how these services link within and across areas. The organisational analysis of the SESLHD is a first look at the operations of the local health district, and will support the development of integrated planning and service delivery at the regional level.

This Atlas of the SESLHD is an ideal tool to support this process.

1.1. WHAT ARE INTEGRATED MENTAL HEALTH ATLASES?

Integrated Mental Health Atlases identify the number of mental health services in a designated area, and describe what these services are doing, and where they are located. They also include detailed information on socio-economic and demographic characteristics of an area's population as well as identification of health-related needs, and data on service availability and care capacity. Integrated Atlases of Mental Health allow comparison between small health areas, highlighting variations of care, and detecting gaps in the system. The holistic service maps produced through an Integrated Atlas of Mental Health allow policy planners and decision makers to build bridges between the different sectors and to better allocate services.

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

A detailed description of the Integrated Mental Health Atlas development process can be found in the CESPHN Framework document. A brief description is provided below to assist readers who are selecting to read the SESLHD Annex as a stand-alone document.

This Integrated Mental Health Atlas was developed using the "Description and Evaluation of Services and Directories in Europe for long-term care" (DESDE-LTC) (11). This is an open-access, validated, international instrument for the standardised description and classification of services for Long Term Care (LTC). It includes a taxonomy tree and coding system that allows the classification of services in a defined catchment area according to the main care structure/activity offered, as well as the level of availability and utilisation. It is based on the activities, not the name of the service provider. The classification of services based on the actual activity of the service therefore reflects the real provision of care in a defined catchment area. The DESDE-LTC is focused on the evaluation of the minimal service organisation units or Basic Stable Inputs of Care (BSIC).

It is important to note that child and adolescent services were included in SESLHD and not in SLHD. Therefore the comparisons of the two LHDs are limited to services for the adult population.

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

A Basic Stable Input of Care (BSIC) can be defined as a team of professionals working together to provide care for a defined group of people. They have time stability (typically they have been funded for more than three years) and structural stability. Structural stability means that they have administrative support, their own space, their own finances (for instance a specific cost centre) and their own forms of documentation (i.e. they produce their own report by the end of the year) (See Box 1).

Box 1. Basic Stable Input of Care: criteria

Criterion A: Has its own professional staff
Criterion B: All activities are used by the same clients/consumers
Criterion C: Time continuity (more than three years)
Criterion D: Organisational stability
Criterion D.1: The service is registered as an independent legal organisation (with its own company tax code or an official register). This register is separate and the organisation does not exist as part of a meso-organisation (for example a service of rehabilitation within a general hospital) → **IF NOT:**
Criterion D.2.: The service has its own administrative unit and/or secretary's office and fulfils two additional descriptors (see below) → **IF NOT:**
Criterion D.3.: The service does not have its own administrative unit but it fulfils **three** additional descriptors:
D3.1. To have its own premises and not as part of other facility (e.g. a hospital)
D3.2. Separate financing and specific accountability (e.g. the unit has its own cost centre)
G3.3. Separated documentation when in a meso-organisation (e.g. specific end of the year reports).

We identified the BSIC in the SESLHD 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). The taxonomy presented in *The Integrated Mental Health Atlas of the Central and Eastern Sydney PHN* (see fig.2, p.21, main report) depicts the different types of care used in our system.

There are six main types of care (1):

- **Residential care:** The codes related to residential care are used to classify facilities which provide beds overnight for clients for a purpose related to the clinical and social management of their health condition. It is important to note that consumers do not make use of such services simply because they are homeless or unable to reach home. Residential care can be divided into acute and non-acute branches, and each one of these in subsequent branches (see fig.3, p.22.main report)
- **Day care:** The day care branch is used to classify facilities which (i) are normally available to several consumers at a time (rather than delivering services to individuals one at a time); (ii) provide some combinations of treatment for problems related to long-term care needs (e.g. providing structured activities or social contact/and or support); (iii) have regular opening hours during which they are normally available; and (iv) expect consumers to stay at the facility beyond the periods during which they have face to face contact with staff. Please note that the term "day care" is not often used in the Australian context and these types of services are more commonly referred to as day programs (see fig. 4, p.23, main report).
- **Outpatient care:** The outpatient care branch is used to code facilities which (i) involve contact between staff and consumers for some purpose related to the management of their condition and associated clinical and social needs and (ii) are not provided as a part of delivery of residential or day services, as defined above (see fig.5, p.24, main report).
- **Accessibility to care:** The accessibility branch classifies facilities whose main aim is to facilitate accessibility to care for consumers with long term care needs. These services, however, do not provide any therapeutic care (see fig. 6, p.25, main report).
- **Information for care:** These codes are used for facilities that provide consumers with information and/or assessment of their needs. Services providing information are not involved in subsequent monitoring/follow up or direct provision of care (see fig.7, p.25, main report).
- **Self-help and voluntary Care:** These codes are used for facilities which aim to provide consumers with support, self-help or contact, with un-paid staff that offer any type of care as described above (i.e. residential, day, outpatient, accessibility or information)(see fig. 8, p.26, main report).

A detailed description of each one of the branches is available here:

http://www.edesdeproject.eu/images/documents/eDESDE-LTC_Book.pdf

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

2. MAPPING THE AREA: SOCIO AND ECONOMIC INDICATORS

2.1 THE BOUNDARIES AND JURISDICTION

CESPHN boundaries

The CESPHN was established in 2015 to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes. More than 1.4 million individuals reside in the CESPHN (12). The region covered by CESPHN includes three former Medicare Locals (ES, IWS and SES). As previously described, it also incorporates 16 LGAs and is bounded by two LHDs; SLHD and SESLHD. The SVHN and Sydney Children's Hospital Networks (SCHN) (3) are also nested within the boundaries of CESPHN.

A note on boundaries in the SESLHD

The Statistical Local Area (SLA) is the most appropriate unit of analysis when considering the subcomponents of the CESPHN. In the most recent realignment of the district boundaries in 2011, the boundaries between the two LHDs were defined using SLA, instead of LGA, with approximately half of the City of Sydney LGA being part of the SLHD, and the other half part of the SESLHD (13-15).

In the SESLHD, all the LGA boundaries correspond to SLA boundaries for all SLAs, except for Sydney Inner and Sydney East, which are both part of the Sydney LGA, as well as for Sutherland Shire East and West, which are both part of the Sutherland Shire LGA. We used LGAs in the overall analysis of social and demographic indicators in the CESPHN. However we preferred to use SLAs for the specific analysis of the two local health districts (SLHD and SESLHD) due to the division of the Sydney LGA in two parts managed each of one managed by a different LHD. Furthermore, the SESLHD also includes Lord Howe Island which is bounded at the SLA level, however is only considered part of "Unincorporated NSW" when using the LGA geographical unit. Therefore, overall, the SESLHD includes the SLAs of Botany Bay, Hurstville, Kogarah, Randwick, Rockdale, Sutherland Shire, Sydney Inner and East, Waverley, Woollahra and Lord Howe Island. Additionally, in 2015 the SESLHD formalised a Service Level Agreement with Norfolk Island to provide health services (including mental health services) to this geographical region.

The territorial analysis of SESLHD has additional problems due to the existence of a nested subsystem of specialised mental health care in this area: the St. Vincent´s Health Network. A specific analysis of this nested subsystem is available at Annex 3 in this report.

2.2 SOCIOECONOMIC INDICATORS

The SESLHD provides services to a population of over 840,000 people, with 27% of these people born overseas in a non-English speaking country and 32% of the population speaking a language other than English (LOTE) at home. Table 1 summarises the main socio and economic indicators in the SES SLAs. The SESLHD includes highly urbanised areas of Eastern Sydney, Southern Sydney and industrialised areas around Port Botany (16).

The figures below show visualisation of some selected indicators using choropleth maps. Overall, these SLAs are characterised by high population densities, high rates of people born in non-English speaking countries, high percentages of people with low English proficiency, and low percentages of Aboriginal and Torres Strait Islander people, by comparison to NSW, and Australia as a whole. This region is also globally less disadvantaged than NSW and Australia as a whole. Indeed, none of the SLAs is located in the lower IRSD deciles, calculated based on the entire Australian population, and the SESLHD areas present lower unemployment rates, lower percentages of people with less than $600 per week, and higher percentages of people with year 12 of high school completed than NSW and Australia as a whole.

Sydney East has the highest population density of the CESPHN. Sydney Inner and Sydney East have the relatively low dependency indexes due to the lower number of children and adolescents in these SLAs, while the rate of ageing population is high in these areas. Sydney East presents the highest ageing index (169.5 versus 80.9 on average in the SESLHD).

These LGAs show low percentages of persons who declared needs for assistance, low percentages of lone parents, high percentages of persons living alone and people who are not married or in a de facto relationship. A high rate of people born in non-English speaking countries, a high unemployment rate, high percentages of people with low English proficiency and of persons with less than $600 per week live in Sydney Inner, which is part of the most disadvantaged (indicated by the IRSD decile) areas of the district. On the contrary, people earning less than $600 per week are underrepresented in Sydney East (29.5% versus 44.4% on average), which is part of the least disadvantaged areas of the district.

Apart from Lord Howe Island (22 persons per km^2), Sutherland Shire East and West are the least populated area (685 and 590 persons per km^2 respectively). It is important to take into account that this is where the Royal National Park is located. These areas are those which present the lowest percentages of born abroad as well as the lowest unemployment rates, but also the lowest rates of people with year 12 of high school completed, and the highest dependency ratios of the district. In addition, they are characterised by an underrepresentation of persons who expressed needs for

assistance, and of persons not married, or in a de facto relationship, compared to the overall SES population.

The middle section of the SESLHD is made up of the SLAs of Hurstville, Rockdale, Kogarah and Botany Bay. These areas are characterised by relatively high dependency indexes, high unemployment rates, high percentages of dwellings with no home internet connection, high percentages of people born in non-English speaking countries, high percentage of people who have a low English proficiency, high percentages of people earning less than $600 per week, as well as low percentages of people with year 12 of high school completed. This section of the LHD may be considered as relatively disadvantaged by comparison with the top section of the district, which is made up of the less disadvantaged SLAs (Woollahra, Waverley and Randwick) and presents higher rates of people with year 12 of high school completed (17).

