THE INTEGRATED MENTAL HEALTH ATLAS OF THE CENTRAL AND EASTERN SYDNEY PHN

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ABBREVIATIONS

ABS Australian Bureau of Statistics
ADC Acute Day Care
AOD Alcohol and other drugs
ARIA Accessibility/Remoteness Index of Australia
ATAPS Access to Allied Psychological Services
AW Aboriginal Worker
BSIC Basic Stable Inputs of Care
CALD Culturally and Linguistically Diverse
CBA Community Based Activity Program (Buckingham House)
CCG Clinical Commission Groups
CCM Clinical Case Manager
CCMH Concord Centre for Mental Health
CESPHN Central and Eastern Sydney PHN
D2DL Day2Day Living
DESDE- LTC Description and Evaluation of Services and Directories in Europe for long-term care
DSA Disability Services Australia
ES Eastern Sydney
FACS Family and Community Services
GIS Geographical Information System
HASA Health and Safety Assistant
HASI Housing and Accommodation Support Initiative
ICF International Classification of Functioning
IWS Inner West Sydney
IRSD Index of Relative Socio-Economic Disadvantage
LGA Local Government Area
LHD Local Health District
LOTE Language Other Than English
LTC Long Term Care
MB Professor Marie Bashir Centre
MBE Medicare Benefits Expenditure
MD Mental illnesses
mhGAP Mental Health Gap Action Program
MHEC Mental Health Emergency Care
MHN Mental Health Nurse
MHNIP Mental Health Nurse Incentive Program=
MHSRRA Mental Health Services in Rural and Remote Areas
MTC Main Type of Care
NA Not Available at the Time of Publication
NGO Non-Governmental Organisation
NDIS National Disability Insurance Scheme
NHSD National Health Services Directory
NICE National Institute for Health and Care Excellence
NSW New South Wales
OT Occupational Therapist
PARC Prevention and Recovery Care

PC Primary Care
PHIDU Public Health Information Development Unit
PHN Primary health network
PIR Partners in recovery
PW Peer Worker
SA1 Statistical area 1
SCHN Sydney Children's Hospital Network
SES South Eastern Sydney
SESLHD South Eastern Sydney LHD
SF Support Facilitator
SLA Statistical Local Area
SLHD Sydney Local Health District
SMHSOP Specialist Mental Health Services for Older People
SSI Settlement Services International
SVHN St Vincent's Hospital Network
SWS South Western Sydney
SW Social Worker
TAMHSS Transforming Australia's Mental Health Service Systems
WHA World Health Assembly
WHO World Health Organisation
WS Western Sydney

A note on the language

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

EXECUTIVE SUMMARY

The 2014 *National Review of Mental Health Programmes and Services* by the National Mental Health Commission drew attention to the need of local planning of care for people with a lived experience of mental illness in Australia and the relevance of a bottom-up approach to understanding "services available locally [in] the development of national policy". It also 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 Central and Eastern Sydney PHN (CESPHN) 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 CESPHN. 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 CESPHN, when compared to other regions and countries. These are:

1) the good availability of inpatient acute care and outpatient care,
2) a lack of acute and sub-acute community residential care as alternatives to hospital care;
3) a comparative lack of services providing acute day care and non-acute day care (i.e. day centres providing structured activities to promote health and social inclusion);
4) lower availability of specific employment and housing services for people with a lived experience of mental illness;
5) lower availability of supported accommodation initiatives.

Taken together the information in this Atlas highlights key areas for consideration for future planning for the provision of mental health services in the CESPHN. 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

The Integrated Mental Health Atlas of the CESPHN provides information on all services specifically designed for people with a lived experience of mental illness in the CESPHN. It includes: Health, Social, Home, Education, Employment and Justice Services. The Atlas does not map ALL the services used by people with a lived experience of mental illness (e.g. primary care, fee for service care or services designed for other target groups such as homelessness). Although very relevant, these services fall outside the scope of this PHN commissioned project.

PRIMARY HEALTH NETWORKS IN AUSTRALIA

Primary Health Networks are part of major health care reform in Australia following the Horvath's review of Medicare Locals in 2014. Critical objectives of PHNs are to increase the efficiency of medical services for patients and to improve coordination of care to ensure patients receive the right care in the right place at the right time. To achieve these objectives the Department of Health has outlined the need for PHNs to "understanding the health care needs of their PHN communities through analysis and planning" including the description of service availability, gap analysis, and an action plan to address these gaps where needed (3).

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

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

- a "National Health Services Directory (NHSD)" which will provide a consistent directory of key primary health services, including: after hours services;
- a "Primary Health Map" that will enable capability to view health needs, overlaid with the location of the health services identified from the NHSD; and
- PHN websites with centralised content and "reporting dashboard" – providing a template website solution to support centralised reporting and sharing of content and service information (3).

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

MENTAL HEALTH CARE REFORM

The philosophy of mental health care reform has been built on key principles of community psychiatry internationally, with four interlinked areas of action (4):

- Deinstitutionalisation and the end of the traditional model of care of internment in mental hospitals;
- Development of alternative community services and programs;
- Integration with other health services;
- Integration with social and community services.

More recently this has also included a focus on recovery oriented and person-centred care.
Australia started its journey of reform in 1983, with David Richmond's report on care for people experiencing mental illness and intellectual disabilities in New South Wales (NSW): *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled*. But it took ten years to establish the first National Mental Health Strategy (5). Since then, there have been considerable systemic changes made, including the closure or downsizing of many large psychiatric hospitals and the development of the community mental health and consumer movement (6).

Australia's reform journey continues and application of reform is variable. For example, the Australian mental health system has high rates of readmission to acute care, with at least 46% of patients hospitalised being readmitted during the year following the admission (7). There are also high rates of compulsory community treatment orders, ranging from 30.2 per 100,000 population in Tasmania to 98.8 per 100,000 population in Victoria (8); and high rates of seclusion with 10.6 seclusion events per 1,000 bed days in 2011-12 (9). In NSW specifically, the rate of seclusion was 8.5 per 1,000 bed days in 2012-2013 (10). These features are associated with a system characterised by a fragmented, hospital-based, and inefficient provision of care (5). It has been argued that Australia lacks a clear service model, that reform has not been informed by evidence, and that quality and access to care is a lottery dependent on postcode (5).

Unfortunately, there is currently limited evidence to help determine the most efficient and effective models of care for mental health services. Some International and Australian models may however guide improved service planning. Thornicroft and Tansella (11) conducted a review of the relevant evidence on mental health service planning and a series of surveys including more than 170 experts with direct experience of mental health system planning. They integrated the data and developed a balanced care model for the provision of mental health relevant to different resource settings. According to that model, high-resources settings, such as Australia, need to focus on:

- The recognition and treatment of common mental illness **in primary care** for common mental illnesses;

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

Similarly, the Transforming Australia's Mental Health Service Systems (TAMHSS) group has recently recommended *The Essential Components of Care for Community-Oriented Mental Health Services* to be provided in Australia (12). In addition to inpatient hospital care, the Australian mental health system should guarantee the provision of:

- Access and triage
- Early intervention
- Care coordination
- Crisis intervention and acute treatment in the community
- Recovery oriented practices for community living
- Engagement and community based support for people with complex needs
- Medication
- Physical health care
- Effective psychological therapies

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

Recently, the Australian government prioritised several areas of reform following the National Mental Health Commission's Review of Mental Health Programmes and Services 'Contributing Lives, Thriving Communities'(13). This report recommended changes to the mental health system to improve its longer-term sustainability. Overall, it called for a planned and unitary 'mental health system'- that is an integrated system - instead of the current "collection of often uncoordinated services that have accumulated spasmodically over time, with no clarity of roles and responsibilities or strategic approach that is reflected in practice" (13).

One of the foundations of the Australian Government's current reform agenda (as outlined in its Response to Review) (13) is a stepped care approach. The stepped care approach is a staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs by promoting person-centred care and building more options and range into the market (See Figure 1).

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

Source: (Australian Government response to the review of mental health programmes and services, 2015)(13)

The stepped care model focuses on promotion and prevention for healthy populations, increasing early interventions for at risk groups, providing and promoting access to lower cost and lower intensity services for individuals with mild mental illness, increasing service access and evidence-based intervention for individuals with moderate mental illness and improving access to primary mental health care intervention and coordinated care for individuals with severe mental illness (13). To assist the development of the stepped care model the Australian Government has developed a list of priority actions in their Draft Fifth National Mental Health Plan. The Mental Health Plan recognises that "A regional focus is critical to efforts to achieve a better integrated service system". It has incorporated in Action 2 " a series of key priorities related to the development of the Integrated Atlas of Mental Health Care: such as: a) joint regional needs assessment and service mapping processes to identify gaps, duplication and inefficiencies in current service arrangements with a view to making better use of existing resources and improving overall sustainability; and b) working with health and social service agencies, the community sector, and service providers to improve integration through region-wide, multi-agency agreements, shared client pathways and information sharing protocols designed to better enable consumers and carers to navigate the system (14). Therefore the Integrated Mental Health Atlas of the CESPHN provides service mapping for one specific area of health care, being targeted mental health services.

CENTRAL EASTERN SYDNEY PHN AND MENTAL HEALTH REFORM

The CESPHN is one of 31 PHNs in Australia. The CESPHN is the second most populated PHN and has a population of more than 1.4 million (estimated residential population as at 2015). It represents an amalgamation of three former Medicare Local regions: Eastern Sydney (ES), Inner West Sydney (IWS) and South Eastern Sydney and aligns with the Sydney Local Health District

(SLHD) and the South Eastern Sydney Local Health District (SESLHD) boundaries(15). The area also encompasses the St Vincent's Health Network (SVHN) and the Sydney Children's Hospital Network (SCHN) (16). Further details on the LGA's covered by the CESPHN can be found in Section 2 of this report (Mapping the Area: Boundaries and Indicators).

In 2015, the Commonwealth government announced six priorities for the PHN's commissioning role for mental health and suicide prevention services (17). These priorities are based on the key areas of reforms issued at the national level, were specifically established for mental health care within the PHNs. Those priorities, listed below, represent a combination of populations to target and services to develop and commission (18):

- Early intervention for Children and young people with or at risk of mental illness
- Enhance and integrate Aboriginal and Torres Strait Islander mental health services.
- Services for people who experience severe and complex mental illness who are supported in primary care.
- Address service gaps in the provision of psychotherapies for underserviced groups and/or hard to reach populations
- improve targeting of and development of low intensity mental health services
- Promote a regional approach to suicide prevention.

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

The areas covered by the CESPHN are mainly urban and characterised by high accessibility of services according to the Accessibility/Remoteness Index of Australia (ARIA) (19, 20). The ARIA is a continuous index developed by the Australian Bureau of Statistics (ABS) to assess remoteness of Australian areas based on road distances between localities and services such as education and health. It allows for classification areas within five groups from "Major Cities of Australia" (high accessibility) to "Very remote Australia" (high remoteness) (19). The provision of mental health care in urban areas presents specific challenges that require tailored planning as mental illnesses are particularly prevalent in urban Australia (21-23).

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

The Atlas of the CESPHN is an ideal tool to support this process (24). This Atlas provided at the PHN level which now represents a key planning structure in health planning, is complemented with supplementary atlases of the SLHD, SESLHD and St Vincent's Health Network (SVHN).

An organisational analysis of SVHN is also available as a separate Annex as it represents a nested system within the CESPHN whose jurisdictional boundaries are not clearly defined.

1.1. WHAT ARE INTEGRATED MENTAL HEALTH ATLASES?

The WHO Mental Health Gap Action Program (mhGAP) (25) highlighted the need for a comprehensive and systematic description of all the mental health resources available and the utilisation of these resources. It is not only important to know the numbers of services in each health area, but also to describe what they are doing and where they are located. This information also enables an understanding of the context of health-related interventions which are essential for the development of evidence-informed policy.

Evidence-informed policy is an approach to policy decisions which is intended to ensure that the decision making process is well-informed by the best available research evidence. Evidence refers to facts intended for use in support of a conclusion. It is important to highlight that evidence alone does not make decisions, as this evidence has to be also valued and filtered by the policy makers. However, evidence-informed policy tries to make this process more transparent so that others can examine it. Evidence-informed policy combines 'global evidence' available from around the world with 'local evidence' from the specific setting in which decisions and actions will be taken. This includes a detailed analysis of the area, taking into account the prevalence of mental illness and other demand driven indicators, together with the availability of resources (26).

An in-depth understanding of the local context is crucial to the implementation of any new strategy. There is no agreed definition of context; however, it can be defined as all those variables that can be related to both the new strategy that we want to implement and the outcome that we want to achieve. In other words, it makes references to "where" the process is happening, including: organisational and divisional structures and cultures; group norms; leadership; political processes; and broader economic, social and political trends and events (27).

The 'integrated care model' (28) has challenged the way health-related care should be assessed and planned. It enables us to identify new routes for linked, consumer-centred approaches to care. Greater integration relies on a global picture of all the services available, regardless of which sector is funding them (e.g. Health, Social Welfare and Family, Employment, Criminal Justice). Such 'systems thinking' enables policy planners to capture the complexity of service provision holistically and ensures that planning of health services accounts for contextual factors that might affect its implementation and sustainability (context analysis). It offers a comprehensive way of anticipating synergies and mitigating problems and barriers, with direct relevance for creating policies that integrate the different systems of care (29, 30).

This is particularly important in the mental health care sector which is characterised by an increasing personalisation of services, care coordination programs such as Partners in Recovery (PIR) and the transfer of social services to the National Disability Insurance Scheme (NDIS).

Within this context, Integrated Atlases of Mental Health are essential tools for decision making and quality assessment. These Integrated Atlases include detailed information on socio-economic and demographic characteristics and health-related needs, as well as data on service availability and care capacity. Integrated Atlases of Mental Health allow comparison between small health areas, highlighting variations of care, and detecting gaps in the system. The holistic service maps produced through an Integrated Atlas of Mental Health also allow policy planners and decision makers to build bridges between the different sectors and to better allocate services (31).

Integrated Atlases of Health include maps and graphics as a main form of presenting the data. As a visual form of communicating health information, they crucially bridge the gap between complex epidemiological presentations of statistics and the varied educational backgrounds represented by policymakers, other decision makers and consumers (32). Policy makers and health planners may use the information presented in the Atlas as a visual reference point from which to quickly present and structure their ideas. In addition, the new knowledge presented in an Atlas will quickly increase a planner's self-efficacy and personal mastery of the field. Consequently, policy makers and health planners will be more willing to make informed decisions bolstered by solid evidence. In parallel, as Atlases are integrated (e.g. they include all funding providers and sectors) they may increase collaboration across services as they can act as a shared reference point from which to discuss the system. It is therefore expected that the Integrated Mental Health Atlas of the CESPHN will change the culture of planning and, from this, the provision of care through facilitating the integration and coordination of services. This will be reflected in the quality of care provided and, in the longer term, better health outcomes for people with a lived experience of mental illness (33).

The Integrated Mental Health Atlas of the CESPHN aligns with some key recommendations made by the *National Review of Mental Health Programmes and Services* by the National Mental Health Commission (6). The report draws attention to the local level of mental health planning in Australia and the relevance of a bottom-up approach to understanding "services available locally [in] the development of national policy". It also calls for responsiveness to the diverse local needs of different communities across Australia: *"Mental Health Networks, in partnership with Local Health Networks, should conduct comprehensive mapping of mental health services, programmes and supports available in regional, rural and remote areas through Commonwealth, state and territory and local governments, private and not-for-profit sectors".*

"Living Well: A Strategic Plan for Mental Health in NSW: 2014-2024" (2) indicates that the current mental health system is highly fragmented, difficult to navigate and characterised by disjointed policy, financing and service delivery systems at national and state levels.

Furthermore, there is a mismatch between top-down policies developed centrally at national and state levels and the local need for efficient resource allocation. The lack of a comprehensive mapping of the available services constitutes an additional barrier to understanding the accessibility of mental health services in this disjointed system.
The Integrated Mental Health Atlas of the CESPHN can help us to understand the current scenario in the provision of mental health care.

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

Typically, general Atlases of health are formed through lists or directories of the services and inclusion of services is based on their official or everyday titles. This is particularly problematic for several reasons (34):

1) The wide variability in the terminology of services and programs even in the same geographical area and the lack of relationships between the names of services and their actual functions (e.g. day hospitals, day centres, social clubs, etc.), as the service name may not reflect the actual activity performed in the setting;
2) The lack of a common understanding of what a service is. The word 'services' is an umbrella term that is used to describe very different components of the organisation of care. It merges permanent, highly structured services, with clinical units, or even short-term programs and interventions.

As an example, the Department of Health defines "Mental health services" as "services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services" (35). This broad definition does not provide a formal description of "services" for their standard description and comparison.

In order to overcome these limitations, we have used the "*Description and Evaluation of Services and Directories in Europe for long-term care"* (DESDE-LTC) (36). 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.

It is important to note that in research on health and social services there are different units of analysis and that comparisons must be made across a single and common 'unit of analysis'

group. Different units of analysis include: Macro-organisations (e.g. a Local Health District), Meso-organisations (e.g. a hospital), and Micro-organisations (e.g. a service). It could also include smaller units within a service: Main Types of Care, Care Modalities, Care Units, Care Intervention Programs, Care Packages, Interventions, Activities, Micro Activities or Philosophy of Care. Our analysis, based on DESDE-LTC, is focused on the evaluation of the minimal service organisation units or Basic Stable Inputs of Care (BSIC).

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

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

There are six main types of care (36):

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

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

In the result section of the Atlas, the figures, rates per 100,000 residents and comprehensive description of MTC by age group and specific population are provided by MTC while the detailed analysis of the service delivery system in the tables is provided by functional teams or BSIC. These different approaches facilitate comparisons of main types of care and the care system in other local jurisdictions and at the same time it allows a detailed description of the structure of service organisation at macro (e.g., hospital), meso (e.g., service of mental health) and micro-levels (e.g., functional teams)

