NSW Rehabilitation Psychiatry Network

24th November 2020

Health

Thank you for participating!

Dr Nicholas Burns

Director of Forensic Mental Health Services, Orange Health Service

"Many thanks to everyone who participated in our second NSW Rehabilitation Psychiatry Network forum, and our first totally virtual event. We are especially grateful to Kari Johannsen and the team from Bendelta for leading us through the virtual process and making the meeting as engaging and interactive as possible. We received some great feedback on our new format, especially from colleagues working in remote and regional areas. We heard from inspiring speakers, whose ideas generated strong dialogue, out of which we have some key initiatives to carry forward. Most importantly, our regular meetings are helping to build a cohesive and visible network with a unified voice. Hopefully, this will ultimately benefit the people who use our services. I look forward to meeting again in 2021."

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The Royal Australian & New Zealand College of Psychiatrists

New South Wales Branch

NSW Rehabilitation Psychiatry Network Meeting – 24th Nov

The purpose of the day was to bring together psychiatrists working in rehabilitation services across the state in order to get to know each other, exchange ideas and build a culture of shared learning. Our aim is to form a cohesive network with a strong unified voice.

With support from Bendelta and our tech facilitator, Kari Johannsen, we designed a day full of engaging and interactive tools and techniques to enable a memorable and impactful experience for all participants. This included polls, check-ins and breakout room discussions.

26
Attendees

Time	Item	Session Lead
9.05 – 9.15	Introduction	Nick Burns, Orange Health Service Meg Simpson, PCLI, Ministry of Health
9.15 – 10.10	Implementing the NICE Guideline Recommendations	Helen Killaspy, University College London
10.10 – 10.20 First Tea Break		
10.20 – 10.40	RANZCP Updates	Nick Burns
10.40 – 11.30	Modes of Care / Measurement	LHDs
11.30 – 11.40 Second Tea Break		
11.40 – 11.55	Overview of NSW non acute situation	Jo Sharpe, InforMH, Ministry of Health
11.55 – 12.45	Non-acute care benchmarking	Nick Burns & Jo Sharpe
12.45 – 1.00	Round up	Nick Burns

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This report includes all slides presented during the NSW Rehabilitation Psychiatry Network Meeting, as well as a sample of responses received in the online polls, Zoom chat, and evaluation survey. Please click on the section of the report that you would like to access.

NICE GUIDELINES (HELEN KILLASPY)

RANZCP UPDATES (NICK BURNS)

LHD PRESENTATIONS

- Dr. Justine Hoey-Thompson (Northern NSW LHD)
- Dr. Kerri Eagle (Sydney LHD)
- Dr. Pradeep Jarabandahalli (Western Sydney LHD)
- Dr. Ness McVie (Hunter New England LHD)
- Dr. Leesa Brown (HNE LHD)
- Dr Maryanne O'Donnell (SESLHD)

NON ACUTE BENCHMARKING (JO SHARPE)

EVALUATION SURVEY

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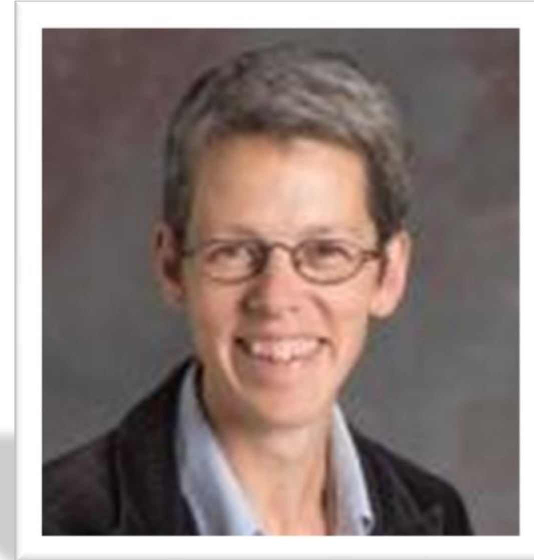
Implementing the NICE Guideline Recommendations



Helen Killaspy
Professor and Honorary Consultant in Rehabilitation Psychiatry

Comment shared in the chat:
"Excellent summary of the Guidelines!"