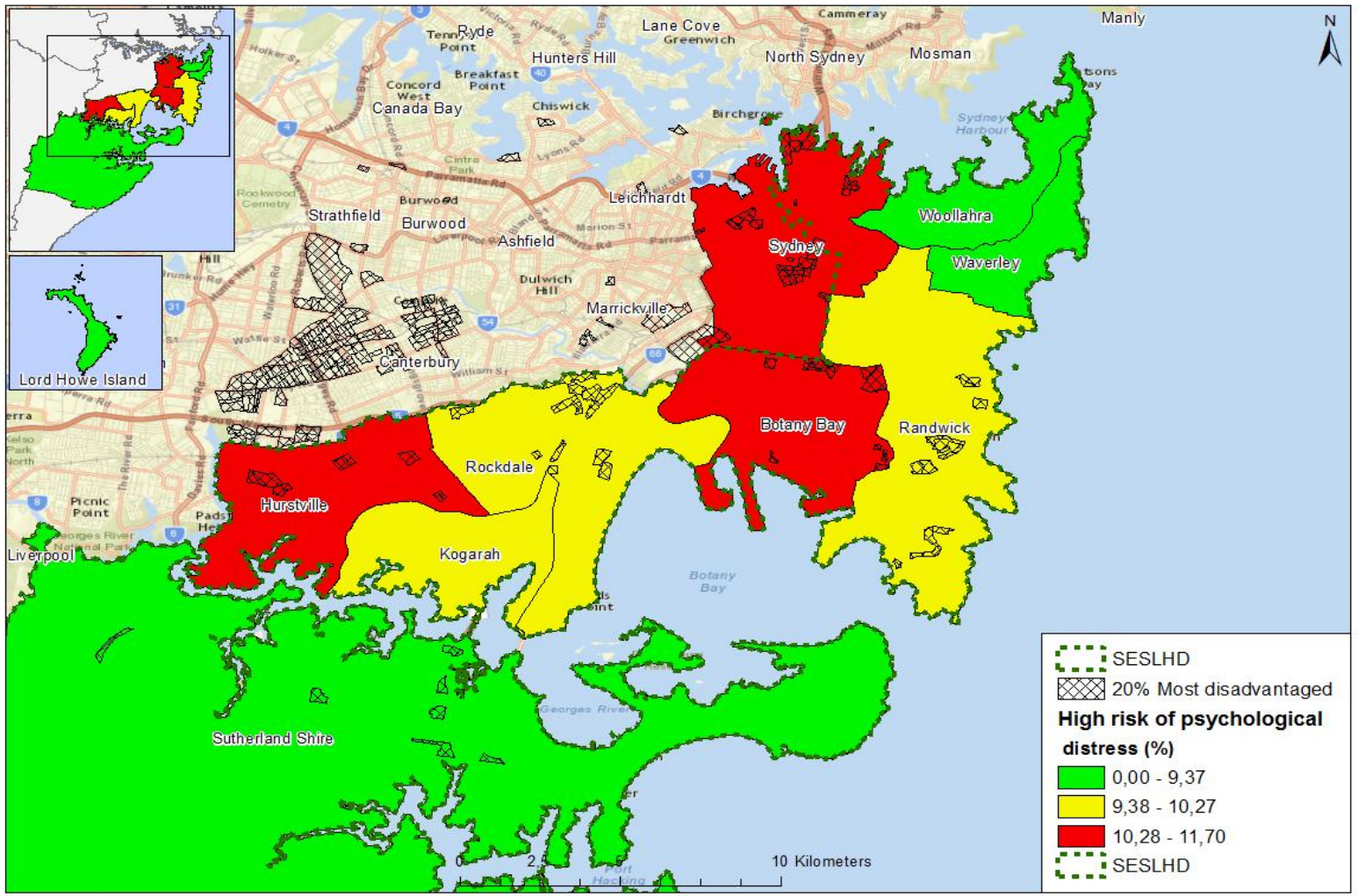


Figure 1 High risk of psychological distress

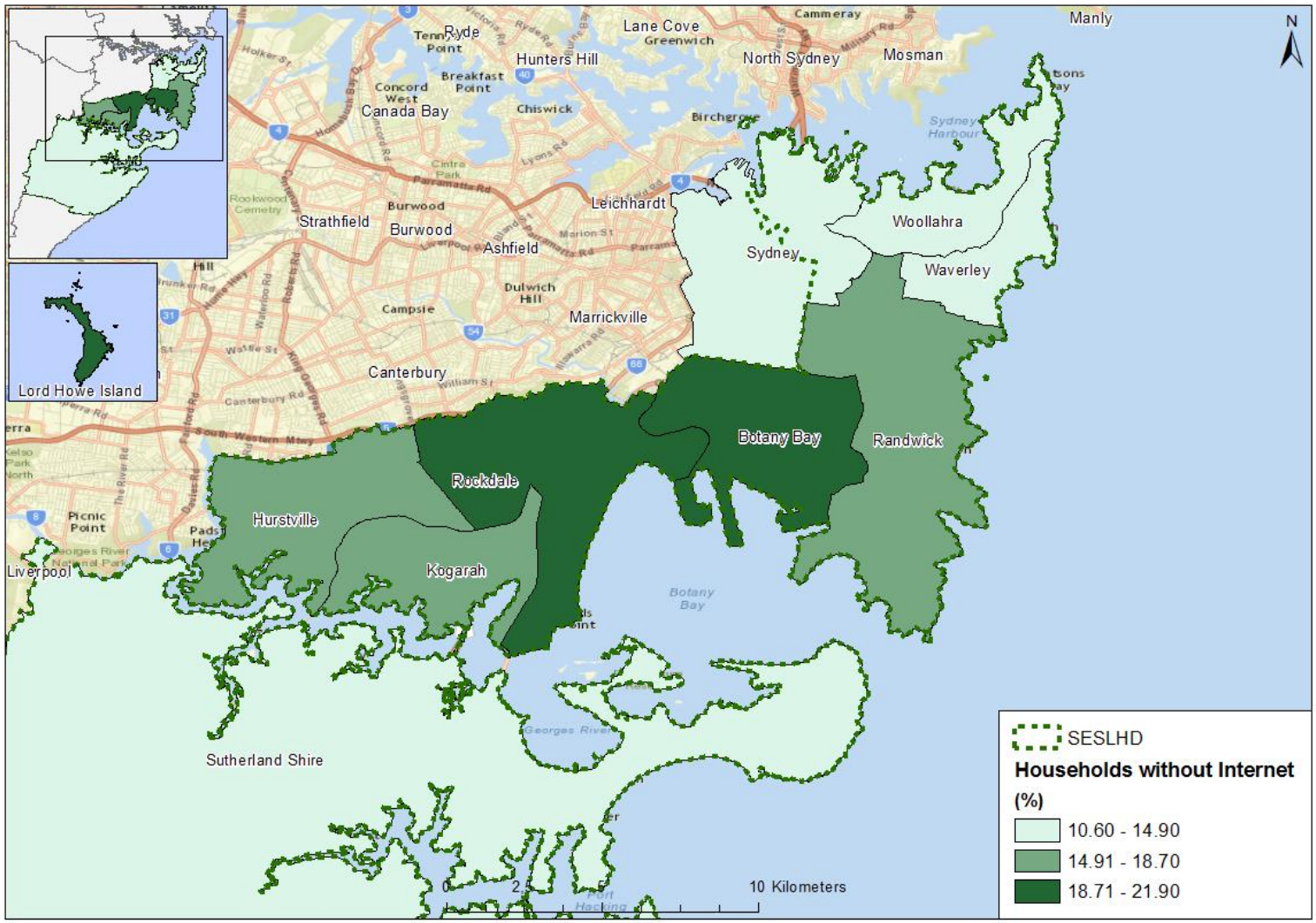


Figure 2 Households without internet

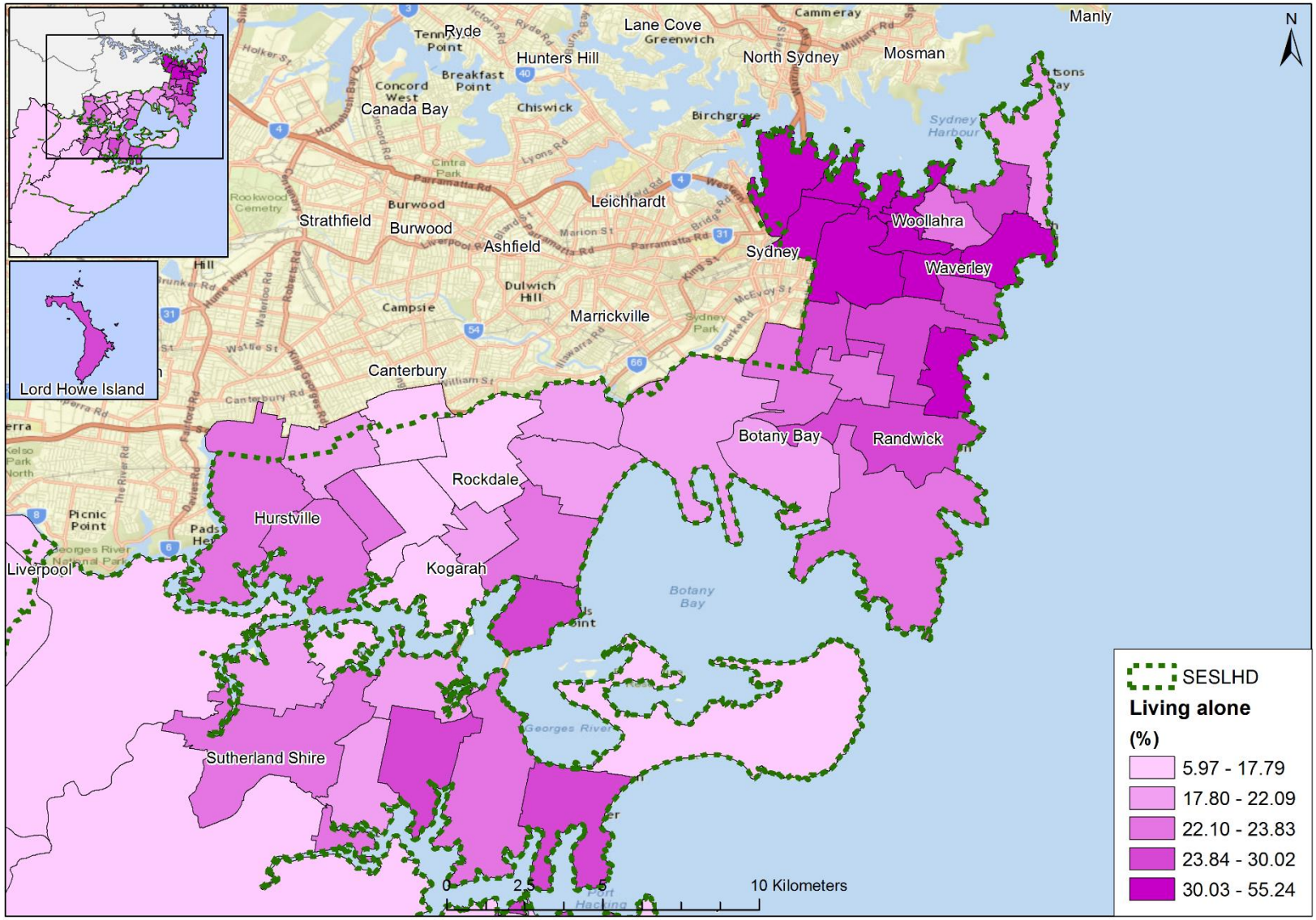


Figure 3 Distribution of people living alone

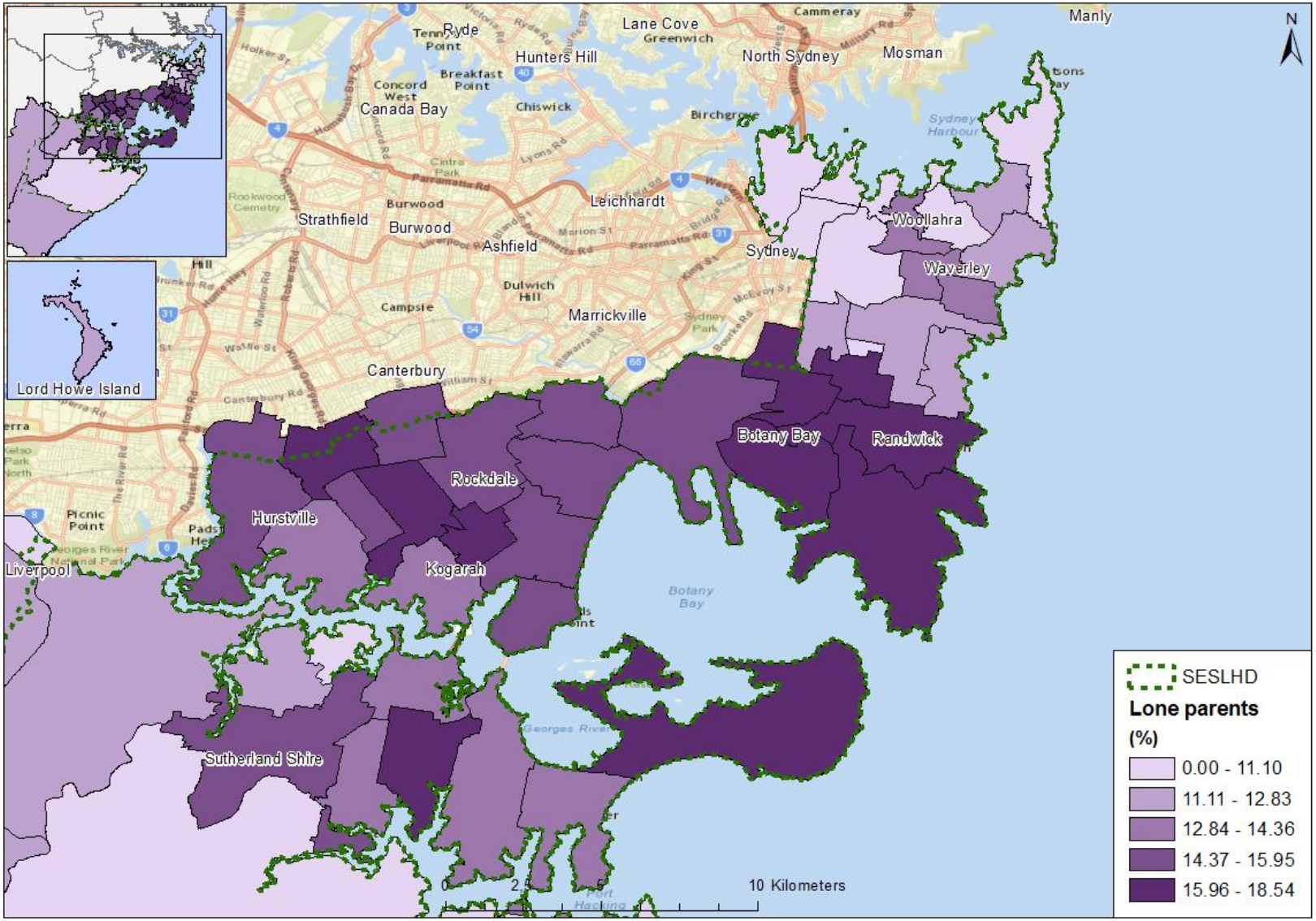


Figure 4 Lone parents

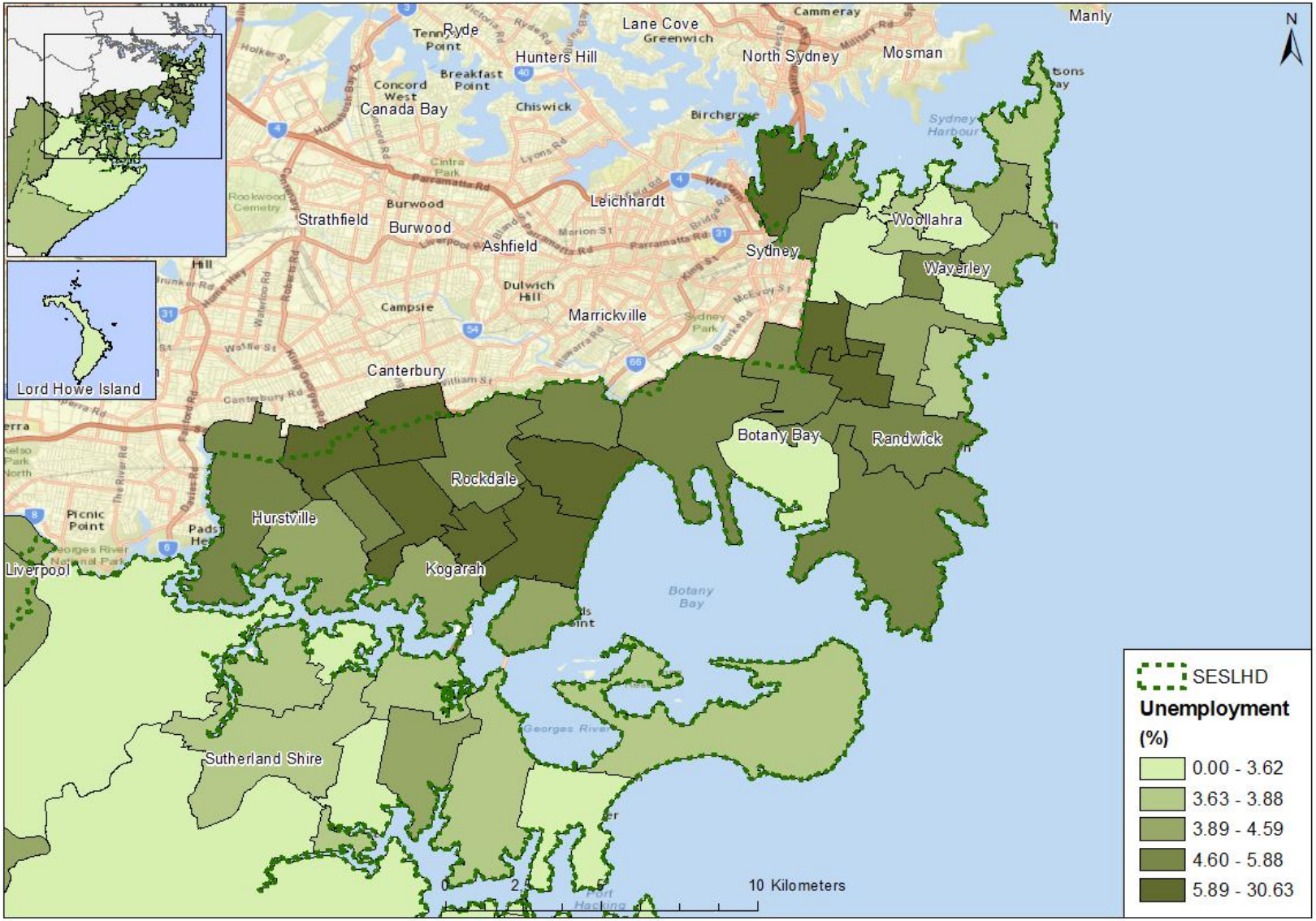


Figure 5 Distribution of unemployment

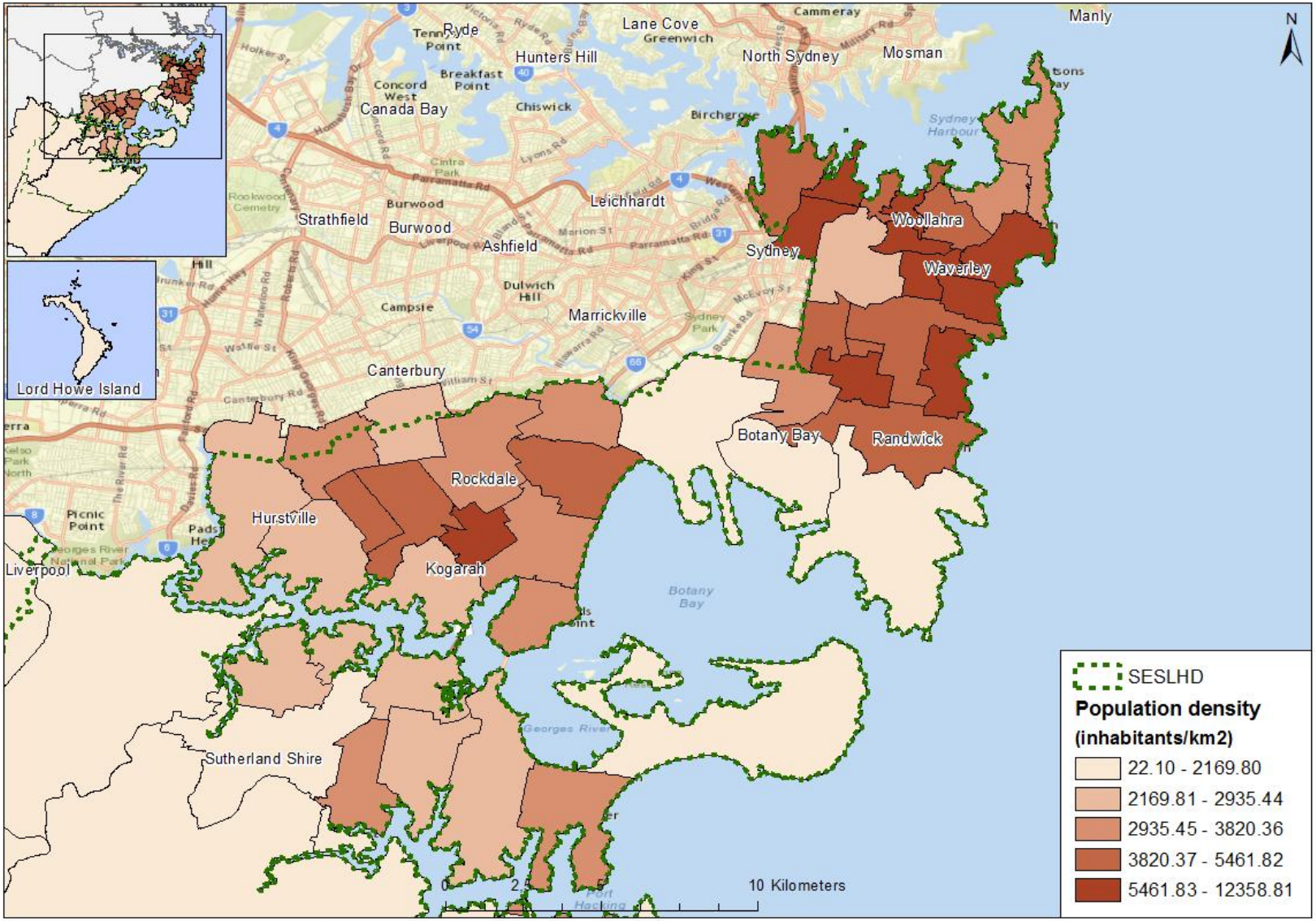


Figure 6 Population density

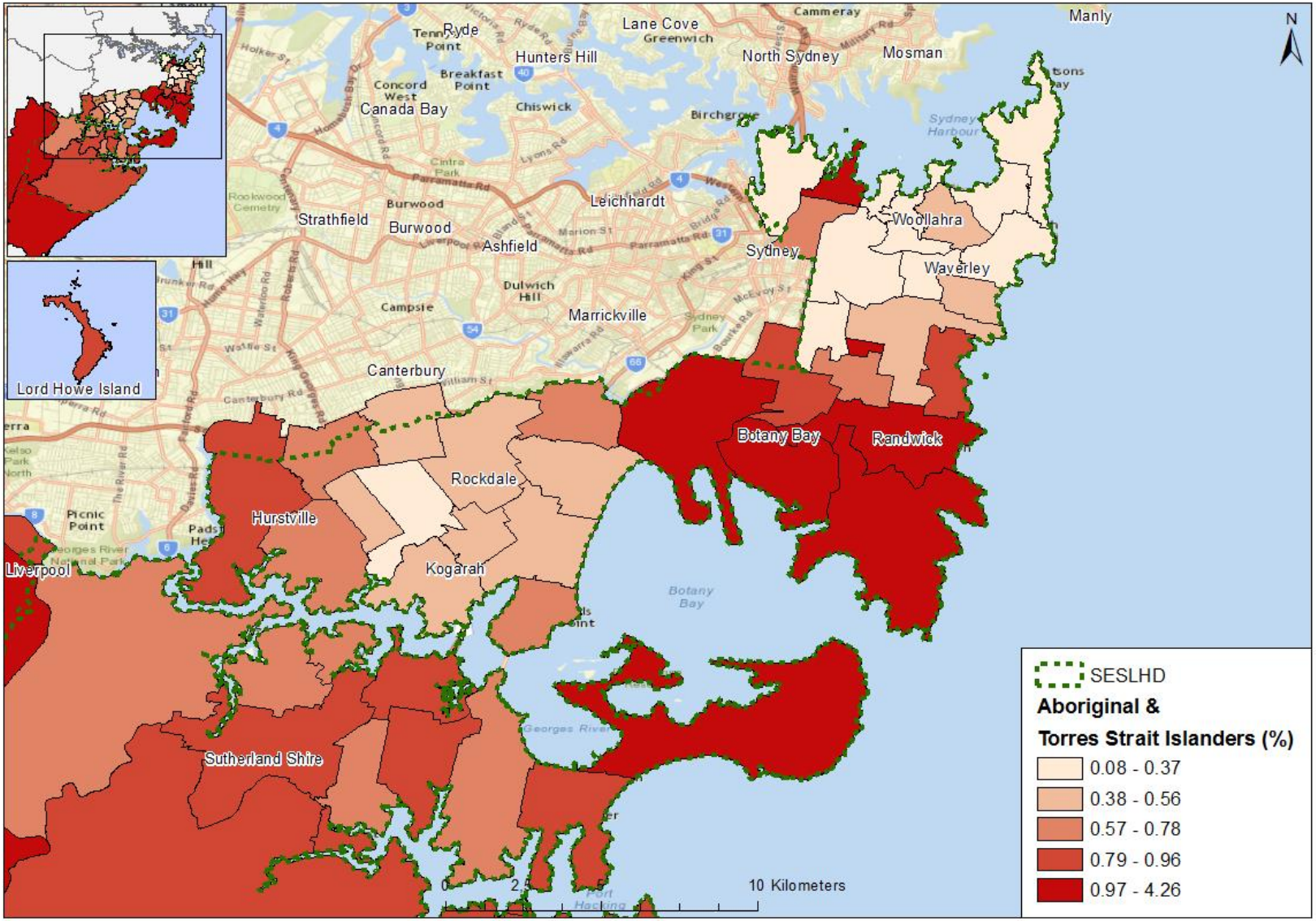


Figure 7 Distribution of aboriginal and Torres Strait islanders

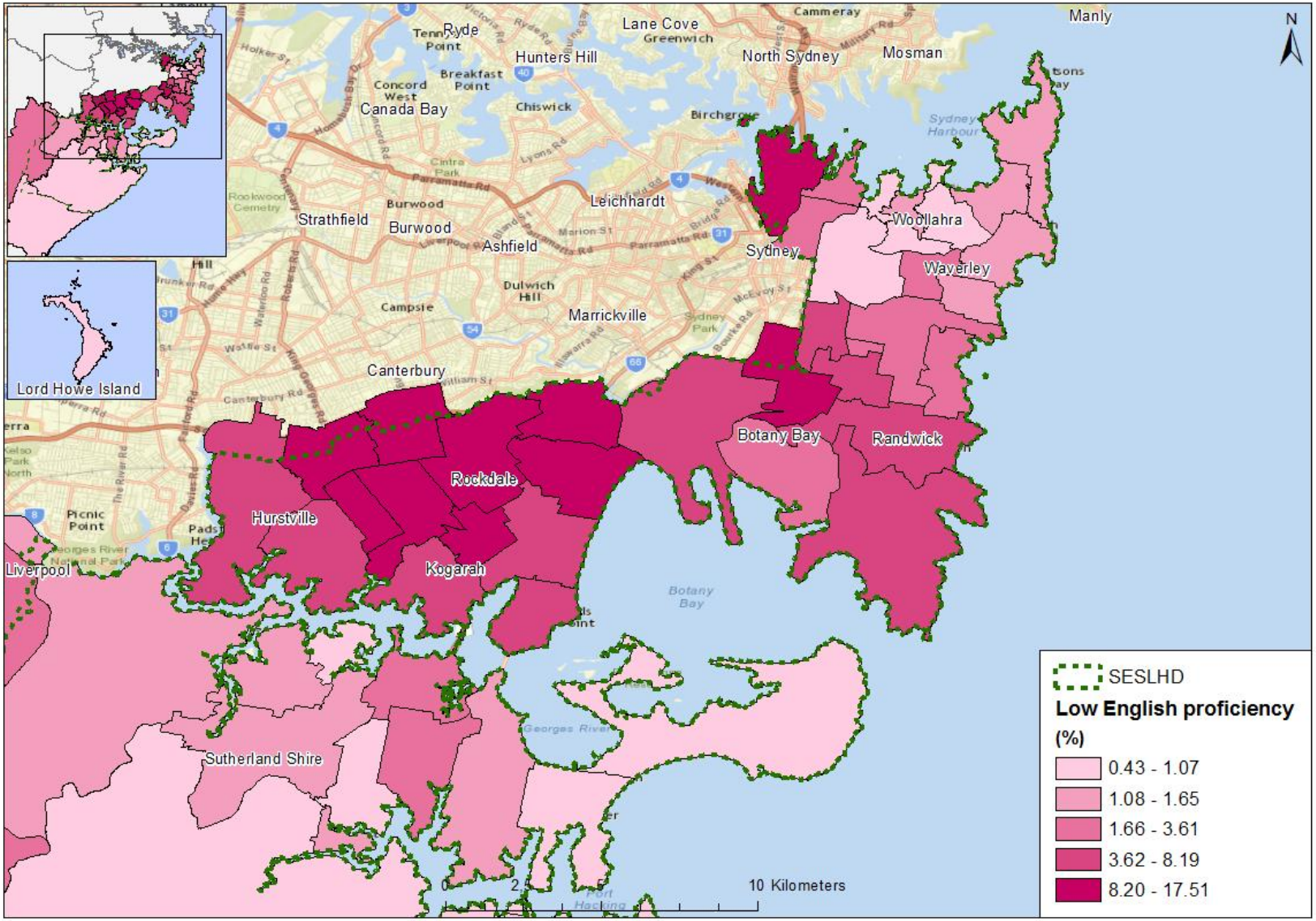


Figure 8 Distribution of low English proficiency

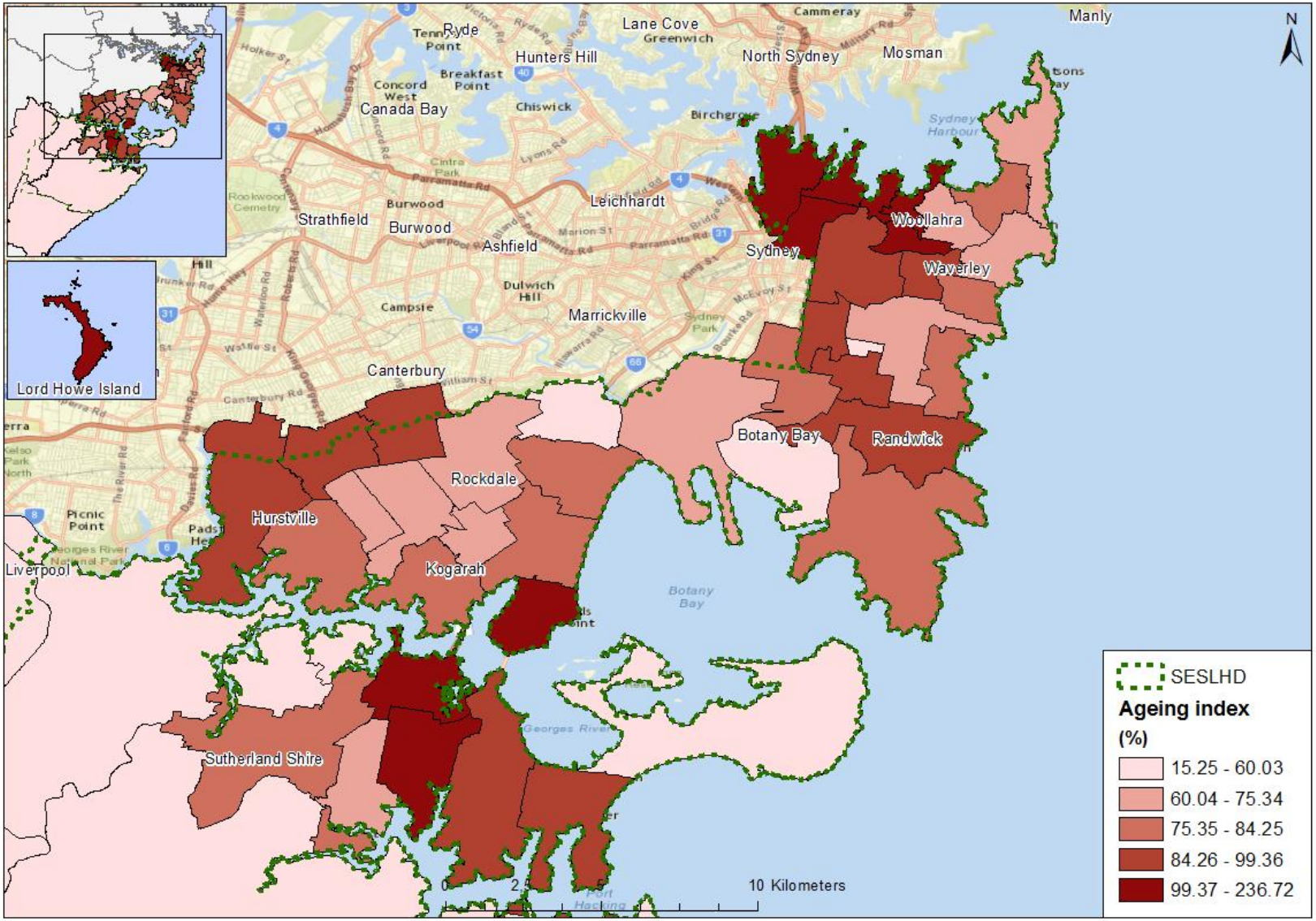


Figure 9 Ageing index

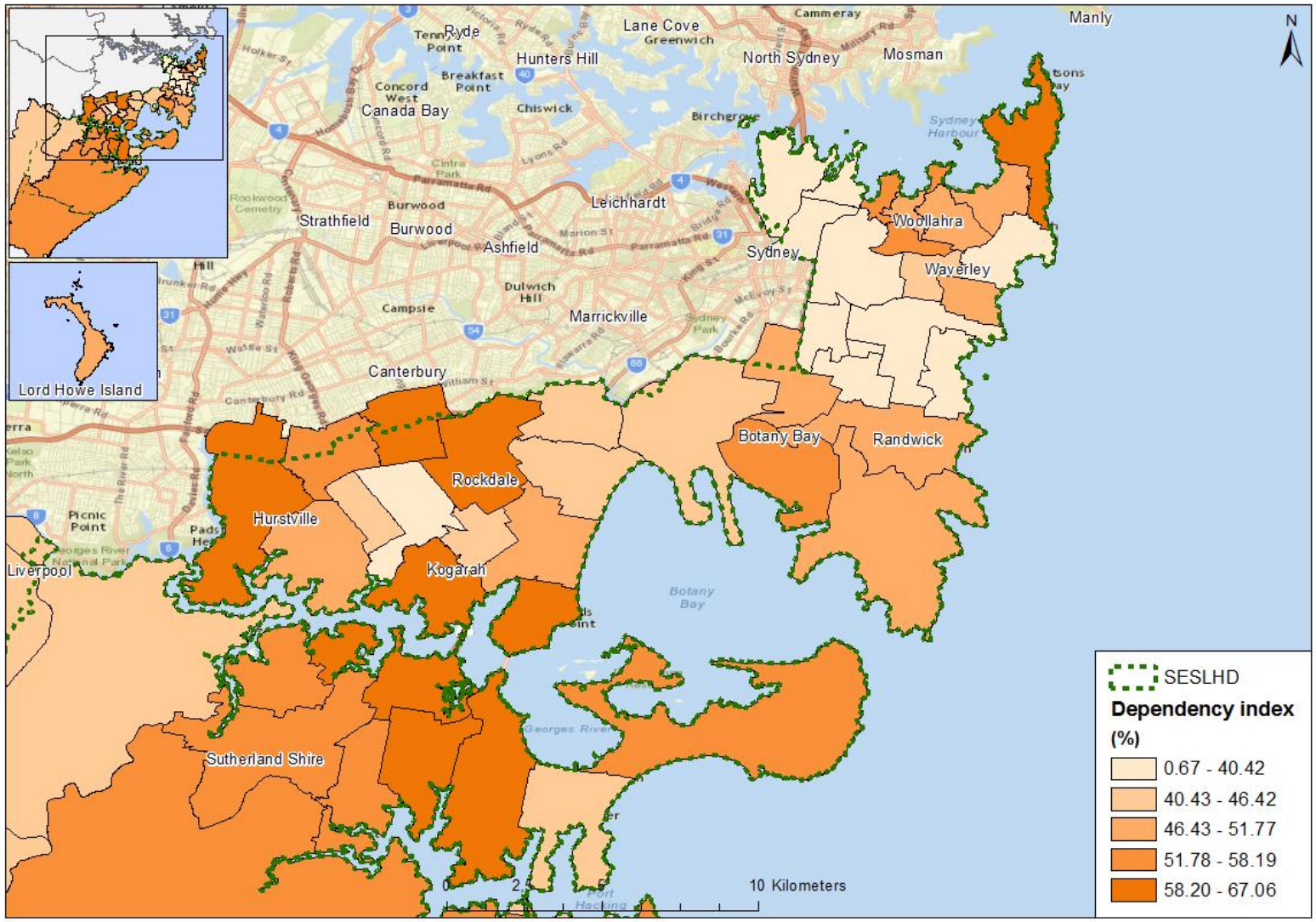


Figure 10 Dependency index

TABLE 1 DESCRIPTION OF THE SOCIO AND ECONOMIC CHARACTERISTICS OF THE AREA (2011)

SLA	Botany Bay	Hurstville	Kogarah	Randwick	Rockdale	Sutherland Shire - East	Sutherland Shire - West	Sydney - Inner	Sydney - East	Waverley	Woollahra	Lord Howe Island	Total LHD	NSW	Australia
Population (% of the LHD)	39,354 (4.9)	78,853 (9.9)	55,805 (7.0)	128,987 (16.1)	97,339 (12.2)	101,002 (12.6)	109,857 (13.8)	23,682 (3.0)	47,928 (6.0)	63,485 (7.9)	52,159 (6.5)	360 (0.0)	798,811 (100.0)	6,917,656 (-)	21,507,719 (-)
Density Index	1,813.5	3,473.7	3,600.3	3,553.4	3,451.7	685.2	590.0	5,638.6	7,988.0	6,900.5	4,275.3	22.1	1,579.0	8,6	2,8
Women (%)	50.5	51.5	51.2	50.9	50.6	51.5	50.7	48.2	44.3	50.8	52.9	51.4	50.6	50.7	50.6
Ageing index	74.8	81.3	74.3	82.4	82.3	92.6	57.9	127.1	169.5	74.1	99.5	109.4	80.9	71.7	68.1
Dependency index	50.4	52.2	49.3	41.0	50.5	57.1	52.1	11.7	17.5	39.1	48.6	44.8	45.0	54.5	54.5
Unemployment rate (%)	5.3	6.1	5.5	5.4	5.9	3.7	3.4	8.3	4.6	4.1	3.7	0.0	4.8	5.9	5.6
Lone parent (%)	4.7	4.2	3.8	3.5	4.1	4.0	3.5	1.6	1.6	2.8	2.8	3.1	3.5	4.3	4.2
Living alone (%)	8.8	7.4	7.0	10.1	8.4	9.9	5.8	12.7	23.2	11.9	12.5	12.3	9.9	8.7	8.8
Not married or in a defacto relationship (%)	45.2	42.3	41.4	48.2	43.5	40.2	36.5	62.5	57.0	46.2	44.2	32.4	44.3	41.7	41.3
Needs assistance for core activities (%)	5.3	5.0	4.2	4.1	5.6	3.8	3.4	1.5	3.1	3.1	2.7	2.7	4.0	5.2	4.9
IRSD decile of disadvantage (1 = high; 10 = low)	4	6	7	8	5	9	9	4	8	9	10	7	-	-	-
Aboriginal and Torres Strait Islander people (%)	1.6	0.6	0.4	1.4	0.6	0.8	0.8	0.3	0.8	0.4	0.2	0.8	0.8	2.5	2.5
Born overseas (%)	48.6	46.1	45.8	46.1	50.3	22.6	20.0	80.8	51.9	49.0	42.4	16.4	41.5	31.4	30.2
Low English proficiency (%)	7.8	10.5	9.3	4.1	9.3	1.4	1.1	11.7	3.2	2.0	1.1	0.8	5.0	4.1	3.2
Year 12 of high school or equivalent completed (%)	54.3	57.9	62.0	65.0	55.5	51.3	51.6	68.7	69.7	69.6	73.0	48.8	60.3	47.6	47.6
Income <$600 per week (%)	51.3	53.5	49.7	44.7	52.7	43.6	43.9	51.2	29.5	33.6	30.1	47.4	44.4	52.4	51.4
Dwellings with no internet connection (%)*	21.9	18.7	16.1	15.6	20.4	14.9	14.9	12.6	12.6	12.6	10.6	-	-	20.1	19.7
Population with psychological distress (%)*	11.7	10.4	10.3	10.2	10.3	8.8	8.8	10.3	10.3	9.4	9.3	-	-	10.5	10.8

**For these two indicators, data were only available at the LGA level. LGA boundaries correspond to SLA boundaries for all SLAs, except for Sydney Inner and East, which are both part of the Sydney LGA, as well as for Sutherland Shire East and West, which are both part of the Sutherland Shire LGA. In these cases, data was provided for the whole LGA. Data was not available for the Lorde Howe Island because does not correspond to an LGA and instead part of unincorporated NSW.*

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

3.1 GENERAL DESCRIPTION

Data on services providing care for people with a lived experience of mental illness in the SESLHD was collected from the 22nd July 2015 to the 9th June 2016.

We found a total of 150 BSICs (or teams), corresponding to 169 MTCs for people with a lived experience of mental health illness or psychosocial issues. We did not include services where the primary presentation is not for mental health, for example: alcohol and other drugs, intellectual disability or homelessness.

With regards to the age distribution of consumers provided for, 66% of the care provided is for adults without any target on specific populations. 6% of the services are specific to children and adolescents, 6% to transition to adulthood, and 8% to older adults respectively.

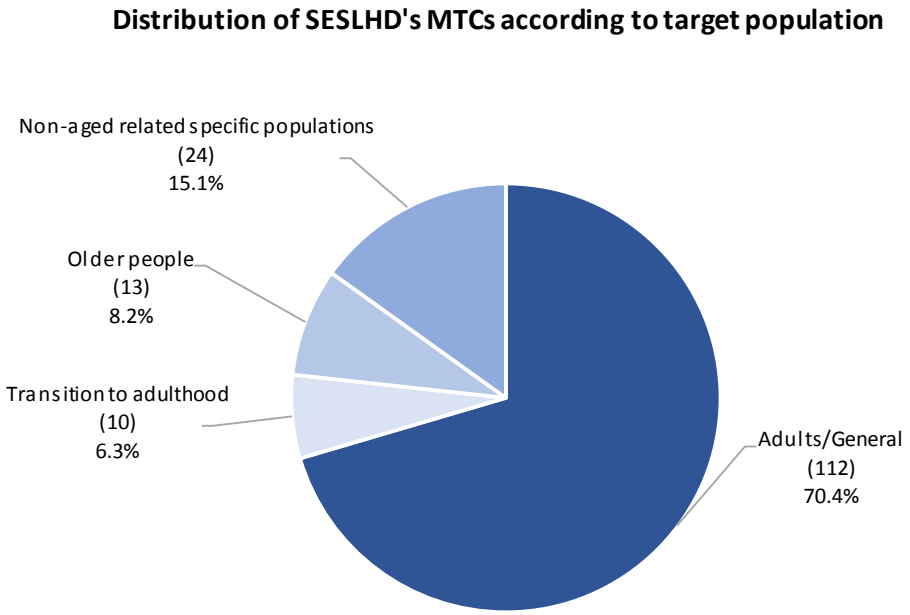
14% of the care provided was dedicated to non-age related specific populations, including carers of people with mental illnesses, the Aboriginal and Torres Strait Islander population, the culturally and linguistically diverse (CALD) population, parents with mental illness, and services that are gender-specific. Four or fewer services were encountered for each of those sub-populations.

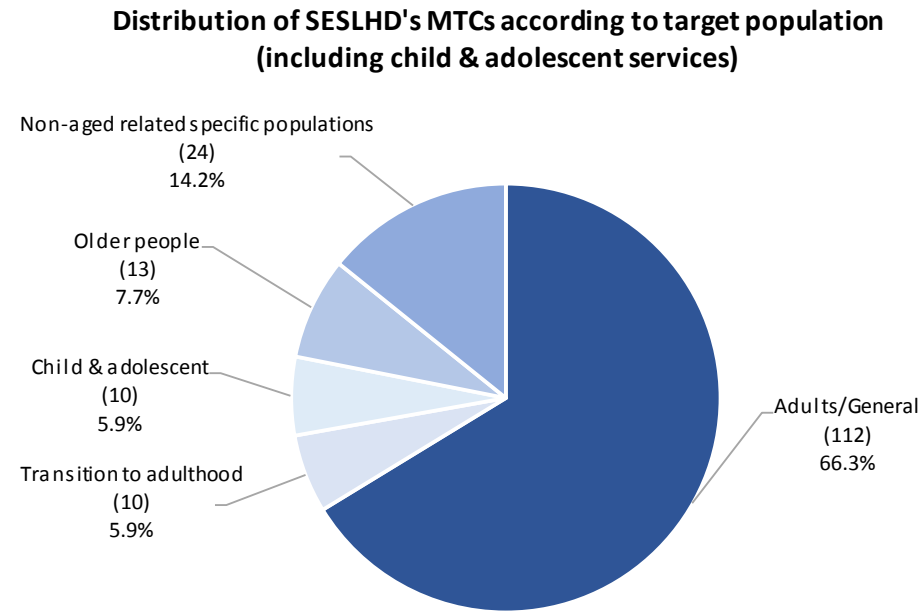
56.8% of the care for people with mental illness is provided by the public health sector while 33.1% is provided by NGOs, 4.1% by family and community services and 5.9% by the justice system. It is important to note here that there are also services available at The Forensic Hospital, Malabar, and Long Bay Hospitals, associated with the Justice and Forensic Mental Health Network. As we have not been systematically mapping justice services at this stage, they are yet to be codified.

With regard to the distribution by MTC, the services provided by the public health sector were mostly classified into outpatient (71.9%) and residential (19.8%).Fewer than 9% were classified as day care, accessibility and guidance and information. In the non-health sector (i.e. NGOs, FACS and others), outpatient care was also the most common (50.7%) followed by day care (16.4%) and accessibility (11%). Residential care was much less developed than in the public health sector (11%) while self-help and voluntary care represented 11% of the care provided in the non-health sector.

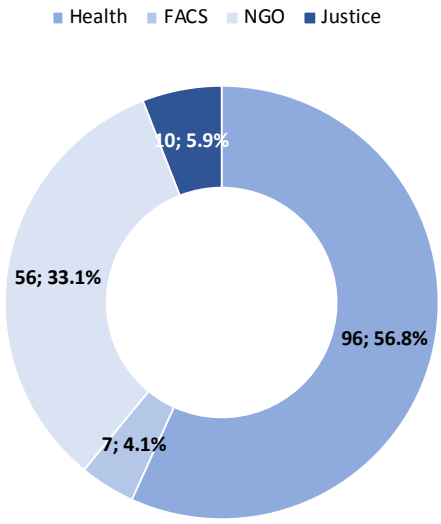
A detailed description of the MTCs identified is provided in the figure below.

