GAPS AND BARRIERS FOR ACTION in South Eastern Sydney

THINKING SYSTEMICALLY AND ACTING LOCALLY

SOUTH EASTERN SYDNEY PARTNERS IN RECOVERY

DEVELOPED IN PARTNERSHIP BY:

[Logos of various organizations]
Priority Areas for sector development identified in South Eastern Sydney

The ultimate objective of the Partners in Recovery program is to improve the system response to, and outcomes for, people with severe and persistent mental illness who have complex needs.

Following a comprehensive analysis of gaps and barriers in the service system, South Eastern Sydney Partners in Recovery (SES PIR) has defined ten priority areas in the South Eastern Sydney region.

These identified areas will serve to focus the activities of SES PIR as we work in partnership to create recovery-orientated, holistic and personalised support for all individuals.

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<td>1</td>
<td>Increase opportunities for social inclusion and participation in the community.</td>
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<td>2</td>
<td>Enhance access to employment, education and training.</td>
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<td>3</td>
<td>Improve access to affordable and social housing as well as emergency accommodation.</td>
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<td>4</td>
<td>Develop the capacity of the community to address squalor &amp; hoarding.</td>
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<td>5</td>
<td>Improve access to:</td>
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<td>• Psychiatry across the public and private sectors.</td>
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<td>• Psychological services that can meet long term support needs.</td>
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<td>• General Practitioners.</td>
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<td>• Community-based support services.</td>
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<td>6</td>
<td>Develop the capacity of the sector to support people experiencing Complex PTSD or personality disorders.</td>
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<td>7</td>
<td>Grow the capacity of the sector to provide culturally appropriate services to:</td>
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<td>• Aboriginal and Torres Strait Islander communities and individuals.</td>
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<td></td>
<td>• Culturally and Linguistically Diverse (CALD) communities and individuals.</td>
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<td>8</td>
<td>Develop a ‘No Wrong Door’ approach to mental health and community services in the region.</td>
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<td>9</td>
<td>Increase access to healthy living supports.</td>
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<td>10</td>
<td>Improve integration of Mental Health and Drug and Alcohol supports.</td>
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1 Context

1.1 Why are we doing this?

The South Eastern Sydney Partners in Recovery (SES PIR) program sets out to integrate support services through partnership building, capacity building and care coordination to ensure the mental health service system is responsive and effective in meeting the needs of people with severe and persistent mental illness. It involves the direct delivery of support and service coordination with individual clients, and system redesign work that is ‘behind-the-scenes’. To ensure that SES PIR targets the areas of priority for the SES region in a manner that is effective and sustainable, a process of priority setting is detailed in this report.

Partners In Recovery program is tasked to identify gaps in the local systems that may benefit from interventions. These may include supporting the development of partnerships, care pathways, integration and coordination, capacity-building activities within a framework of backbone support. As part of the formal process for resource allocation, intelligence in various forms was gathered and reported here, with the following aims:

1. To provide multiple perspectives on the issues related to clinical (mental and physical) services, support services, and mainstream services, and the integration of these sectors; and

2. To support thinking and learning about the relevant systems in smaller sections, at various layers, and as a whole.

To provide background, there are broad driving forces external to the local system that will have an impact on the local PIR. These forces are described as follows:

