Mental Health Review -
Key Service-Related Findings and Recommendations

Prepared for Western New South Wales Local Health District

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TOMORROW’S HEALTH TODAY
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1. Introduction

This Report summarises the findings and recommendations from the Mental Health Service Review commissioned by the Western New South Wales Local Health District (LHD) in relation to the mix of mental health and drug and alcohol services, their alignment with contemporary models and the match between services, demography and need.

When commissioning this Mental Health Service Review, the LHD acknowledged that the mental health and drug and alcohol service it provides has developed into a large and capable service and signalled its intent to develop into a world class rural service. In opening its services up to external appraisal in this way, the LHD has demonstrated its willingness to adapt in light of contemporary models in order to improve outcomes for the people it serves. This places the LHD in an excellent position to be at the forefront of implementing any changes in the New South Wales (NSW) mental health strategy that may result from the strategic plan currently being finalised by the Mental Health Commission of NSW.

2. Background

**Western New South Wales Local Health District**

The NSW health reforms have led to greater emphasis on local decision-making responsibility, new funding arrangements and a policy intent to develop better integrated services that improve access and outcomes. The Western NSW LHD is a relatively new, locally-based organisation with devolved accountability to plan, fund and provide public health services that are safe, high quality and patient-centred for the people of Western NSW in a financially responsible manner.

To support it in fulfilling these functions, the LHD has developed a three-year strategic plan (the Western NSW LHD Strategic Health Services Plan 2013 – 2016) to describe its intended future direction. This strategic plan signals that one of the areas where health service interventions are likely to provide the greatest population outcome gains is strengthening community care and support for people with mental health needs. The LHD’s plan also affirms its commitment to providing care closer to the service user’s place of residence.

In its Strategic Plan, the LHD signalled its intent to undertake a review of the mental health and alcohol and drug (MHDA) services accessed by its population in order to better understand those areas where changes could be implemented to further improve outcomes for people using these services. In commissioning such a review, the LHD wished to ensure the overall mix of services across the whole system makes the most effective and efficient use of LHD resources and reflects contemporary service configurations internationally while aligning with the LHD’s overarching strategic direction. At the same time, the LHD sought to ensure its services meet New South Wales Ministry of Health (Ministry) expectations and
reflect the Ministry’s future strategic direction which will be shaped by a Strategic Plan currently being finalised by the Mental Health Commission of NSW.

Local Health District Mental Health and Drug and Alcohol Services

The LHD’s MHDA programme provides state-wide, supra-district and district inpatient services and community services. The current workforce comprises over 700 staff. It offers services for people of all ages with a mental illness and/or drug and alcohol related problem and their families. The MHDA has seen substantial increases in funding over the last 5 years in both community and inpatient services, with significant growth in state-wide and supra-district inpatient beds.

The LHD has shown creativity in its approach to rapidly expanding its workforce in order to develop its new inpatient services. This ability to innovate in the face of change will stand the LHD in good stead as it takes action to improve its services and to align these with the Mental Health Commission’s strategic direction and Ministry expectations.

Scope of this Review

The Review examined the LHD’s MHDA service configuration including the service mix and volumes and its systems and management infrastructure. The Review included services for all age groups and at all sites and localities across the District. It excluded the state-wide forensic inpatient service, medium secure inpatient unit and involuntary drug and alcohol treatment inpatient service.

The Review scope did not include the safety and quality of current services.

Learning from Areas of Excellence

Although this Review did not involve extensive visits to services or a review of the quality of services, the Reviewers learned of the existence of some pockets of excellence within the LHD services. Given the scope of this Review, most of these are not specifically referenced in the text that follows, however it is important to acknowledge areas of excellence and to share learnings from these services. In order to achieve this, the LHD will need to develop mechanisms for identifying and evaluating services that are perceived to deliver good outcomes and patient experience as well as value for money, and to create opportunities for shared learning across its services in order to replicate effective models of service delivery.

The LHD has signalled to the Reviewers its intent to evaluate the impact of any changes made as a result of this Review as a part of its ongoing quality improvement efforts. Developments in relation to health and medical research in NSW may provide an opportunity for the LHD to develop strategic partnerships with research bodies including the local health and medical research hub and through this, to collaboratively evaluate:

- the impact of any change resulting from this Review
- the effectiveness, cost-efficiency and acceptability of local services and interventions deemed to be worthy of replication or expansion.
Such a partnership would be well aligned with the intent expressed in the *NSW Health and Medical Research Strategic Review* (Ministry of Health, 2012) which signals the importance of research excellence, collaboration and translation (into practice).

3. Methodology

The Review was commissioned by the LHD chief executive and conducted by Health Partners Consulting Group. The Review team comprised Sue Hallwright and Jo Chiplin both of whom have extensive experience in mental health and drug and alcohol strategy development, contracting for services, managing services and service transformation. The process was guided by a Steering Committee (see Appendix I for composition). The Steering Committee included representatives of the Ministry and the Mental Health Commission of NSW, in order to ensure alignment with future directions for NSW.

The methodology used in this Review involved:

- Six days of stakeholder consultations (see Appendix II for individuals and groups consulted)
- A survey monkey to obtain staff views
- A desktop review of relevant documentation and data in order to understand MHDA services, including:
  - funding and expenditure and contractual arrangements
  - current service mix/ configuration and utilisation
  - population served and community service distribution
  - organisational structures that support service delivery
- Benchmarking the existing service mix against services nationally and internationally
- Developing recommendations including guidance regarding a proposed future service configuration that reflects contemporary models
- Implications for service planning and management were also identified and the recommendations to LHD management regarding these areas are included in the document titled “Mental Health Review: Summary of Recommendations”.

In developing this report, the Reviewers also took into consideration the LHD’s strategic priorities described in its Strategic Health Service Plan:

- Develop a coherent Western NSW system of care
- Support high performing primary care
- Close the Aboriginal health gap
- Improve the patient experience
- Live within our means.
4. Caveats

1. The findings of the Review have been drawn from information, views and data provided by the LHD. Prior to preparation of this report, the preliminary findings were discussed and validated with:
   - The LHD chief executive, director operations and acting director MHDA services
   - The Review Steering Committee
   - MHDA leadership
   - Ministry officials.