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Implementing the NICE Guideline Recommendations on Rehabilitation for Adults With Complex Psychosis in the Australian Context

Helen Killaspy

Professor and Honorary Consultant in Rehabilitation Psychiatry

University College London and

Camden & Islington NHS Foundation Trust, London

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Rehabilitation for Adults With Complex Psychosis; NICE Guideline 181 www.nice.org.uk/guidance/ng181

Aims

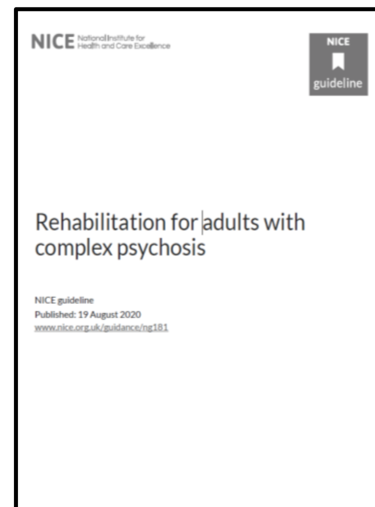
- To ensure people have access to mental health rehabilitation when they need it
- To promote a positive approach to long term recovery

Covers

- Organisation of rehabilitation services
- Assessment, delivery of interventions, culture of services, care planning
- Physical health

Who is it for?

- Health and social care professionals
- Commissioners of services
- Service users and their families/carers



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Development of the NICE guideline on mental health rehabilitation

- Lobbying: 2016-17
- Respond to NICE call for commissioning new guidelines: 2017
- NICE appoint Guideline Committee Chair and Topic Guide through open advertisement: Jan 2018
- Scope drafted: Feb-March 2018
- Public stakeholder consultation on scope: April 2018
- Scope agreed: May 2018
- Guideline Committee appointed through open advertisement: May-June 2018
- 10-12 committee meetings (1-2 days) to agree specification of each evidence review, review evidence, draft recommendations: July 2018-October 2019
- Draft guideline submitted to NICE: December 2019
- Public stakeholder consultation on draft guideline: January to February 2020
- Guideline published: **19th August 2020**

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Why NICE Guidelines matter

- The NICE Charter – independent and authoritative guidance and quality standards, based on the best available evidence, set out the best ways to prevent, diagnose and treat disease and ill health, promote healthy living, and care for vulnerable people
- Legal status of NICE guidelines is reinforced in the NHS Constitution - patients have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if the doctor responsible for the patient's care says they are clinically appropriate
- Commissioners are accountable for commissioning services that can deliver the treatments and interventions recommended by NICE
- Service providers are responsible for delivering them

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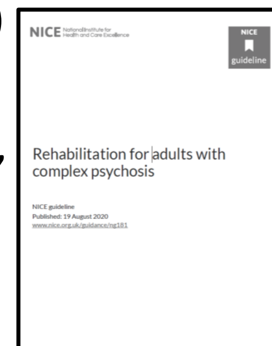
Rehabilitation for Adults With Complex Psychosis; NG 181

In scope

- Primary diagnosis of psychosis (schizophrenia, schizoaffective disorder, bipolar affective disorder, psychotic depression, delusional disorder) **plus**
- Severe, treatment refractory symptoms (positive or negative) **plus 1 or more of**
  - Cognitive impairment associated with psychosis
  - Co-existing mental health conditions (including substance misuse)
  - Pre-existing neurodevelopmental disorder (e.g. ASD, ADHD)
  - Physical health conditions (e.g. diabetes, cardiovascular disease, pulmonary disease) **and**
- Impaired social and everyday function (ADLs, interpersonal and occupational)

Out of scope

- Primary diagnosis of common mental disorder (depression without psychosis, anxiety), personality disorder, obsessive compulsive disorder, eating disorder, substance misuse problem, or moderate to severe intellectual disability



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Content of the Guideline

1.1 Who should be offered mental health rehabilitation?

1.2 Overarching principles of mental health rehabilitation

1.3 Organisation of rehabilitation services

1.4 Improving access to rehabilitation services

1.5 Delivering services within the rehabilitation pathway

1.6 Recovery-orientated rehabilitation services

1.7 Person-centred care planning through assessment and formulation

1.8 Rehabilitation programmes and interventions

- activities of daily living (self-care, cooking, cleaning, shopping, budgeting, maintaining a tenancy)
- interpersonal functioning and social skills
- vocational rehabilitation (leisure, education and work)
- healthy living (diet, weight, exercise, sleep, oral health, health monitoring, accessing health services, self-medication programmes, cessation programmes for smoking and substance misuse)

1.9 Adjustments to mental health treatments in rehabilitation

1.10 Physical healthcare

1.1 Who should be offered rehabilitation?

Offer rehabilitation to people with complex psychosis:

