

# An analysis of the Victorian rehabilitation and recovery care service system for people with severe mental illness and associated disability

Project report



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## Common acronyms and initialisations used in this report

AMHS	area mental health service
CAMHS	child and adolescent mental health service
CAT	crisis assessment and treatment (team)
CCT	continuing care team
CCU	community care unit
HBOS	home-based outreach service
IHBOS	intensive home-based outreach
IRRCS	integrated rehabilitation and recovery care service
HoNOS	Health of Nation Outcome Scale
MST	mobile support and treatment
PDRS	psychiatric disability rehabilitation and support
RDC	response difficulty checklist
RRS	resident rehabilitation service
SAS	supported accommodation service
SECU	secure extended care unit
SRS	supported residential service

## Director's foreword

This report was made possible through the input of many, reflecting the commitment of the staff in the sector, carers and the families of people with enduring mental illness and consumers to continue to ensure that Victoria has one of the best public mental health systems in Australia.

It highlights examples of good practices and the collaboration between clinical services and psychiatric disability rehabilitation support services that results in consumers getting the care and support they need and of the system responding to the consumer's needs rather than the consumer fitting into the available service.

The report also highlights areas where the different elements of the service system need to work together to ensure consumers have access to integrated rehabilitation and recovery care. This will require examining current practices, especially in relation to implementing consistent admission and exit practices, improved collaboration between service elements, expanding services and developing new service models to better meet both need and demand.

This report is a starting point. The Mental Health Branch together with the regional offices of the Department of Human Services will continue to work with the sector, consumers and carers to address service gaps and quality issues. However I encourage area mental health service senior management to take a lead in discussing the findings in this report with their staff and their local psychiatric disability rehabilitation support services providers, using the Alliances for Rehabilitation and Care as a forum. Collaboration and better understanding of each of the service elements roles and responsibilities will improve outcomes for consumers.

I am committed to these recommendations; many of which can be addressed within existing resources through discovering new ways of working together. Others will require longer lead-in times and resources.



**Dr Ruth Vine**  
**Director, Mental Health**



# 1 Introduction

## 1.1 Purpose

The *Analysis of the Victorian rehabilitation and recovery care service system for people with severe mental illness and associated disability* examines the key systemic and practice issues currently limiting the capacity of the public mental health service system to achieve a more integrated, effective and consumer-focused rehabilitation and continuing care response to adults with severe and enduring mental health problems and associated psychosocial disability. It identifies a range of solutions to address these issues as outlined below.

1. It seeks to clarify the role, function and target group of clinical and non-clinical bed-based extended care rehabilitation services and community clinical rehabilitation and psychiatric disability rehabilitation and support (PDRS) services, in the context of consumer need, in order to optimise use of these resources and ensure services match resources to consumer need.
2. It recommends strategies to improve the systemic interface between these service elements, particularly across critical transition points (as consumers move from an extended care facility to the community). This will achieve better continuity of care and optimise rehabilitation and recovery outcomes for consumers who require both clinical and psychosocial rehabilitation support responses of appropriate and flexible intensity to live independently in the community.
3. It provides a clear framework to manage demand for rehabilitation and recovery services across the continuum of care and improves exit pathways from clinical extended care facilities in order to address critical system blockages. In this context priority consideration has been given to identifying:
  - priorities for service growth to address areas of critical under supply
  - cost-effective solutions to address identified service gaps including redeveloping existing resources and new service models.

## 1.2 Project overview

The report provides a description of the intended purpose, function and entry and exit pathways of each of the service elements that constitute Victoria's current mental health rehabilitation and care system. These include:

- 24-hour clinical extended care services – secure extended care units (SECU) and community care units (CCU)
- Non-clinical bed-based rehabilitation services – PDRS residential rehabilitation services
- Clinical ambulatory services – mobile support and treatment (MST) teams and continuing care teams
- PDRS home-based outreach services (HBOS) and supported accommodation services (SAS).

Next, drawing on available data, the report examines patterns of service use comparing the severity of symptomatology and level of disability experienced by consumers of different service elements as well as entry and exit pathways. From the analysis of service utilisation data, the report then identifies critical issues in the way the service system currently operates and outlines principles to guide the development of the service system.

The report then recommends solutions to address the identified issues in order to strengthen the service system and make better use of existing resources to meet consumer needs. This includes refining and also extending particular service elements.

## 1.3 Context

The Government's *New directions for Victoria's mental health services: the next five years*, launched in September 2002, identifies priorities for service development over the ensuing five years. This includes strengthening rehabilitation and continuing care for people with severe ongoing mental illness and marked disability.

The existing service elements were established some ten years ago. They were designed both to replace core functions of the psychiatric institutions before the latter closed and also to respond to existing unmet need for community-based treatment and care. However, there have been significant changes since then that justify a review of how rehabilitation and care are currently provided. In addition, implementation issues and service gaps have emerged that make the need for such a review more pressing.

Developments in recent years include the following:

### Changing service demands

Many former institutional patients have been placed in community settings requiring various levels and duration of ongoing treatment and psychiatric disability support. However, a small group continues to require intensive bed-based services including containment and protection due to unremitting symptoms and behaviours that are unacceptable to the wider community. At the same time there is pressure to provide adequate treatment for newly emerging populations with severe and ongoing mental illness and associated disability.

Service demand has continued to grow steadily with an increase in the number of consumers with complex needs, in particular those with a mental illness and substance use problem. Complex need consumers also include people with comorbid acquired brain injury or intellectual disability. Other consumer groups with a mental illness and high needs for rehabilitation and continuing care are those exiting prison and people who are also homeless.

### Growth in psychiatric disability and rehabilitation support services

PDRS services have undergone significant expansion, in particular residential rehabilitation services for young people, HBOS and the more recently established intensive home-based outreach support (IBOS) services. The PDRS service sector has also grown in skill and capacity, with increasing sophistication in service delivery. This has included developing innovative collaborative partnerships with clinical services. It is important that Victoria continues to build this sector and strengthen its role in service provision.

### Workforce issues

The following two key issues are impacting on the long-term sustainability of Victoria's public mental health service system.

- 1 **Existing and projected shortages in the skilled mental health workforce**, particularly in the nursing and medical workforce. Shortages in skilled staff, driven by recruitment and retention difficulties, significantly impact on the ability to expand the service system and maintain key positions in some areas.
- 2 **Workforce quality** both in terms of variable practice standards and the need to strengthen mental health leadership across the spectrum of services.

## System blockages

Particular elements of the mental health service system are under strain due to a range of interrelated issues including:

- **increased service demand**, particularly from complex/high need consumers
- the **unequal distribution** of resources due to historical allocations
- **bed blockages** due to insufficient discharge options for long stay high-risk patients in acute inpatient facilities and consumers in extended care clinical services
- **obstacles to achieving continuity of care** across and between clinical and PDRS services.

It is therefore timely to review the practice models of different service elements to ensure the best outcomes for consumers and the most effective use of resources.

## 1.4 Achievements to date

To date the Mental Health Branch has developed two initiatives to address critical issues emerging from the report. These initiatives have been developed to:

- improve cross-sector collaboration between clinical and PDRS service elements to ensure continuity of care and achieve a more coordinated and multidisciplinary response to shared consumers (Alliances for Rehabilitation and Care initiative)
- create consumer flow through clinical extended care facilities by providing more suitable discharge and support pathways for consumers within these facilities, particularly long-stay consumers that are difficult to move to independent living in the community without high levels of support (Integrated Rehabilitation and Recovery Care Service initiative).

The initiatives are described below.

### Clinical and PDRS services alliances for rehabilitation and care

Strengthening organisational alliances and the functional working relationship between clinical mental health and PDRS services will improve recovery, rehabilitation and continuity of care outcomes for shared adult consumers with severe mental illness and associated psychosocial disability.

The Department of Human Services has allocated non-recurrent seed funding to the clinical and PDRS service sectors to:

- **build functional working alliances at the management and staff level** that will improve the level of integration and/or collaboration between the two service sectors
- provide **support to implement practices that will provide sustainable and tangible benefit to shared consumers** (such as electronic information exchange, developing shared rehabilitation and recovery plans and joint staff training)
- encourage innovation in service system delivery to **continuously improve service quality and outcomes for consumers.**

The above outcomes will be facilitated through developing:

- a **memorandum of understanding** (MoU) that will detail the principles, protocols and structural/functional arrangements by which clinical mental health and PDRS services will work together to achieve the integrated delivery of rehabilitation and care services to the target consumer group
- an **action plan** that will articulate the specific processes and activities to be undertaken, including associated timeframes, which will give practical effect to the MoU.

The alliance arrangements and associated systems and structures would be expected to be maintained and further developed as part of the core business of clinical and PDRS services.

### **Integrated rehabilitation and recovery care service**

The integrated rehabilitation and recovery care service (IRRCS) is a new initiative designed to support the successful transition of long-stay consumers from bed-based extended care clinical facilities (SECU and CCU) to the community through providing a dedicated, intensive, sustained and integrated clinical and psychosocial support response. The IRRCS is a collaborative initiative between the PDRS and clinical mental health service sectors and is targeted to consumers with severe mental health issues and enduring psychiatric disability.

Consumers targeted under this initiative will have been assessed as having the potential to live independently in the community if provided with high levels of rehabilitation and clinical outreach support on a transitional basis and, in the longer term, standard ongoing psychiatric disability support from PDRS and clinical community mental health services. In 2006-07, this initiative will target three service configurations involving one SECU and four CCUs located in the southern, western and north-eastern metropolitan areas.

The IRRCS will target consumers who:

- are currently long-term residents of a targeted SECU or CCU
- have a severe mental illness and enduring psychiatric disability
- are able to be managed on a community treatment order and do not require continuing inpatient treatment and care
- are assessed as being able to live in the community if provided with intensive multidisciplinary psychosocial and clinical treatment and support and access to stable and affordable housing
- are assessed as having potential to achieve a level of daily living skills and social functioning such that, after an extended period of community-based intensive and focused rehabilitation support, they could be successfully maintained in the community with a lower level of ongoing psychosocial support and clinical care
- do not pose an unmanageable risk to themselves or the community if they were discharged.

## 2 Overview of relevant service system elements

The public mental health service system has specific components designed to respond to people with ongoing mental illness and associated disability. They include inpatient and community-based residential services, as well as non-bed-based clinical and non-clinical ambulatory services. This section of the report describes the intended core function of these service elements and their target population; key consumer entry and exit pathways; an historical overview; and current supply and distribution.

Table 1 provides an overview of the quantum of beds or consumers supported per service element. Refer to Appendix 1 for information of the distribution of bed-based services across the State. Figure 1 provides an indicative overview of the relationship between these service types and service pathways for consumers. Refer to Appendix 2 for a flow chart that illustrates in more detail the expected interrelationship between these service elements.

**Table 1: Number of beds/consumers supported per service element**

Service type	Number of beds/support capacity
<b>Bed-based rehabilitation services<sup>1</sup></b>	
Secure extended care units	103 beds as at March 2006
Community care units	308 beds as at March 2006
PDRS residential rehabilitation services	260 beds as at March 2006: <ul style="list-style-type: none"> <li>• 96 adult beds (51 beds with 24-hour support)</li> <li>• 164 youth-specific beds (30 beds with 24-hour support)</li> </ul>
PDRS supported accommodation services	135 beds as at March 2006 <sup>2</sup>
<b>Ambulatory rehabilitation services</b>	
Mobile support and treatment teams	3872 consumers (2004–05); 299 EFT (2005–06)
Continuing care teams	22,403 consumers (2004–05); 879 EFT (2005–06)
PDRS home-based outreach services	Standard HBOS: 2797 adult consumers <sup>3</sup> Intensive HBOS: 402 adult consumers <sup>4</sup>

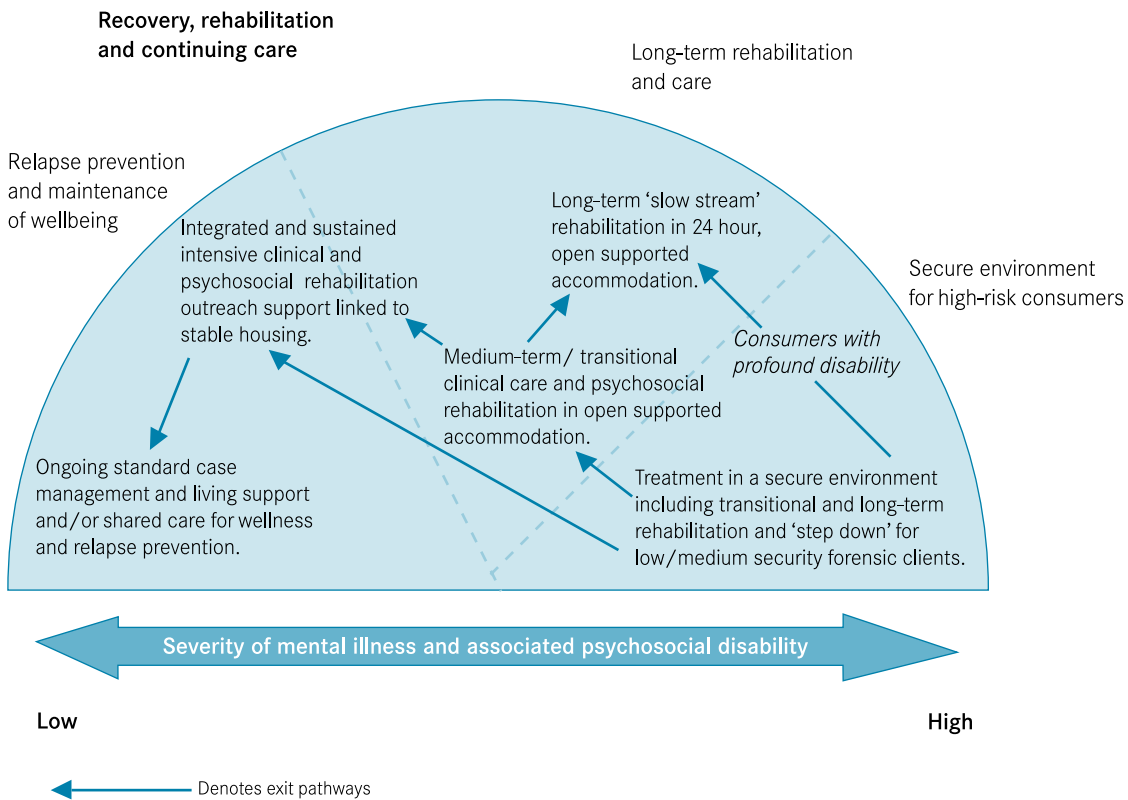
<sup>1</sup> Does not include the 33 beds at the Brain Disorders Service at Royal Talbot

<sup>2</sup> Estimated bed numbers. Some services receive partial funding from the Mental Health Branch.