   Wherever possible, information received has subsequently been validated by the LHD. Where validation was not feasible, this is noted in the text.

2. Assessment of service quality was specifically excluded from the brief for the Review. Reviewers are therefore unable to comment on the quality of service delivery within services.

5. Acknowledgements

The LHD leadership and staff committed a considerable amount of time and effort to providing the Reviewers with requested information where this was practicable and to ensuring the accuracy of this information. This effort, together with the contributions of stakeholders interviewed, staff who responded to the survey monkey and the Review Steering Committee have all been essential to enhancing the relevance of the findings.
6. Findings and recommendations regarding the Services

The findings regarding the LHD’s Mental Health and Drug and Alcohol Services are described under the following headings:

- The mix of inpatient, residential and community mental health services
- Tailoring services to demography and need
- Contemporary community services.

6.1. Mix of inpatient, residential and community mental health services

Contemporary models for mental health and drug and alcohol services involve delivery of care in a least restrictive environment as close to home as possible. This principle was adopted in the Australian National safety priorities in mental health: a national plan for reducing harm (National Mental Health Working Group, 2005) that was endorsed by the Australian Health Ministers’ Advisory Council.

There is strong evidence that, when deinstitutionalisation is done properly, most people who have previously received inpatient care for many years achieve more favourable outcomes when they move into community care (Thornicroft G and Tansella M, 2004).

The Reviewers found that the current LHD service configuration for mental health services is at odds with contemporary models in the following ways:

- high levels of acute and non-acute inpatient care for adults
- high levels of non-acute inpatient care for older people

6.1.1. High levels of inpatient care

*Inpatient and residential services for adults*

For the purposes of this analysis LHD inpatient numbers exclude the forensic and medium secure services and the involuntary drug and alcohol treatment unit. Bed numbers in Western NSW are based on the number of available beds adjusted to reflect out of district utilisation. This information was provided by the LHD (see Appendix III). For non-acute beds this figure may be slightly inflated by people who have come to state-wide inpatient services many years ago and whose address is now shown as Western NSW.

Information about current (2013/14) levels of services across the Australian states was not available. Comparisons have therefore been made between current service levels in Western NSW and service levels detailed in the nationally available 2010/11 data for mental health services in Australia (Australian Institute of Health and Welfare, 2011). It is important to note that there may have been changes to levels of service across Australia during the intervening three years.
The levels of adult inpatient care and residential beds provided by Western NSW LHD in 2013/14 in comparison with NSW and other states in 2010/11 are shown in Chart 1.

Non-acute inpatient services for adults are very high in Western NSW in 2013/14 (33.7 beds per 100,000 adults) relative to the Australian 2010/11 average level (10 beds per 100,000 adults). This means that Western NSW has an estimated 38 beds more than it would have at the national average bed number per 100,000 population. The four states with the lowest level of non-acute inpatient care for adults average just 3.3 beds per 100,000 adults.

The number of Western NSW LHD acute inpatient beds for adults is high (32.9 beds per 100,000 adults) relative to the Australian average of 24.3 beds per 100,000 adults. This means that Western NSW has an estimated 14 beds more than the it would have at the national average bed number per 100,000 population. NSW has the highest level of acute inpatient beds of any state at 28.9 beds per 100,000 adults.

The 24-hour staffed residential services level (11.8 beds per 100,000 adults) is above the Australian average level of (6 beds per 100,000 adults) but approximately the same as the 12.4 beds per 100,000 average level for all states in which inpatient non-acute bed numbers are below the national average.

Note that the comparison with state-level averages is not particularly useful in determining the appropriate residential bed level for this particular LHD which
Findings Regarding the Services

includes a psychiatric institution. The 24-hour staffed residential bed levels that contribute to each state average are likely to vary greatly between LHDs, being much higher where a psychiatric institution has been located and downsized than in communities where no such institution has been located. As non-acute bed numbers decrease, LHDs need to accommodate people who have spent many years in the institution, many of whom may have originated from other districts and have lost connections with their communities and families of origin. Ideally, the number of residential beds within the Western NSW LHD would have been compared with other districts in which psychiatric institutions were historically located and which have low levels of non-acute inpatient care, however this information was not available to the Reviewers.

The nineteen 24-hour staffed residential beds provided for Western NSW are run by the LHD and form a part of its Satellite Housing Integrated Programmed Support (SHIPS) service. The staffing for SHIPS is predominantly nursing-based. This service also provides crisis respite, and regular visits to a hostel on Bloomfield Hospital site and to some satellite housing. It also reportedly provides ambulatory care for 85 people who have moved out of the SHIPS residential facilities and into the community. Some of the stakeholders interviewed questioned the cost-effectiveness of using nursing staff to deliver the SHIPS residential services. Internationally, only a very small number of service users with the most high and complex needs would receive on-site clinical input into their residential care. In New Zealand, even the services for people with the highest needs are now successfully delivered by Non-Government Organisations (NGOs) and predominantly staffed by mental health support workers.

The level of Housing and Accommodation Support Initiative (HASI) places in Western NSW detailed in Appendix IV equates to 31.6 places per 100,000 population and is also well above the average for all states (22.2 places per 100,000 population). As with 24-hour staffed residential services, districts such as Western NSW in which large psychiatric institutions or state-wide services have been located will need to have relatively high levels of supported housing and accommodation in the community to accommodate both local residents requiring support and people who have come to the institution from out of district, but who eventually move into the local community on discharge.

**Non-acute inpatient services for older people**

When compared with average levels for each state in 2010/11, non-acute inpatient beds for older people are also high as seen in chart 2 below.
Findings Regarding the Services

The Western NSW level (35.3 beds per 100,000 older people) is significantly higher than the average for Australia (21.4 beds per 100,000 older people). As is evident from the chart, four states do not offer any non-acute inpatient care for older people. The states with no or low levels of non-acute inpatient care all use 24-hour residential care for older people, while Western NSW appears to have no such care funded through its MHDA budget.