- as soon as it is identified that they have treatment resistant symptoms of psychosis and impairments affecting their social and everyday functioning
- wherever they are living, including in inpatient or community settings

In particular, this should include people who:

- have experienced recurrent admissions or extended stays in acute inpatient or other psychiatric units, either locally or out of area
- live in 24-hour staffed accommodation whose placement is breaking down

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1.2 Overarching principles of mental health rehabilitation

Rehabilitation services for people with complex psychosis should:

- be embedded in a local comprehensive mental healthcare service
- provide a recovery-orientated approach that has a shared ethos and agreed goals, a sense of hope and optimism, and aims to reduce stigma
- deliver individualised, person-centred care through collaboration and shared decision making with service users and their carers
- be offered in the least restrictive environment and aim to help people progress from more intensive support to greater independence through the rehabilitation pathway
- recognise that not everyone returns to the same level of independence they had before their illness and may require supported accommodation (such as residential care, supported housing or floating outreach) in the long term.

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1.3 Organising the rehabilitation pathway

- All local mental healthcare systems should include a defined rehabilitation pathway
- Use the local joint strategic needs assessment to inform the commissioning of specific service components that make up the rehabilitation pathway, to match the needs of the local population.
- Conduct a local rehabilitation service needs assessment to identify the number of people with complex psychosis who:
  - are currently receiving inpatient rehabilitation 'out of area'
  - have recurrent admissions or extended stays (e.g. > 60 days) in acute inpatient units and psychiatric intensive care units, either locally or out of area
  - are currently receiving care from forensic services or early intervention for psychosis services and already have or are developing problems that are likely to need mental health rehabilitation
  - are young adults moving from children and young people's mental health services to adult mental health services
  - live in highly supported (24-hour staffed) accommodation
  - are physically frail and may need specialist supported accommodation

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The mental health rehabilitation care pathway components

Referrals
Acute inpatient wards (80%)*
Forensic units (20%)

Inpatient and community rehabilitation units

Mental health supported accommodation
Residential care
Supported housing
Floating outreach

Clinical Input
Community Rehabilitation Teams
Primary Care

Greater autonomy

> 10 years
1-3 years
> 5 years

Inpatient
Community

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The mental health rehabilitation care pathway

- The exact complement of components required will vary between areas as the pathway should be tailored according to the local rehabilitation service needs assessment
- Services should be provided as locally as possible but more specialist components (e.g. highly specialist inpatient rehabilitation) may need to be provided at a regional level for people with particularly complex needs
- The rehabilitation pathway should be designed to provide flexibility, smooth transitions and support over the longer term, that enables people to:
  - join and leave the rehabilitation pathway at different points
  - move between parts of the pathway that provide higher or lower levels of support according to their changing needs
  - spend different periods of time at different stages of the pathway according to need
  - have access to more than one period of rehabilitation and be swiftly referred back to the pathway if their needs increase and they would benefit from further rehabilitation.

1.4 Improving access to mental health rehabilitation

- Commissioners and service providers should provide information about the local rehabilitation pathway and how it is accessed to health and social care practitioners, people who may benefit from rehabilitation and their families and carers.
- The lead commissioner should work together with service providers to ensure that everyone with complex psychosis has access to rehabilitation services regardless of age, gender, ethnicity and other protected characteristics and monitor and report on access at least every 6 months
- If any differences are found in rates of access for specific groups of people (for example, women or ethnic groups) compared with anticipated rates, these should be addressed, for example through:
  - providing bespoke services for specific groups, such as women-only services
  - providing outreach into other services that work with under-served groups, or home visiting
  - providing tailored information and advocacy

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1.5 Delivering services within the rehabilitation pathway

- Inpatient and community rehabilitation services should be staffed by multidisciplinary teams with relevant skills and competence in mental health rehabilitation:
  - rehabilitation psychiatrists
  - clinical psychologists
  - nurses
  - occupational therapists
  - social workers
  - approved mental health professionals
  - support workers (including peer support workers)
  - specialist mental health pharmacists
- The multidisciplinary team should have access to physical exercise coaches, vocational trainers, welfare rights specialists, dietitians or nutritionists, podiatrists, speech and language therapists and physiotherapists

Inpatient rehabilitation

- There are different types of inpatient rehabilitation unit (see RCPsych typology – high dependency, community, highly specialist) https://www.rcpsych.ac.uk/docs/default-source/members/faculties/rehabilitation-and-social-psychiatry/mental-health-inpatient-rehabilitation-services-typology-table-20-3-19.pdf?sfvrsn=8fc19480_4
- Inpatient rehabilitation services should have an expected maximum length of stay (which should be used as a guide rather than an absolute) to reduce the chance of people becoming ‘institutionalised’
- Consider using a standardised tool to assess, monitor and drive up quality