<sup>3</sup> Average capacity reported in each quarterly data collection period for 2005–06.

<sup>4</sup> See above comment.

**Diagram 1: Spectrum of interventions for consumers with severe/enduring mental illness and psychosocial disability**



## 2.1 Bed-based rehabilitation services

The bed-based rehabilitation services include:

### Clinical extended care facilities

- Secure extended care units
- Community care units

### Non-clinical rehabilitation facilities

- PDRSS residential rehabilitation services
- PDRS supported accommodation services

### Secured extended care units

Built to replace locked institutional wards, secure extended care units (SECU) were established from 1995 to 1999 within mainstream public hospitals. Secure/extended care inpatient clinical services provide intensive treatment and support for consumers who have unremitting and severe symptomatology together with an associated significant disturbance in behaviour that inhibits the consumer's capacity to live in the community.

Key service requirements for secure/extended care inpatient services are to:

- provide secure extended mental health treatment and care on an involuntary basis where necessary
- provide appropriate psychosocial rehabilitation and behaviour management programs to help modify disruptive behaviours and maximise social and personal functioning
- maintain active individualised care planning to monitor the changing needs of consumers and their suitability for less restrictive treatment and care
- provide family support and educational programs to foster continued links between consumers, their families and the community
- facilitate consumer access to other services appropriate to their health and welfare needs
- develop and maintain links with referring agencies, other service system elements, and service providers to ensure effective admission, exit and follow-up planning
- provide liaison and consultation services to other agencies on the treatment and management of consumers with treatment-resistant illnesses and difficult behaviours.

The target consumer group typically have a history of multiple or lengthy inpatient admissions, severe and unremitting symptoms, problems with medication compliance and a predisposition to aggression or other socially unacceptable behaviour. Some SECU consumers may also have co-existing acquired brain injury (ABI) or intellectual disability and/or a dual diagnosis of substance use.

Length of stay is determined by the consumer's response to treatment and rehabilitation interventions. Although the catchment for SECU is regional, typically covering more than one area mental health service (AMHS); the SECU function is integral to the operation of an AMHS. This is because it provides a critical discharge option for high-risk consumers in acute inpatient units who require longer term inpatient treatment and care. MST services, PDRS services and CCUs represent a discharge option for SECU consumers.

Although operating in a secure setting, SECUs are expected to function in accordance with the principles of rehabilitation wherever possible. It is anticipated that most consumers will progress over time so they can move to a less restrictive service environment. However, SECUs also provide secure, long-term care to some consumers who may have reduced capacity to benefit from rehabilitation due to the severity of their mental illness, and other disabling conditions such as ABI or intellectual disability. An important requirement of the SECU role is to care for a small number of consumers who can not be supported to live in the community because of their level of disturbance, difficult behaviours and concomitant risk to the community or to themselves.

As at March 2006, there were 103 SECU beds across Victoria. The three metropolitan SECUs comprise between 20 and 26 beds each and are located on public hospital campuses in Dandenong, Sunshine and Heidelberg. The number of SECU beds in rural regions includes a 12-bed unit in Ballarat, eight in Bendigo, six in Gippsland and three beds in Barwon and Warrnambool respectively.

### Community care units

Community care units (CCU) provide a structured residential environment in a community setting, with 24-hour on-site clinical staffing. As well as ongoing clinical interventions, CCUs provide an opportunity for community living and aim to enhance consumers' daily living skills and their quality of life. Targeted consumers have severe ongoing or recurrent symptoms, comorbid conditions, difficult behaviours, are prone to relapse and often have a history of multiple inpatient admissions, may have difficulty in complying with treatment and have marked disability in terms of everyday functioning. While the service is intended to be rehabilitative, clinical needs are paramount. Given the complexity of consumers' treatment and rehabilitation needs, this consumer group typically requires a longer period of support to make gains in their everyday functioning.

CCUs provide a step-up function for MST services and an important step-down option for SECU consumers. Depending on their level of continuing disability, exit options for CCU consumers include their own private accommodation or public housing with disability support through PDRS HBOS or day programs and clinical management from an MST team or CCT. Other options for consumers with greater support needs include supported accommodation services that provide daily support/supervision.

CCUs were designed to replace open adult extended care wards in the former stand-alone psychiatric institutions. Most CCUs were built and opened over the period 1994 to 1999 as the institutions were decommissioned. The majority of CCUs have 20 beds in a variety of configurations ranging from clusters of one to five-bed units and are usually situated on a suburban residential block with street frontage. All have 24-hour clinical staffing (largely comprising nursing staff) with allied health staff working a five-day week and medical/consulting psychiatric input.

An early prototype with 10 beds was established in 1988 in the inner east through the Willsmere Decommissioning Project. This development also included purchasing five units and a house in adjoining suburbs. This accommodation was designed as a step-down option for exiting residents of the CCU, with staff of the latter providing outreach support as needed. This component was not included in the later development of CCUs and exit pathways were less overtly identified.

A service brief prepared in 1994 guided the development of CCUs in the latter part of the 1990s. However, detailed service guidelines were never published. Arguably, this gave leeway to variation across CCUs in terms of consumer entry and exit criteria and the services provided.

Under the 1994 service framework, each of the adult area mental health services was to have its own community care unit. This was achieved for metropolitan AMHS, although not all rural AMHS established this service type. As a result, three rural AMHS are currently developing CCUs and one (Mildura) continues to use CCU beds in an AMHS in the same rural region.

As at March 2006, there were 308 CCU beds across Victoria. Two-thirds are in configurations of 20 beds in residential neighbourhoods, sometimes on a hospital campus with a street frontage. Three other CCUs comprise 10 to 12 beds, with another of eight beds and one with two beds. In rural AMHS, some CCU beds are collocated with SECU facilities.

### **PDRS residential rehabilitation services**

Residential rehabilitation services (RRS) target consumers with continuing psychiatric disabilities whose mental illness is relatively stable and who can benefit from living in a cluster housing situation and sharing units. The group living situation is used to enhance consumers' everyday functioning, including their capacity to relate to others.

### **Youth residential rehabilitation services**

Seventeen RRSs, with a total of 164 beds, target young people aged 16 to 25 years, with an expected length of stay of one to two years. Youth RRSs vary in whether they provide overnight or an on-call system after hours that in turn influences their target group and function. A significant proportion of current consumers have substance addiction issues.

Youth RRSs serve as a step-down option following an acute admission or alternatively, as a step-up from living with family or friends. It would be expected that the young person would also be receiving clinical services from a local public mental health service (CCT or occasionally a child and adolescent mental health service (CAMHS) or private psychiatrist or GP. Exit options include private accommodation or public housing augmented with psychiatric rehabilitation and disability support.

The systematic rollout of the youth RRS, in contrast to the adult RRS, has resulted in these services being more evenly distributed across the State. In line with their common starting point, they also demonstrate a more consistent service rationale and entry criteria. Four youth RRSs established after 1996 formed part of a major government suicide prevention initiative.

In 2004–05, funding was allocated to the seven rural youth RRSs for additional clinical and PDRS support to increase their capacity to more effectively respond to the needs of young people with comorbid alcohol abuse and illicit drug addiction issues.

### **Adult residential rehabilitation services**

The eight adult RRSs provide a more mixed range of support or care models with length of stay varying according to level of disability, with some services providing 'slow stream' rehabilitation for consumers with more complex needs (such as Appleby Crescent and Victoria Lodge) and others providing transitional rehabilitation with a nominated timeframe of one to two years.

The operating philosophies of adult RRSs and consumer entry criteria may also vary. For instance some, like Rosa Gilbert and Rossdale, have sleepover staff and others such as Trelowarren and Edith Pardy do not. All are supposed to make use of the shared living environment to enhance residents' social and other living skills.

Residents are also presumably consumers of the CCT service of the local AMHS, although in some instances, in-reach clinical support may be provided by an MST service. Adult RRSs act as a step-up option for MST and CCT consumers, and as a step-down for consumers after an acute inpatient admission. Some were originally government-run 'psychiatric hostels', such as Trelowarren and Edith Pardy, before being transferred in the 1980s to the non-government sector. Non-government agencies started others such as Victoria Lodge.

For historical reasons adult RRSs are only available in the metropolitan area. Not all metropolitan mental health areas have an adult RRS and some have more than one.

As at March 2006, there were 260 PDRS services residential rehabilitation beds across Victoria, of which 96 catered for adults and 164 for young people.

### **PDRS support and accommodation services**

For consumers who cannot live independently, PDRS supported accommodation services (SAS) provide long-term accommodation, with support to residents on a daily basis. Disability support may be based on site, with a staffing complement that includes sleepovers or an on-call system overnight.

Alternatively, support may be provided on an in-reach basis according to residents' needs. Kinkora and Wynstay hostels, operated by MHAV Hostels (formerly Mental Health Auxiliaries of Victoria), use this model. MHAV receive funding for residential services provided and HBOS workers from another PDRS services provide psychosocial support to residents.

The most recent SAS initiative is Rooming House Plus that operates from a large government-owned facility in South Melbourne refurbished to accommodate people with a range of disabilities. This includes 38 places for those with psychiatric disability. A housing association manages the tenancies and a disability support service provides the psychosocial rehabilitation.

SASs were not part of the original scope of the project, but are included due to their important 'destination' function in the rehabilitation and continuing care service system. It should be noted that these services have been developed in response to opportunities or crisis (such as the imminent closure of private pension level supported residential services accommodating consumers with a mental illness) rather than as a planned service model.

The consumers of this service model are similar to those in adult RRSs in that SAS consumers have marked psychiatric disability resulting from severe mental illness and require a structured supportive environment. SAS work within a rehabilitation framework and promote independence, while providing meals and housekeeping services as needed.

The difference is that unlike consumers of RRSs, SAS consumers are not required to participate in a transitional rehabilitation program and do not have to 'move on'. Accommodation is stable and home like, residents can stay as long as they like and typically have tenancy rights under the Residential Tenancies Act. Located in residential areas, SASs may comprise flats or bed-sits in one large dwelling, or a cluster of units on the same site. As at March 2006, there were 135 SAS places across the State.

## Pension-level supported residential services

Privately managed pension-level supported residential services (SRS) provide accommodation, meals and 24-hour on-site supervision to low-income people who need a significant level of assistance with daily living. Since the early 1970s SRSs and their precursors have formed a significant element of Victoria's accommodation and support infrastructure for people with mental illness and psychiatric disability (estimated at 66 per cent of all pension-level residents).

The SRS industry is privately funded through resident fees and is regulated by the State Government through the *Health Services Act 1988*. The Department of Human Services licences and regulates operators of SRSs.

The pension-level SRS sector continues to experience bed closures due to issues related to the viability of the business model, increased building and service standards and higher land values. Current capacity is estimated at approximately 2000 beds.

This service model does not have a rehabilitation focus. Based on their assessed need SRS residents with enduring psychiatric disability would be eligible for clinical treatment and psychosocial rehabilitation support. A snapshot survey undertaken by the department found that 20 per cent pension-level SRS residents received an on- or off-site mental health service during September 2003.

A survey of a sample of SRSs undertaken in August 2005 by the department found that some mental health acute inpatient services use SRSs as a short-term discharge option for consumers at risk of homelessness. The practice was particularly concentrated in several geographical areas in the Southern Metropolitan region.

It is important to acknowledge the 2006–07 Budget initiative in which the Government committed \$29.41 million over four years for a suite of measures to support the viability and sustainability of the pension-level SRS sector. This initiative is based on the department's successful supported residential service research and pilot projects, developed across the State over the past few years. The pilots focused on pension-only SRSs as this category typically has a high proportion of residents with psychiatric disabilities and a history of mental illness. The pilots were aimed at enhancing the capacity of SRSs to respond to their existing residents and, in turn, their viability, and did not seek to expand this type of private accommodation service.

## 2.2 Ambulatory mental health services

Ambulatory mental health services considered within the scope of this project include:

Clinical mental health functions/services

- Mobile support and treatment teams
- Continuing care teams

Psychiatric disability rehabilitation and support services

- Home-based outreach support
- Intensive home-based outreach support
- Intensive rehabilitation outreach support – attached to youth residential rehabilitation services
- Day programs

## Mobile support and treatment teams

Mobile support and treatment (MST) teams provide ongoing mobile and assertive long-term treatment, support and rehabilitation to the most severely disabled consumers in their own living environment. MST teams work on an accessible extended-hours outreach basis over seven days a week with a designated group of consumers (staff to client ratio of 1:10-12). Support from crisis assessment and treatment (CAT) teams is provided as required.

This service model aims to avoid or minimise the need for repeated and lengthy hospital admissions. MST services are targeted to consumers with severe and enduring mental illness and associated psychiatric disability who are:

- especially prone to relapse and readmission and have a wide range of psychosocial rehabilitation needs that would typically result in the consumer's admission to hospital
- commonly not compliant with treatment regimes
- typically lack motivation, the ability to function independently and have a poor understanding of their mental illness despite repeated attempts at education
- especially unwilling or unable to attend a centre-based service.

Intensive treatment and rehabilitation support is likely to be needed over years rather than months. MST teams are expected to provide or arrange rehabilitation to develop the consumers daily living skills and enhance their capacity for independent community living, and support the consumer to maintain safe, secure and affordable housing. In 2004–05, MST teams provided services to a total of 3872 consumers.

It is expected that MST teams will work intensively with consumers over an extended period until CCT staff can manage the consumer's treatment. In this context, MST teams provide a step-up function for CCT consumers who require more intensive clinical support, and are a step-down option for CCU and SECU consumers. MST teams can work with intensive home-based outreach support (IHBOS) workers to meet the needs of individuals in the community with high and or complex needs. Step-down options for MST consumers include CCT services for clinical support, and rehabilitation input from home-based outreach support (HBOS) and day programs provided by PDRS services.

The MST service model, established in 1994 in every adult area mental health service in Victoria, was created to replace long-term rehabilitation wards. At this time, PDRS HBOS was not available in all areas.

In rural areas, this function may be covered by integrated rather than separate teams. The integrated teams typically work in satellite locations across a rural AMHS catchment area and combine the functions of crisis assessment and treatment, continuing care and mobile support and treatment. By basing themselves in smaller rural towns, the multi-function integrated teams aim to reduce the travel time resulting from a geographically dispersed consumer group.