<table>
<thead>
<tr>
<th>Driving Forces</th>
<th>Source</th>
<th>Impact</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDIA acts as the coordinator that integrates support services and mainstream health and mental health system.</td>
<td>NDIS</td>
<td>Function of PIR adopted</td>
<td>Supports the NDIS will fund in relation to MH services</td>
</tr>
<tr>
<td>Support services for building skills of clients (self-care, social connection, finance, housing, recreation, education, training and employment).</td>
<td>NDIS</td>
<td>Function of PIR adopted</td>
<td>Supports the NDIS will fund in relation to MH services</td>
</tr>
<tr>
<td>Medical and clinical services are still self-funded (not covered by NDIS).</td>
<td>NDIS</td>
<td>Service affordability remains a problem</td>
<td>Supports the NDIS will fund in relation to MH services</td>
</tr>
<tr>
<td>Increasing inequality in Australia over time, fuelled by wage disparities and dwindling effectiveness of social security system.</td>
<td>Social</td>
<td>Poorer social mobility</td>
<td>Inequality and prosperity and their impacts in a radical welfare state</td>
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<tr>
<td>‘Big data’ revolution changes how clients’ mental health is monitored.</td>
<td>Technological</td>
<td>Data-driven decision-making</td>
<td>Tech Page One</td>
</tr>
<tr>
<td>Event</td>
<td>Domain</td>
<td>Reason</td>
<td>Source</td>
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<tr>
<td>----------------------------------------------------------------------</td>
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<td>---------------------------------------------------------------------------------------------</td>
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<tr>
<td>Policy discourse has picked up recovery as a strong theme.</td>
<td>Ethical</td>
<td>Service system design oriented towards client empowerment</td>
<td>Strategic Plan - NSW Mental Health</td>
</tr>
<tr>
<td>Strong preference for containing health care cost.</td>
<td>Economic</td>
<td>Greater reliance on cost-effectiveness ratios and less reliance on public funding for health services</td>
<td>Many</td>
</tr>
<tr>
<td>Increased funding to Youth Mental Health.</td>
<td>Political</td>
<td>headspace's capacity increases</td>
<td>Mental Health and related provisions in the 2014-15 Federal Budget</td>
</tr>
<tr>
<td>Reduced funding to Partners in Recovery.</td>
<td>Political</td>
<td>Unknown</td>
<td>Mental Health and related provisions in the 2014-15 Federal Budget</td>
</tr>
<tr>
<td>National Partnership Agreement for Homelessness will only last for another year.</td>
<td>Political</td>
<td>Unknown</td>
<td>Mental Health and related provisions in the 2014-15 Federal Budget</td>
</tr>
<tr>
<td>Review of NSW Mental Health Act 2007 – consumers.</td>
<td>Legal</td>
<td>Clients more active in decision-making</td>
<td>NSW Mental Health Act 2007 Review</td>
</tr>
<tr>
<td>Review of NSW Mental Health Act 2007 – carers.</td>
<td>Legal</td>
<td>Carers role more supported</td>
<td>NSW Mental Health Act 2007 Review</td>
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<tr>
<td>New/changed priorities.</td>
<td>National policy</td>
<td>Unknown</td>
<td>National Review of MH Programs and Services</td>
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<tr>
<td>New/changed priorities.</td>
<td>State policy</td>
<td>Unknown</td>
<td>Strategic Plan from Mental Health NSW Commission</td>
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</table>

1.2 How are we doing it?

Priority-setting requires the selection of appropriate frameworks and methodology to make the whole process as transparent and explicit as possible. This report advocates for the adoption of the
heavily researched and consulted frameworks articulated in *Towards a draft Strategic Plan for Mental Health in NSW*
1 and *A Contributing Life*
2 which have a high degree of recency and relevance.

In light of these documents, three principles are to be considered in understanding how priorities should be set:

1. Non-mental health issues are central to mental health clients’ recovery, including physical health, housing, employment, education and social participation.
2. Autonomy of clients is to be respected and integrated into service system design.
3. Whole of person, whole of life-course and whole of system approaches are to be encouraged; service-focussed thinking is to be discouraged.

Considering these, this report aims to identify priority areas for improving the effectiveness and sustainability of the local mental health system through the following methodology:

- Analysis of policy documents related to mental health service reform in Australia.
- Consolidation of literature review already undertaken by National Mental Health Commission.
- Thematic analysis of the action plan summaries of current PIR clients.
- Extensive consultation of high-level stakeholders and frontline workers.
- Workshop on setting priorities.

The priority-setting processes that involved data collection, data analysis, data triangulation, stakeholder consultation, group deliberation, and strategy development are presented below:

1. NSW Mental Health Commission; 2013
2  Meta-analysis of Literature Review

2.1  Methodology

The review approach involves the identification of factors and their relationships with each other in the six literature review reports commissioned for the National Report Card on Mental Health and Suicide Prevention. The complex web of factors is drawn in the form a causal loop diagram as displayed below.

