The Royal Commission into Victoria's MHS: contemporary evidence, practice and policy in rehabilitation psychiatry

Professor Carol Harvey

Department of Psychiatry, University of Melbourne &
NorthWestern Mental Health

NSW Rehabilitation Psychiatry Network Meeting

29 March 2022

Background and Focus on Models of Care: Report to the Royal Commission into Vic's MHS

- Royal Commission into Victoria's MHS (RCVMHS) recognised that people living with severe and persistent mental illness (SPMI) have specific and complex needs
- They need models of care, support opportunities and therapeutic interventions that may address these needs
- Our report to the RCVMHS "Models of Care for Victorians Living with SPMI and Complex Needs" – contemporary evidence for rehabilitation and a useful case study
- We built on two previous reviews we had conducted:

Kakuma R, Hamilton B, Brophy L, Minas H, Harvey C. **Models of Care for people with severe and enduring mental illness**: Evidence Check rapid review - Sax Institute for the NSW Ministry of Health, 2017.

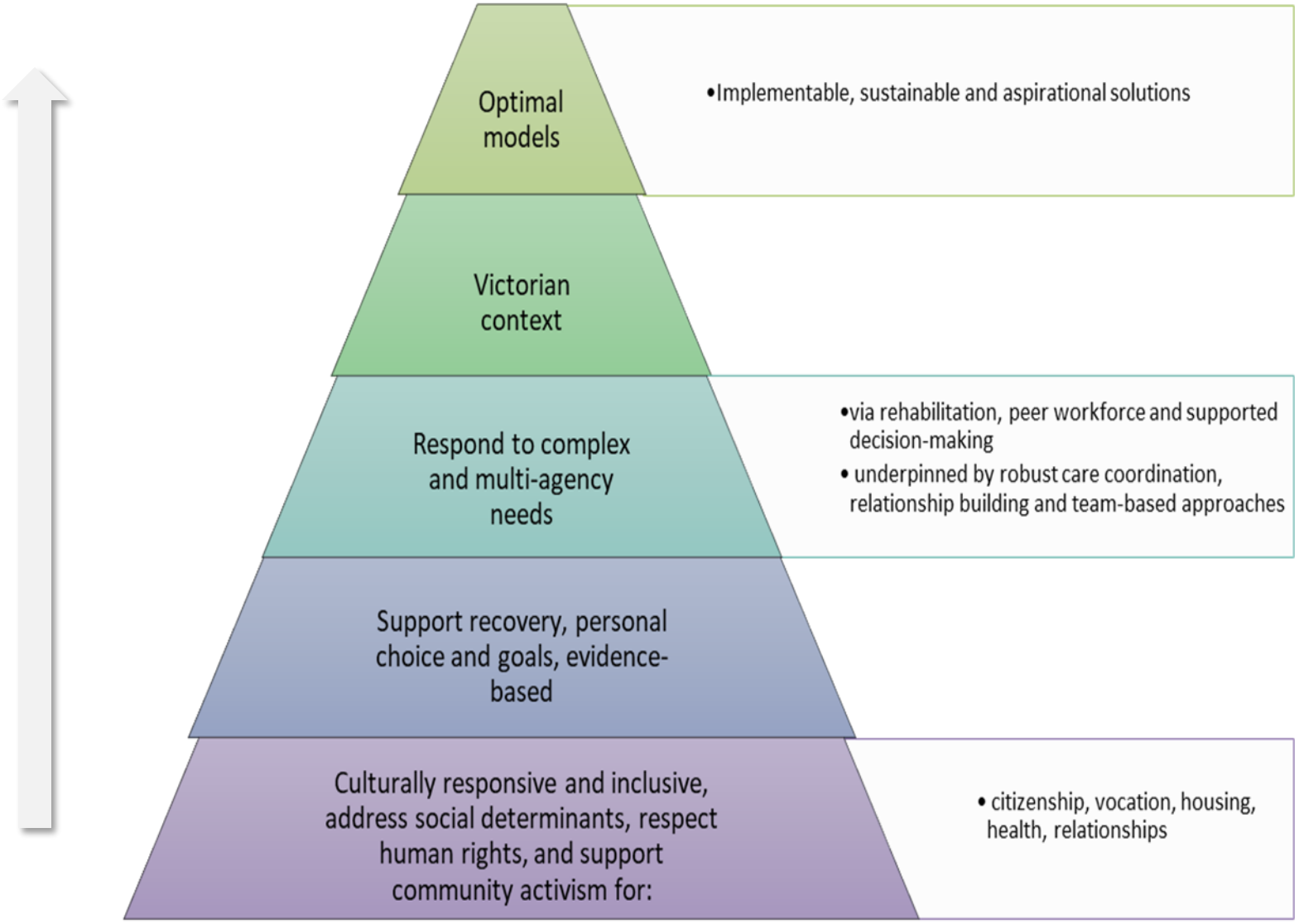
Hayes, L, Brophy, L, Harvey, C, Tellez, J, Herrman, H, Killackey, E. Review for Mind Australia of **Evidence-based Early Intervention Support for Psychosocial Disability** in the NDIS 2016.

