CHIEF PSYCHIATRIST
of Western Australia

Chief Psychiatrist's Review

Building rehabilitation and recovery services

for people with severe enduring mental illness and complex needs - including those with challenging behaviour

www.chiefpsychiatrist.wa.gov.au 2020

Acknowledgements

The Office of the Chief Psychiatrist would like to thank those who participated in this Review and provided their expertise and valuable insights.

Consumer stories

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

Reviewers

Clinical Associate Professor, Dr Geoffrey Smith, Senior Psychiatrist Research and Strategy, Office of the Chief Psychiatrist.

Adjunct Associate Professor Theresa Williams, Director Research and Strategy, Office of the Chief Psychiatrist.

Recommended citation

The Chief Psychiatrist of Western Australia (2020). *People with severe enduring mental illness and challenging behaviour: A targeted review of adult public mental health services in metropolitan Perth.* Perth, WA: Office of the Chief Psychiatrist.

Contents

Message from the Chief Psychiatrist

Our current mental health system is not working effectively for people with severe, enduring mental illness and complex needs. Consumers, carers and clinicians have raised this with me over several years.

This Review was initially known as the 'Challenging Behaviours' Review. However, as it progressed, it became clear that those with challenging behaviour are a small subset of individuals within a much larger group of people with severe, enduring mental illness and complex needs who are not well-served by the current system - a system which largely provides 'episodic' rather than the 'ongoing' treatment and care. We have, therefore, changed the focus of the Review to reflect this.

We have found that if you have co-occurring substance use, or if you struggle to engage with services, or have a history of aggression, you may be seen as 'too difficult' or 'not meeting the entry criteria' for services and rejected or 'bounced' around between agencies. We have received innumerable reports of individuals who have fallen through the cracks in the current mental health system and ended up in the justice system.

The Auditor General's report, *Access to State-Managed Adult Mental Health Services*, confirmed what many already knew; that *"The current mix of mental health services … does not work as intended for some people."* It found that 10% of consumers are using 90% of inpatient mental health services, half the community services and half the mental health services provided through EDs. Furthermore, it found that significant numbers of individuals with severe mental illness remain in acute inpatient beds because of extremely limited access to specialist rehabilitation services.

What is required is an investment to build a coordinated network of mental health rehabilitation and recovery services – both clinical treatment and psychosocial support – that provide continuous treatment, care and support for some of the most vulnerable people in our community to assist them in achieving the same life goals as their fellow citizens.

My sincere thanks to all the consumers, carers and clinicians who have shared their knowledge and expertise in advocating for improved services.

Dr Nathan Gibson
Chief Psychiatrist of Western Australia

Recommendations

Delivering integrated rehabilitation and recovery services

Recommendation 1

The Mental Health Commission and WA Health should develop a comprehensive, integrated mental health rehabilitation and recovery service system to provide person-centred, evidence-based treatment, care and support for people with severe and enduring mental illness and complex needs. This service system should comprise a range of components, including inpatient, residential and community services, with clinical rehabilitation provided by the public mental health sector and psychosocial rehabilitation and support provided by the non-government sector.

Recommendation 2

As a priority, planning for the development of the mental health rehabilitation and recovery service system should be undertaken in collaboration with key stakeholders including consumers and carers, the non-government sector and Health Service Providers.

Recommendation 3

Clinical rehabilitation and recovery services should be established as separate streams with their own governance structure within the adult mental health program with the aim of providing consumers with coordinated, seamless care across a range of treatment settings to facilitate their recovery journey.

Recommendation 4

Public mental health and non-government services should be commissioned in a way that promotes integrated care with the aim of services working collaboratively to jointly meet the complex needs of people with severe and enduring mental illness.

The clinical rehabilitation and recovery workforce

Recommendation 5

In a context in which individuals are likely to be hard to engage, need high levels of support over an extended period and where setbacks can be frequent, it is important that staff have the ability to engage with and form a working alliance with consumers and maintain their therapeutic optimism. As these personal qualities and skills are essential for working with this cohort, Health Service Providers should incorporate them into job specifications and the staff selection process.

Recommendation 6

To deliver high quality treatment and care, Health Service Providers should invest in on-going professional development and ensure that that the rehabilitation and recovery workforce receive adequate supervision and peer support.

Recommendation 7

Health Service Providers should develop strategies to ensure that multidisciplinary teams deliver the full range of evidence-based interventions in all rehabilitation and recovery treatment settings to support consumers in their recovery journey.

Recommendation 8

The Mental Health Commission should fund Health Service Providers to employ peer support workers as essential members of multidisciplinary teams in all rehabilitation and recovery treatment settings.

Integrating treatment for substance use and mental illness

Recommendation 9

Primary responsibility for providing integrated treatment to people with co-occurring severe, enduring mental illness and substance use disorder should reside with rehabilitation and recovery mental health services. To provide integrated mental health and substance use treatment, the Mental Health Commission should invest in building the capacity and capability of the rehabilitation and recovery services workforce, including on-going professional development.

Specialist neuropsychiatry service

Recommendation 10

As a priority, the Mental Health Commission and WA Health should jointly lead a planning process to establish a Specialist Neuropsychiatry Service for people with a co-occurring mental illness and an intellectual, cognitive or developmental disability.

Executive summary

Introduction

In the face of mounting concern by clinicians and families about the quality of current services being provided to people with severe, enduring mental illness and challenging behaviours, the Chief Psychiatrist instigated a formal targeted review aimed at:

- Identifying the number and characteristics of this group of consumers;
- Exploring the barriers and enablers to providing high quality treatment and care;
- Mapping the current range of service types, configurations and models of care;
- Identifying 'best practice' models from other jurisdictions;
- Developing options for future service development; and
- Acting as a catalyst for change.

The Review primarily focused on adults receiving treatment and care from metropolitan Perth public mental health services although, where possible, some consideration has been given to the needs of young people, older adults and those living in rural and remote areas.

Who are we talking about?

It has been estimated that around 25% of people with schizophrenia and related disorders have a severe and enduring illness with complex, long-term needs that impact on their personal, social and occupational functioning. A subset of this group present particular difficulty for services in their treatment and care because of what has been termed 'challenging behaviour': essentially, significantly impaired executive function, severely disorganised behaviour, poor impulse control and serious risk of self-harm and/or harm to others. Without appropriate treatment and care these individuals 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.

The Reviewers decided not to simply focus on this small subset of consumers, but rather to take a broader view of all people with severe, enduring mental illness and complex needs. To do otherwise would only 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'), failing to recognise that the current mix of services is not working as intended for this group of people.

What is the problem with the current approach?

Individuals with severe, enduring mental illness and challenging behaviours and their families face significant challenges in accessing the services needed to support their recovery with many consumers having inappropriate and long stays in acute inpatient units, being caught in revolving cycles of ED visits or at worst, entering the justice system. From a health system perspective they are being cared for in the most intensive highest cost settings. This is both expensive and less effective.

For these vulnerable individuals, the reforms which were anticipated with the *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and other Drug Services Plan 2015-2025* have largely not been realised. While the Plan established a broad strategic vision, it has not translated into the development of the suite of specialised treatment services, the care pathways and the co-ordinated care these individuals require to support their recovery.

While there has been significant growth in the ***'psychosocial rehabilitation and support'*** services provided by the NGO sector, this has not been matched by a corresponding investment in ***'clinical rehabilitation treatment'*** services. This lack of clinical treatment services in WA is in sharp contrast to other Australian jurisdictions such as Victoria and Queensland, where specialised intensive inpatient, residential and community-based rehabilitation and recovery units/teams are standard components of contemporary mental health services.

The idea that individuals with severe, enduring mental illness may need ongoing treatment and support seems to have gone out of vogue with the shift in focus to an 'acute care' model characterised by episodic, rapid throughput across both inpatient and community mental health services. This has had significant system-level consequences with pressure on EDs and high turnover through inpatient beds with almost one in five individuals being readmitted within 28 days.

The RANZCP guideline for people with schizophrenia and related disorders recommends that individuals with severe, enduring mental illness and complex needs should have continuing care from specialist mental health services to ensure that they receive evidence-based interventions delivered by a multidisciplinary team. However, clinicians in WA's community mental health services have limited capacity, because of the time demands of their caseloads, to use their specialist expertise to deliver these interventions. They are also under increasing pressure to discharge to GPs who rarely have access to the required resources or the capacity to deal with the many complex needs of these individuals.

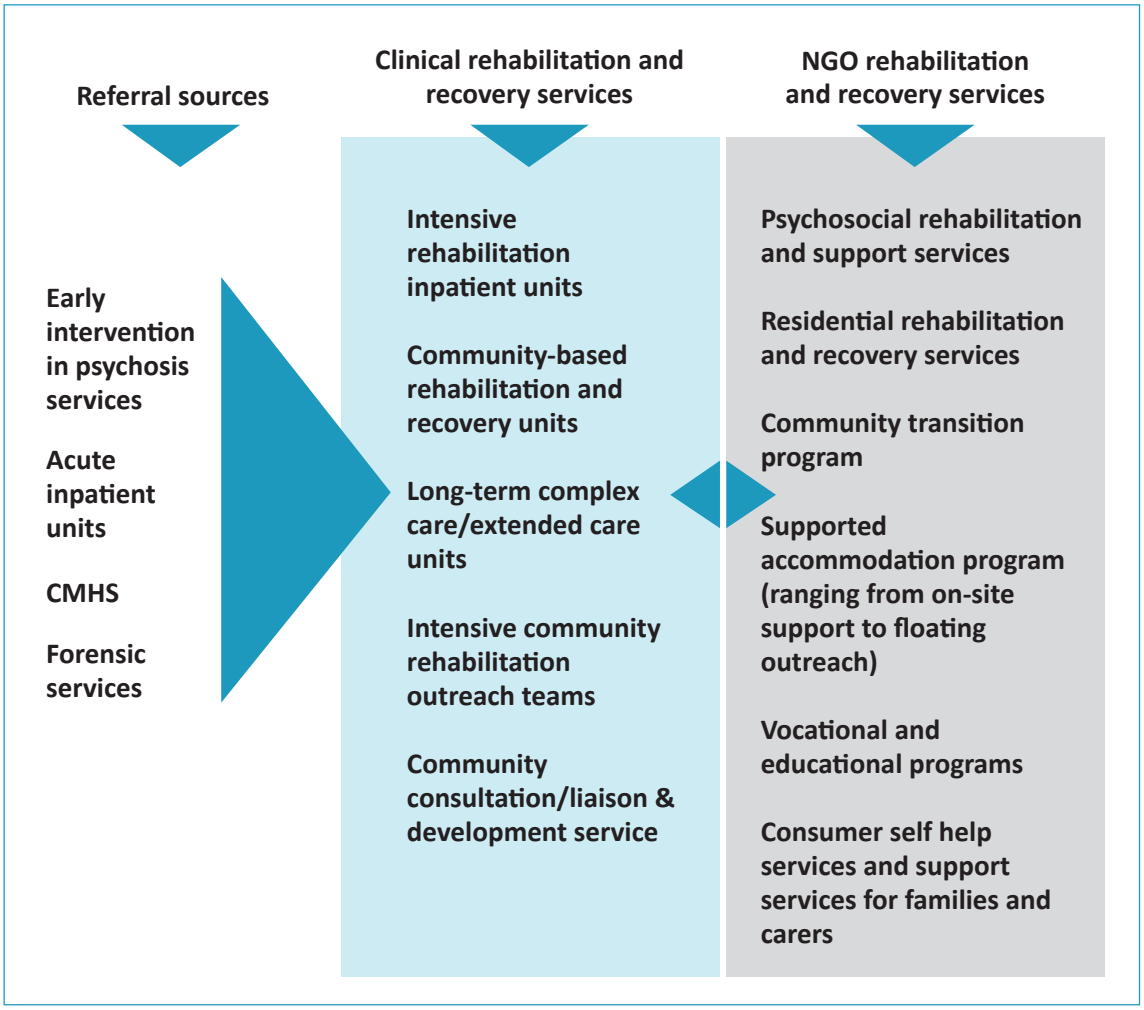
Improving access to a different model of care – ***'ongoing'*** rather than ***'episodic'***, with appropriate multidisciplinary and multi-provider resources – is needed to maximise recovery for this group of consumers. Rehabilitation services meet these requirements.

Building a rehabilitation and recovery service system

Rehabilitation aims to maximise an individual's quality of life and social inclusion by fostering his/her skills, promoting independence and autonomy and aiding community living through appropriate support. There is robust evidence that specialist rehabilitation treatment services are effective for people with severe, enduring mental illness who have long-term complex needs that cannot be adequately met by general mental health services.