## Continuing care and treatment

Continuing care and treatment services are targeted to consumers with severe mental illness and ongoing symptoms who require treatment, monitoring and continuing support. This service model provides psychosocial interventions as well as assistance with medication, psycho-education and relapse prevention programs to assist consumers understand and manage their symptoms and family education and support. Each CCT consumer has a clinical case manager responsible for developing, coordinating and monitoring their treatment, as well as often being the main clinical care provider.

CCT services are usually the first entry point for consumers referred to public mental health services. They provide an initial assessment service for people requesting assistance where a crisis assessment team (CAT) service response is not required. CCT services provide a step-up for consumers of GPs (or shared care) and other primary health providers and PDRS services, and act as a step-down option for MST consumers.

All AMHS provide CCT, typically from a community mental health centre-based in the local community. Most AMHS have at least two CCT teams, located in different parts of their catchment area. Over the period 2004–05, CCT provided services to a total of 22,403 consumers.

## PDRS home-based outreach support

The PDRSS home-based outreach support program provides psychosocial rehabilitation outreach support to consumers with severe mental illness and enduring psychiatric disability. These consumers are referred from clinical mental health services or from the broader community including general practitioners and housing and homeless services. The program has a number of sub programs including:

### 1. Standard home-based outreach support

There are 39 PDRS funded agencies delivering standard home-based outreach support (HBOS) services in metropolitan and rural Victoria. HBOS staff provide rehabilitation activities and disability support on an outreach basis in the client's own environment (including public and private housing) and operate on an indicative client to worker ratio of 1:10.

### 2. Intensive home-based outreach support

Intensive home-based outreach support (IHBOS) services are a relatively new model of psychiatric disability support in Victoria and when established operated on an indicative client to worker ratio of 1:5. They were established in 2002 under the *Victorian homelessness strategy* with the aim of providing an improved service response to people who are homeless or at risk of homelessness and have an enduring and severe mental illness and associated psychiatric disability. This consumer group is typically transient and requires intensive outreach to engage with services. There are 28 PDRS agencies providing IHBOS around Victoria. A review of practice found that most agencies were operating a range of IHBOS client to worker ratios of between 1:5–10.

Under the Transitional Housing Management Mental Health Housing Pathways Initiative developed as part of the *Victorian homelessness strategy*, PDRS HBOS providers have nomination rights over a total of 140 transitional housing properties.

### **PDRS day programs**

PDRS day programs were not included in the original scope of the project but are another element in the rehabilitation and continuing care service system. Day programs are delivered by PDRS agencies in all metropolitan and rural areas.

Some operate from a centre base, whereas others make use of local community facilities. Day program consumers typically have a range of psychiatric disabilities associated with mental illness. Activities offered are based on a psychosocial rehabilitation model and include informal drop-in as well as structured day program activities. The aim is to assist consumers to gain, regain or maintain skills needed for everyday living, and improve quality of life by participating in social, recreational and vocational activities.

### 3 Project methodology and data sources

Data from several sources were used to obtain an overview of how services have been operating and the profile of their respective consumer groups. Some represented routine data collection and others were undertaken on a once-off basis. Both quantitative and qualitative data were collected.

#### Quantitative data

To build a picture of who used which services, the following quantitative data were collected:

- For clinical services, consumer demographic data for 2003–04 and patterns of service use from 1990–2000 to 2003–04 were obtained from RAPID. Consumer scores on the Health of Nation Outcomes Scale (HoNOS) were also analysed, both as a snapshot for 2003–04 to 2004–05, and for episodes over the period 1999–2005. In addition, data from a 2002 snapshot survey using the response difficulty checklist (RDC) was examined.
- For PDRS services, the analysis included data from the routine quarterly data collection for 2003–04. This covered consumer demographics as well as service use. In addition, in a special snapshot survey undertaken in May 2005, a sample of PDRS services rated their consumers using the HoNOS and RDC instruments.

There are a number of caveats in interpreting this data. These include:

- Data were collected at different times. For instance, RDC data for consumers of clinical services were collected in October 2002, compared to 2005 for PDRS consumers.
- Some service elements had low return rates with small sample sizes. This may limit the representativeness of the data and hence its validity. For example, HoNOS snapshot scores for 2003–04 comprised only 7 per cent of CCT available records, and 30 per cent of MST. Further, one particular AMHS provided over half the MST scores and over one-third CCT scores.
- Sub-sets used for analysis may not represent the full data set as incomplete records were excluded. Furthermore, data are not always directly comparable as particular data collections were time series (longitudinal), and others were point-in-time (snapshot). Point-in-time HoNOS scores must be used with care, as these scores represent a broad profile of severity or level of functioning of consumers in various phases in the care episode for that service type at a given time.
- Rater reliability for the HoNOS and RDC instruments was neither tested nor controlled and variability in use may have influenced the ratings obtained. This is particularly relevant to HoNOS and RDC scores for PDRS consumers, as some staff were applying these measures for the first time. Comparative HoNOS benchmarks for the service types analysed in the project are not available.
- The data collected did not identify the source of consumers referral for the different service types nor a consumer's destination if they exited the service. This data gap imposes major constraints on identifying the way consumers currently move through the service system. Instead, to gauge the nature of client flow, it has been necessary to rely on the qualitative data obtained through the survey questionnaire and the targeted interviews, which are outlined next.
- No data were sought on whether consumers of one service were also concurrently using another. Because multiple service use was not recorded, it has not been possible to ascertain how many CCT and MST consumers were also receiving a PDRS service, such as HBOS or IHBOS, and vice versa.

From these caveats, it can be seen that the data collected do not provide a comprehensive and definitive picture of how services are utilised and how consumers move through the service system. However, the data can be used to suggest patterns in service utilisation.

## **Qualitative data**

Qualitative data was collected from a number of sources including:

- a questionnaire sent to both clinical and PDRS services in 2005 – the aim was to obtain staff views on the core functions of their service, the nature of demand pressures and the extent of collaboration with other services
- interviews with selected service providers
- examples of clinical and PDRS services using collaborative ways of providing rehabilitation and continuing care
- comments on a consultation paper distributed in November 2005 that invited comment on findings to date
- a forum in December 2005 to discuss the findings of the project and engage the mental health field in discussion on strategies for developing a more integrated rehabilitation and recovery service system.

## 4 How do the service elements currently operate?

Although the data collected have limitations, they reveal patterns on how the different services have been utilised in recent times and differences in scope of practice within service elements.

### 4.1 Comparative analysis

#### 4.1.1 Severity of mental health symptoms by service element

As Figure 1 indicates all consumers in bed-based services (SECU, CCU and PDRS services RRS) have severe mental illness, although RRS consumers reported greater willingness to cooperate with treatment and rehabilitation plans evidenced by a lower score on the RDC (refer to Figure 4 on page 19).

A comparison of HoNOS and RDC scores for IHBOS and MST consumers indicates that both services have consumers with significant levels of behaviour disturbance and disability.

**Figure 1: Mean HoNOS score by service type (with standard deviation bars)**

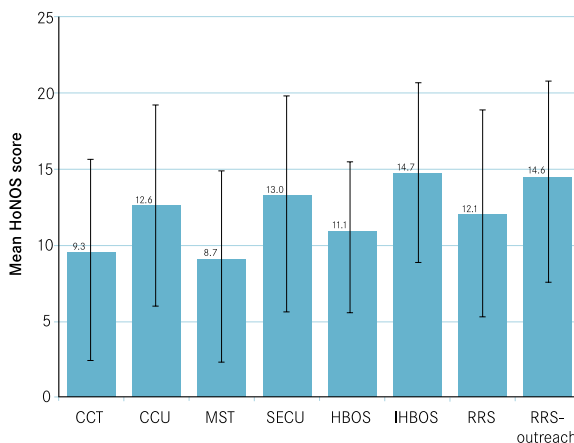
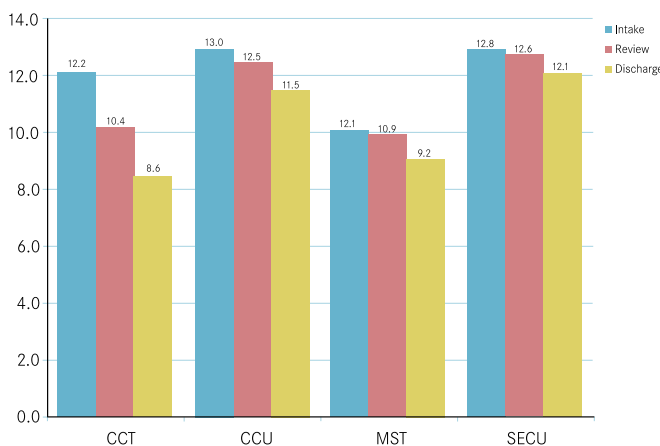


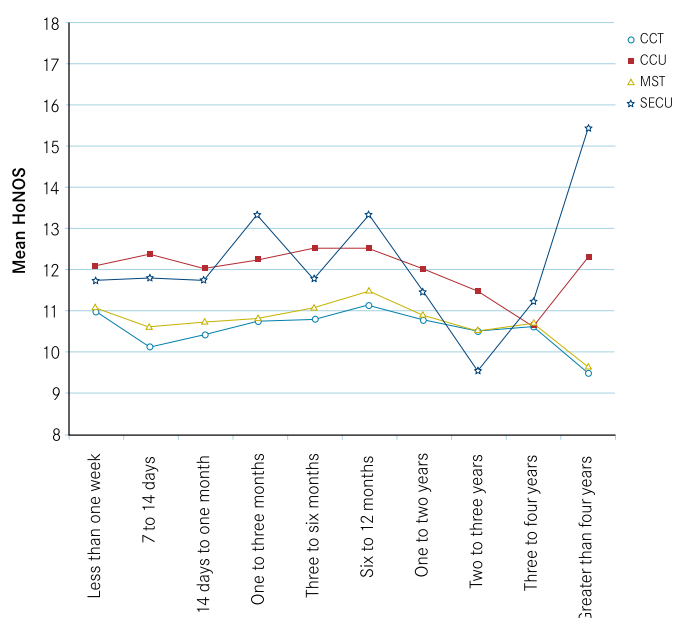
Figure 2 illustrates improvement for consumers within clinical services across the three phases of the care episode (admission, review then discharge). This improvement is more pronounced for community- than bed-based services, with CCT consumers showing the greatest improvement between admission and discharge. SECU consumers demonstrated the lowest rate of improvement from admission to discharge with CCU consumers demonstrating modest improvement from admission to discharge.

**Figure 2: Mean HoNOS scores by clinical services by episode phase**



As indicated in Figure 3, a high mean HoNOS score for SECU consumers is associated with episodes of care longer than four years (long-stay SECU consumers have a mean HoNOS score of 16.7) reflecting the enduring and complex needs of this cohort. This observation is not evidenced for CCU consumers. The mean 'snapshot' HoNOS score for mental and behavioural disorders due to psychoactive illicit substance use is the highest for all diagnostic groups recorded for SECU consumers (19.5).

**Figure 3: Mean HoNOS by length of episode, clinical services**

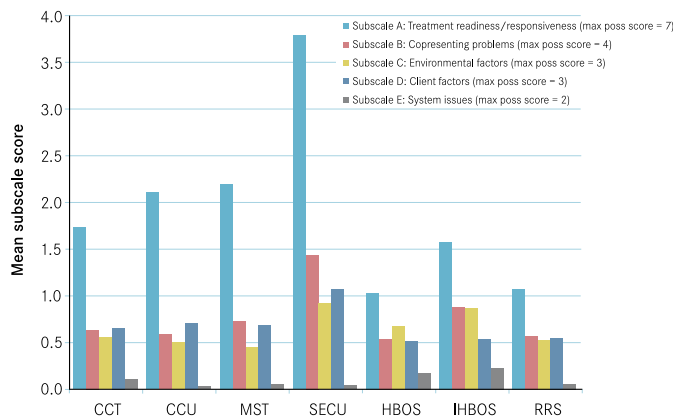


#### 4.1.2 Response difficulty checklist

The RDC provides a set of 19 factors that assist in determining the level of complexity and difficulty in providing direct care to an individual consumer. For the purpose of analysis these factors have been clustered and averaged under five subscales (refer Figure 4). The subscales include:

- **treatment readiness/responsiveness** (symptoms resistant to treatment, unwilling or unable to cooperate, does not recognise mental illness, prone to rapid psychotic relapse and has difficulty in complying with medication)
- **co-presenting problems** (illicit drug use, alcohol use, ABI or intellectual disability, and chronic health problems)
- **consumer factors** (support with activities of daily living, suicide or self-harms, threatens violence, and requires extensive time)
- **environmental factors** (homeless, cultural barriers and socially isolated)
- **system issues** (does not have a coordinated care plan and relationship poorly defined).

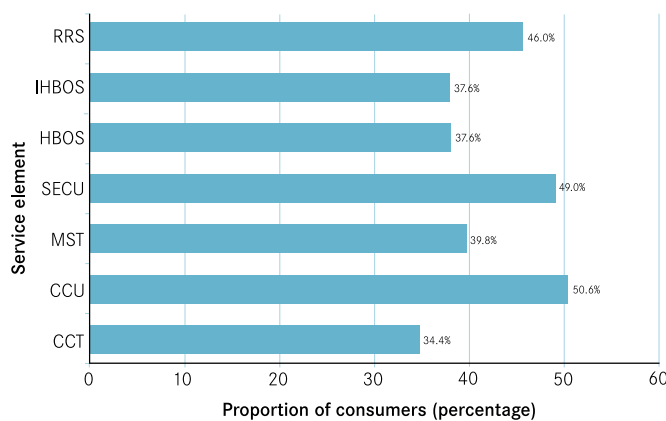
**Figure 4: Mean response difficulty subscale<sup>5</sup> scores by service element**



As Figure 4 indicates SECU consumers recorded the most significant levels of response difficulty across every dimension with CCU and MST consumers recording similar levels of response difficulty. Consumers of IHBOS and RRS also recorded similar levels of response difficulty, with RRS consumers recording a slightly higher difficulty rating for consumer factors. CCU consumers recorded significantly higher difficulties related to treatment readiness and responsiveness compared to consumers in RRS, although on all other dimensions their difficulty response profile was similar.

Figure 5 indicates that consumers of bed-based services (CCU, SECU and RRS) require the greatest support with activities of daily living relative to consumers receiving support from ambulatory services.