Figure 2. Main Type of Care: core codes

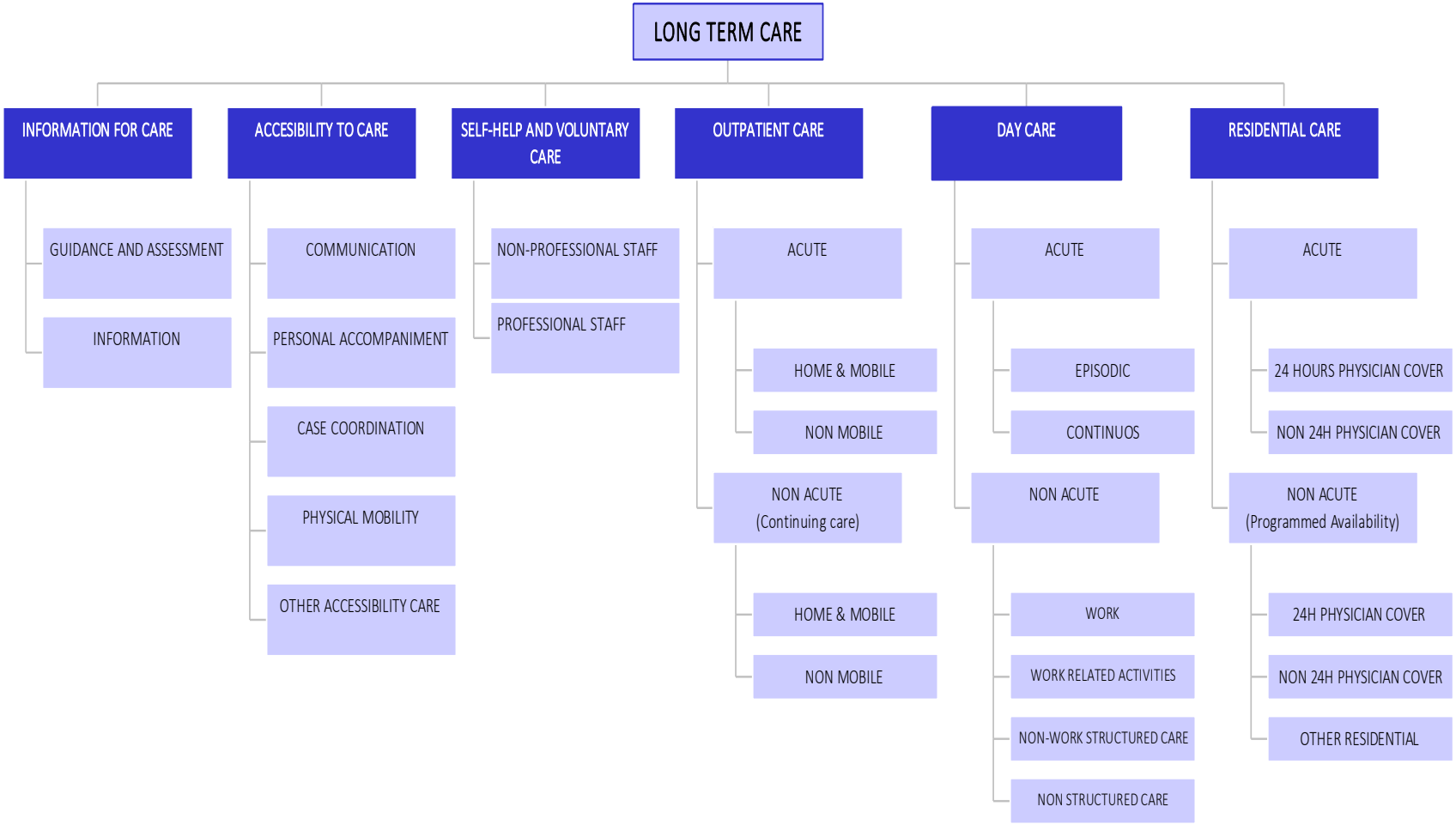


Figure 3. Residential care coding branch

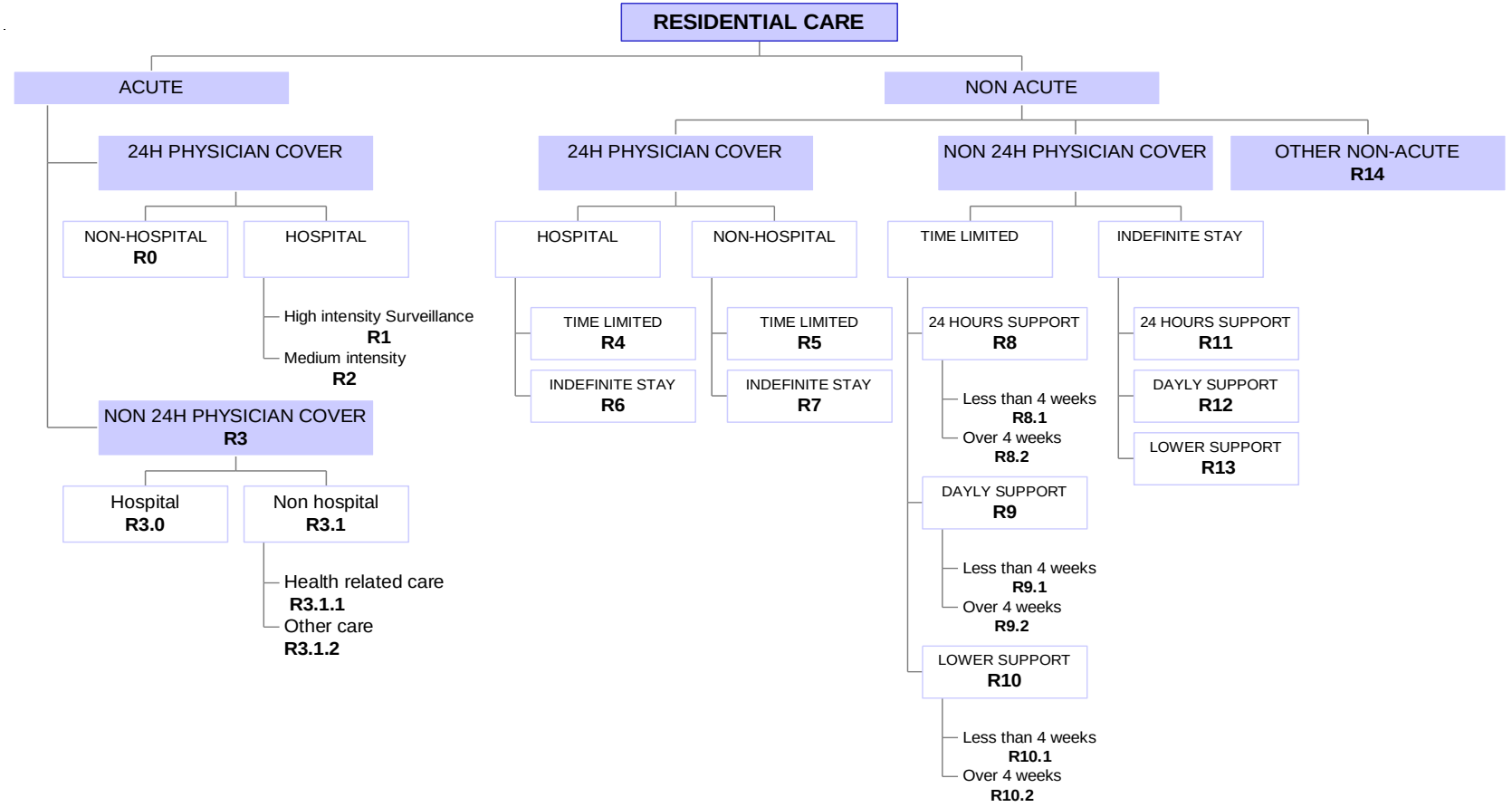


Figure 4. Day care coding branch

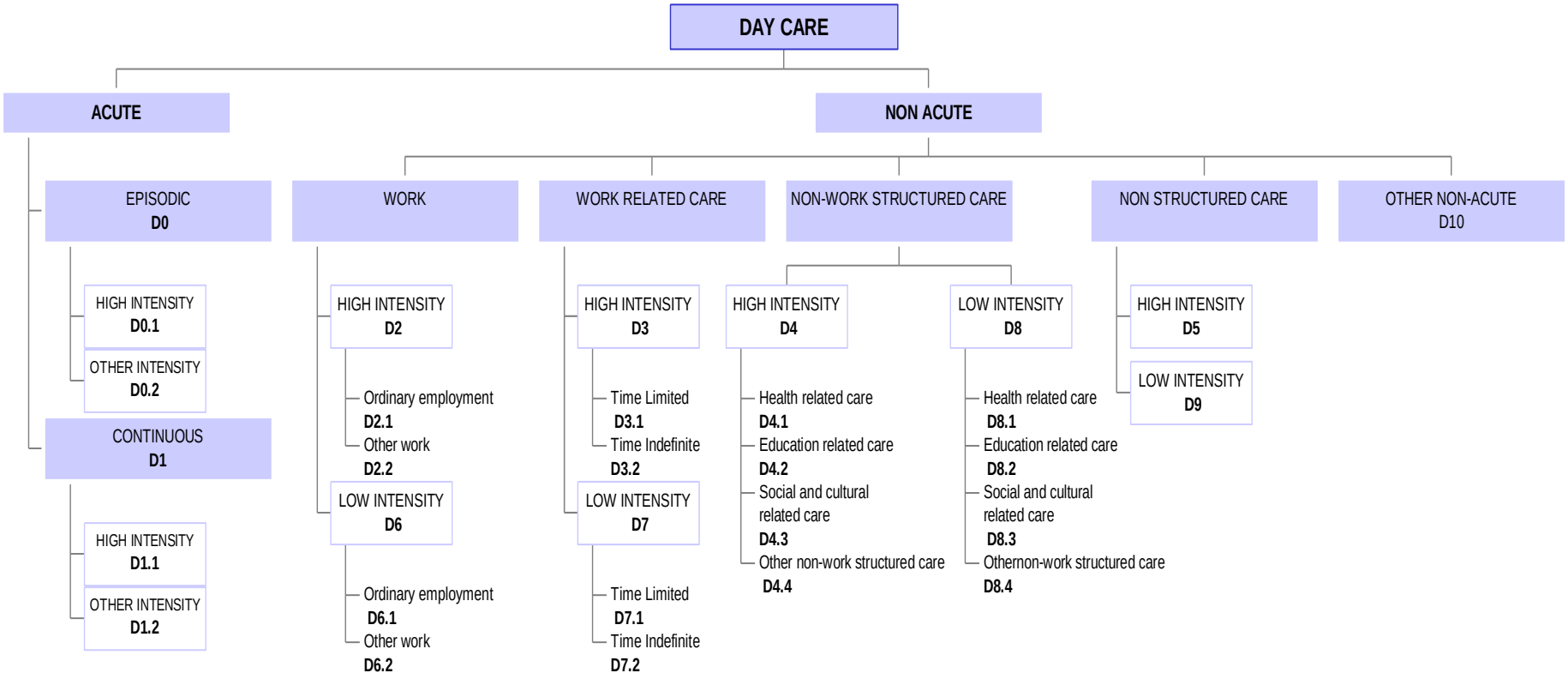


Figure 5. Outpatient care coding branch

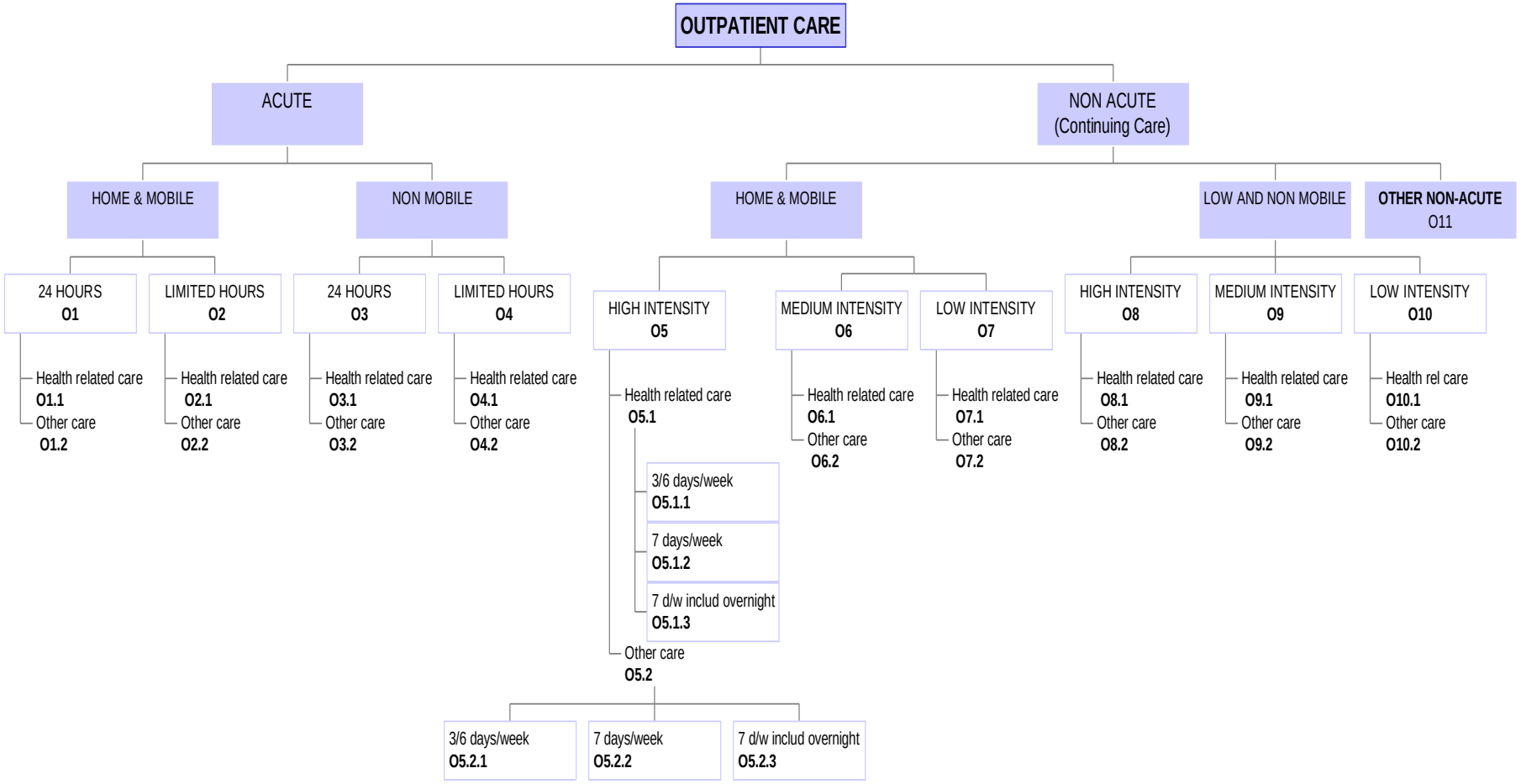


Figure 6. Accessibility to care coding branch

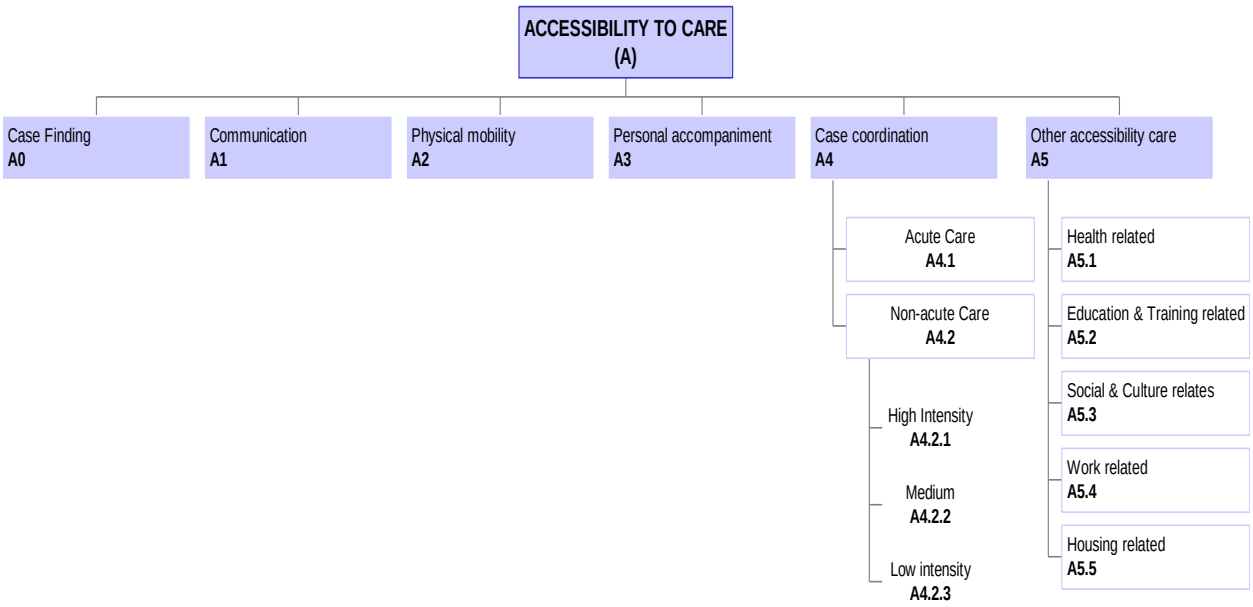


Figure 7. Information for care coding branch

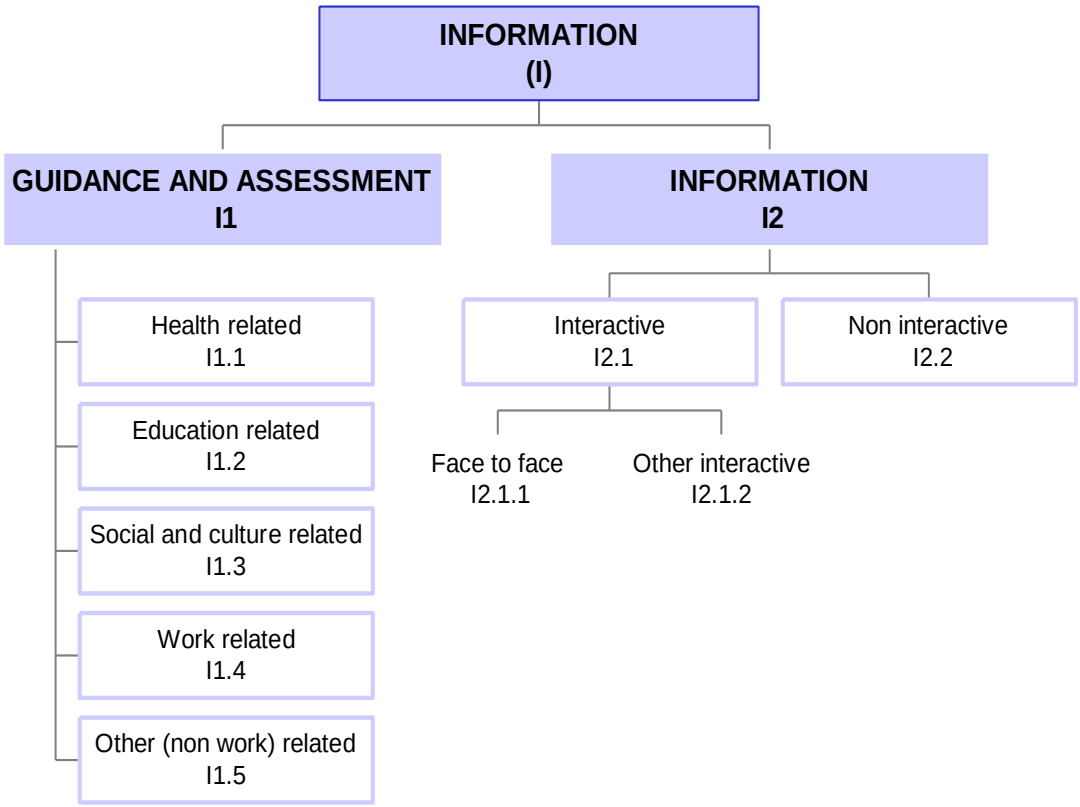
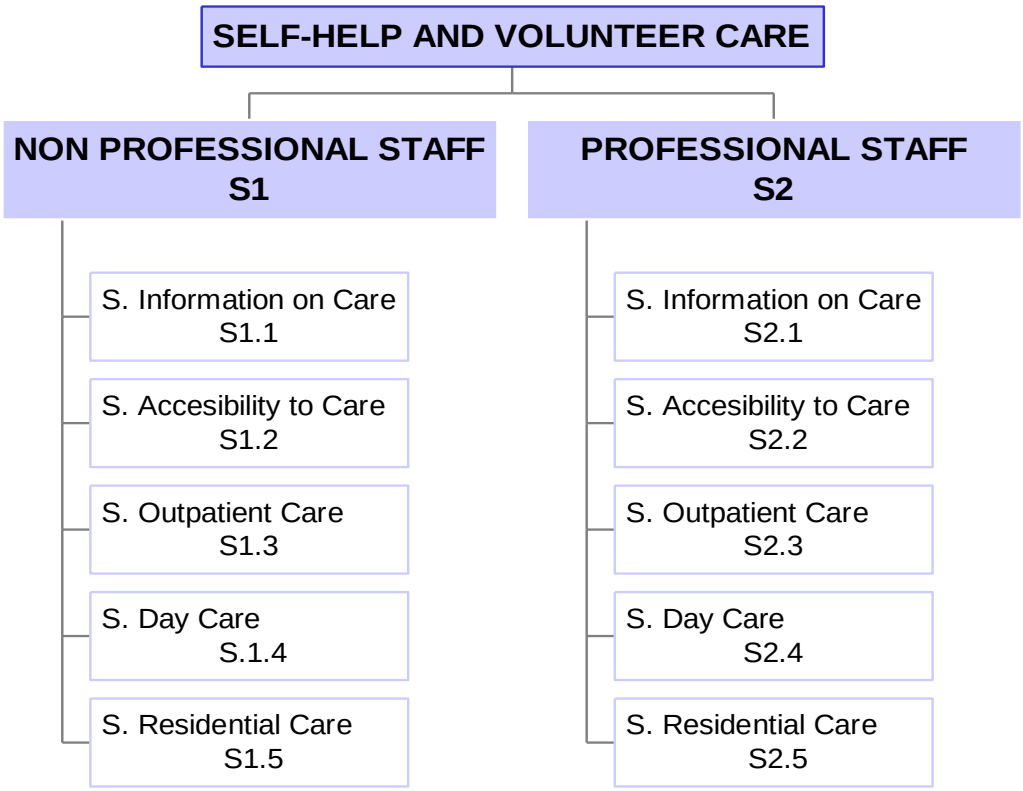


Figure 8. Self-help and volunteer care coding branch



1.2.2. INCLUSION CRITERIA

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

1) **The service targets people with a lived experience of mental illness**: The primary reason for using the service is a mental health issue or a psychosocial disability. The inclusion of services that are generic, and lack staff with the specialised training and experience to treat people with a lived experience of mental illness, may lead to bias which obscures the availability of services providing the specialised focus and expertise needed in mental health.
2) **The service is universally accessible**: The study focuses on services that are universally accessible, regardless if they are publicly or privately funded. We have included services that do not have a significant out-of-pocket cost. In spite of the availability of Medicare-subsidised mental health-related services, access to most private mental health services in Australia requires an individual to have additional private health insurance coverage, high income or savings. The inclusion of private providers would give a misleading picture of the resources available to most people living with mental illness and obscures the data for evidence informed planning of the public health system. Most private services have some level of public funding, for example Medicare subsidies of private hospitals or community-based psychiatric specialist services. It would be useful in future mapping exercises to include an additional layer of private service mapping to inform those who can afford private health care and for planning in the private sector. However, as a baseline the importance of establishing the nature of universal and equitably accessible health care necessitates that these maps remain distinct.
3) **The service has received funding for more than three years:** The inclusion of stable services (rather than those provided through short term grants) guarantees that we are mapping the robustness of the system. If we include services with less than three years of funding it will jeopardize the use of the Atlas for evidence informed planning.
4) **The service is within the boundaries of the CESPHN:** The inclusion of services that are within the boundaries of the CESPHN is essential to have a clear picture of the local availability of resources. However, we included services outside the area if there is an agreement that residents from the CESPHN are able to use them.
5) **The service provides direct care or support to consumers:** We excluded services that were only concerned with the coordination of other services or system improvement, without any contact with people with a lived experience of mental illness.

1.3. WHAT PROCESS WAS FOLLOWED?

There were four distinct steps in the creation of the Integrated Mental Health Atlas of the CESPHN. These steps are explained below and summarised in Figure 10.

Step 1 - Data collection: First we developed a list of all health related services providing care for people aged above 17 experiencing mental illness. For the data relating to the SESLHD (see Annex), services providing care for children and adolescents with a lived experience of mental illness were also included while those services are not included in the data relating to the SLHD (see Annex) or to the analysis of the whole CESPHN. Then we contacted the services by phone to gather the following information: a) basic service information (e.g. name, type of service, description of governance); b) location and geographical information about the service (e.g. service of reference, service area); c) service data (e.g. opening days and hours, staffing, management, economic information, legal system, user profile, number of consumers, number of contacts or admissions, number of days in hospital or residential accommodation, number of available beds or places, links with other services); d) additional information (name of coder, date, number of observations and problems with data collection). We then contacted the providers via email and asked them to fill in an online survey. Alternatively, they could ask for a face-to-face on-site interview with one of the researchers.

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

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

GX All age groups
NX None/undetermined
AX Adults (>17 years old)
OX Elderly (> 64 years old)
TA Period from adolescence to adulthood (16-25 years old)
TO Period from adulthood to older age (60- 70 years old)

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

c) DESDE-LTC code: The third component of the code is the core DESDE-LTC code which is the MTC. As we have explained before (pages 11-19) the services were classified according to their main type of care. This care can be related to: a) Residential care (codes starting with

R); b) Day care (codes starting with D); c) Outpatient care (codes starting with O); d) Accessibility to care (codes starting with A); e) Information for care (codes starting with I); and f) Self-help and voluntary care (codes starting with S).

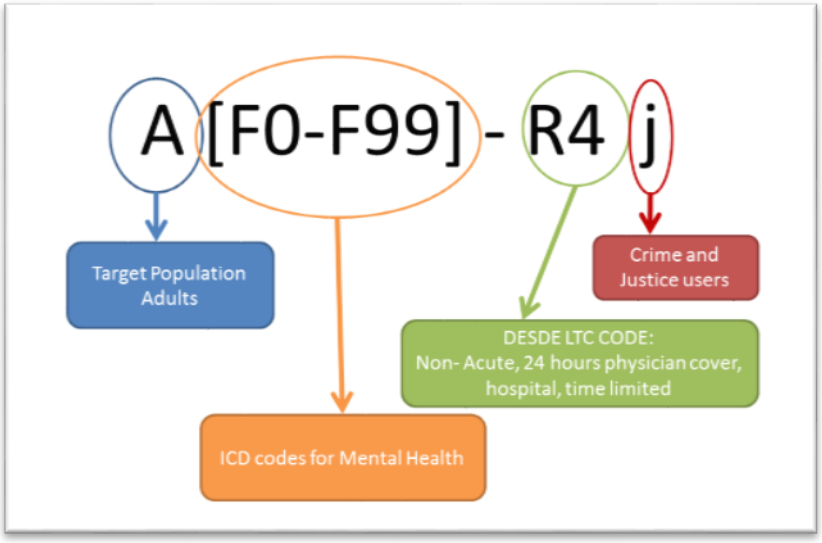
d) Qualifiers: In some cases, a fourth component may be incorporated to facilitate a quick appraisal of those characteristics of the services which may be relevant to local policy. The qualifiers used in these

e) Atlas are:

- **"b" based-care:** This additional code typifies outpatient/ambulatory services that do not provide any care outside their own premises
- **"d" mobile-care:** This additional code is used in those non-mobile services, which have between 20% and 49% mobile contacts.
- **"j" Justice care:** This additional code describes BSIC whose main aim is to provide care to individuals in contact with criminal and justice services.
- **"l" Liaison care:** This additional code describes liaison BSIC where specific consultation for a subgroup of consumers is provided to other area (e.g. outpatient consultation on intellectual disabilities to a general medical service, or consultation on mental illness for the general medical services of a hospital).
- **"s" Specialised care:** This additional code describes BSIC for a specific subgroup within the target population of the catchment area (e.g. services for Elderly people with Alzheimer's disease within the "E" group, or services for Eating Disorders within the "MD" group).
- **"t" Tributary:** This qualifier describes satellite units of care dependent from a main care team. Typically, the team itinerates to different settings where they provide care on a regular basis (e.g. Royal Flying Doctors care team in rural Australia), or part of the team is permanently in the setting but it does not qualify as a SCT due to its dependency from the headquarters (e.g., satellite ambulatory mental health centres in Girona -Spain).
- **"u" Unique:** This additional code describes single-handed BSIC where care is delivered by a health care professional (psychiatrist, psychologist, nurse).

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

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



Step 3 Mapping the BSIC:

BOUNDARIES

The importance of the boundaries of the PHN has been signalled in the 2016 PHN Guidelines(37). In general the boundaries of the PHNs are aligned with LHD boundaries (or equivalent) considering a series of factors such as population size, state and territory borders, patient flow, stakeholder input and administration efficiencies (3).

The CESPHN represents a merger of three former Medicare Locals [Eastern Sydney (ES), Inner West Sydney (IWS), and South Eastern Sydney (SES)]. The CESPHN aligns with the Sydney Local Health District (SLHD) and the South Eastern Sydney Local Health District boundaries. The area also encompasses the St Vincent's Health Network (SVHN) and the Sydney Children's Hospital Network (15).

Jurisdictions and geographical units of analysis

There are multiple jurisdictional units in Australia. The Local Government Areas (LGA) boundaries are one of the most useful units of analysis for planning. At the time of data collection the CESPHN was divided into sixteen LGAs: Ashfield, Botany Bay, Burwood, Canada Bay, Canterbury, Hurstville, Kogarah, Leichhardt, Marrickville, Randwick, Rockdale, Strathfield, Sutherland Shire, Sydney, Waverley, and Woollahra. It also encompasses Lord Howe Island which is defined at the Statistical Local Area (SLA) level and Norfolk Island. SLA is an Australian Standard Geographical Classification (ASGC) defined area that consists of one or more Collection Districts. In aggregate, the SLAs cover the whole of Australia without gaps or overlaps (38).

For the Geographical Information Systems (GIS) analysis of an area the size of the CESPHN, the most effective unit of analysis is the postcode. The use of postcodes ensures that concentrated pockets of deprivation and disadvantage are captured enabling the design of targeted programs and services.

INDICATORS

A series of indicators were calculated to describe the area. They were built based on information extracted from Australian Bureau of Statistics (ABS) census data and population health surveys for the latest year available. This information was also visualised using choropleth maps (maps that use different colours inside defined geographical areas), which were depicted using the GIS to illustrate the distributions and small-area variations in each of the indicators calculated.

The indicators taken into account to describe LGAs and those which were used as base layers for the mapping in CESPHN (are highlighted in bold) are as follows:

- Density index: population/km^2
- Ageing index: (population >64 years old/ population 0-15) *100
- Dependency index: (population between 0-15 + and >64 years old/ population 16-64) *100
- Unemployed rate: (number of unemployed people/ population 16-64 years old) *100
- Percentage of lone parents: (number of lone parents/total population) *100
- Percentage of people living alone: (number of households with just 1 person/ total population) *100
- Percentage of Aboriginal and/or Torres Strait Islanders living in the area: (number of Aboriginal and/or Torres Strait Islanders living in the area/ total population) *100
- Percentage of people with low English proficiency: (population speaking English not well or not at all/total population) *100
- Population: Total population (place of usual residence) of each LGA of the CESPHN (population of the LGA/total population of the CESPHN) *100
- Percentage of women in the population: (number of women/total population) *100
- Percentage of people not married or in a de facto relationship: (number of people non married or in a de facto relationship/population >17 years old) *100
- Percentage of people who expressed need of assistance with core activities: (Number of people who express they are in need of assistance with core activities/ population 16-64 years old) *100
- Index of Relative Socio-Economic Disadvantage (IRSD): decile of the area (lowest to highest corresponds to the most disadvantaged to the least). The IRSD

is a general socio-economic index summarising a range of information about the economic and social conditions of people and households within an area. It includes variables related mostly to education level, employment status, level of income and disabilities.

- Percentage of people born overseas: (population born overseas/ total population) *100
- Percentage of people with year 12 of high school or equivalent completed: (population with year 12 of high school completed or equivalent or more/ population ≥ 15 years old) *100
- Percentage of people with less than $600 income per week: (number of people with less than $600 income per week/population 16-64 years old) *100
- Percentage of private dwellings with no internet connection: (number of private dwellings with no internet connection/total number of private dwellings) *100 (calculated from PHIDU data) (42)
- Percentage of people with psychological distress: age standardized ratio of people with high or very high levels of psychological distress according to the Kessler psychological distress scale (K10) which is a scale of non-specific psychological distress based on ten questions related to negative emotional states in the prior four weeks (calculated from PHIDU data) (43-45) .

A second set of maps was then constructed to visualise the locations of the services/BSIC in relation to some of these indicators. These maps were enhanced with the derivation of a spatial accessibility metric, classifying all areas within the CESPHN by their distance to the mental health services being presented.

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

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

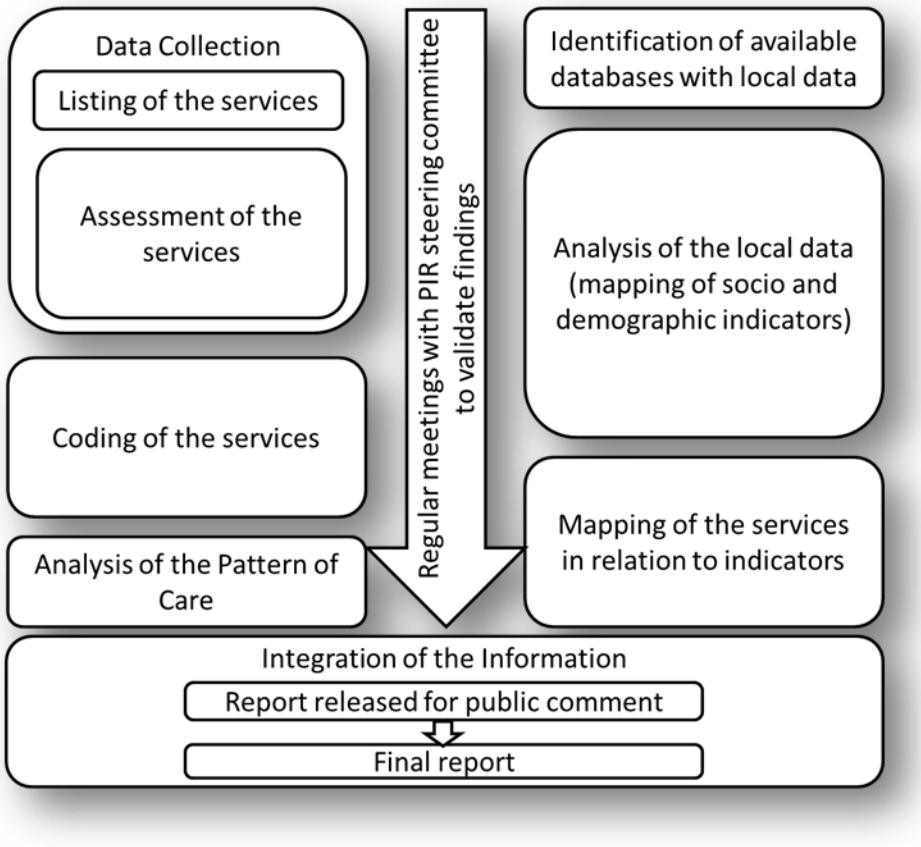
- **Availability:** Defined as the presence, location and readiness for use of services or other organisational units in a care organisation or a catchment area at a given time. A service is available when it is operable or usable upon demand to perform its designated or required function. The availability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

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

- **Workforce capacity:** Maximum number of staff available in a care delivery organisation or in a catchment area at a given time. Care workforce capacity usually refers to paid staff providing direct care (e.g. it excludes voluntary care providers and administrative staff). It is typically measured in Full Time Equivalents units (FTE), in this case 37.5 hours per week. Rates have been calculated by 100,000 residents.

This analysis allowed us to compare the availability and capacity rates with other areas and to estimate if the provision is adequate with regard to the populations needs. We have compared the area of CESPHN with urban and rural areas from Northern Europe (Norway, Finland) and Southern Europe (Italy, Spain) and the UK. The information on the other countries has been mainly developed as part of the REFINEMENT project (46), funded by the European Commission, which focused on the links between the financing of mental health care in Europe and the outcomes of mental health services. The information on Spain is from the Integrated Mental Health Atlas of Catalonia.

Figure 10. Steps followed in the development of the Atlas



2. MAPPING THE AREA: BOUNDARIES AND INDICATORS

2.1. THE BOUNDARIES AND JURISDICTION

The CESPHN represents amalgamations of three former Medicare Locals [Eastern Sydney (ES), Inner West Sydney (IWS), and South Eastern Sydney (SES)]. As described in the Methods section, the CESPHN aligns with the Sydney Local Health District (SLHD) and the South Eastern Sydney Local Health District (SESLHD) boundaries. The area also encompasses the St Vincent's Health Network (SVHN) and the Sydney Children's Hospital Network (SCHN) (15).

A note on boundaries in the LHD annexes

The SLA is the most appropriate unit of analysis when considering the subcomponents of the CESPHN. In the most recent realignment of the district boundaries in 2011, the boundaries between the two LHDs were defined using SLA, instead of LGA, with approximately half of the City of Sydney LGA being part of the SLHD and the other half as part of the SESLHD (39-41).

In the SESLHD region, all the 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. Furthermore, the SESLHD also includes Lord Howe Island which is bounded at the SLA level and Norfolk Island. 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.

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

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

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

2.2. SOCIOECONOMIC INDICATORS

The prior mental health needs assessment of CESPHN has shown several specificities of this PHN. In particular, there are high rates of psychological distress (10% on average against 8% for NSW as a whole), potentially preventable hospitalisations with utilisation data showing admission rates above national average, low rates of community mental health team follow up and a lack of resources for GPs to adequately manage mental health within primary care setting (24).

Table 1 summarises the main socio and economic indicators in the CESPHN LGAs. Later figures will present visualisations of key indicators using choropleth maps.

Overall, the LGAs within the CESPHN are characterised by high population densities, high rates of people born overseas, high percentages of people with low English proficiency and low percentages of Aboriginal and Torres Strait Islander peoples by comparison to NSW and Australia as a whole. This territory is also globally less disadvantaged than NSW and Australia as a whole. Indeed, most of the LGAs are located in the higher IRSD deciles, calculated based on the entire Australian population, and the CESPHN area presents on average a lower percentage of people with less than $600 per week, and a higher percentage of people with year 12 of high school completed, than NSW and Australia as a whole.

The Sydney LGAs cover areas with the highest population density of the CESPHN. They present a relatively low dependency index, a low percentage of persons who declared need for assistance, low percentages of lone parents, high percentages of persons living alone and of not married or in a de facto relationship people.

By contrast, Lord Howe Island is the least populated area (22 persons per km^2) followed by Sutherland Shire (632 persons per km^2), in which the Royal National Park is located. These areas are those which present the lowest percentages of born overseas, as well as the lowest unemployment rates, but also the lowest rates of people with year 12 of high school completed.

Canterbury appears as a particularly socially and economically disadvantaged area (indicated by the low IRSD decile), and is also the zone with the highest percentages of unemployed individuals, of people with low income and low English proficiency as well as with the lowest percentage of people who completed Year 12 of high school or equivalent. In addition, Canterbury is the LGA with the highest percentage of the population with high or very high psychological distress, higher than the State and national average.

The Woollahra, Waverley, Canada Bay and Leichhardt LGAs were the least socially and economically disadvantaged, as indicated by their high IRSD decile. Finally, Marrickville and Sydney were the areas with the highest percentage of Aboriginal and Torres Strait Islander people. The following geographical analysis (maps) of the social and demographic characteristics of the CESPHN by LGAs and has been developed using ABS data and Public Health Information Development Unit (PHIDU) data.

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

LGA	Population (% of the PHN)	Density index	Women (%)	Aging index	Dependency index	Unemployment rate (%)	Lone parent (%)	Living alone (%)	Not married or in a de facto relationship (%)	Needs assistance for core activities (%)	IRSD decile of disadvantage (1 = high; 10 = low)
Ashfield	41.213 (3.1)	4965.4	51.4	90.3	43.7	6.1	3.7	10.1	45.9	6.4	8
Botany Bay	39.354 (2.9)	1813.5	50.5	74.8	50.4	5.3	4.7	8.8	45.2	5.3	5
Burwood	32.424 (2.4)	4566.8	50.9	91.2	43.4	6.8	3.9	6.8	48.7	5.5	7
Canada Bay	75.763 (5.6)	3826.4	51.4	78.3	46.1	4.3	3.4	8.5	40.1	4.1	10
Canterbury	137.453 (10.2)	4090.9	50.0	63.8	53.0	8.2	4.6	7.1	43.9	5.7	2
Hurstville	78.853 (5.9)	3473.7	51.5	81.3	52.2	6.1	4.2	7.4	42.3	5.0	8
Kogarah	55.805 (4.1)	3600.3	51.2	74.3	49.3	5.5	3.8	7.0	41.4	4.2	9
Leichhardt	52198 (3.9)	4971.2	52.6	59.4	38.3	4.0	3.2	12.1	41.9	3.4	10
Lord Howe Island*	360 (0.0)	22.1	51.4	109.4	44.8	0.0	3.1	12.3	32.4	2.7	-
Marrickville	76502 (5.7)	4636.5	50.5	68.3	34.7	5.3	3.9	11.5	48.6	4.6	8
Randwick	128.987 (9.6)	3553.4	50.9	82.4	41.0	5.4	3.5	10.1	48.2	4.1	9
Rockdale	97.339 (7.2)	3451.7	50.6	82.3	50.5	5.9	4.1	8.4	43.5	5.6	7
Strathfield	35187 (2.6)	2531.4	49.8	68.2	42.2	6.4	3.7	6.1	45.0	4.3	8
Sutherland Shire	210.859 (15.6)	632.1	51.1	73.3	54.5	3.5	3.7	7.7	38.3	3.6	10
Sydney	169.502 (12.6)	6348.4	47.2	106.0	18.1	5.8	2.2	17.2	56.5	2.9	8
Waverley	63.485 (4.7)	6900.5	50.8	74.1	39.1	4.1	2.8	11.9	46.2	3.1	10
Woollahra	52.159 (3.9)	4275.3	52.9	99.5	48.6	3.7	2.8	12.5	44.2	2.7	10
Total PHN	1347443 (100.0)	2131.7	50.5	77.3	42.6	5.3	3.6	9.9	45.1	4.3	-
NSW	6.917.656 (-)	8.6	50.7	71.7	54.5	5.9	4.3	8.7	41.7	5.2	-
Australia	21.507.719 (-)	2.8	50.6	68.1	54.5	5.6	4.2	8.8	41.3	4.9	-

** As Lord Howe Island does not constitute a LGA, the socioeconomic indicators were provided at the SLA level. Based on the SLA level, Lord Howe Island was located in the 7th decile of the IRSD.*

LGA	Aboriginal and Torres Strait Islander People (%)	Born abroad (%)	Low English proficiency (%)	Year 12 of high school or equivalent completed (%)	Income <$600 per week (%)	Dwellings with no internet connection (%)	% of the population with high or very high psychological distress (K10)
Ashfield	0.6	47.3	9.3	63.6	48.6	17.1	10.6
Botany Bay	1.6	45.1	7.8	54.3	51.3	21.9	11.7
Burwood	0.4	55.8	12.6	64.2	56.4	17.6	10.8
Canada Bay	0.4	37.9	6.0	62.5	41.9	14.3	9.4
Canterbury	0.6	51.8	15.7	53.4	60.8	23.7	11.1
Hurstville	0.6	43.7	10.5	57.9	53.5	18.7	10.4
Kogarah	0.4	43.2	9.3	62.0	49.7	16.1	10.3
Leichhardt	1.0	30.5	2.3	70.7	31.9	12.1	8.8
Lord Howe Island*	0.8	13.0	0.8	48.8	47.4	-	-
Marrickville	1.5	36.9	7.6	64.2	41.3	15.8	9.4
Randwick	1.4	41.6	4.1	65.0	44.7	15.6	10.2
Rockdale	0.6	46.7	9.3	55.5	52.7	20.4	10.3
Strathfield	0.3	56.9	11.8	67.1	52.2	14.6	10.5
Sutherland Shire	0.8	18.0	1.2	51.4	43.8	14.9	8.8
Sydney	1.3	49.2	5.6	69.9	37.9	12.6	10.3
Waverley	0.4	42.6	2.0	69.6	33.6	12.6	9.4
Woollahra	0.2	35.5	1.1	73.0	30.1	10.6	9.3
Total PHN	0.8	40.2	6.7	61.6	45.4	16.0	-
NSW	2.5	27.3	4.1	47.6	52.4	20.1	10.5
Australia	2.5	26.0	3.2	47.6	51.4	19.7	10.8

** As Lord Howe Island does not constitute a LGA, the socioeconomic indicators were provided at the SLA level. Based on the SLA level, Lord Howe Island was located in the 7th decile of the IRSD.*

Figure 1112. Population density (inhabitants/km2)