Other inpatient services

Acute inpatient services for older people
The level of acute inpatient care for older people (26.5 beds per 100,000 older people) is close to the average for Australia (21.3 beds per 100,000 older people).

Acute inpatient services for children and youth
The level of acute inpatient care for children and youth within Western NSW (7.6 beds per 100,000 people) is above all of the state averages (and therefore above the average for Australia (4.4 beds per 100,000 children and young people). This assessment has been based on the 5 beds for Western NSW and not the full 8 beds for the supradistrict services.

Relative expenditure on inpatient care

One way to gain a high-level view of the degree to which a mental health system has moved away from the historical predominance of inpatient care towards a more contemporary community care predominance is to look at the percentage of the mental health budget that is spent on inpatient care. By way of comparison, the percentage of the mental health budget spent on inpatient care across the United States in 2005 was 29.1% (Frank RG, 2012), substantially lower than the current...
estimated percentage of expenditure on inpatient care\(^1\) in Western NSW (approximately 59.3%). The low level of inpatient care in the United States is supplemented by a high level of residential and support service. The percentage of the mental health budget spent on residential services in the United States in 2005 was 20.9%, bringing the combined inpatient and residential share of their mental health budget in 2005 to 50% which is still lower than the percentage spent on inpatient services alone in Western NSW in 2013/14. Expenditure on the full spectrum of residential and support services in Western NSW (including HASI) was not available to the Reviewers.

The high level of residential service in the United States underscores the need to expand residential services when reducing non-acute inpatient services, in order to ensure adequate support in the community for people moving out of the hospital.

*Unity occupancy*

Three of the LHD’s inpatient units run at low occupancies. The lower the utilisation of inpatient units, the higher the cost of care per person served, and the greater the opportunity cost: this funding could be used to meet the needs of a greater number of people in services that are better utilised.

*Stakeholder perception*

Feedback from interviews indicates that there is a recognition amongst many stakeholders that Western NSW LHD has high levels of inpatient services compared with contemporary models and that there is a need to expand the capacity and range of community services available both in relation to acute services and those for people with high and complex needs who are in non-acute services. However, survey monkey findings indicated that some staff considered current or higher bed numbers were needed, and there were also stakeholders interviewed who raised concerns about reducing inpatient bed numbers across the LHD. It is the Reviewers’ experience that anxiety about moving away from an inpatient-focused model of service delivery can be due, at least in part, to a lack of first-hand experience of the possibilities available within a service model that is more strongly focused on community alternatives and the positive outcomes that this can have for people who use these services.

6.1.2.**Community Mental Health Services**

*Community service levels*

Many of the stakeholders interviewed raised concerns about the perceived high vacancy rates across many LHD MHDA services at the time of the stakeholder

\(^1\) Calculation includes 25% of the expenditure on state-wide inpatient services as this is the approximate percentage of state-wide inpatient services accessed by residents in Western NSW
Interviews and survey monkey. The vacancies were causing widespread concern amongst stakeholders interviewed. It is the Reviewers’ understanding that the LHD has now agreed a workforce profile for MHDA services which will enable recruitment into vacant positions within the approved profile. As a result of the timing of this Review, feedback received regarding the adequacy of the level of community service may have reflected the high level of vacancies at the time of the interviews rather than the adequacy of the budgeted level of service.

The combined community services Full Time Equivalent (FTE) figures used in this document relate to services for all age groups. The Reviewers have compared the LHD MHDA mental health workforce profile FTE numbers as at 28 March 2014 with FTE numbers for individual states in 2010/11. This comparison is less reliable than the comparison for bed numbers above, and should be interpreted with caution. The following factors have affected the reliability of this comparison.

- There may have been growth in the FTE numbers for each state since 2010/11.
- Reportedly the community FTE numbers for individual states used in these comparisons were actual FTE numbers (excluding vacant positions) and vacancy rates for these services are unknown. In recognition of this, and following advice from the LHD, the Reviewers have adjusted the budgeted FTE in the 28 March 2014 workforce profile down to 90% to allow for what would be an acceptable vacancy level.
- The Reviewers did not have access to detail regarding the inclusions and exclusions for direct care staff in the figures for individual states that have been used for comparison, and so there may be differences between the inclusions and exclusions used in this Review and those used to calculate the figures for each state.

For any mental health system, the general consensus is that the number of inpatient beds required is highly contingent upon what other (community) services exist locally (Thornicroft G and Tansella M, 2004) and therefore higher levels of community care are required where there are lower levels of inpatient care. For this reason, the community FTE figure for the district health board with the lowest level of inpatient care in New Zealand is included for comparative purposes.

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2 Weekly FTE figures were used
Findings Regarding the Services

The community-based direct delivery FTE for Western NSW (59.9 FTE per 100,000 population) appeared high relative to the national average in 2010/11 (47.1 FTE per 100,000). As above, the comparability of these figures is uncertain as there may have been growth in community services across the country since 2010/11. The Western NSW figure is low relative to the district health board with the lowest levels of inpatient care in New Zealand (81.7 FTE per 100,000 population). Note that reductions in inpatient care need to be accompanied by higher levels of community care so that clinicians can follow people closely in the community. As with residential care, districts in which psychiatric institutions have historically been located will need higher levels of community care than other districts, because of the disproportionately high number of people with very high clinical and support needs in those communities relative to the local population.

**Recommendations: Mix of Inpatient Residential and Community Services**

**The Reviewers recommend that the LHD:**

**Recommendation 1.** Moves to a more contemporary model of care by decreasing inpatient care and increasing community services and residential services for adults who are acutely mentally unwell, adults with non-acute mental health conditions and older people with non-acute mental health conditions.