FIGURE 11 DESCRIPTION OF THE MTCS IDENTIFIED

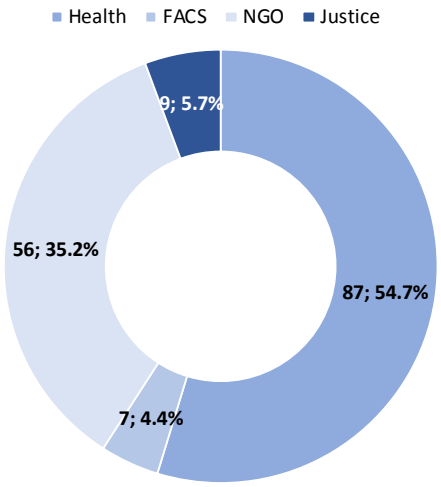


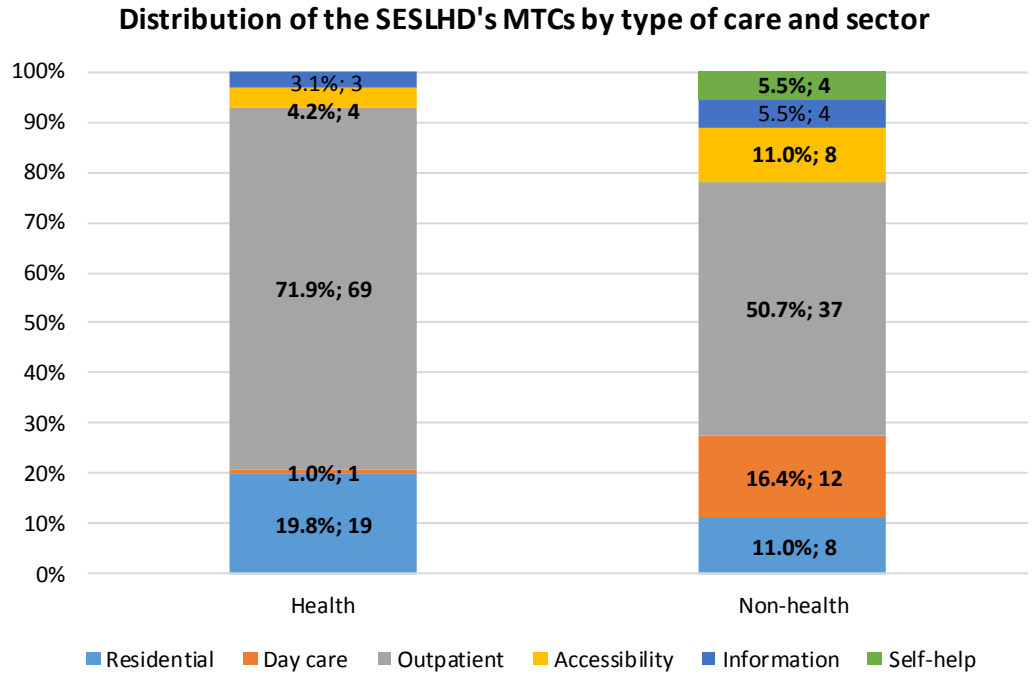


Distribution of the SESLHD's MTCs according to sector



Distribution of the SESLHD's MTCs according to sector (including child & adolescent services)




Distribution of the SESLHD's MTCs by type of care and sector
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3.1%; 3
4.2%; 4
71.9%; 69
1.0%; 1
19.8%; 19
5.5%; 4
5.5%; 4
11.0%; 8
50.7%; 37
16.4%; 12
11.0%; 8
Health
Non-health
Residential
Day care
Outpatient
Accessibility
Information
Self-help

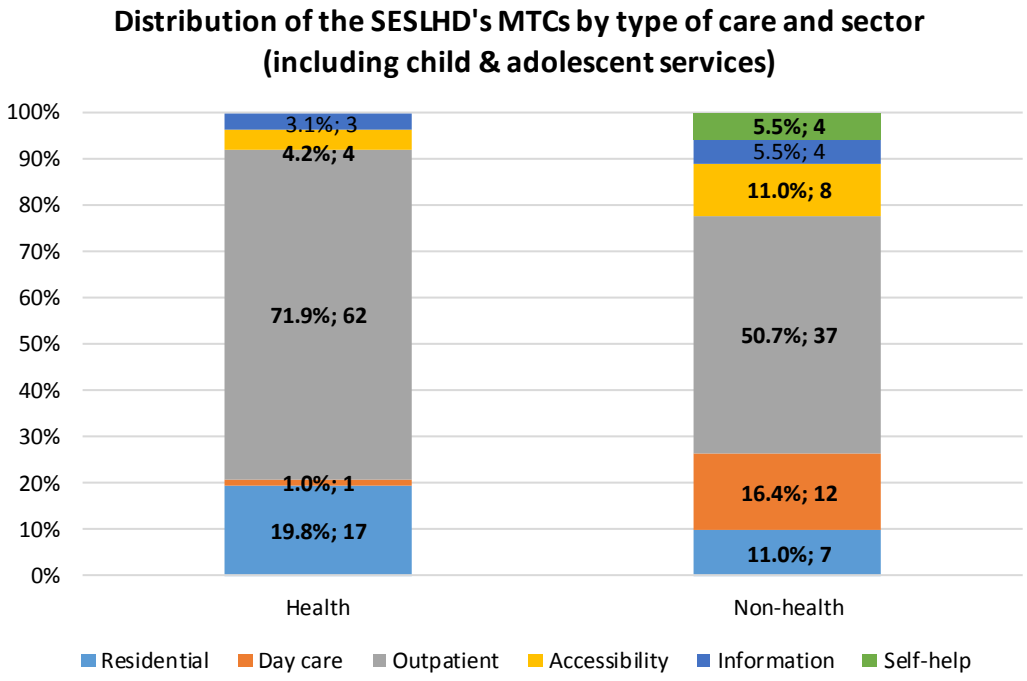

Distribution of the SESLHD's MTCs by type of care and sector (including child & adolescent services)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3.1%; 3
4.2%; 4
71.9%; 62
1.0%; 1
19.8%; 17
5.5%; 4
5.5%; 4
11.0%; 8
50.7%; 37
16.4%; 12
11.0%; 7
Health
Non-health
Residential
Day care
Outpatient
Accessibility
Information
Self-help

TABLE 2 DESCRIPTION OF THE MTCS PER TYPE OF POPULATION AND SECTOR

MTC	Definition	Adults					Specific populations																				Total			
							Children and adolescents					Transition to adulthood					Older adults					Non-age related specific populations								
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J
RESIDENTIAL: Facilities that provide beds overnight for purposes related to the clinical and social management of their long term care																														
R1	Acute, 24 hours physician cover, hospital, high intensity	5	0	0	0	5	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	5	0	0	3
R2	Acute, 24 hours physician cover, hospital, medium intensity	7	0	0	0	7	2	0	0	0	2	0	0	0	0	0	2	0	0	0	2	0	0	0	0	0	11	0	0	0
R3	Acute, non-24 hours physician cover, hospital	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
R4	Non-acute, 24 hours physician cover, hospital, time limited	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	3	3	3	0	0	3
R8.2	Non-acute, non-24 physician cover, time limited, 24 hours support, over 4 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0
TOTAL R		**14**	**0**	**0**	**1**	**15**	**2**	**0**	**0**	**1**	**3**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**0**	**0**	**3**	**0**	**0**	**1**	**5**	**6**	**19**	**0**	**1**	**7**

MTC	Definition	Adults					Specific populations																				Total			
							Children and adolescents					Transition to adulthood					Older adults					Non-age related specific populations								
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J
DAY CARE: Facilities that involve contact between staff and users for some purpose related to management of their condition and its associated clinical and social dificulties																														
D2.2	Non-acute, work, high intensity, other work	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
D5	Non-acute, non structured care, high intensity	0	0	4	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	5	0
D8.3	Non-acute, non-work structured care, low intensity, social and cultural related care	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	2	0
D8.4	Non-acute, non-work structured care, low intensity, other non-work structured care	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
D9	Non-acute, non structured care, low intensity	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
D10	Other non-acute day care not classified anywhere else	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0

MTC	Definition	Adults					Specific populations																				Total			
							Children and adolescents					Transition to adulthood					Older adults					Non-age related specific populations								
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J
TOTAL D		1	0	10	0	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	1	0	12	0

MTC	Definition	Adults					Specific populations																				Total				
							Children and adolescents					Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
OUTPATIENT: Facilities that involve contact between staff and users for some purpose related to management of their condition and its associated clinical and social difficulties																														
O1.1	Acute, mobile, 24h, health related care	2	0	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	1	3
O2.1	Acute, home and mobile, limited hours, health related care	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
O3.1	Acute, non-mobile, 24h, health related care	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
O4.1	acute, non-mobile, time limited, health related care	1	0	0	0	1	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	3

MTC	Definition	Adults					Specific populations																				Total				
							Children and adolescents					Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
O5.1	Non-Acute, Home & Mobile, High Intensity	2	0	0	0	2	0	0	0	0	0	1	0	0	0	1	1	0	0	0	1	1	0	0	0	1	5	0	0	0	5
O5.1.1	Non-Acute, Home & Mobile, High Intensity, 3 to 6 days a week care	0	0	0	0	0	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
O5.2	Non-Acute, Home & Mobile, High Intensity, other care	1	0	12	0	13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	1	0	14	0	15
O6.1	Non-Acute, Home & Mobile, Medium Intensity	1	0	1	0	2	0	0	0	0	0	3	0	0	0	3	4	0	0	0	4	1	0	0	0	1	9	0	1	0	10
O6.2	Non-Acute, Home & Mobile, Medium Intensity, other care	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	0	4	0	4

MTC	Definition	Adults					Specific populations																				Total				
							Children and adolescents					Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
O7.1	Non-Acute, Home & Mobile, low Intensity	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	3	3	0	0	0	3
O7.2	Non-Acute, Home & Mobile, low Intensity, other care	0	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	4
O8.1	Non-Acute, non-mobile, High intensity , health related care	5	0	1	0	6	1	0	0	0	1	1	0	0	0	1	0	0	0	0	0	1	0	0	0	1	8	0	1	0	9
O9.1	Non-Acute, non-mobile, Medium intensity , health related care	17	0	3	0	20	2	0	0	0	2	3	0	2	0	5	5	0	0	0	5	1	0	1	0	2	28	0	6	0	34
O9.2	Non-Acute, non-mobile, Medium intensity , other care	1	0	2	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2	1	0	3	1	5

MTC	Definition	Adults					Specific populations																				Total				
							Children and adolescents					Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
O10.1	Non-acute, non-mobile, low intensity, health related care	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
O10.2	Non-Acute, Home & Mobile, Medium Intensity, other care	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
O11	Other non acute care	3	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	3
TOTAL O		**37**	**4**	**22**	**2**	**65**	**7**	**0**	**0**	**0**	**7**	**8**	**0**	**2**	**0**	**10**	**10**	**0**	**0**	**0**	**10**	**7**	**0**	**6**	**1**	**14**	**69**	**4**	**30**	**3**	**106**

MTC	Definition	Adults					Specific populations																				Total				
							Children and adolescents					Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOTAL	H	FACs	NGO	J	TOT
ACCESSIBILITY: Facilities which main iam is to provide accesibility aids for users wiwth long term care needs																															
A1	Communication	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0	0	0	1
A3	Personal Accompaniment by non-care professionals.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

A4	Case Coordination	1	0	2	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	3	0	4
A5.1	Other accessibility care: health related	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
A5.3	Other accessibility care: health related: social and cultural services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
A5.4	Other accessibility care: health related: work related	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
A5.5	Other accessibility care: health related: housing related	0	3	1	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	1	0	4
TOTAL A		**3**	**3**	**4**	**0**	**10**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**2**	**4**	**3**	**5**	**0**	**12**
INFORMATION AND GUIDANCE: Facilities which main aim is to provide users with information and or assessment of their needs. This service does not entail subsequent follow-up or direct care provision																															
I1.1	Professional assessment and guidance related to health care	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
I2.1.1	Information, interactive, face to face	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
I2.1.2	Information, interactive, other	1	0	2	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	0	3
I2.2	Information, non interactive	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1

TOTAL I		**3**	**0**	**4**	**0**	**7**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**4**	**0**	**7**
VOLUNTARY CARE: Facilities which main aim is to provide users with long term care needs with support, self-help or contact with un-pain staff that offers accessibility, information, day, outpatient and residential care (as described avobe), but the staff is non-paid																															
S1.1	Non-professional staff, information on care	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
S1.2	Volunteers providing access (personal accompaniment)	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
S1.3	Non-professional staff outpatient care	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
TOTAL S		**0**	**0**	**4**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**	**4**
TOTAL		**58**	**7**	**44**	**3**	**112**	**9**	**0**	**0**	**1**	**10**	**8**	**0**	**2**	**0**	**10**	**13**	**0**	**0**	**0**	**13**	**8**	**0**	**10**	**6**	**24**	**96**	**7**	**56**	**10**	**169**

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

3.2 ADULTS

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

3.2.1 RESIDENTIAL CARE

3.2.1.1 RESIDENTIAL CARE PROVIDED BY THE PUBLIC HEALTH SECTOR

ACUTE INPATIENT SERVICES

A total of 9 BSICs/services, corresponding to 12 MTCs, were identified which provide acute inpatient care in the SESLHD. Five of the 12 MTCs that provide care for any mental illness are considered high intensity units (code R1), while the other are medium intensity (R2).

The number of acute beds from the public health sector per 100,000 residents is 157, or 24.31 per 100,000 residents. The number of BSICs from the public health sector providing acute care is 9, or 1.39 per 100,000 residents.

TABLE 3 ACUTE INPATIENT SERVICES: AVAILABILITY AND PLACEMENT CAPACITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	Beds/Places	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Kiloh - Observation Unit	AX[F00-F99]-R1		16	Randwick	ES
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Kiloh- General Acute	AX[F00-F99]-R2		30	Randwick	ES
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Mental Health Intensive Care Unit	AX[F00-F99]-R1		12	Randwick	ES
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Psychiatric Emergency Care Centre	AX[F00-F99]-R2		4	Randwick	ES
St George Mental Health Service	Inpatient Unit	AX[F00-F99]-R2	AX[F00-F99]-R1	19 9	Kogarah	SES

St George Mental Health Service	Psychiatric Emergency Care Centre	AX[F00-F99]-R2		6	Kogarah	SES
St Vincent's Mental Health Service	Acute Inpatient Unit	AX[F00-F99]-R2	AX[F00-F99]-R1	21 6	Darlinghurst	SV
St Vincent's Mental Health Service	Psychiatric Emergency Care Centre	AX[F00-F99]-R2	AX[F00-F99]-O3.1	6	Darlinghurst	SV
Sutherland Mental Health Service	Acute ward	AX[F00-F99]-R2	AX[F00-F99]-R1	18 10	Caringbah	SES
Total	9			157		
Rate per 100,000 residents (>17 years old)	1.39			24.31		

The next table shows the workforce capacity related to adult acute inpatient services in the area covered by the SESLHD. The total number of FTEs related to adult acute inpatient services is 310.6, or 48.10 per 100,000 residents. Psychiatrists and mental health nurses, as expected, account for the greater percentage of the workforce.

TABLE 4 ACUTE INPATIENT UNIT: WORKFORCE CAPACITY

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT	Edu	Peer	Others
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Kiloh - Observation Unit	32.6	3.0		26.1					3.5
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Kiloh- General Acute	46.5	4.3		42.2					
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Mental Health Intensive Care Unit	40.9	3.5	1.0	27.1	1.0	1.0		0.2	7.1
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Psychiatric Emergency Care Centre	19.2	1.7		17.0	0.5				
St George Mental Health Service	Inpatient Unit	44.2	4.6	0.5	34.7	2.0	1.0	1.0	0.4	
St George Mental Health Service	Psychiatric Emergency Care Centre	13.8	1.5		11.3	0.5	0.5			

St Vincent's Mental Health Service	Acute Inpatient Unit	43.7	3.8	0.5	36.6	2.3	0.5		
St Vincent's Mental Health Service	Psychiatric Emergency Care Centre	24.4	2.0		21.8	0.6			
Sutherland Mental Health Service	Acute ward	45.3	3.6	0.5	37.0	2.0	1.0	0.2	1.0
Total		310.6							
Rate per 100,000 residents (>17 years old)		48.10							

*FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist; Edu: Educator; Peer: Peer worker. *NA: Not available at the time of completion of the study*

NON-ACUTE INPATIENT AND RESIDENTIAL SERVICES

A total of 2 BSIC were identified as providing non-acute inpatient and residential care in the SESLHD. These 2 BSIC are rehabilitation units located at the Prince of Wales Hospital and at Sutherland Hospital.

TABLE 5 NON-ACUTE INPATIENT SERVICES: AVAILABILITY AND PLACEMENT CAPACITY

Provider	Name	Main DESDE Code	Beds/Places	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Euroa Centre Mental Health Rehabilitation Unit	AX[F00-F99]-R4	14	Randwick	ES
Sutherland Mental Health Service	Rehabilitation unit	AX[F00-F99]-R4	20	Caringbah	SES
Total	2		34		
Rate per 100,000 residents (>17 years old)	0.31		5.27		

The number of non-acute beds provided by the public health sector is 34 or 5.27 per 100,000 residents at the hospital setting, and 0.00 at the community. The number of services from the public health sector providing non-acute care is 2, or 0.31 per 100,000 residents.

The table below describes the workforce capacity in non-acute care in the SESLHD. As in the case of acute care, mental health nurses and psychiatrists are the professionals with the highest

representation. The total number of FTE for non-acute inpatient services is 46.2, or 7.16 per 100,000 residents.

TABLE 6 NON-ACUTE INPATIENT SERVICES: WORKFORCE CAPACITY

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT	Edu
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Euroa Centre Mental Health Rehabilitation Unit	21.2	1.4	1.0	16.8	1.0	1.0	
Sutherland Mental Health Service	Rehabilitation unit	25.0	1.5	1.0	19.0	1.0	2.0	0.5
Total		46.2						
Rate per 100,000 residents (>17 years old)		7.16						

*FTE: Full Time Equivalents; Psych/reg: Psychiatrists-registar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist. *NA: Not available at the time of completion of the study*

OTHER RESIDENTIAL CARE

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

Family and Community Services (FACS) is an additional service from the public sector that provides in-home care for vulnerable people. FACS provides services to the following groups:

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

FACS aims to improve the lives of vulnerable people and to support their participation in social and economic life. No specific team in FACS specialises in the care of people with a lived experience of mental illness, however people with a lived experience of mental illness are one of FACS' main client groups. For this reason, we have included FACS services as ambulatory mobile care (Outpatient code) and Accessibility care (services that assist consumers to access social housing). FACS services in the SESLHD are described and listed after the following section on Social Housing.

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

SOCIAL HOUSING

According to the last report published by FACS NSW (18), as of the 30th of June 2013, there were a total of 110,059 households living in social housing: 25,973 living in community housing and 4,469 living in Aboriginal Housing. FACS manages 149,972 properties in all NSW, comprising 117,798 social housing dwellings, 27,450 properties in the community housing sector and 4,724 Aboriginal Housing properties.

We have identified three main obstacles for evidence informed local planning 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 illness; 2) it is not possible to know how many people with a lived experience of mental illness were using the properties (data on mental health status is not collected); and 3) properties are not restricted to specified districts (i.e. a person living in Redfern may be relocated in Campbelltown if there is a property available there). These obstacles are compounded if the person with a lived experience has an additional dual diagnosis or co-existing comorbidity.

An additional challenge is that social housing may or may not include direct support. People with a lived experience of mental illness who need support at home receive this type of care through the Housing and Accommodation Support Initiative (HASI). HASI is a partnership between NSW Health, Housing NSW and an array of non-government organisations (NGOs) that provide people with a lived experience of mental illness, 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 is provided for people with a lived experience of mental illness 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 seven BSIC/services delivered by FACS providing direct care related to housing. Although this is not specifically for people with lived experience of mental illness, most of their clients experience mental illness. Four of the seven 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) and therefore are coded as "Outpatient" care (O). The other BSICs are focused on helping consumers to access social housing (through assessment and eligibility), and are coded as "Accessibility" ("A").

It is important to recognize that although these BSIC/services are mainly providing care for people within the boundaries of the SESLHD, they also provide support to people from throughout the state if needed. The services are also not specifically for people with a lived experience of mental illness.

The total number of BSICs/services from FACS services providing tenancy support (non-acute, mobile, outpatient care, low intensity) in the SESLHD is 4, or 0.62 per 100,000 residents. The total number of FTEs case workers providing this type of care is 35, or 5.42 per 100,000 residents.

The number of BSICs/services from FACS providing assessment and eligibility care (accessibility to social housing) in the SESLHD is 3, or 0.46 per 100,000 residents, with 57 caseworkers, or a rate of 8.83 case workers per 100,000 residents.

TABLE 7 BSICS RELATED TO SOCIAL HOUSING: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
FACS	Tenancy Support*	AX[Z55-65]-O7.2	9.0	Maroubra	ES
FACS	Tenancy Support*	AX[Z55-65]-O7.2	9.0	Maroubra	ES
FACS	Tenancy Support*	AX[Z55-65]-O7.2	7.0	Strawberry Hills	ES
FACS	Tenancy Support*	AX[Z55-65]-O7.2	10.0	Miranda	SES
Total	4		35		
Rate per 100,000 residents (>17 years old)	0.62		5.42		
FACS	Eligibility and Assessment*	AX[Z55-65]-A5.5	16.0	Hurtsville	SES
FACS	Eligibility and Assessment*	AX[Z55-65]-A5.5	28.0	Strawberry Hills	ES
FACS	Eligibility and Assessment*	AX[Z55-65]-A5.5	13.0	Maroubra	ES

Total	3	57
Rate per 100,000 residents (>17 years old)	0.46	8.83

FTE: Full Time Equivalents

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

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

We have contacted the following community housing providers:

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

Only St George Community Housing (SGCH) has properties devoted to the HASI program. At the time of the interview (October 2015), SGCH had a total of 12 properties in the area of SES (1 in Botany Bay, 5 in Randwick, 2 in Kogarah, and 4 in Sutherland)

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

Ecclesia Housing also has 6 transitional properties in the area of St Vincent's, where Neami National provide the support. These 6 transitional properties may host a total of 20 people up to 19 months.

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

3.2.1.2 RESIDENTIAL CARE PROVIDED BY NGOS

We have not been able to identify any NGOs providing residential care in the area of the SESLHD.

3.2.2 DAY CARE

3.2.2.1 DAY CARE PROVIDED BY THE PUBLIC HEALTH SECTOR

We have only identified 1 BSIC (service) funded by the public health sector providing a day program in the SESLHD. The Recovery College is an innovative educational initiative in Australia, focused on learning and growth for better mental health. It aims to promote healing, wellbeing and recovery by providing learning opportunities for people to become experts in their mental health self-care, and achieve their goals and inspirations. The courses offered by the Recovery College are open to people older than 17 years, with a lived experience of mental illness, who live in the SESLHD. It is also open to their carers, relatives and friends, and to SESLHD staff.

TABLE 8 DAY CARE PROVIDED BY THE PUBLIC HEALTH SECTOR: AVAILABILITY

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service	Recovery College	AX[F00-F99]-D8.4	Kogarah	ES-SES
Total	1			
Rate per 100,000 residents (>17 years old)	0.15			

The Recovery College is only staffed with educators and casual employees, according to need.

The number of day care services provided by the public health sector is 1, or 0.15 per 100,000 residents. There is a workforce capacity of 1.5 FTEs, or 0.23 FTEs per 100,000 residents.

TABLE 9 DAY CARE PROVIDED BY THE PUBLIC HEALTH SECTOR: WORKFORCE CAPACITY

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	OT	Edu	Others
Eastern Suburbs Mental Health Service	Recovery College	1.5					1.5	
Total		1.5						
Rate per 100,000 residents (>17 years old)		0.23						

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

3.2.2.2 DAY CARE PROVIDED BY NGOS

SOCIAL AND CULTURE RELATED

We have identified 8 NGO funded BSIC/services, plus a satellite service, within the boundaries of the SESLHD providing day programs which offer social and/or cultural activities specifically for people with a lived experience of mental illness. The first service, Buckingham House (RichmondPRA), is located within the SESLHD, but is open to residents of the whole CESPHN. Two different programs operate from Buckingham House: the Community Based Activity Program (CBA) targeting people with psychosocial disabilities living in boarding houses; and the Day to Day Living Program (D2DL), targeting people with a lived experience of mental illness living within independent, inpatient or supported accommodation in the CESPHN. Transport services operate from the Prince of Wales, Royal Prince Alfred and Concord hospital mental health inpatient units to enable consumers to attend the D2DL program at Buckingham House. Transport services also collect consumers from Independent Community Living Accommodation (Bondi) and other community organisations.

The Buckingham House D2DL program has 76 designated places, however there are more than 150 people registered as attendees. People can drop in to this service without any obligation to maintain regular contact. The program offers a series of structured activities which range from cooking to painting classes, to relaxation, and programs to quit smoking. The service also organises social and leisure activities (e.g. cinema, barbecues or bowling). Some of these activities may include a small fee.

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

The Wayside Chapel (Uniting Care) also run a D2DL program in Potts Point. This program provides structured activities 5 days a week, and operates from a drop in centre that is open 7 days a week, from 9am to 8pm. The D2DL program was originally funded to support consumers living within Sydney City. Extension of this original area of coverage has however occurred. The Wayside Chapel D2DL program also has a satellite service, Chapel by the Sea, at Bondi.

The remaining 5 BSIC/services provide a mix of structured and unstructured activities. The Recreational Program run by Aftercare aims to increase the social activities of people with a lived experience of mental illness, and runs groups in the community. Mortdale Community Services has a Mental Health Drop-in Centre, and a specific Arts program which is supported by volunteer professional artists. Holdsworth House in Woollahra runs the Holdsworth House Club Program.

Finally, the Anglican Church runs a social club for people with a lived experience of mental illness in Riverwood. People can attend on a weekly basis and do different activities of their own choice.

Additional day programs, not specifically for people with a lived experience of mental illness, were also identified in the mapping process. These include the Men's Shed (St Vincent de Paul Society at St Mary MacKillop), which welcomes people with a lived experience of mental illness, but is not specifically for them. Similarly, the Creativity Centre, managed by Eastern Respite and Recreation, provides day care for people with intellectual disabilities, but it is not limited to people with disabilities. Rough Edges provides day care, but it targets people who are experiencing homelessness.

The total number of BSICs/services from the NGO sector providing social and culture-related day care within the boundaries of the SESLHD is 9, or 1.39 per 100,000 residents. The total number of FTEs for those services is 26.8, or 4.15 for 100,000 residents.

TABLE 10 SOCIAL AND CULTURE-RELATED DAY CARE PROVIDED BY NGOS: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	FTE	Town / Suburb	Area of Coverage
Aftercare	Recreational Program	AX[F00-F99]-D10		3.0	Randwick	ES
Anglican Church	Social Group	AX[F00-F99]-D9		1.0	Riverwwod	SES
Holdsworth Club Program	Holdsworth Club Program	AX[F00-F99]-D5		15.0	Woollahra	ES
Mortdale Community Services	Mental Health Arts Development	AX[F00-F99]-D8.3		0.4	Mortdale	SES

Mortdale Community Services	Mental Health Drop in Centre	AX[F00-F99]-D9		0.2	Mortdale	SES
RichmondPRA	Buckingham House –D2DL	AX[F00-F99]-D5		2.7	Surry Hills	SV-ES
RichmondPRA	Buckingham House-CBA program	AX[F00-F99]-D10		1.0	Surry Hills	SV-ES
Uniting Church	The Wayside Chapel/Chapel by the Sea (satellite)	AX[F00-F99]-D5t		NA	Bondi Beach	ES
Uniting Church	Wayside Chapel - D2DL	AX[F00-F99]-D5	AX[F00-F99]-D2.2	3.5	Kings Cross	SES
Total	9			26.8		
Rate per 100,000 residents (>17 years old)	1.39			4.15		

*FTE: Full-Time Equivalents. *NA: Not available at the time of completion of the study*

3.2.3 OUTPATIENT CARE

3.2.3.1 OUTPATIENT CARE PROVIDED BY THE PUBLIC HEALTH SECTOR

ACUTE MOBILE OUTPATIENT CARE

We identified 4 BSIC/services providing acute mobile outpatient care for adults with a lived experience of mental illness in the SESLHD. Two of the services provide acute, home and mobile care, 24 hours a day. Staff in these teams are on duty for 14 hours a day, and an on-call service operates between the hours of 22:30 to 08:30. The remaining two services provide acute, home and mobile care which is time limited.

The total number of BSICs/services from the public health sector providing acute mobile outpatient care within the boundaries of the SESLHD is 4, or 0.62 per 100,000 residents.

TABLE 11 ACUTE MOBILE OUTPATIENT CARE PROVIDED BY THE PUBLIC HEALTH SECTOR: AVAILABILITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Euroa Centre Acute Care Team	AX[F00-F99]-O1.1	AX[F00-F99]-O3.1e	Randwick	ES

St George Mental Health Service	Acute Care Team	AX[F00-F99]-O2.1v	Kogarah	SES
St Vincent's Mental Health Service	Acute Care Team	AX[F00-F99]-O2.1	Darlinghurst	SV
Sutherland Mental Health Service	Acute Care Team	AX[F00-F99]-O1.1v	Caringbah	SES
Total	4			
Rate per 100,000 residents (>17 years old)	0.62			

There are a total of 57.9 FTEs of professionals providing acute and mobile care, or 8.97 per 100,000 residents within the boundaries of the SESLHD. Mental health nurses are the largest group of professionals.

TABLE 12. ACUTE MOBILE OUTPATIENT CARE PROVIDED BY THE PUBLIC HEALTH SECTOR: WORKFORCE CAPACITY

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT	CCM	Edu
Eastern Suburbs Mental Health Service Prince of Wales Hospital	Euroa centre Acute Care Team	19.0	1.6	3.5	10.4	3.5			
St George Mental Health Service	Acute Care Team	14.0	1.0					13.0	
St Vincent's Mental Health Service	Acute Care Team	9.6	1.5			1.0	0.5	5.6	1.0
Sutherland Mental Health Service	Acute Care Team	15.3	0.5	1.7	10.0	3.1			
Total		57.9							
Rate per 100,000 residents (>17 years old)		8.97							

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; CCM: Clinical case manager; SW: Social worker; OT: Occupational therapist; Edu: Educator

ACUTE NON-MOBILE OUTPATIENT CARE

In the SESLHD there is after-hours emergency coverage at the Sutherland Hospital emergency department. This service is however part of the Sutherland Acute Care Team BSIC, and has been recorded in the acute mobile outpatient care table. The Psychiatric Emergency Care Centre (PEEC) of the St Vincent's Hospital, which mainly provides acute residential care (see residential section), also provides non-mobile outpatient care (DESDE 2 = O3.1).

NON ACUTE MOBILE OUTPATIENT CARE

We found 4 BSIC/services providing non-acute mobile outpatient care within the boundaries of the SESLHD.

Three services provide high intensity care (i.e. they have the capacity to see patients three times per week if needed). One of these teams, the Rehabilitation Team, based at St George Hospital, has a social focus, while the other two services have a health focus. One BSIC provides medium intensity care (i.e. contacts are made at least on a fortnightly basis).

The number of services from the public health sector providing non-acute mobile outpatient care is 4, or 0.62 per 100,000 residents.

TABLE 13 NON-ACUTE MOBILE OUTPATIENT CARE PROVIDED BY THE PUBLIC HEALTH SECTOR: AVAILABILITY

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service	The Maroubra Centre Case Manager and Assessment Team	AX[F00-F99]-O6.1	Maroubra	ES
Eastern Suburbs Mental Health Service	The Maroubra Centre Mobile Community Treatment Team	AX[F00-F99]-O5.1	Randwick	ES
St George Mental Health Service	Rehabilitation team	AX[F00-F99]-O5.2	Kogarah	SES
St Vincent's Mental Health Service	Case Management Team	AX[F00-F99]-O5.1	Darlinghurst	SV
Total	4			
Rate per 100,000 residents (>17 years old)	0.62			

The table below shows the workforce providing non-acute mobile outpatient care related to health needs. **The total number of FTEs is 52.3, or 8.1 per 100,000 residents.** The teams providing non-acute mobile outpatient care are multidisciplinary, and comprised mostly of mental health nurses.

TABLE 14 NON-ACUTE MOBILE OUTPATIENT BSICS PROVIDED BY THE PUBLIC HEALTH SECTOR: WORKFORCE CAPACITY

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT	CCM	AbW
Eastern Suburbs Mental Health Service	The Maroubra centre Case Manager and Assessment Team	18.6	1.1	3.8	8.7	3.0	1.0		1.0
Eastern Suburbs Mental Health Service	The Maroubra Centre Mobile Community Team	7.2	0.2	1.0	5.0	1.0			
St George Mental Health Service	Rehabilitation team	5.0						5.0	
St Vincent's Mental Health Service	Case Management Team	21.5	2.0	0.5				19.0	
Total		52.3							
Rate per 100,000 residents (>17 years old)		8.1							

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

NON-ACUTE NON-MOBILE OUTPATIENT CARE

We have identified 25 BSICs/services providing non-acute non-mobile outpatient care within the boundaries of the SESLHD

Three of these services are clozapine clinics. Their primary objective is to monitor the physical health of people with a lived experience of severe mental illness, particularly in relation to the risk of metabolic syndrome. Four teams also aim to promote physical activity for people with a lived experience of mental illness (Keeping the Body in Mind Program). Two of the programs provide services for adults and operate in Bondi Junction and Maroubra. The Keeping the Body in Mind Program in Kogarah and Sutherland targets younger adults (at least at the moment- see the transition to adulthood section).

There are 3 consultation liaison services. A specialised clinic for eating disorders in the SLHD area supports people from across the state of NSW.

Three of the BSIC/services identified in the SESLHD are classified as non-mobile, but they have high mobility. However, we have been informed that less than 50% of the contacts are made outside the office. These "high mobility" services are reflected with the letter "w".

The Prince of Wales Hospital has a team composed of allied health professionals who are mainly targeting the social needs of people with a lived experience of mental illness (in other areas these professionals may be split across the different teams).

We have also found some specialised services: two target personality disorders (St Vincent's and St George Hospitals' Outlook team for which personality disorders are a major component, but also depression and anxiety); neuropsychiatric illnesses (Prince of Wales); and affective disorders (St Vincent's). St Vincent's Hospital also has a specific team that targets people with a lived experience of mental illness and HIV/AIDs.