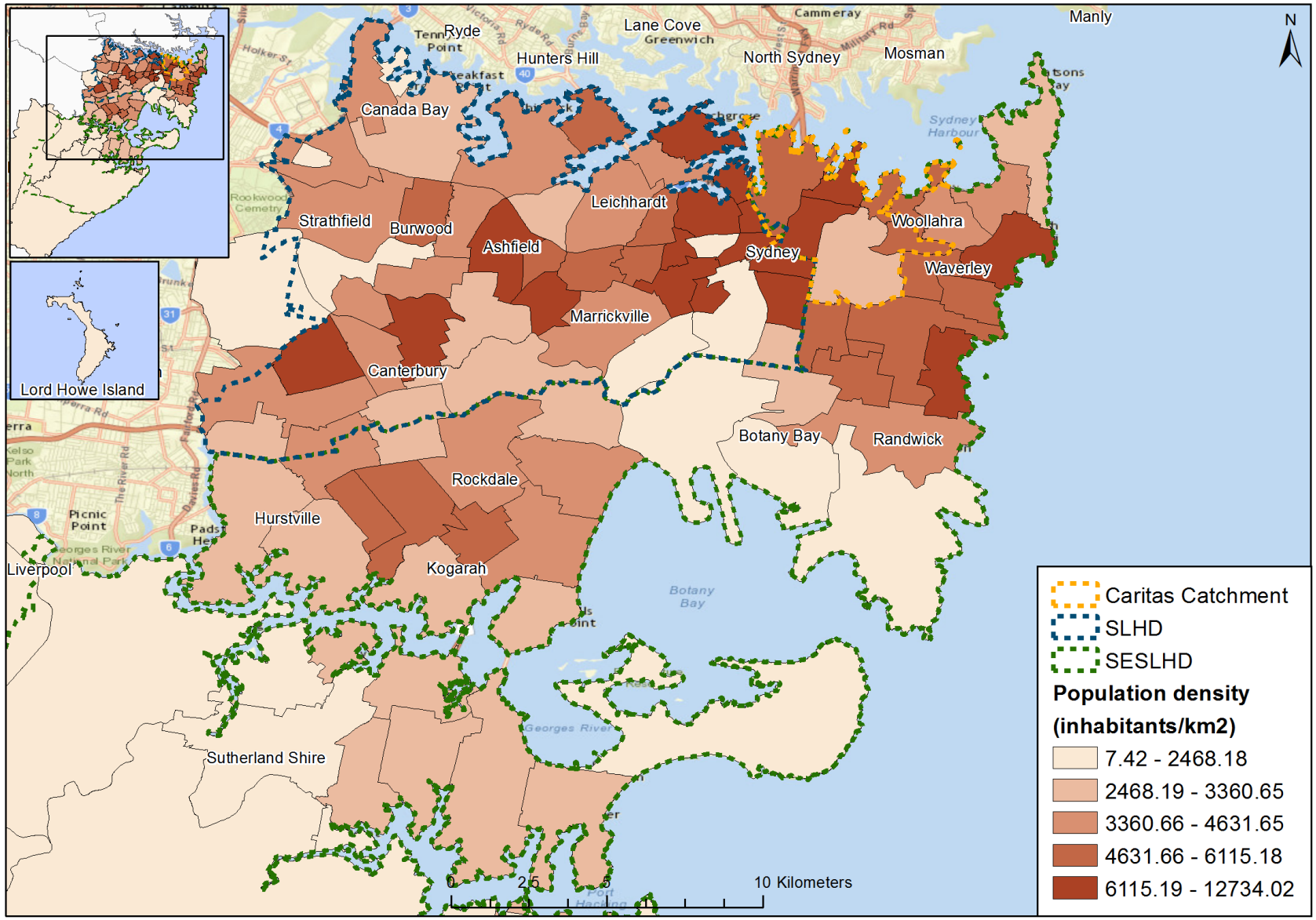


Figure 13. High psychological distress

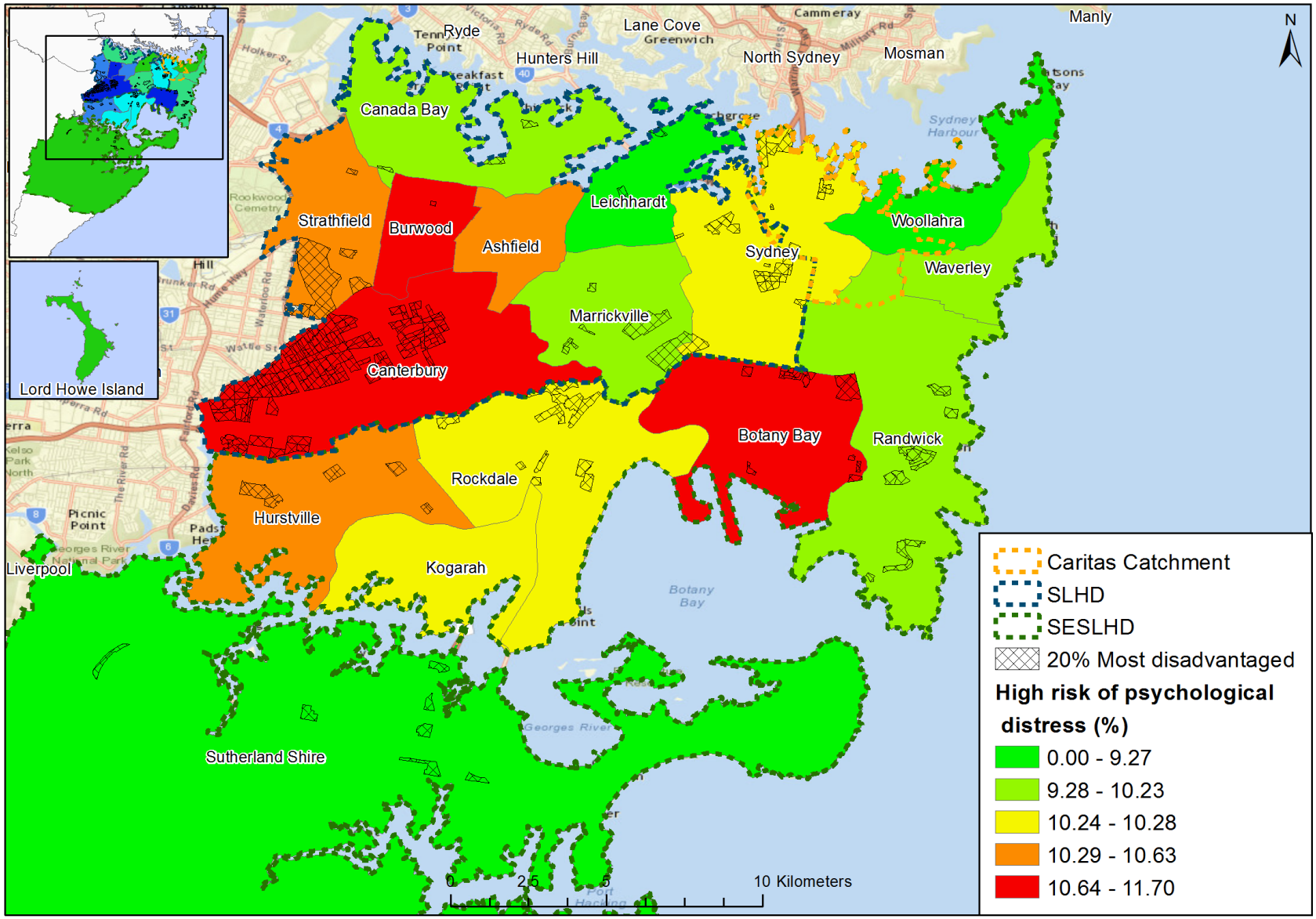


Figure 14. Distribution of lone parents

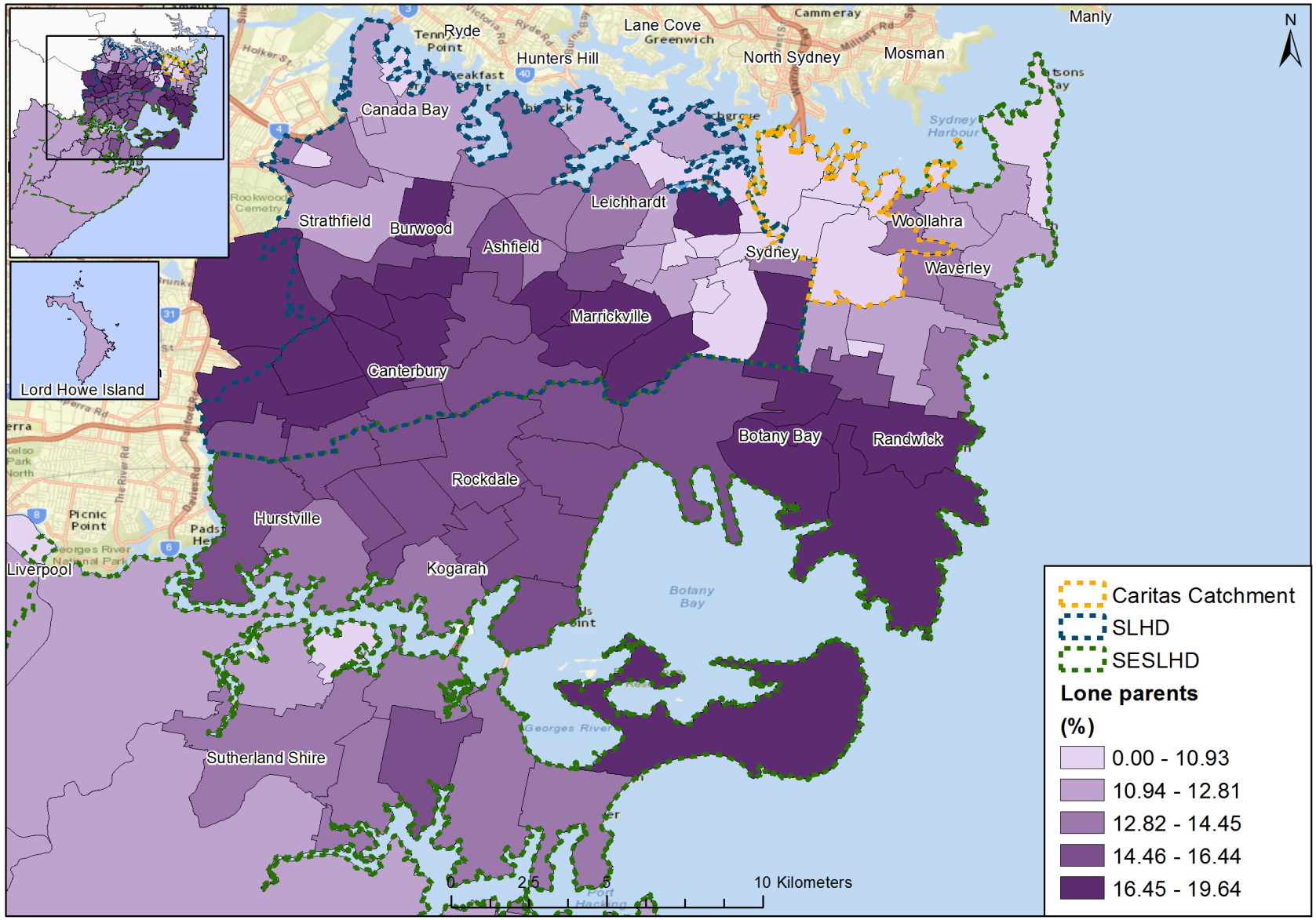


Figure 15. Distribution of people living alone

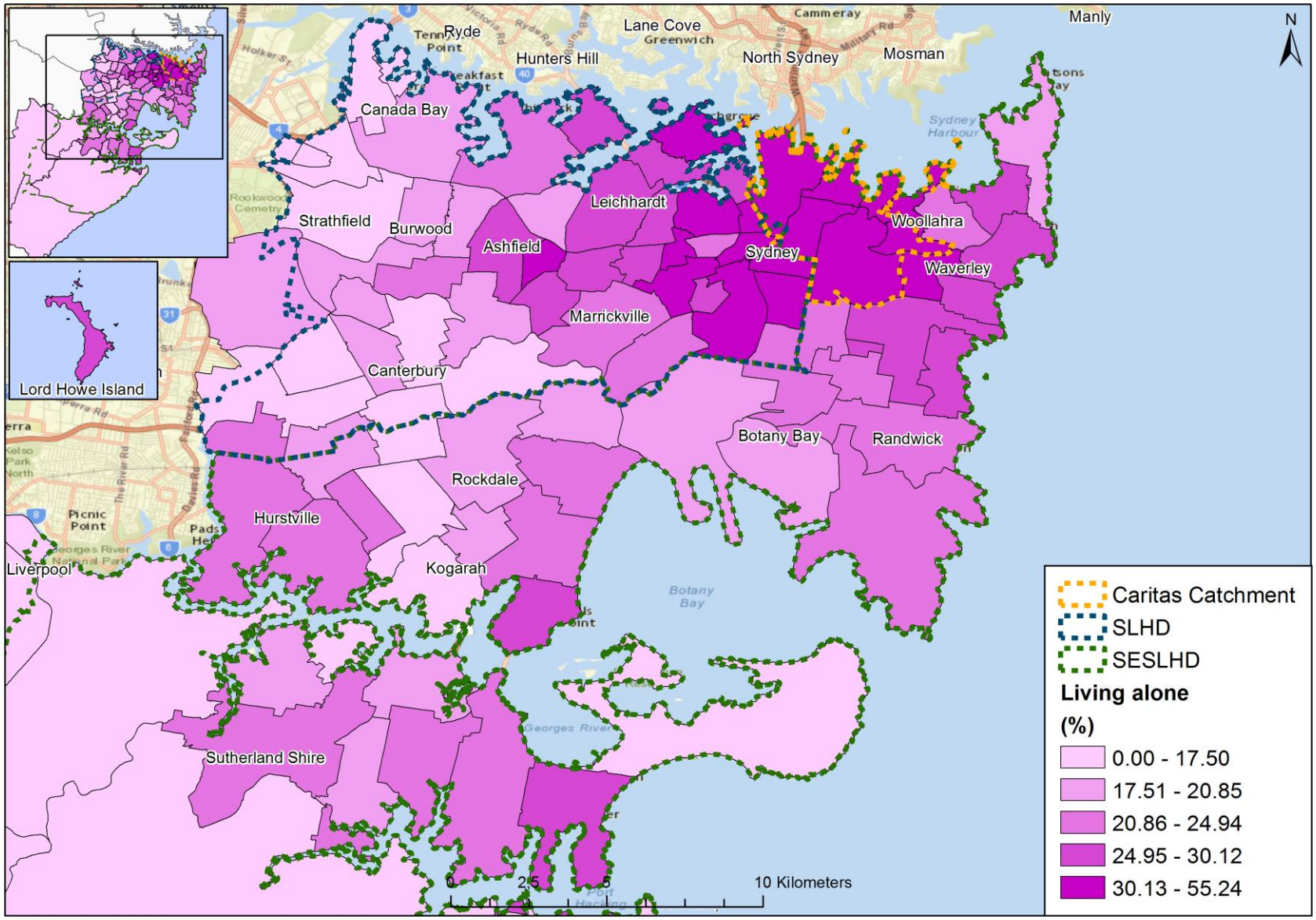


Figure 16. Distribution of unemployment

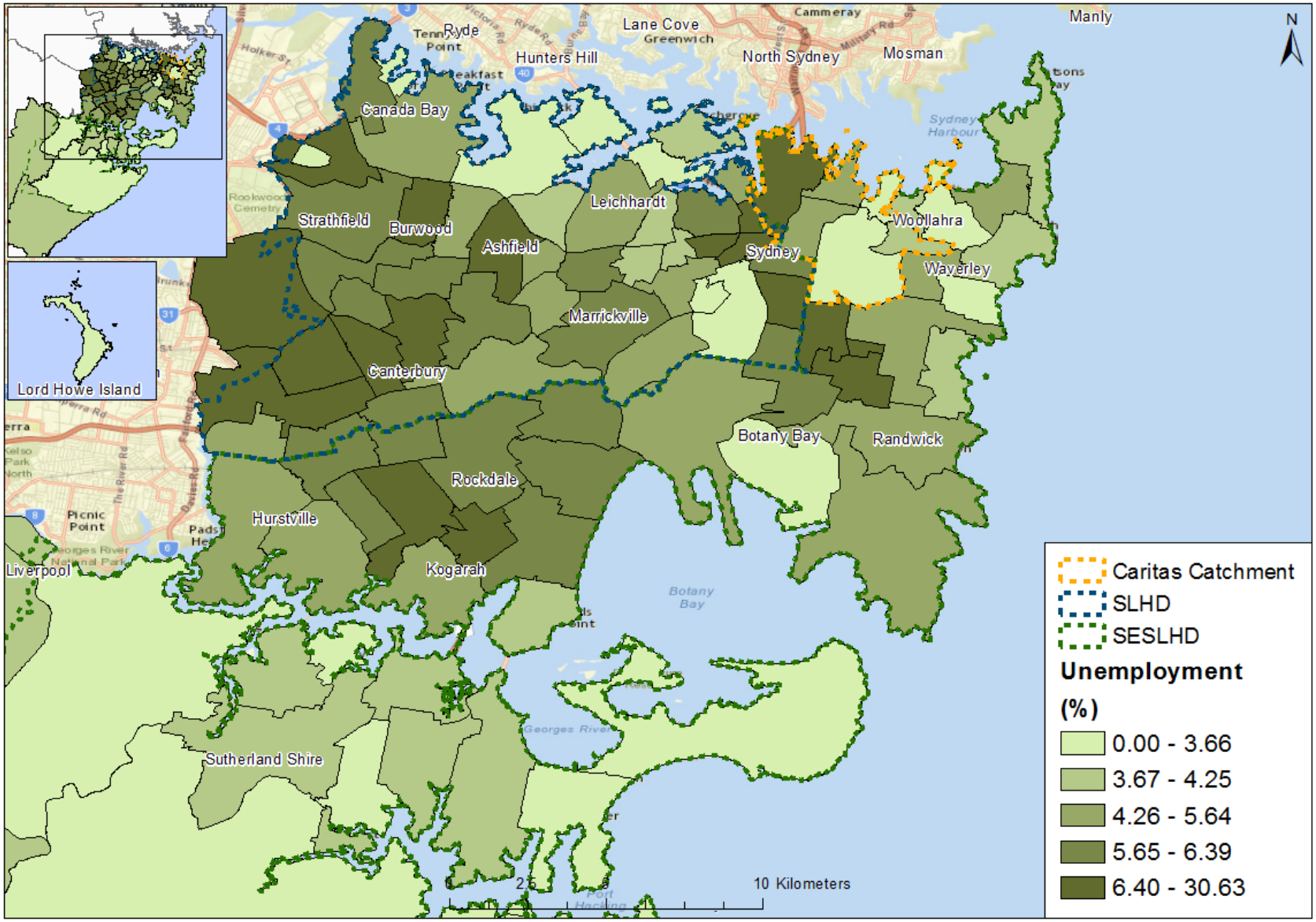


Figure 17. Distribution of household without internet

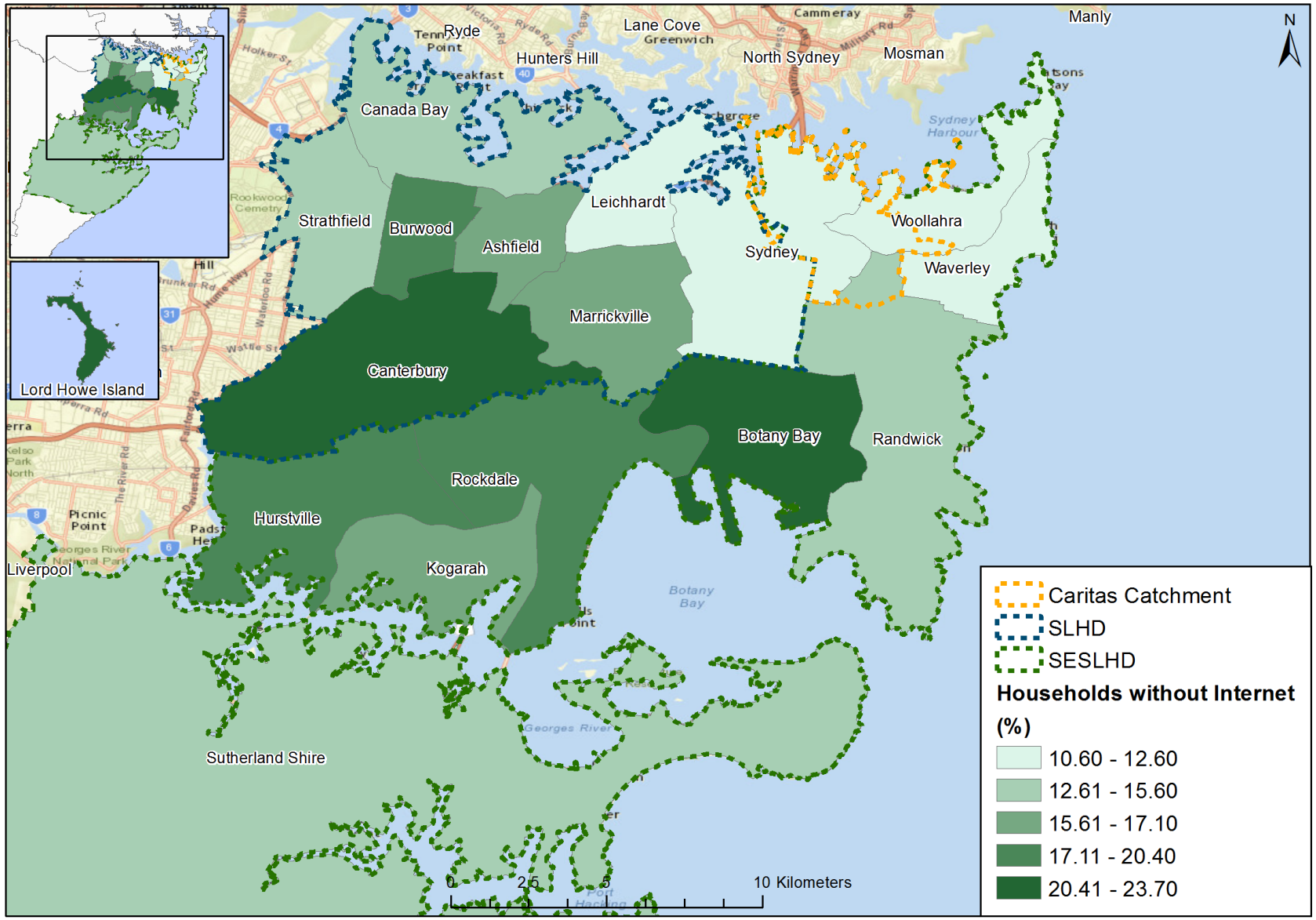


Figure 18. Distribution of Aboriginal and Torres Strait Islander peoples

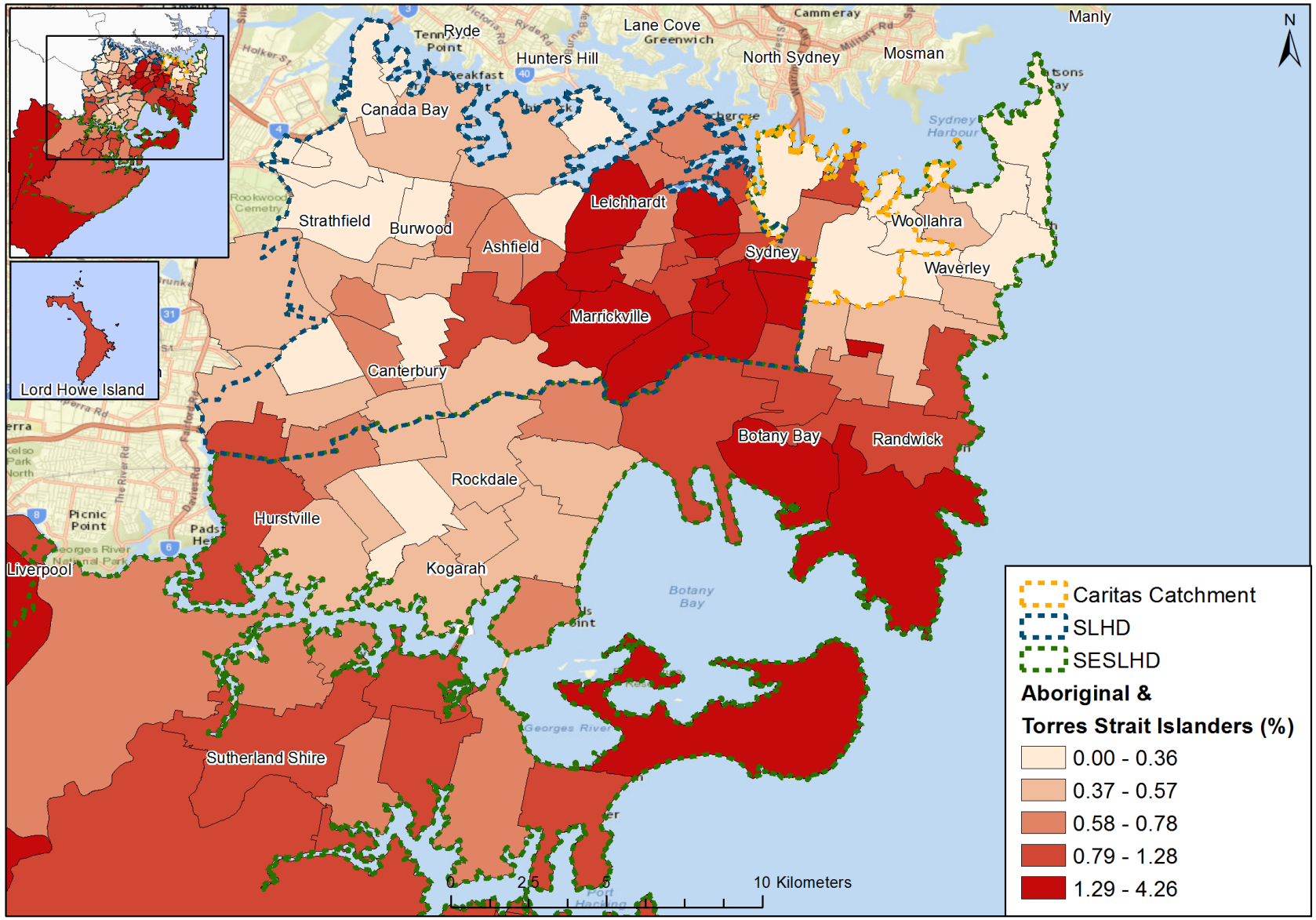


Figure 19. Distribution of low English proficiency

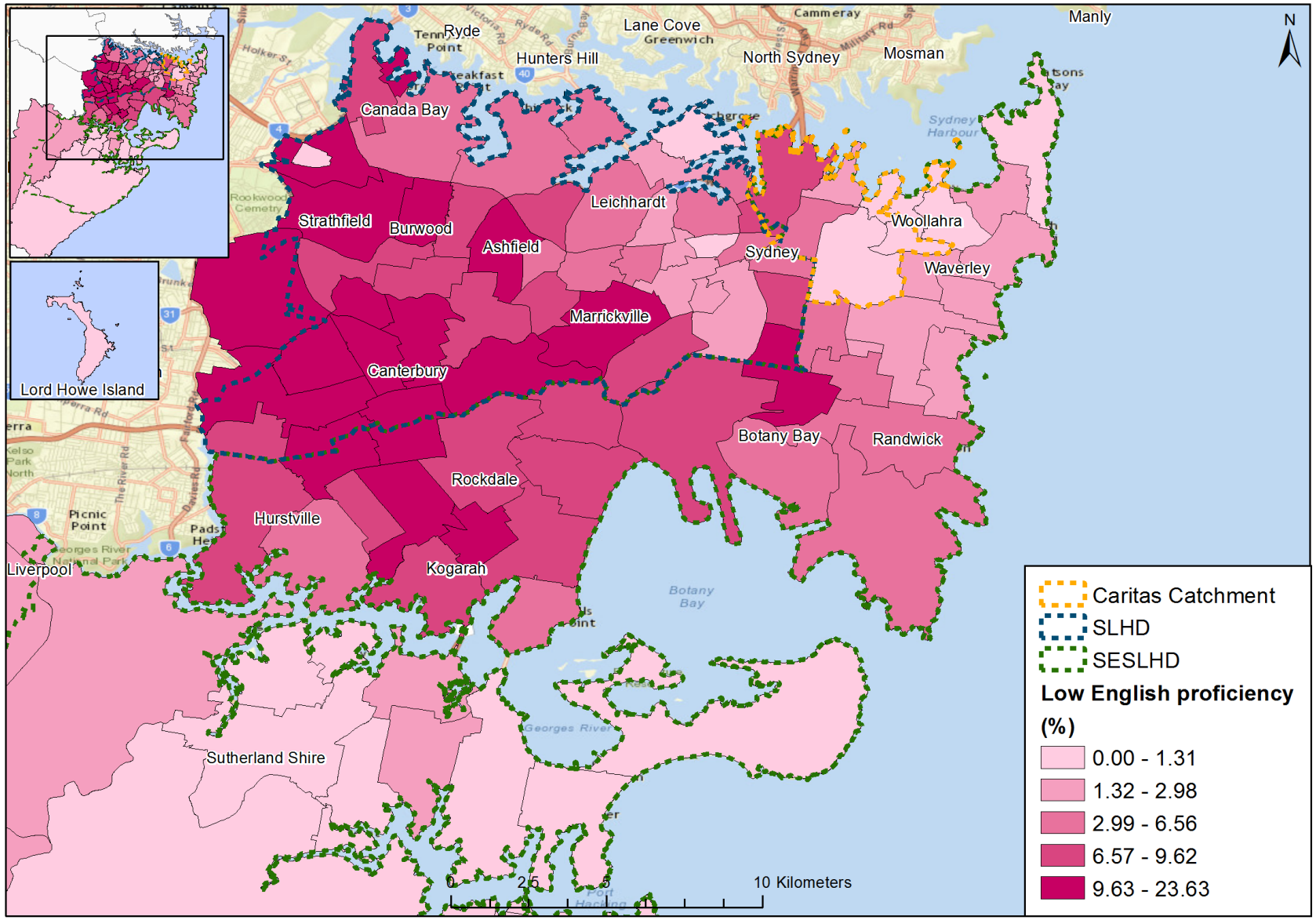


Figure 20. Ageing index

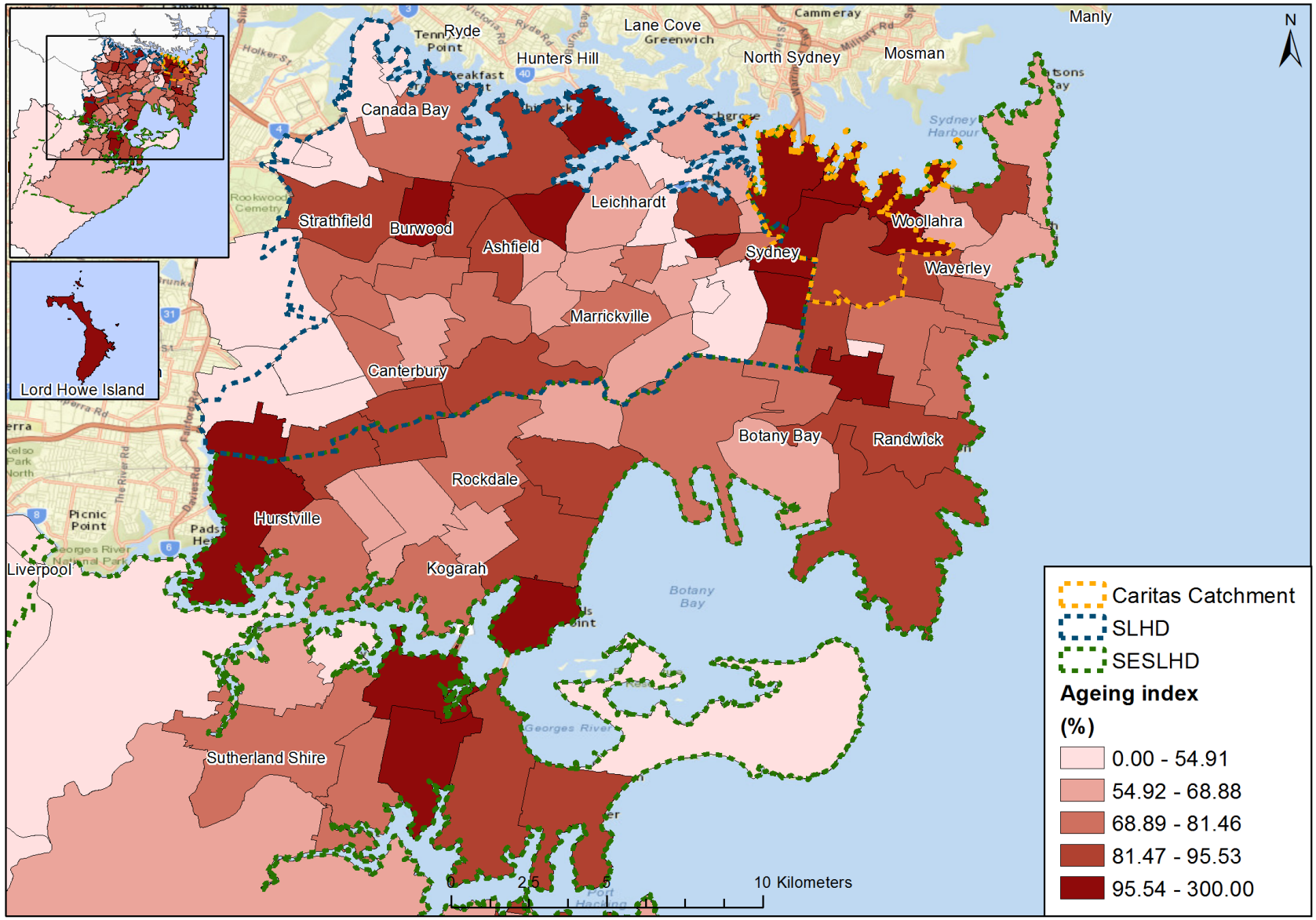
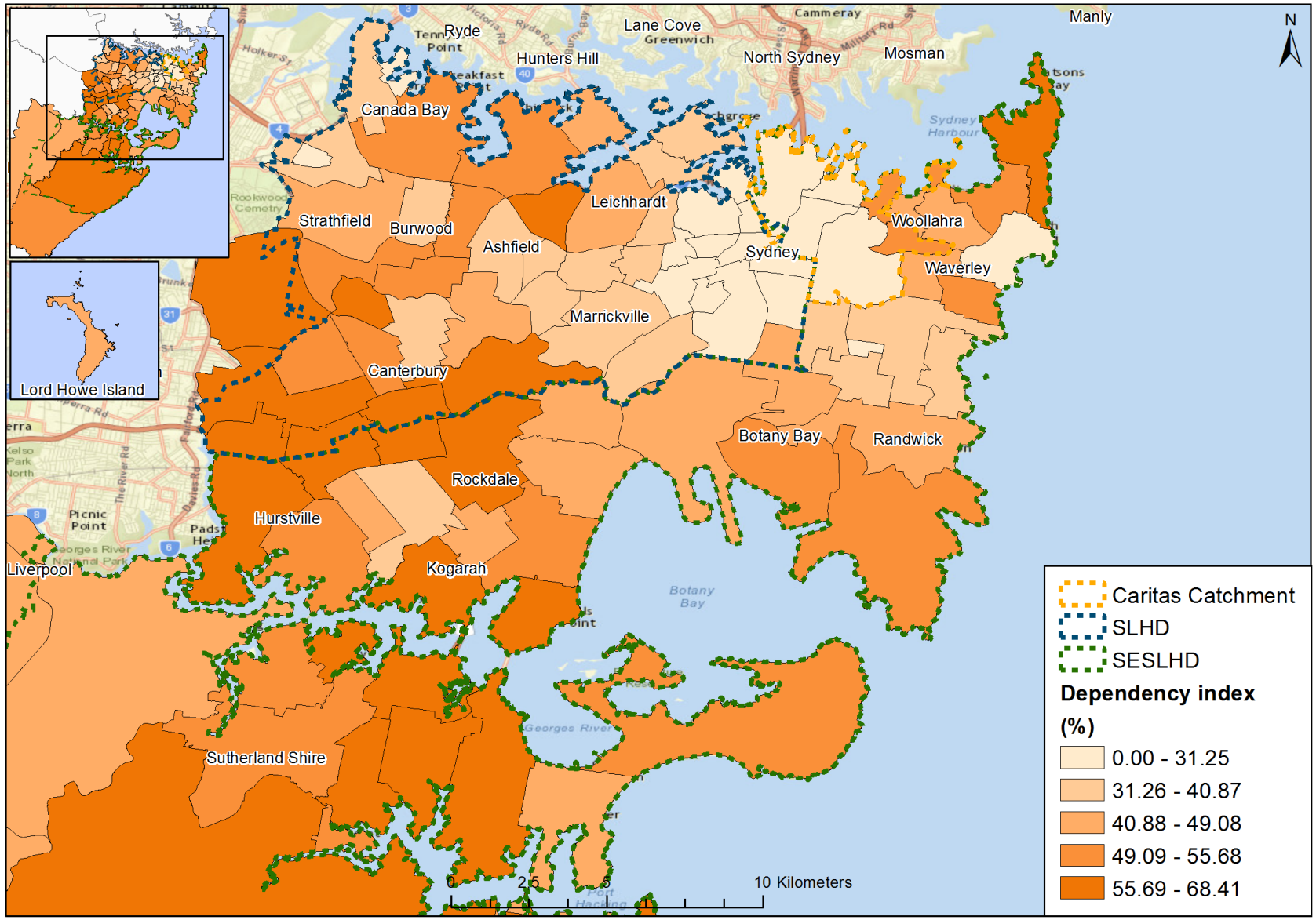


Figure 21. Dependency indexes



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 CESPHN was collected from the 22nd July 2015 to the 25th November 2016. Data was collected via 40 on-line responses complemented with 61 face-to-face or telephone interviews with mental health provider organisations.