**Figure 5: Proportion of consumers who requires assistance with activities of daily living by service element**



*5 The RDC subscales organise the 19 individual items on the RDC into five discrete individual, system and environmental dimensions that may negatively influence the client's responsiveness to treatment*

### 4.1.3 Focus of effort

Figure 6 illustrates the focus of effort<sup>6</sup> of each of the service elements. The focus of effort areas included:

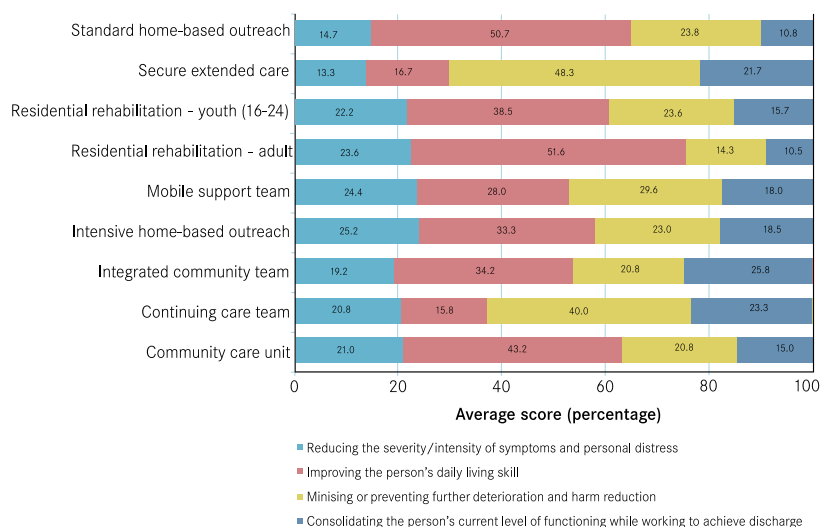
- reducing the severity of symptoms and personal distress
- improving the person’s daily living skills
- minimising and preventing further deterioration or self-harm
- consolidating the person’s current level of functioning while working to achieve discharge.

This data indicates, consistent with the core function of these service models, the principle focus of effort of standard HBOS, residential rehabilitation, and CCU services is on improving individual consumer’s daily living skills and consolidating current level of functioning with the view to transiting the consumer to services offering a lower level of support. In contrast, intensive HBOS and MST service expend considerably more effort on reducing symptom severity and minimising deterioration, consistent with the more complex needs of this cohort.

Minimising deterioration is the core focus of effort of the majority of SECU services (48.3 per cent of all SECU consumers), which reflects the treatment orientation of this service element.

CCT service place the lowest emphasis on improving the individual’s daily living skills (15.8 per cent), with the greatest proportion of effort expended on minimising or preventing further deterioration (40 per cent).

**Figure 6: Average service goal scores by service type**



<sup>6</sup> Data collected for a survey questionnaire sent to clinical and PDRS services.

### 4.1.3 Analysis of bed blockages

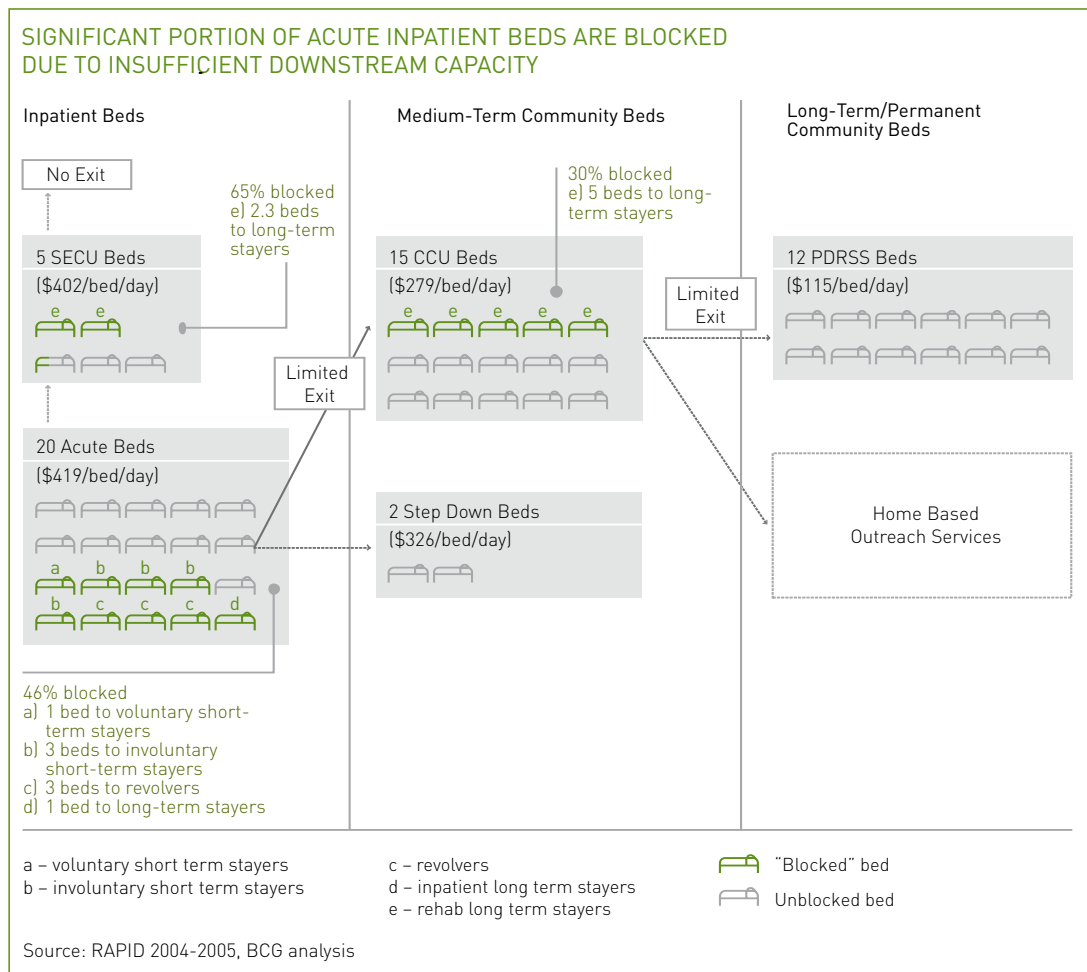
The analysis of adult inpatient and community beds undertaken by the Boston Consulting Group (BCG) identified that 6 per cent of patients in an adult acute inpatient unit stay longer than three months due to insufficient ‘down stream’ capacity. RAPID data indicates that 65 per cent of SECU consumers and 30 per cent of CCU consumers stay more than 300 days.

The BCG analysis contends that:

- an estimated 20 per cent of SECU consumers can be moved to a less intensive service option
- an estimated 30 per cent of CCU beds are blocked by long-stay consumers who should be discharged to long-term non-rehabilitation beds with 24-hour non-clinical staffing for higher need consumers.

Diagram 2 illustrates the exit pathways from and between inpatient, extended care and PDRS bed-based services.

**Diagram 2: Average bed capacity in area mental health services (illustrative)**



Source: The Boston Consulting Group (2006) Governments working together. Improving mental health outcomes: the next wave of reform

## 4.2 Bed-based services

### 4.2.1 Secure extended care units

#### Current consumer profile

Secure extended care units (SECU) have the highest proportion of males (76.5 per cent) of all service elements. Around a third of SECU consumers are young adults aged 19 to 29 years. The service also had the highest proportion of involuntary consumer and those with schizophrenia. The SECU consumer group scored the highest of all service types on the RDC. Most consumers (93.9 per cent) had an RDC score of four or more (33 per cent higher than the next highest, IHBOS at 60 per cent). The degree of change in HoNOS scores was the lowest, indicating progress was slower than consumers in other types of services with almost half of all SECU consumers HoNOS score in the 14 plus range. In 2003–04, there were 222 separations from 103 beds and 228 admissions, with an annual occupancy rate of 91.8 per cent.

In terms of length of service use, two cohorts were evident:

- Cohort 1: Consumers who stay two years or beyond. SECU had the highest proportion of consumers staying for four years or more, which was associated with high levels of behavioural disturbance and symptomatology. Long-stay consumers include former institutional patients, mostly male, with extended histories of mental illness. A number of long-stay consumers also had cognitive impairments as a result of ABI and intellectual disability.
- Cohort 2: Younger consumers with mental illness and substance addiction who are prone to aggression who tend to stay up to 12 months.

#### Client flow and demand pressures

SECU staff identified a lack of engagement between individual consumers and the clinical mental health service supporting them prior to admission to the SECU, which made planning for post-discharge options difficult. It is of note that SECU managers estimated that up to 25 per cent of current consumers are ready for discharge but remain in the SECU due to the lack of available exit options/pathways such as CCU place or intensive treatment and psychiatric disability support and affordable housing for those assessed as able to live independently in community. This creates significant upstream pressure on acute inpatient units and downstream pressure on MST and CCT services who are stretched to adequately support high-risk consumers who require placement in a SECU facility.

Difficulty is also experienced in finding suitable discharge options for SECU consumers who do not require the intensive clinical treatment and care provided by SECU services but continue to require a structured supported environment into the foreseeable future, and are unlikely to progress significantly in developing their daily living skills such as people with enduring mental illness and psychiatric disability and an acquired brain injury or intellectual disability. One response to this consumer group includes hostel-type accommodation that provide on-site supervision in a home like environment and other supports including meals and recreation.

'Bed blockage' is clearly evident in SECUs. It was estimated that for each SECU, there were on average eight consumers waiting for a vacancy. Half of those waiting were identified as being in acute inpatient units, which is a major concern given the impact on acute bed availability and

the unsuitability of the acute environment for extended care. A third were MST consumers and, unexpectedly, 15 per cent were CCT clients, which would place considerable strain on this service type given, if assessed as eligible, such consumers require the intensive support, containment and protection provided by a SECU.

### Service collaboration

All SECUs have a formal collaborative relationship with MST, CCT and dual diagnosis services. A significant majority have a formal collaborative relationship with acute inpatient units, or PDRS services and other SECUs. On average, each SECU reported a formal collaborative relationship with 10 other mental health services. This is the lowest number compared with all mental health services.

### Example of good practice

There are examples of SECU working collaboratively with other services, including PDRS services, to improve consumer outcomes. For instance, the North East SECU used the Victorian Dual Disability Service to assess consumers with dual disability and severe behaviour problems. This led to in-service staff training and productive liaison with local Department of Human Services Disability Services and their behavioural intervention support teams. In addition, links were developed with Neami, the local PDRS services, leading to music activities for younger male SECU clients.

## 4.2.2 Community care units

### Current consumer profile

There are similarities between community care unit (CCU) and SECU clients in that there is a higher proportion of men (71 per cent) than women (29 per cent) in CCUs, and one third of consumers are aged 19 to 29 years. CCUs also have a high proportion of involuntary consumers and those with a diagnosis of schizophrenia. Throughout 2003–04, a total of 530 consumers lived in a CCU.

In terms of symptomatology and levels of disability, CCU consumers had similar but slightly lower HoNOS ratings than SECU consumers. In respect to the RDC instrument CCU consumers recorded the lowest levels of reported suicide risk and harmful alcohol use; the highest proportion of consumer requiring significant support with activities of daily living; and high levels of symptoms resistant to treatment, requiring extensive time but showing little or no progress.

In respect to service utilisation, a high proportion of CCU consumers required a bed stay of between six months and two years. Service utilisation data from 1999 to 2005 indicates two distinct CCU cohorts in terms of length of stay, with about a quarter exiting within 12 months, and another quarter exiting within one to two years. The average number of annual bed days per consumer or length of episode over a five year period 1999–2000 to 2003–04 does not appear to be associated with level of severity.

An examination of RDC data demonstrated the CCU group, compared to MST consumers, were less able to cooperate and needed more assistance with daily living, were more likely to be medication-compliant and were less likely to be illicit substance users. Comparison with RRS consumers showed the CCU consumers as being more likely to have symptoms resistant to treatment, and to be uncooperative and less accepting of being mentally ill.

### Scope of practice

It was evident from both quantitative and qualitative data that there is considerable variation in how CCUs operate and their target consumer profile. Many CCUs started with a full complement of former patients of long-term institutional wards, with staff also coming from those wards. This reflected their role as replacement facilities. However, several CCUs (including Doveton) did not need to be used for former institutional patients. These CCUs admitted a different group of consumers, who did not have extended institutional backgrounds. They also recruited new staff. Over time, the variability in the original consumers and staff group, and the extent to which other services such as residential rehabilitation were available in the local area have resulted in marked differences in how CCUs operate.

It has been reported that some CCUs see themselves as providing 'active rehabilitation' with associated throughput and will refuse entry if a consumer is not seen as having 'rehabilitation potential'. The timeframe for active rehabilitation being used in this instance is described as up to 12 months. However, CCUs were originally intended to allow for gains to be gradually achieved and consolidated over a much longer timeframe, which might be three to five years. Particular CCUs have also reportedly declined to take back consumers returning from a period in a SECU, especially if there have been previous incidents of aggression. This is concerning as CCUs are funded to provide 24-hour clinical staffing in order to manage high-need consumers.

Few CCUs have any of the original group of former institutional patients. Most have been placed in other facilities, including a privately run SRSs or other accommodation, with or without support. It would appear an active discharge policy was pursued by CCUs regarding those former institutional patients whose rehabilitation was considered to have reached a plateau. This also enabled other consumers to be admitted who were seen as capable of making progress in achieving rehabilitation goals. Some CCUs also use some of their beds for short-term 'assessment' for their AMHS. Some rural CCUs provide a 'step-down' from the local acute inpatient unit, and longer-term supported accommodation, which may be in short supply in the local area.

From the data provided, it cannot be assumed that the existing CCUs across the state provide similar services to a comparable group of consumers. This was a matter of concern raised by respondents.

### Client flow and demand pressures

Also of concern to respondents were the limited pathways out of CCUs. This issue has been particularly pressing for rural AMHS. In addition, some respondents considered that CCU staffing was based on an outmoded institutional ward model with nursing staff on a 24-hour roster and allied staff working business hours.

As indicated previously, a further problem identified was the reported refusal by some CCUs to take in consumers from the local acute inpatient unit (that is part of their AMHS) or the regional SECU on the grounds the consumers did not have rehabilitation potential. A further factor influencing decisions by CCUs not to take particular individuals was the design of the facility. The obvious consequence was that consumers remained in the most resource-intensive end of the service spectrum.