TABLE 15 NON-ACUTE NON-MOBILE OUTPATIENT CARE PROVIDED BY THE PUBLIC HEALTH SECTOR: AVAILABILITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service Prince of Wales	Allied Health Team	AX[F00-F99]-O9.1		Randwick	ES
Eastern Suburbs Mental Health Service Prince of Wales	Clozapine Clinic	AX[F00-F99]-O9.1		Randwick	ES
Eastern Suburbs Mental Health Service	Community Rehab Team	AX[F00-F99]-O9.2		Maroubra	ES
Eastern Suburbs Mental Health Service	Keeping body in mind	AX[F00-F99]-O9.1		Bondi Junction	ES
Eastern Suburbs Mental Health Service	Keeping body in mind	AX[F00-F99]-O9.1		Maroubra	ES
Eastern Suburbs Mental Health Service	Neuropsychiatric Institute	AX[F00-F99]-O9.1		Randwick	ES
Eastern Suburbs Mental Health Service	Peer support team	GX[F00-F99]-O11		Randwick	ES
Eastern Suburbs Mental Health Service	Physical Health Liaison	AX[F00-F99]-O9.1u	AX[F00-F99]-A5.1u	Maroubra	ES
St George Community Mental Health Service	Clozapine clinic	AX[F00-F99]-O9.1		Kogarah	St George
St George Community Mental Health Service	Connections	AX[F00-F99]-O8.1w		Kogarah	SES

St George Community Mental Health Service	Peer support team	GX[F00-F99]-O11		Kogarah	SES
St George Mental Health Service	Consultation Liaison Team	AX[F00-F99]-O8.1		Kogarah	SES
St George Mental Health Service	Directions Team	AX[F00-F99]-O8.1w		Kogarah	SES
St George Mental Health Service	Outlook Team	AX[F60-69]-O8.1w		Kogarah	SES
St Vincent's Mental Health Service	Anxiety Disorders Clinical	AX[F40-48]-O9.1		Darlinghurst	SV
St Vincent's Mental Health Service	Borderline Group-Day Care	AX[F60.3]-O9.1		Darlinghurst	SV
St Vincent's Mental Health Service	Community Rehab Team	AX[F00-F99]-O9.1		Darlinghurst	SV
St Vincent's Mental Health Service	Consultation Liaison Team	AX[F00-F99]-O9.1	AX[F10-F19]-O9.1	Darlinghurst	SV
St Vincent's Mental Health Service	HTH/HIV Team	AX[F00-F99]-O9.1		Darlinghurst	SV
Sutherland Community Mental Health Service	Clozapine clinic	AX[F00-F99]-O9.1		Caringbah	Sutherland
Sutherland Community Mental Health Service	Peer support team	GX[F00-F99]-O11		Caringbah	Sutherland
Sutherland Mental Health Service	Consultation Liaison Team	AX[F00-F99]-O8.1l		Caringbah	SES
Sutherland Mental Health Service	Continuing and extended care team (CONNECT)	AX[F00-F99]-O9.1w		Caringbah	SES
Sutherland Mental Health Service	MindSet*	CX[F00-F99]-O9.1	AX[F00-F99]-O9.1	Caringbah	SES
Sutherland Mental Health Service	Specific treatment and rehabilitation team (START)	AX[F00-F99]-O9.1w		Caringbah	SES
Total	25				
Rate per 100,000 residents (>17 years old)	3.87				

**This is a secondary MTC for a service primarily providing care for children in the SESLHD.*

The number of BSICs/services from the public health sector providing non-acute non-mobile outpatient care is 25, or 3.87 per 100,000 residents.

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

The total number of FTEs of professionals providing non-acute non-mobile outpatient care in the public health sector is 125.2, or 19.39 per 100,000 residents.

TABLE 16 NON-ACUTE NON-MOBILE OUTPATIENT CARE PROVIDED BY THE PUBLIC HEALTH SECTOR: WORKFORCE CAPACITY

Provider	Name	Total FTE	Psych/ reg	Psychol	MHN	SW	OT	CCM	SF	Ab W	Peer
Eastern Suburbs Mental Health Service Prince of Wales	Allied Health Team	14.8						14.8			
Eastern Suburbs Mental Health Service Prince of Wales	Clozapine Clinic	0.6			0.6						
Eastern Suburbs Mental Health Service	Community Rehab Team	8.8	0.4	1.0			5.0	2.4			
Eastern Suburbs Mental Health Service	Keeping body in mind	3.0			1.0						2.0
Eastern Suburbs Mental Health Service	Keeping body in mind	3.0			1.0						2.0
Eastern Suburbs Mental Health Service	Neuropsychiatric Institute	NA									
Eastern Suburbs Mental Health Service	Peer support team	3.7									3.7
Eastern Suburbs Mental Health Service	Physical Health Liaison	NA									
St George Community Mental Health Service	Clozapine clinic	0.6			0.6						
St George Community Mental Health Service	Connections	6.1	0.5	0.6				5.0			
St George Community Mental Health Service	Peer support team	3.2									3.2
St George Mental Health Service	Consultation Liaison Team	2.2	1.2		1						

St George Mental Health Service	Directions Team	13.9	0.4	0.5				13.0			
St George Mental Health Service	Outlook Team	8.1	0.1	4.0				4.0			
St Vincent's Mental Health Service	Anxiety Disorders Clinical	4.5	2.2	2.3							
St Vincent's Mental Health Service	Borderline Group-Day Care	1.0			1.0						
St Vincent's Mental Health Service	Community Rehab Team	2.6	0.2	0.4		1.0	1.0				
St Vincent's Mental Health Service	Consultation Liaison Team	6.3	3.5	1.6	1.2						
St Vincent's Mental Health Service	HTH/HIV Team	2.0	0.2	1.2	0.6						
Sutherland Community Mental Health Service	Clozapine clinic	0.6			0.6						
Sutherland Community Mental Health Service	Peer support team	3.2									3.2
Sutherland Mental Health Service	Consultation Liaison Team	1.5	1.5								
Sutherland Mental Health Service	Continuing and extended care team (CONNECT)	11.9		2.0	3.3	4.0	2.0		0.6		
Sutherland Mental Health Service	MindSet	NA									
Sutherland Mental Health Service	Specific treatment and rehabilitation team (START)	23.6		11.0	3.0	5.0	2.0			2.0	0.6
Total		125.2									
Rate per 100,000 residents (>17 years old)		19.39									

FTE: Full Time Equivalents; Psych/reg: Psychiatrist-registrar; Psychol: Psychologist; MHN: Mental health nurse; SW: Social worker; OT: Occupational therapist; CCM: Clinical case Manager; SF: support facilitator; AW: Aboriginal worker; Peer: Peer worker; NA: Not available at the time of completion of the study.

ACCESS TO ALLIED PSYCHOLOGICAL SERVICES (ATAPS)

In addition, there are 93 private providers under the ATAPS program in the SESLHD. The numbers of ATAPS providers providing non-acute outpatient care per 100,000 residents is 12.7 in the whole area, ranging from 0 in Lord Howe Island, to 24.86 in Waverley. According to the DESDE LTC system, the ATAPS program will receive the code **Gx[F00-F99]-O9.1.** Even though these individual services have not been included in the mapping comparison with other local health care areas their FTEs and workforce capacity have been included in the atlas (table 19).

TABLE 17 ATAPS: WORKFORCE CAPACITY

	Clin Psych	MHN	Psych	SW	SW (MHA)	OT	Grand Total	Total population over 17	Rate per 100,000 residents
Sydney	9.0	0.0	13.0	3.0	0.0	0.0	25.0	155,615	16.1
Botany Bay	1.0	0.0	1.0	0.0	0.0	0.0	2.0	30,959	6.5
Hurstville	1.0	0.0	1.0	0.0	1.0	0.0	3.0	62,114	4.8
Kogarah	1.0	0.0	1.0	0.0	0.0	0.0	2.0	43,909	4.6
Randwick	4.0	1.0	10.0	1.0	1.0	0.0	17.0	106,275	16.0
Rockdale	0.0	0.0	1.0	0.0	0.0	0.0	1.0	77,416	1.3
Sutherland Shire	4.0	0.0	16.0	0.0	2.0	1.0	23.0	162,496	14.2
Waverley	1.0	0.0	10.0	0.0	1.0	1.0	13.0	52,288	24.9
Woollahra	3.0	0.0	4.0	0.0	0.0	0.0	7.0	42,492	16.5
Lord Howe Island	0.0	0.0	0.0	0.0	0.0	0.0	0.0	306	0.0
Total							93.0	733,870	12.7

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

3.2.3.2 OUTPATIENT CARE PROVIDED BY NGOS

ACUTE MOBILE OUTPATIENT CARE

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

ACUTE NON-MOBILE OUTPATIENT CARE

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

NON-ACUTE MOBILE OUTPATIENT CARE

We found 19 BSICs/services providing non-acute mobile outpatient care within the boundaries of the SESLHD.

Mission Australian and Neami National provide the support component of the HASI program.

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

Brown Nurses is a service which provides in-home care to socially and economically disadvantaged individuals with complex needs, especially, but not exclusively, with a lived experience of mental illness. Its area of coverage is Greater Sydney, although it has a special focus on the SLHD and St Vincent's area.

Tenancy support services provided by FACS, described above in the residential care section, are included here. Additionally, Partners In Recovery BSICs, also described in a dedicated section, and provided by Aftercare, Neami National, and The Benevolent Society, are included here as Outpatient non-acute mobile services.

The number of BSICs/services from the NGO sector providing non-acute mobile outpatient care is 19, or 2.94 per 100,000 residents, including relevant Partners in Recovery (PIR)

TABLE 18 NON-ACUTE MOBILE OUTPATIENT CARE PROVIDED BY NGOS: AVAILABILITY

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	Alexandria	SES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	Randwick	ES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	Randwick	ES
Aftercare	Personal Helpers and Mentors	AX[F00-F99]-O5.2	Sylvania Waters	SES
Anglicare	Personal Helpers and Mentors	AX[F00-F99]-O6.2	Bondi Beach	ES

Brown Nurses	Brown Nurses	AX[F00-F99]-O6.1	Glebe	SV
FACS	Tenancy Support*	AX[Z55-65]-O7.2	Maroubra	ES
FACS	Tenancy Support*	AX[Z55-65]-O7.2	Maroubra	ES
FACS	Tenancy Support*	AX[Z55-65]-O7.2	Strawberry Hills	ES
FACS	Tenancy Support*	AX[Z55-65]-O7.2	Miranda	SES
Mission Australia	HASI	AX[F00-F99]-O5.2	Waterloo	ES-SV
Neami National	HASI - City	AX[F00-F99]-O5.2	Darlinghurst	SV
Neami National	HASI - Eastern	AX[F00-F99]-O5.2	Darlinghurst	SV
Neami National	HASI/ Recovery Program	AX[F00-F99]-O5.2	Hurtsville	SES
Neami National	Help Housing Recovery	AX[F00-F99]-O6.2	Darlinghurst	SV
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	Pagewood	ES
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	Hurtsville	SES
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	Darlinghurst	SV
The Benevolent Society	Partners in Recovery*	AX[F00-F99]-O5.2	Hurtsville	SES
Total	19			
Rate per 100,000 residents (>17 years old)	2.94			

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

The table below shows the workforce providing non-acute mobile outpatient care related to health needs. The total number of FTEs is 124.2, or 19.24 per 100,000 residents.

TABLE 19 NONACUTE MOBILE OUTPATIENT CARE BY NGOS: WORKFORCE CAPACITY

Provider	Name	Total FTE	MHN	SW	nCCM	MHW	SF	SupW	Others
Aftercare	Partners in Recovery*	3.0					3.0		
Aftercare	Partners in Recovery*	5.0					5.0		
Aftercare	Partners in Recovery*	6.0					6.0		
Aftercare	Personal Helpers and Mentors	5.0						5.0	
Anglicare	Personal Helpers and Mentors	12.0		4.0	6.0	2.0			
Brown Nurses	Brown Nurses	5.0	5.0						
FACS	Tenancy Support*	9.0							9.0
FACS	Tenancy Support*	9.0							9.0
FACS	Tenancy Support*	7.0							7.0
FACS	Tenancy Support*	10.0							10.0
Mission Australia	HASI	4.0					4.0		
Neami National	HASI - City	6.0					6.0		
Neami National	HASI - Eastern	4.0					4.0		
Neami National	HASI/ Recovery Program	11.7						11.7	
Neami National	Help Housing Recovery	3.0					3.0		
Neami National	Partners in Recovery*	10.5					10.5		

Neami National	Partners in Recovery*	5.0	5.0
Neami National	Partners in Recovery*	5.0	5.0
The Benevolent Society	Partners in Recovery*	4.0	4.0
Total		124.2	
Rate per 100,000 residents (>17 years old)		19.24	

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

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

NON-ACUTE NON-MOBILE OUTPATIENT CARE

We have identified 6 BSICs/services providing non-acute non-mobile outpatient care within the boundaries of the SESLHD.

Wesley Mission has a financial counselling service, and a psychological service in Sydney (City, Pitt Street) that can be used by people from the Greater Sydney Area.

Wesley Mission also provides psychological services and financial counselling for all people in the Greater Sydney Area. In addition, Wesley Mission supports people with a lived experience of mental illness who are homeless, or at risk of being homeless, by providing outpatient (community), mobile, non-acute care. They meet their consumers fortnightly, or monthly, and help them to find a home or to maintain their property. In case it is needed, they also have 17 properties across Greater Sydney that can be used by their consumers. The main office is located in Ashfield.

The Haymarket Foundation aims to support socio-economically disadvantaged people in Sydney providing medical assistance and crisis accommodation. Although it mainly works with people who are homeless, it also provides psychological services for people with a lived experience of mental illness who are vulnerable (they do not need to be homeless).

Southern Community Welfare provides general counselling to people with depression and anxiety in the SES.

Lastly, OneWave is a non-profit surf community raising awareness for mental health. They have a 12-week surfing program for people experiencing mental illness, in partnership with different mental health organisations. While learning to surf, participants also work on their self-confidence, self-esteem and social skills.

In addition, Exodus Foundation has a service that provides social care for people with psychosocial conditions, specifically homelessness (for this reason it was not included in the calculation of rates nor in the tables for the Atlas), but has a special focus on their mental health needs.

The number of BSICs/services from the NGO sector providing non-acute non-mobile outpatient care is 6, or 0.93 per 100,000 residents.

TABLE 20 NONACUTE NONMOBILE CARE BY NGOS: AVAILABILITY

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Haymarket Foundation	Psychological Services	AX[F00-F99]-O8.1	East Sydney	Greater Sydney
One Wave is all it takes	One Wave is all it takes	AX[F00-F99]-O9.2	Bondi	ES and Sutherland
Southern Community Welfare	Psychologists	AX[F00-F99]-O9.1	Kirrawee	SES
Wesley Mission	Financial Counselling/Gambling	AX[Z55-65]-O9.2	Sydney	Greater Sydney Area
Wesley Mission	Homelessness support for people with MH issues	AX[F00-F99]-O10.2	Surry Hills	SV-ES-SES
Wesley Mission	Psychological Services	AX[F00-F99]-O9.1	Sydney	Greater Sydney Area
Total	6			
Rate per 100,000 residents (>17 years old)	0.93			

The table below shows the workforce providing non-acute non-mobile care related to health needs. The total number of FTE is 19.8, or 3.07 per 100,000 residents.

TABLE 21 NON-ACUTE NON-MOBILE OUTPATIENT BSICS PROVIDED BY NGOS: WORKFORCE CAPACITY

Provider	Name	Total FTE	Psych/reg	Psychol	CCM	nCCM	Others
Haymarket Foundation	Psychological Services	1.0		1.0			

One Wave is all it takes	One Wave is all it takes	0.8		0.2	0.6
Southern Community Welfare	Psychologists	2.0	2.0		
Wesley Mission	Financial Counselling/Gambling	8.0			8.0
Wesley Mission	Homelessness support for people with MH issues	6.0			6.0
Wesley Mission	Psychological Services	1.0		1.0	
Total		19.8			
Rate per 100,000 residents (>17 years old)		3.07			

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

3.2.4 ACCESSIBILITY SERVICES

3.2.4.1 ACCESSIBILITY SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR

We have found 3 BSICs in the public health sector providing accessibility care in the SESLHD. In addition, the Physical Health Liaison service of the Prince of Wales Hospital, which mainly provides outpatient care (see the corresponding section), also provides accessibility services (DESDE 2 = O5.1u). Therefore, the total number of MTCs providing accessibility services in the public health sector amounts to four.

The number of BSICs from the public health sector providing accessibility services is 3, or 0.27 per 100,000 residents. The number of FTEs of professionals providing accessibility services is 5, or 0.46 per 100,000 residents.

TABLE 22 ACCESSIBILITY SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR: AVAILABILITY

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service	Transitional Care Team	AX[F00-F99]-A4	Randwick	ES
St George Mental Health Service	GP Support	AX[F00-F99]-A5.1	Kogarah	SES

St George Mental Health Service	Paid Peer Support Worker	AX[F00-F99]-A3	Kogarah	SES
Total	3			
Rate per 100,000 residents (>17 years old)	0.27			

TABLE 23 ACCESSIBILITY SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR: WORKFORCE CAPACITY

Provider	Name	Total FTE	MHN	CCM	Peer
Eastern Suburbs Mental Health Service	Transitional Care Team	2.0	1.0	1.0	
St George Mental Health Service	GP Support	2.0	2.0		
St George Mental Health Service	Paid Peer Support Worker	1.0			1.0
Total		5			
Rate per 100,000 residents (>17 years old)		0.46			

FTE: Full-Time Equivalents; MHN: Mental health nurse; CCM: Clinical case manager; Peer: Peer worker

3.2.4.2 ACCESSIBILITY SERVICES PROVIDED BY NGOS

We have found 1 BSIC/ service, in the SESLHD provided by a NGO, facilitating access to employment for people with a lived experience of mental illness. RichmondPRA-in partnership with Ostara supports people with a lived experience to access employment.

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

In addition to these NGO services, three accessibility BSICs are provided by FACS.

The total number of BSICs/services from the NGO sector, and including FACS services, providing accessibility services is 7, or 1.08 per 100,000 residents. The rate of services providing accessibility to employment is 1, or 0.15 per 100,000 residents, and 0.62 per 100,000

residents for accessibility to housing (we did not identify any service providing accessibility to cultural activities).

TABLE 24 ACCESSIBILITY SERVICES PROVIDED BY NGOS: AVAILABILITY

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
FACS	Eligibility and Assessment*	AX[Z55-65]-A5.5	Hurtsville	SES
FACS	Eligibility and Assessment*	AX[Z55-65]-A5.5	Strawberry Hills	ES
FACS	Eligibility and Assessment*	AX[Z55-65]-A5.5	Maroubra	ES
Neami National	Way2Home	AX[F00-F99]-A5.5	Darlinghurst	SV
RichmondPRA + Ostara	Disability Employment Service	AX[F00-F99]-A5.4	Caringbah	Greater Sydney Area
The Benevolent Society	Community Options Program	AX[F00-F99]-A4	Hurtsville	SES
The Benevolent Society	Community Options Program	AX[F00-F99]-A4	Rosebery	ES
Total	7			
Rate per 100,000 residents (>17 years old)	1.08			

**Please note FACS BSICs are also coded separately in a dedicated FACS section*

The table below describes the workforce providing accessibility services in NGOs.

Accessibility services provided by NGOs for people with a lived experience of mental illness have a total workforce of 85.3, or 13.21 FTEs per 100,000 residents.

TABLE 25 ACCESSIBILITY SERVICES PROVIDED BY NGOS: WORKFORCE CAPACITY

Provider	Name	Total FTE	nCCM	MHW	SupW	Others
FACS	Eligibility and Assessment*	16.0				16.0

FACS	Eligibility and Assessment*	28.0			28.0
FACS	Eligibility and Assessment*	13.0			13.0
Neami National	Way2Home	18.3		18.3	
RichmondPRA + Ostara	Disability Employment Service	2.0		2.0	
The Benevolent Society	Community Options Program	4.0	4.0		
The Benevolent Society	Community Options Program	4.0	4.0		
Total		85.3			
Rate per 100,000 residents (>17 years old)		13.21			

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

**Please note FACS BSICs are also coded separately in a dedicated FACS section*

PARTNERS IN RECOVERY

Partners in Recovery in the SESLHD was managed by the ES Medicare Local and the SES Medicare Local, and is now managed by the CESPHN. The main objective of the PIR program is to increase the accessibility to a different range of services for people with a lived experience of mental illness. Interestingly, though, these providers are not just focused on accessibility, but take a more holistic approach, providing also some counselling or coaching. Theoretically, the code of the PIR program should be an A4 (accessibility/care manager), but some organisations report that they are providing more intensive direct day care, so they received an outpatient code (O5.2). They can meet according to the needs of the 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 2019). Advance Diversity Services, located in Rockdale, has the only PIR especially devoted to the CALD populations.

The total number of PIR identified in the SESLHD is 9, or 1.39 per 100,000 residents. *Note that, in this Atlas, PIRs were also taken into account in the rates of services providing accessibility and outpatient services when applicable (based on their main DESDE code) as they recently obtained stable funding (at least three years). However, it was not the case at the time of completion of the previous integrated atlases of mental healthcare developed in Australia.*

TABLE 26 PIR PROGRAMS: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	FTE	%FTE	Town / Suburb	Area of Coverage
Advance Diversity Services	PIR-CALD	AX[F00-F99]-O5.2	4.0	8.4%	Rockdale	ES-SES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	3.0	6.3%	Alexandria	SES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	5.0	10.5%	Randwick	ES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	6.0	12.6%	Randwick	ES
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	10.5	22.1%	Pagewood	ES
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	5.0	10.5%	Hurtsville	SES
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	5.0	10.5%	Darlinghurst	SV
St George Mental Health Service	Rehabilitation team	AX[F00-F99]-O5.2	5.0	10.5%	Kogarah	SES
The Benevolent Society	Partners in Recovery*	AX[F00-F99]-O5.2	4.0	8.4%	Hurtsville	SES
Total	9		47.5	100%		
Rate per 100,000 residents (>17 years old)	1.39		7.36			

FTE: Full-Time Equivalents

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

ABILITY LINKS

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

3.2.5 INFORMATION AND GUIDANCE

3.2.5.1 INFORMATION AND GUIDANCE SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR

We have identified 3 BSICs/services providing information and guidance only for people with a lived experience of mental illness.

The total number of BSICs or services from the health sector providing information and guidance for people with a lived experience of mental illness is 3, or 0.46 per 100,000 residents.

TABLE 27 INFORMATION AND GUIDANCE SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR: AVAILABILITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service	Consumer Support	GX[F00-F99]-I2.1.2		Randwick	ES
St Vincent's Mental Health Service	Triage Service	GX[F00-F99]-I1.1		Darlinghurst	SV
Sutherland Mental Health Service	Intake and assessment Service	GX[F00-F99]-I1.1e	GX[F00-F99]-O4.1	Caringbah, Kogarah	SES
Total		3			
Rate per 100,000 residents (>17 years old)		0.46			

The table below describes the workforce providing information and guidance.

The specific services for people with a lived experience of mental illness have a total workforce of 7, or 1.08 FTEs per 100,000 residents.

TABLE 28 INFORMATION AND GUIDANCE SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR: WORKFORCE CAPACITY

Provider	Name	Total FTE	Psychol	MHN	OT	CCM
Sutherland Mental Health Service	Intake and assessment Service	5.0	2.0	2.0	1.0	
Eastern Suburbs Mental Health Service	Consumer Support	NA				

St Vincent's Mental Health Service	Triage Service	2.0		2.0
Total		7		
Rate per 100,000 residents (>17 years old)		1.08		

FTE: Full-Time Equivalents; Psychol: Psychologist; MHN: Mental health nurse; OT: Occupational therapist; CCM: Clinical case manager. NA: Not available at the time of completion of the study

3.2.5.2 INFORMATION AND GUIDANCE SERVICES PROVIDED BY NGOS

We have identified 3 BSICs/services, corresponding to 4 MTCs, providing information for people with a lived experience of mental illness.

One of them is provided by the Mental Health Association, while the others are provided by Eastern Area Tenants Service and the Sutherland Council.

The number of BSICs from the NGO sector providing information and guidance for people with a lived experience of mental illness is 3, or 0.46 per 100,000 residents in the SESLHD.

TABLE 29 INFORMATION AND GUIDANCE SERVICES PROVIDED BY NGOS: AVAILABILITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	Town / Suburb	Area of Coverage
Eastern Area Tenants Service	Information Services	AX[F00-F99]-I2.1.1		Bondi Junction	ES
Mental Health Association	Information Services	GX[F00-F99]-I2.2	GX[F00-F99]-I2.1.2	Woolloomooloo	STATE
Sutherland Council	Information Services	GX[F00-F99]-I2.1.2		Sutherland	SES
Total		3			
Rate per 100,000 residents (>17 years old)		0.46			

3.2.6 SELF AND VOLUNTARY SUPPORT

3.2.6.1 SELF AND VOLUNTARY SUPPORT PROVIDED BY NGOS

We have found four BSICs/services based on volunteer staff providing care for people with a lived experience of mental illness.

They are: Hearing Voices Network NSW, which provides support groups on a monthly basis in Newtown, Chatswood, Woolloomooloo, Sutherland, Penrith, Newcastle, Campbelltown, Dapto, Bathurst, Goulburn, Queanbeyan, Taree, Deniliquin, Wollongong, and Ulladulla, of which Woolloomooloo and Sutherland are in the SESLHD. The Compeer friendship program, run by St Vincent de Paul Society aims to improve the quality of life of adults with a mental illness through one-to-one friendship with a caring volunteer; and Schizophrenia Fellowship provides a Support Group in Bondi Junction.

The total number of BSICs/services from the NGO sector providing self and voluntary support services in the SESLHD is 4, or 0.62 per 100,000 residents.

TABLE 30 SELF AND VOLUNTARY SUPPORT PROVIDED BY NGOS: AVAILABILITY

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Hearing Voices	Groups	AX[F00-F99]-S1.3	Different locations	IWS and SES
Schizophrenia Fellowship	Support Group	AX[F00-F99]-S1.3	Bondi Junction	ES
St Vincent de Paul	Compeer	GX[F00-F99]-S1.2	Different locations	SES and SLHD
Wesley Mission	Lifeline	AX[F00-F99]-S1.1	Sydney	Greater Sydney
Total	4			
Rate per 100,000 residents (>17 years old)	0.62			

3.3 AGE SPECIFIC POPULATIONS

3.3.1 SERVICES FOR CHILDREN AND ADOLESCENTS

We identified 8 BSICs/services, or 5.22 per residents under 18 years of age, providing specific care for children and adolescents with a lived experience of mental illness. One of these BSICs also provides care for adults: it has been described above.

TABLE 31 SERVICES PROVIDING CARE FOR CHILD AND ADOLESCENT: AVAILABILITY, PLACEMENT AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	Beds/Places	FTE	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service	Child and Family East/Sydney Children Hospital	CC[F00-F99]-O9.1			NA	Randwick	ES
Eastern Suburbs Mental Health Service	Child and Family East	CC[F00-F99]-O5.1.1			4.2	Randwick	ES
Eastern Suburbs Mental Health Service	The Adolescent Service	CA[F00-F99]-O5.1.1			7.9	Randwick	ES
St George Mental Health Service	Children and Adolescent Mental Health Services	CX[F00-F99]-O8.1			12.0	Hurstville	SES
Sutherland Mental Health Service	MindSet	CX[F00-F99]-O9.1	AX[F00-F99]-O9.1		NA	Caringbah	SES
Sutherland Mental Health Service	Children and Adolescent Mental Health Services	CX[F00-F99]-O4.1v			1.6	Caringbah	SES
Sydney Children's Hospital	Child and Adolescent Mental Health Unit	CX[F00-F99]-R2		8	34.0	Randwick	NSW
Sydney Children's Hospital	Inpatient Adolescent Unit	CA[F00-F99]-R2	CA[F00-F99]-O4.1v	8	34.0	Randwick	SES
Total	8			16	93.7		
Rate per 100,000 residents (<18 years old)	5.22			10.45	14,51		

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

3.3.2 TRANSITION TO ADULTHOOD

3.3.2.1 OUTPATIENT CARE PROVIDED BY THE PUBLIC SECTOR

There are 8 BSICs, or 7.27 per 100,000 residents aged 16-25 years of age, provided for this age group by the public sector, with a FTE of 33.09, or 30.06 per 100,000 residents aged 16-25 years.

TABLE 32 OUTPATIENT CARE FOR TRANSITION TO ADULTHOOD IN THE PUBLIC HEALTH SECTOR: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service	Early Psychosis Team	TA[F20-29]-O6.1	4.4	Bondi Junction	ES
Eastern Suburbs Mental Health Service	Headspace	TA[F00-F99]-O9.1	6.4	Bondi Junction	ES
Eastern Suburbs Mental Health Service	Youth Mental Health Team	TA[F00-F99]-O6.1	2.65	Bondi Junction	ES
St George Mental Health Service	Keeping body in mind	TA[F00-F99]-O9.1	6.4	Hurstville	SES
St George Mental Health Service	Youth Mental Health Team	TA[F00-F99]-O8.1	1.0	Kogarah	SES
St Vincent's Mental Health Service	Early Psychosis team	TA[F20-29]-O5.1	4.8	Darlinghurst	SV
Sutherland Mental Health Service	Keeping body in mind	TA[F00-F99]-O9.1	3.4	Caringbah	SES
Sutherland Mental Health Service	Youth Mental Health Team	TA[F00-F99]-O6.1	4.0	Caringbah	SES
Total	8		33.09		
Rate per 100,000 residents 16-25 years old)	7.27		30.06		

FTE: Full Time Equivalents

3.3.2.2 OUTPATIENT CARE PROVIDED BY NGOS

We identified 2 outpatient BSICs, or 1.82 per 100,000 residents aged 16-25 years, with 14 FTE, or 12.9 per 100,000 residents.

TABLE 33 OUTPATIENT CARE PROVIDED FOR TRANSITION TO ADULTHOOD BY NGOS: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
Aftercare	Headspace	TA[F00-F99]-O9.1	6.2	Hurstville	SES

Aftercare	Headspace	CY[F00-F99]-O9.1	8.0	Miranda	Sutherland
Total	2		14.2		
Rate per 100,000 residents 16-25 years old)	1.82		12.9		

FTE: Full Time Equivalents

3.3.3 SERVICES FOR OLDER PEOPLE

We identified 10 BSICs/services, corresponding to 13 MTCs and including 4 satellites, providing specific care for older people with a lived experience of mental illness. **The total number of such BSICs in the SESLHD was 9.03 (standardised per 100,000 residents aged 64 and above to maintain comparability): 2.71 per 100,000 residents for services providing residential care and 7.22 per 100,000 residents for services providing non-acute outpatient care. The total number of FTEs of professionals providing mental health care for older people in the SESLHD is 81.7, or 73.7 per 100,000 residents.**

Three MTCs providing residential care for older people have been identified. We found 8 services providing non-acute mobile outpatient care for older adults in the SESLHD.

We have identified two specialist mental health services for older people provided by the community mental health services of the SESLHD. They provide outpatient (community) non-acute mobile care for people with a lived experience older than 64 years. It is worth mentioning the Euroa Team, which promotes integrated of mental health care for older people following a holistic approach, similar to the Psychogeriatric team at St Vincent.

TABLE 34 SERVICES PROVIDING CARE FOR OLDER PEOPLE: AVAILABILITY, PLACEMENT AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	Beds/Places	FTE	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service	Aged Care Team Euroa-community	OX[F00-F99]-O6.1	OX[F00-F99]-O5.1		25.0	Randwick	ES
Eastern Suburbs Mental Health Service	Aged Care Team Euroa-inpatient	OX[F00-F99]-R2		8*	7.0	Randwick	ES
St George Mental Health Service	Community Health Team Older People	OX[F00-F99]-O6.1			7.4	Kogarah	SES
St George Mental Health Service	Sub-acute older person unit	OX[F00-F99]-R4		16	27.0	Kogarah	SES
St Vincent's Mental Health Service	Psychogeriatric team - Elisabeth Lodge aged care facility (satellite)	OX[F00-F99]-O9.1t			NA	Rushcutters Bay	SV

St Vincent's Mental Health Service	Psychogeriatric team - Gertrude Abbott aged care facility (satellite)	OX[F00-F99]-O9.1t			NA	Surry Hills	SV
St Vincent's Mental Health Service	Psychogeriatric team - Lulworth aged care facility (satellite)	OX[F00-F99]-O9.1t			NA	Elizabeth Bay	SV
St Vincent's Mental Health Service	Psychogeriatric team - Presbyterian aged care facility (satellite)	OX[F00-F99]-O9.1t			NA	Paddington	SV
St Vincent's Mental Health Service	Psychogeriatric team- Community Home Visit	OX[F00-F99]-O6.1	OX[F00-F99]-R2 OX[F00-F99]-O9.1		11.4	Darlinghurst	SV
Sutherland Mental Health Service	Community Health Team Older People	OX[F00-F99]-O6.1			3.9	Caringbah	SES
Total	10			22	81,7		
Rate per 100,000 residents >64 years old)	9.03			19.86	73.77		

*FTE: Full Time Equivalents; * 2 inpatient beds are assigned to the Neuropsychiatry Institute.*

3.4 NON-AGE RELATED SPECIFIC POPULATIONS

3.4.1 GENDER SPECIFIC SERVICES

We identified 3 BSICs/services, corresponding to 4 MTCs, providing specific care based on gender. **The total number of gender-specific MTCs amounts to 0.91 per 100,000 women in the SESLHD.** The total number of FTEs of professionals providing care in gender-specific services is 4.25 per 100,000 women.