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	High Dependency Rehabilitation Unit	Community Rehabilitation Unit	Longer Term High Dependency Rehabilitation Unit	Highly Specialist Inpatient Rehabilitation Unit
Client group	Severe symptoms, (multiple) co-morbidities, significant risk histories, ongoing challenging behaviours. Most patients detained under MHA. Most referrals (80%) come from acute inpatient units, and 20% from forensic units.	Ongoing complex needs so cannot be discharged directly from high dependency rehab unit to supported accommodation. Most referrals from high dependency rehab unit or acute inpatient unit. Can take detained patients if registered as a ward (may have CTO/S41 patients if not registered as ward).	High levels of disability from treatment refractory symptoms and/or complex co-morbid conditions that require longer period of inpatient rehabilitation to stabilise. Significant associated risks to own health/safety and/or others. Most patients detained under MHA. Most referrals from high dependency rehab unit.	Specific co-morbidities that require very specialist approach e.g. psychosis plus traumatic brain injury, degenerative neurological disorder or autism. Challenging behaviour is often a significant issue.
Focus	Thorough assessment, engagement, maximising benefits from medication, reducing challenging behaviours, psychosocial interventions, re-engaging with families and communities. Step down for forensic services and repatriation of people from out-of-area placements.	Facilitating further recovery, managing medication (self-medication), psychosocial interventions (CBT, family work), gaining skills for more independent living including ADL skills and community activities (leisure, vocational).	To stabilise symptoms adequately such that function improves and move on to a less supported component of the rehabilitation pathway becomes feasible. Interventions as for high dependency and community rehab units in a highly supported setting.	To stabilise symptoms and challenging behaviours adequately. Managing challenging behaviours and physical aspects of co-morbidities is key.
Recovery goal	Move on to community rehabilitation unit or supported accommodation.	Move on to supported accommodation	Move on to community rehabilitation unit or supported accommodation.	Move on to a specialist, long term supported accommodation facility.
Location	Usually hospital based	Community based	Usually hospital based	Hospital based
Length of stay	Up to 1 year	1-2 years	3+ years	2+ years
Functioning	Domestic services provided, but ADL skills encouraged through OT	Self-catering, cleaning, laundry, budgeting etc with staff support	Domestic services provided, but ADL skills encouraged through OT	Domestic services provided. Physiotherapy, speech and language therapy and OT provided to improve all aspects of functioning
Risk management	Controlled access ('locked'). Higher staffed, full MDT	"Open" units. Staffed 24 hours by nurses and support workers with regular input from MDT.	Controlled access. Higher staffed, full MDT. May have air lock and higher staffing than standard HDRU if target client group require this.	Usually controlled access. Higher staffed, full MDT plus physiotherapy and SALT. Unlikely to need airlock.

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Community rehabilitation teams

For people with complex psychosis living in supported accommodation, specialist clinical care should be provided by a multidisciplinary community rehabilitation team that should:

- hold overall clinical responsibility for their mental health while they are living in the community
- provide a designated care co-ordinator for each person but operate with a shared team caseload approach
- make the majority of contacts with the person in their home rather than at the team base
- work closely with staff at the person's supported accommodation to tailor people's care plans to their needs and clarify which staff are responsible for providing specific treatments and support
- support and oversee the person's progression through the rehabilitation pathway by:
  - increasing the intensity of treatment and support during periods of relapse
  - providing ongoing contact and support during periods of inpatient care and enabling discharge as soon as possible
  - adjusting care plans to enable the person to gain the skills and confidence to manage in more independent accommodation
- liaise with the person's GP about their physical healthcare
- liaise with the relevant service when the person is ready to be discharged from the team to ensure a smooth transition

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1.6 Recovery orientated rehabilitation services

- Staff in rehabilitation services should aim to foster people's autonomy, help them take an active part in treatment decisions and support self-management.
- Staff should build on people's strengths and encourage hope and optimism by:
  - helping people choose and work towards personal goals, based on their skills, aspirations and motivations
  - developing and maintaining continuity of individual therapeutic relationships wherever possible
  - helping them find meaningful occupations (including work, leisure or education) and build support networks using voluntary, health, social care and mainstream resources
  - helping people to gain skills to manage both their everyday activities and their mental health, including moving towards self-management of medication
  - providing opportunities for sharing experiences with peers
  - encouraging positive risk-taking
  - developing people's self-esteem and confidence through validating people's achievements and celebrating progress
  - recognising that people vary in their experiences and progress at different rates
  - improving people's understanding of their experiences and the treatment and support that may help them – for example, through accessible written information, face-to-face discussions and group work