Key steps to implement this recommendation will include:

i. For acute inpatient services for adults:
Findings Regarding the Services

a. Enhancing community services that will reduce demand for acute inpatient care, including mobile community crisis responsiveness, home-based treatment, community services for people experiencing a first episode of psychosis and community-based, evidence-informed interventions for people with severe personality disorders.

b. Replacing some acute inpatient beds with community alternatives to admission (e.g. crisis respite services that can accept people prior to admission or on discharge from hospital).

ii. For non-acute inpatient and residential services for adults:

a. Undertaking a comprehensive needs assessment of current inpatients who have spent more than six months in Bloomfield and those currently living in SHIPS facilities (including their ongoing support and treatment service needs) 3.

b. Gathering reliable data regarding admission rates and lengths of stay in hospital 4 and in SHIPS houses.

c. Based on this information, finalising the future level of non-acute inpatient bed numbers and negotiating with the Ministry to ensure that it supports the LHD’s intent in regard to changes in bed numbers.

d. Progressively replacing District adult non-acute inpatient services, with community rehabilitation and support services (including 24-hour residential services, assertive community treatment and 24-hour HASI (if this becomes available).

e. Progressively developing other community services for people currently using SHIPS services who do not have high clinical treatment needs and re-focusing the SHIPS residential and ambulatory service on people who do have high clinical treatment needs (those who are acutely unwell and those with complex and high needs requiring both assertive clinical treatment and support).

iii. For non-acute inpatient services for older people

Replacing older people’s non-acute services with residential aged care focused on the needs of older people with mental illness and supplemented by clinical support from LHD services. The number and nature of residential aged care services will need to be determined following comprehensive needs assessment of current service users.

iv. Low occupancy units

Review the utilisation and function of low occupancy units in order to inform future decision-making

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3 The Ministry will be undertaking this work for people in inpatient units on the Bloomfield site as part of a needs analysis for all identified individuals in Schedule 5 Hospitals

4 Despite considerable time and effort devoted by LHD staff to obtaining this information, the Reviewers were unable to get a clear picture of admission rates to inpatient units on the Bloomfield site or the total lengths of hospital stay for all discharged service users, which will be essential for more detailed planning
v. For all Services

The successful implementation of the significant change recommended above will rely on the efforts of skilled and motivated staff working alongside service users and their families. To support staff in preparing for the changes that will be required of them, the LHD will need to develop a clear workforce strategy that identifies:

- processes for engaging and involving staff and their representatives in the planned change
- the future staffing mix for each service area
- the education, training and supervision required to support staff in their roles
- mechanisms for supporting the workforce to make the changes required.

6.2. Tailoring community services to demography and need

Feedback from interviews and the survey monkey indicates that there is a strong perception amongst key stakeholders that there is an inequitable split of community services for some specific populations.

From stakeholder interviews it was apparent that most staff believe that there is under-servicing for:

- certain geographical areas
- specific population groups particularly:
  - people with drug or alcohol issues
  - infants children and young people.

As noted above, the Reviewers were unable to obtain current vacancy information as against the workforce profile within the time frame of this Review, so they were unable to assess the degree to which perceived under-servicing may be a result of high vacancies as opposed to low service levels.

In addition to concerns about under-resourcing of services for some specific population groups there was strong stakeholder feedback regarding a lack of responsiveness to the needs of Aboriginal populations resulting in Aboriginal people under-utilising community services and being over-represented in acute inpatient services.

6.2.1. Geographical areas

75.7% of staff who responded to the survey monkey consider that mental health services are not equitably spread across the district. 59.9 percent of respondents do not believe drug and alcohol services are spread equitably across the district and another 21.1% did not know.

In the analysis of the spread of community services that follows, the number of community mental health FTEs (in services for all age groups) has been drawn from the 28 March 2014 version of the workforce profile. Note that some of these
positions are vacant, and therefore the observations regarding service equity below relate to the budgeted level of service rather than the staff in position.

The “adjusted” population figures used to calculate relative levels of community service for each area were adjusted for remoteness, disadvantage, Aboriginal and Torres Strait Islander (ATSI) population, low English fluency and age, using an algorithm developed as a part of a Counselling Services Review commissioned by the LHD. Chart 4 below shows the level of community FTEs per 100,000 adjusted population for each of the main towns with mental health services in Western NSW. These figures exclude district-wide services (for all of the Western NSW district). The first two columns for “all Orange region” and “all Dubbo region” include all of the FTEs for the relevant towns in each region plus FTEs involved in delivering region-wide services for each region.

The community FTE number for Orange includes 15.4 FTE for ambulatory care services delivered by the SHIPS.

The work below to compare the level of services to the population size (adjusted for various demographic and socio-economic factors as above) should in future be complemented by work to establish the distribution of people who have the highest and most complex needs. Services for this latter group who require “continuing care” should be distributed based on where people are currently living rather than population numbers, while the remainder of services are more appropriately distributed based on population and demography.

The Reviewers were unable to access information regarding the spread of people with high and complex needs, however it is likely that there is a disproportionately high number of people with high and complex needs living within the Orange community, because people living for a long time in Bloomfield hospital may choose to move into the local community on discharge, and because the SHIPS program which provides services for people with high and complex needs is also located within the Orange community.

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5Because of the highly variable levels of need across the district the LHD agreed to use of this algorithm although it is yet to be validated
It appears that the community-based mental health services outlined in the staff profile from 28 March 2014 are approximately equitably spread between the two regions: Dubbo and Region (59 FTE per 100,000 adjusted population) and Orange and Region (62.8 FTE per 100,000 adjusted population). However if the FTE numbers for the ambulatory care component of the SHIPS program are excluded because of its focus on people with high and complex need, Orange and region’s FTE number drops to 52 FTE per 100,000 adjusted population, which is significantly less service than that for Dubbo and region.

There are some apparent inequities in the spread of services within each region. The highest levels of mental health service relative to population are in Bourke, Orange, Lightning Ridge and Mudgee, with the lowest levels of service in Bathurst, Forbes and Dubbo. Note that the Reviewers were advised that a significant number of people from out of the district (who have moved into the community from state-wide inpatient services) now live in Orange (both within SHIPS houses and in the wider community). This group of people will have a high level of need, and it is therefore appropriate that Orange has a higher level of community service relative to its population than other localities.