3.4.1.1 RESIDENTIAL CARE PROVIDED BY NGOS

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

TABLE 35 RESIDENTIAL CARE PROVIDED BY NGOS: AVAILABILITY, CAPACITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
B Miles Women's Foundation	Refuge in Darlinghurst	AXF[F00-F99]-R8.2s	9.0	Darlinghurst	SV

Total	1	9
Rate per 100,000 residents (women >17 years old)	0.3	2.73

FTE: Full Time Equivalents

3.4.1.2 DAY CARE PROVIDED BY NGOS

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

TABLE 36 DAY CARE PROVIDED BY NGOS: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	Beds/Places	FTE	Town / Suburb	Area of Coverage
The Marmalade Foundation Limited	Lou's Place	AXF[F00-F99]-D5	30	2.0	Potts Point	Greater Sydney, Central Coast, Illawarra
Total	1		30	2		
Rate per 100,000 residents (women >17 years old)	0.3		9.10	0.61		

FTE: Full Time Equivalents

3.4.1.3 OUTPATIENT CARE PROVIDED BY NGOS

TABLE 37 OUTPATIENT CARE PROVIDED BY NGOS: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	FTE	Town / Suburb	Area of Coverage
B Miles Women's Foundation	Outreach Support Services in Housing	AXF[F00-F99]-O6.2s	AXF[F00-F99]-O9.2	3.0	Edgecliffe	Asfiled, Leichard, Marrickfille, city of sydney
Total	1			3		
Rate per 100,000 residents (women >17 years old)	0.3			0.91		

The **B-Miles Outreach Support Services** also covers the area of Greater Sydney. It supports women who are already housed and require tenancy support, assistance to access resources and support to maintain their living arrangements. They provide support in-home or wherever the client prefers. They can meet the client on a weekly basis if needed (DESDE-LTC code: Ax[F00-F99]-O6.2). It is staffed with 3 FTE (non-clinical case managers).

3.4.2 SERVICES FOR CARERS

We have identified 1 BSIC (service), or 0.15 per 100,000 residents over 17 years, providing care for carers of people with a lived experience of mental illness, and staffed with 4 FTE, or 0.62 per 100,000 residents.

TABLE 38 SERVICES FOR CARERS: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
Aftercare	Family and Carers (FACES)	AX[e310][F00-F99]-O6.2	4.0	Sylvania Waters	SES-ES-SV
Total	1		4		
Rate per 100,000 residents >17 years old)	0.15		0.62		

FTE: Full Time Equivalents

3.4.3 SERVICES FOR PARENTS WITH MENTAL ILLNESS

We identified 3 BSICs or services, or 0.46 per 100,000 residents over the age of 17 years, providing care for parents with a lived experience of mental illness, with a workforce capacity of 5.2, or 0.81 per 100,000 residents.

TABLE 39 SERVICES FOR PARENTS WITH MENTAL ILLNESS: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service	Perinatal team	AX[F00-F99]-O6.1s	2.2	Randwick	ES
St George Mental Health Service	Perinatal team	AX[F00-F99]-O5.1	1.4	Kogarah	SES

Sutherland Mental Health Service	Perinatal team	AX[F00-F99]-O8.1	1.6	Caringbah	SES
Total	3		5.2		
Rate per 100,000 residents >17 years old)	0.46		0.81		

FTE: Full Time Equivalents

3.4.4 SERVICES FOR OFFENDERS

We found nine BSICs , or 1.39 per 1000,000 residents over 17 years, providing specific care for offenders. These provide 220 beds, or 34.07 per 100,000 residents. It is important to note here that there are also services available at the Forensic Hospital in Malabar, and Long Bay Hospital, associated with the Justice and Forensic Mental Health Network. As we have not been systematically mapping justice services at this stage, they are yet to be codified.

TABLE 40 SERVICES FOR OFFENDERS: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	Beds/Places	FTE	Town / Suburb	Area of Coverage
Justice Health and Forensic Mental Health Network	Community Forensic Mental Health Service	AX[F00-F99]-O10.1j			NA	Sydney, Balmain, Kogarah, Burwood, Sutherland and Waverley	NSW
Justice Health and Forensic Mental Health Network	Long Bay Correctional Centre	AX[F00-F99]-R3j	AX[F00-F99]-O1.1j	85	NA	Malabar	NSW
Justice Health and Forensic Mental Health Network	The Forensic Hospital-Austinmer Adolescent	CA[F00-F99]-R1j		6	NA	Malabar	NSW
Justice Health and Forensic Mental Health Network	The Forensic Hospital - Austinmer Women	AXF[F00-F99]-R1j		17	NA	Malabar	NSW
Justice Health and Forensic Mental Health Network	The Forensic Hospital - Bronte	AXM[F00-F99]-R1j		33	NA	Malabar	NSW
Justice Health and Forensic Mental Health Network	The Forensic Hospital - Clovelly	AXM[F00-F99]-R4j		27	NA	Malabar	NSW
Justice Health and Forensic Mental Health Network	The Forensic Hospital - Dee Why	AXM[F00-F99]-R4j		32	NA	Malabar	NSW

Justice Health and Forensic Mental Health Network	The Forensic Hospital - Elouera	AXM[F00-F99]-R4j	20	NA	Malabar	NSW
Justice system	Justice-co-existing disorders project	AX[F00-F99]-O9.2ms		1.0	Sydney	SES-ES-SV
Total	8		215	1		
Rate per 100,000 residents >17 years old)	1.24		34.07	0.15		

FTE: Full Time Equivalents

3.4.5 MULTICULTURAL SERVICES

We identified five BSICs/services, or 0.77 per 100,000 residents, with a FTE of 19.2, or 2.97 per 100,000 residents, providing care to people from a multicultural and linguistically diverse background, with a lived experience of mental illness in the SESLHD. These include JewishCare, Jewish House, Bilingual Mental Health Counselling Services (located at the Prince of Wales Hospital and the St George Community Mental Health Centre). Additional multicultural services are provided within PIR services.

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

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

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

TABLE 41 MULTICULTURAL SERVICES: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	Other DESDE code(s)	FTE	Town / Suburb	Area of Coverage
Advance Diversity Services	PIR-CALD	AX[F00-F99]-O5.2		4.0	Rockdale	ES-SES
Eastern Suburbs Mental Health Service	Bilingual Counselling Services	GX[F00-F99]-O9.1	GX[F00-F99]-A1	2.6	Maroubra	ES
Jewish Care	Mental health and wellbeing	AX[F00-F99]-A4	AX[F00-F99]-D8.3	7.0	Woollahra	ES
Jewish House	Psychological Services	AX[F00-F99]-O9.1		2.0	Bondi	ES
St. George Community Mental Health Service	Bilingual health workers	GX[F00-F99]-O7.1		3.6	Caringbah	SES
Total	5			19.2		
Rate per 100,000 residents >17 years old)	0.77			2.97		

FTE: Full Time Equivalents

3.4.6 SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

We have identified three specific BSIC/service for Aboriginal and Torres Strait Islander peoples with a lived experience of mental illness. Two BSIC are managed by the SESLHD and one is managed by the Benevolent Society and provides 1 FTE of non-clinical case manager.
The FTE for these services is 4, or 0.62 per 100,000 residents.

TABLE 42 SPECIFIC SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES: AVAILABILITY AND WORKFORCE CAPACITY

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
Eastern Suburbs Mental Health Service	Aboriginal support workers	GX[IN][F00-F99]-O7.1	1.0	La Perouse	ES
Sutherland Community Mental Health Service	Aboriginal support workers	GX[IN][F00-F99]-O7.1	2.0	Caringbah	Sutherland & St. George
The Benevolent Society	Aboriginal Engagement Coordinator	AX[IN][F00-F99]-O5.2	1.0	Hurstville	SES

Total	3	4
Rate per 100,000 residents >17 years old)	0.46	0.62

FTE: Full Time Equivalents

3.4.7 HOMELESSNESS SERVICES

The complexity of homelessness requires a detailed analysis. We acknowledge that most people who experience homelessness also have an additional mental health issue. However, the main objective of this Atlas is to describe the services which target mental illness/mental health. If we were to include the services for people experiencing homelessness in general in the analysis, we would bias the picture.

4 MAPPING MENTAL HEALTH SERVICES

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

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

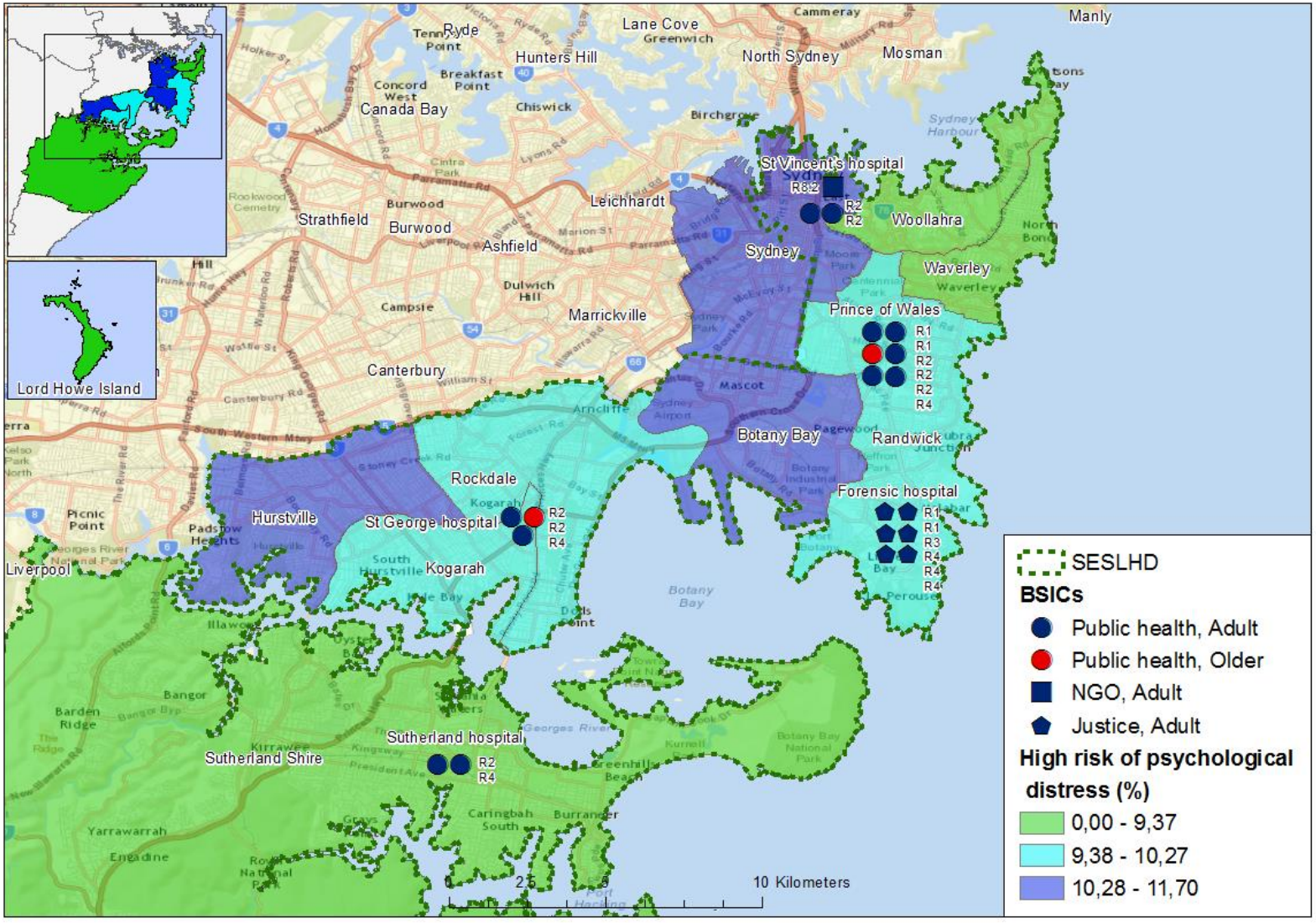


Figure 12 Geographical distribution of psychological distress and residential services.

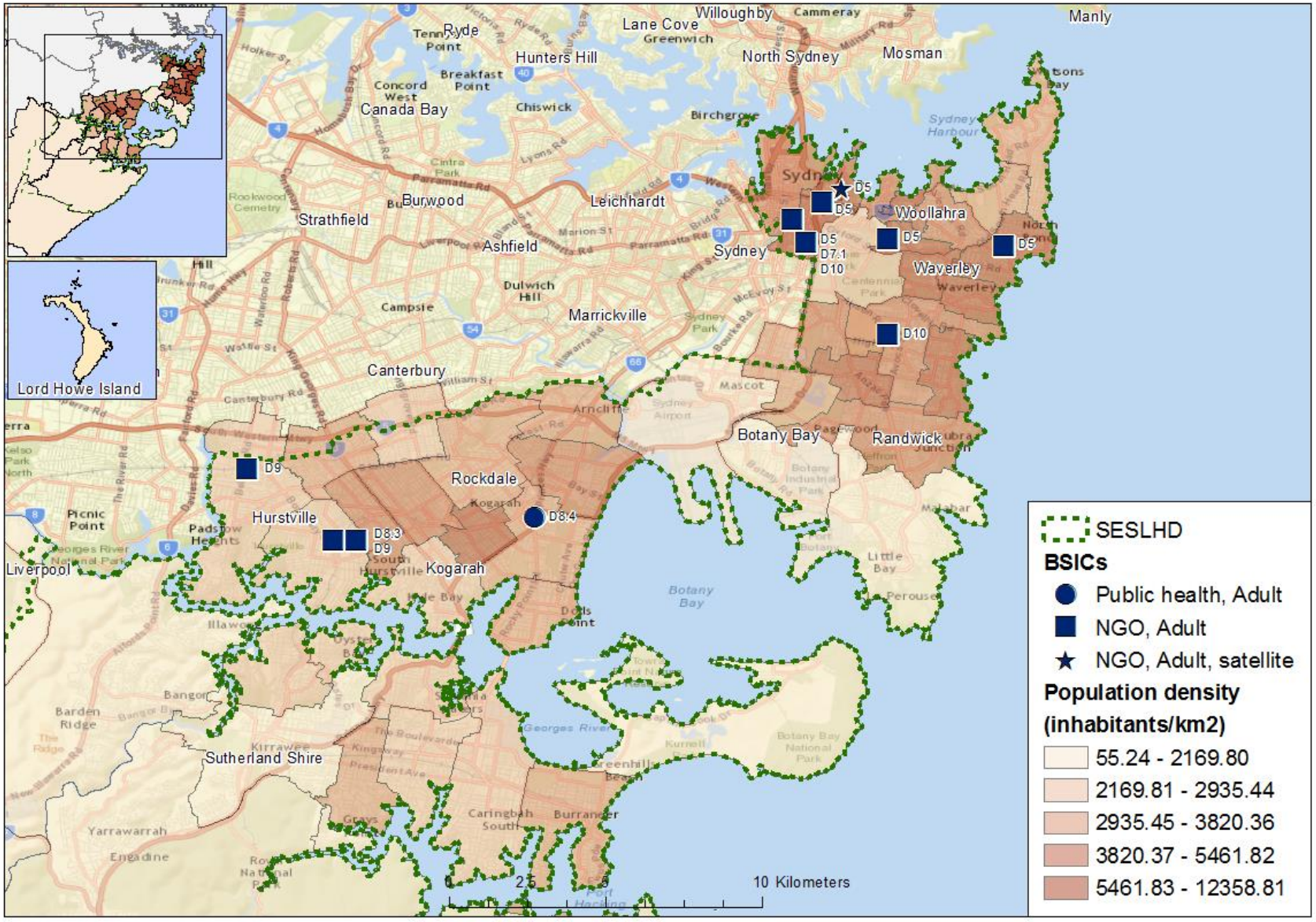


Figure 13 Geographical distribution of population density and day program services.

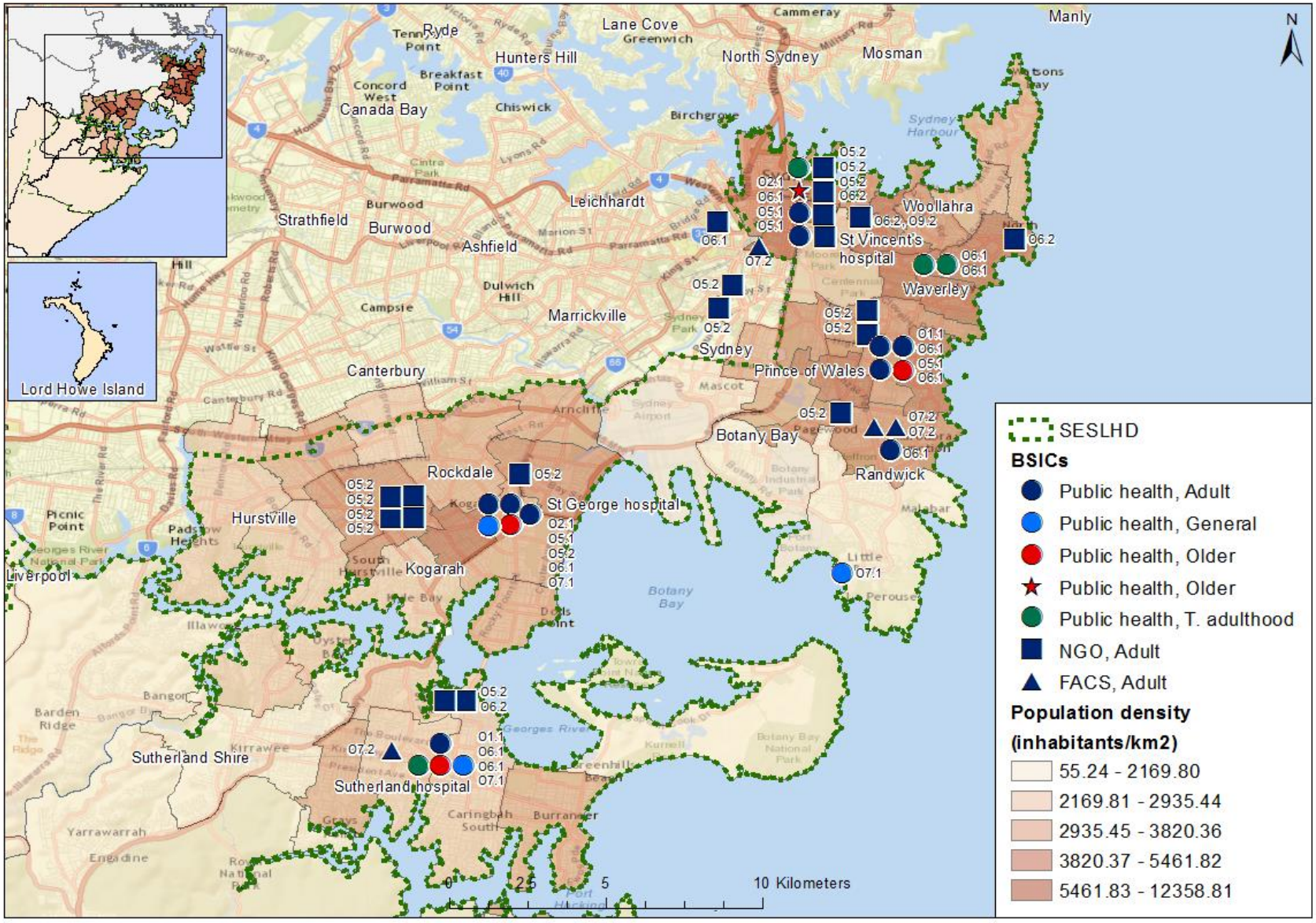


Figure 14 Geographical distribution of population density and outpatient mobile services.

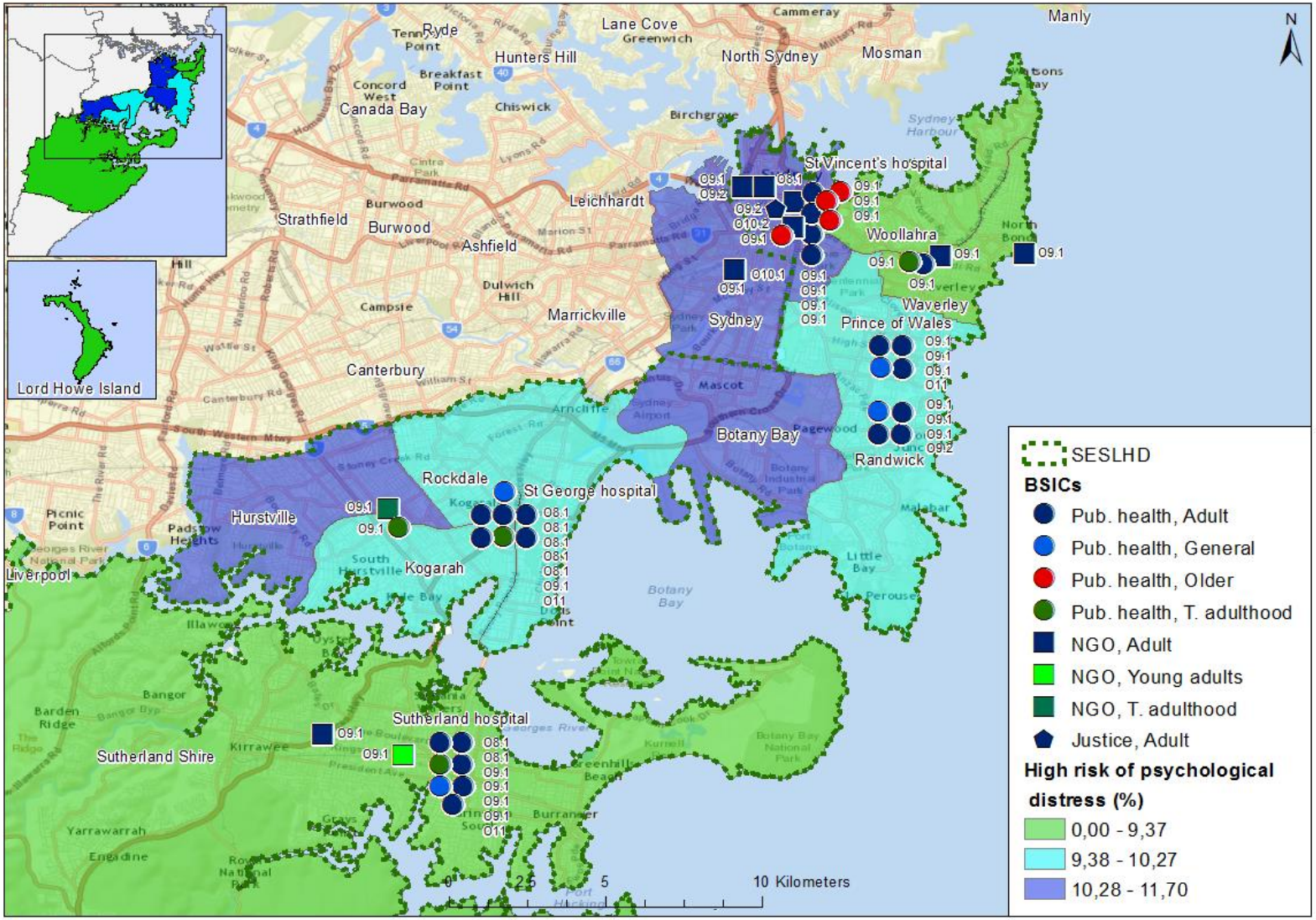


Figure 15 Geographical distribution of psychological distress and outpatient non-mobile services.

5 DESCRIPTION OF THE PATTERN OF CARE IN THE SESLHD

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

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

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

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

The first gap is related to an absence of services staffed with psychiatrists, psychologists and nurses, who provide care for people with a lived experience of mental illness who are experiencing a crisis. They provide the same type of care as the hospital (in an inpatient unit) but are embedded in the community. These are small units, with a strong focus on recovery (e.g. crisis homes). The second gap is related to the lack of supported accommodation for people with mental illness. This has already been pointed out by other Atlases and it is one of the major strategic areas for IWS PIR. The third gap refers to a lack of day care related to health. Acute day care related to health includes services providing an alternative to hospitalisation. People experiencing a mental health crisis are not admitted to a hospital, but treated in the community. They spend all day at the facility, but they sleep at home. On the other hand, non-acute day care includes day care centres staffed with at least 20 percent of highly skilled mental health 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 mental health, such as cognitive training. There is also a lack of day care related to cultural and leisure activities; however, this is partially met by the "Active Linking Initiative" and the presence of Buckingham House and Lou`s Place in the boundaries between SESLHD and the SLHD.

On the other hand, there is good development of non-acute mobile services, and the non-acute and non-mobile community mental health services, managed by the SESLHD. We have also identified new services targeting, specifically, the physical health of people with a lived experience of mental illness.

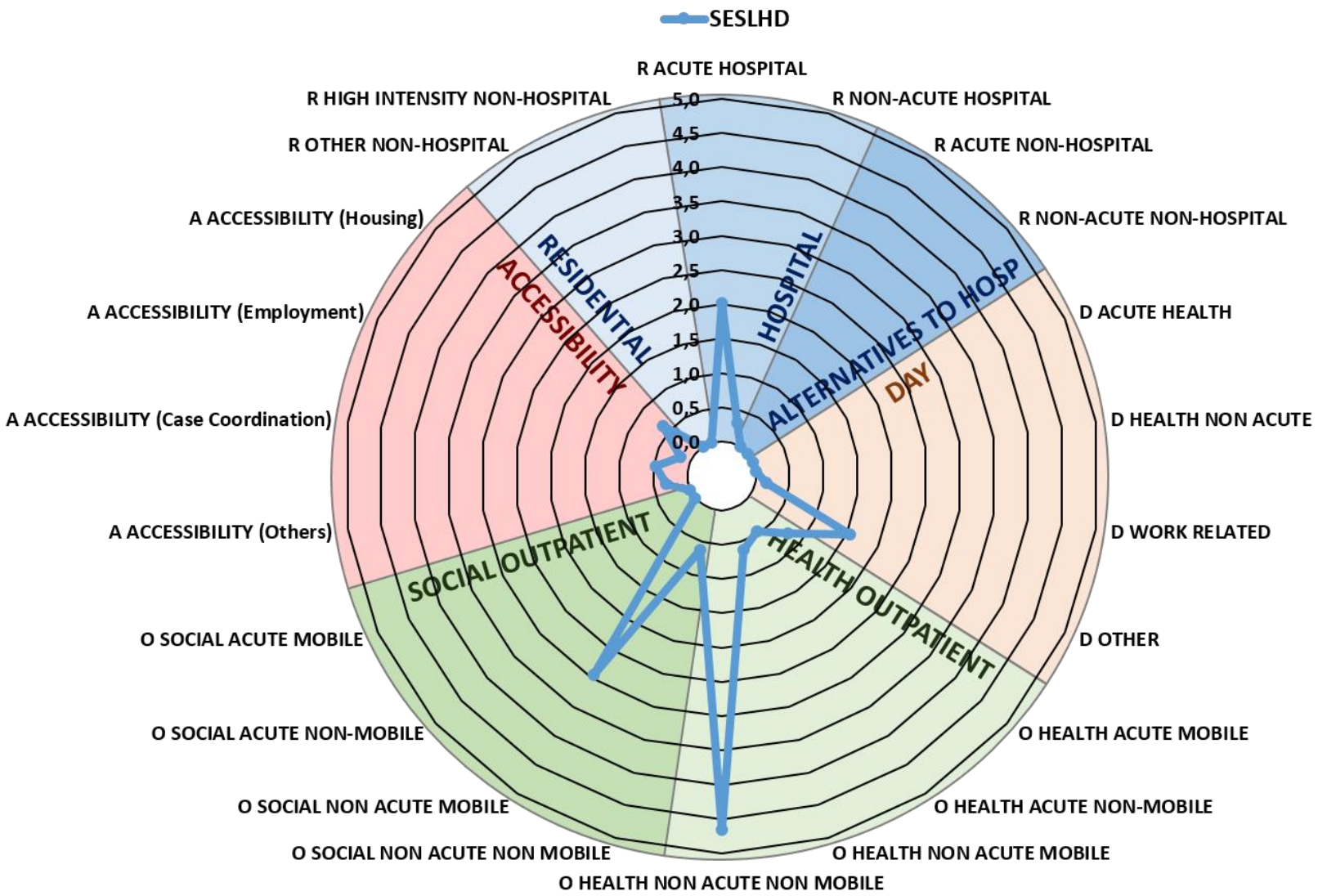


FIGURE 16 THE PATTERN OF MENTAL HEALTH CARE IN THE SESLHD. AVAILABILITY OF MTC PER 100,000 RESIDENTS.

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

The rate of professionals in the public mental health sector providing care for people with a lived experience of mental illness per 100,000 residents in the SESLHD is around 71.18 per 100,000 residents (excluding private providers under ATAPS or the Better Access Program). The rate of professionals working in NGOs providing care for people with a lived experience of mental illness per 100,000 residents of the SESLHD amounts to 39.59.

The profile of professionals in the two sectors is very different. In the health sector, the largest group of professionals are mental health nurses, followed by clinical case managers and psychologists. In the NGO sector, there are very few clinical professionals, which may reduce the capacity of this sector to provide more intensive care. However, some organisations may hire these professionals on a casual position, according to need.