Models of Care for Victorians Living with SPMI and Complex Needs: Team and Expertise

- Professor Carol Harvey, University of Melbourne
- Professor Lisa Brophy, La Trobe University
- Ms Justine Fletcher, University of Melbourne
- Dr Catherine Minshall, La Trobe University
- Associate Professor Bridget Hamilton, University of Melbourne
- Dr Priscilla Ennals, NEAMI National
- Ms Cath Roper, University of Melbourne
- Dr Peter McKenzie, La Trobe University
- Professor Richard Newton, Monash University
- Professor Helen Killaspy, University College London

Multidisciplinary academics with **extensive experience** derived from **working and evaluating clinical and community-managed sectors** in Victoria, along with **lived experience** perspectives. Our expertise is in **researching** and **implementing models of care** for **consumers living with SPMI** and **multi-agency needs**, across **inpatient, residential and community** settings.

Models of Care for Victorians Living with SPMI and Complex Needs: Underpinning Principles



Models of Care for Victorians Living with SPMI and Complex Needs: Definitions

Persons living with SPMI and complex needs:

Diagnosis, duration, difficulties with everyday, social and occupational functioning: diagnosis often over-emphasised

- ~ 25% of people newly diagnosed with SMI (schizophrenia, bipolar disorder, major depression) will develop complex problems and needs (*NICE 2020*)
- > 80% referred for mental health rehabilitation - primary diagnosis of schizophrenia, schizoaffective disorder or other psychosis, ~ 8% bipolar affective disorder (*NICE 2020*)

Model of Care: multi-dimensional concept, varied definitions (e.g. *NSW Agency for Clinical Innovation 2013*)

