Targeted Review

People with Severe Mental Illness and Challenging Behaviour

Draft for discussion

September 2019
Consumer stories

The consumer stories used to illustrate important points in this report have been de-identified. Names are fictitious.

Reviewers

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Chief Psychiatrist’s overview

To be completed
Executive summary

To be completed
Findings and recommendations

Key Finding
The need for a comprehensive, integrated mental health rehabilitation and recovery system

There is good evidence that much of the disability and distress experienced by people with severe, enduring mental illness can be reduced if the evidence-based treatment and support strategies that exist today were made widely available and applied consistently and systematically over the various stages of their illness. Today the majority of people with severe, enduring mental illness are living in the community, but many do not attain a level of functioning or well-being that is commensurate with a good quality of life.

The current approach to the provision of treatment and care in Western Australia has become overly short-term, episodic and crisis driven and is not suited to this group of people who require ongoing, coordinated treatment and support. The pressure on community mental health services is such that many evidence-based interventions are no longer widely available.

There is, in particular, an urgent need for investment in the provision of clinical rehabilitation treatment services to address major gaps in services and for better coordination in the provision of public and NGO services to reduce fragmentation to meet both peoples’ complex clinical and support needs.

Recommendation 1
Western Australia develop a comprehensive, integrated mental health rehabilitation and recovery service system to provide person-centred, evidence-based treatments and interventions (including inpatient, residential and community components) for people with severe and enduring mental illness and complex needs aimed at maximising the quality of life and social inclusion of each individual. This service system should comprise a range of clinical rehabilitation and recovery services provided by the public mental health system and psychosocial rehabilitation and support services provided by the NGO sector as outlined in Figure 7.
In establishing comprehensive mental health rehabilitation and recovery services, particular attention needs to be paid to the following:

**Preventing fragmentation**
- Ensuring services are integrated and work as a system to enable individuals to get the coordinated treatment and support they need in a timely manner and to prevent them falling through the gaps between services.
- Rehabilitation and recovery services need to establish and maintain a close, collaborative relationship with early intervention, acute inpatient, community mental health and forensic services to ensure timely access and effective coordination.
- Close, formal collaboration between clinical and NGO rehabilitation and recovery services, primary care, housing and vocational services is required to ensure the coordination of care in meeting the complex needs of shared clients.

**Ensuring the quality of treatment and care**
- Community-based services need to adopt an active, outreach approach in the provision of treatment and care to minimise the risk of relapse and support individuals to live as fulfilling a life as possible.
- The importance of maintaining continuity of care, particularly for consumers with complex needs who are hard to engage, cannot be overstated.
- Building a working alliance with individuals to support ongoing engagement in treatment and care is fundamental and proper regard needs to be given to the personal qualities, attitudes and skills required in the selection and professional development of staff.
- A multidisciplinary team approach is essential to ensure that individuals with multiple, complex needs have access to the broad range of evidence-based interventions to support their recovery.
- Peer support workers play an important role as part of the multidisciplinary team in providing non-clinical interventions that support personal recovery.

**Key finding**

**Integrating treatment for serious mental illness and substance misuse**
Substance co-morbidity is common amongst individuals with serious mental illness, often leading to poor outcomes and presenting a serious impediment to their treatment and recovery. There is a complex inter-relationship between addictive behaviours and mental illness and delivering effective treatment which addresses both mental health and substance use has posed a significant challenge to the two service systems which largely operate separately. This separation has been regularly identified as a major barrier to providing effective, holistic treatment. There is good evidence that integrated treatment of co-occurring mental health and substance use disorders is more effective than separate treatments offered either in parallel or in sequence but requires a major change to the current approach.
Recommendation 2

In establishing the rehabilitation and recovery service system, there will need to be investment in building and maintaining the appropriate staff skills mix to enable the provision of Integrated Mental Health and Substance Use Treatment.

Key finding

Services for people with intellectual disability and mental illness

People with an intellectual disability experience mental illness at significantly higher rate than the general population. There is evidence that they have higher psychiatric inpatient admission rates, longer length of stay and higher associated costs. Mental health services are not providing an effective service for these individuals, many of whom have complex needs and atypical presentations, requiring a high level of expertise.

Recommendation 3

A Statewide Specialist Dual Diagnosis Service needs to be established to meet the needs of people with co-occurring mental illness and complex intellectual, cognitive or developmental disability.

Key finding

Housing options for people who are currently ‘falling through the gap’

Lack of stable, secure and safe housing has serious implications for mental and physical health and well-being and is a major impediment to recovery. Housing problems often contribute to relapse of mental illness and admission to hospital and delayed discharge. People with comorbidity, particularly when accompanied by challenging behaviour, and those who have been through the justice system, have significant difficulty in being accepted by housing providers/or maintaining their accommodation and often end up homeless.

Recommendation 4

A range of supported housing options specifically tailored to the needs of people with severe and enduring mental illness, complex needs and challenging behaviours who are currently ‘falling through the gap’ needs to be developed.
1 Introduction

If we really want to transform the quality and safety of health care, we can’t just do more of what we do now. Even doing it more efficiently won’t be enough. We have to do different things and we have to do things differently.

(Fiona Godley, 2009)

The Chief Psychiatrist has become increasingly concerned about the standard of care being provided to people with a serious, enduring mental illness and challenging behaviour. These individuals have multiple complex needs and, without appropriate care, are at high risk of becoming homeless, facing criminal charges or ending up in prison. They are some of the most vulnerable people in our community.

As the independent statutory officer responsible for the oversight of treatment and care provided by mental health services across WA, the Chief Psychiatrist has a unique vantage point from which to gather insights from consumers, carers and clinicians into the standards of care being provided and to monitor emerging priorities in service delivery across the mental health system.

Clinicians have raised with the Chief Psychiatrist the difficulties they face, despite their best efforts, in meeting the complex needs of these individuals within the current service system. Families, in telling their stories and advocating for better services for their loved ones, have highlighted the high personal cost of inadequate treatment and care. The human cost to the individual consumers is often hidden to the wider community but is immense. Both clinicians and families have expressed their frustration with the current service system. They have identified service gaps, fragmented services or parts of the service system that are not well structured to meet the needs of these individuals and their families.

As a consequence, the Chief Psychiatrist instigated a formal targeted review into the treatment and care of people who have a serious mental illness with complex needs and challenging behaviour. The Research and Strategy team within the Office of the Chief Psychiatrist were tasked with undertaking this thematic review to investigate the issues and, in partnership with key stakeholders, develop options to enhance future clinical services. The Review is intended to be a catalyst for change. It aims to stimulate debate, build a

broad consensus for a way forward and importantly, galvanise action to improve the treatment and care provided to these individuals and their families.

Specifically, the Review will:

- Identify the characteristics of this group of consumers.
- Explore the barriers and enablers to providing high quality treatment and care.
- Estimate the number of consumers in this cohort.
- Map the current range of service types, configurations and models of care.
- Gain an understanding of the consumer journey through the mental health service system to identify service use and the adequacy of the service response.
- Identify ‘best practice’ models from other jurisdictions.
- Develop options for future service development.
- Disseminate the findings widely to inform future directions.

The scope of the Review extends to all metropolitan adult mental health services, both inpatient and community.

The methodology is outlined in Appendix 1.
2  Who are we talking about?

Helen’s story

Helen is a woman in her mid-30’s. When she was 16 she was diagnosed with schizophrenia and had her first admission to a psychiatric inpatient unit. Since then she has been admitted to hospital on average about four times a year, mostly as an involuntary patient, and when she is in hospital her mental health improves. However, when she returns to the community she places herself at great risk by injecting herself with substances such as household bleach. Her judgement and ability to make decisions is seriously impaired and she has a Guardian.

When Helen is in the community her behaviour is challenging and she begs, steals and threatens members of the public. She has been charged many times with minor offences. Her behaviour towards her family is often threatening and when she does return home to live she regularly damages the house and police are often called out.

Helen is itinerant and attempts to get her hostel accommodation have been refused because of her complex needs and her risky behaviour.

Her community mental health team have made repeated requests for her to be admitted to the only mental health extended care inpatient unit in the State but this has been refused as she is considered unsuitable, mainly because of her substance abuse.