We identified a total of 232 BSIC (or teams), corresponding to 251 MTC, for people with a lived experience of mental illness or psychosocial conditions. 10 functional teams had more than one MTC. We did not include services where the primary presentation is not for mental health, for example: alcohol and other drugs, intellectual disability or homelessness.

With regards to the age distribution of consumers provided for, 76% of the care provided is for adults without any target on specific populations. 5% of the services are specific to transition to adulthood and 6% are specific for older people.

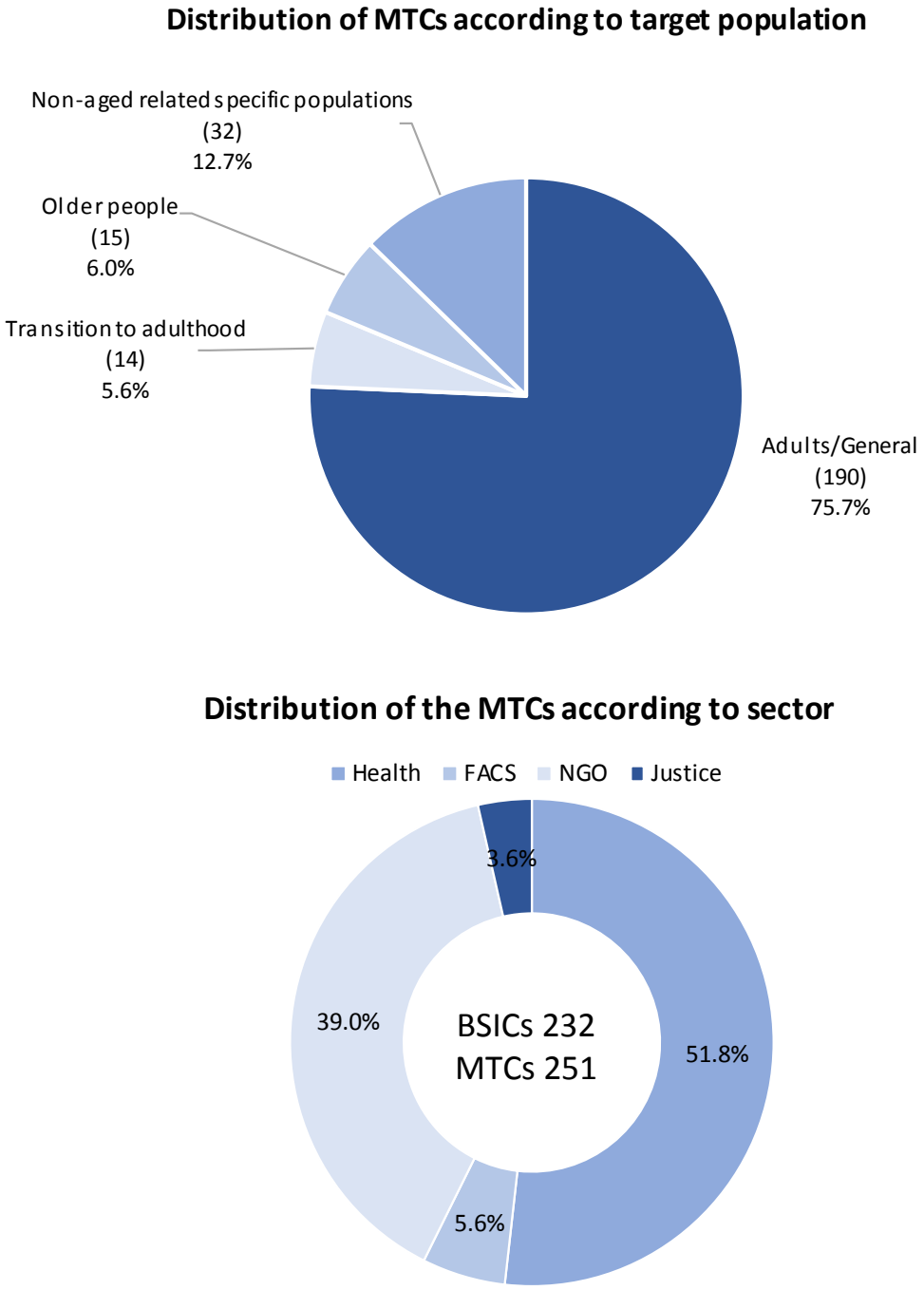
13% of the care provided was dedicated to non-age related specific populations including carers of people with a lived experience of mental illness, the Aboriginal and Torres Strait Islander population, culturally and linguistically diverse (CALD) population, parents with a mental illness and services that are gender-specific.

52% of the care for people with mental illness is provided by the public health sector while 39% is provided by NGOs, 5.6% by family and community services and 3.6% by the justice system.

With regard to the distribution by MTC, the services provided by the public health sector were mostly classified into outpatient (69%), and residential (24%).Fewer than 7% were classified as day care, accessibility or guidance and information. In the non-health sector (i.e. NGOs, Department of Family and Community Services (FACS) and others), outpatient care was also the most common (51%) followed by accessibility (15%) and day care (13%). Residential care was much less developed than in the public health sector (9%), while self-help and voluntary care represented 11.5% of the care provided in the non-health sector.

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

Figure 22**.** Description of the MTC identified (N=251)



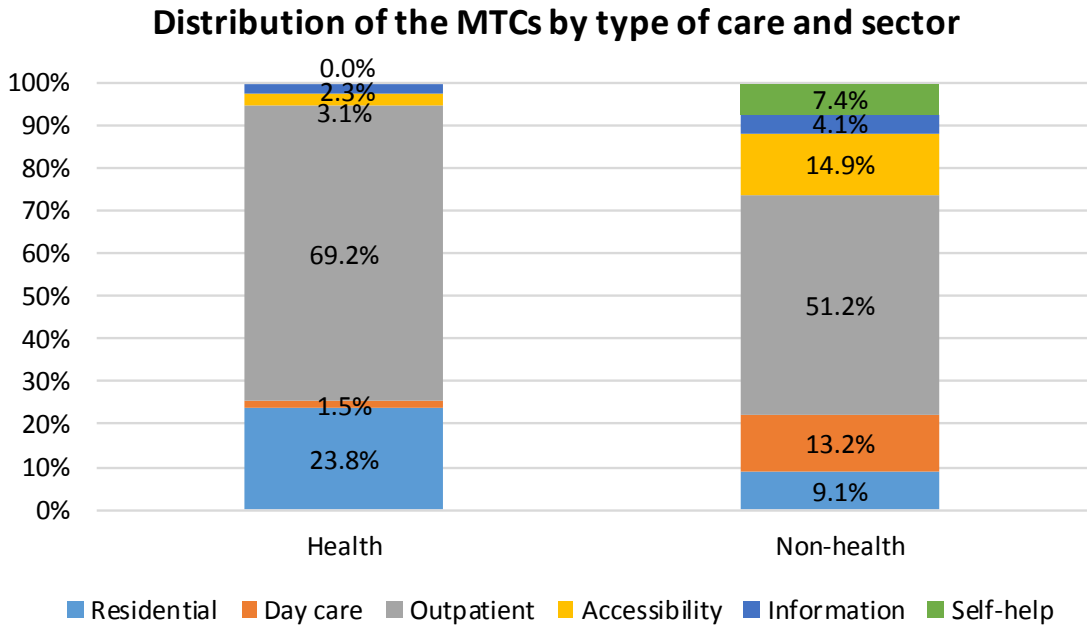

Distribution of the MTCs by type of care and sector
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0.0%
2.3%
3.1%
69.2%
1.5%
23.8%
7.4%
4.1%
14.9%
51.2%
13.2%
9.1%
Health
Non-health
Residential
Day care
Outpatient
Accessibility
Information
Self-help

Table 2. Description of the MTC per type of target population and care sector (N of MTC=251)

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT
RESIDENTIAL: Facilities that provide beds overnight for purposes related to the clinical and social management of their long term care																										
R1	Acute, 24 hours physician cover, hospital, high intensity	10	0	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	10	0	0	2	12
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	1	1
R2	Acute, 24 hours physician cover, hospital, medium intensity	13	0	0	0	13	0	0	0	0	0	2	0	0	0	2	0	0	0	0	0	15	0	0	0	15
R4	Non-acute, 24 hours physician cover, hospital, time limited	3	0	0	0	3	0	0	0	0	0	1	0	0	0	1	0	0	0	3	3	4	0	0	3	7
R6	Non-acute, 24 hours physician cover, hospital, indefinite stay	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT
R8.2	Non-acute, non-24 physician cover, time limited, 24 hours support, over 4 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0	1
R9.2	Non-acute, non-24 physician cover, time limited, daily support, over 4 weeks	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
R10.2	Non-acute, non-24 physician cover, time limited, lower support, over 4 w.	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
R11	Non-acute, non-24 physician cover, indefinite stay, 24 hours support	0	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3
R13	Non-acute, non-24 physician cover, indefinite stay, lower support	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
TOT R		**28**	**0**	**4**	**1**	**33**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**0**	**0**	**3**	**0**	**0**	**1**	**5**	**6**	**31**	**0**	**5**	**6**	**42**

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT
DAY CARE: Facilities that involve contact between staff and users for some purpose related to management of their condition and its associated clinical and social difficulties																										
D2.1	Non-acute, work, high intensity, ordinary employment	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
D2.2	Non-acute, work, high intensity, other work	0	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3
D3.1	Non-acute, work related care, high intensity, time limited	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
D4.1	Non-acute, non-work structured care, high intensity, health related care	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
D5	Non-acute, non structured care, high intensity	0	0	4	0	4	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	5	0	5
D7.1	Non-acute, work related care, low intensity, time limited	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1

MTC	Definition	Adults					Specific populations														Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT
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	1	0	1	0	0	2	0	2
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	1	0	0	0	1
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	2	0	2
D10	Other non-acute day care not classified anywhere else	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
TOT D		**2**	**0**	**14**	**0**	**16**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**2**	**2**	**0**	**16**	**0**	**18**

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	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	5	0	0	1	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	1	6
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	2	0	0	0	2
O3.1	Acute, non-mobile, 24h, health related care	4	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	4
O4.1	acute, non-mobile, time limited, health related care	4	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	4
O5.1	Non-Acute, Home & Mobile, High Intensity	2	0	0	0	2	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	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	20	0	21	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	1	0	22	0	23

MTC	Definition	Adults					Specific populations														Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT
O6.1	Non-Acute, Home & Mobile, Medium Intensity	6	0	1	0	7	5	0	0	0	5	6	0	0	0	6	2	0	0	0	2	19	0	1	0	20
O6.2	Non-Acute, Home & Mobile, Medium Intensity, other care	0	0	6	0	6	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	0	8	0	8
O7.1	Non-Acute, Home & Mobile, low Intensity	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	10	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	0	0	10
O8.1	Non-Acute, non-mobile, High intensity , health related care	9	0	1	0	10	1	0	0	0	1	0	0	0	0	0	1	0	0	0	1	11	0	1	0	12
08.2	Non-Acute, non-mobile, High intensity , other care	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
O9.1	Non-Acute, non-mobile, Medium intensity , health related care	20	0	5	0	25	3	0	4	0	7	5	0	0	0	5	1	0	1	0	2	29	0	10	0	39

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT
O9.2	Non-Acute, non-mobile, Medium intensity , other care	1	0	3	0	4	0	0	0	0	0	0	0	0	0	0	0	0	3	1	4	1	0	6	1	8
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	1	0	0	0	1	1	0	0	1	2
O10.2	Non-Acute, Home & Mobile, Medium Intensity, other care	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
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	3	0	0	0	3
TOT O		**59**	**10**	**37**	**2**	**108**	**10**	**0**	**4**	**0**	**14**	**12**	**0**	**0**	**0**	**12**	**9**	**0**	**8**	**1**	**18**	**90**	**10**	**49**	**3**	**152**

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT
ACCESSIBILITY: Facilities which main aim is to provide accessibility aids for users with long term care needs																										
A1	Communication	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
A4	Case Coordination	1	0	7	0	8	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	8	0	9

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT
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	2	0	0	0	2
A5.3	Other accessibility care: health related: social and cultural services	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
A5.4	Other accessibility care: health related: work related	0	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3
A5.5	Other accessibility care: health related: housing related	0	4	1	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	1	0	5
TOT A		**3**	**4**	**13**	**0**	**20**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**2**	**4**	**4**	**14**	**0**	**22**
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	2	0	0	0	2
I2.1.1	Information, interactive, face to face	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
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	1	0	2	0	3

MTC	Definition	Adults					Specific populations															Total				
							Transition to adulthood					Older adults					Non-age related specific populations									
		H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT	H	FACs	NGO	J	TOT
I2.2	Information, non interactive	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
TOT I		**3**	**0**	**5**	**0**	**8**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**5**	**0**	**8**
VOLUNTARY CARE: Facilities which main aim is to provide users with long term care needs with support, self-help or contact with un-pain staff that offers accessibility, information, day, outpatient and residential care (as described above), but the staff is non-paid																										
S1.1	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	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	1	0	1
S1.3	Non-professional staff outpatient care	0	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	4	0	4	0	0	7	0	7
TOT S		**0**	**0**	**5**	**0**	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**	**4**	**0**	**0**	**9**	**0**	**9**
TOT		**96**	**14**	**78**	**3**	**191**	**10**	**0**	**4**	**0**	**14**	**15**	**0**	**0**	**0**	**15**	**10**	**0**	**16**	**6**	**32**	**131**	**14**	**98**	**9**	**251**

*Note: Note funded for mapping child and adolescent services in SLHD so excluded here. *H:Health; FACS: Department of Family and Community Services; NGO: Non-Government Organisation; J: Justice; TOT: Total*

3.2. ADULTS

In this section we describe the availability and placement capacity (number of places or beds available in every functional team) of the BSIC/services providing care for adults (> 17 years old) with a lived experience of mental illness, by care sector. Specific care services related to transition from adolescence to adulthood, 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 20 BSIC/services, corresponding to 24 MTC, were identified which provide acute inpatient care in the CESPHN. Two of these BSIC are specific for people with eating disorders. Ten out of the 24 MTC that provide care for any mental illness are considered high intensity (code R1), while the others are medium intensity (R2).

In the SLHD, the Manning acute unit in Concord is specialised in providing care for people with a first episode of mental illness, while Norton is for people with recurrent and more established disorders. The short stay unit at the Marie Bashir centre in Camperdown admit people during 72 hours with substance abuse/dependence related problems with an acute episode.

In the SESLHD, the Kiloh unit in Randwick has a separate observation ward for people who are severely troubled by symptoms of mental illness. This BSIC provides close observation and frequent monitoring of consumers. SESLHD also has two psychiatric emergency care centres that provide short term (ideally 24-48 hour) admission for patients in mental health crisis, who may then be discharged to ongoing support in the community.

The number of acute beds from the public health sector per 100,000 residents, excluding the 26 beds for people with eating disorders, is 289 or 26.40 per 100,000 residents. The number of BSICs from the public health sector providing acute care per 100,000 residents is 1.55 (excluding the two specific services for people with eating disorders).

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
SLHD Mental Health Service	Female High Dependency unit-CCMH	AX[F00-F99]-R1		12	Concord	IWS
SLHD Mental Health Service	Female High Dependency unit-MB	AX[F00-F99]-R1		8	Camperdown	IWS
SLHD Mental Health Service	Intensive Psychiatric Unit-CCMH	AX[F00-F99]-R1		10	Concord	IWS
SLHD Mental Health Service	Jara	AX[F00-F99]-R2		30	Concord	IWS
SLHD Mental Health Service	Male High Dependency unit-CCMH	AX[F00-F99]-R1		10	Concord	IWS
SLHD Mental Health Service	Male High Dependency unit-MB	AX[F00-F99]-R1		8	Camperdown	IWS
SLHD Mental Health Service	Manning Acute Unit	AX[F00-F99]-R2		24	Concord	IWS
SLHD Mental Health Service	Norton Acute Unit	AX[F00-F99]-R2		24	Concord	IWS
SLHD Mental Health Service	Short-stay unit MB	AX[F00-F99]-R2		6	Camperdown	IWS
St George Mental Health Service	Inpatient Unit	AX[F00-F99]-R2	AX[F00-F99]-R1	19 9	Kogarah	SES

Provider	Name	Main DESDE Code	Other DESDE code(s)	Beds/Places	Town / Suburb	Area of Coverage
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	17			289		
Rate per 100,000 residents (>17 years old)	1.55			26.40		
SLHD Mental Health Service	Acute Unit - Eating Disorders	AX[F50]-R2		6	Camperdown	State
SLHD Mental Health Service	Acute Unit-MB	AX[F50]-R2		20	Camperdown	IWS
Total	2			26		
Rate per 100,000 residents (>17 years old)	0.18			2.38		

The next table shows the workforce capacity related to adult acute mental health inpatient services in the CESPHN. The total number of FTEs related to adult acute inpatient services per 100,000 residents is 50.91, excluding BSICs for people with eating disorders. Psychiatrists and mental health nurses, as expected, account for the highest percentage of the workforce. In addition, the Female High Dependency Unit (CCMH), the Manning Acute Unit (CCMH), the Norton Acute Unit (CCMH) and Jara (CCMH) share the following professionals with the subacute units at the CCMH: 0.68 Dietitian, 0.23 Speech Pathology, 0.38 Physiotherapy and 0.63 Music Therapist. In the Marie Bashir Centre, the Male and Female High Dependency Unit share 0.97 Welfare Officer. In the Mental Health Intensive Care Unit of the Prince of Wales, *"Others"* refers to 0.6 diversional therapist, 5.66 Health and Safety Assistant (HASA) and 0.82 exercise physiologist.

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				
SLHD Mental Health Service	Female High Dependency unit-CCMH	23.6	2.9	0.6	18.6	1.0	0.5			
SLHD Mental Health Service	Female High Dependency unit-MB	25.8	2.5	0.3	20.2	1.3	1.0			0.5
SLHD Mental Health Service	Intensive Psychiatric Unit-CCMH	20.7	1.6		18.2	0.5	0.4			
SLHD Mental Health Service	Jara	37.3	6.5	1.0	27.0	1.8	1.0			
SLHD Mental Health Service	Male High Dependency unit-CCMH	20.7	1.6		18.2	0.5	0.4			
SLHD Mental Health Service	Male High Dependency unit-MB	25.8	2.5	0.3	20.2	1.3	1.0			0.5
SLHD Mental Health Service	Manning Acute Unit	34.8	4.9	0.7	24.3	3.0	2.0			
SLHD Mental Health Service	Norton Acute Unit	37.9	4.8	0.6	28.5	2.0	2.0			
SLHD Mental Health Service	Short-stay unit MB	20.0	1.6		17.9	0.5				
St George Mental Health Service	Inpatient Unit	44.2	4.6	0.5	34.7	2.0	1.0	1.0	0.4	

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT	Edu	Peer	Others
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		557.2								
Rate per 100,000 residents (>17 years old)		50.91								
SLHD Mental Health Service	Acute Unit - Eating Disorders	21.0	1.3	1.4	17.5		0.8			
SLHD Mental Health Service	Acute Unit-MB	40.4	4.6		32.4	2.4	1.0			
Total		61.4								
Rate per 100,000 residents (>17 years old)		5.61								

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.

NON-ACUTE INPATIENT AND RESIDENTIAL SERVICES

A total of 5 BSIC were identified as providing non-acute inpatient and residential care in the CESPHN. Kirkbride provides non-acute care time limited (up to 3 months), and it is located at CCMH. Broughton is a rehabilitation unit also located at CCMH and provides longer-term care (12 months or more - not time limit) for people with a lived experience of mental illness. The 35 beds are distributed as follows: 5 forensic beds (for people who are in legal custody); 9 disability beds (for people who experience chronic and long term mental illness); and 21 rehabilitation beds, to facilitate the transition from the hospital to the community.

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

In the SESLHD, there are rehabilitation units at the Prince of Wales Hospital and 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
SLHD Mental Health Service	Broughton	AX[F00-F99]-R6	35	Concord	IWS
SLHD Mental Health Service	Kirkbride	AX[F00-F99]-R4	15	Concord	IWS
Sutherland Mental Health Service	Rehabilitation unit	AX[F00-F99]-R4	20	Caringbah	SES
Total	4		84		
Rate per 100,000 residents (>17 years old)	0.37		7.67		
SLHD + Schizophrenia Fellowship	Respite-Eurella	AX[F00-F99]-R9.2	9	Burwood	IWS
Total	1		9		
Rate per 100,000 residents (>17 years old)	0.09		0.82		

The number of non-acute beds provided by the public health sector per 100,000 residents is 7.67 at the hospital setting, and 0.82 in the community. The number of BSICs/services from the public health sector providing non-acute care per 100,000 residents is 0.37 in hospital setting and 0.09 in the community.

The table below describes the workforce capacity in non-acute care in the CESPHN. As in the case of acute care, mental health nurses and psychiatrists are the professionals with the highest representation. As noted above, Kirkbride and Broughton share several professionals with some of the acute units at the CCMH. Eurella is staffed with 2 FTE (mental health workers) who work during business hours from Monday to Friday providing support to the residents. The total

number of FTEs for non-acute inpatient services per 100,000 residents is 9.17 in hospital setting and 0.18 in the community in the CESPHN.

Table 6. Non- acute inpatient services: workforce capacity

Provider	Name	Total FTE	Psych/reg	Psychol	MHN	SW	OT	MHW	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		
SLHD Mental Health Service	Broughton	31.7	2.8	0.7	24.0	2.2	2.0		
SLHD Mental Health Service	Kirkbride	22.5	1.6	0.4	17.5	2.0	1.0		
Sutherland Mental Health Service	Rehabilitation unit	25.0	1.5	1.0	19.0	1.0	2.0		0.5
Total		100.4							
Rate per 100,000 residents (>17 years old)		9.17							
SLHD + Schizophrenia Fellowship	Respite-Eurella	2.0						2.0	
Total		2.0							
Rate per 100,000 residents (>17 years old)		0.18							

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

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

SOCIAL HOUSING

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

- Aboriginal and Torres Strait 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

According to the report published by FACS NSW (47), as of the 30th of June 2013 there were a total of 110,059 households living in public housing: 25,973 living in community housing and 4,469 living in Aboriginal Housing. FACS manages 149,972 properties in NSW, comprising 117,798 public housing dwellings, 27,450 properties in the community housing sector and 4,724 Aboriginal Housing properties.

However, the DESDE-LTC codification of public housing (and the NGOs) is difficult for several reasons. Firstly, it is not possible to know how many of the properties are specifically devoted to people with a lived experience of mental illness. Secondly, it is not possible to know how many people with a lived experience of mental illness were using the properties (data on mental health status is not collected); and thirdly, properties are not restricted to specified districts (i.e. a person living in Redfern may be relocated out of the district area if there is a property available there). The separation of property, management and care provision, together with case complexity and comorbidity provided additional obstacles for coding these services. As a matter of fact, social housing may or may not include direct support. People with a lived experience of mental illness who need support at home receive this type of care through the Housing and Accommodation Support Initiative (HASI). HASI is a partnership between NSW Health, Housing NSW and an array of organisations that provide people with mental illness with access to stable housing linked to clinical and psychosocial rehabilitation services. HASI can be delivered at an individual's privately owned or rented property, or through social housing. Consequently, it could be argued that the way housing for people with mental illness is provided is more accurately conceptualised as a financing mechanism than a service providing care.

Therefore, we have included FACS services as ambulatory mobile care (O code) and accessibility (code A–assisting consumers to access social housing through assessment and eligibility). We have excluded from this analysis the services providing care for people with intellectual disabilities.

Fourteen (14) BSIC/services delivered by FACS providing direct care related to housing were identified. Although these services are not specifically for people with mental illness, most of the FACS service users experience mental illness.

Ten of the 14 FACS services provide tenancy support, that is, non-acute, mobile, outpatient care of low intensity (contact with the client is lower than once a month) and therefore are coded as "Outpatient" care (O). One of the services is composed of specialists who provide tenancy support people with more complex needs which covers all the SLHD. The other BSIC are

focused on helping the client to access social housing (through assessment and eligibility), and is coded as "Accessibility" ("A").

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

The total number of BSIC/services from FACS services providing tenancy support (non-acute, mobile, outpatient care, low intensity) in CESPHN is 0.91 per 100,000 residents. The total number of FTE support workers providing this type of care is 93.00, with a rate of 8.50 per 100,000 residents.

The number of BSIC/services from FACS providing assessment and eligibility care (accessibility to social housing) in the CESPHN is 0.37 per 100,000 residents, with a rate of 6.76 support workers per 100,000 residents.

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

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

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
FACS	Waterloo Tenancy Team*	AX[Z55-65]-O7.2	10.0	Waterloo	Waterloo
Total	10		93.0		
Rate per 100,000 residents (>17 years old)	0.91		8.5		
FACS	Sydney District Access & Demand Team*	AX[Z55-65]-A5.5	17.0	Ashfield	IWS
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	4		74.0		
Rate per 100,000 residents (>17 years old)	0.37		6.76		

FTE: Full Time Equivalents

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

COMMUNITY HOUSING

The same limitations that have been 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. These services only provide the property, while the psychosocial support is provided by other NGOs. In addition, although community housing properties are located in the CESPHN, these properties can be utilised by the whole state, and it is difficult to know how many of these properties are designated specifically for people with a lived experience of mental illness, as they are accessible to all vulnerable groups in the general population.

For consistency, the same coding principles adopted for Social Housing have been applied to the Community Housing sector. That is, services which provide both accommodation and in-home support to people with a lived experience of mental illness are coded as residential care and services which provide in-home support only are coded as outpatient care. Following these

principles there were no community housing organisations that were coded as providing residential care to people with a lived experience of mental illness in the CESPHN.

To increase understanding of the number of people with a lived experience of mental illness residing in community housing in the CESPHN services were contacted and asked to identify how many residents they had who were being supported by HASI or a similar program. From feedback it was identified that there were 36 properties in the IWS and 28 properties in ES. Details of these community housing organisations and their properties is provided below.

The following community housing providers were contacted:

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

Only St George Community Housing (SGCH) has properties devoted to the HASI program. At the time of the interview (October 2015), SGCH had a total of 10 properties in the area of IWS (1 in Burwood, 2 in Canterbury, 6 in Ashfield and 1 in Strathfield) and 12 in the area of SES (1 in Botany Bay, 5 in Randwick, 2 in Kogarah, and 4 in Sutherland)

Metro and B Miles also identified managing properties which have been specifically designated for people with a lived experience of mental illness. Metro Housing is a generic specialist housing provider, with a particular focus on psychosocial disabilities. It mainly covers the area of IWS. It has 12 transitional properties that are managed in partnership with the LHD, and an additional 20 transitional properties in partnership with Aftercare.

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

Ecclesia Housing has 6 transitional properties in the area of St Vincent's (SESLHD), where Neami National provide the support. 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 CESPHN. However, most of them recognise that a high percentage of their consumers have a psychosocial disability.

3.2.1.2. RESIDENTIAL CARE PROVIDED BY NGOS

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

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

One NGO funded BSIC was identified as providing residential care to people with a lived experience of mental illness in the CESPHN. This service, Casa Venegas, is managed by St John of God and provides 43 beds spread across 16 sites in Sydney's Inner West and West (15 within the CESPHN across Belfield, Burwood and Concord). Casa Venegas has a mix of houses and bedsit accommodation, some of which are privately leased, some which are owned by the Department of Housing and one which is managed by Metro Housing. The service has been coded as a single BSIC with a number of satellites which represent the different accommodation sites.

Casa Venegas provides non-acute residential services for people with a lived experience of mental illness. Approximately 71% of the population serviced by Casa Venegas has a diagnosis of schizophrenia and a further 15% have a diagnosis of schizo affective disorder. Casa Venegas provides both high and low supported accommodation which is non-time limited. The low support accommodation service has a goal of assisting consumers to transition to community housing.

Residents of Casa Venegas' high support accommodation receive daily assistance (Monday to Friday) and have 24 hour on-call support (non-medical) during the week. Residents within the high support accommodation pay rent which includes an additional fee for utilities and a shopping service. Residents of the lower level supported accommodation receive support 1 to 2 times a week, pay a subsidised rent and are required to pay their own utility bills.

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

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

FTE: Full-Time Equivalents

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

- Ashfield Biala: This service is run by Aftercare and provides supported residential accommodation for adults aged between 18 and 40 who are recovering from a serious mental illness. The service is a transitional service which operates five days a week and clients of the service can stay for up to two years. The service can accommodate up to 24 clients (21 beds within the CESPHN and 3 located in North Parramatta). The housing is provided through the Metro Community Housing Co-op.
- Camperdown Units Program: provides 12 units for people diagnosed with a mental illness. Care for these units is provided by the Community Mental Health Service Team.
- Sydney Residential Outreach Team: This service is run by RichmondPRA (now known as flourish) and provides 32 packages of outpatient care for people with severe mental illness. The intensity of support ranges from low (1-2 visits per week) to high (2-3 visits per day up to a total of up to 10 hours per week).

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

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

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

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

3.2.2. DAY CARE (STRUCTURED DAY PROGRAMS)

3.2.2.1. DAY CARE/STRUCTURED DAY PROGRAMS PROVIDED BY THE PUBLIC HEALTH SECTOR

We identified 2 BSIC/services providing structured day programs (i.e. programs with planned activity program for individual clients) funded by the Public Health Sector. One of these is specific for people with a diagnosis of Eating Disorders. It is located at the Professor Marie Bashir Centre and provides care to all the State. The second, Recovery College is an innovative educational initiative, 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 to 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 region. It is also open to their carers, relatives and friends, and to SESLHD staff.

Table 8. Day programs 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
SLHD Mental Health Service	Day Program-Eating Disorders	AX[F50]-D4.1	Camperdown	State
Total	2			
Rate per 100,000 residents (>17 years old)	0.18			

The day program for eating disorders is staffed with a multidisciplinary team of professionals including psychiatrists, psychologists, mental health nurses, occupational therapists, and dietitians. The Recovery College is staffed with educators and casual employees, according to needs.

The number of day care/program services provided by the public health sector per 100,000 residents is 0.18.

Table 9. Day programs 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	
SLHD Mental Health Service	Day Program-Eating Disorders	3.4	0.1	1.0	0.3	0.5		1.4
Total		4.9						
Rate per 100,000 residents (>17 years old)		0.45						

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/PROGRAMS PROVIDED BY NGOS

SOCIAL AND CULTURE RELATED

We identified 8 NGO funded, BSIC/services providing day programs which offer social and/or cultural activities for people with a lived experience of mental illness in the CESPHN. 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's mental health inpatient units to enable consumers to attend the D2DL program at Buckingham House. Transport services also collect consumers from Independent Community Living Accommodation (Bondi) and other community organisations.

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

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

The Wayside Chapel (Uniting Care) also run a D2DL program in Potts Point. This program provides structured activities 5 days a week and runs 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 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 provide a mix of structured and unstructured social and cultural 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.

Additional day programs not specifically for people with a lived experience of mental illness were also identified in the mapping process. The St Vincent de Paul Society manages a Men's

Shed (St Mary MacKillop), which welcomes people with a lived experience of mental illness, but is not specifically for them. Similarly, the Creativity Centre, managed by Eastern Respite and Recreation, provides a day program for people with intellectual disabilities, but it is not limited to this population. Rough Edges provides a day program which targets people who are experiencing homelessness.

The total number of BSIC/services from the NGO sector providing social and culture-related day care for people with a lived experience of mental illness within the boundaries of CESPHN is 0.82 per 100,000 residents. The total number of FTEs for those services is 2.45 for 100,000 residents.

Table 10. Social and culture-related day programs 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 -D0DL	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	Wayside Chapel - D2DL	AX[F00-F99]-D5	AX[F00-F99]-D2.2	3.5	Kings Cross	SES
Uniting Church	The Wayside Chapel/Chapel by the Sea (satellite)	AX[F00-F99]-D5t		NA	Bondi Beach	ES
Total	9			26.8		
Rate per 100,000 residents (>17 years old)	0.82			2.45		

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

WORK-RELATED

There are 4 BSIC providing work-related day care for people with a lived experience of mental illness within the boundaries of the CESPHN. Although these BSIC are located in the area of SLHD, their consumers can come from across Greater Sydney.