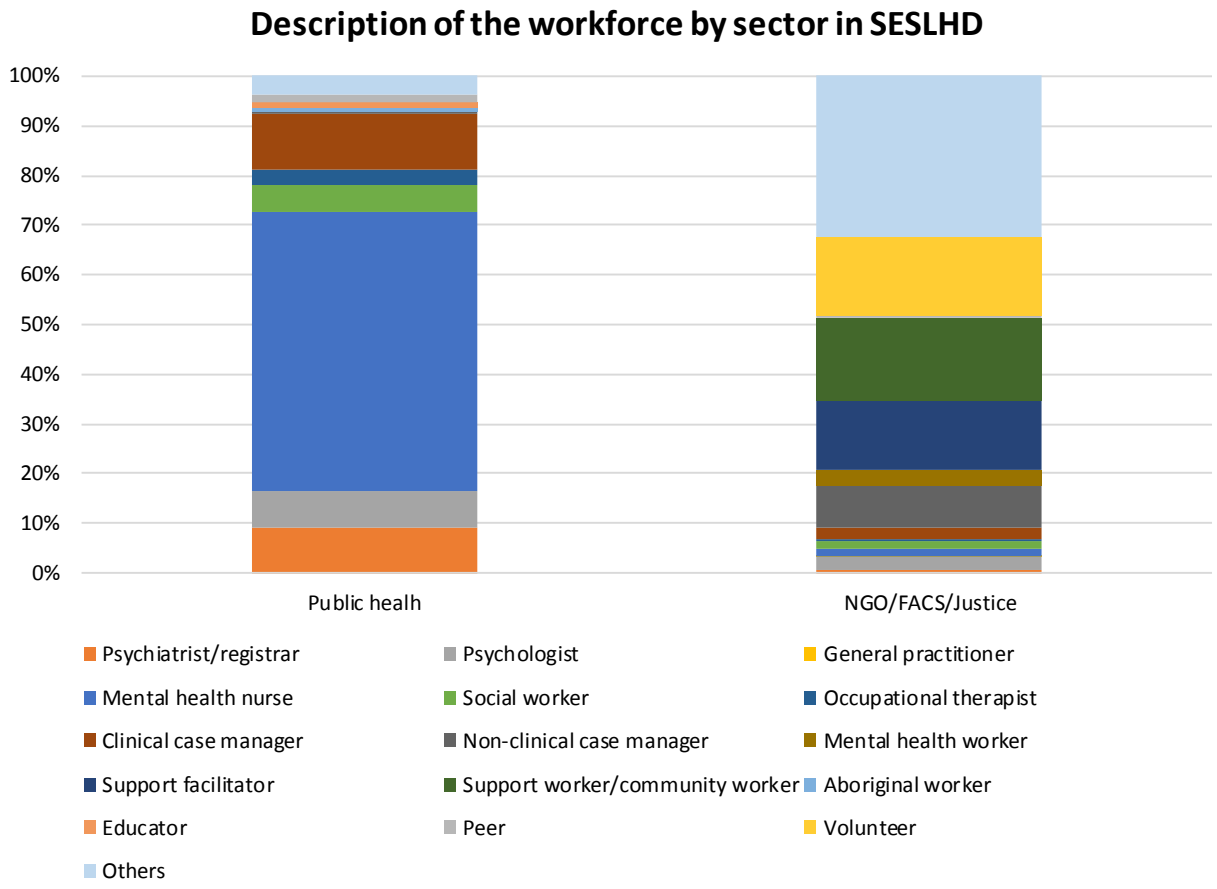


FIGURE 16 DESCRIPTION OF THE WORKFORCE BY SECTOR

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

The SESLHD has a larger availability of acute inpatient care, when compared with both South Western Sydney and Western Sydney, but lower than SLHD. At a more detailed level, the acute units in SESLHD are smaller, but the number of beds per 100,000 residents is higher, than in SW and SWS. This may be explained by the higher number of patients coming from outside the SESLHD.

In day care, SESLHD has a higher rate of social and cultural related services than SLHD, SWS, and WS, and a lower rate of work related support than SLHD. In common with all these areas, SESLHD lacks health related day services.

Outpatient social care related services (acute and non-acute) in SESLHD have a higher mobility than in South Western Sydney and Western Sydney, which are more office and telephone based. In comparison to SLHD, the reverse applies: that is, SESLHD has fewer mobile services but more non mobile services than SLHD. In regard to health related outpatient services, SESLHD has a higher rate of non acute health related outpatient services than SLHD, WS and SWS. SESLHD

has innovative services targeting the physical health needs of people with a lived experience, which were not found in other areas.

The main difference with regard to accessibility-related services, is related to coding issues: in IWS, Partners in Recovery (PIR), was coded as an Accessibility-related service, while in Western Sydney and South Western Sydney it was coded as an outpatient/community service. In SES PIR all PIR teams are coded as outpatient related and ES PIR only one of the teams is coded as accessibility while the remaining were coded as outpatient. In contrast, in SLHD, five of the six PIR were coded as Accessibility, and only one as Outpatient. The difference in how the different organisations (and even inside the organisation) conceptualise the main activities of PIR requires further analysis.

Lastly, the availability of residential care in the community for people with a lived experience of mental illness is higher in the SLHD, South Western Sydney and Western Sydney than in the SESLHD. In the case of WS and SWS, this is mainly explained by the presence of the CHIP Hostel on the grounds of Cumberland Hospital (Western Sydney) and the presence of limited time facilities in South Western Sydney provided by Neami National. In SLHD, this is largely due to the presence of Casa Venagas, some facilities of which are in the SLHD.

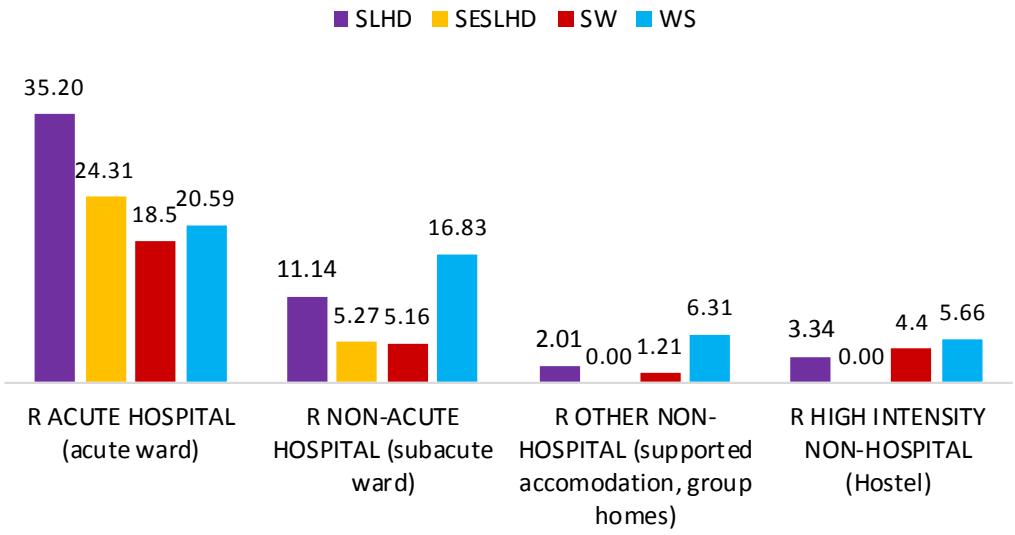


FIGURE 17 NUMBER OF BEDS IN THE SESLHD VS. SLHD, SOUTH WESTERN AND WESTERN SYDNEY (ADULTS)

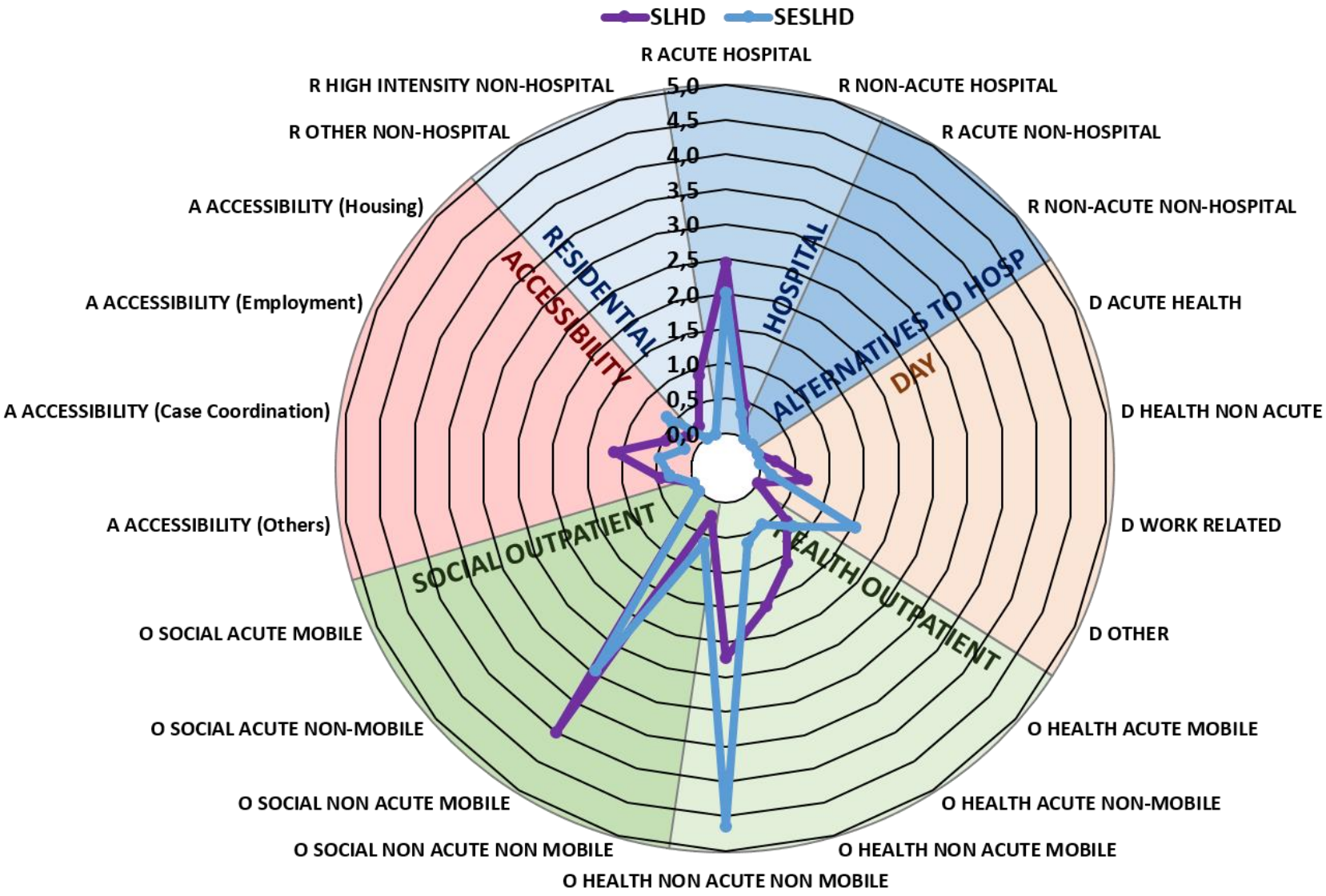


FIGURE 18 PATTERN OF MENTAL HEALTH CARE IN THE SESLHD (PURPLE LINE) AND IN SLHD (ORANGE LINE). AVAILABILITY OF MTC PER 100,000 RESIDENTS.

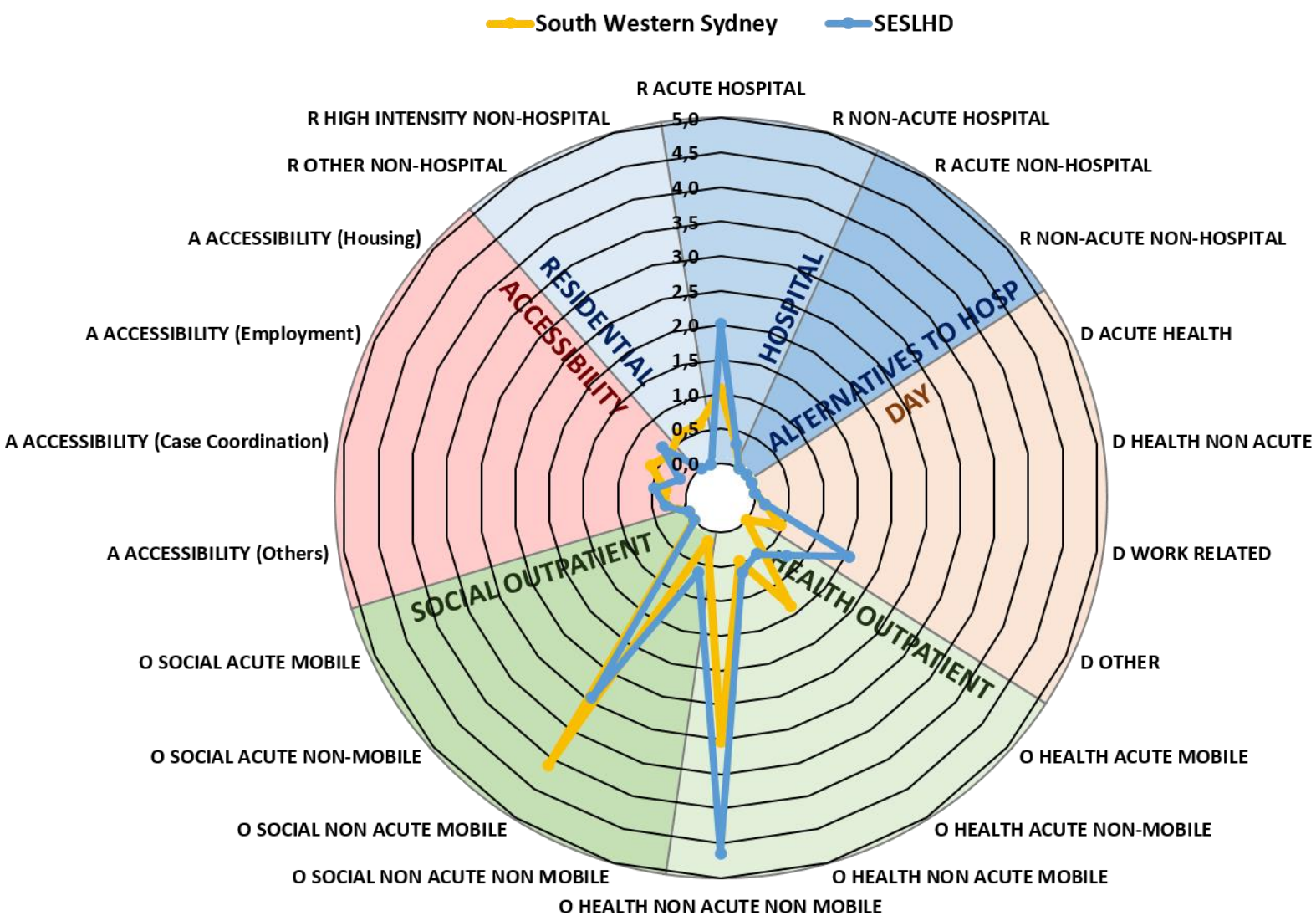


FIGURE 19 PATTERN OF MENTAL HEALTH CARE IN THE SESLHD (BLUE LINE) AND IN SOUTH WESTERN SYDNEY (ORANGE LINE). AVAILABILITY OF MTC PER 100,000 RESIDENTS.

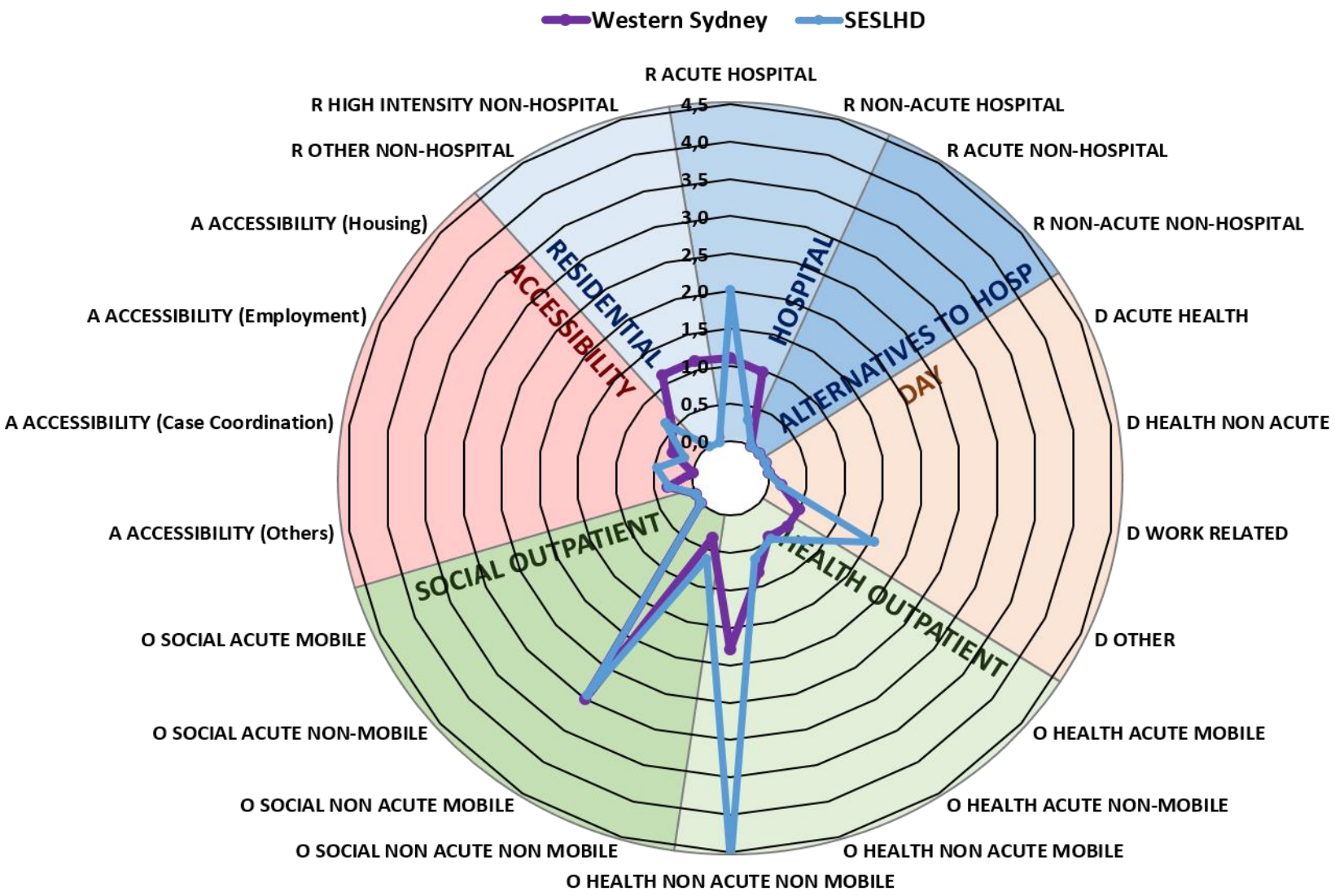


FIGURE 20 PATTERN OF MENTAL HEALTH CARE IN THE SESLHD (PURPLE LINE) AND IN WESTERN SYDNEY (BLUE LINE). AVAILABILITY OF MTC PER 100,000 RESIDENTS.

6 INTERNATIONAL COMPARISONS

International comparisons are useful for: 1) learning about national systems and policies; 2) learning why those systems take the forms they do; and 3) learning lessons from other countries for application elsewhere (19). In the absence of a gold standard for planning the provision of mental health services, international comparisons may also be useful for asking questions that are taken for granted.

However, in order to conduct meaningful comparisons, it is important to use a standardised tool that goes beyond terminological variability. We have mapped the pattern of mental health in different European areas using the DESDE-LTC. The use of a common language allows us to compare the SESLHD with different community care models in Europe. The information on the different European countries has been presented as part of the REFINEMENT research project funded by the European Commission (20). The table below describes the areas selected.

TABLE 43 SOCIO-DEMOGRAPHIC INDICATORS IN 5 LOCAL AREAS OF MENTAL HEALTH CARE IN COUNTRIES WITH DIFFERENT MODELS OF CARE

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

6.1 NORTHERN EUROPE COMMUNITY MENTAL CARE MODEL

Figures below compare the SESLHD with an area in Norway (Sør-Trøndelag), and with an area in Finland (Helsinki and Uusimaa).

The main characteristic of the Northern Europe Community Mental Care Model is the high availability of different types of services. Indeed, Norway has one of the highest per capita health

1 Including Portsmouth and Southampton Unitary Authorities.

care expenditures per capita. Both Finland and Norway raise funds for mental health mainly from general taxes.

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

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

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

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

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

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

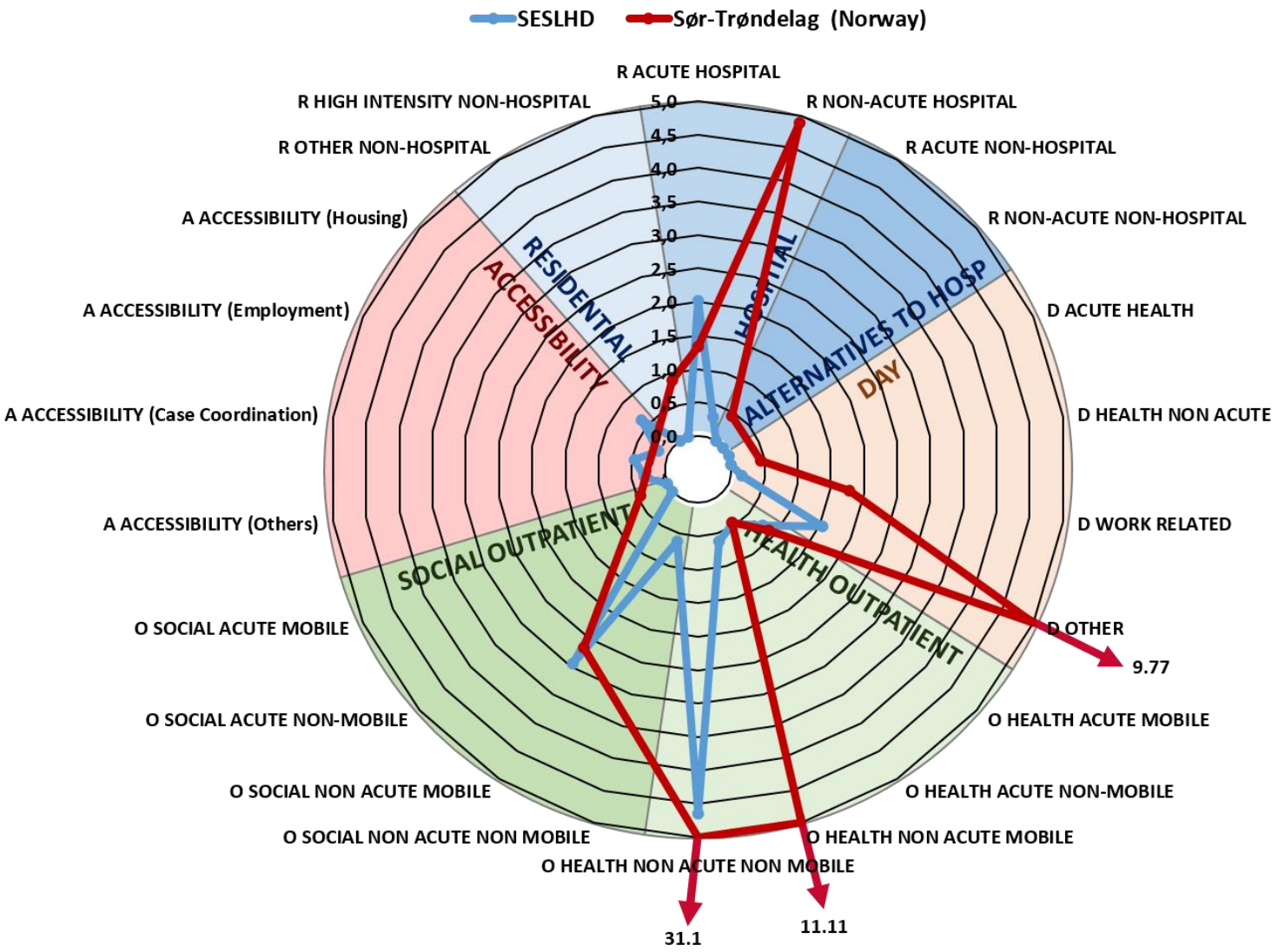


FIGURE 21 PATTERN OF MENTAL HEALTH CARE IN THE SESLHD (BLUE LINE) AND SØR-TRØNDELAG –NORWAY (RED LINE). AVAILABILITY OF MTC PER 100,000 RESIDENTS.

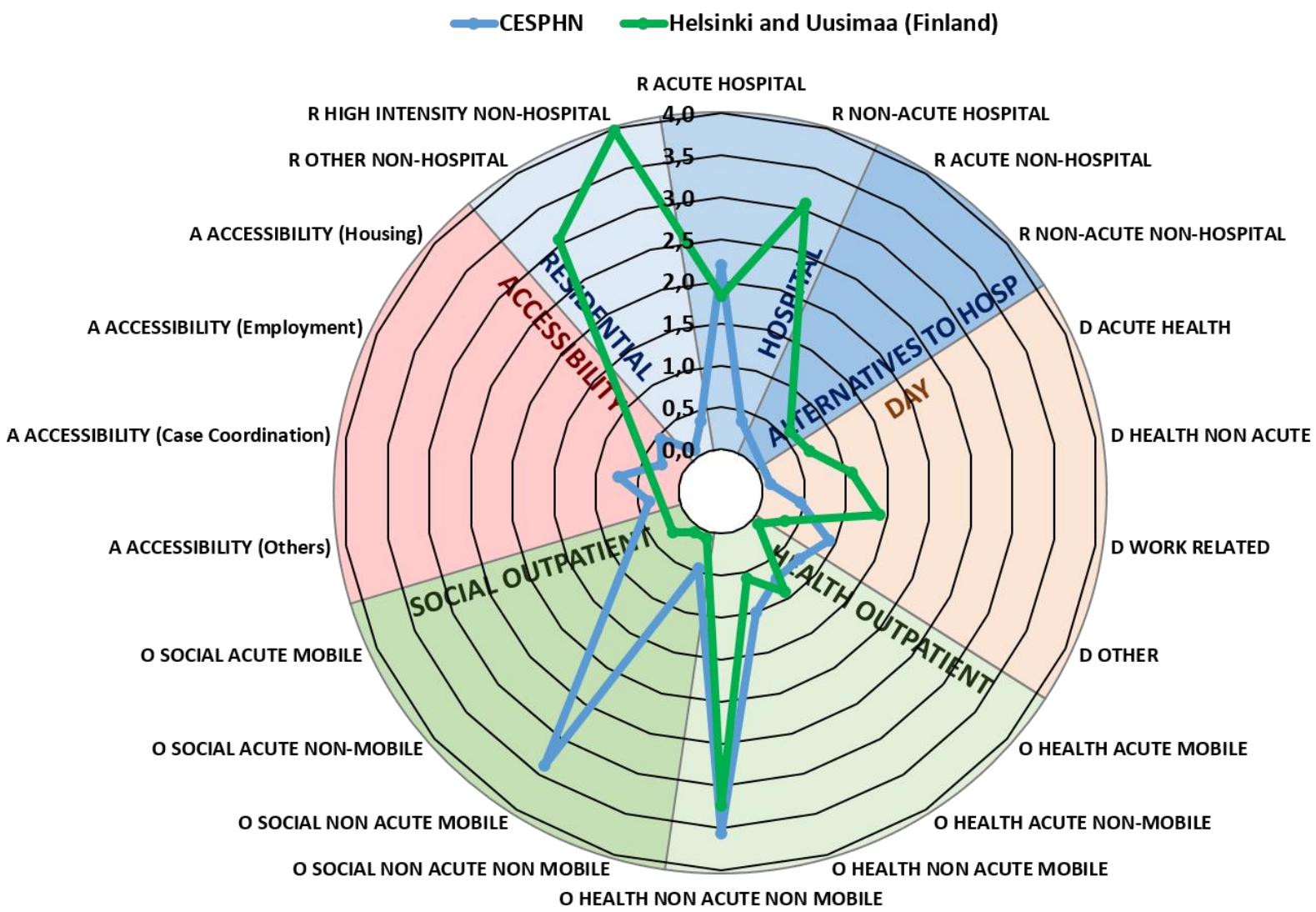


FIGURE 22 PATTERN OF MENTAL HEALTH CARE IN THE SESLHD (BLUE LINE) AND HELSINKI AND UUSIMAA – FINLAND (GREEN LINE). AVAILABILITY OF MTC PER 100,000 RESIDENTS.

6.2 SOUTHERN EUROPE MODEL OF MENTAL HEALTH CARE

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

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

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

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

The 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 SESLHD (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 social housing for people with a lived experience of mental illness.

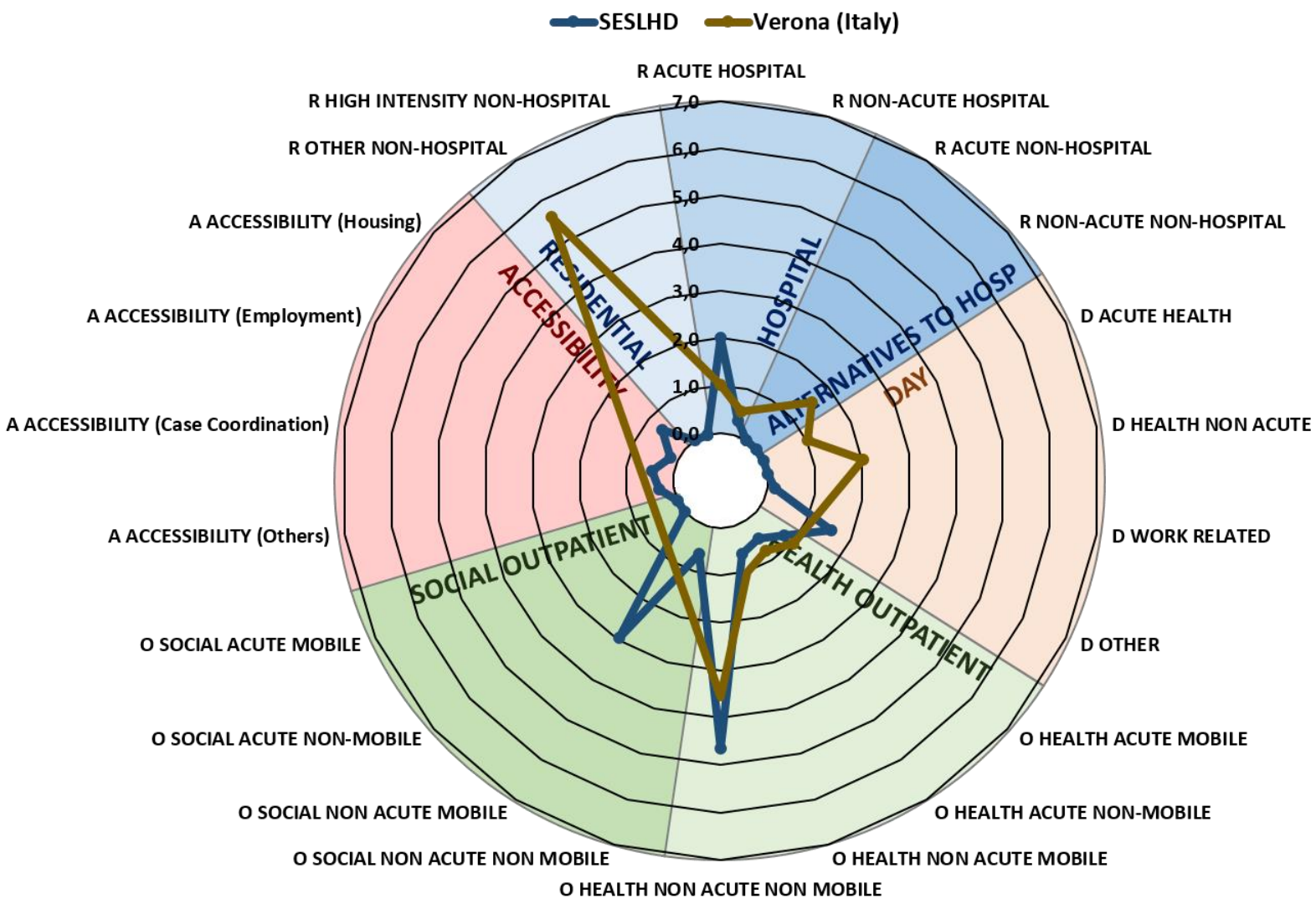


FIGURE 23 PATTERN OF MENTAL HEALTH CARE IN THE SESLHD (BLUE LINE) AND VENETO- ITALY (BROWN LINE). AVAILABILITY OF MTC PER 100,000 RESIDENTS.