Her family have become increasingly concerned about how vulnerable she is to sexual exploitation and to physical harm when she is in the community. They are also worried about her very poor physical health as doesn’t look after herself properly. Helen’s family don’t see any way out of the current situation and, with an increasing sense of desperation, have said that maybe prison is the only place where she can be safe and receive some rehabilitation treatment for her mental health and substance misuse.
It is estimated that there are over 6,000 people aged 18 to 64 suffering from a psychotic illness in contact with Western Australian public specialised mental health services.\(^2,3\) Two thirds of them will have experienced their first episode of illness before the age of 25 years. The most common disorders are Schizophrenia and related disorders (primarily Schizoaffective and Schizophreniform Disorders) which accounts for just over two thirds of people with psychosis; or approximately 4,000 to 4,500 individuals in Western Australia.\(^4\)

It has been estimated that around 20% (approximately 800 to 1,000 in WA) of people with schizophrenia and related disorders have a severe and enduring illness and develop complex, long-term problems that may include:

- poor engagement with services;
- non-acceptance of treatment and/or treatment resistance;
- severe pervasive negative symptoms;
- cognitive impairment;
- comorbidities (including substance misuse, intellectual disability, poor physical health);
- severe difficulties with social and everyday functioning;
- vulnerable to self-neglect and exploitation;
- repeated hospitalisations and/or long hospital stays; and
- homelessness.\(^5\)

A subset of this group have been recognised by services as presenting particular difficulty in their management because of what has been termed ‘challenging behaviour’. In addition to a number of the above difficulties, this group displays:

- significantly impaired executive function;
- severely disorganised behaviour;
- poor impulse control; and
- a serious risk of self-harm and/or harm to others.

It is a group that also has high levels of homelessness and substance misuse and frequently comes into contact with the justice system. Although the exact number is not known, it is probably in the order of 10-12% of the group of people with severe and enduring illness (approximately 75 to 100 people).

\(^4\) Ibid.
\(^5\) Joint Commissioning Panel for Mental Health (2016). \textit{Guidance for commissioners of rehabilitation services for people with complex mental health needs}. Available at: \url{https://www.jcpmh.info/good-services/rehabilitation-services/}
A clinician perspective

One senior clinician, in a letter to the Chief Psychiatrist, described the difficulty in being able to provide adequate treatment and care for these individuals within the current service system as follows:

“All these young men have a history of challenging anti-social behaviour prior to the onset of a psychotic process. In two of them, at least I think, it is fair to say this was the early emergence of the serious psychotic illness. All have a history of substance and alcohol abuse. All have a history of, at times, impulsive and unexpected violent behaviour.

When obviously psychotic (paranoid) and impaired they can find themselves admitted to acute in-patient units. However, rarely are their stays long, as they can contain their expression of psychosis and present with ‘capacity’ or they are violent and are discharged immediately...

Currently all three are technically homeless.

The inpatient unit ...advised that they cannot contain such patients as they are too risky and great emphasis is placed on the ‘anti-social personality’ diagnosis and history of substance abuse as a justification for their presumed ‘capacity’.

With the only contemporary, realistic option of safe treatment and appropriate containment being via the forensic system, we find ourselves encouraging victims to charge these consumers with assault but, as you probably know, this can be a tortuous and often futile process ...

As our services unconsciously collude to exclude them from treatment, we work surreptitiously to ensure the justice system takes responsibility for them... But we know that their treatment is likely to be sub-optimal.”

While this Review could simply focus on the relatively small group of people with severe, enduring mental illness with associated ‘challenging behaviour’, as described above, this would only serve to perpetuate the myth that the major problem leading to services having difficulty in providing treatment and care for them lies primarily with individual consumers – ‘patient factors’ – rather than in the service system.

The question is how well does the current model of mental health service provision cater for people with complex needs and severe enduring mental illness?
What is the problem with the current approach?

**Mark’s story**

Mark is in his early twenties and is currently housed and supported in a share-house provided by a mental health NGO. This is his third housing placement, having had to be relocated on two occasions; the first, resulting from delusional beliefs about his housemate and, the second, from escalating antisocial and abusive behaviour towards neighbours. Despite intermittent relapses in his condition and his continued alcohol and drug misuse, the NGO and its support workers have managed to keep him engaged in their program.

Mark’s family gave a history of gradually increasing social withdrawal from early adolescence leading to him being diagnosed by private psychiatrist with social anxiety and depression at aged 17. The following year, he had his first admission to hospital with a mental illness characterised by delusional belief about his family and command hallucinations.

Mark’s progress has subsequently been punctuated by four further admissions, two of which have been under the Mental Health Act, each precipitated by his dropping out of treatment and discontinuing his medication. He has also experienced intermittent periods of homelessness. He has not had consistent, ongoing, coordinated treatment and support having had admissions to 3 different inpatient units and attended four separate community mental health services. He has been diagnosed as having schizophrenia with comorbid drug and alcohol abuse.

The onset of his illness in adolescence brought his education to a premature close. At one stage, he enrolled in a bridging course with a view to gaining entry to university, but ended up dropping out of the program. He has never had a job and is now in receipt of the sickness allowance.

Mark’s family remain supportive and maintain regular contact with him. However, he has not been able to live with them because of threatening behaviour which led to them having to take out a Violence Restraining Order. He has faced court on two charges of threat to injure, endanger or harm a person and one of criminal damage, resulting in a spent conviction and a community service order.
Mark’s future is very uncertain. His relationship with community mental health services remains tenuous. From early in the course of his illness, he has been reluctant to accept treatment and periodically drops out of treatment and stops his medication. This has led, on two occasions to him being discharged to his general practitioner; this being despite the fact that he does not have one.

He continues to abuse drugs and alcohol, and it has proved extremely challenging trying to get him to attend drug and alcohol services. Without the continuing support of his current accommodation provider, he is at significant risk of homelessness. This would, undoubtedly, heighten the ever-present risk of him ending up in the forensic system.

Despite his young age Mark’s life is in a holding pattern with the risk of going downhill. The main focus of his mental health treatment is to ensure he stays on medication. It isn’t clear where his life is heading and despite his earlier hopes to go to university, there is little being done to actively engage with him and provide the evidence-based treatments which could support him re-gain his life and begin his recovery journey.

During the consultation, a leading Western Australia carer advocate commented that maybe the problem is not with the person with ‘challenging behaviour’ but in the lack of fit between the complex needs of people with severe, enduring mental illness and the way that services are currently organised and delivered; that is, it is ‘the services that are challenged’ rather than the people that are ‘challenging’.

A recent report by the Auditor General lends weight to this view, noting that the current mix of mental health services has not changed significantly and is not working as intended for some people. Key findings included:

- More people are accessing community treatment services but the lack of growth in funding and capacity has meant people are receiving less hours of care;
- 10% of people are using 90% of inpatient care and 50% of emergency and community care;
- People who require extended care are, in the absence of alternative options, being treated in acute care beds (126 people spent more than a year in an acute bed and 158 people had multiple stays that totalled 365 days over a 4 year period);
- The current mix of services increases pressure on EDs which are being used as a gateway to mental health as hospital care is becoming harder to access and people spend more time in ED to access a secure mental health bed;
Despite significant investment in step-up/step down facilities there is no access to these services for people who are homeless or who may have lost their accommodation during an extended hospital stay.⁶

Further evidence of the shortcomings in current service system comes from a WA study of people who had been charged with committing a serious offence and were referred by the courts to the Frankland Centre. It found that:

- 20% had been discharged from community mental health services within 3 months prior to offending;
- an additional 38% were considered to be ‘lost to follow-up’ by mental health services; and
- 41% were homeless at the time of offending.⁷

Significantly, the study concluded:

“…. There exists a sub-group of patients who are at high risk of serious offending, and that special interventions within mainstream mental health services may reduce this risk. …. For many of this cohort, life-long follow-up by mental health services may be required.”

Western Australia has two dubious distinctions when compared with other States. Firstly, the latest Report on Government Services for the 5 year period 2013/14 to 2016/2017 showed that WA had the highest rate of re-admission within 28 days of discharge of all Australian States/Territories (at 18.6 % compared with national average of 14.9%). Figure 1 shows that the WA 28-day re-admission rate has been consistently trending up over the 5-year period.⁸

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⁷ Griffiths, R., (2018). Mental disorders and serious offending in Western Australia: factors preceding serious offending in patients with suspected mental disorders admitted by the Courts to a Western Australia inpatient forensic mental health unit. Perth, WA.
Secondly, in 2018, the Australian College of Emergency Medicine, in a snapshot of 65 Australian emergency departments, found that while mental health comprised 4% of presentations, they made up 19% of patients waiting for beds and 28% of those experiencing access blocks. In a media statement, it commented:

“The problem of access block was worse in some jurisdictions compared with others, and particularly notable in Western Australia (66.7%) and Queensland (38.7%).”