![Influence Diagram at All Levels](image-url)

**Figure 1: Influence Diagram at All Levels**
2.2 Findings

Through understanding of the density of relationships around factors and root causes illustrated in Figure 1 and 2, the following observations were made:

- Interventions can be introduced at four different levels (see Figure 1):
  - Bio-psychological level (yellow)
  - Individual skills level (green)
  - Service system level (teal)
  - Social determinants level (red)

2.2.1 Bio-psychological level

- Dialogue and activities related to mental health must always be framed in terms of comorbidities, either between mental health and drug abuse or mental health and physical health.
- Stress has bi-directional relationships with drug-related comorbidities and a separate bi-directional relationship with physical conditions, bridging the mutual influence between drug and physical comorbidities.
2.2.2  **Individual skills level**
- The psycho-social disability that can result from serious mental illness can make it difficult for people to participate in the community of their choice, compounded by the omnipresence of stigma.
- Stigma also limits the consumers’ and public’s recognition of the illnesses and their causes and risk factors, resulting in detering people initiating treatment for their mental illness.

2.2.3  **Service system level**
- Problems are frequently identified within crisis-type services and the identification ability is influenced by the complexity of presentations, the capability of staff, and the connectedness between services.
- The use of technology can promote service coordination to ensure high accessibility to relevant services.

2.2.4  **Social determinants level**
- Broad determinants like housing, education and employment are interrelated and, more importantly, have impacts on all previous levels (although the individual ties were not explicitly drawn in the influence diagram).
- Prevention strategies and early life interventions at this level may have the biggest impact, given that improvement in broad determinants will have a multiplier effect on reducing disease prevalence (see Figure 2).

3  **Qualitative Analysis of Action Plan**

3.1  **Methodology**
Action plan summaries of seventy-six clients of SES PIR were provided. Within these, ten summaries were not completed and hence were excluded from the analysis. Categories set by PIR for framing needs (e.g. housing and employment) were deconstructed and new categories were created based on the descriptive texts in the summaries. This was done to suspend the assumption that these nationally standardised PIR categories are most appropriate for describing the clients’ needs.

The analyst’s assumptions and beliefs that may be said to influence the analysis were also made explicit. The analysis is informed by a multidisciplinary framework, but it is possible that a personal cognitive preference towards clients achieving maximum autonomy is at work. This is balanced by analysing data from multiple points-of-view, based on various theories of distributive justice, namely libertarianism, egalitarianism and utilitarianism. The number of clients who have expressed a particular need is calculated.

Thematic analysis was conducted to describe the variations within each need category, the meaning behind the expressions and presentations, the missing dialogue in the system, and the cross-cutting issues that are systemic and causal in nature (through the WHO system building block framework).

It becomes apparent that the relative ranking of needs will be affected by decisions on the way categories are defined and set.. Therefore, cross-cutting issues that underlie multiple need categories will provide a useful perspective; they are also more likely to address the ‘causes of causes’.
3.2 Findings

3.2.1 Health Services (34)
This is the need area most frequently identified by clients. There are two distinct but interrelated issues: accessibility and affordability. The support facilitators have been pivotal in providing information on the services available and capacity for navigating the service system. However, service affordability is not easily resolved. Clients that are already aware of the services available express difficulty in paying for GP consultations and psychological sessions. In some instances facilitators provide information on bulk-billing or free services as a more affordable alternative. These observations apply equally to both physical and mental health services. Six clients either self-identified or were prompted by the facilitators to arrange appointments for psychiatric reviews of their medication and mental health status.

3.2.2 Social Support (32)
The second most identified area of need is social support. Six clients have indicated their willingness to participate in leisure activities, namely exercise groups and art sessions. Seven have identified specific support groups in which they could participate. Eleven clients have not actively pursued the opportunities for social connections, possibly due to a mixture of lack of confidence, poor social skills and low awareness of available opportunities. Eight clients had significant issues with their relationships with significant others. Two of the eight clients expressed difficulty in meeting their sexual needs.

3.2.3 Self care (30)
This area provides possibly the best indicator for the clients’ daily functioning. Nineteen said that they would benefit from support in maintaining the cleanliness of their homes. Six were keen to get help with their personal hygiene, especially showering. Two would like to learn cooking. Three simply indicated that they need to organise their daily lives better. Four clients have pets and did not express any need for taking care of them, however, two of the clients may be limited in their housing options because of this.