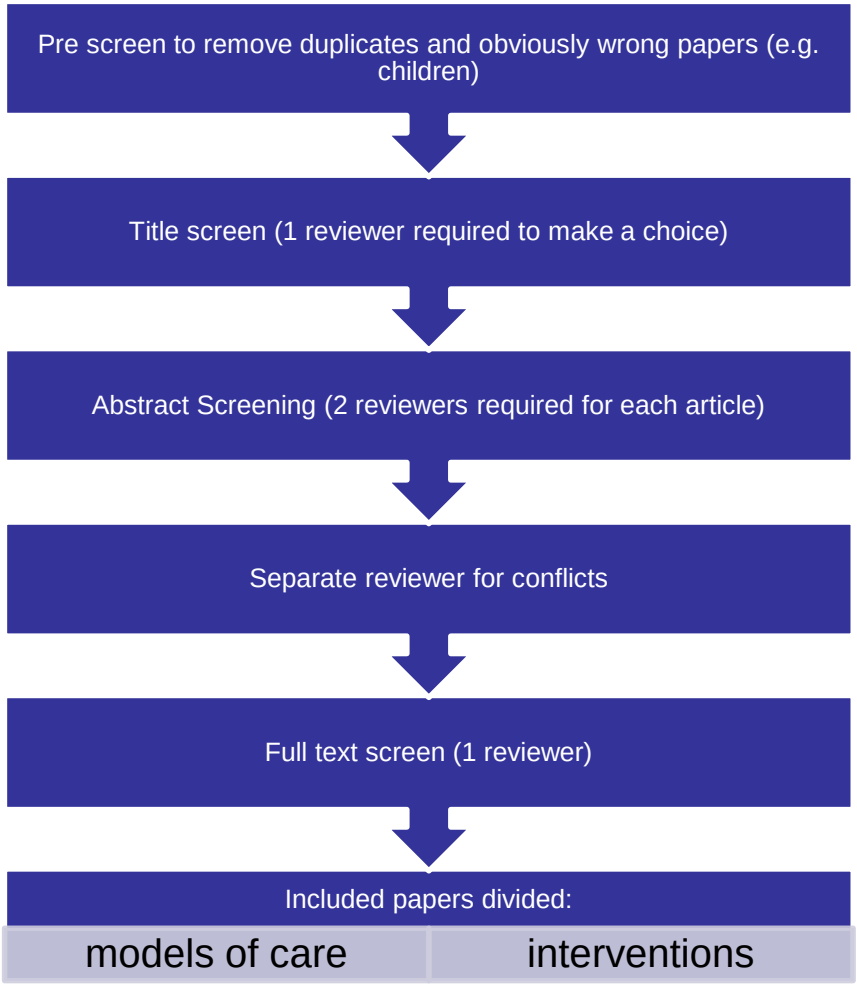
- Delivery component = how care is provided & content component = what treatment and care is delivered (*Kakuma 2017*)
- Collective experience: no one model of care for this group