It was estimated that on average, six consumers were identified as a priority for each CCU vacancy. Around a third (31 per cent) of those waiting were identified as being in acute inpatient units and 13 per cent in SECU. However, a surprising finding was the proportion of people on the CCU waiting list who are currently CCT consumers (36 per cent). It would be expected that these consumers

would be eligible for mobile intensive treatment provided by an MST service. This finding could indicate that the local MST service has a full caseload, so referral to a CCU is seen as the only other viable option.

In 2003–04, there were 461 separations from 296 beds and 467 admissions. Despite demand pressure, data on bed status indicates this service element sustains a relatively high level of bed vacancy in any given period (annual occupancy rate of 85.8 per cent). As at 30 June 2006, 12 per cent of CCU beds were not occupied (37 beds in total).

### **Service collaboration**

All CCUs have a formal collaborative relationship with acute inpatient, MST and CCT services. Most have a collaboration with SECU, dual diagnosis, PDRS, GP and vocational services. On average, each CCU reported a formal collaborative relationship with 14 other mental health services. This is slightly above average when compared to all mental health services.

### **Example of good practice**

In some areas, the CCU and the local PDRS services have established partnerships to enable collaborative service delivery. For instance in Geelong, Barwon AMHS works together with Pathways, the local PDRS services, in providing joint programs. As a result, their CCU is used more for short-term rehabilitation and step-down purposes, with longer term rehabilitation being undertaken by Pathways in the community.

## **4.2.3 PDRS residential rehabilitation services**

### **Current consumer profile**

Like the bed-based clinical services, the service utilisation data indicates that residential rehabilitation services (RRS) cater for more men than women (60 per cent compared with 40 per cent). The age distribution of consumers is skewed to the younger age bracket, with 58 per cent aged from 19 to 29 years, reflecting the major expansion of RRS for young people in the late 1990s. A comparison of HoNOS scores suggests that RRS clients are as severely mentally ill and disabled as CCU clients, although RDC scores were lower, indicating that most RRS clients were more willing and able to cooperate with treatment and rehabilitation than CCU clients. Highest mean 'snapshot' HoNOS score were associated with long engagement with this service.

Overall, consumers of RRS had the lowest RDC score of all service types; were least likely to require extensive time but not show progress; were most likely to recognise they have a mental illness; were least likely to threaten violence; and of all PDRS services, were least likely to have serious problems with alcohol.

### **Scope of practice**

The qualitative data indicates concerns about RRSs and their role in the service system. It would appear that RRS operate on a number of different rehabilitation models, with some using the congregate nature of the service to enable development of social skills. However, it was also noted that not all RRS have 24-hour staffing, with implications for the type of consumer they could support. A further issue raised by respondents was the inadequate range of post-RRS options for consumers, particularly for adults.

On average improving the person's daily living skills/functioning is the primary rehabilitation goal of more than half the adult RRSs (51.6 per cent), the highest of all service types, and considerably higher than for youth RRSs (38.5 per cent). There is a considerable degree of variance about the primary goals of rehabilitation for consumers of youth RRSs.

### **Demand pressures**

The estimated demand for RRS beds comprised an average of four people for each adult RRS vacancy and five for every youth RRS vacancy. The three main services with clients waiting for adult RRS places were acute inpatient units (29 per cent), homeless outreach services (17 per cent) and CCUs (14 per cent). For youth RRSs, the services were CCT (51 per cent), child and adolescent mental health services (30 per cent) and GPs (25 per cent), showing the different range of services used by this younger age group.

The occupancy rate of the 260 RRS beds was reported as 68 per cent in the quarterly data set (QDC), although it is recognised that the QDC contains inaccuracies.

### **Service collaboration**

A significant majority of adult RRS have a formal collaborative relationship with acute inpatient, MST, CCT, HBOS, GPs, community health and recreation and vocational services.

All youth RRSs have a formal collaborative relationship with CCT. A significant majority have a collaborative relationship with acute inpatient, MST, dual diagnosis, HBOS, drug and alcohol services and housing services. On average youth and adult RRS have formal collaborative relationships with 13 other mental health services. This is approximately average across all mental health services.

### **Example of good practice**

Shepparton, a major provincial centre north of Melbourne, illustrates how PDRS and clinical staff can work together to enhance what an adult RRS can provide. This area has yet to have a community care unit. In 2001, the Mental Illness Fellowship (MIF) set up a supported residential rehabilitation program (SRRP) in collaboration with the Goulburn Valley AMHS. MIF staff manage the facility, which comprises five two-bedroom units, and provide practical assistance and personal support to the consumers. The Goulburn Valley AMHS clinical staff provide psychiatric treatment and care. It should be noted that this service model, as a substitute for a CCU, cannot effectively support consumers with severe mental illness, particularly those with difficult behaviours and are not treatment compliant and who require 24-hour clinical care.

#### **4.2.4 PDRS supported accommodation services**

As described in section 2.1 there are 135 supported accommodation services(SAS) places across the State. Project respondents identified the need for a more intensively supported version of supported accommodation services, with 24-hour on-site supervision and support for consumers with enduring psychiatric disability and low levels of functioning. The service model proposed would include providing meals with other hotel-type services provided on-site or purchased in, depending on some consumers current level of functioning. The aim would be to provide a structured home like environment, but not active rehabilitation, and throughput would not be expected or required.

Examples such as Macaulay's Chiron program in Kensington show the key role these services can play in providing an exit option for CCU consumers, and possibly also for SECU consumers (see box below).

### Example of good practice

In Melbourne's inner west in 2003, Macaulay, the local PDRS services, set up Chiron. This program aimed to provide long-term housing in the community for people with severe ongoing mental illness and disability. Priority access is given to consumers of the local CCU service identified as being unable to benefit further from rehabilitation input provided by this service model. The CCU staff assisted with the transition, which was deliberately gradual. The consumers are now supported by PDRS workers and personal care assistants, with the support flexible and varied according to the consumers' needs. Clinical care is provided as required from the local MST team. Two years later many of the consumers function much more independently, for instance, by handling their own finances, using public transport, managing medication and appointments, and interacting with neighbours.

## 4.3 Ambulatory mental health services

### 4.3.1 Mobile support and treatment teams

#### Current consumer profile

Service utilisation data show that mobile support and treatment (MST) teams have a higher proportion of male than female consumers (58 per cent to 42 per cent). MST teams also work with an older consumer group compared to the other clinical services, with the highest proportion of consumers aged 40 to 54 years (one third) and lowest of those aged 19 to 29 years (a quarter). Compared with CCT, there was a higher proportion of consumers with a primary diagnosis of schizophrenia and with involuntary status. However, the period of contact showed a similar pattern between MST and CCT services.

Both MST and CCT services have two distinct cohorts receiving services, with 15 per cent in contact over six to 12 months, and another 15 per cent for one to two years.

In respect to the RDC, almost half of MST consumers were reported as having symptoms that were resistant to treatment and requiring extensive time. This cohort exhibited the lowest level of difficulty arising from cultural barriers and were least likely to be homeless or at risk of homelessness. Consumers of MST services have on average more than twice as many contacts with the service compared with CCT consumers.

Since their inception in Victoria, MST teams have been demonstrably effective in engaging with consumers with long histories of severe and persistent mental illness, and meeting their treatment needs. MST teams have been very successful in reducing the hospitalisation of their consumers group and are appreciated by consumers and their families. In line with this record, it is noticeable that in terms of HoNOS scores, MST consumers show a greater improvement from intake to discharge than consumers of bed-based clinical services. HoNOS scores were lower for consumers of rural than for metropolitan MST teams, suggesting that the integrated teams see a consumer group with a wider range of symptomatology and disability.

**Demand pressures**

Of the four consumers waiting for a vacancy in each MST service, 59 per cent were currently receiving services from a CCT service, 18 per cent from CCU and 13 per cent from an acute inpatient unit.

**Service collaboration**

All MST services reported a formal collaborative relationship with SECU. Most have a collaborative relationship with acute inpatient, CCT, dual diagnosis, PDRS services and GPs. None had a relationship with the courts.

On average, each MST service reported a formal collaborative relationship with 13 other mental health services. This is approximately the average across all mental health services.

**Example of good practice**

In 2002 funding for the Mental Health Homelessness Program included funding for a MST position and intensive HBOS workers in the outer east. Eastern Health collocated the MST position with the Eastern Access Community Health (EACH) IHBOS positions. This innovative approach has enabled timely clinical assessments in the context of an assertive outreach team approach. It has also facilitated education between the clinical and PDRS service sectors. It is an example of excellent partnership and effective practice.

**4.3.2 Continuing care and treatment****Current consumer profile**

CCT had the most even distribution of male and female consumers of all the clinical services (55 per cent male and 45 per cent female consumers). In terms of age, there were three almost equal cohorts, all representing around a third of the total clientele. The three groups were aged 19 to 29 years, 30 to 39 years and 40 to 54 years.

CCT had the lowest proportion of consumers with a primary diagnosis of schizophrenia (46 per cent) across all service types. Mood disorders was the second most common diagnosis amongst CCT consumers. Around half of the CCT consumers (56 per cent) had been involuntary. Scores on HoNOS and RDC demonstrated that CCT consumers showed the greatest change from intake to discharge in their mean HoNOS scores. In comparison with MST, CCUs and SECU, CCT consumers comprised the lowest proportion of those with RDC scores of four or above.

**4.3.3 PDRS home-based outreach support service models****Current consumer profile**

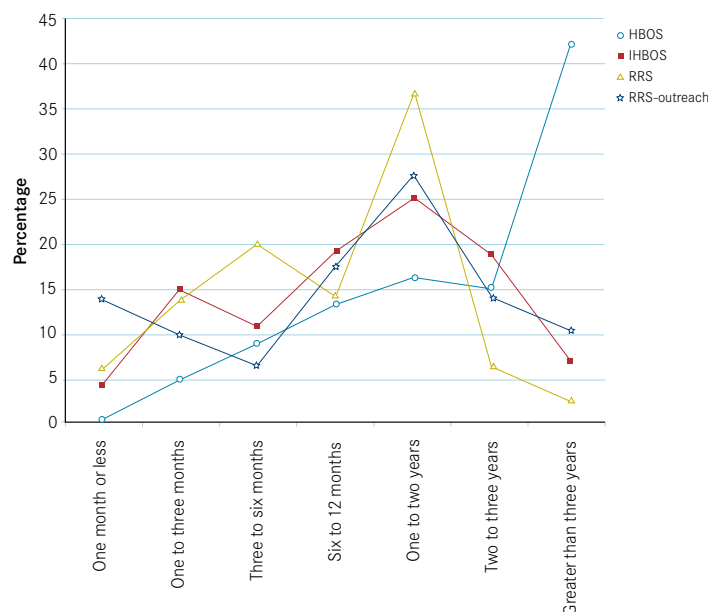
Consumers of both standard and intensive home-based outreach support (HBOS) services are close to an equal gender distribution (48 per cent women and 51 per cent men) and generally are older than those of other service types. There are three age cohorts, with 37 per cent aged from 40 to 54 years (the highest proportion in this age group across all service types), 30 per cent are 30 to 39 years and 19 per cent are 19 to 29 years.

Intensive home-based outreach support services (IBHOS) work with consumers who are transient, difficult to engage and often not connected to mental health services. Both the HoNOS and RDC scores collected for IHBOS consumers indicate a consumer group with severe mental disorder and associated disabilities. Both the average scores and the proportion of consumers with high ratings on both measures were notably greater than those for MST consumers.

As Figure 7 indicates the distribution of length of support period for PDRS services is quite variable, with a significant proportion of standard HBOS consumers receiving service for over three years. Symptom complexity/severity as measured by level of RDC and HoNOS (Figure 6) does not appear to be a significant variable influencing length of the support period provided by standard HBOS services. Further, HoNOS data for standard HBOS consumers also indicate a large cohort (44 per cent) whose mental illness appears to be stable, and who have relatively low levels of complexity and disability. These consumers have been using standard HBOS services for three years or more.

This evidence suggests that HBOS might need to more assertively discharge long-stay consumers who have achieved improved functionality in order to free-up capacity for new clients.

**Figure 7: Current length of service by PDRS service, 2004-05**

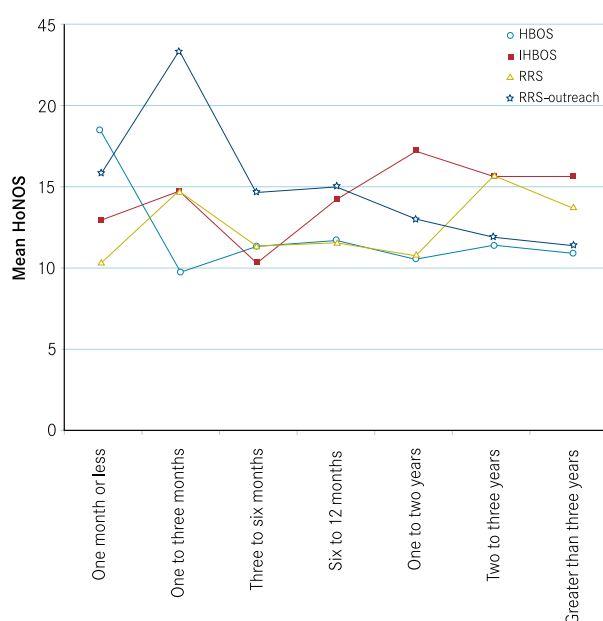


The proportion of standard HBOS consumers with an RDC score of four or more is significantly lower than for IHBOS consumers (37.5 per cent compared with 60 per cent). IHBOS consumers recorded mean RDC scores second only to SECU consumers. Further:

- IHBOS consumers had significantly higher difficulty in maintaining stable housing (39.7 per cent) compared with consumers receiving standard HBOS support (8.8 per cent)
- standard HBOS consumers were least likely to have difficulties complying with medication compared to consumers of all other service types, and less than half as likely as IHBOS consumers
- standard HBOS consumers were also three times less likely to have a serious problem with illicit drug use compared with IHBOS consumers

- IHBOS service reported twice the rate of consumers unwilling to cooperate with the treatment/ care plan compared with standard HBOS consumers (10 times the rate of consumers who were unable to cooperate) and were twice more likely to threaten others with violence compared to standard HBOS consumers.

**Figure 8: Mean HoNOS score by current length of service (case not closed), PDRS services**



### Demand pressures

Because of the focus on people who are homeless or at risk of homelessness, IHBOS are well connected to homeless services. Those waiting for IHBOS vacancies were being seen by GPs (22 per cent), Homeless Outreach Psychiatric Service (18 per cent), homelessness services (13 per cent) and HBOS (31 per cent). In respect to standard HBOS services, 11 people were identified as a priority for a vacancy, demonstrating this service is in demand.