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

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

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
RichmondPRA	Pre-Employ Institute	AX[F00-F99]-D7.1	0.8	Surry Hills	Greater Sydney Area
RichmondPRA	Prestige Packing	AX[F00-F99]-D2.2	3.0	Marrickville	IWS
RichmondPRA	Social Enterprise: Courien and warehousing	AX[F00-F99]-D2.1	3.5	Marrickville	IWS
RichmondPRA	Social Enterprise: Scanning and Document Destruction	AX[F00-F99]-D2.2	0.5	Marrickville	IWS
Total	4		7.8		
Rate per 100,000 residents (>17 years old)	0.37		0.71		

The total number of BSIC/MTC (or services) from the NGO sector providing work-related day care within the boundaries of the CESPHN is 0.37 per 100,000 residents. The number of full time equivalents is 7.8 or 0.71 per 100,000 residents.

3.2.3. OUTPATIENT CARE

3.2.3.1. OUTPATIENT CARE PROVIDED BY THE PUBLIC HEALTH SECTOR

ACUTE MOBILE OUTPATIENT CARE

We identified a total of 7 BSIC providing acute mobile outpatient care for adults with a lived experience of mental illness in the CESPHN. Six of the services provide acute home and mobile care, 24 hours a day seven days a week. In general, the staff within these services are on duty for 14 hours, and from 22:30 to 8:30 they are available on-call. The acute care team at St George Hospital operates from 8am to 10:30pm, 7 days a week:

The total number of BSIC/services from the public health sector providing acute mobile outpatient care within the boundaries of CESPHN is 0.64 per 100,000 residents.

Table 12. 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
SLHD Mental Health Service	Acute Care Service - Camperdown	AX[F00-F99]-O1.1		Camperdown	Campersown, Redferd, Marrickville
SLHD Mental Health Service	Acute Care Service - Canterbury	AX[F00-F99]-O1.1		Campsie	IWS
SLHD Mental Health Service	Acute Care Service- Croydon	AX[F00-F99]-O1.1		Croydon	IWS
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	7				
Rate per 100,000 residents (>17 years old)	0.64				

With regard to the workforce, there are a total of 98.70 FTEs of professionals providing acute and mobile care, or 9.02 per 100,000 residents within the boundaries of CESPHN. Mental health nurses make up the largest group of professionals.

Table 13. 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			
SLHD Mental Health Service	Acute Care Service - Camperdown	20.2	2.0		15.7	2.5			
SLHD Mental Health Service	Acute Care Service - Canterbury	11.0	2.0		8.0	1.0			
SLHD Mental Health Service	Acute Care Service- Croydon	9.6	1.2		7.4	1.0			
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		98.7							
Rate per 100,000 residents (>17 years old)		9.02							

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

ACUTE NON-MOBILE OUTPATIENT CARE

We identified 5 additional BSIC corresponding to 5 MTC, providing acute care, but these are non-mobile.

In SLHD, one is located in the CCMH, another at the Marie Bashir Centre, and the third is located at the Emergency Department of the Royal Prince Alfred Hospital. The Psychiatric Admission Unit at the CCMH and the Assessment Unit at the Marie Bashir Centre provides 24 hour coverage. The emergency department nursing teams are staffed during business hours.

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).

The number of MTC from the public health sector providing acute non-mobile outpatient care per 100,000 residents is 0.46.

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

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
SLHD Mental Health Service	Assessment Unit- MB	AX[F00-F99]-O3.1	Camperdown	IWS
SLHD Mental Health Service	Emergency Department Nursing team Canterbury	AX[F00-F99]-O4.1	Campsie	IWS
SLHD Mental Health Service	Emergency Department Nursing team Concord	AX[F00-F99]-O4.1	Concord	IWS
SLHD Mental Health Service	Emergency Department Nursing team RPAH	AX[F00-F99]-O4.1	Camperdown	IWS
SLHD Mental Health Service	Psychiatric Admission Unit-CCMH	AX[F00-F99]-O3.1	Concord	IWS
Total	5			
Rate per 100,000 residents (>17 years old)	0.46			

The table below shows the workforce providing acute-non mobile care within the boundaries of CESPHN. Similar to the mobile team, mental health nurses were the largest group of professionals. The total number of FTEs of professionals providing acute non-mobile outpatient care in the public health sector amounts to 1.61 per 100,000 residents in the CESPHN.

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

Provider	Name	Total FTE	Psychol	MHN
SLHD Mental Health Service	Assessment Unit- MB	6.7	0.7	6.0

Provider	Name	Total FTE	Psychol	MHN
SLHD Mental Health Service	Emergency Department Nursing team Canterbury	0.5		0.5
SLHD Mental Health Service	Emergency Department Nursing team Concord	0.5		0.5
SLHD Mental Health Service	Emergency Department Nursing team RPAH	3.9		3.9
SLHD Mental Health Service	Psychiatric Admission Unit-CCMH	6.0		6.0
Total		17.6		
Rate per 100,000 residents (>17 years old)		1.61		

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

NON ACUTE MOBILE OUTPATIENT CARE

We found 11 BSIC/services providing non-acute mobile outpatient care within the boundaries of the CESPHN.

In the SLHD area, we have identified five community mental health teams that provide outpatient care in the different districts. The frequency of the contacts with the consumers is medium (at least fortnightly). These teams provide the central care around which specialist services elements are developed (i.e. early intervention, assertive outreach team, inpatient services, etc.). The other 2 BSIC are specialist services providing high intensity care (i.e. mobile assessment and treatment team and Assertive Outreach Team).

In the SESLHD area, we have identified one team providing high intensity care (i.e. they have the capacity to see patients 3 times per week if needed),one rehabilitation team in Kogarah and 1 case management team that provides medium intensity care (i.e. contacts are made at least on a fortnightly basis)

The number of services from the public health sector providing non-acute mobile outpatient care per 100,000 residents is 1.0.

Table 16. 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	Case Manager and Assessment Team	AX[F00-F99]-O6.1	Maroubra	ES
Eastern Suburbs Mental Health Service	Mobile Community Team	AX[F00-F99]-O5.1	Randwick	ES
SLHD Mental Health Service	Assertive Outreach Team-Croydon	AX[F00-F99]-O5.1.1	Croydon	IWS
SLHD Mental Health Service	Community mental health service- Camperdown	AX[F00-F99]-O6.1	Camperdown	IWS
SLHD Mental Health Service	Community mental health service- Canterbury	AX[F00-F99]-O6.1	Campsie	IWS
SLHD Mental Health Service	Community mental health service- Croydon	AX[F00-F99]-O6.1	Croydon	IWS
SLHD Mental Health Service	Community mental health service- Marrickville	AX[F00-F99]-O6.1	Marrickville	IWS
SLHD Mental Health Service	Community mental health service- Redfern	AX[F00-F99]-O6.1	Redfern	IWS
SLHD Mental Health Service	Mobile Assessment and Treatment Team	AX[F00-F99]-O5.1.1	Camperdown	IWS
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	11			
Rate per 100,000 residents (>17 years old)	1.0			

The table below shows the workforce providing non-acute mobile outpatient care related to mental health needs. The total number of full-time equivalent workers is 13.69 per 100,000 residents. The teams providing non-acute mobile outpatient care are multidisciplinary and composed mostly of mental health nurses. The core team at Marrickville has 3 additional multilingual workers, the core team at Croydon has 1 GP who is shared with other teams.

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

Provider	Name	Total FTE	Psych /reg	Psychol	GP	MHN	SW	OT	CCM	Sup W	AbW	Edu	Peer	Others
Eastern Suburbs Mental Health Service	Case Manager and Assessment Team	18.6	1.1	3.8		8.7	3.0	1.0			1.0			
Eastern Suburbs Mental Health Service	Mobile Community Team	7.2	0.2	1.0		5.0	1.0							
SLHD Mental Health Service	Assertive Outreach Team-Croydon	12.4	1.4	2.0		4.0	2.0					1.0	2.0	
SLHD Mental Health Service	Community mental health service-Camperdown	12.6	1.7	1.5		6.0		1.4					2.0	
SLHD Mental Health Service	Community mental health service-Canterbury	19.6	2.0	2.6		4.6	3.4	1.0		3.0			2.0	1.0
SLHD Mental Health Service	Community mental health service-Croydon	16.4	1.2	2.0	1.1	6.3	2.8	1.0		1.0				1.0
SLHD Mental Health Service	Community mental health service-Marrickville	17.3	1.8	1.4	0.1	7.2	2.8	1.0						3.0
SLHD Mental Health Service	Community mental health service-Redfern	8.7	1.5	0.6	0.1	4.9	1.0	0.6						
SLHD Mental Health Service	Mobile Assessment and Treatment Team	10.6	0.9	1.0		5.1	1.6	1.0					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					

Provider	Name	Total FTE	Psych /reg	Psychol	GP	MHN	SW	OT	CCM	Sup W	AbW	Edu	Peer	Others
Total		149.9												
Rate per 100,000 residents (>17 years old)		13.69												

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

NON-ACUTE NON-MOBILE OUTPATIENT CARE

We have identified 32 BSIC providing non-acute non-mobile outpatient care within the boundaries of CESPHN.

In the SLHD, there are two metabolic clinics, located at Concord Hospital and Royal Prince Alfred Hospital (Camperdown). The main objective of these clinics is to monitor the physical health of people with a lived experience of severe mental illness, especially with regard to the risk of metabolic syndrome. The metabolic clinics are open once per week. The SLHD also has a Physical Health Unit in Marrickville staffed with 1 FTE exercise physiologist and 1 FTE dietitian. It is an office-based service with low intensity of contact (fortnightly-monthly).

In SESLHD, there are four teams that aim to promote physical activity in people with a lived experience of mental illness (Keeping the Body in Mind Program). Two of these progams provide services for adults and those in transition to adulthood and operate in Bondi Junction and Maroubra. The Keeping the Body in Mind Program in Kogarah and Sutherland targets younger adults at the time of data collection).). The SESLHD also has a peer support program which provides individual consultations and group based activities aimed at facilitating recovery principles of hope, choice, self-determination and social connectedness. Peer support programs are run in ES and SES.

There are 7 consultation liaison services and one specialised clinic for eating disorders, which supports people from across NSW.

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).

Lastly, we have found some specialised services: two of them are targeting 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 18. 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	TA[F00-F99]-O9.1		Bondi Junction	ES
Eastern Suburbs Mental Health Service	Keeping body in mind	TA[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
SLHD Mental Health Service	Ambulatory clinic-Eating Disorders	AX[F50]-O9.1		Camperdown	State
SLHD Mental Health Service	Consultation Liaison Canterbury	AX[F00-F99]-O8.1		Campsie	IWS
SLHD Mental Health Service	Consultation Liaison Concord	AX[F00-F99]-O8.1		Concord	IWS
SLHD Mental Health Service	Consultation Liaison RPAH	AX[F00-F99]-O8.1		Camperdown	IWS
SLHD Mental Health Service	Consultation Liaison-CNC	AX[F00-F99]-O8.1		Camperdown	IWS
SLHD Mental Health Service	Metabolic Clinic I	AX[F00-F99]-O9.1		Camperdown	IWS
SLHD Mental Health Service	Metabolic Clinic II	AX[F00-F99]-O9.1		Concord	IWS
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

Provider	Name	Main DESDE Code	Other DESDE code(s)	Town / Suburb	Area of Coverage
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	32				
Rate per 100,000 residents (>17 years old)	2.92				

**This is a secondary MTC for a service primarily providing care for children in the SESLHD. Please see the SES Annex for more details.*

The number of BSIC/services from the public health sector providing non-acute non-mobile outpatient care per 100,000 residents is 2.92.

The table below shows the workforce providing non-acute non-mobile care related to health needs. The metabolic clinics are staffed with the equivalent of 0.2 FTE psychiatrists, 0.2 FTE cardiologists, 0.2FTE nurses and 0.2FTE endocrinologists. The total number of FTEs of professionals providing non-acute non-mobile outpatient care in the public health sector amounts to 13.25 per 100,000 residents.

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

Provider	Name	Total FTE	Psych /reg	Psychol	MHN	SW	OT	CCM	SF	AbW	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									
SLHD Mental Health Service	Ambulatory clinic-Eating Disorders	0.1	0.1								

Provider	Name	Total FTE	Psych /reg	Psychol	MHN	SW	OT	CCM	SF	AbW	Peer
SLHD Mental Health Service	Consultation Liaison Canterbury	0.5			0.5						
SLHD Mental Health Service	Consultation Liaison Concord	0.5			0.5						
SLHD Mental Health Service	Consultation Liaison RPAH	12.1	10.6	1.0	0.5						
SLHD Mental Health Service	Consultation Liaison-CNC	6.6	5.6		1.0						
SLHD Mental Health Service	Metabolic Clinic I	NA									
SLHD Mental Health Service	Metabolic Clinic II	NA									
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		1.0						
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						

Provider	Name	Total FTE	Psych /reg	Psychol	MHN	SW	OT	CCM	SF	AbW	Peer
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		145									
Rate per 100,000 residents (>17 years old)		13.25									

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)

There are 152 private providers under the ATAPS program in CESPHN. The numbers of ATAPS providers providing non-acute outpatient care per 100,000 residents is 13.89 across the region, ranging from 0 in Lord Howe Island to 37.67 in Burwood. According to the DESDE LTC system, the ATAPS program should receive the code **Gx[F00-F99]-O9.1u**. 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 20).

Table 20. ATAPS: workforce capacity

	Clin Psych	MHN	Psych	SW	SW (MHA)	OT	Grand Total	Total population over 17	Rate per 100,000 residents
Ashfield	2.0	2.0	1.0	0.0	0.0	0.0	5.0	33,849	14.8
Burwood	4.0	1.0	4.0	0.0	1.0	0.0	10.0	26,545	37.7

Canada Bay	2.0	0.0	7.0	0.0	0.0	0.0	9.0	60,888	14.8
Canterbury	0.0	1.0	7.0	0.0	0.0	0.0	8.0	105,137	7.6
Leichhardt	0.0	2.0	10.0	0.0	2.0	0.0	14.0	42,514	32.9
Marrickville	2.0	0.0	4.0	0.0	3.0	0.0	9.0	63,730	14.1
Strathfield	1.0	0.0	3.0	0.0	0.0	0.0	4.0	28,045	14.3
Sydney	9.0	0.0	13.0	3.0	0.0	0.0	25.0	155,615	16.1
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							152.0	1,094,578	13.9

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

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

3.2.3.2. OUTPATIENT CARE PROVIDED BY NGOS

ACUTE MOBILE AND NON-MOBILE OUTPATIENT CARE

We have not found any BSIC providing acute mobile outpatient care nor acute non-mobile outpatient care provided by NGOs within the boundaries of CESPHN.

NON-ACUTE MOBILE OUTPATIENT CARE

We found 37 BSIC providing non-acute mobile outpatient care within the boundaries of the CESPHN. Aftercare, New Horizons, Mission Australia and Neami National provide the support component on the HASI program. These teams have been described in the residential section of the Atlas (section 3.2.1).

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

Aftercare also provides low level support at home, five days a week, for approximately 21 places, and the properties are managed by Metro Community Housing.

Brown nurses is a service which provides in-home care to socially and economically disadvantaged individuals with complex needs, especially, but not exclusively, with mental illnesses. Their area of coverage is Greater Sydney, although it has a special focus on the SLHD and SVHN catchment regions.

The number of BSIC/services from the NGO sector providing non-acute mobile outpatient care per 100,000 residents is 3.38, including Partners in Recovery (PIR) programs providing those type of services – see specific section dedicated to PIR.

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

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Aftercare	HASI central	AX[F00-F99]-O5.2	Lylifield	IWS
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	Alexandria	SES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	Randwick	ES
Aftercare	Partners in Recovery*	AX[F00-F99]-O5.2	Randwick	ES
Aftercare	Personal Helpers and Mentors	AX[F00-F99]-O5.2	Sylvania Waters	SES
Aftercare	PHaMs Canada Bay	AX[F00-F99]-O5.2	Auburn	Canada Bay, Leichardt, Auburn, Ashfield, Bankstown

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Aftercare	PHaMs Rozelle	AX[F00-F99]-O5.2	Lylifield	Balmain, Rozelle, Lilyfield
Aftercare	Transitional Housing Program-Biala (METRO)	AX[F00-F99]-O6.2	Ashfield	IWS
Anglicare	PHaMs	AX[F00-F99]-O6.2	Bondi Beach	ES
Brown Nurses	Brown Nurses	AX[F00-F99]-O6.1	Glebe	SV
FACS	Balmain/Leichhardt/Marrickville Tenancy Team*	AX[Z55-65]-O7.2	Ashfield	Balmain, Leichhardt, Marrickville
FACS	Burwood/Glebe Tenancy Team*	AX[Z55-65]-O7.2	Burwood	Burwood, Glebe
FACS	Redfern Tenancy Team*	AX[Z55-65]-O7.2	Redfern	Redfern
FACS	Riverwood/Canterbury Tenancy Team*	AX[Z55-65]-O7.2	Riverwood	Riverwood, Canterbury
FACS	Specialists across the district*	AX[Z55-65]-O7.2	Ashfield	IWS
FACS	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
FACS	Waterloo Tenancy Team*	AX[Z55-65]-O7.2	Waterloo	Waterloo
Mission Australia	HASI	AX[F00-F99]-O5.2	Waterloo	ES-SV
Neami National	HASI - City	AX[F00-F99]-O5.2	Darlinghurst	SV
Neami National	HASI - Eastern	AX[F00-F99]-O5.2	Darlinghurst	SV

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
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
Neami National	Partners in Recovery*	AX[F00-F99]-O5.2	Ashfield	IWS
Neami National	PHaMs	AX[F00-F99]-O5.2	Ashfield	IWS
New Horizons	HASI	AX[F00-F99]-O5.2	Marrickville	IWS
New Horizons	PHaMs Croydon-Bankstown	AX[F00-F99]-O6.2	Marrickville	IWS
New Horizons	PHaMs Redfern-Waterloo-City	AX[F00-F99]-O6.2	Marrickville	IWS
New Horizons	PHaMs Redfern-Waterloo-City	AX[F00-F99]-O6.2	Marrickville	IWS
RichmondPRA	HASI-Boarding House	AX[F00-F99]-O5.2	Five Dock	IWS
RichmondPRA	Sydney Residential Outreach Team	AX[F00-F99]-O5.2	Five Dock	IWS
The Benevolent Society	Partners in Recovery*	AX[F00-F99]-O5.2	Hurtsville	SES
Total	37			
Rate per 100,000 residents (>17 years old)	3.38			

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

The table below shows the workforce providing non-acute mobile outpatient care related to health needs. The total number of FTEs workers is 23.40 per 100,000 residents.

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

Provider	Name	Total FTE	MHN	SW	nCCM	MHW	SF	SupW	Peer	Others
Aftercare	HASI central	9.0						9.0		
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		
Aftercare	PHaMs Canada Bay	5.0						5.0		
Aftercare	PHaMs Rozelle	5.0						5.0		
Aftercare	Transitional Housing Program-Biala (METRO)	3.0						3.0		
Anglicare	PHaMs	12.0		4.0	6.0	2.0				
Brown Nurses	Brown Nurses	5.0	5.0							
FACS	Balmain/Leichhardt /Marrickville Tenancy Team*	10.0						10.0		
FACS	Burwood/Glebe Tenancy Team*	10.0						10.0		
FACS	Redfern Tenancy Team*	10.0						10.0		
FACS	Riverwood/Canterbury Tenancy Team*	10.0						10.0		
FACS	Specialists across the district*	8.0						8.0		

Provider	Name	Total FTE	MHN	SW	nCCM	MHW	SF	SupW	Peer	Others
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
FACS	Waterloo Tenancy Team*	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			
Neami National	Partners in Recovery*	4.0					4.0			
Neami National	PHaMs	4.4						4.4		
New Horizons	HASI	10.5						10.5		
New Horizons	PHaMs Croydon-Bankstown	9.0						9.0		

Provider	Name	Total FTE	MHN	SW	nCCM	MHW	SF	SupW	Peer	Others
New Horizons	PHaMs Redfern-Waterloo-City	5.0						5.0		
New Horizons	PHaMs Redfern-Waterloo-City	1.0						1.0		
RichmondPRA	HASI-Boarding House	11.0						11.0		
RichmondPRA	Sydney Residential Outreach Team	7.0				4.0			2.0	1.0
The Benevolent Society	Partners in Recovery*	4.0					4.0			
Total		256.1								
Rate per 100,000 residents (>17 years old)		23.40								

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; Peer: Peer support worker.

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

NON-ACUTE NON-MOBILE OUTPATIENT CARE

We have identified 9 BSIC/services providing non-acute non-mobile outpatient care within the boundaries of CESPHN. DSA (described above as part of the Better Access Initiative), also provides non-acute non-mobile care. This BSIC is thus also taken into account in the calculation of availability and FTE rates in this section.

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

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

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The Haymarket Foundation aims to support socio-economically disadvantaged people in Sydney providing medical assistance and crisis accommodation. Although they mainly work with people who are homeless, they also provide 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 region.

Lastly, One Wave is a non-profit surf community raising awareness for mental health. They have a 12-week surfing program for people experiencing mental illness, done 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 BSIC/services from the NGO sector providing non-acute non-mobile outpatient care per 100,000 residents is 0.82 (9 BSIC).

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

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Haymarket Foundation	Psychological Services	AX[F00-F99]-O8.1	East Sydney	Greater Sydney
One Wave is all it takes	One Wave is all it takes	AX[F00-F99]-O9.2	Bondi	ES
Schizophrenia Fellowship	Sunflower Health Services	AX[F00-F99]-O9.1	Burwood	IWS
Schizophrenia Fellowship + LHD + Bulldog NSW	Physical Activity	AX[F00-F99]-O9.1	Belmore	Greater Sydney
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	Financial Counselling/Gambling	AX[Z55-65]-O9.2	Ashfield	Greater Sydney

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	9			
Rate per 100,000 residents (>17 years old)	0.82			

The table below shows the workforce providing non-acute non-mobile care related to health needs. The total number of FTE is 1.74 per 100,000 residents. We have to keep in mind, though, that the Sunflower Health Service is staffed with casual providers (i.e. psychologist and dietitians) who are hired in a casual position according to needs.

Table 24. Non-acute non-mobile outpatient BSIC 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
Schizophrenia Fellowship	Sunflower Health Services	NA					
Schizophrenia Fellowship + LHD + Bulldog NSW	Physical Activity	NA					
Southern Community Welfare	Psychologists	2.0	2.0				
Wesley Mission	Financial Counselling/Gambling	8.0				8.0	
Wesley Mission	Financial Counselling/Gambling	0.3				0.3	
Wesley Mission	Homelessness support for people with MH issues	6.0				6.0	
Wesley Mission	Psychological Services	1.0		1.0			

Total	19.1
Rate per 100,000 residents (>17 years old)	1.74

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 BSIC in the public health sector providing accessibility care in the CESPHN. 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 MTC providing accessibility services in the public health sector amounts to 4.

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

Table 25. 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 26. 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 3 BSIC facilitating access specifically to employment in the CESPHN for people with a lived experience of mental illness. RichmondPRA - in partnership with Ostara - and Schizophrenia Fellowship supports people to access employment. 2 BSIC or services provide accessibility support related to cultural and leisure activities through the Active Linking Initiative.

Finally, 3 BSIC or services provide accessibility services relating to housing. Way2Home provides accessibility support related to finding secure, affordable and safe housing for people with complex health needs (including mental illness). The Community Options programs of the Benevolent Society support individuals with complex care needs (including mental illnesses) to remain living independently in the community.

The total number of BSIC/services from the NGO sector providing accessibility services is 1.55 per 100,000 residents, including Partners in Recovery (PIR) programs providing those type of services – see specific section dedicated to PIR. Not including PIR, the rate of services providing accessibility to employment is 0.27 per 100,000 residents while it amounts to 0.46 for accessibility to housing and 0.18 for cultural activities.

Table 27. Accessibility services provided by NGOs: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
The Benevolent Society	Community Options Program	AX[F00-F99]-A4	Hurtsville	SES
The Benevolent Society	Community Options Program	AX[F00-F99]-A4	Rosebery	ES
Aftercare	Partners in Recovery	AX[F00-F99]-A4	Alexandria	IWS
Mission Australia	Partners in Recovery	AX[F00-F99]-A4	Waterloo	IWS
New Horizons	Partners in Recovery	AX[F00-F99]-A4	Marrickville	IWS
RichmondPRA	Partners in Recovery	AX[F00-F99]-A4	Five Dock	IWS
Schizophrenia Fellowship	Partners in Recovery	AX[F00-F99]-A4	Burwood	IWS
Total	7			
Rate per 100,000 residents (>17 years old)	0.64			
Aftercare	Active Linking Initiative	AX[F00-F99]-A5.3	Five Dock	IWS
Newtown Community Center	Active Linking Initiative	AX[F00-F99]-A5.3	Newtown	IWS
Total	2			

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Rate per 100,000 residents (>17 years old)	0.18			
RichmondPRA + Ostara	Disability Employment Service	AX[F00-F99]-A5.4	Caringbah	Greater Sydney Area
RichmondPRA + Ostara	Disability Employment Service	AX[F00-F99]-A5.4	Redfern	Redfern
Schizophrenia Fellowship	Disability Employment Service	AX[F00-F99]-A5.4	Burwood	IWS
Total	3			
Rate per 100,000 residents (>17 years old)	0.27			
Neami National	Way2Home	AX[F00-F99]-A5.5	Darlinghurst	SV
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
FACS	Sydney District Access & Demand Team*	AX[Z55-65]-A5.5	Ashfield	IWS
Total	5			

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Rate per 100,000 residents (>17 years old)	0.46			
Total	17			
Rate per 100,000 residents (>17 years old)	1.55			

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

The table below describes the workforce providing accessibility services. The accessibility services provided by NGOs for people with a lived experience of mental illness have a total workforce of 12.51 per 100,000 residents.

Table 28. Accessibility services provided by NGOs: workforce capacity

Provider	Name	Total FTE	nCCM	MHW	SF	SupW	Others
The Benevolent Society	Community Options Program	4.0	4.0				
The Benevolent Society	Community Options Program	4.0	4.0				
Aftercare	Partners in Recovery	4.0			4.0		
Mission Australia	Partners in Recovery	4.0			4.0		
New Horizons	Partners in Recovery	4.0			4.0		
RichmondPRA	Partners in Recovery	6.6			6.6		
Schizophrenia Fellowship	Partners in Recovery	5.0			5.0		

Provider	Name	Total FTE	nCCM	MHW	SF	SupW	Others
Total		31.6					
Rate per 100,000 residents (>17 years old)		2.89					
Aftercare	Active Linking Initiative	5.0				5.0	
Newtown Community Centre	Active Linking Initiative	2.0				2.0	
Total		7.0					
Rate per 100,000 residents (>17 years old)		0.64					
RichmondPRA + Ostara	Disability Employment Service	2.0		2.0			
RichmondPRA + Ostara	Disability Employment Service	2.0				2.0	
Schizophrenia Fellowship	Disability Employment Service	2.0				2.0	
Total		6.0					
Rate per 100,000 residents (>17 years old)		0.55					
Neami National	Way2Home	18.3				18.3	
FACS	Eligibility and Assessment*	16.0					16.0
FACS	Eligibility and Assessment*	28.0					28.0
FACS	Eligibility and Assessment*	13.0					13.0

Provider	Name	Total FTE	nCCM	MHW	SF	SupW	Others
FACS	Sydney District Access & Demand Team*	17.0				17.0	
Total		92.3					
Rate per 100,000 residents (>17 years old)		8.43					
Total		136.9					
Rate per 100,000 residents (>17 years old)		12.51					

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

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

PARTNERS IN RECOVERY

Partners in Recovery (PIR) in the SLHD region is managed by New Horizons, while in SESLHD it was previously 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. Theoretically, the code of the PIR program should be an A4 (accessibility/care manager), but some organisations report that they are providing more intensive direct day care, so they received an outpatient code (O5.2). They can meet according to the needs of the consumer, with the capacity 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 specifically devoted to the CALD populations.

We identified 14 PIR BSIC in the CESPHN. The total number of PIR providers per 100,000 residents is 1.37.

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

Table 29. 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	5.3%	Rockdale	ES-SES
Aftercare	Partners in Recovery	AX[F00-F99]-O5.2	3.0	4.0%	Alexandria	SES
Aftercare	Partners in Recovery	AX[F00-F99]-O5.2	5.0	6.7%	Randwick	ES
Aftercare	Partners in Recovery	AX[F00-F99]-O5.2	6.0	8.0%	Randwick	ES
Aftercare	Partners in Recovery	AX[F00-F99]-A4	4.0	5.3%	Alexandria	IWS
Mission Australia	Partners in Recovery	AX[F00-F99]-A4	4.0	5.3%	Waterloo	IWS
Neami National	Partners in Recovery	AX[F00-F99]-O5.2	10.5	14.0%	Pagewood	ES
Neami National	Partners in Recovery	AX[F00-F99]-O5.2	5.0	6.7%	Hurtsville	SES
Neami National	Partners in Recovery	AX[F00-F99]-O5.2	5.0	6.7%	Darlinghurst	SV
Neami National	Partners in Recovery	AX[F00-F99]-O5.2	4.0	5.3%	Ashfield	IWS
New Horizons	Partners in Recovery	AX[F00-F99]-A4	4.0	5.3%	Marrickville	IWS
RichmondPRA	Partners in Recovery	AX[F00-F99]-A4	6.6	8.8%	Five Dock	IWS
Schizophrenia Fellowship	Partners in Recovery	AX[F00-F99]-A4	5.0	6.7%	Burwood	IWS
St George Mental Health Service	Rehabilitation team	AX[F00-F99]-O5.2	5.0	6.7%	Kogarah	SES
The Benevolent Society	Partners in Recovery	AX[F00-F99]-O5.2	4.0	5.3%	Hurtsville	SES
Total	15		75.1	100%		
Rate per 100,000 residents (>17 years old)	1.37		6.86			

FTE: Full-Time Equivalents

ABILITY LINKS

Ability Links is a program funded by FACS, but it does not provide care specifically for people with a 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, the service often works with people with mental illness. They have estimated that at least 70% of their 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). They provide care for people from 9 to 65 years old.

3.2.5. INFORMATION AND GUIDANCE

3.2.5.1. INFORMATION AND GUIDANCE SERVICES PROVIDED BY THE PUBLIC HEALTH SECTOR

We have identified 34 BSIC/services providing exclusively information and guidance for people with a lived experience of mental illness.

The total number of BSIC or services from the health sector providing information and guidance for people with a lived experience of mental illness is 0.27 per 100,000 residents.

Table 30. 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)		0.27			

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 0.64 FTEs per 100,000 residents.

Table 31. Information and guidance services provided by the public health sector: workforce capacity

Provider	Name	Total FTE	Psychol	MHN	OT	CCM
Eastern Suburbs Mental Health Service	Consumer Support	NA				
St Vincent's Mental Health Service	Triage Service	2.0				2.0
Sutherland Mental Health Service	Intake and assessment Service	5.0	2.0	2.0	1.0	
Total		7				
Rate per 100,000 residents (>17 years old)		0.64				

FTE: Full-Time Equivalents; Psychol: Psychologist; MHN: Mental health nurse; 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 4 BSIC/services, corresponding to 5 MTC, 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, Sutherland Council and the Inner Sydney Regional Council.

The number of BSICs from the NGO sector providing information and guidance for people with a lived experience of mental illness is 0.37 per 100,000 residents in the CESPHN.

Table 32. 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
Inner Sydney Regional Council	Information Services/ Tenant	AX[Z55-65]-I2.1.1		Waterloo	City of Sydney

Provider	Name	Main DESDE Code	Other DESDE code(s)	Town / Suburb	Area of Coverage
Mental Health Association	Information Services	GX[F00-F99]-I2.2	GX[F00-F99]-I2.1.2	Wooloomooloo	STATE
Sutherland Council	Information Services	GX[F00-F99]-I2.1.2		Sutherland	SES
Total		4			
Rate per 100,000 residents (>17 years old)		0.37			

3.2.6. SELF AND VOLUNTARY SUPPORT

3.2.6.1. SELF AND VOLUNTARY SUPPORT PROVIDED BY NGOS

We have found 5 BSIC/services based on volunteer staff providing care for people with a lived experience of mental illness.
They include the following:

- Hearing Voices Network, NSW that provides support groups on a monthly basis in Newtown, Chatswood, Woolloomooloo, Sutherland, Penrith, Newcastle, Campbelltown, Dapto, Bathurst, Goulburn, Queanbeyan, Taree, Deniliquin, Wollongong, Ulladulla, of which Newtown, Woolloomooloo and Sutherland are in the CESPHN.
- The Compeer friendship program, run by St Vincent de Paul Society, which aims to improve the quality of life of adults with a mental illness through one-to-one friendship with a caring volunteer;
- Wesley Mission –Lifeline (Sydney and Sutherland)
- Newtown Community Centre, which provides free counselling to people with psychosocial conditions (a service run by volunteers); and
- Schizophrenia Fellowship, which has a support group in Bondi Junction.

The total number of BSIC/services from the NGO sector providing self and voluntary support services in the CESPHN is 0.46 per 100,000 residents.

Table 33. Self and voluntary support provided by NGOs: availability

Provider	Name	Main DESDE Code	Town / Suburb	Area of Coverage
Hearing Voices	Groups	AX[F00-F99]-S1.3	Different locations	IWS and SES
Newtown Community Center	Counselling	AX[Z55-65]-S1.3	Newtown	IWS
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	ES and SES
Total		5		
Rate per 100,000 residents (>17 years old)		0.46		

3.3. AGE SPECIFIC POPULATIONS

3.3.1. TRANSITION TO ADULTHOOD

We identified 10 BSIC/services providing targeted care for populations with a lived experience of mental illness transitioning to adulthood. The total number of such BSIC per 100,000 residents (16-25) in the whole PHN amounts to 5.33. The total number of FTEs of professionals providing care for transition to adulthood in the CESPHN is 25.88 per 100,000 residents.