An integrated rehabilitation and recovery system network

An effective rehabilitation and recovery system requires an integrated, collaborative network of services delivering treatment and support through a combination of public mental health providers and NGOs, with the former providing the ***clinical rehabilitation treatment*** component and the latter the ***psychosocial rehabilitation and support*** component. The way in which services are commissioned must ensure that the two sectors provide integrated care so as to jointly meet the complex needs of people with severe, enduring mental illness.



In WA, some essential components of a rehabilitation and recovery service system are ***currently unavailable*** such as inpatient rehabilitation units (SECUs), community rehabilitation units (CCUs) and a community transition program; whilst others ***need significant enhancement*** such as intensive assertive community outreach, residential rehabilitation and recovery services and supported accommodation.

Clinical rehabilitation and recovery services

A clinical rehabilitation and recovery service system should include the following core components:

- Intensive Inpatient Rehabilitation Units (SECUs);
- Community Rehabilitation and Recovery Units (CCUs);
- Long Term Complex Care/Continuing Care Units;
- Intensive Community Rehabilitation Outreach Teams; and
- Community Consultation/Liaison and Development Service.

The Government recently announced its commitment to investing $25 million to develop Perth's first residential rehabilitation CCU which will be run by an NGO. This investment is a positive first step towards building a rehabilitation and recovery service system. It is, however, important that a range of CCUs are developed to meet the needs of different cohorts – with some being located on or adjacent to hospital sites, and some based in the community being managed and staffed by clinical services. This will ensure that those individuals with significant levels of disability and at high risk of harm to themselves and/or others can access intensive, specialised clinical services in a rehabilitation treatment setting.

There is an urgent need to develop a clearly articulated rehabilitation and recovery plan to guide future investment. This will avoid services being developed in a piecemeal way - exacerbating what is already a fragmented, poorly coordinated system which makes it more difficult for consumers and their families to navigate.

Delivering integrated clinical rehabilitation and recovery services

Coordinated, seamless treatment is particularly important for people with severe, enduring mental illness and complex needs whose recovery journey often necessitates access to and transition across a range of clinical settings - community, residential and inpatient. Clinical rehabilitation and recovery services should operate as a distinct service stream, with its own identity, clearly articulated purpose and governance structure which is aligned with, but not incorporated into, acute services. This will ensure continuity of care and minimise barriers as consumers move between rehabilitation treatment settings.

NGO community transition program

The NGO sector currently provides a range of psychosocial programs. However, within the current funding parameters and limited resources, they can find it difficult to meet the multiple complex needs of individuals with challenging behaviour. It is proposed that the NGO sector be funded to provide an additional program, the **Community Transition Program**. This program would specifically target consumers in Intensive Rehabilitation Inpatient Units (SECUs) and clinically run Community Rehabilitation and Recovery Units (CCUs) who, because of their severe mental illness and complex needs, require a high level of combined clinical treatment and psychosocial support to enable them to re-integrate into the community.

Early access

The Review signals an important shift in emphasis to early and continuous access to rehabilitation and recovery services. Despite the onset of psychosis being mainly in late adolescence or early adulthood, referral to rehabilitation services has generally been initiated late in the course of illness when other options have been exhausted. An international study of a specialist early intervention psychosis services (EIP) found that if symptoms did not remit within 3 months with adequate treatment, there was a high risk of poor long-term outcome This highlights the need for timely access to rehabilitation services for those who can be identified early as requiring assertive ongoing treatment and care. It attests to the importance of collaboration and clear pathways between rehabilitation, EIP, acute and forensic mental health services.

Special populations

Although this Review primarily focussed on adults living in metropolitan Perth, the needs of young people (particularly those in the 16 to 17 age group), older adults or those in rural and remote areas are important and have been considered. In planning for the development of metropolitan-based rehabilitation and recovery services, there will need to be capacity and the flexibility to respond appropriately to the needs of these populations.

Accessing the NDIS

There have been fewer than expected numbers of people with a psychosocial disability accessing the NDIS and despite recent positive developments such as the Complex Support Needs Pathway, interface issues with mainstream mental health services continue to be a significant challenge. The level of support required to assist this cohort to engage with and access the NDIS should not be underestimated.

This highlights the importance of developing a Community Transition Program, where it is envisaged that NGOs, as part of their role, will actively engage with consumers to ensure that they are linked into the NDIS in a timely fashion. The additional demand on clinical services supporting consumers to access the NDIS also needs to be recognized and considered when planning and resourcing rehabilitation and recovery services.

Housing

There is a lack of safe, suitable and sustainable accommodation for individuals with challenging behaviours, particularly for people with a history of treatment in the forensic mental health system. A WA study of persons referred on hospital orders to the forensic inpatient unit 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 their use of inpatient and forensic services.

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. There is an urgent need to develop a strategy to specifically address their housing needs.

Integrating treatment for substance use and mental illness

Substance co-morbidity is common amongst individuals with severe mental illness, often complicating their treatment and leading to poorer outcomes. There is a complex inter-relationship between addictive behaviours and mental illness. 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 has been identified as a major barrier to providing effective, holistic treatment and requires a cultural shift away from a dichotomous view of mental illness and substance misuse.

There is evidence that integrated treatment of co-occurring mental health and substance use disorders is more effective than separate treatment, whether offered either in parallel or in sequence. Mental health rehabilitation and recovery services need to take responsibility for providing integrated treatment for people with severe, enduring mental illness and co-occurring substance use; and in order to achieve this, there needs to be an investment in building both the capacity and capability of their clinical workforce.

Specialist Neuropsychiatry Service

Challenging behaviour is the most common reason people with a co-occurring mental illness and an intellectual, cognitive or developmental disability are referred to acute mental health and emergency services. Consequently, these individuals are most commonly treated in a costly hospital setting, often presenting in crisis and with the interventions largely focussed on symptom containment.

Unlike other jurisdictions such as Victoria, WA does not have a specialist neuropsychiatric service for people with a co-occurring mental illness and intellectual, cognitive or developmental disability. The need to establish a dedicated statewide neuropsychiatry service was recognised in the *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and other Drug Services Plan 2015-2025.* To date there has been little progress and there is a pressing need for action to establish a Specialist Neuropsychiatry Service.

The clinical rehabilitation and recovery workforce

Access to evidence-informed interventions is a key part of supporting recovery for consumers with complex needs. The delivery of these interventions requires a multidisciplinary approach in which each profession brings its unique knowledge, skills, experience and perspective to bear. This specialist role of the professions has been all but displaced in community mental health services by the generic case management model, the demands of which leave little time for practitioners to provide the full range of evidence-informed treatments that are so important in promoting recovery. It is important that clinical services investigate ways to balance the need for delivering discipline specific, evidence-informed interventions with the need for co-ordinating complex care.

Peer support workers have become a more recent addition to the multidisciplinary team in contemporary rehabilitation and recovery services. There is now a growing evidence base which supports their positive impact in providing a bridge between consumers and clinical staff. This enhances engagement and supports consumers on their recovery journey. In some jurisdictions their work has extended beyond the multidisciplinary team to roles such as peer educators, peer researchers and, more broadly, to contributing to service design and development.

Proper regard should be given to the personal qualities required to work in rehabilitation and recovery services. In a context in which consumers with complex needs are likely to be hard to engage, need high levels of support over an extended period and where setbacks can be frequent, it is important that staff have the ability to engage with and form a working alliance with consumers and maintain their therapeutic optimism. As these personal qualities and skills are essential for working with this group of consumers, HSPs should incorporate them into job specifications and the staff selection process. The clinicians who work in rehabilitation should be those who have chosen to be there, and who are therefore fully committed to the role, not those who might have been unwillingly assigned as a ‘resource’ that can be moved by HSPs between a range of service programs.

Investing in change

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

The recent report of the WA Auditor General found that people with severe, enduring mental illness and complex needs are currently using a significant number of bed-days in acute mental health units. In the five year period from 2013 to 2017, 126 people spent 365 or more consecutive days in acute inpatient units (82,874 bed days) at an estimated cost of $115 million. This equates to an annual average of 45 acute inpatient beds. A further 158 people had multiple stays in acute inpatient beds totalling 365 days or more over that same period.

This has far-reaching effects not only on the quality of life for the people themselves and their families, but also on the healthcare system. It reduces the beds available for people requiring access to acute inpatient care, which in turn puts back pressure on hospital EDs (the main gateway into inpatient care) and on community mental health services.

It can be anticipated that the proposed investment will have the effect of increasing access to acute inpatient services, reducing the pressure on EDs and forensic services and increasing access to community mental health care.

1. Introduction

The Chief Psychiatrist has become increasingly concerned about the standard of care being provided to people with a severe, 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.

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…

> **“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 Godlee, Editor in Chief, BMJ)[1]

Clinicians have raised 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

1 Godlee, F. (2009). Through the patients’ eyes. *BMJ*, 338.b588.

the needs of these individuals and their families.

In light of this mounting concern, the Chief Psychiatrist instigated a formal targeted Review into the treatment and care of adults who have a severe mental illness with complex needs and challenging behaviour. The Research and Strategy team within the Office of the Chief Psychiatrist was tasked with undertaking this Review to investigate the issues and, in partnership with key stakeholders, develop options to enhance future 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.

The Review is intended to be a catalyst for change.

Specifically, the Review aimed to:

- 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.

While the primary focus of the Review was on those aged between 18 and 64 years who are receiving treatment and care from Perth metropolitan mental health services, the reviewers have tried to address, where possible, some of the needs of children and young people, older adults and those living in rural and remote areas, which were raised during the consultations.

The Review 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 failed 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 misuse.

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 she 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 WA's 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 account for just over two thirds of people with psychosis; or approximately 4,000 to 4,500 individuals in WA.[4]

It has been estimated that around 25% of people with schizophrenia and related disorders[5] 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 poor physical health, alcohol and substance use, intellectual disability);
- severe difficulties with social and everyday functioning;
- vulnerability to self-neglect and exploitation;
- repeated hospitalisations and/or long hospital stays; and
- homelessness.[6]

A subset of this group has been recognised by clinical mental health services as presenting particular difficulty in the provision of treatment and care 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 co-morbid substance use and frequently comes into contact with the justice system.

2 Whiteford, H., Buckingham, B., Harris, M. *et al.* (2017). Estimating the number of adults with severe and persistent mental illness who have complex, multi-agency needs. *Australian and New Zealand Journal of Psychiatry,* 51, 799-809.

3 Morgan, V., Waterreus, A., Jablensky, A. *et al.* (2012). People living with psychotic illness in 2010: The second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry,* 46, 735-752.

4 Ibid.

5 National Institute for Health and Clinical Excellence (2020). *Rehabilitation for adults with complex psychosis and related severe mental health conditions: NICE guideline DRAFT.* UK: NICE.

6 Joint Commissioning Panel for Mental Health (2016). *Guidance for commissioners of rehabilitation services for people with complex mental health needs*. Available at: https://www.jcpmh.info/good-services/rehabilitation-services/

There is limited information on the number of Western Australians who make up this cohort as well as a gap in our knowledge about their pattern of service utilisation and their journey through the service system.[7]

There is an urgent need to address these information gaps as part of any future planning process. This is particularly pertinent in relation to Aboriginal people who have higher rates of mental illness and suicide and higher rates of substance use than the general population but have less access to mental health services.[8]

This Review could have simply focussed on the relatively small group of people with severe, enduring mental illness with associated 'challenging behaviour', as described above. However, this would only have served 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?

7 Western Australian Auditor General (2019). *Access to State-managed adult mental health services.* Perth, WA: Office of the Auditor General.