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How does WA find itself in this situation?

Mark Brown, writer in residence with the UK Centre for Mental Health, calling upon his experience as the development director of a research and community development company and his own lived experience, suggests one possibility:

“Not every mental health difficulty goes away. Not every challenge that mental health difficulty creates can be ‘cured’. Some people have mental health difficulties that don’t go away. The reality is not a failure of treatment; it’s a statement of fact.

The idea of care in mental health - in the sense of an individual’s requirement for support, guidance and assistance from others – has been crowded out by ideas about resilience, independence, empowerment and recovery which have shifted the focus of services from ongoing provision to episodic intervention.”

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The idea that people with severe, enduring mental illness may need ongoing care and support has gone out of vogue, possibly in part as a result of a number of factors including

10 Brown, M., (2019). Some people have mental health difficulties that don’t go away – so why do we provide care that does? London, UK: Centre for Mental Health. Available at: https://www.centreformentalhealth.org.uk/sites/default/files/mark_2_article.pdf
an ideological shift from ‘institutional’ to ‘community’ care and a misconception about the concept of ‘recovery’. Rachael Perkins, an international advocate in the recovery movement commented that recovery should never be used as an excuse for not providing services.\(^{11}\)

A key driver for the shift from ongoing provision of care to episodic interventions has been the ‘mainstreaming’ of mental health services within general health. This has led to responsibility for mental health services being subsumed within the general hospital system, bringing with it the dominance of an episodic, rapid throughput acute care model across both the inpatient and community sectors. In taking on this mantle, mental health services have been caught up in the “metrics-driven, pay-for-performance, throughput-obsessed health care system”.\(^{12}\) As a result we are faced with pressure on Emergency Departments with high levels of access block; high turnover through inpatient beds with an average length of stay of 12 days and rates of 28-day re-admissions of almost 1 in 5; and difficulty in people accessing community mental health services associated with pressure to discharge back to general practitioners.

This acute care model does not work well for people with severe and enduring mental illness with complex needs requiring long-term care and support. The Royal Australian and New Zealand College of Psychiatrists’ clinical practice guidelines for the management of schizophrenia and related disorders recommend that:

> “It is preferable that people with schizophrenia who have significant ongoing symptoms and disability and a history of serious severe psychotic relapses are followed up by specialist mental health services. These individuals will benefit from the input of a multidisciplinary team and regular assertive follow-up to ensure continuity of treatment. The GP may play an important role in managing physical health conditions. GPs should receive appropriate clinical information, including the treatment plan, and should have regular communication with mental health clinicians.”\(^{13}\)

According to the figures provided by the Health Service Providers, there are currently about 320 people being intensively case managed by assertive community outreach teams (see Appendix 2). Based on the estimated number of people who could benefit from the input of a multidisciplinary team and regular assertive follow-up to ensure continuity of treatment, there remain a large group of people living in the community, diagnosed with schizophrenia and related disorders who are not being adequately supported to achieve their full recovery potential. Many of these people are receiving support from general adult CMHS, while

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others may not be receiving any care from public specialist mental health services but are known to their general practitioner.

Very often, case managers in community mental health teams have limited capacity, because of the time demands of their caseloads, to provide their specialist expertise in delivering the complex, multifaceted evidence-based interventions required to meet the needs of this group of consumers. And few general practitioners will have access to the required resources or capacity to deal with their complex needs. A similar finding in the UK led the Joint Commissioning Panel for Mental Health to remark, “a large ‘clinical iceberg’ of under-treatment is suspected”\(^1\).

Improving access to a different model of care – ‘ongoing’ rather than ‘episodic’, with appropriate multidisciplinary and multi-provider resources - is needed to maximise recovery for this group with complex needs and severe, enduring mental illness.

\(^1\) Joint Commissioning Panel for Mental Health: Guidance for commissioners of rehabilitation services for people with complex mental health needs. Available at www.jcpmh.info
4 What services are currently available?

None of the metropolitan health services currently provide a fully integrated, co-ordinated clinical rehabilitation and recovery service, covering both community and inpatient care, which delivers specialist treatment and care to consumers with serious mental illness and challenging behaviours.

Across public mental health services there are components of a rehabilitation and recovery treatment service system. However, the coverage is mixed with people living in some parts of the Perth metropolitan area having no access to specialised community mental health rehabilitation and recovery services.

Specialist inpatient services are particularly limited and are located only at Graylands Hospital (Statewide catchment) and Bentley Hospital (East Metropolitan Health Service catchment).

As part of this review, as survey of metropolitan health service providers was conducted. It identified the availability of specialist mental health services primarily dedicated to providing treatment and care to consumers with serious mental illness and challenging behaviour. It included acute/sub-acute inpatient and community-based adult services but excluded forensic mental health services. The results are mapped in Figure 2. Detailed survey findings including service descriptions, catchments, staffing, hours of operation and consumer numbers are outlined in Appendices 2 and 3.
Figure 2: Specialist public mental health rehabilitation and recovery services in metropolitan Perth

Community-based specialist rehabilitation and recovery services

Specialist intensive community mental health outreach teams are known by a variety of names - Intensive Community Outreach Team (ICOT), Assertive Community Treatment Team (ACTT) or Community Support and Rehabilitation Program (CSPR). However, they have broadly similar models of care and share many common features including:

- Operate Monday to Friday during office hours.
- Small caseloads (usually between 7 to 12 consumers per FTE).
- Multi-disciplinary (minus clinical psychologists).
- District-based catchments.
- Not part of a comprehensive, integrated rehabilitation program which includes rehabilitation inpatient beds.

Although they vary in their level of staffing and case-loads, the North and South Metropolitan Health Services have specialist intensive outreach teams which, in combination, provide full geographic coverage of their respective area catchments.

The East Metropolitan Health Service has specialist outreach teams which cover the Midland and Bentley mental health catchments. However, there are no equivalent teams within either the Armadale or the City East Community Mental Health Services (CMHS) for people with complex needs and challenging behaviour living within their respective catchment areas. The Mobile Clinical Outreach Team is administered by the East Metropolitan Health Service but this is a specialist federally funded program which provides a targeted service for those who are homeless or at risk of becoming homeless and covers both the inner city areas of Perth and Fremantle.

**Inpatient rehabilitation and recovery services**

The John Milne Centre, based at Bentley Hospital, provides a 12 bed extended care/rehabilitation service for consumers across the East Metropolitan Health Service catchment. Graylands Hospital provides a State-wide inpatient extended care/rehabilitation service.
5 Rehabilitation and recovery services for people with severe and enduring mental illness

Some people have mental health difficulties that don’t go away – so why do we provide care and support that does?

(Mark Brown, consumer advocate)

Mental health rehabilitation services were first established during the era of deinstitutionalisation starting in the mid 1960’s as part of the process of ‘resettling’ the long-term ‘residents’ of psychiatric hospitals in community-based settings. The 1970’s saw a rapid growth in investment in community mental health services (CMHS), with the emergence in the last two decades of specialist community teams, such as crisis intervention teams, early intervention in psychosis services and assertive community treatment teams.

In Western Australia, while there has been significant investment in ‘psychosocial rehabilitation support,’ there is a lack of clinical rehabilitation treatment services. It has become increasingly evident that there are inadequacies in the availability of a full range of evidence-based treatment interventions for people with severe, enduring mental illness and complex needs.

It has proved very difficult to get recognition of the need for a significant investment in longer-term services to support the rehabilitation and recovery of this group in the current environment. As Roberts and his colleagues have noted:

“…. rehabilitation appears to have been the forgotten need in mental health services. There appears to have been a blind spot in fully accounting for the needs of people with enduring mental health problems which has been considered a ‘denial of disability’.”