There are lower levels of both child and adolescent mental health services and older people’s mental health services in Bathurst and Dubbo than there are in Orange.
Findings Regarding the Services

It is more difficult to assess the spread of drug and alcohol services, because the LHD services form only a part of the wider continuum of services, and the FTE numbers for drug and alcohol services (other than Magistrates Early Referral into Treatment (MERIT) and Opioid Treatment Programme (OTP)) are so low. Dubbo and Region has 12.9 FTE and Orange and Region 17.4 FTE per 100,000 adjusted population. The highest levels of drug and alcohol service relative to population are in Orange, Cowra, Condobolin, and Lightning Ridge and the lowest levels of service in Mudgee and Parkes.

In summary, the spread of both the mental health services and the drug and alcohol services indicated in the 28th March 2014 workforce profile does not appear to be well aligned to the adjusted population levels within each region.

6.2.2. Specific Population Groups

Analysis of the number of community-based direct care FTEs (see above for source of this data) gives the following levels of FTE per 100,000 unadjusted relevant age group for LHD services.

- Children and adolescents: 51.9
- Adults: 67.6
- Older people: 31.8
- Drug and Alcohol: 13.4

No figures for other districts or states were available for the Reviewers to perform benchmarking in regard to the number of direct care FTE within public services per 100,000 people for the differing age groups or for people with drug and alcohol issues.

Services for People with Drug or Alcohol Issues

Review findings indicate that there is widespread concern amongst key stakeholders that the level of drug and alcohol services available does not meet the need of the Western NSW population. There is a clear perception that drug and alcohol service delivery is one of the greatest areas of unmet need for this population, and particularly for Aboriginal people and youth.

Findings of the Review indicate that there are a mixture of state, commonwealth and other sector-funded services available within Western NSW, with residents also able to access some services provided in other parts of the State. The Reviewers were unable to obtain data regarding the total level of drug and alcohol services available across all providers for people living in Western NSW. Furthermore there was no comparable data available regarding levels of drug and alcohol services available in other parts of NSW or Australia.
Findings Regarding the Services

The Reviewers were advised that the LHD provides only a small component of the full spectrum of service. The LHD services include:

- 8 state-wide Involuntary Drug and Alcohol Treatment (IDAT) inpatient beds on the Bloomfield site
- 10.9 FTE for community based OTP programmes
- 5 FTE for MERIT programme
- 15.6 FTE for community based drug and alcohol services for Orange and region
- 10 FTE for community based drug and alcohol services for Dubbo and region.

The LHD-provided community services equate to 13.4 FTE per 100,000 population. After removing OTP and MERIT programs, 9.4 FTE per 100,000 population were available to provide drug and alcohol services within the community.

In addition to the LHD services there is a range of other drug and alcohol services available to people of Western NSW including those provided by local NGOs such as The Lyndon Community who provide Commonwealth-funded detoxification, residential rehabilitation and community outreach services. The Reviewers were unable to obtain a detailed list of drug and alcohol services available to the people of Western NSW either provided or funded by organisations other than the LHD.

*The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing* (Slade T, Johnston A, Teesson M, Whiteford H, Burgess P, Pirkis J and Saw, S, 2009) estimates that 5.1% of the population aged 18-65 years will experience a substance use disorder in any one year. For Western NSW this equates to 8,192 people in any one year. Unfortunately there is no evidence regarding how many of these people will require treatment in a specialised drug and alcohol service (compared with those who could more appropriately have their needs met in primary care or other community services).

**Services for Infants Children and Youth**

Review findings indicate that there is widespread concern amongst key stakeholders that the level of community based infant, child and youth services available does not meet the need of the Western NSW population. There is a clear perception that, along with alcohol and drug service delivery, this is one of the greatest areas of unmet need for this population, and particularly for youth with a combination of mental health, drug and alcohol and other social issues such as family violence. There were also concerns raised by a number of key stakeholders regarding suicide rates amongst this group of young people. Other stakeholders noted that low levels of community-based child and adolescent psychiatrists were impacting on admission rates to the child and youth inpatient unit.
Because the Reviewers were unable to obtain current vacancy information as against the workforce profile, they were unable to assess the degree to which perceived under-servicing may be a result of high vacancies as opposed to low service levels. Furthermore there was no comparable data available to the Reviewers regarding levels of community based infant, child and youth services available in other parts of NSW or Australia.

6.2.3. Meeting the needs of aboriginal people

A consistent theme in the stakeholder interviews was concern regarding the responsiveness of current service models to the needs of Aboriginal People. In particular it was reported that:

- Aboriginal people are not well engaged with LHD community MHDA services, present late for treatment and have higher rates of inpatient admission than the general population.
- The LHD has a strong Aboriginal trainee scheme however there are limited positions in the LHD MHDA services for the trainees after graduation. This is a particular issue for those trainees who graduate with a generic mental health qualification (such as the Bachelor of Health Sciences in Mental Health) rather than a qualification that allows them to be registered with a specific professional body.
- There is limited and patchy coordination and collaboration between LHD MHDA services and Aboriginal Health Services.
- In general, neither traditional clinic-based medical models of service delivery nor telemedicine are culturally appropriate for Aboriginal people, particularly in the early stage of engagement.
- The majority of Aboriginal people in the district live in the rural and remote areas and are subject to the general challenges faced by people in these communities when trying to access MHDA services (see section 6.3.4).

The Reviewers received the following data regarding admission rates to acute inpatient units for Aboriginal populations:

- The Aboriginal population for Dubbo is 11% whereas use of the Dubbo acute inpatient unit by Aboriginal people\(^6\) is 33%.
- The Aboriginal population across Western NSW is 9.1% whereas the use of the Lachlan acute and intensive care units by Aboriginal people is 17.8%.

This data validates the concerns raised by stakeholders regarding over-representation of Aboriginal people in acute inpatient units.

\(^6\) from LHD service utilisation data November 2012 – October 2013
Findings Regarding the Services

**Recommendations: Tailoring services to demography and need**

**It is recommended that the LHD:**

**Recommendation 2.** Enhances and strengthens the current hub and spoke approach as its model for the delivery of community services, in order to:

- ensure an equitable spread of services across the District
- adequately meet the needs of those population groups perceived as currently being underserviced.