8 COAG Health Council (2017). *The Fifth National Mental Health and Suicide Prevention Plan*. Canberra, ACT: COAG.

3. What is the problem with the current approach?

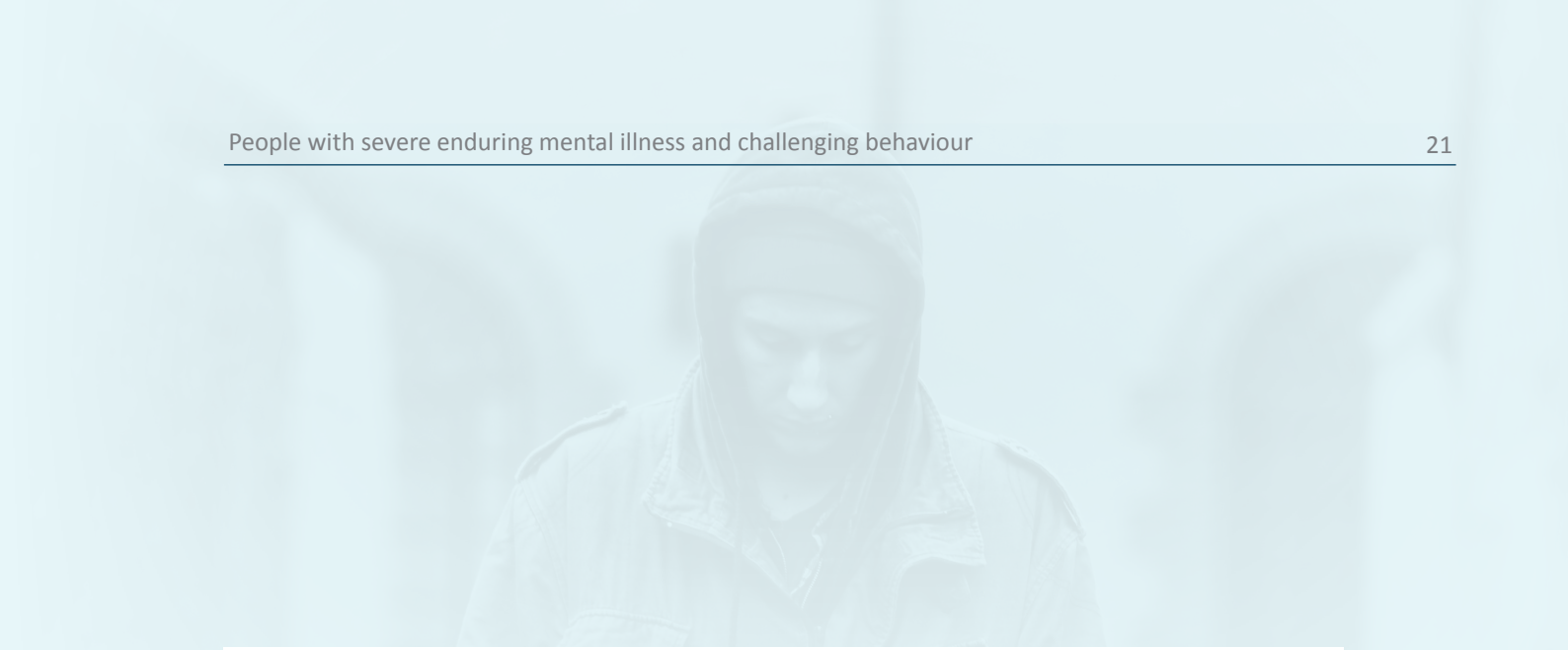
Mark's story

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 use, 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 as an involuntary patient 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 use.

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 GP; this being despite the fact that he does not have one.

He continues to use drugs and alcohol, and it has proved extremely challenging trying to get him to attend alcohol and drug 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.

3.1 A mental health system under pressure

During the consultation, a leading WA 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*'.

...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 are spending 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.[9]

Further evidence of the shortcomings in the 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 a secure forensic mental health inpatient unit, 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.[10]

9 Office of the Auditor General (2019). *Access to state-managed adult mental health services*. Perth, WA: Office of the Auditor General.

10 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. (Unpublished)

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."*

3.1.1 A clinician perspective

One senior clinician, in a letter to the Chief Psychiatrist, described the difficulty in providing adequate treatment and care for these individuals within the current service system.

"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'.

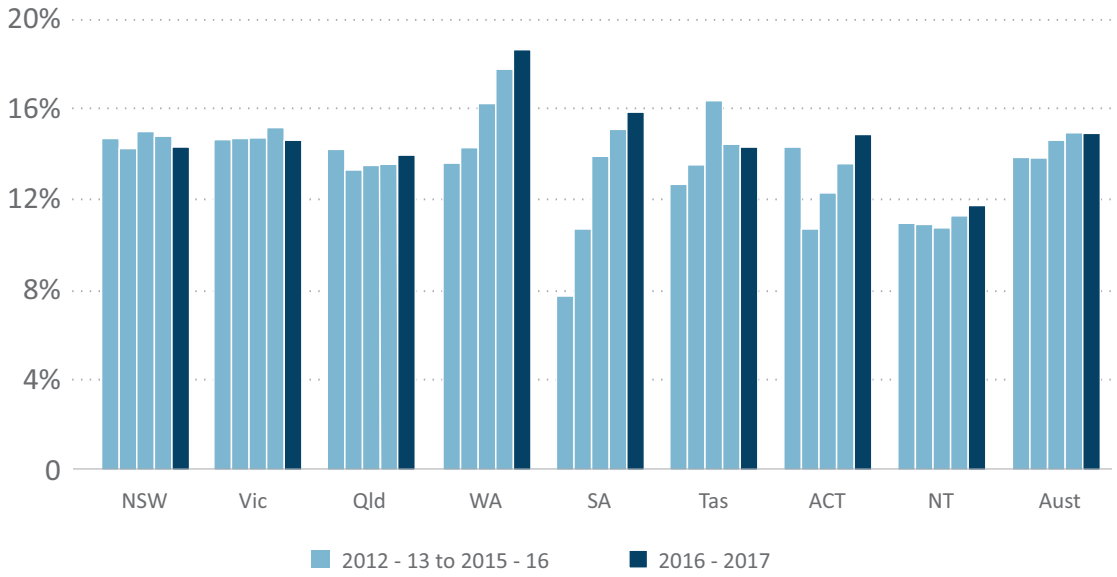
With the only contemporary, realistic option of safe treatment and appropriate containment being via the forensic system, we find ourselves encouraging victims to charge these consumers with assault but, as you probably know, this can be a tortuous and often futile process …

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."

3.1.2 WA compared with other States

Western Australia has two dubious distinctions when compared with other States. Firstly, the 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.[11]

Figure 1: Readmissions to acute psychiatric units within 28 days of discharge 2012/13 to 2016/17



Source: Report on Government Services: Australian Government, Canberra, ACT, 2019 (see footnote 11 below)

Secondly, in 2018, the Australian College of Emergency Medicine, in a snapshot of 65 Australian EDs, 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. It noted:

> *"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%)."*[12]

11 Productivity Commission (2019). Part E, Chapter 13: *Mental health management*. In: Report on government services: Australian Government, Canberra. Available on: https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/health/mental-health-management/rogs-2019-parte-chapter13.pdf

12 Australasian College for Emergency Medicine (26 February 2018). Media release: *ACEM calls for new approach to mental health care in EDs*. Melbourne, Victoria: ACEM.

3.1.3 Longstanding structural and systemic challenges

Many of the structural and systemic challenges identified in this Review are well recognised. Recently the *Review of the Clinical Governance of Public Mental Health Services in Western Australia* outlined a number of these issues:

> *"There is a significant gap in integrated system-wide planning, which is noted in past reviews. There is no detailed system-wide service plan that incorporates all providers and describes service access, models of care or pathways and coordination of services. The lack of integration between clinical and non-clinical sectors has led to poorly integrated and ineffective services. Consumers are having difficulties getting the help they need and face a difficult journey through the system. Planning lacks focus on the differing needs of patient groups. The population with severe mental illness (SMI) accounts for only 10 per cent of patients yet consumes 90 per cent of hospital care and 50 per cent of ED and community services but there appears to be few dedicated services that provide for this group. There is also an urgent need to improve the viability of the accommodation sector, which is critical to the system."*[13]

Individuals with severe, enduring mental illness and challenging behaviours and their families face significant challenges in accessing the services needed to support their recovery, with many consumers having inappropriate and long hospital stays, being caught in revolving cycles of ED visits or at worst, entering the justice system.[14] From a health system perspective they are being cared for in the most intensive highest cost settings, which is both expensive and less effective.

For these vulnerable individuals, the reforms which were anticipated with the *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and other Drug Services Plan 2015-2025* have not been realised.[15] While the Plan established a broad strategic vision, it has not translated into the development of the clinical services needed to address the gaps in treatment and care for this cohort. Although in recent years there has been a significant investment in new services such as Step-Up/Step-Down facilities, they are not designed to meet the multiple, complex needs of this group. Nor does the seemingly ad hoc development of services over recent years facilitate access to the suite of specialised treatment, the care pathways and the co-ordinated services these individuals require to support their recovery.

The urgent need for a rehabilitation and recovery system plan was highlighted by the recent announcement by the WA Government to invest $25 million to develop Perth's first residential rehabilitation Community Care Unit (CCU). While this investment is a positive step, there is a danger that in the absence of a clearly articulated rehabilitation and recovery strategy, this piecemeal approach to developing services will exacerbate

13 Department of Health (2019). *Review of the clinical governance of public mental health services in Western Australia*. Perth, WA: Government of Western Australia.

14 Western Australian Mental Health Commission (2015). *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.* Perth, WA: MHC.
Western Australian Auditor General (2019). *Access to state-managed adult mental health services.* Perth, WA: Office of the Auditor General.

15 Ibid.

what is already a fragmented and poorly co-ordinated system. This makes the journey through services even more complex for consumers and their families and increases the risk that individuals will 'fall through the gaps' between services.

This much needed clinical service planning has been impeded by the current reliance on activity data as well as the lack of key information which maps how particular cohorts journey through the mental health system.

"Without systematically examining people's pathways in combination with existing information on lived experience, the MHC cannot develop, prioritise and cost appropriate solutions to provide mental health care efficiently for key groups of vulnerable people."[16]

Within the current governance system, it is unclear where ultimate accountability for outcomes for people with severe and enduring mental illness and challenging behaviour resides – whether with the Mental Health Commission, the WA Department of Health or the Health Service Providers. Although steps are being taken to address the governance issues and to clarify roles and responsibilities through the WA Health Governance model, it remains a work in progress. Governance/ accountability continues as a significant system vulnerability in regard to providing services for this cohort.

…there is a danger that in the absence of a clearly articulated rehabilitation and recovery strategy, this piecemeal approach to developing services will exacerbate what is already a fragmented and poorly co-ordinated system.

3.2 How does WA find itself in this situation?

Mark Brown, writer in residence with the UK Centre for Mental Health, calling upon 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."*[17]

16 Western Australian Auditor General (2019). *Access to state-managed adult mental health services.* Perth, WA: Office of the Auditor General.

17 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

The idea that people with severe, enduring mental illness may need ongoing care and support has gone out of vogue, possibly as a result of a number of factors including an ideological shift from 'institutional' to 'community' care and a misconception about the concept of 'recovery'. Rachael Perkins, an international consumer advocate in the recovery movement commented that recovery should never be used as an excuse for not providing services.[18]

The idea that people with severe, enduring mental illness may need ongoing care and support has gone out of vogue, possibly as a result of a number of factors including an ideological shift from 'institutional' to 'community' care and a misconception about the concept of 'recovery'.

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 what has been referred to as the *"metrics-driven, pay-for-performance, throughput-obsessed health care system"*.[19]

Rather than providing integrated, co-ordinated, trauma-competent care, the service response is too often siloed with a focus on the immediate issue such as a crisis presentation to an ED. The system-level consequences of this acute care model are pressure on EDs 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 GPs.

This acute care model does not work well for people with severe and enduring mental illness with complex needs requiring long-term treatment 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."*[20]

18 Perkins, R., Repper J. (2016). Recovery versus risk? From managing risk to the co-production of safety and opportunity. *Mental Health and Social Inclusion,* 20: 101-106.

19 Ofri, D. (2019). Perchance to think. *New England Journal of Medicine,* 380, 1197-1119.

20 Galletly, C., Castle, D., Dark, F., *et al*. (2016). Royal Australian & New Zealand College of Psychiatrists' clinical practice guide lines for the management of schizophrenia and related disorders. *Australian and New Zealand Journal of Psychiatry,* 50, 1-117.

Improving access to a different model of care – 'ongoing' rather than 'episodic'….. is needed to maximise recovery for people with complex needs and severe, enduring mental illness.

According to the figures provided by the HSPs in a 2019 survey, there are currently about 320 people being intensively case managed by assertive community outreach teams in metropolitan Perth (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 community mental health services, while others may not be receiving any care from public specialist mental health services but are known to their GP.

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. Few GPs 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."*[21]

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 people with complex needs and severe, enduring mental illness.

21 Joint Commissioning Panel for Mental Health (2016). *Guidance for commissioners of rehabilitation services for people with complex mental health needs.* Available at www.jcpmh.info

4. Building a rehabilitation and recovery service system for people with severe enduring mental illness

People who receive treatment and care from rehabilitation services are eight times more likely to achieve/ sustain community living when compared to those who are supported by generic community mental health teams.