3.3.1.1. OUTPATIENT CARE PROVIDED BY THE PUBLIC SECTOR

Table 34. 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

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
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
SLHD Mental Health Service	Early Intervention Psychosis - Camperdown	TA[F20-29]-O6.1	4.9	Camperdown	IWS
SLHD Mental Health Service	Early Intervention Psychosis - Croydon	TA[F20-29]-O6.1	10.6	Croydon	IWS
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	10		48.55		
Rate per 100,000 residents 16-25 years old)	5.33		25.88		

FTE: Full Time Equivalents

3.3.1.2. OUTPATIENT CARE PROVIDED BY NGOS

Table 35. 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

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
New Horizons	Headspace	TA[F00-F99]-O9.1	7.6	Ashfield	IWS
University of Sydney	Headspace	TA[F00-F99]-O9.1	3.5	Camperdown	STATE
Total	4		25.3		
Rate per 100,000 residents 16-25 years old)	2.13		13.49		

FTE: Full Time Equivalents

3.3.2. SERVICES FOR OLDER PEOPLE

We identified 8 BSIC corresponding to 15 MTC and including 4 satellites, providing specific care for older people with a lived experience of mental illness. The total number of such MTC in the whole CESPHN was 6.84 (standardised per 100,000 residents aged 65 and above to maintain comparability): 1.71 per 100,000 residents for services providing residential care and 5.7 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 whole CESPHN amounts to 46.56 per 100,000 residents.

Three MTC providing residential care for older people have been identified. We found 6 BSIC providing non-acute mobile outpatient care for older adults in the CESPHN.

We have identified two specialist mental health services for older people (SMHSOP), provided by the community mental health services of the SLHD: one in the Canterbury team and the other in Camperdown. They provide outpatient (community) non-acute mobile care for people with a lived experience older than 64 years old. By contrast, in the SESLHD area, we have found 5 teams. It is worth mentioning the Euroa Team, which integrated continuity of mental health care for older people following a holistic approach, similar to the Psychogeriatric team at St Vincent.

Table 36. Services providing care for older people: availability, placement and workforce capacities

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

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-inpatient	OX[F00-F99]-R2		8*	7.0	Randwick	ES
SLHD Mental Health Service	SMHOP Canterbury	OX[F00-F99]-O6.1			NA	Campsie	IWS
SLHD Mental Health Service	SMHSOP Camperdown	OX[F00-F99]-O6.1			NA	Camperdown	IWS
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	Psychogeariatric team - Elisabeth Lodge aged care facility (satellite)	OX[F00-F99]-O9.1t			NA	Rushcutters Bay	SV
St Vincent's Mental Health Service	Psychogeariatric team - Gertrude Abbott aged care facility (satellite)	OX[F00-F99]-O9.1t			NA	Surry Hills	SV
St Vincent's Mental Health Service	Psychogeariatric team - Lulworth aged care facility (satellite)	OX[F00-F99]-O9.1t			NA	Elizabeth Bay	SV
St Vincent's Mental Health Service	Psychogeariatric team - Presbiterian aged care facility (satellite)	OX[F00-F99]-O9.1t			NA	Paddington	SV
St Vincent's Mental Health Service	Psychogeariatric 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	12			22	81.7		
Rate per 100,000 residents >64 years old)	6.84			12.54	46.56		

*FTE: Full Time Equivalents; NA: Not available at the time of completion of the study; * 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 NGO funded BSIC, corresponding to 4 MTC, providing specific care based on gender.

3.4.1.1. RESIDENTIAL CARE PROVIDED BY NGOS

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

Table 37. 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		9.0		
Rate per 100,000 residents (women >17 years old)	0.18		1.61		

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 38. 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 Cost, Illawhora

Provider	Name	Main DESDE Code	Beds/Places	FTE	Town / Suburb	Area of Coverage
Total	1		30	2.0		
Rate per 100,000 residents (women >17 years old)	0.18		5.38	0.36		

FTE: Full Time Equivalents

3.4.1.3. OUTPATIENT CARE PROVIDED BY NGOS

The B-Miles Outreach Support Services also covers the area of Greater Sydney. It supports women who are already housed and require tenancy support, assistance to access resources and support to maintain their living arrangements. They provide in-home support or support 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).

Table 39. 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	Edgecliff	Ashfield, Leichardt, Marrickville, City of Sydney
Total	1			3.0		
Rate per 100,000 residents (women >17 years old)	0.18			0.54		

FTE: Full Time Equivalents

3.4.2. SERVICES FOR CARERS

We have identified 6 BSIC providing care for carers of people with a lived experience of mental illness. They are all provided by NGOs. All of them, except one, are managed by Schizophrenia Fellowship: two out of them provide non-mobile non-acute outpatient support related to the social needs of the carers, while the other three are support groups run by volunteers in different locations across the SLHD region. Carer Assist, one of the non-mobile non-acute outpatient services, has it main office in Bankstown, although they may use their office in Burwood if needed. To avoid problems related to geographical accessibility they rely on telephone visits and e-mail communication. An additional service is managed by Aftercare.

The total number of BSIC/services providing care for carers of people with a lived experience of mental illness is 0.55 per 100,000 residents. The total number of FTEs of professionals providing care for carers in the whole CESPHN is 0.60 per 100,000 residents.

Table 40. 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
Schizophrenia Fellowship	Carer Assist	AX[e310][F00-F99]-O9.2e	2.0	Bankstown	Greater Sydney
Schizophrenia Fellowship	Educational groups	AX[e310][F00-F99]-O9.2	0.6	Gladesville	Greater Sydney
Schizophrenia Fellowship	Support Group	AX[F00-F99]-S1.3	NA	Balmain	IWS
Schizophrenia Fellowship	Support Group	AX[e310][F00-F99]-S1.3	NA	Burwood	IWS
Schizophrenia Fellowship	Support Group	AX[e310][F00-F99]-S1.3	NA	Inner West	IWS
Total	6		6.6		
Rate per 100,000 residents >17 years old)	0.55		0.60		

FTE: Full Time Equivalents

3.4.3. SERVICES FOR PARENTS WITH A LIVED EXPERIENCE OF MENTAL ILLNESS

We identified 3 BSIC or services providing care for parents with mental illness. **There are 0.27 BSICs per 100,000 residents. The total number of FTE professionals providing care for parents with mental illness in the whole PHN amounts to 0.48 per 100,000 residents.**

Table 41. Services for parents with mental illnesses: 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)	0.27		0.48		

FTE: Full Time Equivalents

3.4.4. SERVICES FOR OFFENDERS

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

The Forensic Mental Health Service (FMHS) component of this network, comprises the state-wide Community and Court Liaison Service (SCCLS), Community Correctional Mental Health Service (CCMHS) and Community Forensic Mental Health Service (CFMHS) and works closely with the Forensic and Long Bay Hospitals. Together these services provide comprehensive mental health care to people who come into contact with the NSW criminal justice system or are at an increased risk of such contact (http://www.justicehealth.nsw.gov.au/our-services/forensic-mental-health-youth-services).

Although The Forensic Mental Health Service is a state-wide service, it has been included in this Atlas as it has some of its key components geographically are located within the CESPHN boundaries. These components include the Forensic Mental Hospital and the Long Bay Hospitals at Malabar. The Forensic Hospital is a 135 bed, stand-alone high secure mental health facility. The hospital provides specialist mental health care for mentally ill patients who have been in contact with the criminal justice system and high risk civil patients. The patient demographic consists of those found not guilty by reason of mental illness, those unfit to plead, mentally disordered offenders or those at risk of offending. The Units in the Hospital cater for adults and young people, both male and female. The hospital has six units, with care being provided on

each unit by three care teams. Unfortunately FTE data for these units was not available at the time of Atlas publication.

In addition to the Forensic Hospital, the Forensic Mental Health Service SCCLS also provides non-acute non-mobile outpatient care which operates from local courts across the state.

The number of BSIC/services providing outpatient care for offenders per 100,000 residents is 0.73.

Table 42. 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 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			214			
Rate per 100,000 residents >17 years old)	0.73			19.55			

FTE: Full Time Equivalents

3.4.5. MULTICULTURAL SERVICES

We identified 6 BSIC, corresponding to 7 MTC, providing services to people from a multicultural and linguistically diverse background with a lived experience of mental illness in the CESPHN. These include Jewish House, JewishCare, Bilingual Mental Health Counselling Services (located at the Prince of Wales Hospital and St George Community Mental Health Centre) and a Greek support group for people with a lived experience of mental illness. Additional multicultural services are also provided with the PIR program.

JewishCare runs a Mental Health and Wellbeing Program that provides two MTC to consumers with a lived experience of mental illness. The MTC include an accessibility service and a day program. The program is based in Woollahra however staff from JewishCare can travel to meet with individuals in the community and they provide services in a satellite office on the North Shore and in Headspace at Bondi Junction. The Mental Health and Wellbeing Program provides short and long term care coordination for adult consumers with a lived experience of mental illness. Care coordination can involve individual assessments, referrals and linkages to appropriate services, assistance with developing independent living skills, advocacy and provision of information. In addition to individual support the team also works with families, groups and the community as a whole. Social inclusion groups run from the Woollahra centre and in the local community on a weekly basis. Anyone can be referred to JewishCare's Mental Health and Wellbeing Team. The majority of consumers however have an affiliation with the Jewish faith.
The second BSIC is provided by Jewish House. Jewish House is located in Bondi. The service runs a 24 hour crisis line which is open to all members of the public and an individual psychiatry and psychology services.

The Schizophrenia Fellowship has a support group for people with a lived experience and Greek background in Newtown.

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

The total number of BSIC providing multicultural services for people with a lived experience of mental illness is 0.55 per 100,000 residents.

Table 43. 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
Schizophrenia Fellowship	Greek-speaking group Mental Health Support	AX[F00-F99]-S1.3		NA	Newtown	IWS
St. George Community Mental Health Service	Bilingual health workers	GX[F00-F99]-O7.1		3.6	Caringbah	SES
Total	6			19.2		
Rate per 100,000 residents >17 years old)	0.55			1.75		

FTE: Full Time Equivalents

3.4.6. SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

We have identified 5 BSIC providing services for Aboriginal and Torres Strait Islander people with a lived experience of mental illness.

Two BSIC are managed by the SLHD (the Community Mental Health Service provides inreach to the Aboriginal Mental Health Unit which has been coded as a satellite service). The two BSIC are staffed by 0.4 FTE Psychiatrist, 2.0 FTE Aboriginal Mental Health Workers, and 1.0 FTE Clinical Nurse Consultant.

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 total number of BSIC/services providing specific care for Aboriginal and Torres Strait Islander people with a lived experience of mental illness is 0.18 per 100,000 residents in the CESPHN (Aboriginal and Torres Strait Islander people represent 0.8% of the population of the CESPHN).

Table 44. Specific services for Aboriginal and Torres Strait Islander Peoples: availability and workforce capacity

Provider	Name	Main DESDE Code	FTE	Town / Suburb	Area of Coverage
AMS & SLHD Community Mental Health Service	Psychiatric clinical supervision	GX[IN][F00-F99]-O6.1	0.2	Redfern	SLHD
Eastern Suburbs Mental Health Service	Aboriginal support workers	GX[IN][F00-F99]-O7.1	1.0	La Perouse	ES
SLHD Mental Health Service	Aboriginal mental health unit (satellite)	GX[IN][F00-F99]-O10.1t	3.2	Redfern	Camperdown, Redfern
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	Hurtsville	SES
Total	5		7.4		
Rate per 100,000 residents >17 years old)	0.46		0.68		

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.

In spite of this, it may be worth mentioning "Common Ground" (Mission Australia, Camperdown). This is a crisis accommodation facility with approximately 104 units. It is also known as The Camperdown Project and it provides 24/7 support for people with high risk of becoming homeless and who have previously experienced homelessness (i.e. low wage people) instead of those with a lived experience of mental illness. There is no time restriction, and it is provided at the own home of the consumers. This means that they can drink, or smoke, if they desire to, or have a pet. There is overnight security. Professionals from the Community Mental

Health Team at the SLHD visit some of the residents on a regular basis (please refer to the Pathways to Housing Project for more information).

3.4.8. ALCOHOL AND OTHER DRUG SERVICES

Although the use of Alcohol and Other Drugs (AOD) services have not been mapped in this atlas. A separated coding and mapping of these services is required to fully understand the mental health delivery system of the region. can be considered a mental health issue, its complexity requires a detailed and separate analysis. As an example "We Help Ourselves" (WHOs) is a not for profit organisation that supports people with alcohol and other drugs related problems, taking also special care of the mental health needs of their consumers. WHOs provides different residential-based programs, based in Rozelle (Sydney), such as New Beginnings (a drug-free residential program for women), Gunyah (a drug-free residential program for men), OSTAR (an opioid substitution to abstinence residential program), RTOD (a residential treatment for stabilisation of opioid dependence). In addition WHOs provides transitional programs, community-based programs, and also has some properties in the community to support transition from the facility to living in the community.

4. MAPPING THE MENTAL HEALTH SERVICES

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

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

Figure 23. Geographical distribution of high risk of psychological distress and residential services

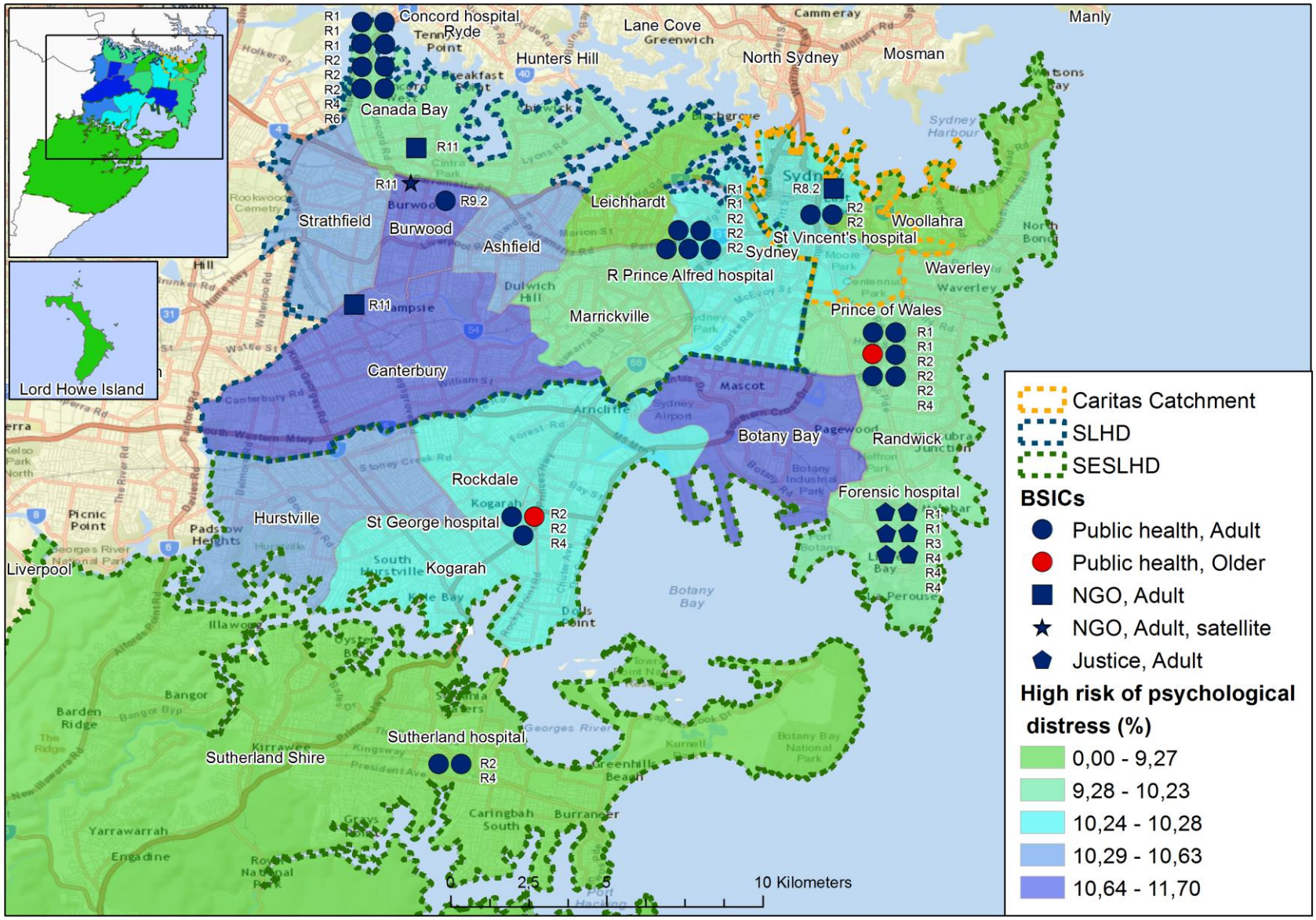


Figure 24. Geographical distribution of population density and day program services

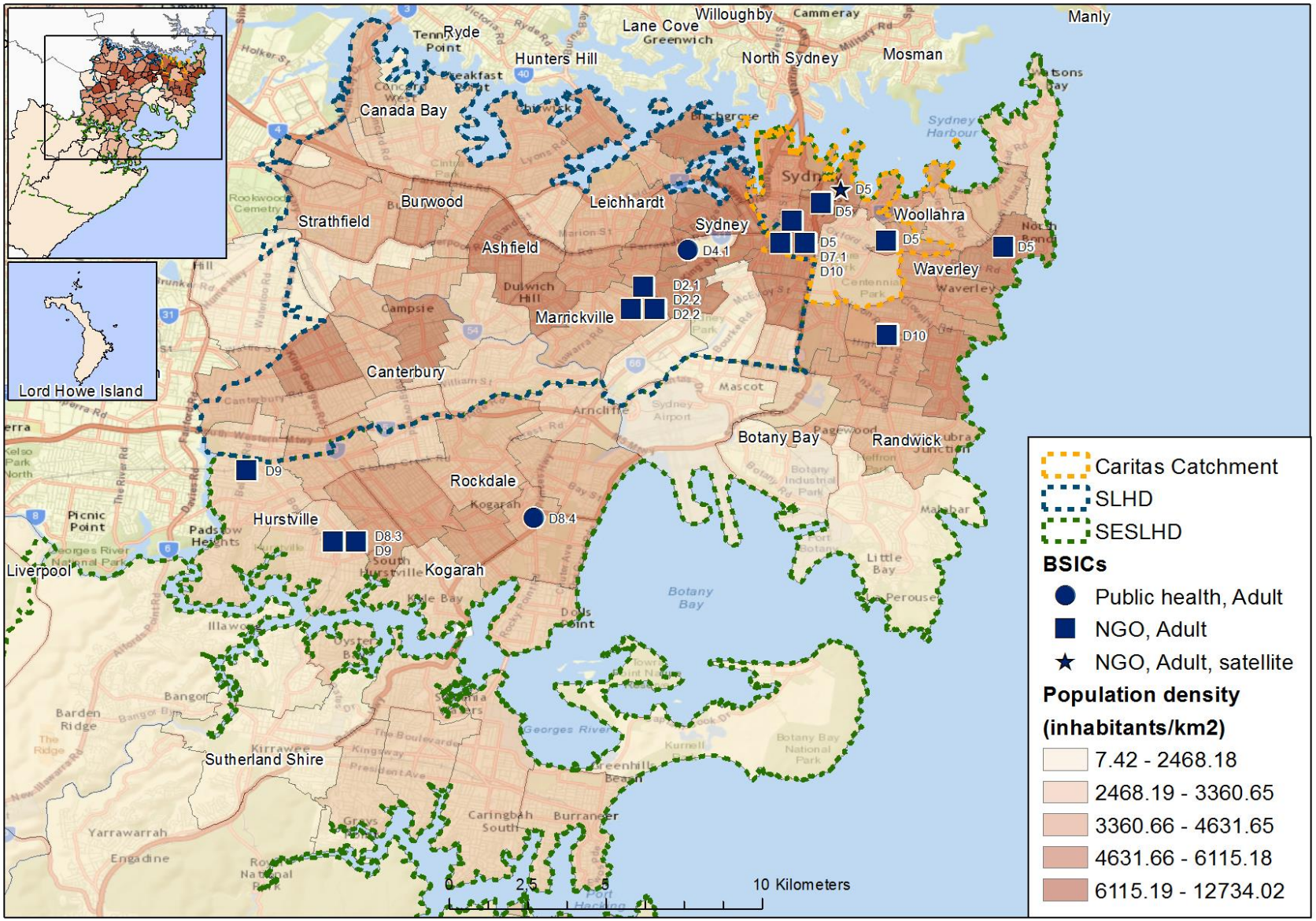


Figure 25. Geographical distribution of high risk of psychological distress and outpatient non-mobile services

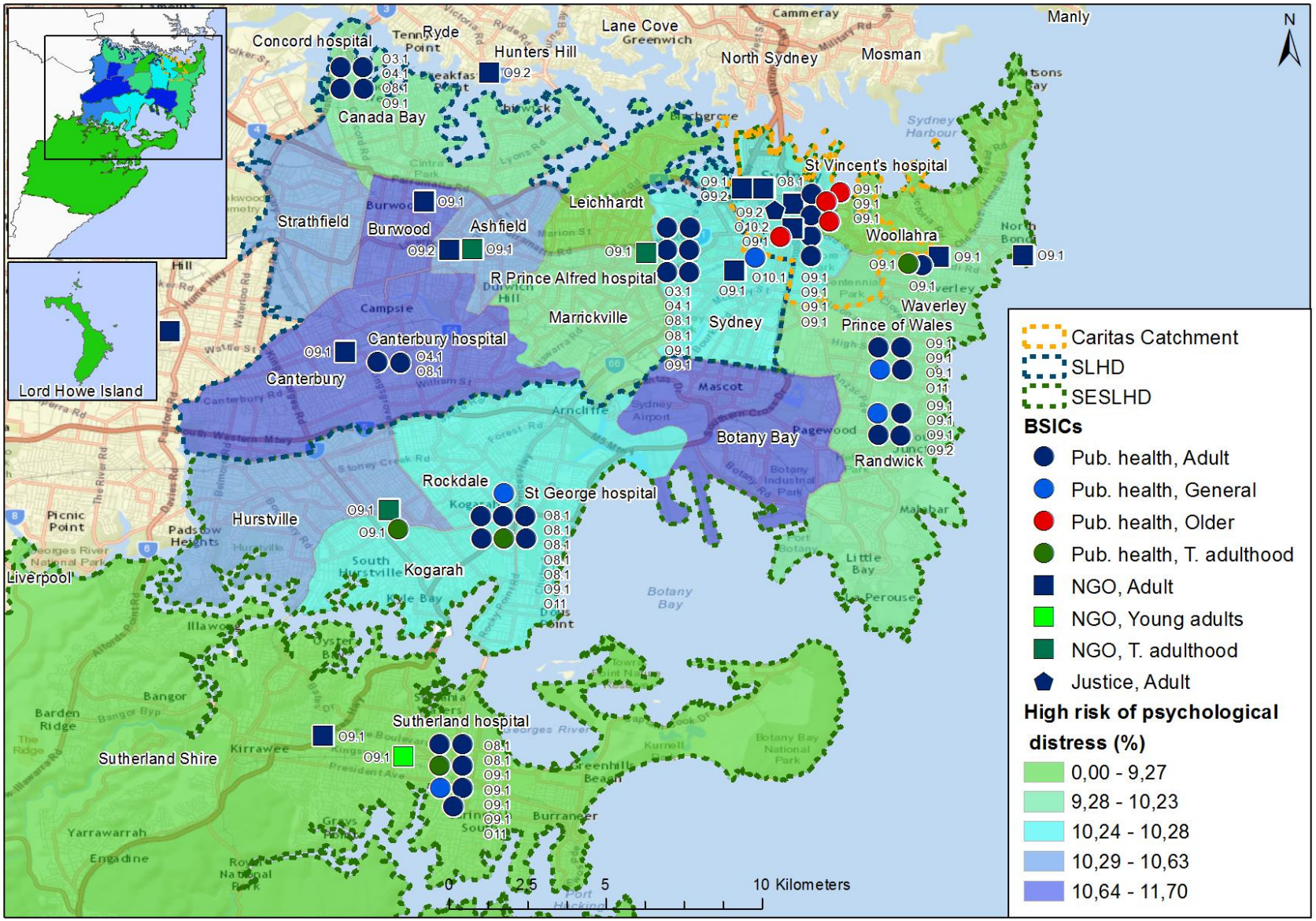
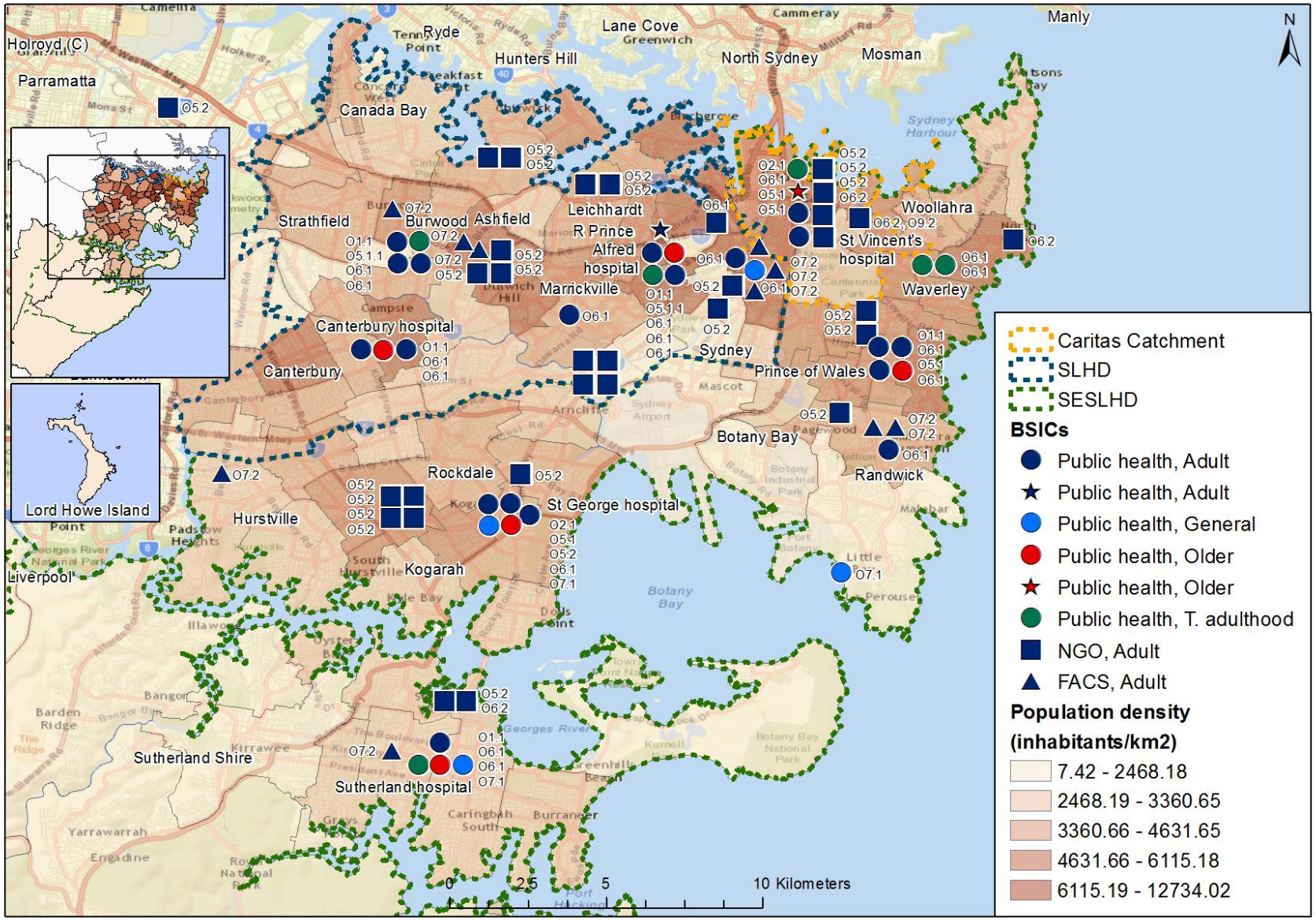


Figure 26. Geographical distribution of population density and outpatient mobile services



5. DESCRIPTION OF THE PATTERN OF CARE

The figure below depicts the pattern of adult mental health care in the CESPHN. 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:

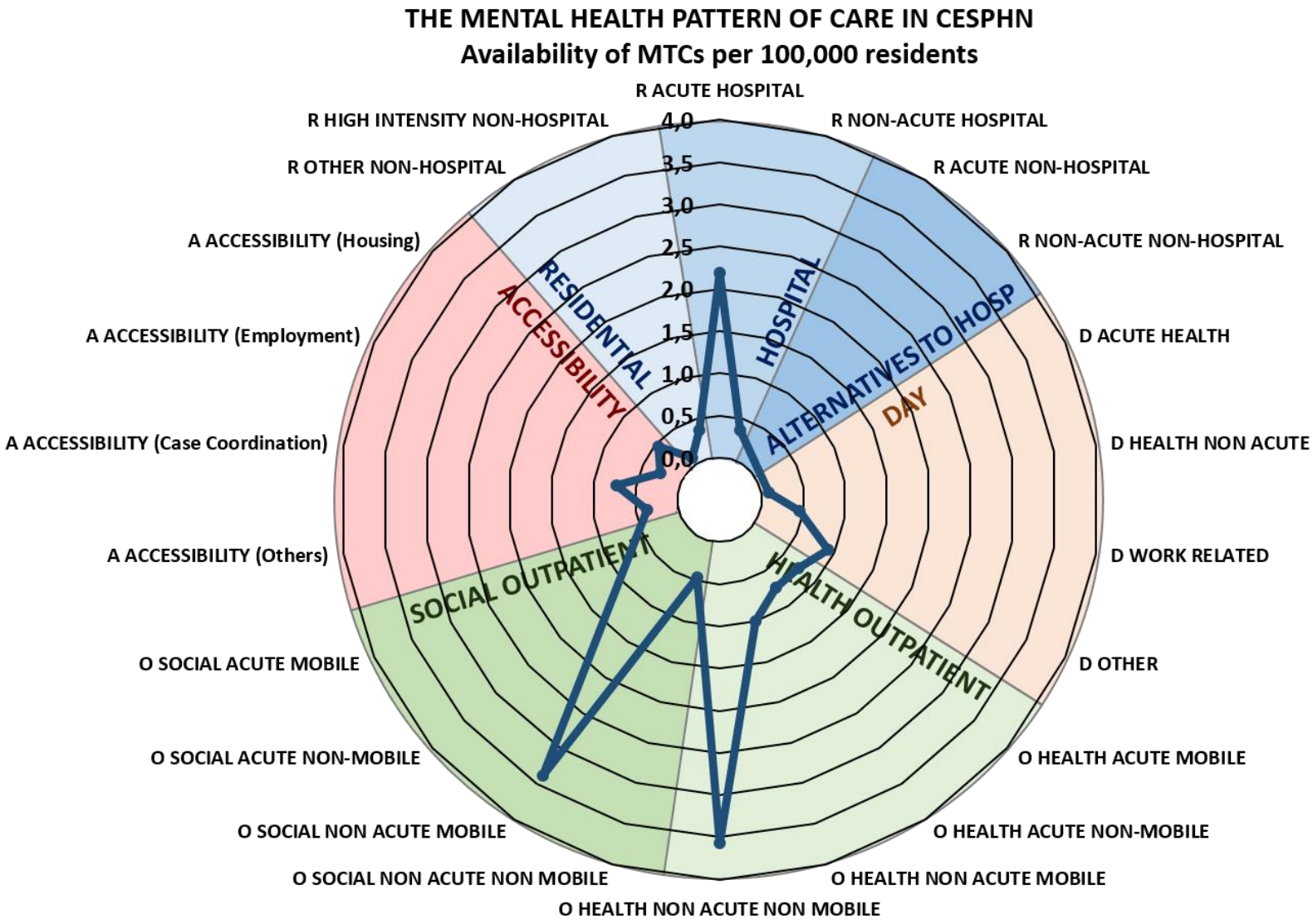
- Non-hospital acute and sub-acute care
- Lack of medium or long-term accommodation for people with mental illness
- Acute and non-acute health-related day care

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 into the community. These are small units, with a strong focus on recovery (e.g. crisis homes). The second gap is related to the lack of supported accommodation for people with mental illness. This has already been pointed out by other Sydney Atlases and it is one of the major strategic areas for PIR IWS. The third gap refers to a lack of day care related to mental health. Acute care related to mental health services that provides an alternative to hospitalisation. People experiencing a mental health crisis are not admitted in 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 include day care centres staffed with at least 20% 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 programs related to cultural and leisure activities; however, this is partially met by the “Active Linking Initiative” and the presence of Buckingham House and Lou`s Place in the boundaries between SESLHD and the SLHD.

On the other hand, there is good development of mobile services, both acute and non-acute, managed by the SLHD and SESLHD. We have also identified new services targeting, specifically, the physical health of people with a lived experience, such as the metabolic clinics, the Sunflower Health services by Schizophrenia Fellowship and the Keeping the Body in Mind Program. In addition there are several specific programs for target groups as well as local peer support programs (eg in the SESLHD).

Lastly, contrasting with other areas, there is a higher availability of services related to employment, mainly explained by the presence of three social firms in the area managed by RichmondPRA.