Key steps to implement this recommendation will include:

i. Undertaking a review of the population demography, need and current health services availability across the District\(^7\).

ii. Deciding what size population is necessary to warrant having a dedicated MHDA service/team based in a local town and whether there is sufficient local infrastructure to support one.

iii. Using the outcomes from i. and ii. above along with other relevant population based planning tools or data to decide on the spread of community MHDA services both across regions (Orange and region and Dubbo and region) and within each region and adjusting service levels accordingly, ensuring that the model allows for the delivery of outreach services to those towns/areas that will not have a resident community mental health service.

iv. Undertaking specific work with respect to the two key population groups currently perceived as being underserviced:

*People with drug or alcohol misuse*

a. Undertake a stocktake of the level and spread of all drug and alcohol services available to people who live in the District (including LHD services, other state or Commonwealth services and those funded from sources outside of health).

b. Obtain data from other parts of the state/other states to compare current Western NSW service levels with those in other parts of Australia.

c. Decide on appropriate service levels for this community.

d. Take steps to progressively address any identified service gaps within LHD-funded or –delivered services.

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\(^7\) This should include the full spectrum of health services including LHD-provided services, aboriginal medical services, general practice teams, Medicare local services and any other state- or Commonwealth-funded health services delivered in the District.
Infants, Children and Youth

- Undertake a stocktake of the level, spread and types of services available for infants children and youth experiencing mental health problems across the District.
- Obtain data from other parts of the State/other States to compare current Western NSW service levels with those in other parts of Australia.
- Explore options for integrated or collaborative service delivery models across health and social services for those young people with multi-agency need (including evidence–informed models such as Multi-Systemic Therapy and other wrap-around type services).
- Decide on appropriate service levels and models of service delivery for infants children and youth.
- Take steps to progressively address any identified gaps.

**Recommendation 3. Ensures that future service configuration and models of service delivery enhance the responsiveness of services to the needs of Aboriginal people.**

Key steps to implement this recommendation will include:

i. Ensuring future community-based multidisciplinary teams in areas with high Aboriginal populations include roles for Aboriginal mental health workers who have graduated from the Aboriginal training scheme.
ii. Taking steps to increase linkages with Aboriginal Health Services – including exploring options for greater integration with these services particularly in rural and remote areas.
iii. Involving Aboriginal communities in service planning.
iv. Providing ongoing support and training for culturally appropriate practice in MHDA services.
v. Providing dedicated resource to enable ongoing training, linking and mentoring for the emerging Aboriginal health worker graduates.

6.3. Contemporary community services

The focus for this section is on the components of the LHD’s community services, the way they are configured and the way they relate to other health and human services.

Service quality is outside the scope of this Review and was therefore not evaluated. There was, however, consistent feedback during stakeholder interviews regarding two aspects of quality in particular: the degree to which the services reflect a recovery-oriented approach and their responsiveness to the needs of culturally and linguistically

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8 This section considers the composition of services, the integration between multiple providers and technology enablers but does not include qualitative aspects to community-based MHDA care.
Findings Regarding the Services

diverse groups. The LHD may wish to explore these issues further through its own quality improvement processes.

Contemporary community-based MHDA services:

• for mental health are delivered by multidisciplinary teams which include psychiatrists (Mental Health Commission of Ireland 2006)
• in recent years include the new discipline of peer support specialists, as there is increasing qualitative and anecdotal feedback regarding the powerful and positive impact that peer support specialist roles can have in improving outcomes for people who use mental health and drug and alcohol services and there is emerging evidence that the financial benefits of employing peer support workers exceed the costs, in some cases by a substantial margin (Trachtenberg T, Parsonage M, Shephard G and Boardman J, 2013)9
• are shaped by the emerging evidence about service effectiveness
• increasingly use supportive technology including:
  - electronic clinical records that enable multiple staff or providers ready access to an up-to-date, single shared record and service users to have web-based access to their record and share information with providers
  - mobile devices that reduce time-consuming double-entry of notes
  - satellite phones that increase responsiveness in remote areas
  - telemedicine, providing timely access to expert advice and interventions even for healthcare providers and service users in remote settings and providing opportunities for professional development without the need for travel or extended periods of time off work
• collaborate closely with other health and human services, particularly in smaller and more remote communities where more integrated care may provide additional benefits in off-setting isolation for staff.

As noted above, there was insufficient information about the entire spectrum of drug and alcohol services available within Western NSW for the Reviewers to consider whether the current configuration and service delivery aligns well with contemporary models. This section therefore primarily focuses on community mental health services. Where findings or recommendations are also relevant for drug and alcohol services this is noted in the text.

Reviewers found that the current LHD community mental health services:
  o have limited multidisciplinary input including limited access to psychiatrist time
  o have no peer support specialists
  o have insufficient availability of some evidence-informed services in some or all parts of the district

9 Early signals from the NSW Mental Health Commission indicate that peer support is likely to feature in the future strategic direction for MHDA services in NSW
Findings Regarding the Services

- experience challenges providing services in some rural and remote communities – this finding is also true for drug and alcohol services
- are making innovative use of telemedicine to support people in rural and remote communities who are acutely unwell
- have patchy collaboration with other healthcare providers and human services, with pockets of excellence – this finding is also true for drug and alcohol services.

6.3.1. Limited multi-disciplinary input

Feedback from stakeholder meetings and the survey monkey responses consistently indicated that mental health service delivery within the LHD is predominantly nursing-based, and in many areas lacks comprehensive multidisciplinary input. This is particularly evident within community services where the majority of positions in the workforce profile are nursing roles. There was considerable feedback regarding the professional silos that exist within services and the lack of support for multidisciplinary team functioning in system structures and processes.

The workforce profile for 28 March 2014 shows that of the 38 FTE career medical officers and psychiatrist in the budget, only 9.2 FTE are allocated to the community while 28.6 FTE are allocated to inpatient teams. Stakeholders reported that community psychiatrists commonly work in relative isolation from other community mental health workers and are not always familiar with the other community mental health services available for the people that they see.

6.3.2. Lack of peer support specialist services

The Review identified that there are no formal peer support specialist roles within the Western NSW LHD MHDA services, although some more informal peer support is offered through the O’Brien Centre on the Bloomfield site.