> **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) [22]

There is a robust body of evidence that rehabilitation services are effective for people with severe, enduring mental illness who have long-term and complex needs which cannot adequately be met by general adult mental health services.[23]

It has been shown that:

- People who receive treatment and care from rehabilitation services are eight times more likely to achieve/sustain community living when compared to those who are supported by generic community mental health teams.[24]
- Approximately two thirds of people being treated by rehabilitation services achieve successful community living within 18 months of admission to an inpatient rehabilitation unit and two-thirds sustain this over five years and around 10% achieve independent living within this period.[25,26]

22 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

23 Joint Commissioning Panel for Mental Health (2016). *Guidance for commissioners of rehabilitation services for people with complex mental health needs.* UK: JCPMH.

24 Lavelle, E., Ijaz, A., Killaspy, H., *et al*. (2011). *Mental health rehabilitation and recovery services in Ireland: a multicentre study of current service provision, characteristics of service users and outcomes for those with and without access to these services*. Final Report for the Mental Health Commission of Ireland.

25 Mental Health Strategies (2010). *The 2009/10 national survey of investment in mental health services*. London, UK: Department of Health.

26 Killaspy, H., Zis, P. (2013). Predictors of outcomes of mental health rehabilitation services: a 5-year retrospective cohort study in inner London, UK. *Social Psychiatry and Psychiatric Epidemiology*, 48(6): 1005-1012.

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, 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 WA, 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.

Across public mental health services in the Perth metropolitan area there are components of clinical rehabilitation treatment services. However, none of the metropolitan HSPs provide a fully integrated clinical rehabilitation and recovery service which includes both community, residential and inpatient care (see Appendix 2 for detailed service mapping).

In WA, while there has been significant investment in *'psychosocial rehabilitation support'* there is a lack of *'clinical rehabilitation treatment services'*.

Access to specialist clinical rehabilitation community care is mixed, with people living in Armadale and the Peel region having no dedicated assertive community outreach team and, for those in the Perth inner city, access is restricted to individuals who are homeless. Inpatient rehabilitation services are particularly limited, being provided only at Graylands Hospital (Statewide catchment) and Bentley Hospital (East Metropolitan Health Service catchment).

This lack of services in WA is in sharp contrast to other Australian jurisdictions such as Victoria and Queensland, where specialised intensive inpatient, residential and community-based rehabilitation and recovery units/teams are standard components of a contemporary integrated clinical treatment system for people with severe, enduring mental illness

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'."*[27]

27 Roberts, G., Holloway, F., Davenport, S. *et al.* (2006). Rehabilitation and recovery now. In: Roberts, G., Davenport, S., Holloway, F., *et al.* (eds.) *Enabling recovery: the principles and practice of rehabilitation psychiatry*. London, UK: Royal College of Psychiatrists, p.xvii.

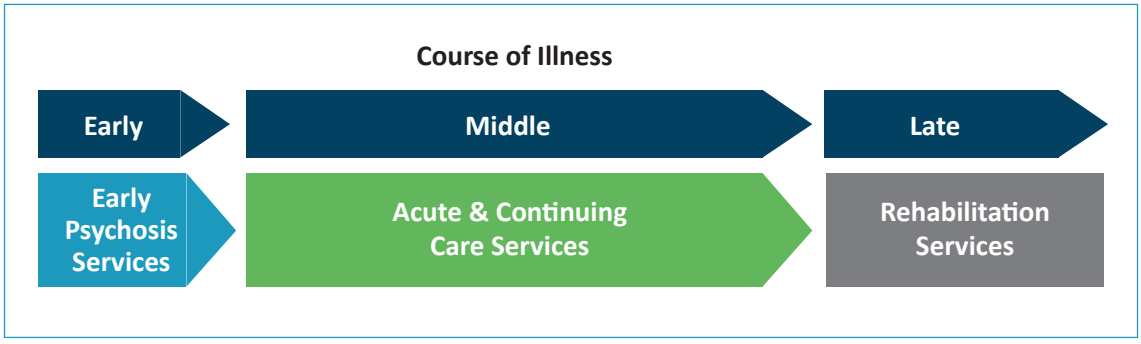
4.1 Early access to rehabilitation and recovery services

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 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 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. [28] Disengagement rates remain high in EIP services with an average of 30% of people disengaging from treatment despite ongoing therapeutic need.[29] 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.[30]

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

Despite the recommendation that rehabilitation 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.[31] This pattern is illustrated in the Figure 2.

Figure 2: Traditional path to rehabilitation and recovery services



28 Friis, S., Melle, I., Johannessen, J. *et al*. (2016). Early predictors of ten-year course in first-episode psychosis. *Psychiatric Services,* 67, 438-443.

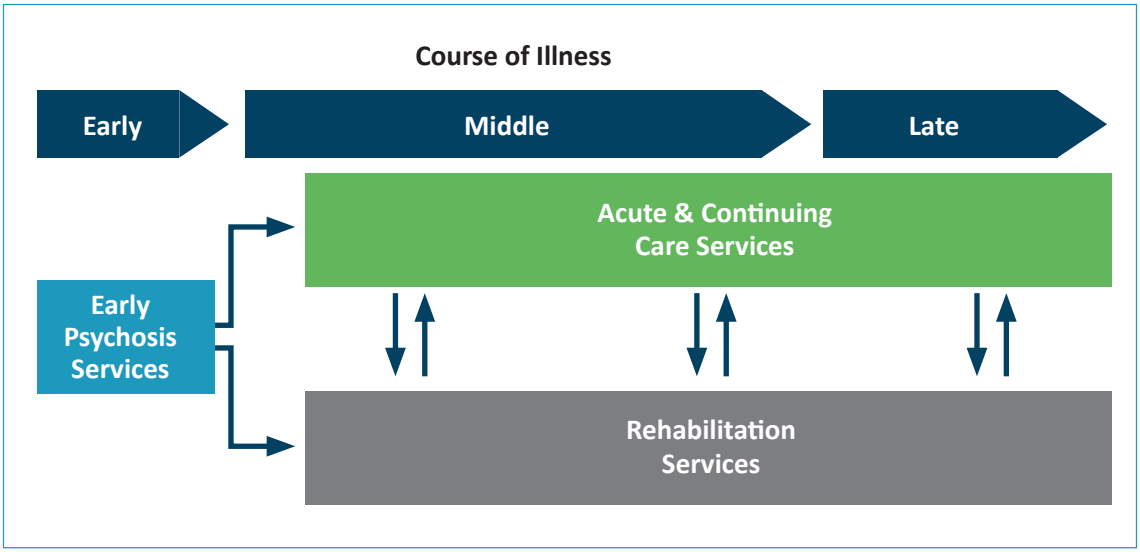
29 Doyle, R., Turner, N., Brennan, D. *et al*. (2014). First episode psychosis and disengagement from treatment: a systematic review. *Psychiatric Services,* 65, 603-611.

30 Killaspy, H. (2018). Contemporary mental health rehabilitation. *Epidemiology and Psychiatric Sciences,* 28, 1-3.

31 Power, P., Smith, J., Shiers, D. *et al*. (2006). Early intervention in first-episode psychosis and its relevance to rehabilitation psychiatry. In: Roberts, G., Davenport, S., Holloway, F. *et al.* (ed.) *Enabling recovery: the principles and practice of rehabilitation psychiatry*. London, UK: Royal College of Psychiatrists.

It is important that individuals who will need longer-term care from rehabilitation services are identified as early as possible to minimise the impact of psychosis on their personal and social functioning. Accordingly, there needs to be a close collaborative relationship between 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. This is illustrated in Figure 3.

Figure 3: Early and continuous access to rehabilitation and recovery services



In the words of one HSP this highlights the need for:

> *"an important shift in emphasis for those people we know 'bounce around' in the clinical treatment system for many years, sometimes punctuated by periods of homelessness or incarceration, and often at great cost to their personal health and wellbeing, and the wellbeing of their families and carers."*

4.2 Rehabilitation and recovery services: 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.[32] The focus is on enabling individuals' functioning, rather than simply addressing clinical symptoms and incorporates the importance of services maintaining therapeutic optimism for recovery. It is an active process, with short, medium and long-term goals designed to *"restore or optimise physical, mental and social capability."*[33]

32 Killaspy, H., Harden, C., Holloway, F. *et al*. (2005). What do mental health rehabilitation services do and what are they for? A national survey in England. *Journal of Mental Health,* 14, 157-165.

33 National Institute for Health and Clinical Excellence (2020). *Rehabilitation for adults with complex psychosis and related severe mental health conditions: NICE guideline DRAFT.* UK: NICE. p.1.

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. Crucially, treatment and support should also include close attention to healthy living and physical health care.

4.2.1 Principles

The principles underpinning rehabilitation and recovery services are outlined below.[34]

Figure 4: Principles of rehabilitation and recovery

Optimism	That recovery is possible and always underpins individual care.
Empowerment	Working callaboratively with consumers to promote self determination.
Strengths focus	Recognising people's capacity to change and focusing on their strengths.
Accessible	Rehabilitation services are provided in a timely manner, with "no wrong door" into the system.
Trauma informed	Recognising and responding to the impact of trauma and avoid re-traumatisation.
Callaborative partnerships	With consumers, their family/carers, staff and organisations providing services to help an individual to achieve their goals.
Person-centred	Fully involving each individual in their mental health care, recognising their unique needs, concerns and preferences.
Evidence-based	Interventions are provided to promote recovery and social inslusion.
Social Integration	Support full integration of people into their communities where they can realise their rights of citizenship.
Quality of life	Strive to help individuals improve the quality of all aspects of their lives, including social, occupational, educational, residential and financial.
Culturally & spiritually secure	Services encourage and support diversity.

34 Mental Health Adult Program (2009). *Clinical framework for the delivery of rehabilitation services*. Perth. WA. North Metropolitan Area Health Service, DoH.

4.2.2 Interventions

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, with each step negotiated and aimed at goals that are personally meaningful and desired.

In their study of people with psychotic disorders, Jablensky et al., 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:

> *"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."* [35]

A list of the evidence-based interventions that have been recommended for provision within a rehabilitation and recovery service network is provided in Figure 5: [36]

Figure 5: Evidence-based interventions in rehabilitation and recovery

35 Jablensky, A., McGrath, J., Herrman, H. *et al*. (2000). Psychotic disorders in urban areas: An overview of the study on low prevalence disorders. *Australian and New Zealand Journal of Psychiatry,* 34, 221-236.

36 Craig, T. What is psychiatric rehabilitation? (2006). In: Roberts, G., Davenport, S., Holloway, F. *et al.* (ed.) *Enabling recovery: the principles and practice of rehabilitation psychiatry*. London, UK: Royal College of Psychiatrists.

4.3 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 are people with psychosis and severe disability in public community mental health services who do not access NGO services and consequently lose an opportunity for services to support them in their recovery journey.[37]

Rehabilitation and recovery services for people with severe, enduring mental illness and complex needs must be commissioned in a way that:

- ensures public mental health services and NGOs work jointly with consumers across inpatient, residential and community services to meet both their clinical and psychosocial needs; and

- recognises the intensity of the interventions and skill levels required of staff in NGOs and reflects this in the funding arrangements.

Providing co-ordinated care and ensuring seamless transitions between services is complex with many opportunities for people to 'fall through the gaps'. Strong governance and management systems with clear dispute resolution protocols will be needed to ensure that care is not fragmented. Commissioning and funding arrangements, driven by a rehabilitation and recovery system plan, should explicitly support continuity of care and integrated service delivery as guiding principles. System level oversight will require that there is appropriate data collection, data linkage and analysis to monitor, evaluate and balance service provision between the psychosocial support and clinical rehabilitation treatment sectors to ensure seamless patient journeys and positive outcomes for them and their families.

37 Harvey, C., Brophy, L., Parsons, S. *et al*. (2016). People living with psychosocial disability: Rehabilitation and recovery-informed service provision within the second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry*, 50, 534-547.