### Service collaboration

There is no one service that all standard HBOS have a formal collaborative relationship with. A significant majority have a collaborative relationship with MST, CCT, day programs, homelessness services, housing services, community health and vocational services.

IHBOS have a similar range of collaborative relationships as standard HBOS and also work formally with drug and alcohol treatment services. On average, each standard HBOS and IHBOS has a formal collaborative relationship with 12 other mental health services. This is approximately average for all mental health services.

## Example of good practice

St Luke's in conjunction with Bendigo Health Care linked intensive HBOS to SECU residents. The target group comprised consumers from the Bendigo SECU who were ready for discharge but had few exit options. The aim was to assist these consumers move into housing in the community, providing support that was adjusted according to changing needs. Brokerage funds were used to purchase additional resources as required. This model has been found to reduce hospital admissions by stabilising consumers' accommodation and building their capacity to live successfully in the community.

## 4.4 Summary

The analysis of service utilisation data indicates that:

- Overall the service system is targeting consumers most in need evidenced by their high levels of symptomatology and disability, even if it is not always clear why consumers are using one particular service rather than another.
- SECU, MST, CCT and PDRS HBOS services have consistent targeting and scope of practice and are largely fulfilling their service mandate.
- Considerable variability in practice (particularly targeting) appears to exist within CCU services including an unacceptably high level of bed vacancy in some areas.
- A number of consumers may not be receiving the service best suited to their needs indicating available resources are being used inefficiently, leading to system blockages and service overlap and duplication. Additionally, service gaps are not being clearly identified and remedied.
- Qualitative data identified evidence of collaborative practice between clinical and PDRS services that suggest ways forward and will be discussed in more detail in Section 7 of this report.



## 5 Guiding principles for system development

Before considering both the problems identified and possible solutions, it is important to articulate the principles that should guide the development of the mental health rehabilitation and continuing care service system. The following principles are drawn from *New directions for Victoria's mental health services* and informed by the now extensive international and local literature on good practice in this area.

### Priority to those in greatest need

People who are most severely affected by mental illness and associated disability will receive priority access to public mental health services. Mental health services will target and provide priority access to these consumers and ensure resources are matched to consumer need, which will vary in intensity over time. This includes consumers with challenging and difficult behaviours who may require extensive effort to achieve improvements in daily living skills and social functioning. Services will assertively exit consumers able to transit to other less intensive services in order to free up capacity to support consumers with complex needs.

### Care in the community wherever possible

Mental health treatment and support should be provided in the community wherever possible. This requires a range of services working collaboratively to support consumers moving from inpatient facilities to the community to reduce relapse, optimise recovery and rehabilitation outcomes and engage consumers in community life.

In line with mental health legislation, mental health treatment and support should be provided in the least restrictive setting that enables the effective provision of care and using the least intrusive interventions consistent with the safety and protection of consumers, their families and friends, staff and the wider community.

Where possible, the rehabilitation or community integration process should involve a minimum number of accommodation changes for individual consumers on the basis that rehabilitation is most effective when it is delivered in situ, that is, where the consumer is going to use the skills being learnt or re-learned. In line with this a 'destination environment' should be identified for each consumer. Where the consumer's current level of symptoms and associated disability make such placement premature, staff should plan for, and implement care that will continue to improve the individual's daily living skills and functioning while working over time to achieve discharge.

### Service quality and responsiveness

Mental health services should meet accepted standards of good practice, delivering services consistent with their intended purpose and consumer target group, and be available when consumers require them. Services should be responsive to the consumer's individual rehabilitation and recovery needs and seek to build on the consumer's strengths.

Use of a recovery orientation is particularly beneficial for people who have experienced mental illness and associated disability. This orientation should underpin the interaction between consumers and direct service staff, and the aims and process of intervention, as well as the way services operate.

## Continuity of care

The mental health service system should work cohesively to ensure continuity of care for consumers. This requires the different parts of the service system to identify shared consumers, work collaboratively and effectively to maximise rehabilitation and recovery outcomes for individual consumers, ensuring the planned transition between service elements as required. The mental health service system should also develop strong relationships with other services that are critical to enabling the ongoing health and wellbeing of the consumers such as housing, primary health, disability, welfare, education and employment services.

## Consumer and carer participation

Mental health services will be strongly committed to consumer and carer participation in developing, reviewing and implementing their individualised rehabilitation and recovery care plans as well as participating in and contributing to service reviews and evaluations.

Analysis of available data has highlighted points of tension in the current rehabilitation and care service system. Resolving these problems calls for refining and supplementing the current service system, rather than its radical overhaul. Examples of good practice are in place and act as signposts for further change.

Moreover, there are already projects underway that will provide a basis for enhancing the service system. These include two initiatives (summarised on page 3) that will:

- **strengthen collaborative alliances** between clinical and PDRS services
- support the **transition of long-stay consumers of extended care clinical services to the community**, through providing a high-level and sustained package of psychosocial rehabilitation and assertive clinical outreach support.

The key issues impacting on the delivery of an integrated rehabilitation and continuing care system include:

- **lack of consistency in core practices within specific service elements** particularly admission/access and exit practices
- **inadequate cross-sector collaboration** resulting in lack of continuity of care and poor consumer flows within and across service elements and lost opportunities to use complementary functions and skills between the service elements to maximise outcomes for consumers
- **system blockages** due to insufficient throughput, access to post exit options and pathways and practice issues
- **service gaps and supply issues** including the availability of long-term non-clinical supported accommodation for people who require 24-hour care due to their limited functional capacity and potential for rehabilitation, and the lack of access to affordable housing in order to provide a stable basis from which to achieve rehabilitation potential.

## 6 Defining the issues

### 6.1 Lack of consistency in core practices within service elements

#### 6.1.1 Secure extended care units

SECUs largely continue to fulfil their original brief in respect to their target consumer group and scope of practice. Anecdotal evidence, however, suggests that some SECU services are selective about accepting consumers who are not perceived to be 'rehabilitation ready'. This contributes to bed blockages in acute inpatient units who have consumers on SECU waiting lists for prolonged periods and are sometimes discharged to unsuitable options such as pension-level SRSs. Further, there is some concern that the model of care in some SECUs does not provide sufficient rehabilitation input to prepare them for community-based reintegration options.

Additionally, developing and maintaining optimal liaison arrangements with area-of-origin AMHSs, including case-management input, is critical in order to achieve timely and planned discharge from SECUs. This issue particularly applies to AMHS whose SECU service is out of area. It is imperative that SECUs have formal service agreements with AMHSs utilising SECU beds to ensure AMHSs exercise responsibility in maintaining effective, timely and optimal throughput of SECU beds.

#### 6.1.2 Community care units

CCUs clearly have a mandate to take people who require 24-hour clinical support because of their psychiatric symptoms and related behaviours that require regular medical review and the like. The function of CCUs, however, vary considerably due to different interpretations of their core function. Over time CCUs have made idiosyncratic changes to how their target consumer group is defined and what services are provided. Some CCUs have defined their role as providing short-term rehabilitation for the 'rehabilitation ready', rather than targeting consumers with complex clinical conditions who require 24-hour clinical support to achieve gains in symptom reduction, daily living skills and social functioning. By targeting consumers with less complex clinical needs whose functioning can improve within one to two years, these CCUs are operating in a manner similar to that of adult and youth PDRS residential rehabilitation services. This represents a significant departure from the original purpose of CCUs and raises the question of how CCUs and adult RRS should be differentiated, given their differing staffing profile and governance arrangements.

In addition, in some rural areas, CCUs have assumed a broader mandate in order to respond to service gaps. For instance, a few CCU beds are used to provide short-term step-down service for patients being discharged from an acute inpatient unit due to the absence of prevention and recovery centre (PARC) sub-acute places.

CCUs are currently performing three core functions: a step-down service for consumers exiting acute inpatient and SECU services, a transitional rehabilitation services and long-term care for people with enduring psychiatric disability in an open environment.

#### 6.1.3 PDRSS residential rehabilitation services

The role of adult PDRS residential rehabilitation services has not been clearly defined resulting in considerable variability in consumer targeting, admission and exit practice and the nature of the rehabilitation model. The function of this service model in relation to CCUs has also not been clearly articulated as indicated previously.

If adult and youth RRS consumers were systematically provided with in reach support from MST and CCT services this would enable them to take the more seriously mentally ill. The long-term role of this service element, in the context of the broader service system, might then be to provide medium-term (two to three years) transitional rehabilitation during which time they would prepare people for more independent living options or to shared accommodation with less intensive supports. It appears that people in youth RRS, particularly those with dual diagnosis issues, may require this length of support to stabilise or withdraw from substance use.

#### 6.1.4 Community ambulatory services

The data indicates that consumers of MST and PDRS IHBOS have comparable levels of clinical need and disability, consistent with their target consumer groups.

Not all MST teams continue to meet their service requirement of working extended hours across a seven day week as originally designed and funded, indicating practice is not aligned with consumer requirements for clinical input to support recovery. Some MST services are also reported to have shifted their target consumer group away from those with enduring mental illness. These variations are of concern and warrant investigation.

The main issues for CCT services are increased consumer demand and complexity, especially in terms of dual diagnosis, high caseloads, discharge planning and caseload management practices. Increased consumer demand creates pressure to discharge consumers, perhaps before they are ready and without proactive discharge planning, resulting in a significant proportion of consumers re-entering the system within a 12-month period. Conversely many 'cases' have been identified as inactive and some consumers are receiving infrequent levels of contact coordinated by this service element. The possibility of more collaboration with HBOS and other local PDRS services as a exit or shared care option for some consumers may help to reduce artificially inflated caseloads and enable CCT to increase priority access to new or former consumers if their clinical condition deteriorates. The Alliance initiative will provide a mechanism to encourage more collaborative service delivery with local PDRS services.

In addition, attention by AMHS management is critical in respect to CCT staff caseload management, clinician skill levels to match complexity of consumer need and facilitating access to ongoing training for clinical skill development. Examples are updating skills in clinical case management such as providing training on how to incorporate a recovery orientation within the CCT service model and develop relapse prevention and rehabilitation plans with consumers and their families. These functions should be undertaken in conjunction with PDRS services in the case of shared consumers, and linked to GPs and private psychiatrists when the care of the consumer is shared.

Further, AMHS management needs to consider systemic improvements and using data analysis to regularly analyse and monitor performance, particularly in relation to consumer contacts, outcome measurement and indicators for discharge planning. In addition, formal collaborative partnerships with other service elements within and external to CCT and MST services are required in order to optimise throughput and ensure access is maximised.

## 6.2 Inadequate cross-sector collaboration

### 6.2.1 Inadequate cooperation between clinical service elements of an AMHS

The functional relationships between elements of the clinical service system have not been adequately developed, especially for services operating within the same service catchment. As a result some clinical service elements operate as separate, stand-alone services, rather than as part of a seamless integrated and collaborative clinical mental health service system with mutual consumers and a shared responsibility to ensure priority of access (based on assessed severity of need) and continuity of care as consumers transit between service elements.

The impact of this issue is illustrated by services within the same AMHS refusing to accept consumers from a more resource-intensive part of the AMHS such as from a SECU to CCU service or from an acute inpatient unit to SECU or CCU. Improved collaborative discharge planning is also required between bed-based and ambulatory services to ensure the smooth transition of consumers from these facilities, particularly those with complex needs.

SECU and CCU services are part of a broader system. Individual service managers need to take account of whole-of-system pressures, with leadership from clinicians and demand management leadership from senior management, and proactively discharge consumers who can be supported by less intensive service options in the community in order to accept new admissions, particularly from acute inpatient services.

To achieve the proper discharge of identified consumers, AMHS management need to ensure SECU and CCU management develop and maintain optimal liaison and planning arrangements with MST, CCT and PDRS services.

A well-coordinated and overall systems approach to managing the needs of consumers, most seriously affected by mental illness, in a particular AMHS's catchment area, is critical to addressing the idiosyncratic practices within service elements and ensuring services are responsive to the needs of their consumer base. An effective system will optimise service provision and enable genuine service gaps to be identified (including recognising skills and clinical competency issues) and take proactive steps to remedy the situation.

### 6.2.2 Inadequate collaboration across the clinical and PDRS service sectors

Clinical and PDRS service sectors appear to operate relatively independently with few structural points of cross-over and integration resulting in a non-strategic, ad hoc approach to resource allocation. Priority of access to PDRS services is not clear for consumers of clinical mental health services. Examples of collaborative projects combined assessment and joint service delivery exist, but they are not consistent or systematic.

Despite services indicating they have a range of collaborative relationships in place, there is little evidence of systematic collaboration in terms of assessment and service delivery between MST teams and PDRS IHBOS and HBOS services. While CCT and MST clinicians recognise the potential collaborative partnerships can provide for their consumers, anecdotally they note the lack of time to develop such strategies for their individual consumers.

This suggests that management could develop basic structural frameworks to support such collaboration including formalising partnerships through regular meetings to discuss opportunities for the transition, transfer or shared care of suitable consumers, allocating portfolios to identified persons who can source and facilitate appropriate contacts.

The number of PDRSS services operated by different NGOs within an AMHS catchment area appears prolific. Forming relevant partnerships with separate NGO service elements would seem a logistical challenge for an AMHS given individual clinical service elements would need to expend a considerable amount of time to forge and maintain these partnerships.

It would appear considerable opportunity exists to improve collaboration between the two sectors to better target and support high-need consumers, (including joint assessment and the development of shared rehabilitation and recovery plans) and improve continuity of care particularly at critical transition points. Creative solutions need to be developed that respond to the particular challenges that exist within each catchment area.

## Day programs

The entry and exit pathways for consumer are not well articulated for day programs, especially in terms of local clinical services and PDRS outreach services. Day programs are an important element of the rehabilitation and continuing care system as they provide opportunities for consumers of other service elements such as CCUs and MST, to engage in community-based psychosocial rehabilitation activities and use of wider community resources.

In April 2006, VICSERV released a discussion paper on the future directions for PDRS service day programs. The paper proposes changes to existing day programs in order to strengthen their role in enhancing community inclusion for people with psychiatric disabilities. It could therefore be anticipated that the core function of day programs within the rehabilitation and continuing care system will be more clearly articulated shortly.