Figure 27. The pattern of mental health care in the CESPHN

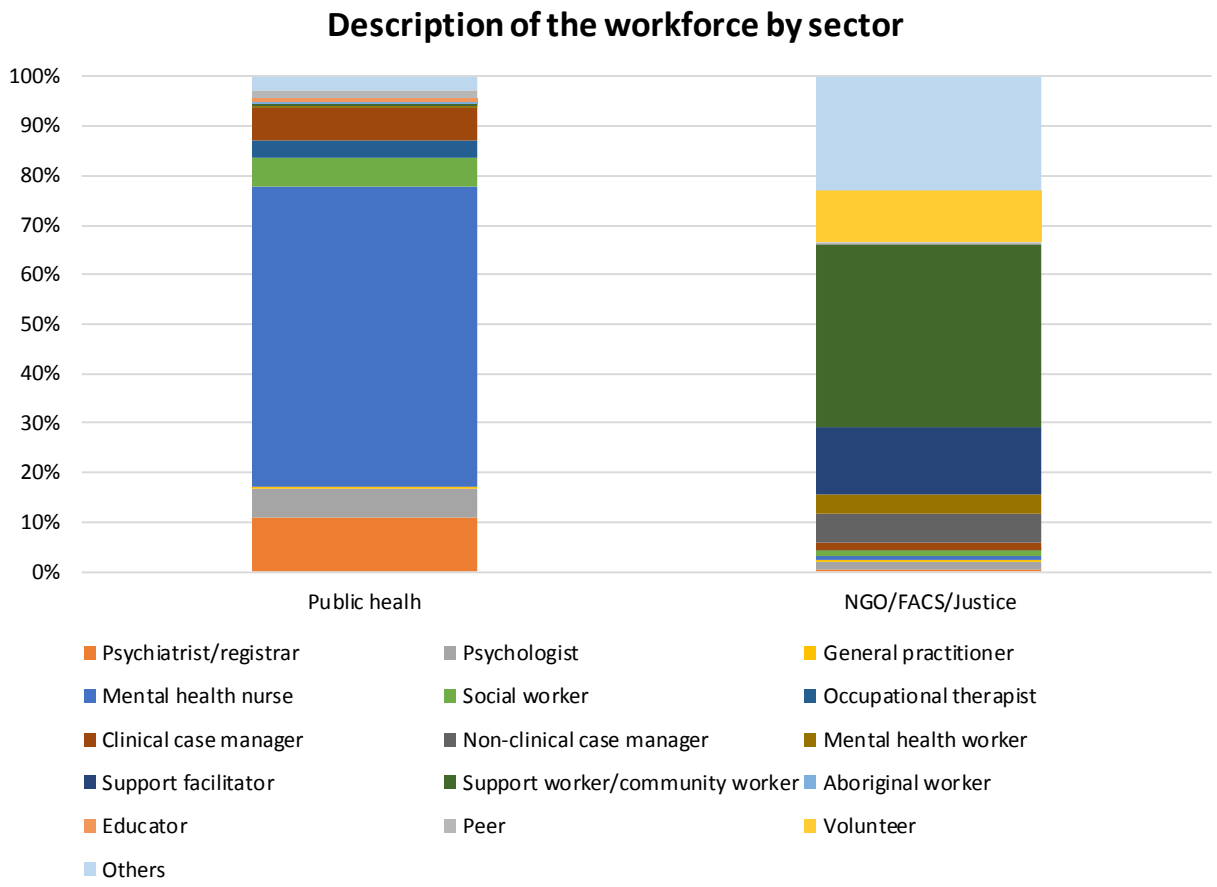


In this section we present an overview of the workforce capacity in the CESPHN. This data has to be interpreted with caution as we did not get any response from some service providers. In addition, the different terminology used by the providers complicates the analysis (e.g. support facilitator, non-clinical 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 CESPHN is around 83.71 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 CESPHN amounts to 41.68.

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

Figure 28. Description of the workforce by sector



The two figures below compare the mental health pattern of care between the CESPHN and South Western Sydney LHD, and between the CESPHN and Western Sydney LHD. The CESPHN has a larger availability of acute inpatient care, when compared with both South Western Sydney and Western Sydney. When looked at in detail, the acute units in IWS are smaller, but the number of beds per 100,000 residents is higher, than in the other areas as demonstrated in the figure below. To fully analyse placement capacity in the CESPHN it is important to take into account the high number of patients coming from outside this region. This is particularly the case in the IWS and SVHN areas. It will require the combined analysis of service availability, placement capacity and service utilisation data.

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

Outpatient/community services (acute and non-acute) in the CESPHN have a higher mobility than in South Western Sydney and Western Sydney, which are more office and telephone based.

In addition, SESLHD and SLHD have innovative services targeting the physical health needs of people with a lived experience, which were not found in Western Sydney and South Western Sydney.

With regard to accessibility-related services, the main difference is related to coding issues: in 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. 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 South Western Sydney and Western Sydney than in the CESPHN. 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.

Figure 29. Number of beds in the CESPHN vs. South Western and Western Sydney (Adults)

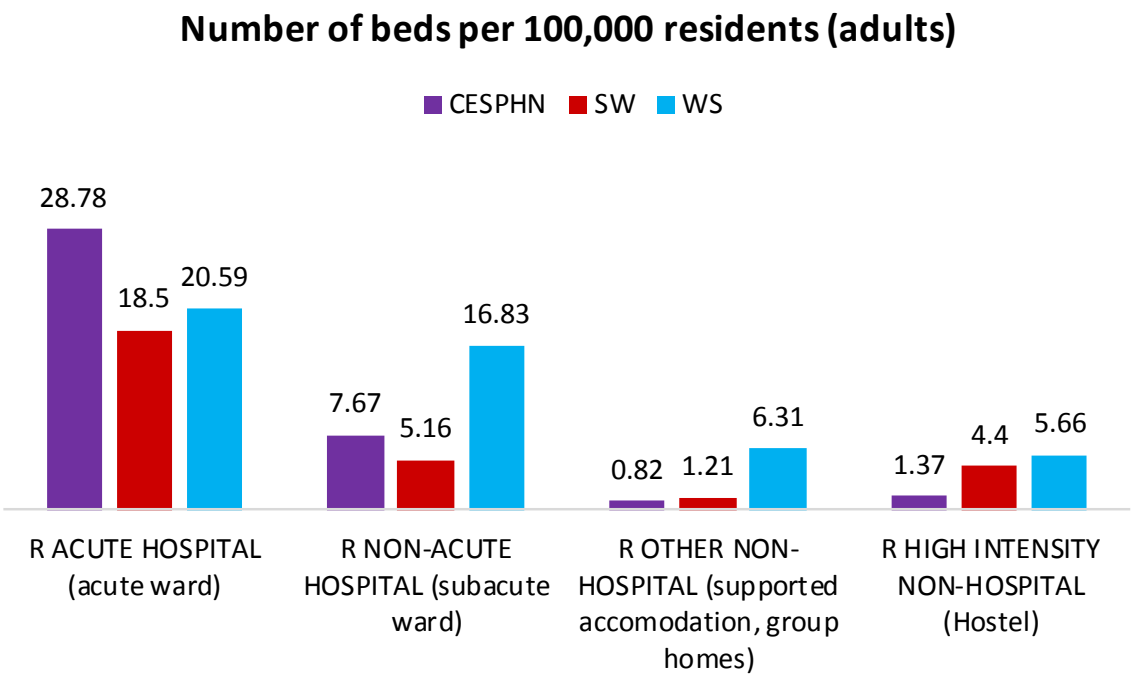


Figure 30. Pattern of mental health care in SLHD (purple line) and in SESLHD (blue line)

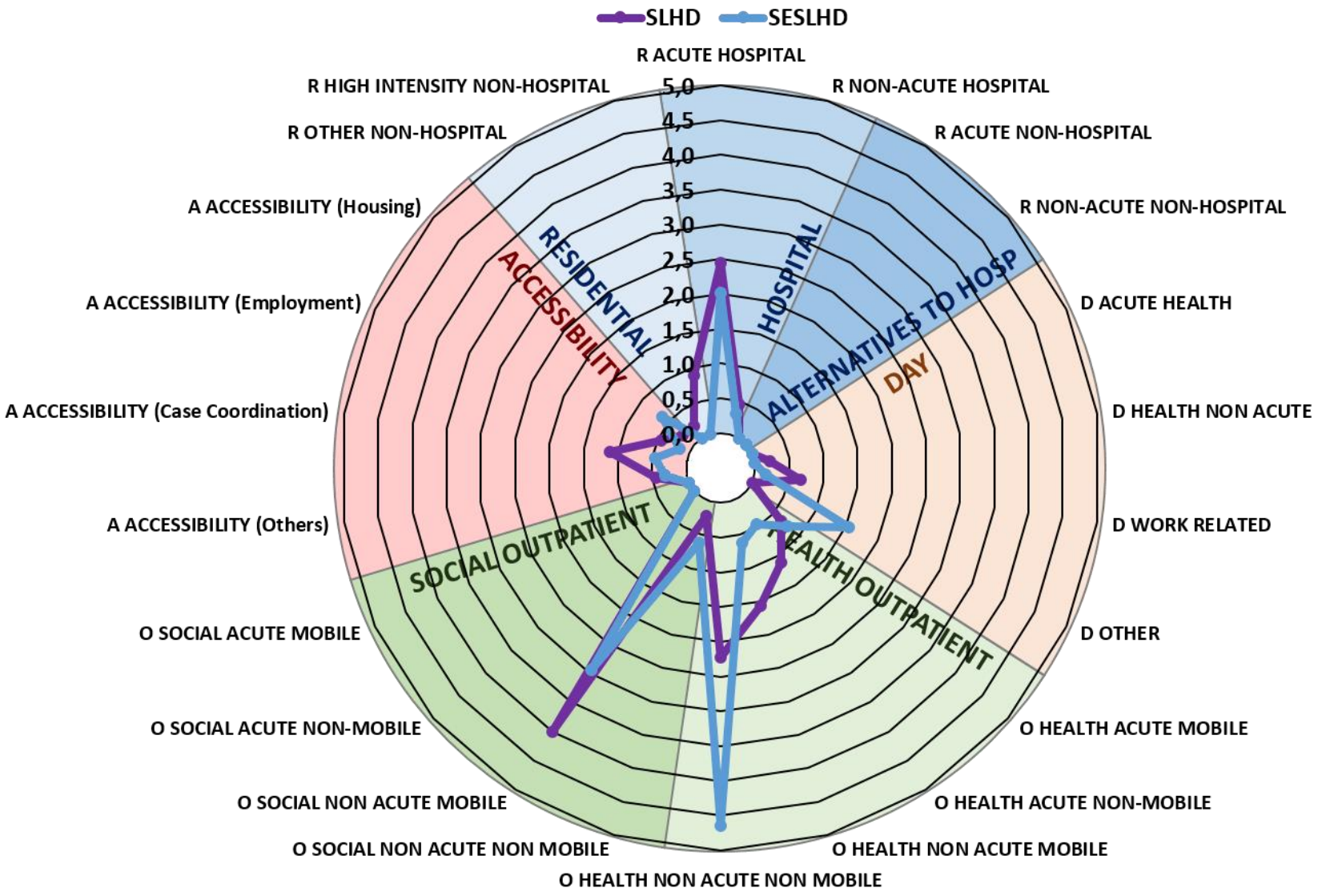


Figure 31. Pattern of mental health care in the CESPHN (blue line) and in South Western Sydney (orange line)

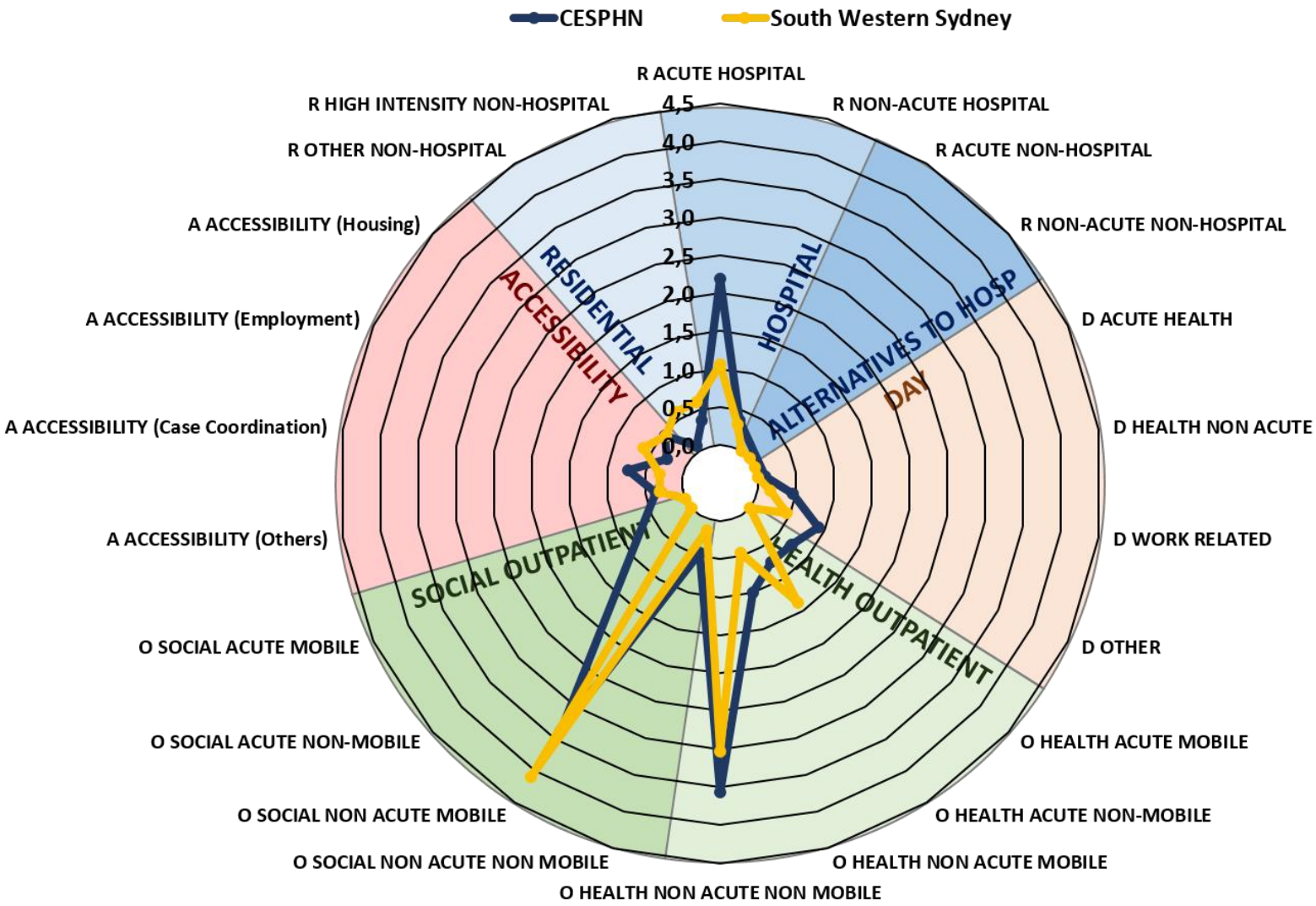
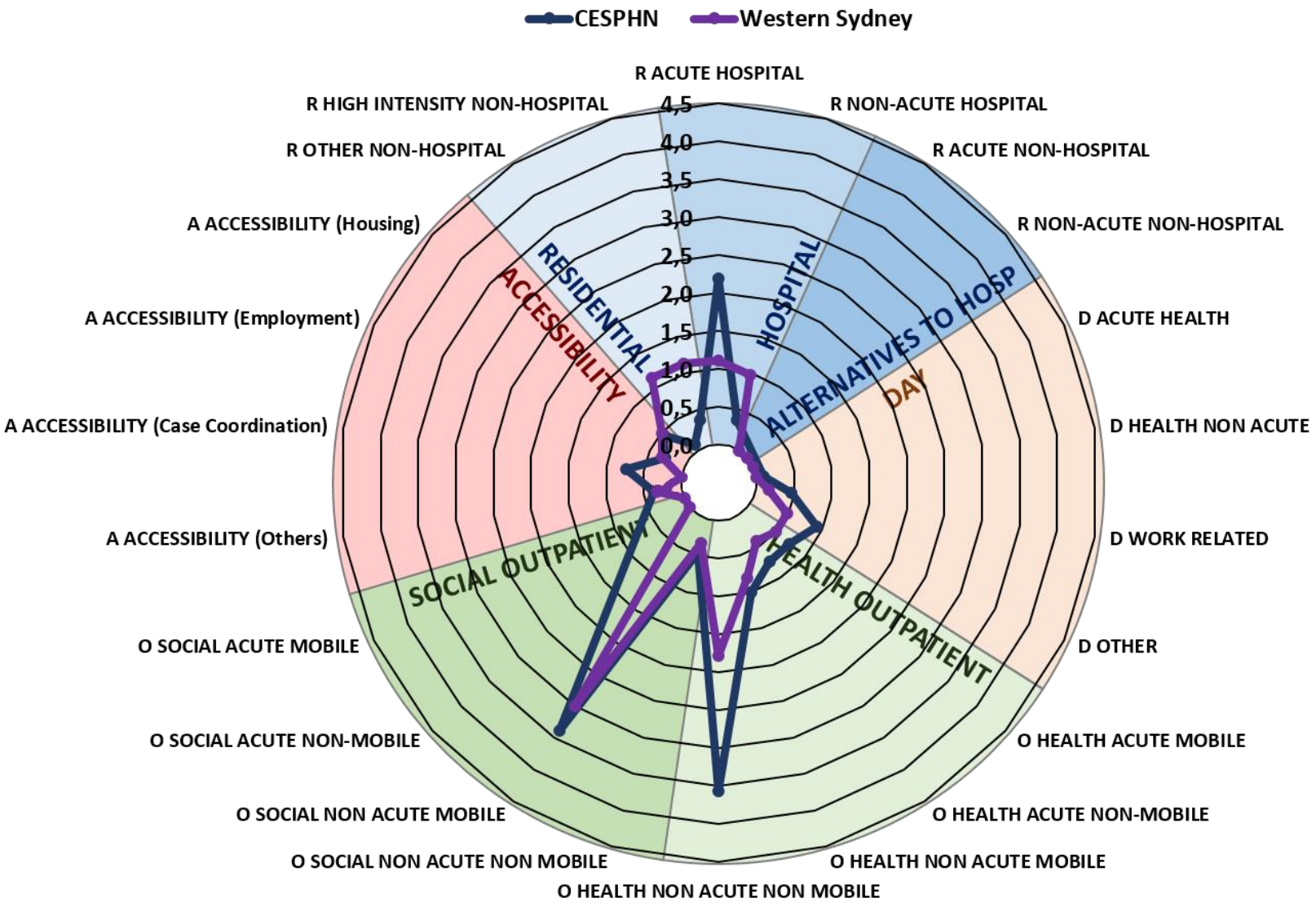


Figure 32. Pattern of mental health care in the CESPHN (blue line) and in Western Sydney (purple line)



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 (45). In the absence of a gold standard for planning the provision of mental health services, international comparisons may also be useful for asking questions that are taken for granted.

To conduct meaningful comparisons, it is important to use a standardised tool that goes beyond terminological variability. We have mapped the pattern of mental health in different European areas using the DESDE-LTC. The use of a common language allows us to compare the CESPHN 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 (34).

Table 45. 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)	Hampshire1 (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)

1 Including Portsmouth and Southampton Unitary Authorities.

	Sør-Trøndelag (Norway)	Helsinki and Uusimaa Hospital District (Finland)	ULSS20 - Verona (Italy)	Girona (Spain)	Hampshire1 (England)
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 HEALTH CARE MODEL

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

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

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

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

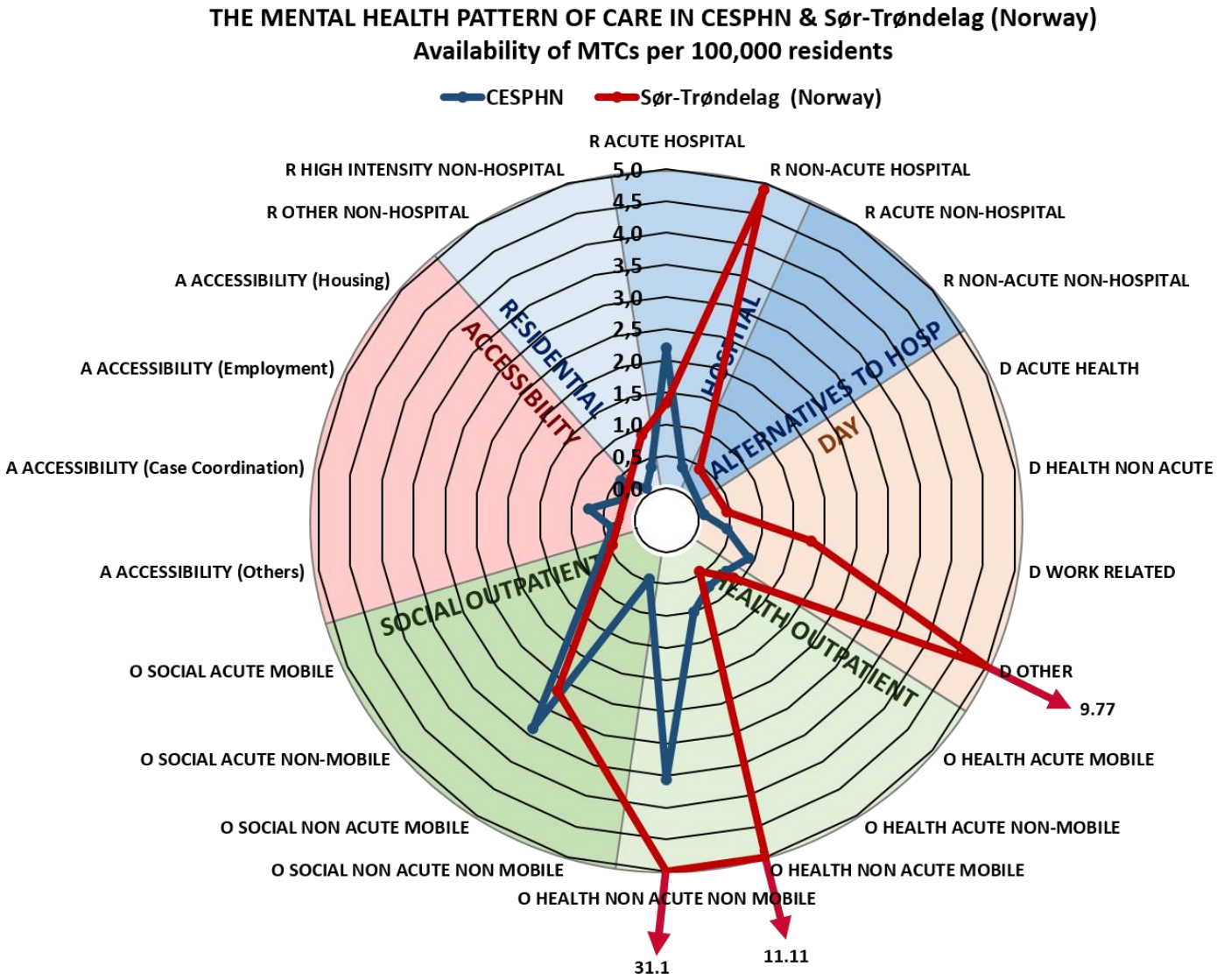
The main difference with the CESPHN is related to the high availability of non-acute care at the hospital, day programs related to employment and social and cultural issues, and outpatient non-acute care, both mobile and non-mobile. The addition of the ATAPS providers, however, would reduce the difference 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 universal accessible services as a municipal activity, or to purchase the services from an external provider. Primary care is organised by the municipalities, and represents the main access point for people with mental illness while specialised care is organised by the hospital districts.

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

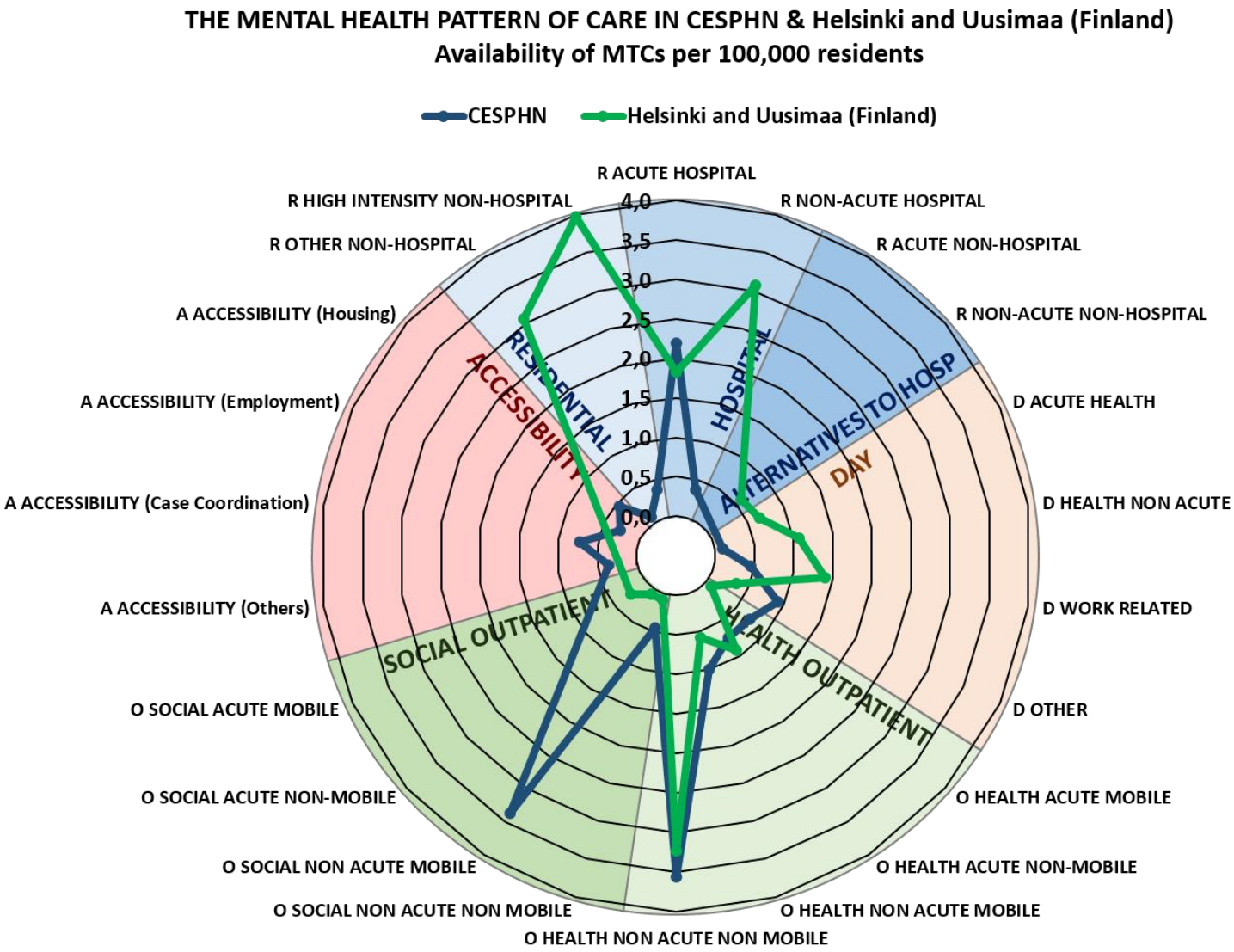
When comparing the CESPHN and the Finnish area, the main contrast is the high number of residential and day care/programs in Finland, as well as the high availability of non-acute inpatient care.

Figure 33. Pattern of mental health care in the CESPHN (blue line) and Sør-Trøndelag –Norway (red line)



Accessibility care was not coded in the European areas

Figure 34. Pattern of mental health care in the CESPHN (blue line) and Helsinki and Uusimaa – Finland (green line)



Accessibility care was not coded in the European areas

6.2. SOUTHERN EUROPE MODEL OF MENTAL HEALTH CARE

The figures below compare the CESPHN 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.

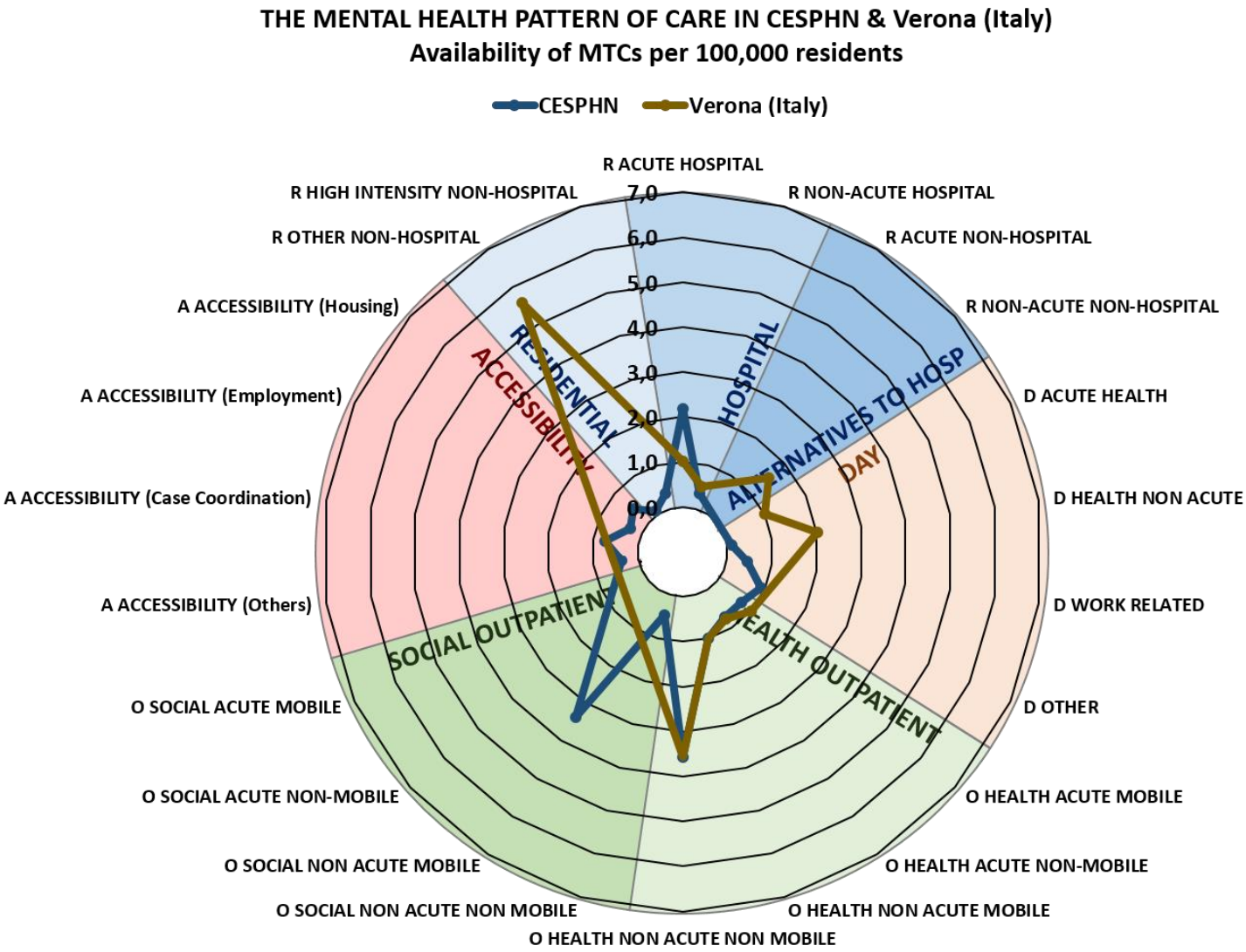
In Italy, the Local Health Authorities, which are the local branches of the Regional National Health System, are the purchasers of health care services. They also finance social care services together with the municipalities. There are 21 Local Health Authorities in the Veneto Region. Each Local Health 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.