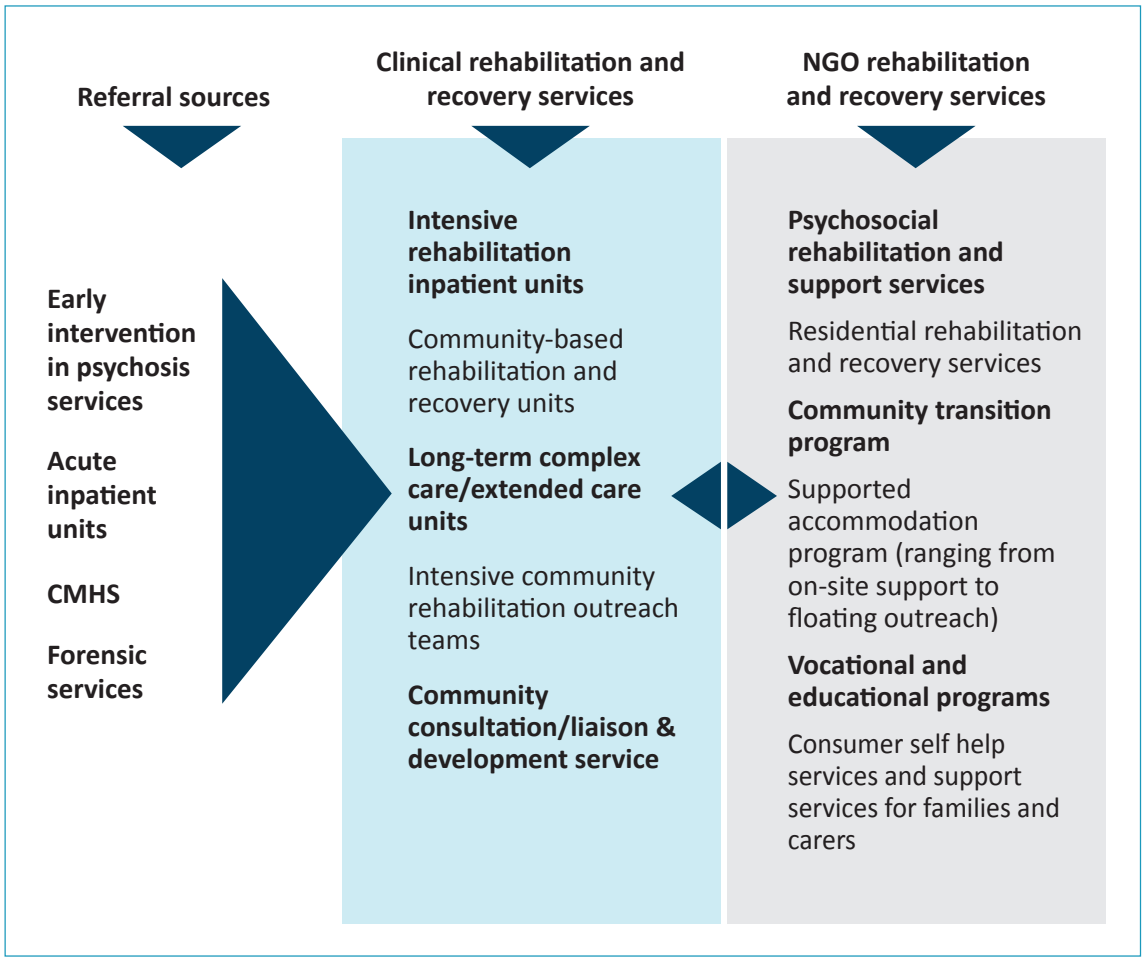
4.3.1 Components of an integrated rehabilitation and recovery system

The challenge for mental health services in Western Australia is to ensure that 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.

Developing a rehabilitation and recovery system will require detailed planning where the principles of co-production and co-design underpin the process and all stakeholders are included from the outset.[38] People with severe, enduring mental illness and complex needs are not well represented in planning discussions and decision making, so specific strategies will need to be developed to ensure that their voices are actively sought and heard. It is also important that the needs of carers and their contribution to care are considered and supported in this process.

Components of an integrated network of rehabilitation and recovery services are outlined below.

Figure 6: Components of an integrated rehabilitation and recovery system network



38 Sustainable Health Review (2019). *Sustainable Health Review: Final Report to the Western Australian Government*. Perth: WA. Department of Health.

Some key components of a rehabilitation and recovery system are currently unavailable in WA (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). As highlighted earlier the estimated number of inpatient and residential services beds and places in community services needs to be determined as part of a co-designed planning process.

There are currently no Intensive Inpatient Rehabilitation Units (SECU's) in WA.

4.4 Clinical rehabilitation and recovery services

A clinical rehabilitation and recovery service system should include the following core components:

- Intensive Inpatient Rehabilitation Units (SECUs);
- Community Rehabilitation and Recovery Units (CCUs);
- Long Term Complex Care/Continuing Care Units;
- Intensive Community Rehabilitation Outreach Teams; and
- Community Consultation/Liaison and Development Service.

Intensive Inpatient Rehabilitation Units

These units (also known as Secure Extended Care Units or SECUs) 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.

There are currently no Intensive Inpatient Rehabilitation Units (SECUs) in WA.

Community/Hospital-Based Rehabilitation and Recovery Units

These units (also known as Community Care Units or CCUs) 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. The length of stay on the unit will be expected to be 1 to 3 years.

...developing a range of CCUs with different models of care which target different cohorts, including some being managed by clinical services and located on, or adjacent to, hospital sites...

There was an announcement in June 2020 that the WA Government intends to fund Perth's first adult CCU (20 beds) to provide high-level support and rehabilitation with clinical in-reach services, peer support and residentially-based psychosocial supports. It will be provided in a homelike environment in the community.

A study comparing hospital-based and community-based residential rehabilitation services in Queensland found that consumers with a significantly higher level of disability and risk of violence were better able to be managed when the CCU is on a hospital site.[39] This highlights the importance of developing a range of CCUs with different models of care which target different cohorts, including some being managed by clinical services and located on, or adjacent to, hospital sites, with ready access to acute inpatient services should it be required. This will ensure that those individuals with a high level of disability and a high risk of harm to themselves and/or others can access treatment in a residential rehabilitation setting.

Where a CCU is run by an NGO it is important that the model of care is appropriate for a cohort with high levels of disability and complex needs. A clinical in-reach approach is unlikely to deliver the necessary level of intensive evidence-based treatment interventions needed by individuals with this high level of acuity. Therefore it is strongly recommended that a multidisciplinary clinical rehabilitation team be located on site.

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 be considered for supported community living. Other rehabilitation options will often have been tried unsuccessfully. This group poses a significant risk to their own health and safety and/or the safety of others. These units will generally be located on hospital grounds, although some beds may be located in the community.

Length of stay will be up to 5 years; or even longer in a small number of cases.

39 Meecham, T., Stedman, T., Parker, S. *et al.* (2017). Comparing clinical and demographic characteristics of people with mental illness in hospital and community-based residential rehabilitation units in Queensland. *Australian Health Review*, 41, 139-143.

Intensive Community Rehabilitation Outreach Teams

These mobile treatment and recovery-orientated multidisciplinary teams aim to improve 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 and 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 of the north, south and east metropolitan HSPs, providing services for around 320 people. All operate office hours, Monday to Friday. A study of Intensive Community Outreach Teams (ICOT) in NMHS showed that they reduced the use of inpatient beds.[40]

Further detailed planning is required to determine the number of individuals who require this level of intensive community treatment and the level of resources needed to establish Intensive Community Rehabilitation Outreach Teams.

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 by:

- *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 including NDIS providers, Primary Health Networks and community housing associations; and
- *Building and maintaining partnerships* with the range of agencies that are critical for the wellbeing of people with enduring mental illness and complex needs.

4.4.1 Delivering integrated clinical rehabilitation and recovery services

Co-ordinated, seamless care is particularly vital for people with severe and enduring mental illness and complex needs whose recovery journey is rarely straightforward. To achieve the best possible quality of life they need access to a full range of person-centred, evidence-based treatments in a range of different settings where the treatment and care is provided by mental health rehabilitation clinicians with specialist skills.

To realise this goal, clinical treatment services should be configured in such a way that those who need long-term intensive rehabilitation and recovery services can access care in a continuum of settings, from the hospital to the community. By operating as an integrated

40 Hammond G., Bromwell D., Janca A. *et al.* (2012). Assessment of systemic resource utilisation before and after enrolment into assertive treatment: Lessons from the Intensive Community Outreach Team implementation. (Unpublished).

…an effective specialist clinical rehabilitation and recovery service should have its own identity, clearly articulated purpose and governance structure which is aligned with, but not incorporated into, acute services.

service stream, treatment and care can be provided with agreed clinical pathways to minimise 'silos' and the risk of individuals 'falling through the gaps'.

Based on the UK experience, an effective specialist clinical rehabilitation and recovery service should have its own identity, clearly articulated purpose and governance structure which is aligned with, but not incorporated into, acute services.[41] Rather than the episodic, rapid throughput approach which characterises acute care, rehabilitation and recovery services are underpinned by a model of care that recognises the need to deliver longer term treatment and support. Operating within this model of care reinforces the need for clinical rehabilitation and recovery services to be managed as a service stream distinct from acute services.

Consideration should be given to rehabilitation and recovery services having an identified funding stream. This is particularly pertinent given that some of the very few specialist rehabilitation services available in WA are being incorporated into 'mainstream' mental health services.

In order to function effectively, rehabilitation and recovery services require an executive management team with the authority to accept admissions and facilitate transfers between the full range of clinical rehabilitation and recovery units/teams. This will minimise access barriers and enable individuals to move through agreed care pathways so as to optimise their recovery.

Strong clinical leadership will be vital to the success of rehabilitation and recovery services. The importance of clinical leadership as a key determinant in delivering safe, high quality services has been repeatedly demonstrated. This message was reinforced in a recent review of public mental health services which highlighted the need for services to be clinically led, supported by management and driven by the needs of consumers and carers.[42]

In planning for and developing clinical mental health rehabilitation and recovery services, particular attention needs to be paid to ensuring that they operate as an integrated service system as detailed in Figure 7.

41 Tait, S. (2020). *An observational study of psychiatric rehabilitation services within the United Kingdom*. Perth, WA.
42 Department of Health (2019). *Review of the clinical governance of public mental health services in Western Australia.* Perth, WA: DoH.

Figure 7: Operating as an integrated service system to prevent fragmentation and ensure quality

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 enable their changing needs to be met as they transition between services.
- Rehabilitation and recovery services need to establish and maintain a close, collaborative relationship with other public mental health services to ensure timely access and effective coordination.
- Close, formal collaboration between clinical and NGO rehabilitation and recovery services, primary care, the NDIA, 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.
- Embed cultural capability into all aspects of treatment and care to ensure that services are responsive to the needs of Aboriginal people and people from culturally and linguistically diverse backgrounds.
- 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.
- On-going professional development opportunities are essential to enhance the specialist rehabilitation skills of the rehabilitation and recovery workforce.
- Clinical leadership together with clear governance and oversight arrangements are essential to ensure high quality, responsive services.

4.4.2 Special populations: youth, older adults and people living in rural and remote areas

Although this Review primarily focussed on adults living in metropolitan Perth, the needs of young people, older adults and those in rural and remote areas are important and have been considered.

During the consultation there was particular concern in relation to early access for those young people who require intensive rehabilitation. In order to be responsive to these needs, adult rehabilitation and recovery services need to have flexible boundaries for young people aged 16 to 17 who may require this level of intensive specialist care because of the early onset and severity of their illness. In exceptional circumstances, in order to provide appropriate treatment and care and support recovery, a small number of these individuals may require access to a rehabilitation and recovery inpatient or residential service.

Although Intensive Inpatient Rehabilitation Units are primarily for adults between the ages of 18 and 65 years it is also important, during any planning process, that consideration is given to ensuring access for those few people aged over 65 years who have severe challenging behaviours that cannot be managed in facilities for the frail aged and/or who require a more secure treatment setting.

In planning for the development of metropolitan-based clinical rehabilitation and recovery services, the needs of rural people should also be taken into account so that equity of access is not constrained by metropolitan HSP boundaries.

4.4.3 Measuring outcomes

The significant investment required to develop clinical rehabilitation and recovery services will need to be accompanied by specific goals and outcome measures. The case studies outlined earlier in ‘Helen’s story’ and ‘Mark’s story,’ together with the clinician letter to the Chief Psychiatrist, highlight many of the issues which need to inform the development of key system-level indicators for this cohort. These case studies draw attention to major challenges such as being homeless or having tenuous accommodation; lack of access to mental health services and evidence-based interventions; difficulties in accessing alcohol and drug treatment and having contact with the justice system, to name a few. At present there are limited, if any, indicators which would capture these issues.

Developing outcome measures will require a shift from the current emphasis on the ***quantity of care*** to instead giving weight to the ***quality of care*** by measuring timely access to appropriate treatment, continuity of care and support for individuals to meet their recovery goals over the longer term.

4.5 Non-Government sector rehabilitation and recovery services

The NGO sector currently provides a range of psychosocial programs. However, within the current funding parameters and with limited resources, the NGOs can find it difficult to meet the multiple complex needs of individuals with challenging behaviour. During the Review consultations the importance of having a close working relationship with the clinical treating team was highlighted. The concept of an NGO 'provider of last resort' was raised as a model which operates in the disability sector and is worthy of consideration for this cohort.