6.3.3. Gaps in some evidence-informed specialised services

Although there is some variability across the district, Review findings indicate that the following key evidence-informed services are either insufficient or completely lacking in some areas:

- acute responsiveness/crisis resolution (this will be particularly important if the level of acute inpatient care is decreasing)
- assertive community treatment for people with high and complex needs (this will be particularly important if the level of non-acute inpatient care is decreasing)
- early psychosis intervention
- interventions for people with severe personality disorders e.g. dialectical behaviour therapy
- cross-sectoral wrap-around services for young people with multi-agency involvement.
Findings Regarding the Services

Whilst the population size would not warrant the establishment of stand-alone teams to provide these specialised functions in rural and remote areas and smaller towns, to date there has been little work to explore the development of these specialised functions in areas with a larger population, or for the whole district with capacity to provide back-up and support to teams in smaller towns and rural and remote areas.

6.3.4. Challenges in rural and remote communities

The Reviewers heard that there are significant recruitment and retention issues for services in rural and remote communities. Currently many of the LHD MHDA services provided in rural and remote areas are delivered by staff who “fly in and fly out” to deliver clinic-based services on designated days of the week or month. Feedback received during the Review indicated that at times these fly in fly out services are staffed by “bureau” or “agency” staff who do not have an ongoing relationship with the LHD or the wider community. There is also reportedly a high level of “burn-out” amongst clinicians who are physically located within these communities, due to professional isolation and community expectations that they are available twenty four hours a day to respond to any mental health or situational crises that arise. Some of the stakeholders interviewed suggested that closer integration with other health and social services providers may reduce isolation and help to address burnout and improve retention.

6.3.5. Innovative use of technology

New and more innovative models of service delivery to rural and remote areas have been put in place by the LHD or are under development, including the Mental Health Emergency Care Team – Rural Access Program (MHEC-RAP) which uses telecommunication to support practitioners in rural and remote areas and the Mental Health Rural Outreach Service (MHROS) which is still in the early stages of development. In general feedback about these services was very positive however there are concerns that:

- MHEC-RAP is focussed on acute care only and does not address the needs of those people with ongoing mental health problems.
- MHROS has to date had very limited staffing and its approach to providing ongoing support for rural services is therefore yet to be fully developed.
- The innovative use of technology for these models is hindered by the lack of an electronic clinical record.
- Establishing a face-to-face relationship first may be important in enhancing the engagement of service users and effectiveness of telemedicine consultations for some service user groups e.g. those with the most severe conditions and aboriginal service users.
6.3.6. Collaboration and integration

Stakeholders interviewed and the survey monkey responses indicate inconsistent levels of collaboration with other healthcare providers and human services across the district. The majority of respondents to the survey monkey reported that collaboration with other health services was below or significantly below what is required.

The Mudgee service was frequently mentioned as an excellent example of collaboration between primary care and the LHD mental health services, but this example has not been replicated more widely.

Some of the stakeholders interviewed suggested that the need for collaboration and integration across primary and specialised MHDA services is most pressing in rural and remote areas, where closer working relationships may also reduce isolation and where the task of integration may be simplified as a result of the relatively small number of healthcare providers in those communities.

A Commonwealth-funded “Partners in Recovery” initiative is being coordinated by the Western NSW Medicare Local, and aims to support people with severe and persistent mental illness with complex needs and their carers and families by getting multiple sectors, services and supports to work in a more collaborative, coordinated and integrated way. This relatively new initiative is yet to become fully operational but has the potential to provide a mechanism for improving coordination and collaboration.

**Recommendations: Contemporary community services**

*It is recommended that the LHD:*

**Recommendation 4.** Revises its community mental health team structure and composition across the district with the aim of increasing access to evidence-based approaches, multidisciplinary input, peer support and collaborative working.

Key steps to implement this recommendation will include:

i. Developing multidisciplinary community mental health teams and increasing the level of psychiatrist time in community services and involvement in multidisciplinary teamwork.

ii. Developing a peer support specialist workforce, including investing in peer support specialist training and the infrastructure necessary to support the development of this discipline.
Findings Regarding the Services

iii. Expanding the range of evidence-informed community services, basing decisions about the volumes and locations of services on population and need, and focusing initially on:
   • enhanced extended hours acute responsiveness
   • assertive community treatment and support for service users with the highest needs
   • early psychosis intervention
   • dialectical behavioural therapy and other psychological therapies for people with severe personality disorders
   • wrap-around services for young people involved with multiple agencies.

iv. Fostering the delivery of more integrated services across primary care, medicare locals and general practitioners (GPs) in all areas, for example through:
   • co-location of staff
   • integrated care pilots
   • shared care programmes with general practice
   • joint appointments of some staff across services
   • development of multi-service care planning approaches which enable people to have one health care plan that is actioned across different services
   • joint training initiatives
   • provision of consultation-liaison services to primary care
   • sharing information about the Mudgee GP-LHD collaboration and replicating this approach elsewhere in the district.

**Recommendation 5.** Develops and implements a rural and remote MHDA action plan aimed at enhancing community care for rural and remote areas by addressing issues in relation to recruitment, retention and access to professional support and supervision for staff working in those areas, including clearly defining the role of MHROS.

Key steps to implement this recommendation will include:

i. Expanding access to telemedicine support for all types of clients, not just those who are acutely unwell.\(^\text{10}\)

ii. Ensuring staff have access to the technology and tools necessary to support efficient and effective practice in rural and remote areas

iii. Developing, piloting and evaluating an integrated approach to healthcare delivery for people with mental health or drug and alcohol needs in at least one rural or remote area in partnership between the LHD, primary care, Medicare Locals and NGOs.