Models of Care for Victorians Living with SPMI and Complex Needs: Method

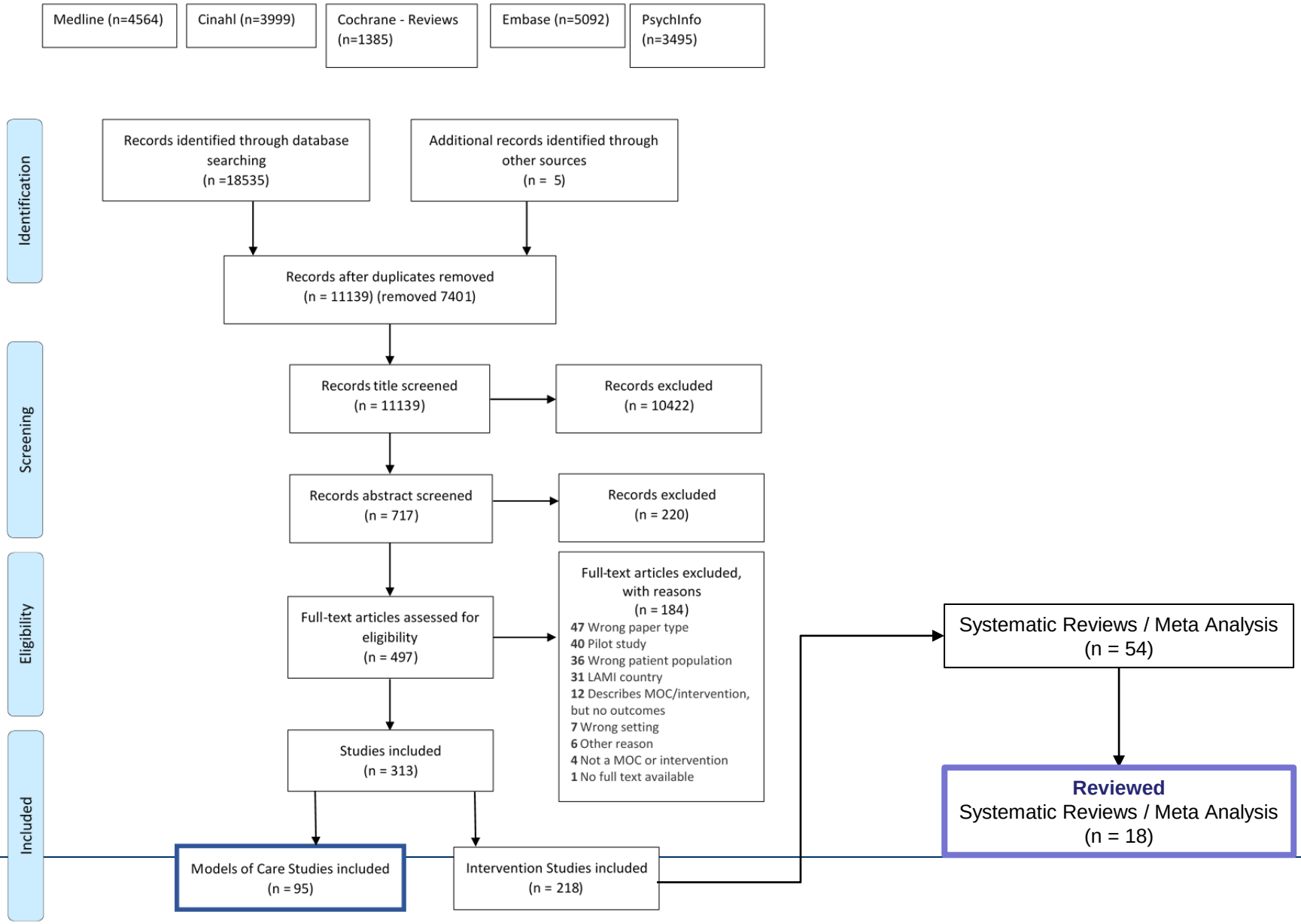
Search Terms

Severe Mental Illness	• Diagnosis e.g. schizophrenia • Persistent/enduring • Complexity e.g. dual diagnosis
Models of Care and/or Interventions	• Services e.g. community mental health services • Recovery oriented
Outcomes and Experience	• Quality of Life • Admissions to inpatient units • Consumer satisfaction

Screening Process



Models of Care for Victorians Living with SPMI and Complex Needs: PRISMA Chart



Models of Care for Victorians Living with SPMI and Complex Needs: Our Recommendations

Housing First (HF)

- **Best practice model** (Kakuma 2017 & this review: 13 of 25 studies): **effective** (housing stability/reduced days homeless, reduced mental health service use, improved continuity of care and consumers' self-reported symptoms and behaviours) and **cost-effective** (e.g. overall cost savings (including housing) to government)
  - immediate access to permanent rent-subsidised housing with no housing readiness requirements; consumer self-determination and choice in housing and any treatment plan; individualised, recovery-oriented outreach supports without pre-conditions related to participation in treatment
- Much evidence from a similar country (Canada), including published implementation and scaling-up wisdom
- Clinical support component for consumers with SPMI in HF = Assertive Community Treatment (ACT)

Models of Care for Victorians Living with SPMI and Complex Needs: Our Recommendations

Two other housing types recommended – emerging practice models (some consumers need access to peers and/or staff to mitigate loneliness, or seek extra support)

- **"Congregate" or group Housing First**
  - Access to some communal spaces and/or on-site staff support

- **High-support Accommodation**
  - Congregate or group settings with shared facilities and on-site support 24/7
  - Should replace Supported Residential Services (SRSs) and provide rehabilitation and recovery-oriented support
  - = Supported Independent Living (NDIS) – needs improved uptake with enhanced support (via MHCSS, peers)

Strengths-Based and Recovery-Oriented Practice Models

- **Promising/best practice model** (*Kakuma 2017* & this review: 7 studies): **effective** (improved personal recovery, wellbeing and caseworker-reported functioning, consumer self-efficacy and general quality of life and reduced unmet needs, reduced psychiatric and substance-related hospital admissions)
- Good Australian evidence (3 of 7 studies)

Models of Care for Victorians Living with SPMI and Complex Needs: Our Recommendations