It is proposed that the NGO sector be funded to provide an additional program, the ***Community Transition Program.*** This program would specifically target consumers in Intensive Rehabilitation Inpatient Units (SECUs) and Community/Hospital-Based Rehabilitation and Recovery Units (CCUs) 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 found that the *"program achieved* [its] *outcomes in terms of appropriateness, effectiveness and efficiency."*[43]

4.6 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.[44] 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

43 Abello, D., Fisher, K., Sitek, T. (2010). *Evaluation of the Integrated Rehabilitation and Recovery Care Program.* Sydney, NSW: Social Policy Research Centre, University of NSW.

44 Office of the Public Advocate (2018). *The illusion of 'choice and control'.* Melbourne, Victoria: Office of the Public Advocate.

detention in the criminal justice and/or mental health systems; and have exhausted or at risk of exhausting workers or service providers.

As the NDIS rolls out 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.

There have been fewer than expected numbers of people with a psychosocial disability who have entered the NDIS and interface issues between the NDIS and mainstream mental health systems continue to be a significant challenge.[45] While there have been some positive recent developments, such as the Complex Support Needs Pathway and the establishment of a Psychosocial Disability Recovery Framework, the level of support required to assist people with a severe and enduring mental illness and challenging behaviour to engage with and access the NDIS should not be underestimated.

This highlights the importance of developing a Community Transition Program, where it is envisaged that NGOs, as part of their role, will actively engage with consumers to ensure that they are linked into the NDIS in a timely fashion. The additional demand on clinical services supporting consumers to access the NDIS also needs to be considered when planning and resourcing rehabilitation and recovery services.

4.7 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,[46] 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 arrangements. 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

45 NDIA (National Disability Insurance Agency) 2019a. *Annual Report NDIS 2018–19*. NDIA. file:///C:/Users/he06404/Downloads/PB%20Annual%20Report%202019%20PDF.pdf

46 Morgan, V., Waterreus, A., Carr, V. *et al*. (2017). Responding to challenges for people with psychotic illness: Updated evidence from the Survey of High Impact Psychosis. *Australian and New Zealand Journal of Psychiatry,* 51, 124–140.

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.

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."*[47] 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.

Housing problems often contribute to a relapse of mental illness and admission to hospital and, furthermore, lack of availability of suitable, supported accommodation often contributes to an extended stay in an inpatient bed.[48] This is not only expensive but importantly affects the individual's well-being. 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.[49] 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. Access to stable, secure and affordable housing has important ramifications not only for consumers, but also for the use of inpatient and forensic services.

The lack of safe, suitable, affordable accommodation for individuals with multiple complex needs, often with a forensic history, was highlighted during the consultations. A consistent message was that consumers are often unable to access supported accommodation as these services are not structured to meet the needs of people with severe mental illness and challenging behaviour. There was concern that very high risk consumers can end up in caravan parks or similar low cost accommodation but without the standards and safeguards required of a licenced psychiatric hostel or supported accommodation service.

There are a number of successful housing programs around Australia such as 50 Lives 50 Homes (Ruah Community Services, WA)[50], 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 use.

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

47 Office of the Public Advocate (2018). *The illusion of 'Choice and Control'.* Melbourne, Victoria: Office of the Public Advocate.

48 Office of the Auditor General (2019). *Access to state-managed adult mental health services*. Perth, WA: Office of the Auditor General.

49 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: North Metropolitan Health Service. (Unpublished)

50 Wood, L., Vallesi, S., Kragt, D. *et al.* (2017). *50 Lives 50 Homes: A housing first response to ending homelessness. First evaluation report.* Perth, Western Australia: Centre for Social Impact, University of Western Australia.

continue to fall through the gaps. There is an urgent need to develop a strategy to specifically address the accommodation and support needs of people in this cohort. In undertaking this planning process, particular attention should be paid to addressing barriers, including giving consideration to no or low threshold access and developing pathways which would facilitate the transition from acute inpatient and rehabilitation treatment units to appropriate accommodation.

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.

5. Integrating treatment for mental health and substance use

Co-morbid substance use is common amongst individuals with severe mental illness, often leading to poor outcomes and presenting a serious impediment to their treatment and recovery.[51]

There is a complex inter-relationship between addictive behaviours and mental illness and delivering effective treatment which addresses both mental health and substance use poses a significant challenge to the two service systems which largely operate separately.[52] This separation has been regularly identified as a major barrier to delivering effective, holistic treatment.[53] Providing integrated mental health and substance use treatment for people with severe, enduring mental illness has been shown to be effective but requires a major change to the current approach.[54]

> **People with drug and alcohol issues are usually excluded from our services or labelled as having a drug induced psychosis.**
>
> *(Clinician, workshop participant)*

5.1 A 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.[55] The 2010 Australian National Survey of Psychotic Disorders reported that alcohol misuse or dependence was common among people with psychosis (58% of males and 39% of females).[56] The proportion with a lifetime history of illicit drug use or dependence was very high (63% males and 42% females). Among the general population, by comparison, 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.

51 Galletly, C., Castle, D., Dark, F. *et al*. (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. *Royal Australian and New Zealand Journal of Psychiatry*, 50, 410-472.

52 Teeson, M., Baker, A., Deady, M. (2014). *Mental health and substance use: Opportunities for innovative prevention and treatment.* NHMRC Centre for Research Excellence in Mental Health and Substance Use.

53 Royal Australian and New Zealand College of Psychiatrists, Victorian Branch (2019). *Formal submission: Royal Commission into Victoria's Mental Health System.* Melbourne, Victoria: RANZCP.

54 Brunette, M., Mueser, K. (2006). Psychosocial interventions for the long-term management of patients with severe mental illness and co-occurring substance use disorder. *Journal of Clinical Psychiatry,* 67 (Suppl. 7), 10–17.

55 Moore, E., Mancuso, S., Slade, T. *et al*. (2012). The impact of alcohol and illicit drugs on people with psychosis: the second Australian National Survey of Psychosis. *Australian and New Zealand Journal of Psychiatry,* 46, 864-878.

56 Morgan, V., Waterreus, A., Jablensky, A. *et al*. (2011). *People living with psychotic illness 2010: Report on the second Australian survey*. Canberra, ACT: Commonwealth of Australia.

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

	Proportion (%)	
	Past year	**Lifetime**
Cannabis	32.8	66.4
Amphetamines	12.5	40.1
Tranquillisers	4.1	11.9
Ecstacy	4.0	23.1
Heroin	3.7	15.7
Hallucinogens	2.7	25.4
Cocaine	2.0	13.3
Solvents/inhalants	0.4	10.3

Source: Morgan V, Waterreus A, Jablensky A, et al. *People living with psychotic illness 2010: the second Australian national survey of psychosis*. Commonwealth of Australia, 2011

There has been growing concern about the traumatic impact of methamphetamine use in Western Australia.[57] 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.[58]

More frequent methamphetamine use has been associated with more frequent presentations to EDs and increased psychiatric hospital admissions. It has been estimated that across Australia in 2013, methamphetamine use accounted for between 28,400 and 80,900 additional psychiatric hospital admissions and between 29,700 and 151,800 additional ED presentations.[59] 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.[60]

57 Department of Premier and Cabinet (2018). *Methamphetamine action plan taskforce: Final report.* Perth, WA: Government of Western Australia.

58 Australian Institute of Health and Welfare (2016). *National Drug Strategy Household Survey 2016: Detailed findings.* Canberra, ACT: AIHW.

59 McKetin, R., Degenhardt, L., Shanahan, M. *et al*. (2018). Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact. *Drug and Alcohol Review*, 37, 196-204.

60 Royal Australian and New Zealand College of Psychiatrists (2015). *Recognizing and addressing the harmful mental health impacts of methamphetamine use. Position statement 82.* Melbourne, Victoria: RANZCP.

Over the long-term people with severe mental illness and co-morbid substance use 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.[61,62,63]

5.2 Barriers to treatment

Despite over a decade of research and policies calling for integrated comorbidity treatment and care, the results have been disappointing with alcohol and other drug (AOD) services and mental health services remaining largely separate with variable levels of collaboration.[64] 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.[65]

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.

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.

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 AOD treatment services. This impacts on both direct patient care and also on the development of specialist co-morbidity treatment skills more broadly.

61 Blanchard, J., Brown, S., Horan, W. *et al*. (2000). Substance use disorders in schizophrenia: review, integration, and a proposed model. *Clinical Psychology Review,* 20, 207-234.

62 World Health Organisation (2009). *Global health risks: mortality and burden of disease attributable to selected major risks*. Geneva, Switzerland: WHO.

63 Lai, H., Sitharthan, T. (2012). Exploration of the comorbidity of cannabis use disorders and mental health disorders among inpatients presenting to all hospitals in New South Wales, Australia. *American Journal of Drug and Alcohol Abuse,* 38, 567-574.

64 Galletly, C., Castle, D., Dark, F. *et al*. (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. *Royal Australian and New Zealand Journal of Psychiatry*, 50, 410-472.

65 Lee, S., Crowther, E., Keating, C., *et al.* (2012). What is needed to deliver collaborative care to address comorbidity more effectively for adults with a severe mental illness. *Australian and New Zealand Journal of Psychiatry,* 47, 333-346.

A 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 a profound negative effect on them and their families.

5.3 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. More broadly, it requires a cultural shift away from a dichotomous view of mental health and substance use related problems.

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.[66] Both the Australian National Mental Health Commission and the RANZCP guidelines on the treatment of schizophrenia recognise the need for and the benefits of integrated treatment.[67,68]

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.

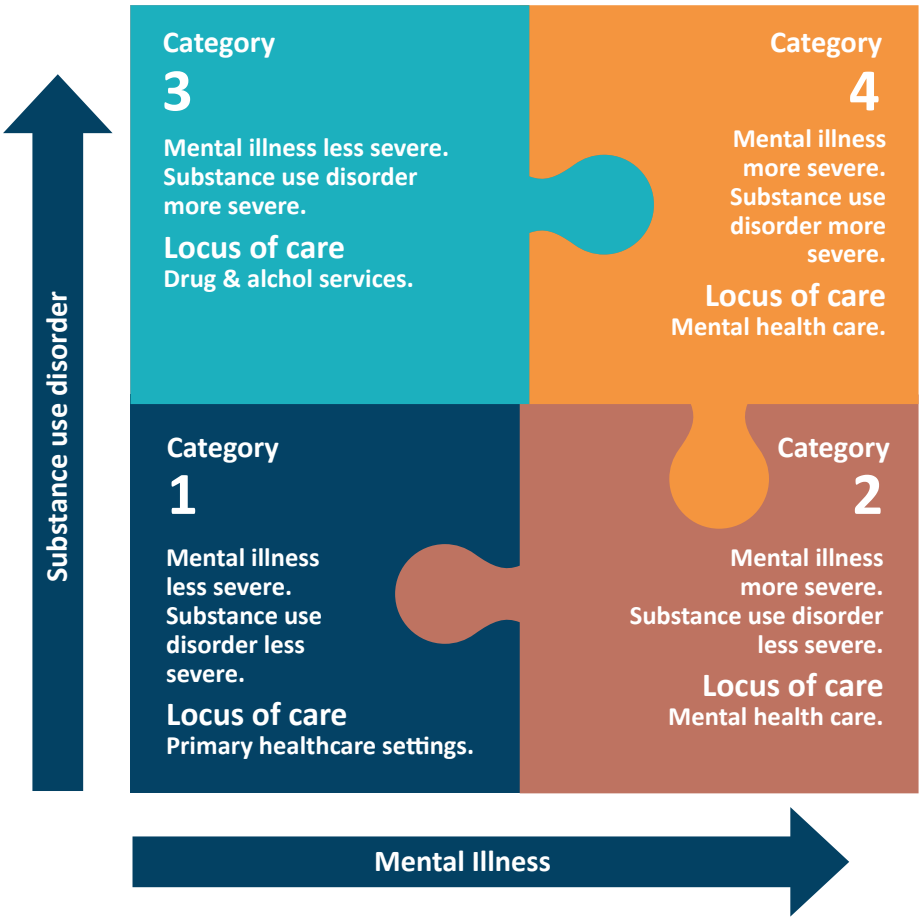
There is long-standing evidence that integrated treatment of co-occurring mental health and substance use disorders is more effective than separate treatments offered either in parallel or in sequence.

66 Brunette, M., Mueser, K. (2006). Psychosocial interventions for the long-term management of patients with severe mental illness and co-occurring substance use disorder. *Journal of Clinical Psychiatry*, 67(Suppl. 7), 10–17.

67 Australian Government National Mental Health Commission (2013). *A contributing life: the 2013 national report card on mental health and suicide prevention*. Sydney, NSW: National Mental Health Commission.

68 Galletly, C., Castle, D., Dark, F. *et al.* (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. *Royal Australian and New Zealand Journal of Psychiatry,* 50, 410-472.