3.2.4 Housing (28)
Housing needs are perhaps the most difficult to meet due to the waiting time, stringent eligibility criteria and low affordability (i.e. housing accounts for a very large proportion of the clients’ incomes). Seventeen clients have submitted a housing application and are currently awaiting the allocation of accommodation. The remaining eleven clients have not submitted an application but are currently experiencing housing instability due to inability to pay rent or mortgage, domestic violence issues, and strained relationships with co-habitants. Four clients require legal support due to their housing issues.
3.2.5 Income (17)
Ten clients have actively identified financial difficulties. Seven clients were assisted with their pension application due to expressed financial difficulties and the potential entitlement for additional pension.

3.2.6 Specific health problems (11)
Four clients have been identified to be overusing alcohol and other drugs; none indicated the need to address these issues immediately. Two clients would like to better control their weight. Five clients have difficulty in understanding their psychiatric medications and mental health diagnoses. This health literacy issue is met by information provision from the facilitators and consultation with the psychiatrists. Please note that many health problems not identified here are addressed in the Health Services section.

3.2.7 Food security (11)
These clients have indicated that they could not afford to buy food and/or do not have sufficient cooking skills. They did not indicate the intention to acquire these skills, therefore all of these clients either receive food services (such as Meals on Wheels) or attend services where free food is provided.

3.2.8 Communication (7)
Six clients have requested assistance to purchase electronic devices (e.g. laptop) to help them find jobs on the internet. Two clients have poor English proficiency. However, the need for interpreters for basic communication with the facilitators was not indicated. It is also not clear whether cross-cultural factors are considered in the engagements.

3.2.9 Education (5)
Five clients would like to participate in education and training activities in order to improve their employment prospects. Appointments with TAFE educators were arranged to explore options; facilitators also assisted in researching options for clients.

3.2.10 Employment (4)
Only four clients were interested in securing employment. All of them do not present to have job-seeking skills and some have arranged appointments to meet job agencies.

3.3 Big Picture Analysis
Using the WHO System Building Blocks Framework³, a systems perspective can be applied to think

³ WHO system building blocks http://www.wpro.who.int/health_services/health_systems_framework/en/
outside the current paradigm or knowledge-base that exists to date. The following piece of analysis provides a rapid critique of the current system in order to include potential blind spots, longer term views, and broader goals.

3.3.1 Workforce
The PIR workforce has been proactive in facilitating clients’ access to services. It is reasonable to question whether all clients require this level of support in all situations, and whether opportunities exist for enabling the clients to take charge of their daily activities rather than having the activities completed for them (e.g. sourcing and completing an application form).

3.3.2 Leadership and governance
There are some issues around awareness of and access to services and resources (for both healthcare and welfare). This suggests the complicated nature of the service system is problematic, calling for greater attention for redesigning the system architecture, including referral processes. Simplification of processes will facilitate self-initiated access, rather than reliance on PIR to navigate the system, which remains the status quo.

3.3.3 Data and information
Inconsistency in documentation style has made need comparison difficult. Objective and consistent measures of the clients’ progress towards achieving their goals were not included in the Action Plan.

3.3.4 Service delivery model
The service model may find it more cost-effective to invest in addressing cross-cutting issues.

a. Sustainability should underpin every action at the client, organisational and system levels. Every actor in the system needs to assume that PIR Program will not continue into the distant future and hence will need to constantly question whether there are there better ways to allocate time and resources to create a better future in the potential absence of PIR, and how a system that provides similar supports to future PIR-type clients can be developed and embedded in the event the program is discontinued.

b. Autonomy is related to sustainability in terms of the level of dependence clients have on PIR staff. Although full autonomy may be unrealistic, even among healthy individuals, it is remains important to strive toward greater autonomy over time.

c. Learning has been identified as the key element to generating and maintaining mental capital in
d. Poverty is underrepresented in the main discourse of mental health reform. Our mental health clients frequently reported affordability issues and cannot afford their basic essentials because they spend a very large proportion of their income on rent and/or addictive products. Improvements in employment prospects have the potential to profoundly influence this situation.