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Universal staff competencies

- Ensure that staff training emphasises recovery principles so that all rehabilitation staff work with a recovery-orientated approach.
- Staff should establish and maintain non-judgemental, collaborative relationships with people with complex psychosis
- Provide support for staff to acknowledge and manage any feelings of pessimism about people's potential for recovery. Support could include helping staff to share experiences and frustrations with each other, for example through supervision, reflective practice and peer support groups
- Ensure staff attend appropriate diversity training and have the skills and competence to deliver non-discriminatory practice and understand that people may experience stigma resulting from their mental health condition, alongside stigma related to being in a minority group
- Ensure that **all** staff are trained and skilled in supporting structured group activities and promoting daily living skills.
- Ensure that staff have skills and competence in risk assessment and management to an appropriate level for the service they work in
- Ensure that staff are competent to recognise and care for people with psychosis and coexisting substance misuse.

Maintaining and supporting social networks

- Discuss with the person whether, and how, they want their family or carers to be involved in their care. Discuss this at regular intervals to take account of any changes in circumstances.
- Ensure that staff receive training in the skills needed to negotiate and work with families and carers, and in managing issues related to information sharing and confidentiality.
- Respect the rights and needs of carers alongside the person's right to confidentiality. Review the person's consent to share information with families and carers and other services regularly
- Give families and carers information about support services in their area that can address their emotional, practical and other needs
- Enable the person to maintain links with their home community by:
  - supporting them to maintain relationships with family and friends, e.g. by finding ways to help with transport
  - helping them to stay in touch with social and recreational contacts
  - helping them to keep links with employment, education and their local community activities. This is particularly important if people are in an out-of-area placement.

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1.7 Person centred care planning

- Offer people a **comprehensive biopsychosocial needs assessment** by a multidisciplinary team within 4 weeks of entering the rehabilitation service.
  - developmental history: milestones; relationships with family and peers; problems at school (problems with social or cognitive functioning, motor development and skills or coexisting neurodevelopmental conditions); occupational and educational history
  - psychological history: relationships, abuse and trauma, coping strategies, strengths, previous psychological or psychosocial interventions
  - social history: accommodation history; culture; ethnicity; and spirituality; leisure activities; finances; current social network including any caring responsibilities; use of substances
  - psychiatric history: past admissions and treatments; response to treatments; side effects; adherence
  - medicines reconciliation by a specialist mental health pharmacist
  - vulnerabilities and risks: self-neglect, exploitation and abuse, risk of harm to self and others
  - current skills in activities of daily living
  - cognitive impairment and capacity

  Be aware that people with complex psychosis often have comorbid mental health problems

  (e.g. anxiety, OCD, ASD, ADHD, BPD, acquired brain injury, cognitive impairment, substance misuse)

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Physical health assessment

- Offer a physical health check as part of the comprehensive assessment including:
  - BMI; waist circumference; pulse and blood pressure; bloods (FBC, U&E, LFTs, HbA1c, lipids, TFTs, prolactin levels, calcium); medication levels (clozapine, mood stabilisers); ECG
  - smoking, alcohol and illicit substance use
  - nutritional status, diet and level of physical activity
  - continence and constipation (particularly if the person is on clozapine)
  - movement disorders
  - sexual health
  - vision, hearing and podiatry
  - oral inspection of general dental health
  - any difficulties with swallowing
- Be aware that people with complex psychosis often have comorbid physical health problems (e.g. obesity, diabetes, cardiovascular disease, COPD,)

Care planning

- Use the results of the comprehensive assessment to make a team formulation to inform treatment and care planning. The care plan should:
- be developed collaboratively with the person
- include the person's personal recovery goals
- clarify actions and responsibilities for staff, the person themselves and their family or carers
- Review people's progress and care plans with them at multidisciplinary care review meetings at least:
  - every month in the inpatient rehabilitation service
  - every 6 months in the community.
- Incorporate both staff-rated and service user-rated measurements of the person's progress into their care plan reviews, so that their support can be adjusted if needed.
- Update care plans according to changes in the person's needs after these meetings and between meetings as needed. At every meeting or review, consider and plan with the person their transition to the next step in the rehabilitation pathway.
- Ensure that care plans are shared with the person and everyone involved in the person's care (clinicians, supported accommodation staff, family and carers, if the person agrees) at each review, each transition point in the rehabilitation pathway and at discharge from the service.