### 6.2.3 Lack of cooperation and connectedness between PDRS services

The different elements of the PDRS service sector do not appear to systematically collaborate to optimise outcomes for common consumers. This is due, in part, to the lack of consistent practice regarding priority of access/entry criteria, and is further hampered by this service sectors somewhat fragmented nature. Priority of access within PDRS services requires clarification.

### 6.2.4 Lack of clarity about consumer movement between the service elements

An underlying problem is the lack of clarity about consumer pathways through the rehabilitation and continuing care service system. This includes inconsistent, poorly articulated or non-transparent entry and exit criteria for particular service elements, as well the lack of a policy framework at the service level to consistently guide the direction of consumer 'flow'. For instance, as consumers' symptoms stabilise, it could be expected that they would move from more to less intensive clinical treatment services. Further, as acute symptoms abate but the disabling effects of mental illness continue, providing rehabilitation should become more prominent. In turn, if a consumer's clinical condition deteriorates, more intensive clinical care could be expected, whether from an outreach or bed-based service. Currently however, it cannot be assumed that these expectations would be met consistently or in a timely way across the service system.

It should be acknowledged that difficulties in achieving effective and efficient consumer flow may reflect problems in accessing particular service elements due to supply and demand pressures. This may explain, for example, why some CCT consumers are referred directly to CCUs, bypassing the step-up function of MST services, which are supposed to provide mobile clinical support at a more intensive level than a CCT service.

While clinical ambulatory and intensive and standard PDRS HBOS services support consumers with like levels of symptom acuity it is not clear from available data what proportion of consumers are common to both sectors and the referral pathways between these sectors.

Evidence indicates that 14 per cent of consumers waiting for an adult RRS place were in a CCU. However, using an adult RRS as a step-down from a CCU as a general rule seems inappropriate, given most adult RRS provide transitional rehabilitation of one to two years. It would largely be expected that CCU staff would work with their residents to identify and prepare them for a 'destination environment', where a further move would not be necessary, and supported by flexible clinical and PDRS support that would change in intensity as the individual's needs changed. However, if there was more urgent need for a CCU bed, it may be a reasonable option in some cases if the person was in a less restrictive option provided by an RRS.

Service elements need to rethink their function within a broader framework that ensures access to consumers most in need. This would require increased collaboration between all service elements in a given service catchment, a preparedness to work together to demonstrably own systemic barriers and develop strategies to address these.

### 6.3 System blockages

Bed blockages in SECU and CCU occur due to range of interrelated factors including:

1. The **lack of alternative options** for consumers. This includes the lack of:
  - intensive clinical and psychosocial support for consumers with complex needs who require a high level of support for an extended period of time post discharge from an extended care facility in order to improve rehabilitation and recovery outcomes and prevent avoidable relapse and unnecessary hospitalisation
  - 'downstream' supported accommodation options (that are also conducive to rehabilitation and recovery over the longer term) for long-stay consumers with enduring psychiatric disability who require structured on-site support in an home-like environment.
2. The absence of an effective **overarching leadership mechanism to control the direction and use of extended care clinical beds** within a given area catchment and ensure the decisions, regarding the use of these beds, take into account whole-of-system pressures.
3. Lack of **consistency in admission and exiting practice** to ensure SECU and CCU services match resources to consumer need consistent with the stated purpose of these services and principles articulated in section 5 of this report.
4. The need to **improve collaborative arrangements with other service elements** within the AMHS (and other AMHS for out-of-area admissions), PDRS and other relevant services (such as housing) to facilitate timely transfers to community mental health treatment and support.

5. **Under supply of SECU beds** resulting in high-risk consumers being managed in acute inpatient units. Although SECU managers have identified that up to 25 per cent of current consumers could be supported in a less intensive environment, a significant proportion of consumers require longer term treatment and care. As a consequence throughput in this service element is constrained.

There are examples in the system of PDRS services effectively reaching into SECU to proactively support the transition of these consumers to the community such as Neami has provided rehabilitation activities for particular consumers in Melbourne's north-eastern SECU. The new IRRCS initiative will also seek to improve the capacity of PDRS sector to support the transition of appropriate SECU and CCU consumers to the community.

System blockages also exist in non-bed-based community mental health services, both clinical and PDRS services. It is incumbent on PDRS and area managers and staff of all service elements to continue to examine and develop good practice regarding their model of care, consumer flow and exit criteria.

## 6.4 Critical service gaps and supply issues

### 6.4.1 Long-term accommodation and support

While the preferred outcome is that consumers in SECU and CCUs be discharged to the community with clinical and PDRS outreach support some consumers, due to the enduring nature of their psychiatric disability, require long-term access to stable and affordable accommodation with on-site, 24-hour, seven-day-a-week psychosocial support. These consumers have needs in excess of what can be provided in a cost-effective manner in the community by clinical ambulatory or PDRS services. Long-term accommodation and support options are currently limited to a small number of SASs or pension-level SRSs provided by the private sector.

### 6.4.2 Supply of existing services

In order to facilitate the proactive discharge of consumers from SECU and CCU, clinical mental health (particularly MST) and PDRS services (particularly IBOS) require the capacity to provide intensive post-exit support. The availability of affordable housing is also a critical enabler.

Given that SECUs cater for high-risk consumers it can be expected that a significant proportion of these consumers will require longer term treatment and care, restricting the level of throughput of this service model. While opportunities to discharge to community mental health care need to be maximised, consideration should be given to assessing the current and projected demand for this service model to provide a business case for expansion.

## 7 Proposed solutions

### 7.1 Achieving consistency in core practices within service elements

It is proposed that service providers of clinical extended care facilities, MST teams, CCT, PDRS RRS and intensive and standard HBOSs review, and where required re-align, current target consumer group profile and scope of practice (including priority of access/entry and exit practice) consistent with the service parameters described in this report and the context of policies outlined in the following documents: *Victoria's mental health service: the framework for service delivery* (1994), *Mobile support and treatment services: guidelines for service provision* (1996), *General adult community mental health services: guidelines for service provision* (1996), *Psychiatric disability rehabilitation and support services: guidelines for service delivery* (February 2003) and *Intensive home-based outreach psychiatric disability rehabilitation and support guidelines* (October 2003). In addition the Mental Health Branch will undertake to develop and issue a program management circular reflecting current policy expectations for SECUs and CCUs.

#### 7.1.1 Community care units

Where the full CCU function is currently not being provided by an existing CCU, then the AMHS management should undertake to redefine the service consistent with the forthcoming program management circular. A residential rehabilitation service with a more diverse clientele and function may be appropriate, to respond to local service needs particularly in rural areas. However, the AMHS would be required to ensure the integrity of the CCU service model is maintained and provide a strong business case for any modification to this service model.

It may be possible and appropriate to broaden the scope of practice within CCUs to cater for a diverse range of consumers across the functions of the CCU and residential rehabilitation service, utilising the skills and resources of both the clinical and PDRS service sectors. Promoting collaborative submissions towards this end could lead to more effective and innovative responses within existing resources.

#### Recommendations

1. That the service elements of the public mental health rehabilitation and continuing care system (clinical and PDRS services) examine the level of congruence between their current practice in respect to target consumer group, focus and scope of practice with that articulated in the following documents and where required, realign current practice to conform with these policy and practice requirements:
  - *Victoria's mental health service: the framework for service delivery* (1994),
  - *Mobile support and treatment services: guidelines for service provision* (1996)
  - *General adult community mental health services: guidelines for service provision* (1996)
  - *Psychiatric disability rehabilitation and support services: guidelines for service delivery* (February 2003)
  - *Intensive home-based outreach psychiatric disability rehabilitation and support guidelines* (October 2003)
  - forthcoming Mental Health Branch SECU and CCU program management circular.

## 7.2 Improving sector collaboration

Improving cross-sector collaboration in order to achieve better continuity of care for consumers will require a change in the way the various service elements relate to each other. The proposed solutions are as follows:

### 7.2.1 Improving cooperation between clinical service elements of an AMHS

This issue involves components of an AMHS refusing to accept consumers from a more resource-intensive part of the AMHS. An example would be refusal by a CCU to take an appropriate referral for a consumer being discharged from the local acute inpatient unit, or the SECU that covers the catchment area.

AMHS management must play a lead role in fostering cooperation across clinical service elements to eliminate the possible development of 'silos' within their services, maximise the efficient use of available resources, ensure consumer flow through the service system and reduce avoidable bed blockages.

At the individual consumer level, it is evident that all AMHS consumers should have a clinical case manager whose responsibility continues through an inpatient admission and includes joint discharge planning prior to the consumer's discharge from an extended care facility.

### 7.2.2 Improving collaboration across clinical and PDRS services

Stronger collaboration is required between the PDRS and clinical sectors to ensure greater congruity in consumer targeting and maximise outcomes for shared consumers with psychiatric disability. Better continuity of care will be achieved for this cohort if clinical services and HBOS services undertake joint planning in respect to service entry, develop shared rehabilitation and recovery plans (including crisis management plans) and undertake shared exit planning.

The identification of ways in which MST and PDRS services can maximise the use of available resources by working more collaboratively should be a key outcome of the Alliances initiative currently being implemented. This initiative provides a systematic vehicle for area and service level collaboration between clinical and PDRS services. Priority attention should be given to improving collaboration between the two service sectors in respect to:

- service level planning, including the collection and systematic analysis of outcome measurement data and the use of a unique client identifier by both sectors to facilitate shared planning at the service and client level (with leadership from the Mental Health Branch)
- developing agreed referral, priority of access and exit criteria between the sectors
- developing and reviewing shared rehabilitation and recovery plans
- identifying agreed key performance indicators and monitoring performance.

Redeveloping PDRS service day programs should also include clarifying how this service element relates to both clinical and other PDRS HBOS services, particularly in respect to the issue of priority of access.

### 7.2.3 Improving collaboration between PDRS service elements

Greater collaboration and shared planning is required across the service elements within the PDRS sector. Clarity is also required regarding consumer pathways through the components of the PDRS service sector. For instance, are consumers referred from one to the other as their level of functioning changes, or can the existing service vary its support up or down in intensity without the consumer having to engage with another service?

This issue is further complicated by multiple PDRS service providers operating in the same catchment area, and variable practice within the sector regarding priority of access and discharge criteria.

#### Recommendations

2. That, using the clinical and PDRS alliance initiative as a systemic vehicle for area/sub regional collaboration, the service sectors work together to develop common tools and mechanisms for the assessment, planning and management of consumers in order to maximise rehabilitation and recovery outcomes.
3. That the PDRS and clinical mental health service sectors work collaboratively to identify and target complex and difficult consumers who require an integrated clinical and PDRSS response to live in the community.
4. That PDRS Residential Rehabilitation Program auspice agencies and area mental health services managing CCUs be invited to submit strategies/service models that will provide a more integrated response to shared consumers with complex and difficult needs, through the redevelopment of existing resources.
5. That the Mental Health Branch and the department's regions consider the capacity of the PDRS service sector to use outcome measure scales consistent with those used by the clinical sector, in order to facilitate improved service level planning between the sectors and a shared understanding of consumer need and progress.
6. That a common unique identifier be introduced across PDRS and clinical mental health service sectors to enable effective cross sector service planning and analysis.
7. That the Mental Health Branch and the department's regions work with the PDRS sector over time to reduce fragmentation and/or rationalise the number of PDRS service providers within defined catchments.

## 7.3 Addressing system blockages and creating consumer flow through the service system

### 7.3.1 Principles and practices of service delivery

The general principles that will underpin the consumer flow chart provided in Appendix 2 of the report are as follows:

1. The factors to be taken into account in determining consumer pathways and 'flow' through the rehabilitation and continuing care service system include the following:
  - symptom severity and likely timeframe for response to treatment
  - risk of harm to self or others
  - social acceptability of symptomatic behaviour
  - level of disability, particularly its effect on consumer's capacity for self-care
  - likely timeframe for response to psychosocial rehabilitation interventions.
2. As consumers' clinical symptoms stabilise and their capacity to undertake rehabilitation increases, consumer movement should be from the most to the least intensive services in terms of clinical support. Conversely, should a consumer's condition deteriorate, more intensive clinical input should be readily available.
3. Where possible, services should be provided in the community and on an ambulatory basis.
4. Clinical bed-based services should be targeted at those whose symptoms are severe or whose associated disability is marked such that it requires 24-hour clinical care.
5. To promote continuity of care and effective resource use, there should be clear structural points for collaboration between clinical and PDRS services. For instance, when an AMHS consumer is identified as needing continuing clinical care, psychosocial rehabilitation or disability support, joint assessment should be undertaken with the local PDRS service as required. Similar points for collaboration are needed between the elements of each service sector such as SECU and AMHS clinical case management, and PDRS, for example HBOS and day programs.

### 7.3.2 Specific strategies to address critical system blockages

To address critical system blockages and create consumer flow through the service system consideration should be given to the following actions:

- Enhance the capacity of clinical mental health and PDRS services to provide intensive clinical and psychosocial support for consumers who need a high level of support post discharge from a SECU or CCU. This would also require access to stable and affordable housing.
- Develop 'downstream' supported accommodation options (that are also conducive to rehabilitation and recovery over the longer term) for long-stay consumers in SECU and CCU with enduring psychiatric disability who require structured on-site support in a home-like environment. This strategy would need to be undertaken in collaboration with the Office of Housing.
- Proactively manage whole-of-system pressures by strengthening or developing and implementing formal mechanisms (through AMHS) to monitor and assertively control the use of SECU, CCU and PDRS RRS beds within a given service catchment.

- Senior AMHS management actively oversee and support strategies to improve collaborative arrangements/partnerships between mental health service within the AMHS (and other AMHS for out of area admissions), PDRS and other relevant services (such as housing, GP and private psychiatrists) to facilitate the proactive discharge of SECU and CCU consumers between service elements and settings.
- Mental Health Branch issue clear policy guidelines to inform admission and discharge practice within SECU, CCU and PDRS RRS to ensure services match resources to consumer need and to promote consistent practice.
- Increase the supply of SECU beds to provide the system with adequate capacity to manage high-risk consumers.

### 7.3.3 Creating consumer flow within the PDRS service sector

Data for this project indicated that consumers might not be making full use of PDRS service elements. For instance, there is some suggestion that HBOS consumers are not being referred to the local PDRS day program that could be supporting their participation in the local community. To resolve this issue, the Mental Health Branch together with Department of Human Services regions should work with VICSERV and PDRS service providers to clarify priority access to PDRS services and the expected nature of consumer flow through the PDRS service system. Clarification should include identifying entry and exit criteria and pathways.