3.4 Final thoughts

- It may be said that while the needs that can be met on the level of current service delivery (and within the circle of influence of support facilitators) are able to be documented, a lack of documentation of needs requiring input at a higher level (or systems level) are not well-recorded as support facilitators are not directly involved in conducting this work. This appears to be due to a variety of confluent factors: PIR staff need to escalate issues that cannot be resolved on an individual or service delivery level; these mechanisms need to be delineated.
- The more entrenched systemic issues that cannot be resolved via partnership or integration activities might require more systemic changes to increase options and accessibility for clients (for example, in the case of employment needs, jobs designed specifically for mental health clients may need to be developed).
- Support coordination with clients is still in the early stages. Existing literature shows that as essential needs are met, people look to higher-order needs such as relationships, mastery of skills, contributions to the community, and so forth.

4 Group identification of barriers

4.1 Methodology

Focus groups were conducted with two separate stakeholder groups, namely the frontline PIR staff and the Advisory Committee. Discussions were structured around identifying specific barriers for each of the domains proposed in the previous qualitative analysis.

4.2 Barriers

4.2.1 Health Services

- Assistance with disability support, pensions and gaining access to specialist medical services in a timely manner.
- Lack of transport to services and availability of appointments.
- Lack bulk-billing psychologists and psychiatrists.

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• Lack of case managers.
• Very long waiting lists.
• Age gap with services, that is, many services are provided for people under 25 years of age, but only limited services exist for the 25-55 years of age demographic.
• Barriers to communication with case managers and referrers.

4.2.2 Social Supports
• Long waiting lists for social and peer-support, friendship services and compeer programs.
• Challenges in building trust due to a long history of disempowerment of consumers by institutions and services.
• Services not being delivered on an individual level.
• Transport access issues.
• Financial constraints.
• Desire for mainstream activities not specific to mental health.
• Stigma around mental health-specific groups.
• PTSD.
• Anxiety.
• Lack of age-appropriate options for mental illness in South Eastern Sydney region.

4.2.3 Self Care
• Self-neglect due to domestic violence.
• Illness.
• Low self-esteem.
• Long waiting lists for under 65 year olds.
• Lack of support for improving living skills and self-care.
• Lack of support with self-management of medication.
• Lack of support to keep pets, combined with high vet costs.
• Absence of cleaning services for people with Bipolar Disorder and absence of subsidised home-care support for people with mental illnesses.

4.2.4 Housing
• Refuges not allowing pets.
• Difficulties accessing housing that meets consumers’ needs in terms of location and quality amenities.
• Problems providing evidence to support application/forms.
• Lack of resources to assist with rental arrears.
• Lack of affordable housing in St George and Sutherland areas.

4.2.5 Income
• Inflexibility of social welfare for people living with a serious mental illness.
• Issues with non-eligibility for Centrelink payments in self-employed consumers, creating financial shortfalls during periods of illness during which work cannot be undertaken (consequently discouraging self-employment that bolsters confidence and hope).
• Difficulties satisfying Centrelink evidence requirements in order to qualify for Disability Support Pension (DSP), creating financial barriers to managing illness.
• Centrelink requirements for a ‘specialist report’ involves a narrow definition of qualifying ‘specialists’, presenting financial barriers to meeting requirements (for example, registered psychologist and social worker and GP reports are excluded), resulting in a lack of affordable options to meet Centrelink’s diagnostic requirements.
4.2.6  Specific Health Problems
- Mental health-specific services can result in disempowerment and monitoring rather than support for consumers, forming a barrier to engagement.
- Lack of information around bulk-billing psychiatrists and health care plans. Lack of education provided to consumers to resolve issues.
- Lack of outreach support services for consumers with chronic health issues where mental health is an obstacle to accessing treatment.
- Difficulties with prioritising seeking specialist services and budgeting for them. Lack of bulk-billing specialists.
- Requirements for psychiatrists to act as case managers reducing focus on therapy, with requests for a separate case manager going unfulfilled.
- Difficulties with health services encouraging consumers to access PIR services despite referrals.
- Lack of medication monitoring for Shire-funded and private services for under 65 year olds.

4.2.7  Food Security
- Lack of cooking and shopping skills.
- Excessive waiting times for local food service resources (often 2 weeks).
- Lack of transport to utilise food services.

4.2.8  Communication
- Disengagement between services and consumers after referrals leading to service-avoidance where participation is voluntary.
- Cost barriers to repairing hardware.
- Insufficient availability of interpreters for CALD community within underfunded services.