Self-Directed, Peer-Delivered and Peer-Led Models

- Peer workers important in supporting recovery-oriented practice and **promising/best practice evidence** for the peer-facilitated Wellness Recovery Action Plan (WRAP) (*Kakuma 2017*)
- Our review: identified models of care featured a strong emphasis on self-directed care and consumers having a central role in determining goals
- **Emerging/promising evidence** (improved recovery outcomes, high satisfaction, better health and wellness)
- Relevant to the aspirations of service delivery in Victoria

Partners in Recovery (PIR) and other Care Coordination Models

- Partners in Recovery was classified as an **emerging practice** (*Kakuma 2017*)
- PIR and similar collaborative care co-ordination approaches can now be considered as **promising practices**: **effective** (reduced unmet needs and improved personal recovery, good consumer satisfaction, beneficial impacts on carers/support persons)
- Offer to consumers unable to access NDIS support coordination (or psychosocial recovery coach) in rural areas?

Assertive Community Treatment (ACT)

- **Best practice model** (*Kakuma 2017* and this review: 12 of 22 identified studies): **effective** (reduced hospital admissions/length of stay, consumer-reported improvement in needs met and fewer unmet needs, higher satisfaction, mixed findings on consumers' social functioning, quality of life, symptoms and personal recovery) and **cost-effective** (compared with standard care)
  - time unlimited model; multidisciplinary team including peer support and substance use and vocational specialists; small case loads - average 10; consumer linked to one key worker; team approach to supporting consumers; 24/7 support
- Highly appropriate for Victoria – available experience (=MSTs)
- Much international evidence, including published fidelity measures and implementation studies

Flexible Assertive Community Treatment (FACT)

- **Promising practice model** (new in this review: 7 of 22 identified studies): tends to be **effective** (reduced admissions/length of stay and compulsory admissions, improved unmet need, quality of life and functioning) and **cost-effective** (16% lower cost compared with standard care)
  - Blends time-limited ACT when consumers needs are high with individual case management when consumer needs are less; multidisciplinary team including peer support and substance use specialists; consumer linked to one key worker; team approach to supporting consumers when in crisis?; small case loads average 11-12
- **Promising option** where the population served is between 40,000-50,000
- Appropriate for Victoria
- Published implementation and fidelity

Models of Care for Victorians Living with SPMI and Complex Needs: Our Recommendations

Inpatient rehabilitation

- **Emerging/promising practice model** (5 studies, some Australian, consistent with *NICE 2020*): **effective** (improved consumer psychosocial function and daily living skills) and **cost-effective** (two UK studies)
  - Open ward, close to where consumers live, staffed 24/7 by multidisciplinary team and peers, recovery-oriented practices
- Secure Extended Care Units (SECUs) might be reconfigured – no longer secure and expected maximum length of stay
- **Separate stream** of forensic rehabilitation units – secure function and forensic inpatient rehabilitation
  - Step-up/step-down from forensic inpatient setting
  - Re-create state-wide capacity to assess and treat consumers with very complex needs not subject to forensic or sentencing orders

Models of Care for Victorians Living with SPMI and Complex Needs: Our Recommendations

Community Care Units (CCUs)

- **Promising practice model** (was emerging/promising practice (*Kakuma 2017*), now Queensland CCU studies published by Parker and colleagues): **effective** (reduced consumer symptoms and service use and involuntary treatment status)
  - Transitional Residential Rehabilitation – recovery-oriented, time-limited stay, integrated workforce (clinical, MHCSS, peers), offer evidence-based interventions
- Already exist in Victoria
- Offer less restrictive alternative to inpatient rehabilitation
- Local and Australian examples for integrated workforce exist

Models of Care for Victorians Living with SPMI and Complex Needs: Our Recommendations

Social and Occupation-focused Models

- **New and Innovative Models of Care (**new in this review, but some long-standing; 8 studies**)**
- Opportunities for social connection and engagement in meaningful activities
  - **Recovery Colleges** = Emerging/promising practice
  - **Life rooms** = Emerging practice
  - **Club houses** = Promising practice
  - **Peer-led residential milieu** = Emerging practice
- “Safe harbours” “opportunities to flourish and participate” “a safe social space” “learning opportunities” “tolerate difference”

Conclusions: Most Appropriate and Optimal Models of Care

Quality features include:

Built resources/design features	Lived experience workforce/expertise	Integrated models/programs/workforce	Recovery oriented and choice and control	Address social determinants of health

Models and interventions we recommended rely on:

Implementation strategies – are we doing what we say we are?	Proxy outcome measures – is it working for people with SPMI?