#### Recommendations

8. That the capacity of clinical mental health and PDRS service sectors to provide intensive clinical and psychosocial support packages for complex and difficult consumers who need a high level of support post discharge from a SECU or CCU be enhanced, building on the outcomes of the Integrated Rehabilitation and Recovery Care Service initiative.
9. That additional 'downstream' accommodation and support options for long-stay consumers in SECU and CCU with enduring psychiatric disability be developed in collaboration with Housing and Community Building.
10. That senior management within AMHS and PDRS agencies develop and implement mechanisms to more effectively manage whole-of-system pressures within their service catchment (such as vacancy management and consistent application of entry and exit criteria).
11. That the Mental Health Branch issue a program management circular for SECUs and CCUs to promote consistent admission and discharge practice.
12. That, through the Alliances initiative, senior management within AMHS and PDRS agencies support strategies to improve the collaborative arrangements/partnerships between mental health service within the AMHS (and other AMHS for out of area admissions), PDRS and other relevant services (such as housing, GP and private psychiatrists) to facilitate the proactive and planned discharge of SECU and CCU consumers to community mental health care.

### Recommendations continued

13. That, through the Alliances initiative, AMHS management be required to report on strategies for resolving bed-blockages in their acute inpatient service and in the SECUs and CCUs that cover their catchment area.
14. That work be undertaken by the Mental Health Branch to model the need for an increase in SECU capacity.
15. That the Mental Health Branch together with the department's regions work with VICSERV and PDRS service providers to clarify and document the nature of consumer access, and flow through, the PDRS service sector. This should specifically target entry and exit criteria and the sector's relationship to clinical mental health services in the context of consumers with severe mental illness and psychiatric disability.

## 7.4 Addressing critical service gaps

### 7.4.1 Expanding the capacity of community-based services

The majority of consumers in RRSs, CCUs and SECUs can be successfully discharged to the community subject to the supply of stable and affordable accommodation augmented with intensive psychosocial outreach support and clinical support, usually from PDRS HBOS/IHBOS and CCT/MST services respectively. More public housing or community-managed housing stock is urgently needed in order to expand the number and range of 'destination environments' for consumers exiting RRSs, SECUs and CCUs. As mental health consumers indicate a preference for single occupancy stock, consideration also needs to be given to mechanisms that can underpin the affordability of private and public rental housing for singles.

The PDRS IHBOS and standard HBOS services have proven to be very successful in reducing unplanned hospital admissions, improving consumers' daily living skills and long-term housing retention rates. Consideration should be given to the progressive expansion of these service models.

### 7.4.2 Long-term accommodation and support

A small proportion of consumers require a 'slow stream' rehabilitation response due to their profound level of disability. This cohort currently resides in a number of service elements including SECUs, CCUs and adult RRSs, limiting throughput in these service models.

An alternative placement for this cohort is an accommodation and support service (excluding those who require ongoing inpatient care in a contained environment due to the risk they pose to themselves or others). However, demand for this service model currently outstrips supply. Consideration should be given to expanding the Rooming House Plus service model and/or increasing the supply of supported accommodation services, which would be dependent on the availability of suitable housing stock that can accommodate up to 10 or so consumers in a congregate facility.

One type of alternative hostel type accommodation currently available to consumers with long-term support needs are SRSs run by the private sector.

Pension-level SRSs provide 24-hour supervision with minimal staff and meals and other domestic services such as laundry. This model of care, in combination with a lack of disposable income, limits opportunity for consumers to maintain or regain daily living skills. The practice of some AMHSs in utilising SRSs as a discharge destination may therefore limit consumers' long-term recovery, in particular younger consumers. The SRS research and pilot projects have shown that with targeted measures, SRSs can offer more than just a bed and three meals a day.

The Government has decided to expand support to pension-level SRSs to stabilise this sector, maintain viability and improve the quality of care provided to people with a psychiatric disability and other disabilities. It should be noted however that SRSs do not substitute for specialist mental health services or PDRS services, which should be provided based on consumers assessed needs.

### Recommendations

16. That the capacity of the clinical mental health service system and the PDRS HBOS program be progressively expanded to provide assertive clinical and psychosocial rehabilitation support to consumers with psychiatric disabilities, and that strategies be put in place to ensure these service sectors function in an integrated and coordinated manner.
17. That Housing and Community Building Division maintain a clear focus on the housing needs of people with severe mental illness and psychiatric disability when allocating existing direct tenure housing stock and new initiatives, such as Affordable Housing, and that the proportion of existing and new stock allocated to this cohort be monitored.
18. That Housing and Community Building Division explore options to assist consumers with a severe mental illness and psychiatric disability to access single occupancy housing stock.
19. That the Mental Health Branch, in collaboration with the Housing and Community Building, explore the capacity to expand the Rooming House Plus service model for consumers with enduring psychiatric disability who require structured on-site psychosocial support.



## 8 Recommendations

### Achieving consistency in core practice

1. That the service elements of the public mental health rehabilitation and continuing care system examine the level of congruence between their current practice in respect to target consumer group, focus and scope of practice with that articulated in the following documents and where required, realign current practice to conform with these policy and practice requirements:
  - *Victoria's mental health service: the framework for service delivery* (1994)
  - *Mobile support and treatment services: guidelines for service provision* (1996)
  - *General adult community mental health services: guidelines for service provision* (1996), *Psychiatric disability rehabilitation and support services: guidelines for service delivery* (February 2003)
  - *Intensive home-based outreach psychiatric disability rehabilitation and support guidelines* (October 2003)
  - forthcoming Mental Health Branch SECU and CCU program management circular.

### Improving cross sector collaboration

2. That, using the clinical and PDRS alliance initiative as a systemic vehicle for area/sub regional collaboration, the service sectors work together to develop common tools and mechanisms for the assessment, planning and management of consumers in order to maximise rehabilitation and recovery outcomes.
3. That the PDRS and clinical mental health service sectors work collaboratively to identify and target complex and difficult consumers who require an integrated multidisciplinary response to live in the community.
4. That PDRS Residential Rehabilitation Program auspice agencies and area mental health services managing CCUs be invited to submit strategies/service models that will provide a more integrated response to shared consumers with complex and difficult needs through the redevelopment of existing resources.
5. That the Mental Health Branch and the departmental regions consider the capacity of the PDRS service sector to use outcome measure scales consistent with those used by the clinical sector, in order to facilitate improved service level planning between the sectors and a shared understanding of consumer need and progress.
6. That a common unique identifier be introduced across PDRS and clinical mental health service sectors to enable effective cross sector service planning and analysis.
7. The Mental Health Branch and the department's regions work with the PDRS sector and VICSERV over time to reduce fragmentation and/or rationalise the number of PDRS service providers within defined catchments.

## Addressing system blockages and creating service flow

8. That the capacity of clinical mental health and PDRS service sectors to provide intensive clinical and psychosocial support packages for complex and difficult consumers who need a high level of support post discharge from a SECU or CCU be enhanced, building on the outcomes of the Integrated Rehabilitation and Recovery Care Service initiative.
9. That additional 'downstream' accommodation and support options for long-stay consumers in SECU and CCU with enduring psychiatric disability be developed in collaboration with Housing and Community Building.
10. That senior management within AMHS and PDRS agencies develop and implement mechanisms in order to more effectively manage whole of system pressures (such as vacancy management and consistent application of entry and exit criteria).
11. That the Mental Health Branch issue a program management circular for SECUs and CCUs to promote consistent admission and discharge practice.
12. That, through the Alliances initiative, senior management within AMHS and PDRS agencies support strategies to improve the collaborative arrangements/partnerships between mental health service within the AMHS (and other AMHS for out of area admissions), PDRS and other relevant services (such as housing, GP and private psychiatrists) to facilitate the proactive and planned discharge of SECU and CCU consumers to community mental health care.
13. That, through the Alliances initiative, AMHS management be required to report on strategies for resolving bed-blockages in their acute inpatient service, and in the SECUs and CCUs that cover their catchment area.
14. That work be undertaken by the Mental Health Branch to model the need for an increase in SECU capacity.
15. That the Mental Health Branch, together with the departmental regions, work with VICSERV and PDRS service providers to clarify and document the nature of consumer access, and flow through, the PDRS service sector. This should specifically target entry and exit criteria and the sector's relationship to clinical mental health services in the context of consumers with severe mental illness and psychiatric disability.

## Addressing system gaps

16. That the capacity of the clinical mental health service system and the PDRSS Home-Based Outreach Support program be progressively expanded to provide assertive clinical and psychosocial rehabilitation support for consumers with psychiatric disability and that strategies be put in place to ensure these service sectors function in an integrated and coordinated manner.
17. That Housing and Community Building Division maintain a clear focus on the housing needs of people with severe mental illness and psychiatric disability when allocating existing direct tenure housing stock and new initiatives, such as Affordable Housing, and that the proportion of existing and new stock allocated to this cohort be monitored.
18. That Housing and Community Building Division explore options to assist consumers with a severe mental illness and psychiatric disability to access single occupancy housing stock.
19. That the Mental Health Branch in collaboration with the Housing and Community Building, explore the capacity to expand the Rooming House Plus service model for consumers with enduring psychiatric disability who require structured on site psychosocial support.

## Appendix 1: Distribution of bed-based service elements

Region	Services
<b>Southern metropolitan area</b>	<p><b>Secure extended care unit (20 beds)</b> Wiringa Unit (Dandenong Campus Southern Health)</p> <p><b>Community care unit (60 beds)</b></p> <ul style="list-style-type: none"> <li>• Doveton CCU (Dandenong Campus, Southern Health – 20 beds)</li> <li>• Middle South CCU (Monash Medical Centre, Southern Health – 20 beds)</li> <li>• Spray Street CCU (Frankston Hospital, Peninsula Health Care Network – 20 beds)</li> </ul> <p><b>PDRS residential rehabilitation services (73 beds)</b></p> <p><b>Youth</b> – 30 non-24-hour beds: Richmond Fellowship of Victoria (RFV): Kamara – 10 beds, Nette Court – 10 beds, Seaford – 10 beds</p> <p><b>Adult</b> – 43 beds: Mental Illness Fellowship (MIF): Rossdale – 7 beds; Rossdale Town house – 7 beds RFV: Edith Pardy – 14 beds; Trelowarren – 15 beds</p> <p><b>Supported accommodation services</b></p> <p>ACSO dual diagnosis unit – 5 mental health beds Sacred Heart Rooming House Plus – 38 beds St Kilda Baptist, Scotsdale – 19 beds</p>
<b>North and west metropolitan area</b>	<p><b>Secure extended care unit (26 beds)</b> Adult mental health rehabilitation unit (North Western Mental Health)</p> <p><b>Community care units (80 beds)</b></p> <ul style="list-style-type: none"> <li>• Mid West CCU (North Western Mental Health – 20 beds)</li> <li>• North West Broadmeadows CCU (North Western Mental Health – 20 beds)</li> <li>• Northern CCU (North Western Mental Health – 20 beds)</li> <li>• Inner West Norfolk Terrace CCU (North Western Mental Health – 20 beds)</li> </ul> <p><b>PDRS residential rehabilitation services (62 beds)</b></p> <p><b>Youth</b> – 20 beds Western Region Health-Macaulay: Rocket St Albans – 10 beds; Essendon – 10 beds</p> <p><b>Adult</b> – 42 beds: RFV: Appleby – 14 beds, Electra St – 10 beds, Victoria St – 18 beds</p> <p><b>Supported accommodation services (27 beds)</b></p> <p>Doutta Galla Health Service: Janoak SRS – 14 beds; Macaulay Chiron – 7 beds; Macaulay Chiron – 6 beds</p>

Region	Services
<b>North and east metropolitan area</b>	<p><b>Secure extended care unit (25 beds)</b>  <i>Bunjil House (Austin Health):</i></p> <ul style="list-style-type: none"> <li>• Northern – 7 beds</li> <li>• St Vincent’s – 5 beds</li> <li>• Central East – 5 beds</li> <li>• Maroondah – 5 beds</li> </ul> <p><b>Community care units (50 beds)</b></p> <ul style="list-style-type: none"> <li>• Central East Canterbury Road CCU (Box Hill Hospital Inner and Eastern Health Care Network – 10 beds)</li> <li>• Outer East Bona Street CCU (Marroondah Hospital, Inner and Eastern Health Care Network – 20 beds)</li> <li>• Footbridge CCU (St Vincent’s Hospital, St Vincent’s Hospital Melbourne – 20 beds)</li> </ul> <p><b>PDRS residential rehabilitation services - North West Metropolitan Region (32 beds)</b>  <b>Youth – 32 beds:</b></p> <ul style="list-style-type: none"> <li>• RFV: Apollo (North East AMHS – 10 beds)</li> <li>• RFV: Chiron (North AMHS – 10 beds)</li> <li>• RFV: Rosa Gilbert (Nth AMHS – 12 beds)</li> </ul> <p><b>Supported accommodation services - North West Metropolitan Region (34 beds)</b>  Bethlehem Community – 10 beds (women only metro-wide cross program funds)  Regina Coeli – 15 beds (women only metro wide cross program funds)  Fintry Bank – 9 beds (male only, Inner east AMHS)</p> <p><b>PDRS residential rehabilitation services - Eastern Metropolitan Region (25 beds)</b>  <b>Youth – 25 beds:</b>  RFV: Narana – 10 beds; Wattlebridge – 7 beds; Denham – 8 beds</p>

Region	Services
<b>Barwon South West</b>	Secure extended care unit – 6 beds (Geelong – 3, Warrnambool – 3: SouthWest Health Care) Community care unit (Barwon Health – 12, Warrnambool – 2) PDRS residential rehabilitation services – 18 youth (Geelong – 10, Warrnambool – 8)
<b>Hume</b>	Secure extended care unit – 0 PDRS residential rehabilitation services – 19 youth (Goulburn – 10, North Eastern/Wodonga – 9)
<b>Grampians</b>	Secure extended care unit – 12 beds (Ballarat Health) Community care unit – 20 beds (Ballarat Health) PDRS residential rehabilitation services – 10 youth (Ballarat)
<b>Gippsland</b>	Secure extended care unit – 6 beds Community care unit – 14 beds (LaTrobe Regional Hospital) PDRS residential rehabilitation services – 10 youth (Traralgon)
<b>Loddon Mallee</b>	Secure extended care unit – 8 beds (Bendigo Health Care Group) Community care unit – 12 beds (Bendigo Health Care Group) PDRS residential rehabilitation services – 10 Youth (Bendigo)

## Appendix 2: Developing an integrated rehabilitation and care service system—flow chart