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 severe, enduring mental illness and 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 the development of trust and a strong therapeutic relationship is essential to supporting continuity of care. It is expected that AOD services will continue to provide specialist input to 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 which are required.

6. Delivering services for people with a co-occurring intellectual, cognitive or developmental disability and mental illness

People with an intellectual disability experience mental illness at a rate which is two to three times that of the general population.[69] Recent evidence from NSW indicates that people with this dual diagnosis have much higher psychiatric inpatient admission rates, length of stay and higher related costs of mental health admissions compared to those without an intellectual disability.[70]

In the absence of adequate and sufficient treatment and support, individuals with mental ill-health and an intellectual, cognitive or developmental disability often turn to acute healthcare and emergency services.[71,72] Consequently, this cohort is most commonly treated in a costly hospital setting, often presenting in crisis and with the interventions largely focussed on symptom containment.[73]

This pattern of repeated and high service use highlights the lack of appropriate services for these individuals, many of whom have complex needs and an atypical presentation of mental illness requiring a high level of psychiatric expertise and service co-ordination.[74]

> **“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)*

Challenging behaviour has been reported as being the most common reason for referral to a mental health service for people with co-occurring mental illness and a complex intellectual, cognitive or developmental disability.[75]

69 Cooper, S., Smiley, E., Morrison, J. *et al.* (2007). Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors. *The British Journal of Psychiatry*, 190, 27-35.

70 Troller, J., Weise, J., Li, S. (2019). *Submission to the Productivity Commission inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth*. Sydney, NSW: Department of Developmental Disability Neuropsychiatry University of New South Wales.

71 Li, X., Srasuebkul, P., Reppermund, S. *et al*. (2018). Emergency department presentation and readmission after index psychiatric admission: a data linkage study. *BMJ Open*, 8, e018613.

72 Department of Health (2015). *Western Australian specialist neuropsychiatry disability service model of care*. Perth: North Metropolitan Health Service Mental Health, DoH.

73 Jess, G., Torr, J., Cooper, S-A. *et al.* (2008). Specialists versus generic models of psychiatry training and service provision for people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 21,* 183-193.

74 Fuller, C., Sabatino, D. (1998). Diagnosis and treatment considerations with comorbid developmentally disabled populations. *Journal of Clinical Psychology*, 54, 1-10.

75 Department of Health (2015). *Western Australian specialist neuropsychiatry disability service model of care*. Perth, WA:

Many factors can contribute to this challenging behaviour and it can be difficult to determine whether the behaviour arises from the mental illness or the cognitive disability.

> *"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."* [76]

6.1 Lack of specialist services in WA

There are significant gaps in WA's public mental health services for people with co-occurring mental illness and complex intellectual, cognitive or developmental disability. These service gaps and the limited availability of treatment are both long-standing and well known.[77,78]

… service gaps and the limited availability of treatment are both long-standing and well known.

In 2015 the North Metropolitan Health Service led the development of the *Western Australian Specialist Neuropsychiatry Disability Service Model of Care* report which aimed to address the needs of this cohort. It was undertaken in collaboration with key stakeholders including the South Metropolitan Health Service, the Department of Health, Disability Services Commission, Mental Health Commission and members of the private mental health and disability sector and carer representatives. It highlighted a number of significant service system challenges, including:

- that treatment is often unavailable in mainstream public mental health services with individuals being *'shuffled between'* disability and mental health services, often falling through the gaps and with many ending up in prison;
- individuals often presenting in a crisis because there was inadequate early intervention and prevention;
- intervention usually being provided only after an acute exacerbation of the problem and mostly restricted to time limited crisis management; and
- a lack of specialist expertise, both in the mental health and disability sectors.[79]

North Metropolitan Health Service, DoH.

76 Ibid. p23.

77 Ibid.

78 Western Australian Mental Health Commission (2015). *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*. Perth, Western Australia: MHC.

79 Department of Health (2015). *Western Australian specialist neuropsychiatry disability service model of care*. Perth: North Metropolitan Health Service Mental Health, DoH.

The report observed that lack of access to specialist mental health treatment leads to increased pressure on mental health inpatient services, citing a local instance:

> *"A man with ID [intellectual disability] who displayed challenging behaviours was admitted into a MH in-patient unit. Four beds on the ward were closed due to safety concerns for other patients and remained closed for three months. Three staff members were assigned to him at all times, most too afraid to go near him due to his violent outbursts. He was referred to a specialist psychiatrist who assessed the man and diagnosed a physical illness. Once treated, the man's behaviour subsided and the ward was re-opened to other patients."*[80]

The report recommendations included the development of a Specialist Neuropsychiatry Disability Service offering specialist support to mainstream mental health and disability services, families, carers and other providers.

Some five years on, mental health clinicians continue to report that within the existing service system it remains difficult to meet the complex needs of this cohort particularly as WA, unlike other jurisdictions such as Victoria, does not have a specialist neuropsychiatry service. During the consultations conducted as part of this Review they noted the need to:

- clarify referral pathways, and support the navigation between services to ensure individuals can get to the right place with a 'no wrong door' approach as carers may have limited capacity to seek help;
- provide advice, education and support to mainstream services to build the capacity of these services to be better equipped to provide services to this cohort;
- enhance links and collaboration between relevant services such as mental health, health, disability and non-government mental health/disability/NDIS service providers;
- ensure that any models of care address the particular needs of children and adolescents and those living in rural and remote areas; and
- increase workforce skills, including addressing the significant gap in psychiatry specialist training places.

The impact the current lack of specialised services is having on older adult mental health services was also raised. Individuals as young as 45 who have a co-morbid cognitive impairment are often directed to older adult services with the comment *"nowhere else can manage them"* or *"the only other option has a 2 year waitlist".* The result is that they are being cared for in an inappropriate setting which is both demoralising for them and their families but also creates a difficulty for services treating older, often frail individuals.

There continues to be strong, consistent support for the need to develop a specialised neuropsychiatry service. The establishment of such a service would benefit people in this cohort by delivering specialised care and as well as providing leadership across the sector to ensure that general mental health services are better equipped to meet

80 Ibid.

their needs. It would address many of the existing barriers for those with challenging behaviour, by supporting engagement with services, increasing access to individualised evidence-based interventions needs and enhancing co-ordination and continuity of complex care.

6.2 Establishing a Specialist Neuropsychiatry Service

It is now some years since the *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and other Drug Services Plan 2015* identified the need to establish a specialised service for people with co-occurring mental illness and intellectual, cognitive or developmental disability.[81] Unfortunately, little progress has been made to plan, fund and establish such a service. In March 2020 the State Government again identified people with a neuropsychiatry and developmental disability as a population group requiring specific consideration and being a priority for action over the coming four years.

There is a pressing need for immediate action to commence planning and secure the funds to establish a Specialist Neuropsychiatry Service.

There is a pressing need for immediate action to commence planning and secure the funds to establish a Specialist Neuropsychiatry Service.[82] The planning process should be underpinned by the principles of co-design and jointly led by the Mental Health Commission and the Department of Health. In developing the statewide model of care, consideration needs to be given to:

- build on the significant work already undertaken by key stakeholders on developing a model of care;
- ensure that the model of care meets the specific needs of particular cohorts including children and adolescents and addresses the need for genuine equity of access for people living in rural and regional areas; and
- address the need to increase local expertise, including the significant gap in specialist psychiatrist training places.

81 Western Australian Mental Health Commission (2015). *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.* Perth, WA: MHC.

82 Department of Developmental Disability Neuropsychiatry (2014). *Accessible mental health services for people with an intellectual disability: A guide for providers.* Sydney, NSW: University of NSW.

7. The way treatment and care is provided

7.1 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?"*[83]

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. In the words of one service provider during the Review consultations *"the helplessness these people experience may be mirrored in their clinical care providers and compassion fatigue is sometimes evident in our responses to their help-seeking."*

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.[84] 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.[85]

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

83 Perkins, R. (2006). You Need Hope to Cope: In *Enabling recovery: the principles and practice of rehabilitation psychiatry* (ed) G, Roberts., S, Davenport., F, Holloway. *et al*. London. UK: The Royal College of Psychiatrists. p.119.

84 Davies, R., Heslop, P., Onyett, S. *et al.* (2014). Effective support for those who are "hard to engage": a qualitative user-led study. *Journal of Mental Health*. 23(2), 62-66.

85 Ibid.

clinicians in rehabilitation services, including key skills which support engagement such as:

- Motivational interviewing;
- Supported decision-making;
- Strengths-based assessments; and
- Including natural supports such as families, carers and friends.[86]

However, it also requires that proper regard is given to the personal qualities required to work effectively with consumers who have a severe, 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."*[87]

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."*[88]

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.[89] The development of effective therapeutic relationships to support engagement and meaningful outcomes for people needs to be valued and supported by services. Training, professional development, supervision, peer support, good work design and adequate resources can all contribute positively to staff well-being and performance, leading to better outcomes for consumers and their families.

7.2 Continuity of care

Maintaining continuity of care for consumers with multiple complex needs who are hard to engage is essential. 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.[90] Key decisions about admission and discharge, made in consultation with the treating team, the consumer, their family and carers, 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

86 National Alliance on Mental Illness (2016). *Engagement: A new standard for mental health care*. Arlington, Virginia.
87 The Sainsbury Centre for Mental Health (1998). *Keys to engagement: Review of care for people with severe mental illness who are hard to engage with services*. London, UK: Sainsbury Centre.
88 National Alliance on Mental Illness (2016). *Engagement: A new standard for mental health care*. Arlington, Virginia.
89 B, Koekkoek., G, Hutschemaekers., B, van Meijel. *et al.* (2011). How do patients come to be seen as 'difficult'? *Social Science and Medicine,* 72, 504-512.
90 The Sainsbury Centre for Mental Health (1998). *Keys to engagement: Review of care for people with severe mental illness who are hard to engage with services*. London, UK: Sainsbury Centre.

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.[91,92] In addition to consumer satisfaction, which is a key indicator of quality of care, an integrated model would have other significant benefits including:

- 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.[93]

7.3 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.*[94] 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."* [95]

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.[96] Such approaches, which balance

91 M, Begum., K, Brown., A, Pelosi. *et al.* (2013). Survey of patients' view on functional split of consultant psychiatrists. *BMC Health Services Research*, 13, 362-366.

92 V, Bird., P, Giacco., P, Nicaise. *et al*. (2018). In-patient treatment in functional and sectorised care: Patient satisfaction and length of stay. *British journal of Psychiatry*, 212, 81-87.

93 T, Williams., G, Smith. (2019). Laying new foundations for 21st century community mental health services: An Australian perspective. *International Journal of Mental Health Nursing*, 28, 1008-1014.

94 Royal Australian and New Zealand College of Psychiatrists, Victorian Branch (2019). *Formal submission Royal Commission into Victoria's Mental Health System.* Melbourne, Victoria: RANZCP, p.20.

95 Lau, G., Meredith, P., Bennett, S. *et al*. (2017). A capability framework to develop leadership for evidence-informed therapies in publicly funded mental health services, *International Journal of Public Leadership*, 13, 151-165.

96 A, Nugter., F, Engelsbel., M, Bahler. *et al*. (2016). Outcomes of Flexible Assertive Community Treatment (FACT) implementation: A prospective real life study. *Community Mental Health Journal*. 52, 898-907.

the need for delivering discipline specific interventions with the need for co-ordinating complex care, are worthy of further investigation.

The survey of rehabilitation services in Perth conducted as part of this Review revealed the absence of clinical psychologists in the multidisciplinary intensive community outreach teams. This was particularly concerning given that access to psychological therapies is a core evidence-based treatment.

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 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.

7.4 Peer workers in a multidisciplinary team

Empowering consumers is a key principle of contemporary rehabilitation and recovery practice. More recently, peer support workers have been added to the multidisciplinary team. 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.[97] Peer support has been found to increase treatment engagement.[98]

In WA 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. At the time of the survey conducted as part of this Review there were no peer workers employed in metropolitan intensive community outreach teams. This is in contrast with mental health rehabilitation services in other jurisdictions, such as Queensland, where Peer Support Rehabilitation Workers 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. Importantly, their work may extend beyond the day-to-day work of the multidisciplinary team and can enhance services in roles such as peer educators and peer researchers and through their contribution to service reconfiguration and system design.[99]

While not part of the multidisciplinary team, the Review acknowledges the continuing and important role of Advocates from the Mental Health Advocacy Service in ensuring the voice of those with SMI and challenging behaviours is heard and that their access to services, in consultation with the treating team, is facilitated.