For consumers with SPMI only:

Inpatient rehabilitation, Community Care Units	High-support accommodation, group Housing First	Assertive Community Treatment and care coordination models exemplified by Partners in Recovery

Consumers diagnosed with SMI, including those with SPMI:

Housing First	PARCs	Strengths-Based and Recovery-Oriented Models	Self-directed, peer-delivered and peer-led models	FACT	Social and Occupation-focused Models

What did the Final Report recommend for Victorians Living with Severe and Persistent Mental Illness (SPMI) and Complex Needs?

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New Rehabilitation Pathway

"The Commission recommends establishing a new rehabilitation pathway for people living with mental illness who require ongoing intensive treatment, care and support. The new rehabilitation pathway includes care in the community, based on the Assertive Community Treatment model, two new bed-based rehabilitation models of care, supported housing and Regional Multiagency Panels" (Vol 1, page 387)

Figure 6.13: Features of Reformed Service Response for People Needing Ongoing Intensive Treatment, Care and Support

Recommendation 5: Core Functions of Community Mental Health and Wellbeing Services

2. commission and ensure that Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services referred to in recommendation 3(2)(a) and (b) work in collaboration to deliver multidisciplinary, holistic and integrated treatment, care and support through a range of delivery modes including:

   a. site-based care (such as centres or clinics);
   b. telehealth;
   c. digital technologies; and
   d. visits to people's homes and other places (including targeted assertive outreach).

Recommendation 12: Developing New Bed-based Rehabilitation Services

1. implement the new whole-of-system rehabilitation pathway described by the Royal Commission in its final report, which includes two new bed-based rehabilitation models of care, for people living with mental illness who require ongoing intensive treatment, care and support.
2. consistent with the 'design and quality features' described by the Royal Commission in its final report, co-design with consumers, clinicians and relevant non-government organisations and services:
    a. the new community rehabilitation model of care and deliver it at a community care unit demonstration site; and
    b. the new intensive rehabilitation model of care and deliver it at a secure extended care unit demonstration site.
3. subject to the evaluation and required adaptation of the new rehabilitation models of care, apply these models to existing community care and secure extended care units and enhance and expand infrastructure accordingly.

Recommendation 25: Supported Housing for Adults and Young People living with Mental Illness

1. ……and ensure that, during the next decade, people living with mental illness are allocated a continuing substantial proportion of social and affordable housing.

2. revise the Victorian Housing Register's Special Housing Needs 'priority access' categories to include people living with mental illness, including people who need ongoing intensive treatment, care and support.

3. ensure that the 2,000 dwellings assigned to Victorians living with mental illness in the Big Housing Build are delivered as supported housing and are prioritised for people living with mental illness who require ongoing intensive treatment, care and support, with Area Mental Health and Wellbeing Services assisting with the selection process.

Recommendation 25: Supported Housing for Adults and Young People living with Mental Illness

5. ensure that the supported housing homes for adults and young people living with mental illness are:

   a. delivered in a range of housing configurations including stand-alone units, self-contained units with shared amenities and various forms of clustered independent units on a single-site property;

   b. appropriately located, provide for the requirements of people living with mental illness and are co-designed by Homes Victoria, representatives appointed by the Mental Health and Wellbeing Division and people with lived experience of mental illness; and

   c. accompanied by an appropriate level of integrated, multidisciplinary and individually tailored mental health and wellbeing treatment, care and support.