4.2.9  Education
- Significant financial constraints preventing enrolment in educational courses.
- Lack of consumer awareness of available educational courses.
- Limited access to support officers at education institutions.

4.2.10  Employment
- Difficulty with securing employment following periods of imprisonment (which is further exacerbated in older consumers).
- Difficulties with appropriate completion of online applications.
- Deficit of personalised service within employment services.
- Overloading of employment services that are tailored to the needs of consumers.

This initial list of barriers is consolidated by PIR staff into three major domains based on implementation feasibility and level of importance.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Barriers and Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>Absence of emergency and temporary accommodation in the SES region.</td>
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<td></td>
<td>Pets not allowed in temporary or emergency accommodation.</td>
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<td></td>
<td>Long waiting lists for social housing.</td>
</tr>
<tr>
<td></td>
<td>Lack of affordable housing stock.</td>
</tr>
<tr>
<td>Health and Support Services</td>
<td>Long waiting lists for specialist mental health support services.</td>
</tr>
<tr>
<td></td>
<td>Shortage of generalist social support services to assist with bills, forms, transport, advocacy and accessing services, day-to-day support.</td>
</tr>
<tr>
<td></td>
<td>Significant lack of bulk-billing psychiatrists.</td>
</tr>
<tr>
<td></td>
<td>Absence of subsidised psychology services for moderate to severe and long-term consumers.</td>
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<tr>
<td></td>
<td>Long wait lists for social support and peer services.</td>
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<tr>
<td></td>
<td>Significant shortages of squalor and hoarding support services.</td>
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<td></td>
<td>Specialist support services for people with Complex PTSD or Personality Disorder.</td>
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<td></td>
<td>Time limitations on support services.</td>
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<td></td>
<td>Lack of affordable lifestyle and healthy living support services.</td>
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<td></td>
<td>Shortage of local specific services for Aboriginal and Torres Strait Islander and CALD services in the SES region.</td>
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<tr>
<td></td>
<td>High demand for specialist clinical mental health services and high case loads.</td>
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<tr>
<td></td>
<td>Challenges navigating processes of government and non-government services without advocacy and support.</td>
</tr>
<tr>
<td>Employment &amp; Education</td>
<td>Services to find meaningful employment for people with severe and persistent mental illness.</td>
</tr>
<tr>
<td></td>
<td>Practical and financial support to access education and training.</td>
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<td></td>
<td>Assistance to access Disability Support Pension.</td>
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</table>
5 Implications

The findings have provided a selection of options for framing the Capacity Building Grants:

1. Causality and risk factor layer - Bio-psychological, individual skills, service system and social determinants level.
2. Client needs layer - Health services, social support, self-care, housing, income, specific health problems, food security, communication, education and employment.
3. PIR program layer - Finance, workforce, leadership and governance, data and information and service delivery model.

The opportunity presented here is to maximise the use of PIR resources in shifting the system from intervention to prevention. The prevention effort should be rooted in tackling complex issues related to the social determinants, targeted at structural changes, and working towards the realisation of self-management and empowerment among the clients.

In light of the barriers identified by the frontline staff and managerial stakeholders, contextualisation of the issues is important in designing interventions that fit in with the local system and facilitating more effective implementation.
### 6 Strategy Workshop

A workshop was facilitated to consolidate the priority issues based on the gaps and barriers identified above. These issues can be classified into three types:

A. Gaps in terms of service accessibility, availability and acceptability.
B. Emerging strengths in the system that will benefit from scaling up.
C. Issues that are not adequately understood which will be benefit from trial and errors.

The priority issues were then mapped against the NSW Mental Health Strategic Priorities. This will help align our efforts with the state-level reforms.