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1.8 Rehabilitation programmes and interventions

- Promote activities to improve **daily living skills** (self-care, housework, laundry, shopping, cooking) as highly as other interventions
- Provide activities to help people develop and maintain daily living skills – individually tailored, goal focused, real-life settings (kitchens, laundry facilities)
- Offer structured group activities (social, leisure or occupational) aimed at improving **interpersonal skills**. These could be peer-led or peer-supported and should be offered: daily in inpatient rehabilitation services; at least weekly in community settings.
- Offer regular opportunities (e.g. 'community meeting') to discuss the choice of group activities
- Offer regular one-to-one sessions with a named member of staff (primary nurse, keyworker, care co-ordinator) to help the person plan and review their activity programme
- Programmes to engage people in **community activities** should
  - be flexible and make reasonable adjustments to accommodate the person's illness and fluctuating needs
  - be individualised
  - develop structure and purpose in the person's day
  - aim to increase their sense of identity, belonging and social inclusion in the community
  - involve peer support
  - recognise people's skills and strengths

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Leisure, education and employment

- Offer people the chance to be involved in a range of activities that they enjoy, tailored to their level of ability and wellness
- Offer people a range of educational and skill development opportunities, for example, recovery colleges and mainstream adult education settings, which build confidence and lead to qualifications if the person wishes
- For people who would like to work towards mainstream employment, consider referring them to supported employment that uses the Individual Placement and Support approach
- Take into account and advise people about the impact of supported employment on their welfare benefits.
- For people who are not ready to return to paid employment, consider alternatives such as transitional employment schemes and volunteering
- Consider providing a cognitive remediation intervention alongside vocational rehabilitation services.
- Develop partnerships, for example with voluntary organisations and local employment advice schemes, to increase opportunities for support to prepare people for work or education

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1.9 Adjustments to mental health treatments in rehabilitation

- First - follow relevant NICE guideline (schizophrenia, bipolar affective disorder etc)
- Consider additional psychological interventions, especially for people who are not ready to engage in CBT e.g. mindfulness, therapeutically informed environments. Consider training all rehabilitation staff in motivational interviewing, positive behaviour support, behavioural activation, trauma-informed care.
- For people with complex psychosis whose symptoms have not responded adequately to an optimised dose of clozapine alone, consider augmenting clozapine with the following, depending on target symptoms:
  - an antipsychotic, for example aripiprazole for schizophrenia and related psychoses and/or
  - a mood stabiliser for psychosis with significant affective symptoms and/or
  - an antidepressant if there are significant depressive symptoms in addition to the psychotic condition

  Be aware of potential drug interactions and note that not all combinations of treatments may be in accordance with UK marketing authorisations. Any off-licence prescribing should be communicated in writing with the person's GP. Seek specialist advice if needed, for example from another psychiatrist specialising in treatment-resistant symptoms or a specialist mental health pharmacist. Do not offer valproate to women of childbearing potential, unless other options are unsuitable and the pregnancy prevention programme is in place. Follow the MHRA safety advice on valproate use by women and girls.

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Medication (abridged)

- Optimise the dosage (as tolerated) of medicines used to manage complex psychosis according to the BNF and therapeutic plasma levels in the first instance
- Only use multiple medicines, or doses above BNF or summary of product characteristics limits, to treat complex psychosis:
  - if this is agreed and documented by the multidisciplinary team and the person (and their family, carer or advocate, as appropriate)
  - as a limited therapeutic trial, returning to conventional dosages or monotherapy after 3 months, unless the clinical benefits of higher doses or combined therapy clearly outweigh the risks
  - if the medicines are being used to treat specific symptoms that are disabling or distressing
  - after taking into account drug interactions and side effects
  - if systems and processes are in place for monitoring the person's response to treatment and side effects (monitoring may include physical examination, ECG and appropriate haematological tests)

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Medication (abridged)