Early access to rehabilitation and recovery services

In the vast majority of cases, psychosis begins in late adolescence or early adulthood, a crucial time for intellectual development, social functioning and emerging personal

15 Brown, M., (2019). Some people have mental health difficulties that don’t go away – so why do we provide care that does? London, UK: Centre for Mental Health. Available at: https://www.centreformentalhealth.org.uk/sites/default/files/mark_2_article.pdf

autonomy. Early intervention services developed in response to the observation that the long-term outcome in psychotic illnesses is established relatively early in the course of the psychotic illness. However, despite the reported short-term benefits of specialist early intervention in psychosis (EIP) services, trials have not shown sustained benefits at 5 and 10 years, even when the specialist intervention is sustained beyond 2 years. The Scandinavian Early Treatment and Intervention in First Episode Psychosis (TIPS) study\(^\text{17}\) found that if symptoms did not remit within 3 months with adequate treatment, there was a considerable risk of a poor long-term outcome and a decade later 10% of the participants had died. Disengagement rates remain high in EIP services with an average of 30% of people disengaging from treatment despite ongoing therapeutic need.\(^\text{18}\) Approximately 15-25% of people who have received EIP services will go on to develop severe and complex needs that will require specialist rehabilitation services.\(^\text{19}\)

This is not to argue against the benefits of EIP services for many, but rather to highlight the necessity for early access to rehabilitation services for those who can be identified early in the course of their illness as requiring continuing care and rehabilitative support.

Despite the recommendation that rehabilitation services should begin early in the course of illness, referrals to rehabilitation services have generally been initiated late in the course when other service options have been exhausted.\(^\text{20}\) This pattern is illustrated in the Figure 3.

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rehabilitation, EIP and acute-care services to ensure that individuals are able to access services based upon their need, with clear pathways that avoid unhelpful delays, as illustrated in Figure 4.

Figure 4: Continuous access to rehabilitation and recovery services

**Rehabilitation and recovery service: purpose, principles, interventions**

Rehabilitation has been defined as a whole system approach to recovery. It maximises an individual’s quality of life and social inclusion by fostering their skills, promoting independence and autonomy in order to give them hope for the future and aiding successful community living through appropriate support. This definition emphasises a focus on enabling individuals’ function, rather than simply addressing clinical symptoms and incorporates the importance of services maintaining therapeutic optimism for recovery.

The main function of mental health rehabilitation and recovery services is to provide specialist treatment and support to help people with complex mental health needs gain or regain skills and confidence to achieve the same kinds of goals in life as other citizens: to live as independently as possible; to engage in rewarding activity; to have good relationships with family and friends; to have adequate income to support these goals; and to participate in society. The principles underpinning rehabilitation and recovery services are outlined in Figure 5:

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A rehabilitation and recovery service system should provide a comprehensive, continuous, coordinated, collaborative and person-centred approach, offering a range of evidence-based services linked to individualised needs assessments and to the personal goals of people, with each step negotiated and aimed at goals that are personally meaningful and desired.

Jablensky et al\textsuperscript{23}, in their study of people with psychotic disorders, found that most services appeared to be provided on a crisis basis and that the availability of evidence-based interventions remains largely unmet. They commented:

\begin{quote}
\textit{“There is at present international consensus that, even in the absence of primary prevention and radical cure, much of the disability and distress associated with the psychotic disorders can be prevented or reduced if the effective interventions and management strategies that exist today are widely available and applied consistently and systematically over the various stages of the illness.”}
\end{quote}

A list of the evidence-based interventions that have been recommended for provision within rehabilitation and a recovery network include:

![Diagram of Clinical Rehabilitation and Psychosocial Support]

Figure 6: Evidence-based interventions in rehabilitation and recovery

A rehabilitation and recovery network of services

An effective rehabilitation and recovery system requires a managed functional network of services across a wide spectrum of care, comprising:

- Inpatient and community rehabilitation units;
- Community rehabilitation teams;
- Psychosocial support and recovery services;
- Supported accommodation services;
- Supported occupation/work services;
- Peer support services;
- Advocacy services; and
- Liaison and consultation services working with primary and secondary care services.

Rehabilitation and recovery services are provided through a combination of public mental health providers and NGOs, with the former providing the clinical rehabilitation component and the latter the psychosocial support component. The pathways through these services should be as seamless as possible, particularly as there is an important group of people with psychosis and severe disability in public community mental health services who do not

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access NGO services and consequently lose an opportunity for services to support them in their recovery journey.  

The commissioning of rehabilitation and recovery services must ensure that public mental health services and NGOs work collaboratively to jointly meet the needs of people with enduring mental illness and complex needs; and further, that the NGOs:

- support consumers in the clinical rehabilitation and recovery system, including inpatient, community rehabilitation units and community-based services; and.
- the intensity of the interventions and the skill levels of their staff is recognised and reflected in the funding arrangements.

**Components of an integrated rehabilitation and recovery system**

The challenge for mental health services in Western Australia is to ensure that these evidence-based interventions are available through the development of an integrated network of rehabilitation and recovery services for people with enduring psychotic illness and complex needs. Components of an integrated network of rehabilitation and recovery services are outlined in the Figure 7.

**Figure 7: Components of an integrated rehabilitation and recovery system network**


draft SMI and Challenging Behaviour Review

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Some key components are currently unavailable in Western Australia (such as inpatient rehabilitation units, community-based rehabilitation units and community transition program); whilst others need significant enhancement (such as intensive assertive community outreach, residential rehabilitation and recovery services and supported accommodation).

**Intensive Inpatient Rehabilitation Units** (also known as Secure Extended Care Units or SECUs): These units, located on a hospital campus, provide specialised clinical and rehabilitation treatment for consumers who experience severe and unremitting symptoms, have severe or multiple comorbid conditions, exhibit challenging behaviours, and histories of significant risk to themselves or others. Most will be detained under the Mental Health Act, while a number of others will have had a forensic admission. The recovery goal is to move the person on to community rehabilitation and, eventually to supported or independent community living. The length of stay on the unit will generally range from 6 months to 3 years with an expected average length of admission of up to 1 year. It has been estimated that Western Australia will need between 50 to 60 such beds.

**Community-Based Rehabilitation and Recovery Units** (also known as Community Care Units or CCUs): These units provide treatment and rehabilitation for people with enduring mental illness and complex needs who cannot be discharged directly from hospital to an independent or supported community placement due to their ongoing high levels of need. They provide individually tailored programs, creating opportunities for consumers that enhance quality of life and assist in a transition to an increased level of independence and eventual move to other community residential options.

They are generally arranged in a cluster housing configuration and may or may not be designed to accept people detained or on CTOs under the Mental Health Act depending on factors such as staffing, location and ready access to other clinical supports. These units can be located on or adjacent to a hospital site or based independently in the community. A comparison of the clinical characteristics of consumers in hospital-based and community-based residential rehabilitation in Queensland identified a significantly higher level of disability and risk of violence amongst consumers managed in a hospital-based setting. This suggests that there would be benefit in having some of these units located on, or adjacent to, hospital sites, with ready access to acute inpatient services should it be required. The length of stay on the unit will be expected to be 1 to 3 years. It has been estimated that Western Australia will require between 90 and 110 beds.

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**Long Term Complex Care/Continuing Care Units:** These units cater for consumers who have high levels of treatment refractory symptoms and complex co-morbid conditions that require a longer period of inpatient care to stabilise before being able to consider supported community living. Other rehabilitation options will often have been tried unsuccessfully. This group poses a significant risk to their own health and safety or the safety and/or the safety of others. These units will generally be located on a hospital grounds although, some beds may be located in the community. Length of admission will be up to 5 years; or even longer in a small number of cases.

**Intensive Community Rehabilitation Outreach Teams:** Mobile treatment and recovery-orientated multidisciplinary teams, aimed at improving the quality of life for consumers with complex mental health needs requiring intensive intervention in the community. These teams assist consumers to develop, or re-engage with, meaningful roles in the community. They do this through the provision of intensive specialist mental health interventions; planning, coordinating and supporting a range of internal and external services; and working with consumers to develop their sense of self-efficacy, personal support systems to assist them to live independently within their chosen community. They are most effective when they provide an extended hours service, on an outreach basis, through home visits and other community-based interventions.

In WA, there are currently 6 assertive community outreach teams (variously labelled and excluding the specialist team for homeless people), 2 in each metropolitan health service, providing services for around 320 people. Based on the estimate of people with severe, enduring mental illness and complex needs, there are an additional 600 to 700 people who could potentially benefit by having access to assertive community outreach services. A study of ICOT services provided by NMHS Adult MHS showed that they reduced the use of inpatient beds.