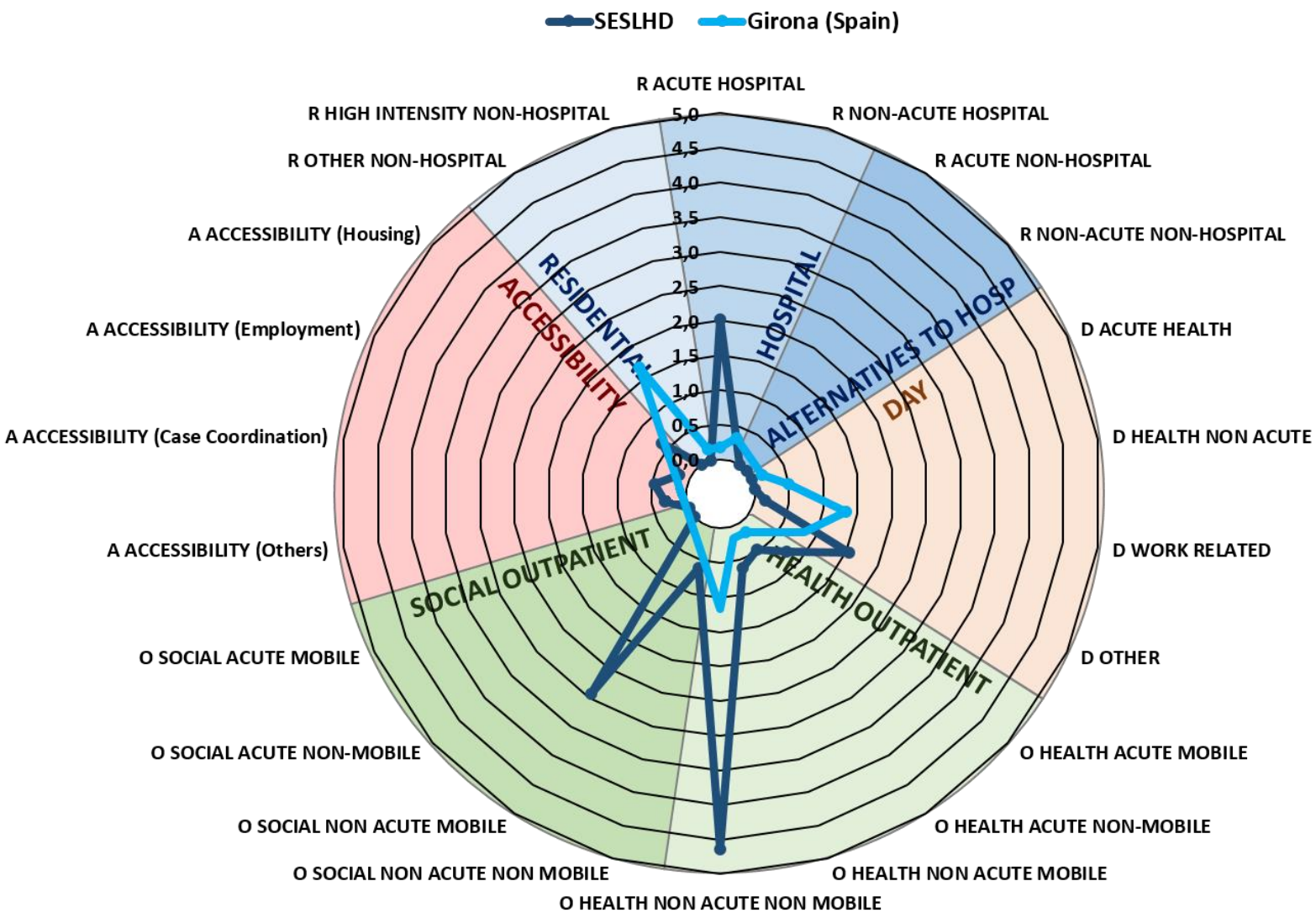


FIGURE 24 PATTERN OF MENTAL HEALTH CARE IN THE SESLHD (BLUE LINE) AND GIRONA –SPAIN (LIGHT BLUE LINE). AVAILABILITY OF MTC PER 100,000 RESIDENTS.

6.3 ENGLISH SYSTEM

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

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

One of the main characteristics of the English model is the high availability of mobile care related to health, and the lack of day care related to health and non-acute care in the hospital, similar to our findings in SESLHD.

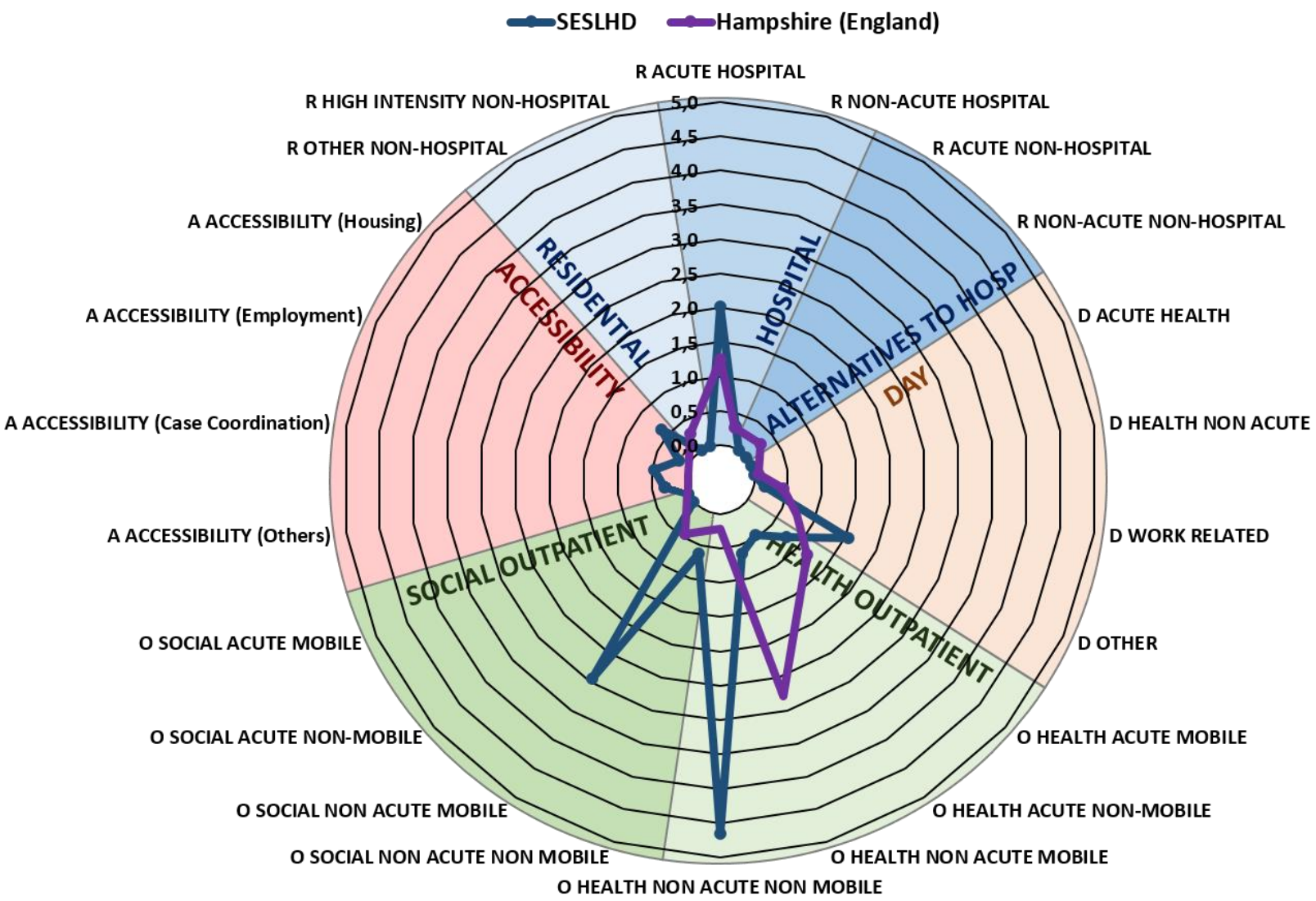


FIGURE 25 PATTERN OF MENTAL HEALTH CARE IN SESLHD AND HAMPSHIRE (ENGLAND). AVAILABILITY OF MTC PER 100,000 RESIDENTS.

6.4 PLACEMENT CAPACITY- CROSS-NATIONAL COMPARISONS

6.4.1 RESIDENTIAL CARE

There are large differences across countries in the rate of bed availability. These rates mirror the different models of mental health care. The SESLHD has a higher rate of acute hospital beds than well-known community-based mental health models such as the Italian and the Spanish one, but also more than the Scandinavian countries. This may be explained by the fact that the SESLHD also treats people from outside their boundaries (i.e. people who work but do not live there, and tourists and backpackers). The rate of non-acute beds in the hospital is similar to Spain and Italy, higher than in UK but lower than in the Scandinavian countries. The absence of alternatives to hospitalizations in the community, especially step-down facilities and health related day care centres, is one of the major gaps of the system. However it is important to take into account the difficulty of coding social and community housing as well as residential care provided by NGOs in the SESLHD. Therefore, the coding provided in the atlas does not fully reflect the availability of social and community housing, although it may point to very different strategies in the coordination of management and care in Australia and several European countries.

TABLE 44 CROSS-NATIONAL COMPARISONS- PLACEMENT CAPACITY- BEDS PER 100,000 RESIDENTS ACCORDING TO TYPE OF RESIDENTIAL CARE

Groups	SESLHD	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	24.31	28.4	26.9	14.0	7.0	26.4
R Non-acute hospital: R4 – R6	5.27	75.1	52.2	12.0	15.4	4.8
Rate of beds per 100,000 residents in the community						
R Acute non-hospital: R0 R3.1.1	0.0	64.4	0.0	0.0	0.0	0.0
R Non acute non-hospital: R5 - R7	0.0	0.0	12.3	16.5	0.0	2.5
R other R9,R10,R12,R13,R14	0.0	0.0	58.6	35.8	12.0	7.5
R non-hospital high intensity R8 R11	0.0	8.9	113.6	0.0	9.7	0.0

6.4.2 DAY CARE

Some of the most advanced models, such as the Finnish one, are characterised by a good balance between inpatient hospital care and acute and non acute day service places. It is also important to

develop work related centres, where people with a lived experience of mental illness can develop work related skills and be paid for their work. The day care sector is progressively disappearing from the SESLHD (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 PIR consumers. 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- PER 100,000 RESIDENTS ACCORDING TO TYPE OF DAY CARE

Groups	SESLHD	Sør-Trøndelag (Norway)	Helsinki and Uusimaa (Finland)	Verona (Italy)	Girona (Spain)	Hampshire (England)
D Health acute	0.00	0	9.62	3.05	4.17	0
D Health non-acute	0.00	0	17.99	40.67	12.51	0
D Work-related	0.00	8	18.15	0	32.53	0
D Other	81	0	12.35	0	27.52	0

7 DISCUSSION

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

The Integrated atlas of the CESPHN, and its associated annexes, provide a standardised identification of existing services, types of care provided and service capacities. This information, when combined with local data such as that collected in the SESLHD Integrated Care Strategy Action Plan, 2015-2018, provide additional information on how the integrated care policy is followed in this area. Together these sources of information can support decision makers and planners to refine and improve the provision of mental health services across the area.

7.1 BOUNDARIES AND SOCIAL AND DEMOGRAPHIC CHARACTERISTICS OF THE SESLHD

Coverage of the SESLHD includes the SLAs of Botany Bay, Hurstville, Kogarah, Randwick, Rockdale, Sutherland Shire, Sydney Inner and East, Waverly, Woollahra and Lord Howe Island. It also includes Norfolk Island (which is not mapped at the SLA level). The majority of these SLAs are urban and are characterised by a high accessibility of services according to the

Accessibility/Remoteness Index of Australia (ARIA) (21). The ARIA is a continuous index developed by the Australian Bureau of Statistics (ABS) to assess remoteness of Australian areas based on road distances between localities and services such as education and health. The provision of mental health care in urban areas represents specific challenges that require tailored planning as mental illnesses are particularly prevalent in urban Australia (7, 9, 10).

One key issue that outlines the problem of boundaries is that of population density at the SA1 level in the City of Sydney. Ultimo, Pyrmont, Surry Hills and Potts Point show a high population density associated with high-rise apartments. As a matter of fact, areas with high-rise apartment buildings and exceptionally high populations may require units of area analysis different than SA1. The research of the health impacts of urban design including the characteristics of neighbourhoods and the hazards associated with living in high-rise buildings is very recent. An increase of death by cardiac arrest (23) and on the mortality rate of suicide by jumping from a high place has been described in Switzerland (24). The importance of urban design, including walkability and green spaces on psychological distress (21) has been emphasised recently (25-27).

While the suburbs of Ultimo, Pyrmont, Surry Hills and Potts Point in the City of Sydney have some of the highest population densities in Australia, the Sutherland Shire comprises very low density areas such as Heathcote and Engadine, which are nevertheless relatively close to highly populated ones. Sutherland Shire incorporates the Royal National Park (classified as inner regional) and Lord Howe Island (classified as very remote Australia) (21). Lord Howe Island is 600 km northeast of Sydney and has a low population size and density (22.1 pop./Km^2*)* which makes this region a rare and extremely distant place for care provision in Australia. The low population density in the southern districts of the SESLHD, together with its closeness to Sydney, generates classification problems in the current rural and remote systems, which has an impact in billing mechanisms and pay incentives in these areas. To address the needs of mental health care for populations living in remote areas, different initiatives have been developed at both state and federal levels. For example, the Mental Health Services in Rural and Remote Areas (MHSRRA) program provides funding to Non-Governmental Organisations (NGOs) to deliver mental health services in rural and remote communities. In addition, the NSW Rural Health Plan endeavours to promote integrated rural health services by enhancing the rural health workforce, strengthening rural health infrastructure, research and innovation, and improving eHealth (30).These initiatives are critically important in improving the accessibility of mental health services in rural and remote areas. However, as stated at the 2013 Review of Australian Government Health Workforce Programs (31): "The proportion of towns with GP billing activity appears to be misleadingly low in RA 1 areas with very little GP activity within the town itself, but whose population can readily access the nearest major city for GP services".

The City of Sydney also holds high rates of people experiencing homelessness, predominantly in the inner city area. Around 11,000 homeless individuals are in this region, mainly in the inner city. The Inner City Sydney Registry Week 2015 surveyed 516 homeless individuals, 64% with

comorbid drug and alcohol and mental illness (32). As such, it is crucial to identify the services that target these individuals.

7.2 KEY CHARACTERISTICS OF THE MENTAL HEALTH SYSTEM IN THE SESLHD

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

The SESLHD Annex has highlighted major strengths and areas for improvement in the pattern of mental health care in the Central, Eastern and South Eastern areas of Sydney. Strengths include:

- Good availability of inpatient residential care
- Good availability of acute, mobile and acute non mobile outpatient care
- Good availability of services for transition to adulthood
- Good availability of early intervention programs

Areas for improvement include:

- Lack of alternatives to hospitalisation for people with moderate to severe mental illness
- Limited availability of acute day care (e.g. day hospitals) and non-acute, high intensity day care (e.g. day centres)
- Limited services which provide accommodation and support.

It is important to note the availability of innovative services targeting the physical health needs of people with a lived experience of mental illness. Keeping The Body in Mind, provided by Eastern Suburbs Mental Health Service, is an example of this. This type of service is meeting a critical unmet need identified by the consumers of each of the IWS, ES and SES PIRs. Physical health services are also provided elsewhere in the CESPHN through Metabolic Clinics, and the Schizophrenia Fellowship with Canterbury Leagues Club (SLHD). These services are also delivered in other systems as programs provided by the community mental health centres (e.g., Get-up program in Verona – Italy) (33).

These results are similar to the ones found in other areas in metropolitan Sydney (i.e. Western Sydney and South Western Sydney) suggesting systemic organisational structural gaps in the mental health care delivery system in NSW. These findings support the main recommendations pointed out by the NSW Commission Plan *Living Well: a strategic Plan for Mental Health in NSW 2014-2024"* (NSW 64) and the *National Review of Mental Health Programmes and Services* by the National Mental Health Commission (64), mainly the lack of alternatives to hospitalisations; and the need for strengthening the community mental health care subsystem. Misalignments in investment and financing have also been pointed out by the *National Mental Health Review* (34)

which indicates that NSW has the lowest residential community care in Australia and the highest expenditure on hospitals (NMHC, 2014, Paper 3).

The following sections of the Atlas provide discussion on the commonalities and differences observed in numbers of BSIC and MTC identified in the SESLHD, compared to local and international jurisdictions. The discussion is framed within the stepped care model, concentrating on secondary and tertiary care services. The purpose of this Atlas was to map all specific services available for persons experiencing mental health issues in the SESLHD. Therefore, we have not included the primary care generic services which also provide mental health care. Further research should analyse the adequacy of mental health treatment provided in primary care to complement these results. However, we have included information on the ATAPS program. We have discussed above the conceptual problems of classification of bridging or borderline programs such as ATAPS. This program can be regarded as a secondary care program for patients experiencing mild mental illness. We have included information on the ATAPS program as part of the secondary care system.

Although the stepped care model has been used to structure the Atlas discussion it is noted that adscription of non-health services into this model may cause some confusion. In the stepped care model adopted in the 2015 government response (35), a clear distinction is made between psychological services for those with mild mental illness, clinical services in primary care backed by psychiatrists for those with moderate mental illness and the clinical care using a combination of GP care, Psychiatrists, mental health nurses and Allied Health that should be provided for those who experience severe mental illness. This distinction in the absence of a fully implemented integrated care system could produce further fragmentation instead of preventing it. For example, the 2016 PHN guidelines include in the broader primary care of child and adolescent services, social support services such as education and employment supports (36). From these guidelines it is not clear to what extent Headspace should be considered a primary care service (according to the population assisted) or a secondary care service (with regards to its staff capacity). A further example blurred delineation within the stepped care model is that of ATAPS mental health nurses and individual practices of psychiatrists which are counted as part of the primary care network in some reports.

7.2.1 RESIDENTIAL CARE

While SESLHD and SLHD provide similar numbers of acute residential MTCs, SESLHD has a lower acute bed capacity, more closely resembling that in Western and South Western Sydney. It is important to note that there are historical agreements related to care sharing between SLHD and SESLHD, and other PHNs and LHDs. This may generate an over-estimate of the bed capacity ratio to the residents of this catchment area.

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

It is important to note that the balance of care of the Australian mental health system is skewed towards hospital care. Although the National Mental Health Commission Review recommended the reallocation of a minimum of $1 billion in Commonwealth acute hospital funding into more community-based psychosocial, primary and community mental health services, the governmental response did not question the current unbalance to hospital provision. There is an on-going debate in the Australian literature on the need to invest in community beds at the expense of hospital beds(37).

Although acute beds within hospitals are a key component of an integrated care system, it is also important to implement residential alternatives in the community. However, more studies are needed on the efficiency of these type of services. Some authors suggest that acute residential care in the community may be more cost-effective than hospital admission (38). 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 (39). Other initiatives in Australia that fit in this model is the Prevention and Recovery Care Model (PARC) in Victoria (40). These services can also function as a 'step-down' from a period of acute psychiatric hospitalization, to facilitate transition from hospital. The key characteristic of these services is that they are staffed with highly-skilled mental health professionals. The development of these types of services in the SESLHD could fill a gap in the provision of mental health care services.

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

FACS in SESLHD provide accommodation support to a wide range of consumers. They are, however, distinctly different from equivalent services in other countries. The equivalent services often have specific divisions related to mental health and are coded as residential care providers

in the integrated mental health atlases following the international recommendations established by the DESDE-LTC consortium.

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

A previous evaluation of the Housing and Accommodation Support Initiative (HASI)(41), 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.

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

If we compare the SESLHD to Italy and Spain, we can see that, unlike the SESLHD, the balance of residential care skews away from acute hospital care and strongly towards residential care in the community. Italy also provides a higher rate of alternatives to hospitalisation, and of health related day care, while Spain provides less health related non acute outpatient care, but more work related day care. These countries provide lower rates of acute hospital care, but more types of other residential care, particularly in the community, and more day care services.

7.2.2 OUTPATIENT CARE

HEALTH RELATED OUTPATIENT CARE

The pattern of outpatient and outreach services according to their Main Types of Care (MTCs) is similar to the one found in other areas of Greater Sydney. SESLHD has a similar availability of acute mobile services to SLHD, but a higher availability than WS and SWS. Availability of acute non-mobile services, which are mostly provided by Emergency Departments, is lower than in SLHD and in SWS. SESLHD has a higher availability of teams providing non-acute non-mobile care. This includes a range of different services, including those targeting physical health, as well as specialised target groups such as the HIV+ population, borderline personality disorders, anxiety disorders and Clozapine Clinics. The relative efficiency of the different models of balance of care (e.g. mobile versus non-mobile teams, acute versus non acute) has not been tested, and a proper analysis will require the incorporation of utilisation data to complete the information on availability and capacity with information on administrative prevalence, administrative incidence and frequency of visits. In any case, the differences identified in the number of teams providing nonmobile outpatient care in the two districts of CESPHN deserve further investigation to understand whether a higher availability of outpatient care teams is related to a better care delivery system or, on the contrary, is reflective of a higher fragmentation of the system.

NON-HEALTH RELATED OUTPATIENT CARE (SOCIAL OUTREACH SERVICES)

The pattern of outpatient and outreach services according to their Main Types of Care (MTCs) in the social sector is similar to other LHDs of Greater Sydney, although there is lower availability of this type of care in SESLHD than in SLHD and SWS. The balance between social and health non acute non mobile services in the SESLHD, with a high rate of health non acute non mobile care, but a lower rate of social outpatient care, is the reverse of that found in SLHD, SWS and WS. It is possible that some of the health non acute non mobile services in SESLHD are also serving an important social function providing more specific care: for example, the Borderline-Day Care group, the Peer Support Team, or the Keeping Body In Mind program. Many of the outreach services provide home/residential support or replace on-site day care. These characteristics have been discussed in the day care and the residential care sections of this report. In any case the efficiency of the balance between generic and specific care types requires further analysis including service utilisation data

ATAPS

The ATAPS program can be conceptualised as either a primary care or a secondary care service. It provides universal access to psychological care for those experiencing mild to moderate mental illness. The ATAPS program was introduced by the Australian government to provide individualised, evidence-based mental health care by trained allied mental health professionals on a free or low fee basis at point of use. To determine whether there is an equitable access to ATAPS services in the SESLHD, it may be important to conduct a spatial analysis of ATAPS referrals, and a corresponding analysis of the distribution of ATAPS professionals. Such an analysis is important to determine if ATAPS reflects the findings of recent analyses of the Medicare '*Better Access*' initiative that found major disparities in the use of mental health services across Australia, with greater use among more advantaged communities (58). This finding indicates the need to also revise the access and use of the Better Access program in this region, as well as other programs included in the Medicare Benefits Schedule (MBS), and the Mental Health Nurse Incentive Program (MHNIP).

7.2.3 DAY CARE

Day care for people with a lived experience of mental illness has been considered a key component of psychiatric reform since the early 1960s (11) "Day Care" (including partial hospitalisation) refers to all services where the consumer stays for part of the day, but not overnight, or just for a single face-to-face contact. There is a whole array of different types of day care services according to the phase and the severity of the mental illness: from acute care (i.e. day hospitals/partial hospitalisation), to non-acute care (i.e. day programs/centres), and recovery oriented programs (i.e. peer support, respite, social clubs, or work-related approaches), just to mention a few. These services should be integrated in a local acute care subsystem which also incorporates mobile care alternatives for crisis intervention at home (crisis resolution teams, medical homes), together with non-mobile emergency services and high-intensity coordination/case-management as in Assertive Community Treatment (11).

ACUTE HEALTH RELATED DAY CARE

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

Acute day care (ADC) provided by qualified mental health professionals (eg psychiatrists, nurses and psychologists) is a less restrictive alternative to inpatient admission for people who are experiencing acute and severe mental illness. Its objective is to deliver personalised, intensive and structured health care interventions in non-residential service locations (11). 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(42) and by the US Agency for Healthcare Research and Quality (AHRQ)(43). The Cochrane review concluded that ADC is at least as effective as traditional methods, and provide suitable options in situations where demand for inpatient care is high, and facilities exist that can be converted to this use. However, they are a less attractive option in situations where the demand for inpatient care is low and can be covered by other options (42). 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(43) 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)(44). 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(45): *Crisis houses or acute day facilities may be considered in addition to crisis resolution and home treatment teams depending on the person's preference and need.*

NON-ACUTE HEALTH-RELATED DAY CARE/PROGRAMS

Non-acute high-intensity day care ("day centres") is a key component of a community mental health system that is missing in the CESPHN. Day programs staffed with at least 20% highly skilled mental health professionals, such as psychologists, neuropsychologists or mental health nurses (D4.1 and D8.1), can provide more intensive rehabilitation and recovery oriented program activities in a highly specialised environment than day centres staffed with non-health professionals (D2 to D10 services). This workforce capacity allows these centres to provide a better focus on tertiary prevention and clinical improvement (e.g. by better training in daily

living, problem solving, stress management, social skills or cognitive rehabilitation). This type of centre can improve socialisation and assist individuals to learn new skills according to their needs. They also include occupational therapy tailored to the patient's needs. They should be provided in a recovery oriented format that promotes peer-support. Day centres allow people with mental illness to have structured, more intensive rehabilitation program on educational, vocational and health activities provided in the same location. These type of centres can provide recovery-oriented practices for community living, one of the key components of care, according to the THAMSS report (46).

In the SESLHD, we have identified one non-acute health related day care centre with high intensity (equivalent to day hospitals), however this is only for people with eating disorders. It is important to note that these services were lacking in all other regions previously mapped in metropolitan Sydney. The presence of this kind of specialised service may be due to the high concentration of the population in the area which facilitates the delivery of highly specialised care.

The lack of day care in the local system may be attributed to several reasons. First, mental health funding has moved from services provided in the public sector - including the more institutional modes provided by the LHDs - to community-based services provided by the NGO sector. This shift has been a significant aspect of deinstitutionalisation, emerging hand in hand with the closure of psychiatric hospitals across the system. Day Hospitals as health-staffed day centres have been unintended victims of this necessary shift in the model of care. NGO-run services have been focused on the less clinical (and less expensive) end of day care, focusing on cultural or respite services. Reduced budgets mean the staff that can be contracted are lower skilled or lack the specific skills needed for more intensive services. Although these types of services (D2-D10) are absolutely necessary, we must not neglect more intensive health related day services (D1, D4.1 and D8.1). Indeed, health-related day centres for mental health can be found in the private health sector in Greater Sydney, suggesting that there may be equity problems in the access to this type of care, adding to findings on inequity of the operation of the *Better Access Program* in Australia (47)

The disappearance of day hospitals and day centres in the public sector could also be attributed to the shift to individualisation of care and tailored programs of daily activities. Individual care based on individual preferences and choices, tends to prioritise face-to-face programs and home-based treatments rather than day care interventions. Crisis resolution or home treatment teams are an effective community intervention to manage psychiatric crises, but they should not be seen as the only alternative to acute inpatient care. A recent systematic review (48) 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(49) and in England (50). 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 (11).

We may also keep in mind that models which prioritize individual care may have unintended adverse effects, if critical services in a community care model are missing from the local system. Likewise, and although this requires further evaluation, the value of choice in recovery oriented systems may be limited by the availability of core services in the system. In order to make useful choices to meet an individual's needs, a whole array of service alternatives should be available at the local care system. Strikingly, the lack of high-intensity Day care (e.g. 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 (51,52).

The reduction or disappearance of day care staffed with health professionals has also been observed in other health systems that are shifting to a competitive market based on personalisation, such as England. Although this shift has been described in the disability sector (53-55), an understanding of the impact of this reform in the overall efficiency of the care system is still missing. Therefore, it is an urgent need to assess the effects of this silent reform on key performance indicators of the system and on the outcomes. This need is made particularly urgent in the transition to the National Disability Insurance Scheme (NDIS), which has a strong emphasis on individualisation and care planning driven by demand.

SOCIAL DAY CARE

We have identified eight BSIC providing social and cultural day care activities within the boundaries of the SESLHD. While these are all located within the SESLHD, many NGOs, particularly RichmondPRA and Lou's Place in St Vincent's Health Network cater for people within the SLHD. Therefore, these services could be considered as part of the CESPHN rather than part of a single LHD.

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

EMPLOYMENT RELATED SERVICES

Competitive employment must be the final goal of any employment intervention in mental health. However, it is necessary to have a broad availability of different employment alternatives for people with mental illness in addition to supported employment. This is very relevant in the transition process to ordinary employment for those who experience severe mental illness, and for those people who are not able or are not willing to work in ordinary employment. It is important to guarantee that there are other options available for people with other abilities who may require more support than that needed in supported employment. Some of these alternative services may

be classified as 'social firms' which are market-oriented businesses that employ people with disabilities; or 'social enterprises', which are primarily focused on training and rehabilitation (56). The recently published NICE clinical guideline for Psychosis and Schizophrenia in adults recommends to: "Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work (but also to…) consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment" (55).

The availability of specific employment services is a positive component of mental health provision. In the CESPHN, we have found a higher availability of employment-related services, such as social firms, in comparison with other areas in NSW, but only one service, located in the SVHN, includes the whole of greater Sydney in its area of coverage. However, SESLHD does have one service providing accessibility to employment (disability employment services). Specific employment services are an effective approach to incorporate people with a lived experience of mental illness into the workforce, if two conditions are met: 1) supported employment is integrated with the mental health treatment (i.e. supported employment specialists works in collaboration with the clinical mental health team); and 2) follow up supports are non-time limited.

Differences in the availability of this type of care provision are clear with Girona (Spain) and Helsinki-Usimaa in Finland, but they are particularly relevant in comparison with Norway. This may indicate the need to develop more alternatives to employment and supported employment services in the area. Employment ranks fifth in the list of unmet needs of SES and IWS PIR consumers, while it came in third in ES (see Table 46).

7.2.4 CARE COORDINATION AND INFORMATION

Recent analysis of interviews with Partners In Recovery (PIR) support facilitators and team leaders has identified that the main component of these roles is to identify and make contact with services in order to meet their consumers' needs (57). One of the challenges to their work was the time taken to interpret and share knowledge about the system in which they work – a system whose boundaries, relationships and key features are difficult to interpret as an outsider. The Atlas can provide a useful tool for navigation and individual care planning for case managers, navigators and coordinators.