- Regularly review medicines used to manage complex psychosis and monitor effectiveness, adverse effects (including constipation for those taking clozapine) and drug interactions
- If pharmacological treatment is not effective, **consider stopping** the medicine:
  - following a thorough review of treatment
  - after agreeing and documenting the decision at a meeting with a multidisciplinary team and the person (and their family, carer or advocate, as appropriate)
  - with caution, particularly if the person has been on the medicine for many years
  - by reducing the dose slowly and closely monitoring the person for symptoms of relapse.
- Monitor drug levels to check adherence and guide dosing
  - At least annually and as needed for clozapine and mood stabilising anti-epileptic medicines (be aware that changes in smoking affect clozapine levels)
  - Every 3 to 6 months for people established on lithium
- Consider annual ECGs

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1.10 Physical healthcare (abridged)

- GPs should develop and use practice case registers to monitor the physical and mental health of people with complex psychosis in primary care
- For people having community rehabilitation, GPs should assume lead responsibility for the person's physical health needs, including health checks and treatment of physical health conditions, working collaboratively with the community mental health rehabilitation team and other services as relevant
- For people having inpatient rehabilitation, the rehabilitation team should ensure that health checks, treatment of physical health conditions and other healthcare needs are addressed
- Nominate a professional from the rehabilitation service to provide continuity of physical healthcare across settings, liaising between the rehabilitation service, primary care, secondary mental health and secondary physical healthcare
- The nominated professional should work in collaboration with a healthcare professional to develop and oversee the physical healthcare plan – this should address any physical health care problems, plus routine monitoring and health promotion/screening and clarify which practitioners are responsible

Breakout

- How will you identify people who need mental health rehabilitation services in your area?
- How can you ensure your services operate with a recovery based approach?

Comment shared in the chat:
"Identifying people requiring rehab services should include clear referral criteria that identifies rehab goals or reasons for referral. Use of scales will help to identify areas"

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Metrics and measures for mental health rehabilitation

NICE Guideline:

- 1.5.4 Consider using tools to support quality improvement such as the Quality Indicator for Rehabilitative Care (QuIRC) for inpatient rehabilitation units, and the QuIRC-Supported Accommodation (QuIRC-SA) for supported accommodation.
- 1.7.10 Incorporate both staff-rated and service user-rated measurements of the person's progress into their care plan reviews, so that their support can be adjusted if needed.

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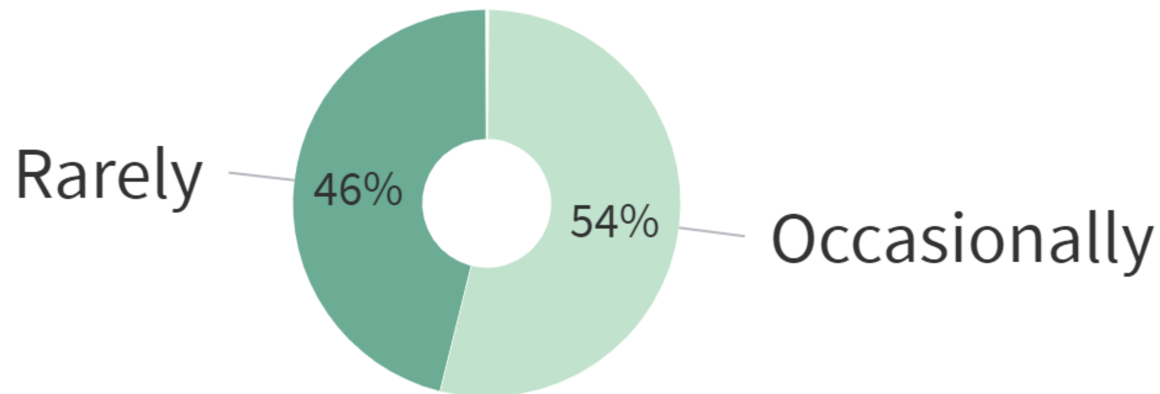
How often do you use outcome measures and metrics to inform your clinical practice?



Online Poll: All responses received

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Defining 'quality'

The effectiveness and safety of treatment and care alongside a positive experience for those who use services (Department of Health. *High Quality Care For All: NHS Next Stage Review final report*. London: The Stationery Office, 2008)

- **Effectiveness** - survival rates, measures of clinical improvement, patient-reported outcome measures
- **Safety** - doing no harm e.g. complication rates
- **Positive experience** - compassion, dignity and respect e.g. satisfaction

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Principles when choosing outcome measures and metrics

Data need to be:

- Available
- Collectable (brief measures, ideally free of copyright restrictions and fees)
- Meaningful (measures should have good psychometric properties – valid, reliable, and sensitive to change)
- Collatable (by data management systems that work!)
- Interpretable (by clinicians as well as performance departments)
- Useful at group and individual level
- Formattable so that results can be fed back in accessible form to staff and service users