**Community Consultation/Liaison and Development Service:** Community rehabilitation needs to be adequately resourced to be able to move beyond simply working with individual consumers to take on a system-level role in working with other key agencies:

- **Providing consultation, advice, education and support** on mental health issues for other service providers, including other mental health and general health services, alcohol and drug services, NGOs, Primary Health Networks and community housing associations;

- **Building and maintaining partnerships** with education and vocational services, correctional services, housing providers, primary health networks and other agencies that are critical for the wellbeing of people with enduring mental illness and complex needs.
Non-Government Sector Rehabilitation and Recovery Services

The NGO sector currently provides a range of psychosocial programs as set out in Figure 7. It is proposed, however, that the sector be funded to provide an additional program, the **Community Transition Program**. This program would specifically target consumers in Intensive Rehabilitation Inpatient Units and Community-based Rehabilitation and Recovery Units who, because of their severe mental illness and complex needs, require a high level of combined clinical and community treatment and support to enable them to re-integrate into the community.

A similar program, the Integrated Rehabilitation and Recovery Care Program, was first piloted in three metropolitan consortia of NGOs in Melbourne in 2007. The program was aimed at assisting selected consumers in SECUs and CCUs to transition from inpatient/residential units to community living and involved:

- The provision of time-limited, high level of psychosocial rehabilitation and clinical support for selected consumers;
- Facilitation of access to appropriate housing or other accommodation options; and
- The provision of increased opportunities for consumer participation in community activities.

The model had three phases: preparation for transition to the community (up to 3 months); high level support in the community (12-15 months); and transition to regular clinical and psychosocial support services in the community (up to 3 months). An evaluation of the program in 2009 found that the “program achieved [its] outcomes in terms of appropriateness, effectiveness and efficiency.”

Accessing the NDIS

In September 2018, the Victorian Office of the Public Advocate released a report examining four key areas in which people with multiple and/or severe disabilities were facing difficulties with the NDIS; namely, access, planning, obtaining service providers and retaining suitable accommodation. Those experiencing the greatest difficulty typically included people with challenging behaviour who put themselves or others at risk of harm; are engaged or have been engaged with multiple government agencies; have a history of unstable accommodation and homelessness; have had periods of detention in the criminal justice and/or mental health systems; and have exhausted or at risk of exhausting workers or service providers.

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With the role-out of the NDIS across WA, these issues are likely to pose a similar risk for people with severe mental illness and complex needs, particularly those in inpatient/residential services. It is envisaged that, as part of their role in the Community Transition Program, NGOs would engage with consumers to ensure that they are appropriately linked into the NDIS in a timely fashion.

Housing

Lack of stable, secure and safe housing has serious implications for mental and physical health and well-being and is a major impediment to the recovery of people with severe, enduring mental illness and complex needs. Morgan et al., in their survey of high impact psychosis (SHIP), reported:

“Of particular concern is the high proportion of people with psychotic illness who have been homeless in the previous 12 months. There were 5.2% currently homeless at the time of the SHIP interview, 10 times the general population estimate of 0.5%. The percentage reporting any homelessness over the past year was higher, at 12.8%. Moreover, homelessness was enduring: those who had been homeless had spent considerable time so, with a mean of 155 days and a median of 99 days of homelessness over the past year. … [Homelessness] is highly correlated with unemployment and financial problems: to deal with the challenge of homelessness, these other two challenges must be met.”

Furthermore, the SHIP study found that 27% of people surveyed had changed housing in the previous year and 23% were on public housing waiting lists, reflecting both a high level of housing instability and a high level of dissatisfaction with existing housing arrangement. In the 12 months leading up to the survey, 7.5% reported that they had nowhere to live at discharge. Many of the supported accommodation pathways are designed for service-users to transition to more independent settings as their skills improve, but many dislike repeated moves. Most, but not all, people expressed a preference for independent accommodation with in-reach support rather than group accommodation.

Housing problems often contribute to relapse of mental illness and admission to hospital and, furthermore, lack of availability of suitable, supported accommodation often contributes to delayed discharges. Furthermore, a WA study of persons referred on hospital orders to the Frankland Centre by the Courts for serious offences found that 41% were homeless at the time of the offence. Access to stable, secure and affordable housing has important ramifications not only for consumers, but also for the use of inpatient and forensic services.

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The Victorian Office of the Public Advocate has found that a significant number of people with complex support needs were “failing to realise the transformational benefits that should be possible through their NDIS plans because of accommodation issues.” This has been a particular problem for people with challenging behaviours, who because of their behaviour are often unable to live sustainably with others. Group living is therefore not a viable option, nor is the private rental market.

People with severe comorbidity, particularly when accompanied by challenging behaviour, and those who have been through the justice system, have very significant problems in being accepted by housing providers/or maintaining their accommodation and often end up homeless. This exacerbates the challenge of providing appropriate treatment and care.

There are a number of successful housing programs around Australia such as 50 Lives 50 Homes (Ruah Community Services, WA), the Haven Model (Haven Foundation, Victoria) and Doorways (Mental Illness Fellowship, Victoria) that should be investigated further. There is a growing body of research demonstrating that the Housing First model, improves residential stability for people with severe mental illness and associated drug and alcohol abuse.

While there has been a significant investment by the Mental Health Commission in supported housing for people with mental illness, there remains a sizeable cohort of people with severe and enduring mental illness, complex needs and challenging behaviour who continue to fall through the gaps.

6. Integrating treatment for mental health and substance use

People with drug and alcohol issues are usually excluded from our services or labelled as having a drug induced psychosis.

(Clinician, workshop participant)

Substance co-morbidity is common amongst individuals with serious mental illness, often leading to poor outcomes and presenting a serious impediment to their treatment and recovery. There is a complex inter-relationship between addictive behaviours and mental illness and delivering effective treatment which addresses both mental health and substance use has posed a significant challenge to the two service systems which largely operate separately.\(^{32}\) This separation has been regularly identified as a major barrier to providing effective, holistic treatment.\(^{33}\) Providing integrated mental health and substance use treatment for people with enduring mental illness has been shown to be effective but requires a major change to the current approach.\(^{34}\)

High prevalence of co-morbidity

There is a high prevalence of alcohol and substance use co-morbidity among people with schizophrenia and severe mood disorders.\(^{35}\) The 2010 Australian National Survey of Psychotic Disorders reported that alcohol abuse or dependence was common among people with psychosis (58% of males and 39% of females).\(^{36}\) The proportion with a lifetime history of illicit drug use or dependence was very high (63% males and 42% females) and by comparison, amongst the general population, the rates were 12% and 6% respectively. Cannabis was found to be the most commonly used illicit drug, with one third of those surveyed having used it in the previous year and two thirds over their lifetime.

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Figure 8: Type of illicit drug used in past year and over a lifetime: people with psychosis


There has been growing concern about the traumatic impact of methamphetamine use in Western Australia. A national drug survey found that people using methamphetamine in the past 12 months were more likely than any other drug users to report being diagnosed with, or treated for, a mental health illness and their rate was three times higher than for non-illicit drug users. This rate has increased almost one and a half times since 2013.

More frequent methamphetamine use has been associated with more frequent presentations to emergency departments and increased psychiatric hospitals admissions with estimates that across Australia in 2013, that methamphetamine use accounted for between 28,400 and 80,900 additional psychiatric hospital admissions and between 29,700 and 151,800 additional emergency department presentations. Many mental health services are under strain as they attempt to provide services to consumers with complex, acute mental health presentations in addition to managing the challenging behaviour associated with their methamphetamine use.

...leading to worse outcomes for consumers

Over the long-term people with serious mental illness and coexisting substance misuse have been found to have poor engagement with treatment programs, poor medication adherence, increased likelihood of relapse, increased use of inpatient services, increased homelessness, poor physical health and social outcomes, increased risk of self-harm/suicide, increased risk of violence and increased contact with the criminal justice system.

Barriers to treatment

Despite over a decade of research and policies calling for integrated comorbidity treatment and care, the results have been disappointing with drug and alcohol and mental health services largely separate with variable levels of collaboration. The attempt at better integration of mental health and AOD services in WA through structural integration in the Mental Health Commission has not resulted in the delivery of integrated services for people with comorbidity at the clinical level. This problem is not unique to WA, with the vast majority of mental health and AOD services across Australia typically operating in silos, being separately staffed, located and funded, and offering care according to their respective service models and practices.