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\(^{10}\) Note the availability of Medicare’s telehealth Medicare Benefits Scheme which pays for psychiatrists delivering video consultations in telehealth-eligible areas.
# Appendix I: Mental Health Review Steering Committee Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scott McPherson (Chair)</td>
<td>Chief Executive, Western NSW LHD</td>
</tr>
<tr>
<td>Adrian Fahey</td>
<td>Acting Director MHDA, Western NSW LHD (from January 2014)</td>
</tr>
<tr>
<td>Professor Ian Hickie</td>
<td>University of Sydney, Brain and Mind Research Institute</td>
</tr>
<tr>
<td>John Feneley</td>
<td>Mental Health Commissioner, Mental Health Commission NSW</td>
</tr>
<tr>
<td>Lindsey Gough</td>
<td>Director Operations, Western NSW LHD</td>
</tr>
<tr>
<td>Mark Noble</td>
<td>Consumer Representative, Western NSW Local Health District (</td>
</tr>
<tr>
<td>Pat Doolan</td>
<td>Western NSW LHD Board Member, Representative Aboriginal Health</td>
</tr>
<tr>
<td>Peter Carter</td>
<td>Acting Director Mental Health Drug and Alcohol Office, NSW Ministry of Health</td>
</tr>
<tr>
<td>Associate Professor Russell Roberts</td>
<td>Director MHDA, Western NSW, LHD (prior to January 2014)</td>
</tr>
<tr>
<td>Dr Scott Clark</td>
<td>MHDA Clinical Director, Western NSW Health</td>
</tr>
</tbody>
</table>
Appendix II    List of Stakeholder Groups Consulted:

- Bourke Aboriginal Health Service
- Brewarrina Aboriginal Health Centre
- Centre for Rural and Remote Mental Health, Director
- Consumer/Consumer Consultant Representatives
- Families and Carers Representatives
- Far West LHD, Clinical Director
- General Practitioners, Cowra
- The Lyndon Community, Director Research and Practice
- Medicare Local, Far West, NSW
- Medicare Local Western NSW
- Mental Health Commission NSW
- Mission Australia, Operations Manager, Western and Far Western Region
- Neami National, Chief Executive
- NSW Ministry of Health, Mental Health and Drug and Alcohol Office,
- Partners in Recovery Coordinators
- Richmond PRA – Chief Executive
- The University of Sydney, Brain and Mind Research Institute, Professor Hickie
- Wellington Aboriginal Health Centre
- Western NSW LHD, Director Allied Health
- Western NSW LHD Executive
- Western NSW LHD MHDA, Aboriginal Health Group
- Western NSW LHD MHDA, Acting Director (2014)
- Western NSW LHD MHDA, Bloomfield Campus Inpatient Services; Nursing and Allied Health Staff
- Western NSW LHD MHDA, Clinical Director
- Western NSW LHD MHDA, Director (prior to January 2014)
- Western NSW LHD MHDA, Dubbo and Region; Community and Inpatient Services, Nursing and Allied Health staff
- Western NSW LHD MHDA Dubbo and Region, Psychiatrists
- Western NSW LHD, MHDA Executive Group
- Western NSW LHD MHDA, Orange and Region Community Services; Nursing and Allied Health staff
- Western NSW LHD MHDA, Orange and Region, Psychiatrists
- WNSW LHD MHDA, Mental Health Emergency Care – Rural Access Programme
- WNSW LHD MHDA, Mental Health Rural Outreach Scheme
- Western NSW LHD MHDA Remote Centres; Nursing and Allied Health staff
- Western NSW LHD MHDA, SHIPS (Satellite Housing Integrated Programmed Support)
- Western NSW, Official Visitors Programme
## Appendix III: Western NSW Bed numbers (provided by Western NSW LHD 04/02/14)

### State-wide

<table>
<thead>
<tr>
<th>Type</th>
<th>Current open</th>
<th>% out of district</th>
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<tbody>
<tr>
<td>Orange Care Rehab (Poplars)</td>
<td>10</td>
<td>8.0%</td>
</tr>
<tr>
<td>Medium Secure Rehab (Castlereagh)</td>
<td>6</td>
<td>33.0%</td>
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<tr>
<td>Forensic (MacQuarie)</td>
<td>20</td>
<td>80.0%</td>
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<tr>
<td>Involuntary D&amp;A Treatment</td>
<td>8</td>
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<tr>
<td>Adult Medium Stay Rehab - Male (Manara)</td>
<td>16</td>
<td>59.0%</td>
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<tr>
<td>Adult Medium Stay Rehab - Female (Turon)</td>
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<td>61.0%</td>
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### Supra District

<table>
<thead>
<tr>
<th>Type</th>
<th>Historical</th>
<th>Current open</th>
<th>Out of district</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS</td>
<td>Acute</td>
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<td>8.0%</td>
</tr>
<tr>
<td>Adult Longer Stay (Canobolas)</td>
<td>Non-acute</td>
<td>20</td>
<td>39.0%</td>
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### Local

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<th>Type</th>
<th>Historical</th>
<th>Current open</th>
<th>Out of district</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orange Intensive Care (Lachlan)</td>
<td>Acute</td>
<td>8</td>
<td>22.0%</td>
</tr>
<tr>
<td>Orange Adult Acute</td>
<td>Acute</td>
<td>20</td>
<td>21.0%</td>
</tr>
<tr>
<td>Orange Subacute (Amaroo)</td>
<td>Acute</td>
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<td>19.0%</td>
</tr>
<tr>
<td>Bathurst Adult Non-Acute (Panorama)</td>
<td>Non-acute</td>
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<td>7.0%</td>
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<tr>
<td>Dubbo Adult Acute</td>
<td>Acute</td>
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<td>9.0%</td>
</tr>
<tr>
<td>Dubbo Rehabilitation and Recovery Unit</td>
<td>Non-acute</td>
<td>10</td>
<td>0.0%</td>
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<tr>
<td>Orange Older Persons Acute (Lachlan)</td>
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<td>1.0%</td>
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<tr>
<td>Orange Older Persons Non-acute (Lachlan)</td>
<td>Non-acute</td>
<td>16</td>
<td>0.0%</td>
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Appendix IV  Western NSW LHD number of HASI places.

*Figures provided by Western NSW LHD*

<table>
<thead>
<tr>
<th>HASI</th>
<th>HASI in the Home</th>
<th>Aboriginal HASI</th>
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</thead>
<tbody>
<tr>
<td>Very high</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td></td>
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References