97 Slade, M., Amering, M., Farkas, M. *et al.* (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry,* 13, 12-20.

98 Dixon, L., Holoshitz, Y., Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: Review and update. *World Psychiatry*, 5, 13-20.

99 WA Peer Supporters' Network (2018). *The peer workforce report: Mental health and alcohol and other drug services.* Perth, WA: WAPSN.

8. Investing in change

The cost of putting in place a comprehensive rehabilitation and recovery system will be substantial, but the cost of not doing so will be even higher.

A recent report by the WA Auditor General found that people with severe, enduring mental illness and complex care needs are currently using a very significant amount of resources, but the desired outcomes are not being achieved.[100] In the absence of alternative options, those who require extended care are being treated in acute care beds. In the 5 year period from 2013 to 2017, 126 people spent 365 or more consecutive days in acute inpatient units (82,874 bed days) at an estimated cost of $115 million. This equates to an annual average of 45 acute inpatient beds. Over the same period, another 158 individuals had multiple stays in acute inpatient beds totalling 365 days or more.

The cost of putting in place a comprehensive rehabilitation and recovery system will be substantial, but the cost of not doing so will be even higher.

These long stays have major implications for the mental health and health systems. They reduce bed capacity for people needing acute inpatient care, which, in turn, puts 'back pressure' on the hospital EDs (the main 'gateway' into inpatient care) and on community mental health services (which spend a substantial amount of time trying to access inpatient beds for people requiring urgent care). The report concluded:

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

and further:

> *"Moving people who require long-term care into more appropriate care settings would effectively increase acute bed capacity in hospitals without expanding [their] numbers."*

Currently, the WA Mental Health Commission pays $1,500 per bed-day for acute inpatient care. By comparison, the average bed day cost of three of the CCUs in Metro South Health in Brisbane range from $471 to $545, around one-third of the bed-day cost of acute care beds in WA. All of the units are staffed 24-hours per day and operated and staffed by public mental health services (Metro South Health). One of the CCUs (mid-cost within the above range) is staffed completely by healthcare professionals while the other

100 Office of the Auditor General (2019). *Access to state-managed adult mental health services*. Perth, WA: Office of the Auditor General.

two have a mix of mental health professionals and peer workers.[101] Any capital expenditure required to build the CCUs would be offset by the significant reduction in operating cost when compared with the cost of acute mental health inpatient care.

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.

In WA, a study investigated outcomes for 190 people referred to an intensive community rehabilitation outreach service (Intensive Community Outreach Teams) in the North Metropolitan Health Service over a 2 year period from October 2012. It was reported that the possible cost savings 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 rehabilitation outreach service.[102] 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 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.[103] The average estimated saving per person was £42,000.

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. The international and local evidence to support this investment is compelling.

101 Personal communication, Dr Frances Dark, Director of the Rehabilitation Academic Clinical Unit for Metro South Mental Health Services. (2020).

102 Hammond, G., Bromwell, D., Janca, A. *et al.* (2012). *Assessment of systemic resource utilisation before and after enrolment into assertive treatment: Lessons from the Intensive Community Outreach Team Implementation.* (unpublished).

103 Bunyan, N., Ganeshalingan, Y., Morgan, E. *et al.* (2016). In-patient rehabilitation: clinical outcomes and cost implications. *BJ Psych Bulletin;* 40: 24-28.

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 HSPs. 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 and we conducted site visits to selected specialist rehabilitation services in Brisbane.

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 HSPs 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. Interviews were also held with consumer and carer representatives and key clinicians.

A discussion paper was widely distributed to key stakeholders and was also made available on the Office of the Chief Psychiatrist website. Comment and feedback was invited prior to the release of a final report.

Appendix 2: Survey of clinical rehabilitation services 2019

A survey of metropolitan HSPs was conducted in 2019 as part of this Review. The aim was to better understand the availability of specialist adult mental health services which are primarily delivering treatment and care to consumers with severe mental illness and challenging behaviour. It included acute/sub-acute inpatient and community-based adult services but excluded forensic mental health services.

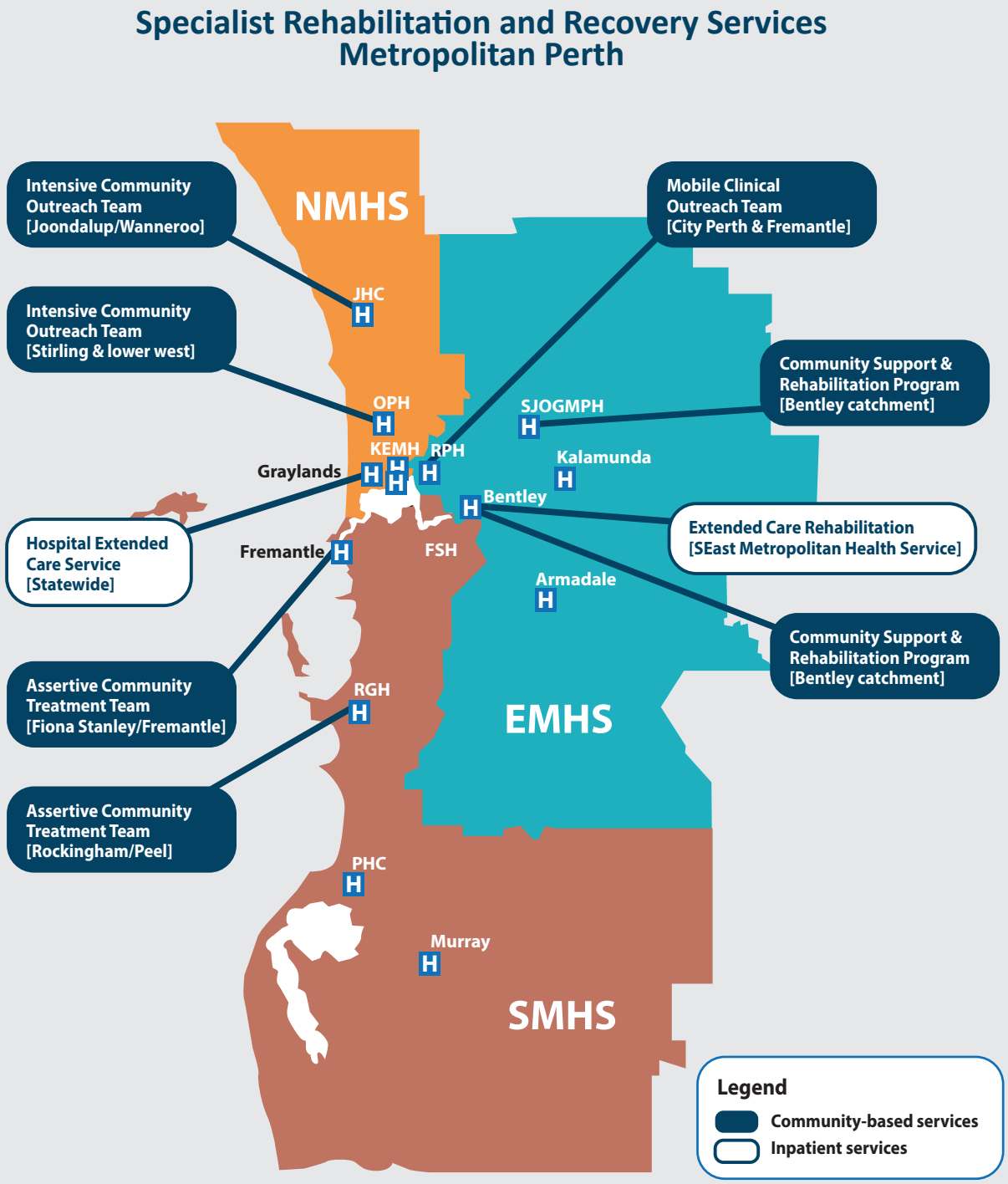
The results are mapped in Figure 10 on page 64. Detailed survey findings including service descriptions, catchments, staffing levels and profiles, hours of operation and consumer numbers are outlined in Appendices 2 and 3.

2.1 Findings

Across public metropolitan mental health services there are some components of a rehabilitation and recovery treatment service system but none of the HSPs provide an integrated specialist rehabilitation and recovery suite of services. In summary:

- There are limited clinical bed-based services, with the most notable feature being the absence of intensive inpatient rehabilitation units and community-based rehabilitation and recovery units.
- There are gaps in the provision of intensive community rehabilitation outreach teams in some parts of the metropolitan area.

Figure 10: Mapping of public mental health specialist rehabilitation and recovery services in metropolitan Perth in 2019



Source: Survey of HSPs conducted as part of this Review. Note that the data was provided by Health Service Providers at differing times between January and May 2019.

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 (CSRP). Although they vary in their staffing and caseloads, these teams 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 and peer workers).
- District-based catchments.
- Not part of a comprehensive, integrated rehabilitation program which includes rehabilitation inpatient beds.

It is notable that there are no peer workers or clinical psychologists in the intensive community mental health rehabilitation and recovery teams.

The provision of community rehabilitation services varies across the metropolitan area. In summary:

- The specialist intensive outreach teams in the North Metropolitan Health Service provide a service across its catchment.
- 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, a specialist program administered by the East Metropolitan Health Service, provides a targeted service for those who are homeless or at risk of becoming homeless in the inner city areas of Perth and Fremantle.
- There is a gap in services in the South Metropolitan Health Service, where the Rockingham-Peel Group Assertive Community Treatment Team does not cover the Peel area.

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 67 bed State-wide inpatient extended care/ rehabilitation service.

2.2 Profile of rehabilitation and recovery services by HSP

South Metropolitan Health Service

Community: South Metropolitan Health Service				
Service Type	**Catchment**	**Hours of operation**	**Staffing Profile/FTE**	**Consumer numbers**
Assertive Community Treatment Team (ACTT)	Fiona Stanley Fremantle Hospital Group catchment (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)	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

East Metropolitan Health Service

Community: East Metropolitan Health Service				
Service Type	**Location/ Catchment**	**Hours of operation**	**Staffing Profile/FTE**	**Consumer numbers**
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) (0.8) • Occupational Therapists (1.7) • 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 3.30Monday to Friday	• Consultant Psychiatrist (0.4) • Clinical Nurse Specialists (2) • Senior Social Worker (1) • Clerical Support Officer (0.1) **TOTAL FTE: 3.5**	

Inpatient: East Metropolitan Health Service

Service Type	Location	Catchment	Bed Description	Bed Type
Extended Care Rehabilitation	Bentley Hospital	All of East Metropolitan Health Service	• 12 bed (John Milne Centre)	Rehabilitation

North Metropolitan Health Service

Community: North Metropolitan Health Service

Service Type	Location/ Catchment	Hours of operation	Staffing Profile/FTE	Consumer numbers
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) • Individualised Community Living Strategy 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

Statewide Inpatient: North Metropolitan Health Service				
Service Type	**Location**	**Catchment**	**Bed Description**	**Bed Type**
Statewide Tertiary level Inpatient Rehabilitation Service	Graylands Hospital	Statewide	• Murchison West – 21 bed mixed gender secure unit • Murchison East – 22 bed mixed gender open ward • Ellis Unit – 14 bed mixed gender secure unit • Casson Unit – 10 bed mixed gender co-morbidity unit	Extended care

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 adults 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 CSRP 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 an 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 provided 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 is also offered to carers, families and community agencies.

The key objectives of the CSRP are to:

- Promote independence of clients, reduce symptoms, enhance function 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 the 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 severe 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 targets 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.
- Develop a consumer-oriented PSOLIS-based Management Plan and Collaborative Action Plan (CAP) for every client.
- 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: (Graylands Hospital: NMHS)

Hospital Extended Care Service (HECS)

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 needs and 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 partnerships with government organisations, General Practitioners and community service providers.
- Provide advice on specialised mental health rehabilitation approaches and services.

Appendix 4: List of figures

Appendix 5: Acronyms and abbreviations

ACTT	Assertive Community Treatment Team
AOD	Alcohol and Other Drugs
BMJ	British Medical Journal
CCU	Community Care Unit
CSRP	Community Support and Rehabilitation Program
CTO	Community Treatment Order
ED	Emergency Department
EIP	Early Intervention in Psychosis
GP	General Practitioner
HECS	Hospital Extended Care Service
HSP	Health Service Provider
ICOT	Intensive Community Outreach Team
MANCAS	Manchester Care Assessment Schedule
MCOT	Mobile Clinical Outreach Team
MH	Mental Health
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NSW	New South Wales
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SECU	Secure Extended Care Unit
SHIP	Survey of High Impact Psychosis
SMI	Severe Mental Illness
TIPS	Early Treatment and Intervention in First Episode Psychosis
WA	Western Australia

This document can be made available in alternative formats on request for a person with disability.