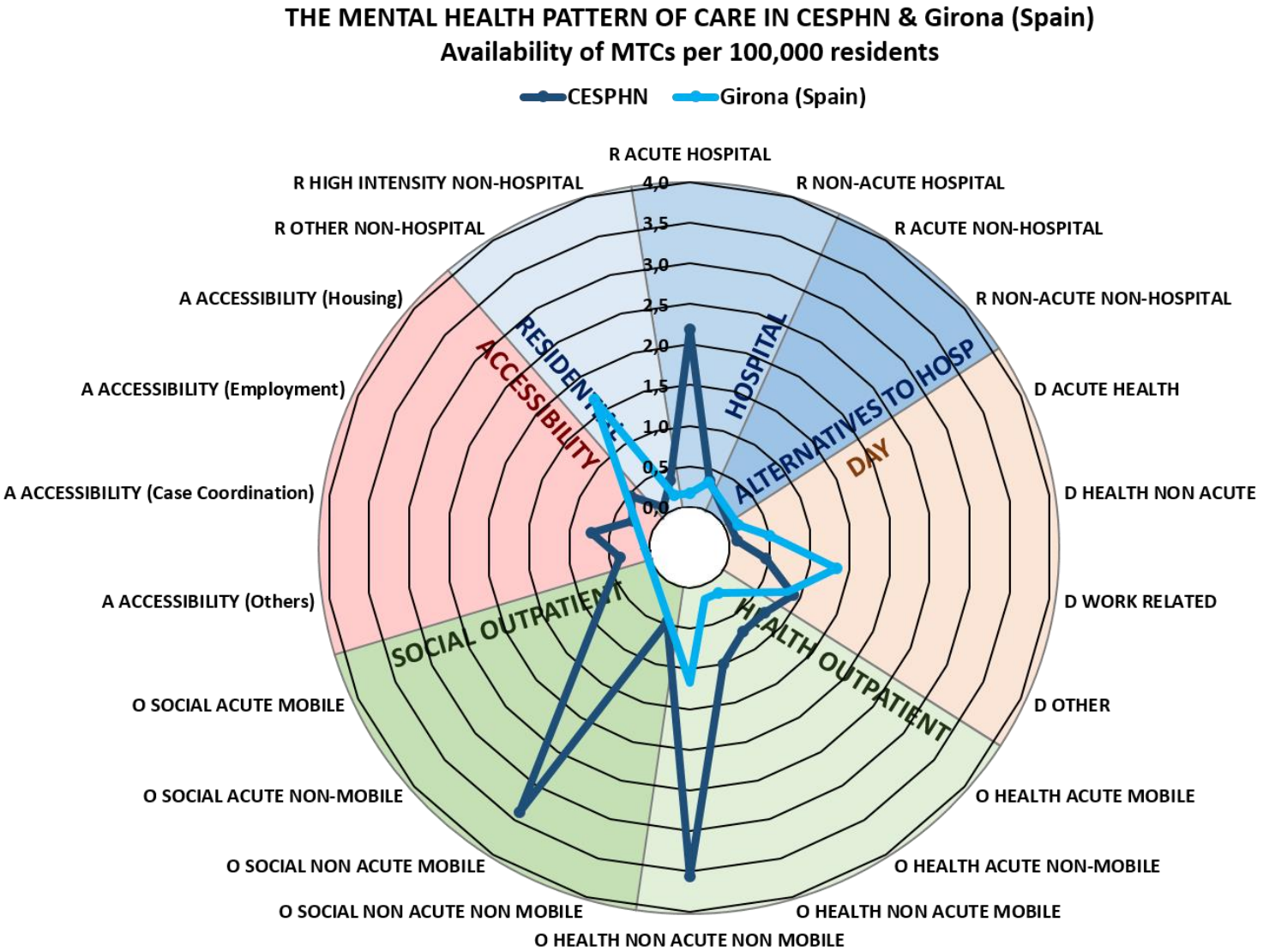
The area has high levels of unemployment, as well as high immigration rates. Both in Italy and Spain, the availability of acute hospital care is lower than in CESPHN area, while the non-acute hospital care is higher. On the other hand, the availability of day care/programs, specifically health related day care, is higher and so is specific public housing for people with a lived experience of mental illness.

Figure 35. Pattern of mental health care in the CESPHN (blue line) and Veneto- Italy (brown line)



Accessibility care was not coded in the European areas

Figure 36. Pattern of mental health care in the CESPHN (blue line) and Girona –Spain (light blue line)



Accessibility care was not coded in the European areas

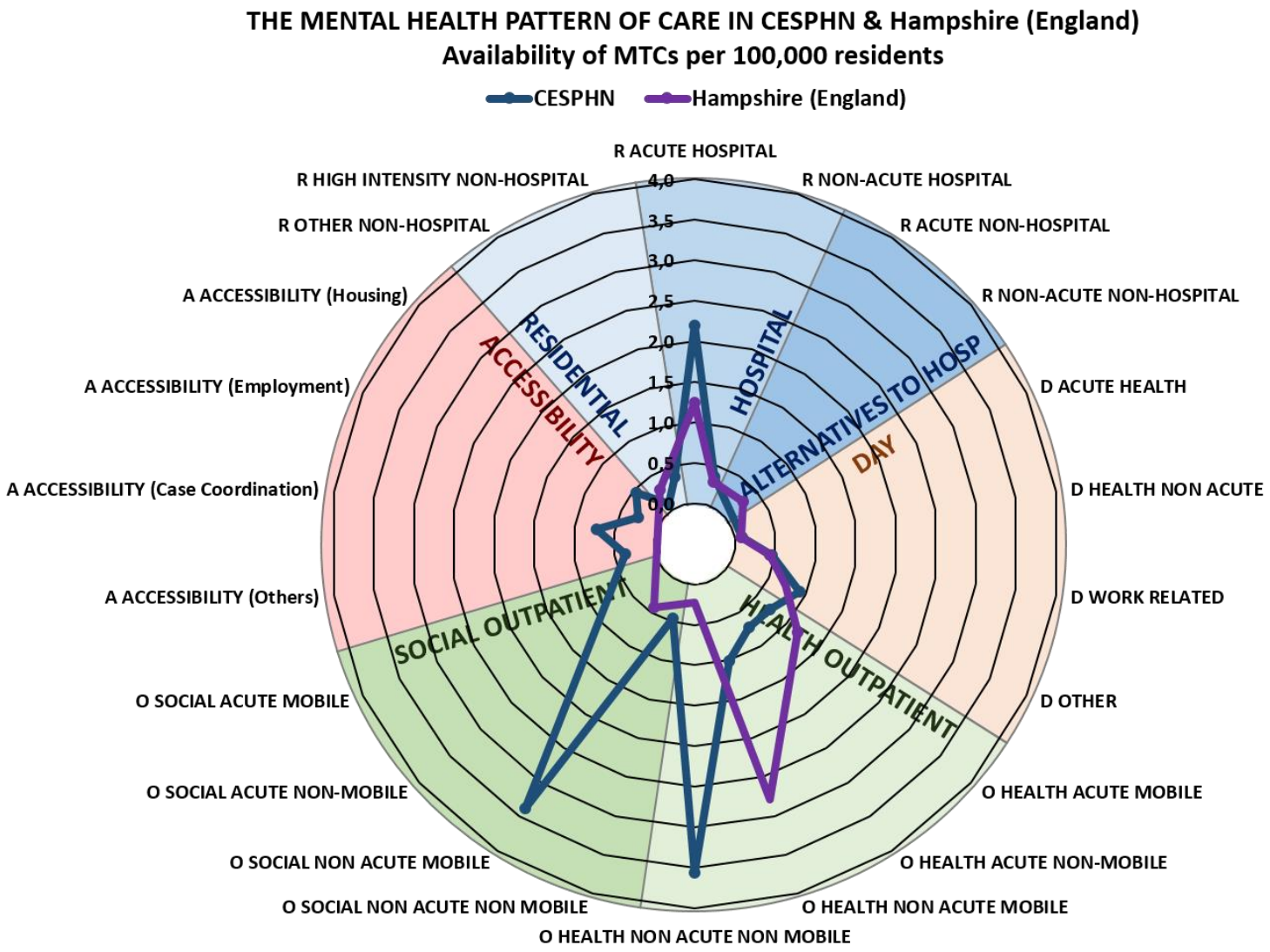
6.3. ENGLISH SYSTEM

Figure 37 compares the CESPHN 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/programs related to health and non-acute care in the hospital, similarly to what we have found in CESPHN.

Figure 37. Pattern of mental health care in the CESPHN (blue line) and Hampshire- England (purple line)



Accessibility care was not coded in the European areas

6.4. PLACEMENT CAPACITY- CROSS-NATIONAL COMPARISONS

6.4.1. RESIDENTIAL CARE

There are large differences across countries related to the availability of beds per 100,000 residents. These rates mirror the different models of mental health care. CESPHN has a higher rate of acute hospital beds than in well-known community-based mental health models such as those of Italy and Spain, but also more than in the Scandinavian countries. This may be explained by the fact that the SLHD also treats people from outside their boundaries (i.e. people who work but do not live there, and tourists and backpackers). The rate of non-acute beds in the hospital is similar to that in 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 CESPHN. In addition, there is a specific strategy to improve and monitor home care and support in the IWS district. 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 46. Cross-national comparisons- Placement capacity- beds per 100,000 residents according to type of residential care

Groups	CESPHN	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	36.5	28.4	26.9	14.0	7.0	26.4
R Non-acute hospital: R4 – R6	7.7	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	0.8	0.0	58.6	35.8	12.0	7.5
R non-hospital high intensity R8 R11	1.4	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 beds at the hospital, and places at day health acute and day health non acute centres. It is also important to develop work related centres, where people with a lived experience of mental illness can develop work related skills and be paid for their work. The day care sector is progressively disappearing from Central and Eastern Sydney (and New South Wales). This scenario is very similar to the English one, where day care has been substituted by individual care. Day care/programs are important as they 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. In IWS, we have found one health day care centre. However, it is specific for people with eating disorders and covers all of NSW.

Table 47. Cross-national comparisons- Placement capacity- beds per 100,000 residents according to type of day care/program

Groups	CESPHN	Sør-Trøndelag (Norway)	Helsinki and Uusimaa (Finland)	Verona (Italy)	Girona (Spain)	Hampshire (England)
D Health acute	0.0	0.0	9.6	3.1	4.2	0.0
D Health non-acute	0.0	0.0	18.0	40.7	12.5	0.0
D Work-related	NA	8.0	18.2	0.0	32.5	0.0
D Other	45.0	0.0	12.4	0.0	27.5	0.0

7. DISCUSSION

It is essential for PHNs to get a full understanding of the availability of services, service capacity (both placement and workforce), and the geolocation of these services to better analyse the region's accessibility to care according to needs. The CESPHN shows evaluation and planning challenges that probably exceed those of any other PHN in Australia, with the exception perhaps of North West Melbourne. It has a very complex organisational system with large social and demographic disparities as well as significant differences in service availability. These challenges coincide with an unprecedented analysis and monitoring of the mental health care system in this region, and with major reform of the mental health sector, the transition to the NDIS and the increasing role of the PHN in the organisation of local health care.

The Integrated Mental Health Atlas of the CESPHN provides information on all services specifically designed for people with a lived experience of mental illness in the CESPHN. It includes: Health, Social, Home, Education, Employment and Justice Services. The information provided in the Atlas should be complemented with other layers of information on generic services used by the target population, such as primary care and generic social services, fully

private care services (fee for service and private insurance provision), and services designed for other target groups where mental health plays a relevant role (for example, homelessness, AOD, Intellectual disabilities, Dementia).

This Atlas offers complementary information to that delivered by a series of documents and strategies recently developed in this region and in its local health districts. These include: the "Mental Health and Suicide Prevention Needs Assessment" of the CESPHN (May, 2016); the series of projects under the "Healthy Strong Communities" program of the SLHD; Community Based Alternatives to Housing in the SLHD (2015); the Pathways to Housing project in the SLHD; the Urban Partnership initiative led by St Vincent's Hospital; the PIR evaluations conducted in IWS, SES and ES, and related reports and strategies such as the SESLHD "Integrated care strategy Action Plan 2015-2018" and its "Mental health clinical services plan 2013-2018".

The structure of this discussion section begins firstly with an overview of the unique geographical, organisational and socio-economic features of the CESPHN. It then describes general features of health care delivery within the CESPHN and moves on to explore identified gaps and service initiatives within mental health specific services. Jurisdictional comparisons have been used to structure the discussion and to focus dialogue on the planning of equitable, sustainable and effective mental health system within the boundaries of the CESPHN. Mental health specific services have been examined within secondary and tertiary levels of the stepped care model.

7.1. GEOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS OF THE CESPHN

The CESPHN has a number of unique characteristics that clearly differentiate this PHN from other PHNs in metropolitan Sydney. The CESPHN is the second most populated of the 31 primary health networks across Australia, with more than 1.4 million residents. One of the key characteristics of the CESPHN is that of population density. The City of Sydney, Ultimo, Pyrmont, Surry Hills and Potts Point are all classified at the Statistical area 1 (SA1) level. This indicates that these suburbs have high population density which, in part, is associated with large numbers of high-rise apartments.. 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 (49) and on the mortality rate of suicide by jumping from a high place has been described in Switzerland (50). The importance of urban design, including walkability and green spaces on psychological distress has been emphasised recently (51-53). These factors may be one of the contributors to the higher levels of observed psychological distress of residents living with the CESPHN boundaries (10% average compared to 8% average for NSW as a whole)(24).

Together with high population density areas, the CESPHN also includes the areas of Sutherland Shire such as Heathcote and Engadine, the Royal National Park, Lord Howe Island and Norfolk

Island, which all show a very low population density. The low population density in the southern districts of the CESPHN, together with their closeness to Sydney, generates classification problems in the current rural and remote systems. Rural and remote areas have different funding structures and initiatives (e.g. Mental Health Services in Rural and Remote Areas – MHSRRA) which impact billing mechanisms and pay incentives. The CESPHN faces challenges as to how these apply these funding structures in areas that are classified as remote yet are close to urban areas and additionally how to provide services to extremely remote areas such as Lord Howe Island and Norfolk Island. 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. A further challenge for mental health service planning in the CESPHN is that the region includes an organisation within its boundaries with a highly complex catchment area in the inner city. As previously stated, the SVHN is considered a "affiliated health organisation" within the health organisational chart of NSW Health, apart from the state-wide health services, the shared services and the core structure of LHDs and specialty networks (54). Therefore, SVHN is a special case which operates mainly as a nested subsystem within the CESPHN, covering part but not all of the Inner City. Although the Network operates across the jurisdictional boundaries of the SLHD and the SESLHD, the governance relationship between the SVHN, and the PHN may require further specification (54). The difficulties for informed public policy and planning of geographic and substantive boundaries of subsystems nested in broader systems have been pointed out previously (55). Problems arise in relation to the territorial scope, the substantive scope (e.g. local mental health policy), the agents or participant organisations operating in the general systems and in the nested system, and the population perspectives with regards to social, demographic and epidemiological indicators. From a systems thinking perspective, a nested subsystem can however increase flexibility and capacity of self-adaptation to changes in the environment of the broader system.

Aside from geographical and organisational challenges, there are also substantial differences in social and demographic indicators across the CESPHN. This PHN incorporates some of the wealthiest areas in the country such as Woollahra, together with clusters of high disadvantage in Canterbury and Belfield. Such diversity requires focussed localised planning. It is important to note that Canterbury and Rockdale are the only LGAs in this region over the mean percentage of dwellings with no internet connections. In addition the City of Sydney also has 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 (59). As such, it is crucial to identify the services that target these individuals.

Taken together the unique geographical, organisational and diverse demographic characteristics of the CESPHN are all factors that need to be considered when assessing and planning specific mental health care services within the CESPHN.

7.2. HEALTH CARE PROVISION IN THE CESPHN

A primary objective of the CESPHN is to provide a person-centred primary health care system with a special focus on delivering integrated care with the two local health districts and specialty health networks (SVHN and SCHN). The SESLHD Integrated Care Strategy Action Plan 2015-2018 and the on-going Healthy Strong Communities - Service Delivery Reform strategy in SLHD (focused on mental health) provide additional information on the integrated care policies followed in these areas.

The CESPHN concentrates a considerable number of health services into its jurisdiction and has a high utilisation of specialised services. According to the NHPA report for 2013-14 (60), The age-standardised average number of GP attendances per person and year in this PHN were 5.9 (6th highest in the Country) whilst the number of specialists attendances per person for the PHN was 1.19, being the highest in Australia. The CESPHN is the PHN in Australia with the lowest percentage of adults who said they delayed or did not see a GP due to cost (2%), and the third PHN with a lower percentage of adults who said they delayed or avoided filling a prescription due to cost (below 5%) (61). The average number of in-hours ED attendances per 1,000 people is the 5th lowest in Australia just above North Sydney; and the rate of hospital admissions was 11% in 20113-14, the 6th lowest in Australia; and third after WS and SWS in metropolitan Sydney. 88.3% of GPs attendances were bulk-billed (5th highest rate in the country), but the costs of a specialised visit are the second highest in Australia, after North Sydney. The average Medicare Benefits Expenditure (MBE) on specialist attendances per person was $109.06 in 2013-2014. The average MBE on GP attendances per person, age-standardised was $277.24 (7th in Australia), below WS and SWS in metropolitan Sydney. In addition, the CESPHN has a substantial use of its health services by population from other jurisdictions.

7.3. MENTAL HEALTH CARE PROVISION IN THE CESPHN

The Integrated Mental Health Atlas of the CESPHN has revealed some important differences between the CESPHN and other locations in the world with regards to the main components of the secondary care subsystem of mental health. These differences are mainly related to:

I. A lack of acute and sub-acute community residential care;
II. A comparative lack of services providing acute day care and non-acute day care/programs (i.e. day centres providing structured activities to promote health and social inclusion);
III. Lower availability of supported accommodation initiatives.

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* (64) 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 CESPHN compared to local and international jurisdictions. The discussion is framed within the stepped care model concentrating on secondary and tertiary care services. The section concludes by considering the implications of these commonalities and differences with relation to the planning of specific mental health services in the CESPHN.

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 (13), 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 (37). From these guidelines it is not clear to what extent Headspace should be considered a primary care service (according to the population assisted) or a secondary care service (with regards to its staff capacity). A further example of blurred delineation within the stepped care model is that of ATAPS mental health nurses and individual practices of psychiatrists, who are counted as part of the primary care network in some reports.

7.3.1. NON-RESIDENTIAL MENTAL HEALTH CARE

We discuss in this section all the provision of care apart from residential care in hospitals and in the community. It is important to note that this atlas does not include the primary care generic services that are also used by persons with a lived experience of mental illness. General services, either in the health or the social sector, are very relevant to understand the overall service provision for this population group. However, they should be coded and analysed separately from services specifically designed for persons with a lived experience.

ATAPS

As detailed above, the ATAPS program can be conceptualised as a primary care or secondary care service. It provides universal access to psychological care for those experiencing mild to moderate mental illness. The ATAPS program was introduced by the Australian government to provide individualised, evidence-based mental health care by trained allied mental health professionals on a free or low fee basis at point of use. To determine whether there is an equitable access to ATAPS services in the CESPHN 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 (66). This finding points out the need to also revise the access and use of the Better Access program in this region, as well as other programs included in the Medicare Benefits Schedule (MBS), and the Mental Health Nurse Incentive Program (MHNIP).

SPECIALISED OUTPATIENT/AMBULATORY CARE

ACUTE

Acute outpatient/ambulatory care or emergency care is provided typically at hospital emergency rooms (O3), at the community mental health centres in working hours (O4) or as domiciliary care by crisis home teams (O1-O2). The pattern of emergency outpatient care availability in the CESPHN is more mobile than those services in South Western Sydney and Western Sydney. The CESPHN also has more teams providing acute mobile emergency care than Western Sydney and South Western Sydney however the inverse pattern is shown in the provision of emergency non-mobile care.

NON-ACUTE

Non-acute outpatient/ambulatory clinics are coded in DESDE-LTC as outpatient low-mobile (O8-O10) or mobile care (O5-O7), depending on the frequency of care provided outside the premises of the service (if less than 50% of the care is provided outside the centre is coded as low-mobile). The availability of this group of services is good in the CESPHN when compared with other PHNs in Sydney. The profile of health-related outpatient care is similar to the one found in Western Sydney although the number of teams providing any type of health-related outpatient care is higher than in CESPHN.

The CESPHN also has more non-acute mobile teams (eg assertive community treatment (ACT)) than that of Western Sydney and South Western Sydney. The fidelity of the activity of the services identified herein according to the original ACT model was not assessed. As there is good quality evidence on the effectiveness of ACT (67), the development of these services in the

CESPHN should be promoted. The recent "Transforming Australia's Mental Health System" (TAMHSS)(12) report also highlights the need of these services.

The service delivery profile of health related outpatient care (acute and non-acute) in the CESPHN is similar to that identified in other models of care such as in Northern Europe (Helsinki-Uusimaa in Finland), or in Northern Italy (Verona). The service provision of outpatient care is significantly higher in the area previously mapped in Norway (Sor-Trondelag) but this could be attributed to local context as this area is a semirural region with higher availability per population. Service availability in the CESPHN is substantially higher than in Girona (Spain), which is characterised by a highly integrated community mental health care system.

It is important to note the availability of innovative services targeting the physical health needs of people with a lived experience of mental illness in the CESPHN. These services include the metabolic clinics in the SLHD and the Keeping the Body in Mind programs in the SESLHD. The Schizophrenia Fellowship, Canterbury Leagues Club NSW and the SLHD also provide a physical health service. These types of services are meeting a critical unmet need identified by the consumers of each of the IWS, ES and SES PIRs (see figure 49). Some of 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) (68).

SOCIAL OUTPATIENT SERVICES (NGO FUNDED)

The profile of outpatient social care is very similar in the three PHNs regions mapped in Greater Sydney (CES, WS and SWS) with a significant proportion of non-acute mobile outpatient care. Only one NGO (Brown Nurses) delivered a BSIC related to health care in this group. The majority of NGO funded mobile outpatient services, are focussed on providing the HASI and PHaMs programs. These programs deliver support related to housing and to daily activities as an alternative to day care (respectively).

The different pattern of this type of care shown in the local areas mapped in Europe and in Australia may indicate very different models of care provision with regards to integrated supported housing. In Australia, social care of supported housing is typically part of the broader social home support system, while in Europe there are specific social care services integrated in the supported housing care system, specifically designed for people with mental illness. The current mapping does not include the generic social care services used by patients with mental illness in Europe. It is also important to note that FACS services offered in Australia differ to equivalent services in other countries. In other countries equivalent services have specific divisions related to mental health and are thus coded as Residential Care providers using the DESDE- LTC tool. In the CESPHN Atlas these services have been coded as outpatient care

DAY CARE

Day care for people with a lived experience of mental illness has been considered a key component of psychiatric reform since the early 60s (4, 69). "Day Care" (including partial hospitalisation) refers to all services where the consumer stays for part of the day but not overnight or just for a single face-to-face contact. There is a whole array of different types of day care services according to the phase and the severity of the mental illness: from acute care (i.e. day hospitals/partial hospitalisation), to non-acute care (i.e. day programs/centres) and recovery oriented programs (i.e. peer support, respite, social clubs, or work-related approaches), just to mention a few. These services should be integrated in a local acute care subsystem that also incorporates mobile care alternatives for crisis intervention at home (crisis resolution teams, medical homes), together with non-mobile emergency services and high-intensity coordination/case-management as in Assertive Community Treatment (4).

-ACUTE HEALTH RELATED DAY CARE

Due to the high demand for beds in the CESPHN and region, 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 CESPHN.

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 (4). 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 (70) and by the US Agency for Healthcare Research and Quality (AHRQ) (71). The Cochrane review concluded that ADC is at least as effective as traditional methods, and provides a suitable option in situations where demand for inpatient care is high, and facilities exist that can be converted to these uses. However, they are a less attractive option in situations where the demand for inpatient care is low and can be covered by other options (70). Day hospitals strengthen the patient's autonomy and links with the community, and 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 (71).

The US AHRQ (71) 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) (72). 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 (73): 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

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 (12).

In the CESPHN we have identified one non-acute health related day care centre with high intensity (equivalent to day hospitals) located within the SLHD, however this is only for people with eating disorders. It is important to note that these services were lacking in all other PHNs previously mapped in metropolitan Sydney. The presence of this kind of specialised service may

be due to the close proximity to Universities in the area and 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 (66):

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 (74) 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 (75) and in England (76). 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 (4).

We may also keep in mind that models that prioritize individual care may have unintended adverse effects if critical services in a community care model are missing from the local system. Likewise, and although this requires further evaluation, the value of choice in recovery oriented systems may be limited by the availability of core services in the system. In order to make useful choices to meet an individual's needs, a whole array of service alternatives should be available at the local care system. Strikingly, the lack of high-intensity Day care (eg Day Hospitals and Day Centres related to health) has not been mentioned as a critical system gap in previous policy documents. Other authors have documented the dismantling of the Australian community mental health system in recent years, but without specific mention of the disappearance of day care (77, 78).

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 (79-81), 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 8 BSIC providing social and cultural day care activities within the boundaries of the CESPHN. 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 that may have other abilities and may require more support than the one 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 (82). The recently published NICE clinical guideline for Psychosis and Schizophrenia in adults recommends to (73): "Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work (but also to…) consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment".

The availability of specific employment services is a positive component of mental health provision in this region. In the CESPHN we have found a higher availability of employment-related services, such as social firms, in comparison with other areas in NSW. This is mainly explained by the strong presence of three social firms managed by RichmondPRA in the area, particularly in Marrickville and Surry Hills. RichmondPRA and Schizophrenia Fellowship also support people with mental illness to find a competitive job in the open market. This is an effective approach to incorporate people with a lived experience of mental illness into the workforce, if 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. In addition to these specific employment services, the CESPHN has a series of services providing accessibility to employment (disability employment services) mainly run by RichmondPRA-Ostara and Schizophrenia Fellowship.

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

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 (83). 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, only 5 out of 14 services providing PIR have been coded as Accessibility (A4 – Care coordination) whilst the rest 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 PHNs 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.

7.3.2. RESIDENTIAL MENTAL HEALTH CARE

HOSPITAL CARE

In general, the rate of acute wards availability in hospital settings is higher in the CESPHN than in other districts in Sydney such as Western Sydney and South Western Sydney. The number of subacute teams' availability is also higher in the CESPHN than in 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. A detailed description of the patients' hospitalisation flows will be needed to produce a more precise estimate.

The comparison of the acute and subacute hospital care availability with other mental health care systems with high availability and capacity of hospital care such as Norway and Finland in Scandinavia, show a lower availability of teams providing hospital care in the CESPHN. The levels of hospital availability are similar to those available in Verona (Italy) which is characterised by a community oriented mental health care model with a significantly larger proportion of day services and alternatives to hospitalisation in the community.

The Atlas provides a description and a comparison of the number of beds available in hospital care by functional teams providing acute and non-acute care per 100,000 inhabitants in CESPHN. The rate of acute bed placement capacity in hospital is higher in the CESPHN than in other districts in the greater metropolitan Sydney such as Western Sydney and South Western Sydney. The number of sub-acute beds per 100,000 people is higher in Western Sydney than in the CESPHN.

The ratio of acute hospital placement capacity in the CESPHN is higher than in the European regions compared in this atlas. It appears the NSW mental health system may favour hospital care over the community care models implemented in the Scandinavian countries or in Southern Europe. In any case, the hospital placement capacity in the CESPHN may be overestimated due to patients coming from other districts and a detailed evaluation of this indicator requires the joint analysis of service utilisation data.

ACUTE AND SUB-ACUTE COMMUNITY RESIDENTIAL CARE WITH 24HR PHYSICIAN COVER (R4, R5, R7)

We have not found any services providing alternatives to inpatient care in the community in the CESPHN. The local systems described in Scandinavia and in Northern Italy provide alternatives to hospital care in the community that are not available in Sydney, including acute care in the community in Norway, and non-acute residential care with physician coverage in the community both in Finland and in Italy. A small proportion of teams provide non-acute health related residential care (crisis homes) in Hampshire (England). This low rate of health-related residential alternatives to hospitalisation in the community have also been found in Western Sydney and South Western Sydney where there were no services of this type, which indicates that it is a structural organisational gap in the care provision system of greater Metropolitan Sydney.

It is important to note that the balance of care of the Australian mental health system is skewed towards hospital care. Even though 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(86).

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. The existing alternatives and structure of care in the home and in the community in metropolitan Sydney are outlined below. However, more studies are needed on the efficiency of these type of services. Some authors suggest that acute residential care in the community may be more cost-effective than hospital admission (11). 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 (87). A similar study completed in Canada demonstrated that scattered housing with intensive case management support increased housing stability for people with a lived experience of mental illness who had been experiencing homelessness (88). Other initiatives in Australia that fit in this model is the Prevention and Recovery Care Model (PARC) in Victoria (89). 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 SLHD has been working towards addressing the need for alternative residential care options in the community for people with a lived experience of mental illness. They have developed a strategic residential care plan which proposes to transition the respite beds at their Eurella Service to a 24-hour residential support program offering step up, step down care. In addition they propose to partner with NGO services to provide additional support at the Camperdown Units program (24-hour supervision).

NON-ACUTE ON-24HR "RESIDENTIAL" CARE IN THE COMMUNITY

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.

7.3.3. SERVICES FOR SPECIFIC POPULATION GROUPS

SERVICES FOR CHILDREN AND ADOLESCENTS

The child and adolescent services were only coded for the SESLHD area and are therefore included in the SESLHD Annex.

SERVICES FOR TRANSITION TO ADULTHOOD

There is a considerable number of transition services from adolescence to adulthood. In the CESPHN there are 14 teams 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 the CESPHN in comparison to the overall availability of services for children and adolescents. This may indicate a problem in the continuity of care in the core outpatient services for adolescent and for adults.

SERVICES FOR ELDERLY 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 specific population group. The variety and availability of the service provision system in the CESPHN is better than in the other PHNs mapped to date as we have identified a broad range of residential, outpatient mobile and non-mobile services in both the public health sector and in NGOs.

SERVICES FOR OTHER POPULATION GROUPS EXPERIENCING MENTAL ILLNESS

The availability of services for other population groups in the CESPHN 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 CESPHN.

7.4. MAIN GAPS IN SERVICE AVAILABILITY AND UNMET NEEDS

The Integrated Mental Health Atlas of CESPHN indicates similar to those identified in other PHNs in Greater Sydney (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 (11, 63). 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 (90).

Table 48 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 4. Physical health 5. Employment & volunteering	3. Company 4. Physical health 5. Employment & volunteering	3. Employment & Volunteering 4. Accommodation 5. Psychological distress

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

7.5. 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 (11). 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 CESPHN 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 (35). 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, so 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.

IMPLICATIONS 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 (64) that described the system is 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 CESPHN 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 (11).

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 (91). 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 CESPHN 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 which is 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) (92), and in specific conditions (e.g., anxiety and depression) (93, 94). 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) (95) can be extrapolated to regions that are characterised by an activity based system which is highly fragmented as in Australia. There is a risk of developing further silos and fragmentation in the different steps of the care system if the care delivery system and the workforce responsibilities and caseload are divided by levels of severity and staging without a full map of the availability of services and the pathways of care as well as a better understanding of the pathways that may ensure care continuity.

7.6. STUDY LIMITATIONS

There are several limitations that need to be acknowledged. *First*, some services may be missing because we did not reach them. However, we presented and discussed services included and coded in the study to the Steering Committee of the Atlas project and, after different iterative reviews, it was agreed that the majority of the services have been included and coded. A small

number of services did not provide information on FTEs. Additionally, the generic services that are not specific to mental health, but that are used by people with mental illness, have not been coded and registered in this atlas.

Some services providing care for people with disabilities and homelessness expressed their interest in the Atlas, but they did not want to be included as their target population was not mental health. This is an issue which has also been identified in other PHNs. The focus on individual care based on a person's level of functioning without any consideration on the target population group may have implications in the care delivery system which should be explored in the future. Questions arise on 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. As stated, 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).

Finally, we have only included services within the boundaries of the CESPHN even though some of the residents in this area may use services from other PHNs, such a South Western Sydney, Western Sydney or Northern Sydney. The issues of remote areas such as Lord Howe Island also covered by CESPHN 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 (31), benchmark analysis and modelling of relative or technical efficiency at local level (96) as it has already been carried out in other metropolitan areas (33).

7.7. FUTURE STEPS

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

- **Needs of the primary care physicians related to the provision of mental health:** general practitioners or family physicians are usually the first contact with the health system and they can play a key role in the prevention of mental illness and the treatment of common mental illness. It is therefore crucial to understand and meet the needs of these professionals.
- **Analysis of professional profiles by main types of care.** Substantial differences have been identified in the professional profiles of the workforce in comparison with similar main types of care in Europe, particularly in the non-health / NGO sector. This would require a detailed analysis in the future.
- **Rates of utilisation of the services**, by MTC, using the information provided in the administrative databases: the analysis of service utilisation will detect hot and cold spots and areas of improvement. The information collected in the local integrated atlas of mental health care can be combined with utilisation and outcome data to produce decision support tools that may help with the analysis of benchmarking and relative efficiency, as well as to redesign and improve available services. The DESDE-LTC system has been previously used for this purpose in other countries (96).
- **Care packages:** the information presented in this atlas may be complemented with an analysis on care packages: set of services and interventions that are provided to a consumer at a single time period (complex or collaborative interventions).
- **Pathways to care:** understanding how people with a lived experience of mental illness navigate the system is a key area of knowledge needed for creating systems which increase accessibility and efficiency. This will allow a continuity of care analysis.
- **Financing mechanisms and financing flows**: this will allow us to delve into important areas such as the *better access program* and housing.
- **Level of integration of the services providing mental health care and the philosophy of care of the services:** a collateral finding that emerges, but that should be included, related to integration is the different philosophy of care of the services. It is important to know the view of the different providers on the public mental health system and their role in it.
- **Analysis of services *for specific target population groups*,** mainly: child and adolescent care, homelessness services, fully private services not accessible through public funding, and alcohol and other drug services, with a particular focus on care for comorbid patients. Cultural and linguistic diversity and Aboriginal and Torres Strait Islander mental health care should be a special focus of attention for the CESPHN, particularly SLHD, whilst care in inner regional areas closer to a main city (Sutherland Shire) and very remote Australia (Lord Howe Island) should be regarded as a relevant topic for SESLHD (97).

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 (33). 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.

7.8. CONCLUSION

This Atlas contributes to the development of evidence-based regional mental health plans. It provides a service mapping to assist in identifying gaps and opportunities for better use of services to reduce duplication and remove inefficiencies. This type of information has been prioritised by the Federal Government to the PHNs to implement the mental health reform (98). Our observations are in line with the report in the National Mental Health Commission's National Review of Mental Health Programmes and Services. This review recommended, amongst others: 1) the development of more community-based psychosocial, primary and community mental health services, as alternatives to acute hospital care; and 2) boosting of the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services.

This is a unique moment for CESPHN 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.

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