Recommendation 51: Commissioning for Integration

1. build on new ways of resourcing and monitoring mental health and wellbeing services (refer to recommendations 48 and 49) and empower Regional Mental Health and Wellbeing Boards (refer to recommendation 4(2)) to:

   a. commission one demonstration project in each region (refer to recommendation 3(3)) in which a provider or providers deliver multiple services to people living with mental illness who require ongoing intensive treatment, care and support;

   b. commission demonstration projects in each region in which a provider or providers deliver multiple services to people living with mental illness who require short-term treatment, care or support and who are in the 'missing middle';

   c. evaluate demonstration projects to inform decisions on scaling approaches and expanding to new providers or provider partnerships that are tailored to the needs of communities and span the full age spectrum; and

   d. monitor provider partnerships using a common set of indicators with an emphasis on improving mental health and wellbeing outcomes.

Practice and Implementation Issues and Concerns

- Language:
  - Unnecessary confusion about consumers who could benefit through avoidance of diagnostic and severity language
  - Consumers with SPMI may be overlooked (as usual!)
- Whole-of-system rehabilitation pathway is described, but not easy to find this in one place
- Governance unclear, including role and function of regional multiagency panels
- Details of eligibility, referral and access and discharge criteria lacking

Practice and Implementation Issues and Concerns

- Is funding ring-fenced?
- Demonstration projects:
  - Must be consistent with current evidence
  - Involve delay in full roll-out
  - Might mean never scaled up – remain demonstrations only
- Workforce capacity, including specific expertise in psychosocial rehabilitation
- Implementation critical, but barely mentioned

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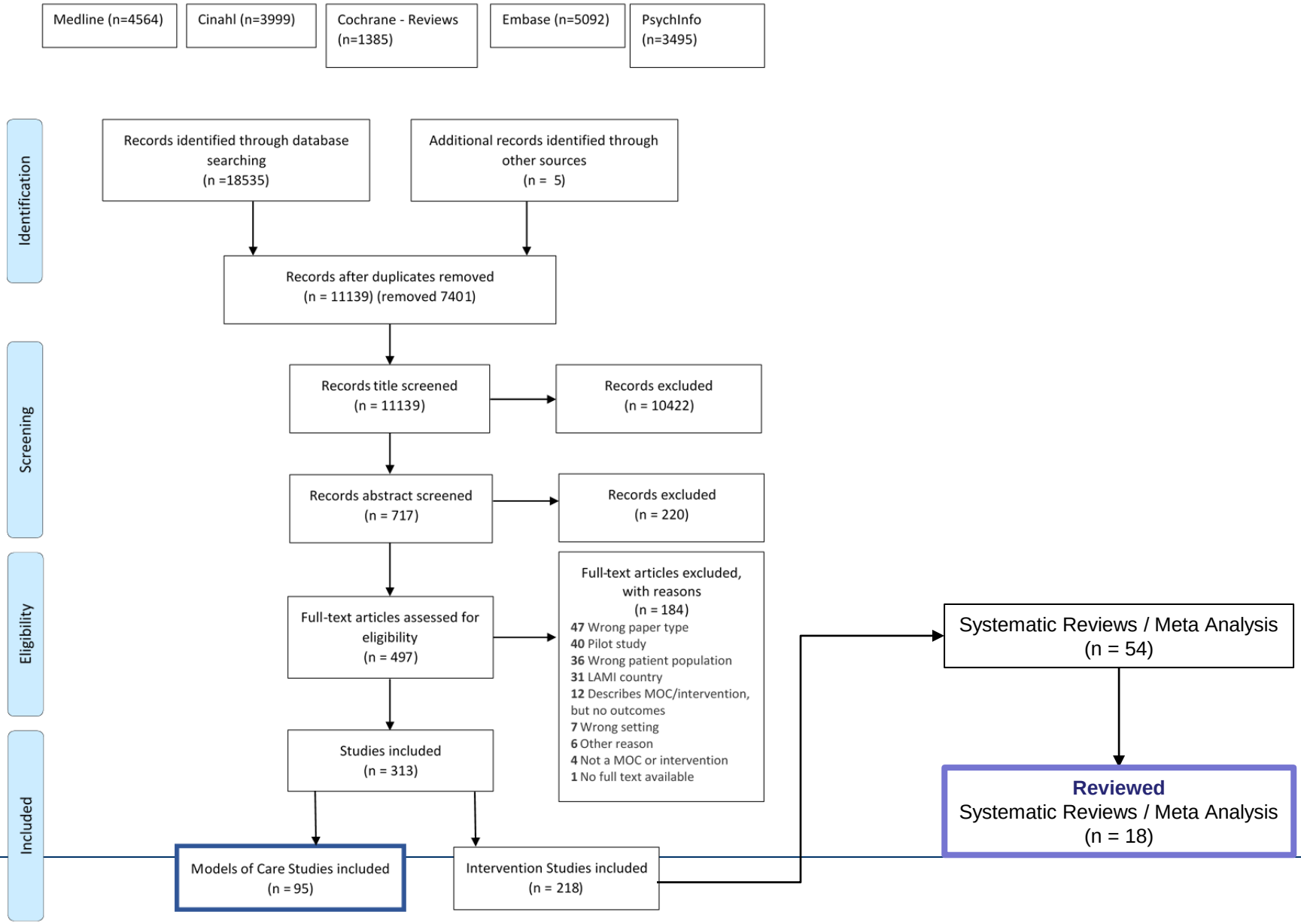