<table>
<thead>
<tr>
<th>NSW priorities</th>
<th>Descriptions</th>
<th>Priority issues</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Building community resilience and wellbeing</td>
<td>Health promotion and prevention. Determinants of mental health includes stable and supportive family, social and community environments, active life and a valued social position, physical security, secure housing and income, meaningful employment.</td>
<td>1.1 Lack of opportunities for participating in mainstream society due to stigma.</td>
<td>C</td>
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<td></td>
<td></td>
<td>1.2 Workplaces not being inclusive of people with mental illness with support and accommodation.</td>
<td>C</td>
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<tr>
<td>2 Towards a better life</td>
<td>Australia is half as successful as other OECD countries in finding work for people with a mental illness. Help people to become well enough to find and keep a job, have a stable home and enjoy life.</td>
<td>3.1 Lack of social housing stock/wait lists for social housing; low affordability in private housing.</td>
<td>A</td>
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<td></td>
<td></td>
<td>3.2 Lack of squalor and hoarding support services.</td>
<td>A</td>
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<tr>
<td></td>
<td></td>
<td>3.3 Absence of emergency and temporary accommodation in the South Eastern Sydney region, especially those that allow pets.</td>
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<td></td>
<td></td>
<td>3.4 Adults not engaged in education, employment or training are at risk of becoming socially disadvantaged and excluded.</td>
<td>C</td>
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<tr>
<td></td>
<td></td>
<td>3.5 No practical and financial assistance to access education and training.</td>
<td>A</td>
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<tr>
<td>3</td>
<td>Breaking the cycle</td>
<td>Youth/adult compounding impact across mental health, addiction and justice. Integrated approaches to co-occurring mental health and addiction issues, with a particular focus on keeping people out of the justice system. Adult severe mental health, both episodic and severe/enduring.</td>
<td>4.1 Health, social and support services do not provide a youth-friendly environment and reach out to youth effectively.</td>
</tr>
</tbody>
</table>
| 4.2 Lack of generalist support services for maintaining:  
- daily living activities which includes paying bills, completing forms, transport, advocacy etc.  
- healthy living which includes cooking, exercise, socialisation, etc.  
These issues are of particular importance in cases of PTSD or personality disorder, and in Aboriginal and Torres Strait Islanders and CALD backgrounds. | A |
| 4.3 Lack of clinical and non-clinical specialist services:  
- Bulk-billing psychiatrists.  
- Care coordination by mental health services.  
- Subsidised psychology support for clients with moderate to severe and long-term problems.  
- Complex PTSD or personality disorder.  
- Aboriginal and Torres Strait Islander, CALD backgrounds. | A |
| 4.4 Challenges navigating processes of government and non-government services without advocacy and support (e.g. assistance to access disability support pension). | A |
| 4.5 Mental health and substance abuse issues are frequently identified at crisis points, rather than earlier. | A |
| 4 | Body and soul | High prevalence mental health including comorbidities with physical health. Acknowledge the holistic health needs of people with mental illness. | 5.1 Clients do not have easy access to General Practitioners that will care for them continuously. | B |
| 5.2 Clients have low health literacy and poor resources or supports to self-manage physical chronic conditions. | A |
## 7 Priorities for Action

The list of priority issues was assessed for implementation feasibility. Issues were excluded on the basis of constraints around budget and scope. The refined list of priority issues are presented as priorities for action as presented below:

<table>
<thead>
<tr>
<th></th>
<th>Priority</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Increase opportunities for social inclusion and participation in the community.</td>
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<tr>
<td>2</td>
<td>Enhance access to employment, education and training.</td>
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<tr>
<td>3</td>
<td>Improve access to affordable and social housing as well as emergency accommodation.</td>
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<tr>
<td>4</td>
<td>Develop the capacity of the community to address squalor &amp; hoarding.</td>
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<tr>
<td>5</td>
<td>Improve access to:</td>
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<tr>
<td></td>
<td>- Psychiatry across the public and private sectors.</td>
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<td></td>
<td>- Psychological services that can meet long term support needs.</td>
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<td></td>
<td>- General Practitioners.</td>
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<td></td>
<td>- Community based support services.</td>
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<td>6</td>
<td>Develop the capacity of the sector to support people experiencing Complex PTSD or personality disorders.</td>
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<td>7</td>
<td>Grow the capacity of the sector to provide culturally appropriate services to:</td>
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<td></td>
<td>- Aboriginal and Torres Strait Islander communities and individuals.</td>
</tr>
<tr>
<td></td>
<td>- Culturally and Linguistically Diverse communities and individuals.</td>
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<tr>
<td>8</td>
<td>Develop a ‘No Wrong Door’ approach to mental health and community services in the region.</td>
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<tr>
<td>9</td>
<td>Increase access to healthy living supports.</td>
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<tr>
<td>10</td>
<td>Improve integration of mental health and drug and alcohol supports.</td>
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</tbody>
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