There are no publicly funded addiction psychiatry positions in WA and the recent cut of a training position means that it is no longer possible to complete sub-specialist training as an addiction psychiatrist in publicly funded health, mental health or alcohol and other drugs treatment services. This impacts on both direct patient care and also on the development of specialist co-morbidity treatment skills more broadly.

Consumers are frequently refused entry by mental health or AOD services based on their primary diagnosis or presenting problem and advised to seek treatment with the other service, without adequate recognition of the mutual influence that each condition has in maintaining or exacerbating the other. Lack of adequate training and professional development and support for mental health and AOD clinicians, combined with their ambiguity about their role in providing comorbidity care, often results in clients falling through the gaps. This failure to better integrate care for this group of consumers has had a profound negative effect on individuals and their families.

Integrating treatment for mental health and substance use

What is needed is integrated treatment for these high risk consumers, many of whom are challenging to engage. There is long-standing evidence that integrated treatment of co-occurring mental health and substance use disorders is more effective than separate treatments offered either in parallel or in sequence. Both Australian National Mental

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Health Commission and the RANZCP guidelines on the treatment of schizophrenia recognise the need for and the benefits of integrated treatment. 47 48

A framework for determining the primary locus of care based upon the severity of the substance use disorder and of the mental illness is outlined below.

Figure 9: Mental illness and substance use disorder: level and locus of care
Source: Adapted from Effective Models of Care for Comorbid Mental Illness and Illicit Substance Use, NSW Ministry of Health, 2015

This framework specifies that the primary responsibility for the provision of integrated treatment and care for people with serious, enduring mental illness and severe co-occurring substance use disorder should rest with mental health services. This is particularly important for people who are difficult to engage in treatment and where continuity of care is key to the development of trust. It is expected that AOD services will continue to provide specialist input for mental health services when necessary.

In order for clinicians in mental health rehabilitation services to provide integrated mental health and substance use treatment, there will need to be investment in building capacity and capability with appropriate on-going professional development to support the specialist skills required.

7. Services for people with intellectual disability and mental illness

We have a silo approach with mental health and intellectual disability and autism rather than tapping into a specialist service to be able to treat people holistically.

(Clinician, workshop participant)

People with an intellectual disability experience mental illness at a rate which is two to three times that of the general population. Recent evidence from NSW indicates that people with a dual disability have much higher psychiatric inpatient admission rates, length of stay and higher associated costs of mental health admissions compared to people without ID. The inability of the community-based service system to adequately support this client group when they are ready for discharge is a key reason for the longer than average length of stay. In the absence of adequate and sufficient support, individuals with mental ill-health and ID often turn to acute healthcare and emergency services.

This pattern of repeated and high service use demonstrates that mental health services are not providing an effective service for these individuals, many of whom have complex needs and an atypical presentation of mental illness which requires a high level of psychiatric expertise and service co-ordination.

Many factors can contribute to challenging behaviour in people with an ID and mental illness and it can be difficult to determine whether the behaviour arises from the mental disorder.

“For this reason, it is essential that mental health and disability service providers collaborate in the comprehensive assessment of challenging behaviour and in its subsequent management. Mental health service providers will be involved in identifying behaviour arising in whole or in part from mental disorders, and in

considering the possible contribution of physical health conditions. Collaboratively, mental health providers will work together with other services such as disability, to implement a comprehensive approach to the management of challenging behaviour. Interagency collaboration and a multidisciplinary approach will ensure services are coordinated and clients are provided with person-centred care.”

Mental health clinicians and services find that within the current system it is difficult to meet the complex needs of people with a dual diagnosis, particularly as unlike other states such as Victoria, there is no specialist service in Western Australia in the area of intellectual disability and mental health.

There is a pressing need to develop a Statewide Specialist Dual Diagnosis Service to provide effective treatment and care for people living with complex or severe intellectual disability and co-occurring serious mental illness. This service would:

- provide a referral pathway to mainstream mental health services;
- offer case reviews and second opinions where there is increased complexity;
- provide time-limited treatment and management until mainstream services were available; and
- advise on strategies to enhance interagency collaboration.

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 noted the need to establish a specialised service to meet the needs of people with co-occurring mental illness and intellectual, cognitive or developmental disability. Despite the identified need there has been little progress towards establishing such a service.

Where individuals have multiple and complex needs including combinations of mental illness, substance abuse, intellectual impairment, acquired brain injury and forensic issues, they can pose a risk to themselves and to the community. Specialist interagency programs can provide an effective, co-ordinated approach to treatment, care and support for these individuals. While the Young People with Exceptionally Complex Needs initiative continues, the program for adults is no longer taking new referrals despite an on-going need to provide such a service.

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54 Ibid. p23.
8. The way treatment and care is provided

**Building hope, relationship and engagement**

The importance of hope in the consumer’s recovery journey cannot be underestimated. This is particularly relevant in the context of rehabilitation where setbacks can be frequent and individuals are likely to need high levels of support over an extended period of time. In the words of Rachel Perkins, a leading consumer advocate:

*But hope does not exist in a vacuum. It occurs in the context of relationship... It is not possible to believe in your own possibilities if everyone around you believes you will never amount to very much. And in this context, mental health professionals are particularly powerful – for good or ill. If those experts who are supposed to be helping you cannot believe in your potential, what hope is there?*

This highlights the significance of ‘therapeutic optimism’ and the personal qualities, attitudes and high level of skill required of clinicians working in a rehabilitation and recovery service.

Many individuals with complex needs and challenging behaviours are described by services as being ‘hard to engage’ or ‘difficult’. They are at high risk of not adhering to or engaging with treatment and dropping out of or being discharged early from services. Many consumers do not see themselves as being mentally unwell and are often intolerant of treatment priorities they perceive as being service-determined, particularly if the focus is on medication compliance. Consumers who are ‘hard to engage’ have reported that engagement is enhanced when services provide practical assistance for everyday living, have genuine two-way conversations and respond to their priorities for support but the most important factor is having a positive relationship with their treating clinicians.

Being able to build a working alliance with consumers who have complex needs and challenging behaviours is fundamental to providing high quality treatment and care. It requires an investment from HSPs to provide on-going professional development to clinicians in rehabilitation services, including key skills which support engagement such as:

- Motivational interviewing;
- Supported decision-making;

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59 Ibid
- Strengths-based assessments; and
- Including natural supports such as families, carers and friends.  

However, it also requires that proper regard is given to the personal qualities required to work effectively with consumers who have a serious, enduring mental illness and challenging behaviours. When HSPs are determining job specifications and descriptions for roles within this specialist service they “…should not be shy of including the personal characteristics which may underpin an ability to engage with the client group”. 

It is also essential that clinicians actively choose to work in a rehabilitation service. The importance of the therapeutic relationship and continuity of care should be recognized so that clinicians are not viewed as ‘FTE’ readily able to be swapped between jobs/services.

*Familiarity breeds engagement, and this population needs skilled providers who are going to stick around. But the system considers providers to be interchangeable.*

Working with consumers with multiple, complex needs and associated challenging behaviours is demanding and often associated with reports of burnout and stress and it is vital that the well-being of staff is actively supported by HSPs.

**Continuity of care**
The importance of maintaining continuity of care for consumers with complex needs who are hard to engage cannot be overstated. It has been argued that, for these individuals, the best way to achieve this in practice is for the same psychiatrist to have responsibility for their care across both inpatient and community settings. Key decisions about admission and discharge would remain with the one psychiatrist. Other members of the treating team could also work in both the community and hospital setting and stay closely involved in the care that a consumer receives during their inpatient stay. There is a growing body of evidence that consumers prefer to see a single consultant psychiatrist throughout their treatment journey and that, when this occurs, they are more satisfied with their inpatient care. In addition to consumer satisfaction, which is a key indicator of quality of care, an integrated model would have other significant benefits including:

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- supporting continuity of care and the therapeutic relationship;
- reducing the administrative and time burden of informational transfer; and
- reducing the risks associations with transitions of care.  

### Multidisciplinary teams delivering evidence-based interventions

Access to a broad range of evidence-based interventions is a key part of supporting recovery for consumers with multiple complex needs. To be able to deliver these interventions requires a multidisciplinary team approach where each profession brings their unique knowledge, skills experience and perspective to provide the full range of evidence-based treatment to best meet the needs of consumers and their families.