Systematic review and narrative synthesis: Killaspy, Harvey et al, World Psychiatry, 2022

- Systematic review and narrative synthesis of contemporary evidence on community-based social interventions to improve social and economic participation for people with severe mental illness (SMI)
- Encouraging amount and quality of recent research evaluating social interventions for people with SMI
- Interventions with a more established evidence base:
  - supported accommodation, supported employment and family interventions
- Interventions at an earlier stage of development:
  - supported education, peer led/supported interventions, social skills interventions and interventions that aim to improve community participation

Systematic review and narrative synthesis: Killaspy, Harvey et al, World Psychiatry, 2022

- Support previous studies which provide good evidence for the Housing First model of supported accommodation, the Individual Placement and Support model of supported employment and family psychoeducation
  - But not a one-size fits all approach
- Considerable research interest in augmentation strategies to enhance outcomes from social interventions, particularly supported employment and social skills training, by addressing cognitive impairments (e.g., augmented with CRT)
  - But whilst evidence for improved cognitive ability, most do not seem to lead to transferable ‘real life’ skills

Systematic review and narrative synthesis: Killaspy, Harvey et al, World Psychiatry, 2022

- Positive findings for peer-led or peer-supported interventions (4 of 5 identified RCTs)
- Family interventions benefitted from addition of peer worker co-facilitators
- Recovery colleges and most community participation interventions
  - included peer workers, also experienced as helpful
  - built confidence and social connections
- Importance of considering all relevant contextual factors and making appropriate, specific adaptations when ‘importing’ social interventions from other countries or settings

Conclusions

- Growing and promising evidence for rehabilitation models of care and social interventions to improve social and economic participation for people living with SPMI/SMI
- Evidence for models and interventions which have existed for some time e.g., ACT, Housing First, TRR, inpatient rehabilitation, IPS, family psychoeducation
  - But some have been dismantled, inadequately implemented or have failed to thrive……and need some diversity of models and adaptation to local context
- Recovery orientation of models and interventions of critical importance, including focus on social connection and occupational outcomes

Conclusions

- Workforce composition also very important – peers, specialists e.g., vocational, dual diagnosis
- Victorian reforms recommend a rehabilitation pathway
- Other positive policy developments e.g., NICE 2020, WHO Package of Rehabilitation Interventions for schizophrenia
- Effective implementation will be critical to success
- Psychiatric rehabilitation is re-emerging from the wilderness!!

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Thank you

Professor Carol Harvey

c.harvey@unimelb.edu.au

psychosocial RESEARCH CENTRE

NorthWestern Mental Health