The availability of coordination services is particularly relevant in the context of PIR in the CESPHN, although there is an apparent lack of a consistency in the actual model of care PIR utilises. The main objective of the PIR program is to increase the accessibility to a different range of services of people with a lived experience of mental illness. Interestingly though, a significant number of these PIR providers are not just focused on the accessibility, but take a more holistic approach, also providing some type of direct care such as counselling or intensive coaching. As such, no services providing PIR have been coded as Accessibility (A4 – Care coordination) whilst all nine PIR have been coded as non-health related outpatient care (O5.2) rather than accessibility.

It is possible that PIR teams have been filling gaps that have been identified in care provision, namely poor access to psychosocial services. This is the situation identified in South Western Sydney where all the teams providing PIR where coded as O5.2 (84). this was also the case in Western Sydney where the 5 teams have all been coded as O5.2 (85). The transfer to NDIS of these services will imply changes in the organisation of care in this system that may have some consequences in the delivery system in some districts, particularly in areas of high psychological distress such as Canterbury. It may also complicate performance assessment of PIR programs when the activities do not fully match the original objective of the delivery program.

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

7.2.5 SERVICES FOR SPECIFIC POPULATION GROUPS

SERVICES FOR CHILDREN AND ADOLESCENTS

Child and adolescent services within the CESPHN were only coded for the SESLHD and are therefore unable to be compared with SLHD. However, a comparison with Western Sydney (WSLHD) and South Western Sydney (SWSLHD) Local Health Districts has been possible. SESLHD has higher availability rates in acute hospital care and mobile and non-mobile health-related outpatient care than SWSLHD and WSLHD. Nevertheless, there is neither community residential care or day care in SESLHS.

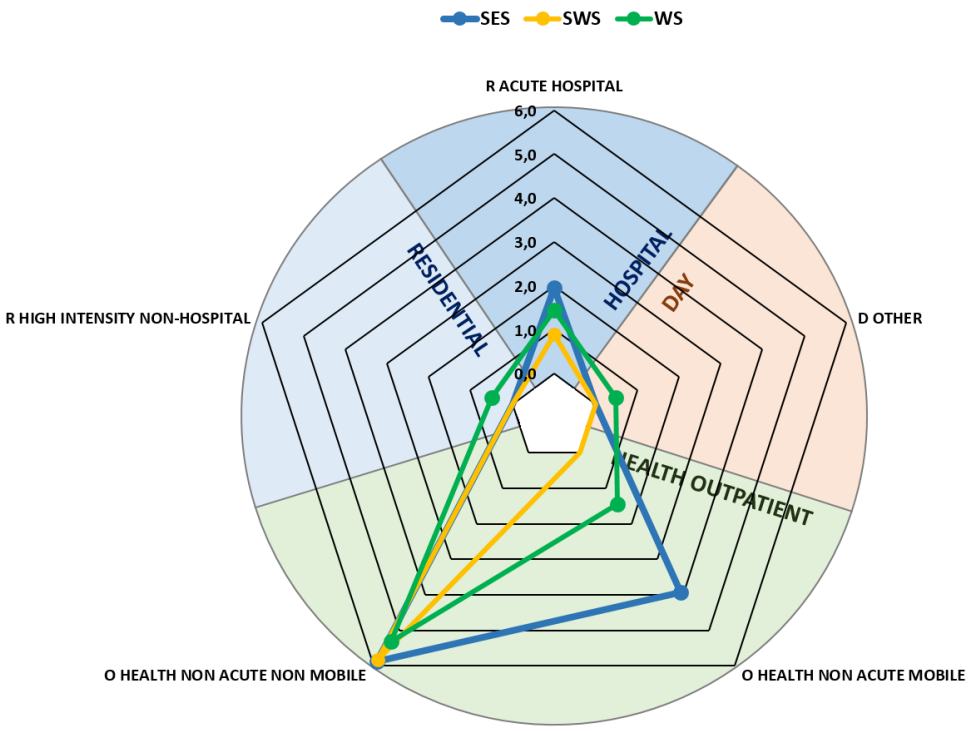


Figure 26 Pattern of mental health care for children and adolescents in SESLHD and SESLHD and WSLHD. Availability of MTC per 100,000 residents (<18 years old).

SERVICES FOR TRANSITION TO ADULTHOOD

There is a considerable number of transition services from adolescence to adulthood. In the SESLHD there are 10 MTCs providing transitional care, while we identified five teams providing this type of care in Western Sydney and six in South Western Sydney. A number of transition services are required at any local level to ensure the transition of consumers with complex needs. At least in the SESLHD where both transitional and child and adolescent services have been mapped, it seems that many resources are devoted to transition services in 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.

SERVICES FOR OLDER PEOPLE EXPERIENCING MENTAL ILLNESS

Services providing care for older people with mental illness are available in the area, with significant differences across the two LHDs. Whilst there is a higher availability of residential care and non-mobile outpatient care in SESLHD (particularly in the St. Vincent's catchment area), the

SLHD is characterised by a significant number of teams providing mobile non-acute outpatient care for this population. The variety and availability of the service provision system in the CESPHN as a whole is better than in the other PHNs mapped to date as we have identified a broad range of residential, outpatient mobile and non-mobile services in both the public health sector and in NGOs.

SERVICES FOR OTHER POPULATION GROUPS EXPERIENCING MENTAL ILLNESS

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

It is important to note the availability of services for carers, parents with mental illnesses (perinatal teams), services for offenders, multicultural services and services for Aboriginal and Torres Strait Islander populations in the SESLHD.

7.3 MAIN GAPS IN SERVICE AVAILABILITY AND UNMET NEEDS

The Integrated Mental Health Atlas of SESLHD indicates similar gaps to those identified in other regions in Greater Sydney (SLHD, SWS and WS). As previously stated these gaps are mainly related to lack of residential alternatives to hospitalisation in the community (e.g. crisis homes, and high intensity rehabilitation support homes); lack of day care (both health related and social day care); and lack of residential support homes and residences with integrated care provision. These areas of care encompass three of the six major delivery areas recommended by Thornicroft and Tansella in their community and mental health model (38.59). They also match the unmet needs reported by PIR consumers in the PIR needs assessments complete in IW, SES and ES. The top 6 unmet needs tend to be focused on daytime activities, employment and volunteering opportunities, social life, psychological distress, physical health and accommodation (60).

TABLE 46 TOP 5 UNMET NEEDS IDENTIFIED IN THE PARTNER IN RECOVERY PROGRAM IN THE THREE PIR AREAS OF THE CESPHN (DATA PROVIDED BY IWS, SES AND ES PIRS).

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

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

IMPLICATIONS OF THE MAIN GAPS FOR THE LOCAL MENTAL HEALTH SYSTEM

FRAGILITY (LACK OF ROBUSTNESS OF THE CARE DELIVERY SYSTEM)

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

This type of problem occurs in high income countries where decision makers and policy planners (the advocates for a new service) take a ‘component view’ rather than a public health orientation, which takes a ‘system thinking perspective’ of the whole pattern of care at the local level and how the different components are related (38). The problem of the component approach is that it results in an inefficient use of scarce resources, as investment is made in new services, whilst the core services are absent or not appropriately resourced and sustained. This leads to a “reactive” system, rather than a “proactive” system based on long term planning informed by local evidence. In addition, the skills and experience acquired by the workforce could be lost when the program is ended. The reliance on time-limited programs, mainly community based, means that the mental health system in the SESLHD is “fragile”. This lack of robustness is particularly relevant under the current situation, where major changes are occurring due to the transition of many mental health services to the NDIS and due to the current changes in organisation and governance related to the commissioning role of the PHNs and their relationship with other components of the system such as LHDs and the Hospital networks.

INTEGRATION OF THE MENTAL HEALTH CARE SYSTEM

According to the government response to the mental health commission report, "Regional integration" is a systems-based approach that seeks to better coordinate and plan regional services to improve system and health outcomes (61). Regional integration works to integrate pathways and services around the needs of consumers, while also striving for the best possible use and targeting of available resources to address individual and community. The emphasis on a system-based approach is critical to generate new informed evidence for policy and planning. As previously stated the specific priorities for regional service integration and delivery led by PHNs include: "development of evidence-based regional mental health plans based on comprehensive needs assessment, and service mapping designed to identify gaps and opportunities for better use of services to reduce duplication and remove inefficiencies". The Government has committed itself to build the capacity of PHNs to lead mental health planning and integration at a regional level in partnership with LHDs, non-government organisations, local NDIS providers, alcohol and other drug services, Indigenous organisations, general practices and other regional stakeholders.

This mapping has provided a description of the service availability and capacity but it has not analysed the level of integration of the mental health care system. However, the analysis of the integration of care cannot be carried out without a prior knowledge of what services are available in the local area, and therefore the information provided here is necessary to carry out and to understand the integration of the care system. In addition, the lack of major components of a fully developed community mental health care system identified in the gap analysis has clear implications for the integration of care, as a system cannot be fully integrated when major components of the system are missing. In any case the need and the number of coordination services that are not part of the routine activities performed in the direct care services may indicate the lack of continuity of care in the system. The transition to NDIS of many non-health services may potentially increase the level of fragmentation.

PROBLEMS IN THE CARE DELIVERY SUBSYSTEM FOR MODERATE TO SEVERE PATIENTS

Many of the gaps identified in this report have a particular impact on the "missing middle", that is, the population with moderate to severe levels of mental illness that is not receiving adequate care. The gaps in the care system for this group were highlighted in the review made by the National Mental Health Commission (62) which described the system as one that responds too late. In particular, the gap in high intensity day care may hinder tertiary prevention or rehabilitation.

When analysing the information, the type of services provided in the SESLHD may better cover the needs of the two extremes of the lived experience of mental illness: on the one hand, those people with mental illness who are relatively well, have good support, and only need low-level support, and on the other hand, those who are in a severe crisis situation that require acute care in a hospital setting. 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 (38).

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 (63). However, the gap in other OECD countries is mainly related to the mild-moderate target group treated in primary care and by community nurses and not to consumers experiencing moderate-severe mental illness treated in specialised care as identified in this analysis. The care pattern for mild-moderate mental illness in primary care in the SESLHD is an area that requires further investigation.

These gaps also have implications for a reform based on the stepped care model. From a policy perspective there is tension between a policy planning strategy aimed at developing an integrated care system and another strategy targeting specific areas of improvement such as suicide prevention, specific population groups and specific systems of care delivery. This tension is particularly relevant in the context of a stepped care model in a system characterised by significant fragmentation. It is important to note, the link between the stepped care model and the integrated care model have not been sufficiently explored, and the evidence available on the implementation of the stepped care model is mainly available on specific interventions within the service delivery system (e.g., psychotherapy) (64), and in specific conditions (e.g., anxiety and depression) (65,66,). A major question is whether the stepped care model implemented in regional areas following an integrated care approach even when in an activity based system such as Germany (e.g., Aachen or Hamburg , Germany) (67) can be extrapolated to regions that are characterised by an activity based system which is highly fragmented as in Australia. There is a risk of developing further silos and fragmentation in the different steps of the care system if the care delivery system and the workforce responsibilities and caseload are divided by levels of severity and staging without a full map of the availability of services and the pathways of care as well as a better understanding of the pathways that may ensure care continuity.

8 STUDY LIMITATIONS

There are several limitations that need to be acknowledged. *First*, some services may be missing because we did not reach them. However, we presented and discussed services included and coded in the study to the Steering Committee of the Atlas project and, after different iterative reviews, it was agreed that the majority of the services have been included and coded. A small number of services did not provide information on FTEs. Additionally, some services that are not specific to mental health, but that are used by people with mental illness, may be absent. Some services providing care for people with disabilities and homelessness specific services expressed their interest in the Atlas, but they did not want to be included as their target was not mental health. This is an issue which has also been identified in other PHNs.

The focus on individual care based on level of functioning, without any consideration of the target population group, may have implications for the care delivery system which should be explored in the future. Questions arise as to whether a service which does not provide a mental health component in its provision system can adequately attend to and meet the specific needs of this population group.

Second, we have not included private providers, as this atlas is focused on services with a minimum level of universal accessibility. The inclusion of private providers in the mapping of publicly available services may increase noise, hamper the interpretation of the results and misrepresents the universality of access to services. Private services should be included as an additional map in future analysis. The CESPHN concentrates a considerable number of private health services into its jurisdiction with the highest number of specialists' attendances per person in Australia; and the costs of a specialised visit are the second highest in Australia after North Sydney.

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

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

Fifth, we have only included services within the boundaries of the SESLHD even though some of the residents in this area may use services from other PHNs, such as SLHD, South Western Sydney, Western Sydney or Northern Sydney. The issues of remote areas such as Lord Howe Island have not been analysed in this report. A complete Atlas of Greater Sydney would solve this problem and allow a full understanding of the pattern of service availability and capacity in relation to service utilisation and patients flows. This information will eventually facilitate hot-spot analysis (68), benchmark analysis and modelling of relative or technical efficiency at local level (69) as has already been carried out in other metropolitan areas (70).

9 FUTURE STEPS

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

- **Services at the Primary Care Level.** General practitioners or family physicians are usually the first contact with the health system, and they can play a key role in the prevention of mental

illness and the treatment of common mental illness. It is therefore crucial to understand and meet the needs of these professionals.

- **Analysis of professional profiles by main types of care.** Substantial differences have been identified in the professional profiles of the workforce in comparison with similar main types of care in Europe, particularly in the non-health / NGO sector. This would require a detailed analysis in the future.
- **Rates of utilisation of the services**, by MTC, using the information provided in the administrative databases: the analysis of service utilisation will detect hot and cold spots and areas of improvement. The information collected in the local Atlas of Mental Health Care can be combined with utilisation and outcome data to produce decision support tools that may help decision for the analysis of benchmarking and relative efficiency, as well as to redesign and improve available services. The DESDE-LTC system has been previously used for this purpose in other countries (80).
- **Care Packages:** The information presented in this Atlas may be complemented with an analysis on care packages: set of services and interventions that are provided to a consumer at a single time period (complex or collaborative interventions).
- **Pathways to care:** understanding how people with a lived experience of mental illness navigate the system is a key area of knowledge needed for creating systems which increase accessibility and efficiency. This will allow a continuity of care analysis.
- **Financing mechanisms and financing flows**: This will allow us to delve into important areas such as the *Better Access Program* and housing.
- **Level of integration of the services providing mental health care and the philosophy of care of the services:** a collateral finding that emerges, but that should be included, related to integration is the different philosophy of care of the services. It is important to know the view of the different providers on the public mental health system and their role in it.
- **Analysis of services *for specific target population groups,*** mainly: child and adolescent care, homelessness services, fully private services not accessible through public funding, and alcohol and other drug services, with a particular focus on care for comorbid patients. Care in inner regional areas closer to a main city (Sutherland Shire) and very remote Australia (Lord Howe Island) should be regarded as a relevant topic for SESLHD (16).

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

- **Case and care coordinators:** The data in this Atlas could facilitate a better understanding of the landscape in which they work and the services that are available to their consumers.
- **Managers and Planners:** The information gathered in this Atlas is useful for the development of bottom up system indicators 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 (70). This can be easily done by introducing the classification system (DESDE) into an on-line program that automatizes the codification of the services. The Department of Social Welfare of Andalusia, in the South of

Spain, has incorporated the DESDE into their web page, so services receive the code after answering some questions. It will be also important to evaluate the impact of this Atlas, as a visual tool to increase the capacity and efficacy of managers and planners in evidence-informed decision making and in system thinking.

- **Consumers:** A user-friendly version of the Atlas may support consumers' to navigate the system, location of services and increase their local knowledge on service availability and capacity. For instance, the results of the Integrated Mental Health Atlas of Western Sydney have been used by Carers NSW in a submission to a NSW Parliament Inquiry into service coordination in communities with high social needs.

10 CONCLUSION

This Atlas contributes to the development of evidence-based regional mental health plans based on comprehensive needs assessment, and service mapping designed to identify gaps and opportunities for better use of services to reduce duplication and remove inefficiencies as requested by the Federal Government to the PHNs to implement the mental health reform (71). Our observations are in line with the report of the National Mental Health Commission's National Review of Mental Health Programmes and Services, which recommended, amongst others: 1) the development of more community-based psychosocial, primary and community mental health services, as alternatives to acute hospital care; and 2) boosting of the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services.

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

This mapping has provided a description of service availability and capacity, but it has not analysed the level of integration of the mental health care system. However, the analysis of the integration of care cannot be carried out without a prior knowledge of what services are available in the local area, and therefore the information provided here is necessary to carry out and to understand integration of the care system. In addition, the lack of major components of a fully developed community mental health care system identified in the gap analysis has clear implications for the integration of care, as a system cannot be fully integrated when major components of the system are missing. In any case the need, and the number, of coordination services, which are not part of the routine activities performed in the direct care services, may indicate the lack of continuity of care in the system. The transition to NDIS of many non-health services may potentially increase the level of fragmentation.

11 REFERENCES

1. Mendoza J, Bresnan, A., Rosenberg, S., Elson, A., Gilbert, Y., Long, P., Wilson, K., & Hopkins, J. Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future. . Caloundra, QLD: ConNectica, 2013.
2. South Eastern Sydney Local Health District. Patient-centred care: A snapshot. 2011 [cited 2016, 21 April]. Available from: http://www.seslhd.health.nsw.gov.au/about_us/documents/FactSheets/new/SESLHD%20indicator%20sheets_Health_Volume%202%20Section%203_FINAL.pdf.
3. Central and Eastern Sydney Primary Health Networks. About Central and Eastern Sydney PHN. 2016 [cited 2016 21 April]. Available from: https://www.cesphn.org.au/about/about-cesphn.
4. Australian Bureau of Statistics. Australian Statistical Geography Standard (ASGS) 2013. Available from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.005July%202011?OpenDocument.
5. Australian Bureau of Statistics. Remoteness structure 2014 [cited 2016, 30 June]. Available from: http://www.abs.gov.au/websitedbs/D3310114.nsf/home/remoteness+structure#Anchor2a.
6. Australian Population and Migration Research Centre. ARIA (Accessibility/Remoteness Index of Australia) 2016. Available from: http://www.adelaide.edu.au/apmrc/research/projects/category/about_aria.html.
7. Australian Bureau of Statistics (ABS). National Survey of Mental Health and Wellbeing: Summary of Results, 2007. 2008 [cited 2016 21 April]. Available from: http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Main%20Features32007?opendocument&tabname=Summary&prodno=4326.0&issue=2007&num=&view=.
8. Caldwell TM, Jorm AF, Dear KBG. Suicide and mental health in rural, remote and metropolitan areas in Australia. Medical Journal of Australia. 2004;181(7):S10-S4.
9. Jablensky A, McGrath J, Herrman H, Castle D, Gureje O, Evans M, et al. Psychotic disorders in urban areas: an overview of the Study on Low Prevalence Disorders. Aust Nz J Psychiat. 2000;34(2):221-36.
10. Caldwell TM, Jorm AF, Dear KB. Suicide and mental health in rural, remote and metropolitan areas in Australia. The Medical journal of Australia. 2004;181(7 Suppl):S10-4.
11. Salvador-Carulla L, Alvarez-Galvez J, Romero C, Gutierrez-Colosia MR, Weber G, McDaid D, et al. Evaluation of an integrated system for classification, assessment and comparison of services for long-term care in Europe: the eDESDE-LTC study. BMC health services research. 2013;13:218.
12. Department of Health. Central and Eastern Sydney PHN factsheet 2016. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/503C7D0F1A39C1D5CA257F1500041405/$File/PHN%20Infographic%20-%20Central%20and%20Eastern%20Sydney.pdf.
13. NSW South Eastern Sydney Local Health District. South Eastern Sydney Local Health District: Our Population. Available from: http://www.seslhd.health.nsw.gov.au/about_us/documents/FactSheet_SESLHD_Our_Population.pdf.
14. Sydney Local Health District (SLHD). Our local health district boundary. 2013 [cited 2016 21 April]. Available from: https://www.slhd.nsw.gov.au/planning/pdf/SLHD%20_Boundary.pdf.
15. South Eastern Sydney Local Health District. South Eastern Sydney Local Health District: Our Boundary 2013. Available from: http://www.seslhd.health.nsw.gov.au/about_us/documents/FactSheet_SESLHD_Our_New_Boundary.pdf
16. NSW South Eastern Sydney Local Health District. South Eastern Sydney Local Health District. Available from: http://www.seslhd.health.nsw.gov.au/
17. NSW South Eastern Sydney Local Health District. About us - Our population. Available from: http://www.seslhd.health.nsw.gov.au/about_us/our_population.asp
18. Family and Community Services. Family and Community Services Annual Report 2013-14: Volume 1: Performance and activities report 2014. Available from: https://www.facs.nsw.gov.au/__data/assets/file/0008/303002/FACS-AR-13_14_Vol-1-Performance.pdf
19. Cacace M, Ettelt S, Mays N, Nolte E. Assessing quality in cross-country comparisons of health systems and policies: Towards a set of generic quality criteria. Health Policy. 2013;112(1-2):156-62.

20. Salvador-Carulla L, Amaddeo F, Gutierrez-Colosia MR, Salazzari D, Gonzalez-Caballero JL, Montagni I, et al. Developing a tool for mapping adult mental health care provision in Europe: the REMAST research protocol and its contribution to better integrated care. Int J Integr Care. 2015;15:e042.
21. Australian Bureau of Statistics (ABS). Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure, July 2011 2014. Available from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1270.0.55.005July%202011?OpenDocument
22. NENAD. Population densities of Australian Capital Cities – Melbourne and Sydney 2016. Available from: http://blog.id.com.au/2015/population/australian-demogr.
23. Drennan IR, Strum RP, Byers A, Buick JE, Lin S, Cheskes S, et al. Out-of-hospital cardiac arrest in high-rise buildings: delays to patient care and effect on survival. Can Med Assoc aphic-trends/population-densities-of-australian-capital-cities-melbourne-and-sydney/ J. 2016;188(6):413-9.
24. Panczak R, Galobardes B, Spoerri A, Zwahlen M, Egger M. High life in the sky? Mortality by floor of residence in Switzerland. Eur J Epidemiol. 2013;28(6):453-62.
25.Hartig T, Kahn PH. Living in cities, naturally. Science. 2016;352(6288):938-40.
26. Astell-Burt T, Mitchell R, Hartig T. The association between green space and mental health varies across the lifecourse. A longitudinal study. J Epidemiol Commun H. 2014;68(6):578-83.
27.Astell-Burt T, Feng X. Investigating 'place effects' on mental health: implications for population-based studies in psychiatry. Epidemiol Psych Sci. 2015;24(1):27-37
28. NSW Department of Health. NSW health organisation chart 2015 [cited 2016 28 June]. Available from: http://www.health.nsw.gov.au/about/nswhealth/Documents/NSW-Health-Org-Chart-2015-11-15.pdf
29. Weible CM, Sabatier PA. A guide to the advocacy coalition framework. In: Fischer F, Miller GJ, editors. Handbook of public policy analysis: Theory, politics, and methods. Boca Raton, FL: CRC Press; 2007. p. 123-36.
30. NSW Government Ministry of Health. Local health districts and specialty networks. Available from: http://www.health.nsw.gov.au/lhd/pages/default.aspx.
31. Department of Health. Australia Government. Department of Health Review of Australian Government Health Workforce Programs: 4.3 Reform of the ASGC-RA rural classification system 2013. Available from: http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~executive-summary
32. City of Sydney. Inner Sydney registry week 2015 2015. Available from: http://www.cityofsydney.nsw.gov.au/community/community-support/homelessness3
33. Ruggeri M, Bonetto C, Lasalvia A, Fioritti A, de Girolamo G, Santonastaso P, et al. Feasibility and Effectiveness of a Multi-Element Psychosocial Intervention for First-Episode Psychosis: Results From the Cluster-Randomized Controlled GET UP PIANO Trial in a Catchment Area of 10 Million Inhabitants. Schizophr Bull. 2015;41(5):1192-203.
34. NSW Commission. "Living Well: s startegic Plan for Mental Health in NSW 2014-2014" 2014.
35. Department of Health. Australian Government Response to Contributing Lives, Thriving Communities -Review of Mental Health Programs and Services 2015 [cited 2016. Available from: https://www.health.gov.au/internet/main/publishing.nsf/content/0DBEF2D78F7CB9E7CA257F07001ACC6D/$File/response.pdf
99 36. Department of Health. PHN programme guidelines 2016 [Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines
37. Allison S, Bstaiampillai T, Goldney R. Acute versus sub-acute beds: should Asutralia onvest in community beds at the expense of hospital beds. Australian & New Zealand Journal of Psychiatry. 2014;48(10).
38. Thornicroft G, Tansella M. The balanced care model for global mental health. Psychological medicine. 2013;43(4):849-63.
39. Siskind D, Harris M, Kisely S, Brogan J, Pirkis J, Crompton D, et al. A retrospective quasi-experimental study of a community crisis house for patients with severe and persistent mental illness. Australian & New Zealand Journal of Psychiatry. 2013;47(7):667-75.

40. Health Do. Adult Prevention and Recovery Care (PARC) services framework and operational guidelines Victoria: Department of Health; 2010 [cited 2015 2 November]. Available from: http://www.health.vic.gov.au/mentalhealthservices/parc.pdf.
41. Bruce J, McDermott S, Ramia I, Bullen J, Fisher KR. Evaluation of the Housing and Accommodation Support Initiatives (HASI) Final Report for NSW Health and Housing NSW. Sydney: Social Policy Research Centre Report, 2012.
42. Marshall M, Crowther R, Sledge WH, Rathbone J, Soares-Weiser K. Day hospital versus admission for acute psychiatric disorders. The Cochrane database of systematic reviews. 2011(12):CD004026.
43. Quality. AfHRa. Management Strategies to reduce Psychiatric Admissions. Draft technical brief. Rockville, MD.: Agency for Healthcare Research and Quality. , 2014.
44. Priebe S, McCabe R, Schutzwohl M, Kiejna A, Nawka P, Raboch J, et al. Patient Characteristics Predicting Better Treatment Outcomes in Day Hospitals Compared With Inpatient Wards. Psychiat Serv. 2011;62(3):278-84.
45. NICE. Psychosis and schizophrenia in adults: prevention and management. UK: National Institute for Health and Care Excellence, 2014.
46. Department of Health and Ageing. National Mental Health Report 2013. Canberra: Department of Health and Ageing; 2013
47. Meadows GN, Enticott JC, Inder B, Russell GM, Gurr R. Better access to mental health care and the failure of the Medicare principle of universality. The Medical journal of Australia. 2015;202(4):190-4.
48. Wheeler C, Lloyd-Evans B, Churchard A, Fitzgerald C, Fullarton K, Mosse L, et al. Implementation of the Crisis Resolution Team model in adult mental health settings: a systematic review. BMC psychiatry. 2015;15:74.
49. Hasselberg N, Grawe RW, Johnson S, Ruud T. An implementation study of the crisis resolution team model in Norway: Are the crisis resolution teams fulfilling their role? Bmc Health Serv Res. 2011;11.
50. Johnson S. Crisis resolution and Home treatment in England: where are we now? In: Economics IoH, editor. Consensus Statement on Improving Mental health Transitions - November 4-6, 2014; Edmonton, Alberta2014.
51. Rosen A, Gurr R, Fanning P. The future of community-centred health services in Australia: lessons from the mental health sector. Australian health review : a publication of the Australian Hospital Association. 2010;34(1):106-15.
52. Rosen A, Gurr R, Fanning P, Owen A. The future of community-centred health services in Australia: 'When too many beds are not enough'. Australian health review : a publication of the Australian Hospital Association. 2012;36(3):239-43.
53. Ferguson I. Personalisation, social justice and social work: a reply to Simon Duffy. Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community,. 2012;26(1):55-73.
54. Duffy S, editor A Fair Society and the Limits of Personalisation.Disussion Paper. The Centre for Welfare Reform First Presented at the Tizard Memorial Lecture, 4th March 2011; 2011.
55. Barnes M. Abandoning Care? A Critical Perspective on Personalisation from an Ethic of Care. Ethcis and Social Welfare. 2011;5(2):153-67.
56. Grove B. Mental Health and Employment: Shaping a new agenda. Journal of Mental Health. 1999;8(2):131-40.
57. Smith-Merry J, Gillespier J, Hancock N, Yen I. Doing Mental Health Care Integration: A Qualitative Study of a New Work Role. Unpublished Working Paper. 2015.
58. Meadows GN, Enticott JC, Inder B, Russell GM, Gurr R. Better access to mental health care and the failure of the Medicare principle of universality. The Medical journal of Australia. 2015;202(4):190-4.
59. Thornicroft G, Tansella M. Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence. The British journal of psychiatry : the journal of mental science. 2004;185:283-90.
60. South Eastern Sydney Partners in Recovery. South Eastern Sydney Partners in Recovery: Two year anniversary 2015 [cited 2016 29 June]. Available from: http://www.sespir.com.au/PDFs/SESPIR-final-two-year-anniversary-report.pdf

61. Department of Health. Australian government response to contributing lives, thriving communities: Review of mental health programmes and services. Canberra: The Author.; 2015.
62 .NSW Commission. "Living Well: s startegic Plan for Mental Health in NSW 2014-2014" 2014.
63. OECD. OECD Reviews of Health Care Quality: Norway 2014 Rasing Standards. OECD, 2014.
64. McQueen D, Smith PS. NICE recommendations for psychotherapy in depression: Of limited clinical utility. Psychiatriki. 2015;26(3):188-97.
65. Heddaeus D, Steinmann M, Liebherz S, Harter M, Watzke B. [psychenet - The Hamburg Network for Mental Health: Evaluation of the Health Network Depression from the Perspective of Participating General Practitioners, Psychotherapists and Psychiatrists]. Psychiatr Prax. 2015;42 Suppl 1:S54-9.
66. Ho FY, Yeung WF, Ng TH, Chan CS. The Efficacy and Cost-Effectiveness of Stepped Care Prevention and Treatment for Depressive and/or Anxiety Disorders: A Systematic Review and Meta-Analysis. Sci Rep. 2016;6:29281.
67. Brocheler A, Bergmann F, Schneider F. Models of mental health care in psychiatry across sectoral borders. Eur Arch Psychiatry Clin Neurosci. 2009;259 Suppl 2:S227-32.
68. Salinas-Pérez JA, García-Alonso CR, Molina-Parrilla C, Jordà-Sampietro E, Salvador-Carulla L. Identification and location of hot and cold spots of treated prevalence of depression in Catalonia (Spain). International Journal of Health Geographics. 2012;11(36):1-10.
69. Torres-Jiménez M, García-Alonso CR, Salvador-Carulla L, Vicente Fernández-Rodríguez. Evaluation of system efficiency using the Monte Carlo DEA: The case of small health areas. European Journal of Operational Research. 2015;22(2):525-35.
70. Fernandez A, Salinas-Perez JA, Gutierrez-Colosia MR, Prat-Pubill B, Serrano-Blanco A, Molina C, et al. Use of an integrated Atlas of Mental Health Care for evidence informed policy in Catalonia (Spain). Epidemiology and psychiatric sciences. 2014:1-13.
71. Australian Government Department of Health. Implementation Circular 2/2016 2016 [cited 2016]. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Circular2_Mental
72. Hopman. K.; Furst, M.C.; Maas. C., Salinas-Perez, J.A.; Fernandez. A., Xu T., , Alvarez-Galvez, J., Prigent A, Gandré C., &; Salvador-Carulla. L. (2016). *The Integrated Mental Health Atlas of the Central and Eastern Sydney PHN Region*. Annex 1: Sydney Local Health District. Mental Health Policy Unit. Brain and Mind Centre. Faculty of Health Sciences. University of Sydney. 30 December 2016