Despite multidisciplinary teams being the accepted orthodoxy in mental health, it has all but been displaced in community mental health services by the generic case management model. The RANZCP, in their recent submission to the Royal Commission into Victoria’s Mental Health System described the current generic case management model as “…outdated, not fit to purpose, and does not have a strong evidence-base.” The generic case management model has led to a pervasive and profound shift in clinical practice for mental health nurses, social workers and occupational therapists working in community mental health teams. Recent research in Queensland concluded that:

“Unfortunately case management rarely leads to evidence-informed care as the demands on case managers are often dominated by general responses to social and environmental factors, including day-to-day non-clinical care coordination tasks.”

While consumers with severe enduring mental illness and complex needs require coordination of their care, there are promising innovative models emerging such as Flexible Assertive Community Treatment (FACT) which attempt to address this challenge through teams which adopt a shared caseload approach and include specialist case managers as well as discipline specific members. Such approaches, which balance the need for delivering discipline specific interventions with the need for co-ordinating complex care, are worthy of worthy of further investigation.

The consequence of the current generic case management model for consumers and their families is that these individuals miss out on receiving the interventions which will maximise

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their recovery. A radical re-think is required to ensure that a truly multidisciplinary approach to providing treatment and care is developed in specialist rehabilitation services.

**Peer workers in a multidisciplinary team**

Empowering consumers is a key principle of contemporary rehabilitation and recovery practice. A more recent addition to the multidisciplinary team are peer support workers. There is now a growing evidence base for the positive impact of peer support workers who, in partnership with professionals, bring their lived experience to support others on their recovery journey. Peer support has been found to increase treatment engagement.

In Western Australia there is considerable variation between services as to whether they employ peer support workers and, where they do, their roles and responsibilities within the multidisciplinary team. There are currently no peer workers employed in local community assertive outreach teams. However, mental health rehabilitation services in other jurisdictions, such as Queensland, have appointed Peer Support Rehabilitation Workers who work as part of the multidisciplinary team and collaborate with the team and the consumer to identify rehabilitation goals, develop a rehabilitation plan and action it.

Peer support workers can provide a bridge between the consumer and the clinical staff and support consumers by providing non-clinical interventions that support personal recovery. They are an essential member of the multidisciplinary team in all parts of a rehabilitation and recovery service.


9. Investing in change

As the recent report of the Western Australian Auditor General (AG)\textsuperscript{73} found, people with severe, enduring mental illness and complex care needs are currently using very significant resources but not achieving the desired outcomes. It found that, in the absence of alternative options, people who require extended care are being treated in acute care beds. Based on the figures in the AG’s report, the estimated cost of people with extended stays being treated in acute care beds (at $1500 per day) is just over $90 million per annum. The report concluded:

“The current mix of mental health services has not changed significantly and does not work as intended for some people.”

A UK study found that approximately 60\% of people discharged from inpatient rehabilitation successfully progressed to supported community accommodation within 12 to 18 months\textsuperscript{74} and, in a further study\textsuperscript{75}, that 40\% progressed to more independent accommodation over 30 months. People receiving support from rehabilitation services have been found to be 8 times more likely to achieve/sustain community living compared with those treated by generic community mental health services.

In terms of cost benefits, the outcomes of 190 people referred to the Intensive Community Rehabilitation Outreach Teams in the North Metropolitan Health Service in the 2 year period from October 2012 were investigated. It was reported that the possible cost saving efficiencies attributable to the decrease in inpatient beds over the 2 year period was approximately $4.5 million contrasted against the increased cost of $0.9 million invested in the community. As with a number of other studies, the most notable impact of the intensive community care was the reduction in the use of acute care beds. A UK study\textsuperscript{76} found that people who had been through rehabilitation services spent significantly less time in hospital in the 2 year post- compared with pre-rehabilitation period. The average estimated saving per person was £42,000.

The cost of putting in place a comprehensive rehabilitation and recovery system as recommended in this report will be substantial, but the cost of not doing so will be even

higher. It can be anticipated that the proposed investment will not only reduce demand on acute inpatient services, but on EDs, forensic services and community mental health services.

More importantly, it will provide people with enduring mental illness and complex needs the opportunity of getting the treatment and support they need to achieve a satisfying and contributing life.
Appendix 1: Methodology

We held small group and individual meetings with clinicians from a broad range of mental health services, including community, inpatient, forensic and specialist aboriginal mental health services, from across all three metropolitan Health Service Providers. We had discussions with a key mental health carer community managed organisation and the peak body representing consumers in Western Australia.

We examined a range of relevant material from selected previous reviews and investigations conducted by the Office of the Chief Psychiatrist.

A literature search was carried out and models of care from other jurisdictions were examined. Follow up interviews were conducted with clinical leads of innovative services in Queensland and Victoria.

We closely examined medical records of selected mental health consumers who had received treatment from multiple mental health services across the metropolitan area. These consumers had been brought to the attention of the Chief Psychiatrist because of their complex needs and their challenging behaviour and it was judged that they exemplified the patient journey.

We conducted a survey of each of the three Health Service Providers to identify the availability of specialist mental health services, both community and inpatient (acute and sub-acute), which are primarily dedicated to providing treatment for consumers with severe and enduring mental illness and challenging behaviours.

A workshop was conducted with key stakeholders to identify significant issues, gain a greater understanding of the complexity of the challenge and to investigate options.

A discussion paper is being distributed to key stakeholders for comment and feedback prior to the release of a final report.
## Appendix 2: Current specialist rehabilitation and recovery services

### Community: South Metropolitan Health Service

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Catchment</th>
<th>Hours of operation</th>
<th>Staffing Profile/FTE</th>
<th>Consumer numbers</th>
</tr>
</thead>
</table>
| Assertive Community Treatment Team (ACTT) | Fiona Stanley Fremantle Hospital Group (service located in Fremantle) | 8.30 to 4.30 Monday to Friday (excluding public holidays) | ▪ Consultant Psychiatrist (0.5)  
▪ Medical Officer (0.8)  
▪ Clinical Nurse Specialist (0.5)  
▪ Mental Health Nurses (4)  
▪ Social Workers (2)  
▪ Therapy Assistant (1)  
TOTAL FTE: 8.8 | 68 |
| Assertive Community Treatment Team (ACTT) | Rockingham-Peel Group (catchment comprises Kwinana, Rockingham, Mandurah, Pinjarra and Waroona) | 8.30 to 4.30 Monday to Friday (excluding public holidays) | ▪ Consultant Psychiatrist (0.5)  
▪ Psychiatric Registrar (0.5)  
▪ Team Leader/Case Manager (1)  
▪ Mental Health Nurses (2)  
▪ Occupational Therapist (1)  
▪ Social Worker (1)  
TOTAL FTE: 6 | 62 |

### Community: East Metropolitan Health Service

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Location/Catchment</th>
<th>Hours of operation</th>
<th>Staffing Profile/FTE</th>
<th>Consumer numbers</th>
</tr>
</thead>
</table>
| Community Support and Rehabilitation Program (CSRP) | Bentley catchment (plus small number of ‘out of area’ consumers discharged from John Milne Centre) | 8.00 to 4.30 Monday to Friday | ▪ Medical Officer (0.8)  
▪ Mental Health Nurses (1.8)  
▪ Social Worker (1)  
▪ Welfare Officer (1)  
TOTAL FTE: 4.6 | 47 |
| Intensive Community Outreach Team (ICOT) | Midland Community Mental Health Team catchment | 8.30 to 4.30 Monday to Friday | ▪ Senior Medical Officer (1)  
▪ Clinical Nurse Specialist (1)  
▪ Allied Health Assistant (Occupational Therapy) (0.80)  
▪ Occupational Therapists (1.70)  
▪ Senior Social Worker (1)  
TOTAL FTE: 5.5 | 42 |
| Mobile Clinical Outreach Team (MCOT)   | Consumers who are homeless or at risk of being homeless in inner city Perth & Fremantle (service located at City East Community Mental Health, Perth) | 7.00 to 3.30 Monday to Friday | ▪ Consultant Psychiatrist (0.40)  
▪ Clinical Nurse Specialists (2.00)  
▪ Senior Social Worker (1.00)  
▪ Clerical Support Officer (0.10)  
TOTAL FTE: 3.6 | |

### Inpatient: East Metropolitan Health Service
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Location/Catchment</th>
<th>Hours of operation</th>
<th>Staffing Profile/FTE</th>
<th>Consumer numbers</th>
</tr>
</thead>
</table>
| Intensive Community Outreach Team (ICOT) | Joondalup Community Mental Health Service (catchment comprises Wanneroo and Joondalup) | 8.30 to 5.00 Monday to Friday | ▪ Consultant Psychiatrist (0.5)  
▪ Clinical Nurse Specialist (1)  
▪ Individualised Community Living Strategy Clinical Nurse (0.5)  
▪ Social Worker (1)  
▪ Occupational Therapist (0.5)  
▪ Senior Occupational Therapist (1)  
**TOTAL FTE: 4.5** | 50 |
| Intensive Community Outreach Team (ICOT) | Stirling and Lower West (catchment includes Osborne, Mirrabooka and Subiaco Clinics) | 8.30 to 5.00 Monday to Friday | ▪ Consultant Psychiatrist (0.5)  
▪ Psychiatric Registrar (1)  
▪ Clinical Nurse Specialist (1)  
▪ Mental Health Nurse (1)  
▪ Social Worker (1)  
▪ Occupational Therapists (2)  
**TOTAL FTE: 6.5** | 50 |

Note: The active consumer numbers constantly vary. The data was provided by Health Service Providers at differing times between January and May 2019.
Appendix 3: Service descriptions

South Metropolitan Health Service

Assertive Community Treatment Team (ACTT)
The ACTT is based on an assertive community treatment model which uses outreach as a way of working with severely mentally ill adult who do not effectively engage with mainstream mental health services. The ACTT teams manage clients with severe and enduring mental illness who have difficulty engaging with services. It is a multidisciplinary service with a low ratio of clients to staff. There is capacity for increased frequency of client contact as the clinical need arises with an emphasis on engaging with clients and developing a therapeutic relationship. It offers specific evidence-based interventions, working with clients in their own environment – often their own home. The service engages with the client’s supports – family, friends and others where appropriate and consent provided. There is an emphasis on hope and the recovery model.

The aims of the ACTT teams are as follows:

- Assist clients to improve their general quality of life.
- Reduce frequency of hospital admissions.
- Reduce duration of inpatient admissions.
- Assist clients to find and keep suitable accommodation.
- Assist clients to sustain family relationships.
- Increase social networks and relationships.
- Assist clients with financial management.
- Encourage medication compliance and education on medication.
- Assist with daily living skills.
- Assist clients to undertake satisfying daily activities, including employment.
- Improve their general health and create a healthy relationship with their general practitioners.
- Stabilise symptoms.
- Intervene at an early stage to reduce the incidence of relapse and assist the patient and their family in recognising early signs of relapse.

East Metropolitan Health Service

Community Support and Rehabilitation Program (CSRP)
The CSPR is a tertiary care service of the Bentley Health Service which provides a clinical service to people suffering from severe and persistent mental illness. The program provides
treatment, rehabilitation and support services to clients to assist them to achieve the best possible outcome. It recognises that for people with severe mental illness optimal outcome is achieved by the simultaneous provision of a comprehensive treatment, rehabilitation and support service provided in an integrated fashion. The focus of the CSRP is to provide evidence-based treatment and rehabilitation in line with the principles of the recovery model, providing medium to long-term support to assist in the maintenance of independence, good health and quality of life. The program operates within a holistic framework, incorporating all aspects of an individual's lifestyle. Using the least restrictive treatment model, assistance is provides in accessing necessary and appropriate services and the learning or re-learning of skills, which will assist individuals to improve and enhance their quality of life, maximise their potential and gain independence in the community. Support and education will also be offered to carers, families and community agencies.

The key objectives of the CSRP are to:

- Promote independence of clients, reduce symptoms, enhance function and to increase quality of life.
- Provide evidence-based individualised and intensive intervention programs, both psychopharmacological and psychosocial, for clients who because of the impairments caused by severe and persistent mental illness, are marginalised and are experiencing difficulties functioning independently in the community.
- Provide support, education and training to carers, significant others and agencies providing services to our target group.
- Link clients with community groups.
- Develop sustainable and valuable networks with community support providers to advocate for the provision of services to the program’s client group.

**Intensive Community Outreach Team (ICOT)**
The ICOT, located at Midland Mental Health Service, comprises doctors, occupational therapists, nurses, social workers, clinical psychologist and others with mental health specialist skills. It helps with improving the management of mental health and well-being by focusing on individual need which may include symptom control, medical, physical health care, improving relationships and managing finances. The ICOT case manager will visit consumers in their home or other places in the community where appropriate.

**Mobile Clinical Outreach Team (MCOT)**
The MCOT is an assertive mental health outreach service that provides mental health care to a cohort of clients with serious and persistent mental illness who are homeless or at risk of homelessness and who are also engaged with the “Street to Home Program.” It is the only mental health team in WA which exclusively target homeless people and has a high level of expertise in working with these clients. MCOT can case manage people within the inner city...
areas of Perth and Fremantle and also provides consultations with non-government agencies outside of this boundary.

The primary role of MCOT is to:

- Undertake mental health assessment and treatment for clients of the Street to Home Program.
- Provide assertive case management services.
- Provide care co-ordination and link individuals with support services, community mental health services or GP and AOD services for ongoing care and support.
- Conduct assertive outreach and develop strong networks with agencies and services with similar interests to make the service more accessible for clients.

**Extended Care Rehabilitation Inpatient: John Milne Centre**
The John Milne Centre is a 12-bed inpatient intensive mental health rehabilitation and treatment unit for adults within the East Metropolitan Health Service catchment who are aged 18 and over with severe and enduring mental illness and associated functional deficits. The unit is not authorized under the Mental Health Act for the admission of involuntary patients. The multidisciplinary service provides medium term rehabilitation and treatment for patients to enable them to live in the community and function at their optimal level. The anticipated median length of stay is 3 months.

**North Metropolitan Health Service**

**Intensive Community Outreach Team (ICOT)**
The ICOT is a tertiary specialist mental health service which delivers community based clinical rehabilitation services to those consumers with severe and persistent mental illness. It provides intensive, specialist evidence-based mental health interventions for consumers who require significant assistance to recover from mental illness. The ICOT provides assertive case management, care coordination and utilises different strategies to engage the consumer and carers to assist with recovery

Key objectives of the ICOT are to:

- Ensure that consumers with complex needs and challenging behaviours, who have minimal engagement with mental health services, have access to treatment.
- Address the physical health care needs of consumers in partnership with the GP.
- Use evidence-based tools to guide clinical decision making and monitor progress towards recovery.
- Identify a consumer’s unmet needs using an evidence-based MANCAS assessment.
- Provide long-term care in the community.
- Refer to other community services in the catchment area to address psycho-social needs.
- Support other community mental health teams, by providing direction to meet the consumers’ rehabilitation needs’
- Provide a range of specialised interventions to meet the individual consumers unmet needs.

**Statewide Inpatient: North Metropolitan Health Service**

The Hospital Extended Care Service (HECS) is a Statewide tertiary level inpatient rehabilitation service based at Graylands Hospital. It provides person-centred care in an inpatient setting through intensive case management that is guided by recovery principles.

The goals of HECS are to:

- Develop, where possible, an ongoing therapeutic relationship with each patient as the basis of change and recovery.
- Identify and address in detail unmet need that cannot be addressed in a community or other setting.
- Provide clinical interventions and strategies to control or minimise disabling psychiatric symptoms guided by the unmet need sand patient preference.
- Develop personalised functional and behavioural interventions to address disruptive behaviours that interfere with living safely in the community.
- Provide focussed consistent pharmaceutical review, reconciliation, and concordance.
- Provide access and referral to specialist allied, and physical health services to maintain and enhance the quality of health care provision.
- Identify and engage support services to enable transition to supported community living where possible.
- Provide education and support for family, carers, community services and relevant support providers to improve the understanding and management of challenging and/or disruptive behaviours that affect community acceptance and safety.
- Develop consultative and collaborative partnership with government organisations, General Practitioners and community service providers.
- Provide advice on specialised mental health rehabilitation approaches and services.
The Chief Psychiatrist aims to ensure that Western Australians receive the highest standard of mental health treatment and care.