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RCPsych recommended routine quality and outcome measures for mental health rehabilitation services

Service Quality

- QuIRC for inpatient units and QuIRC-SA for supported accommodation services

Clinical Improvement

Clinician Rated Outcome Measures

- General clinical improvement - Health of the National Outcome Scale (HoNOS)
- Needs - Camberwell Assessment of Needs Short Appraisal Scale (CANSAS)
- Social function - Life Skills Profile (LSP)

Patient Reported Outcome Measure

- Quality of life - DIALOG (based on seven domains of Manchester Short Assessment of QoL)

Patient experience

- Patient Reported Experience Measure – Family and Friends Test

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Quality Indicator for Rehabilitative Care (QuIRC)

- Standardised quality assessment tool for use in longer term mental health services
- Completed by manager / senior staff member on-line – takes about 45 minutes
- Psychometric properties: excellent inter-rater reliability, good internal consistency, good convergent validity

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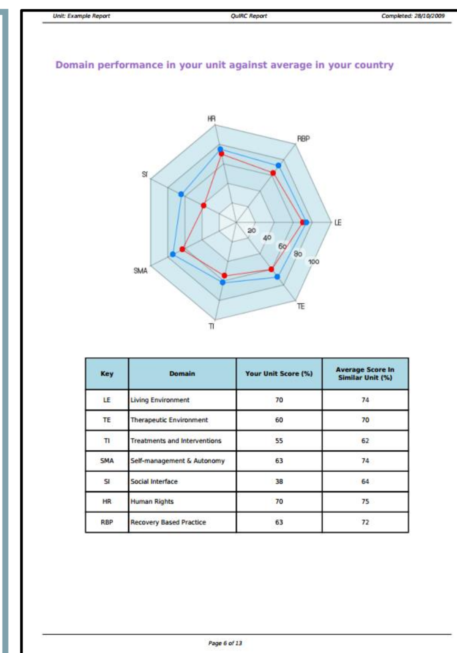
Quality Indicator for Rehabilitative Care (QuIRC)

143 items:

- Staffing, training, supervision
- Built environment/facilities
- Evidence based interventions
- Activities (in and outside the service)
- Care planning processes
- Service user involvement
- Family support
- Promotion of autonomy and independent living skills
- Physical health promotion
- Management of challenging behaviours
- Complaints processes, confidentiality, access to advocacy and lawyer

Assess 7 domains of care:

- Living (built) environment
- Therapeutic environment
- Treatments and interventions
- Self-management and autonomy
- Social interface
- Human rights
- Recovery based practice



Unit: Example Report | QuIRC Report | Completed: 28/10/2009

Domain performance in your unit against average in your country

Key	Domain	Your Unit Score (%)	Average Score In Similar Unit (%)
LE	Living Environment	70	74
TE	Therapeutic Environment	60	70
TI	Treatments and Interventions	55	62
SMA	Self-management & Autonomy	63	74
SI	Social Interface	38	64
HR	Human Rights	70	75
RBP	Recovery Based Practice	63	72

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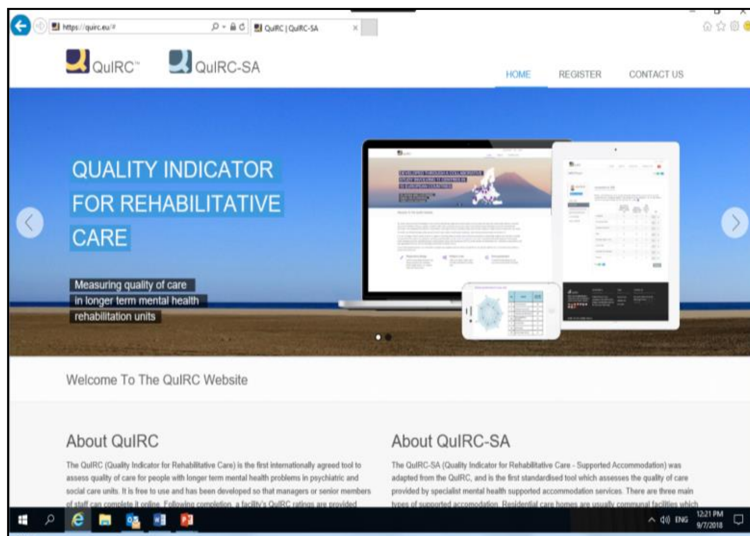
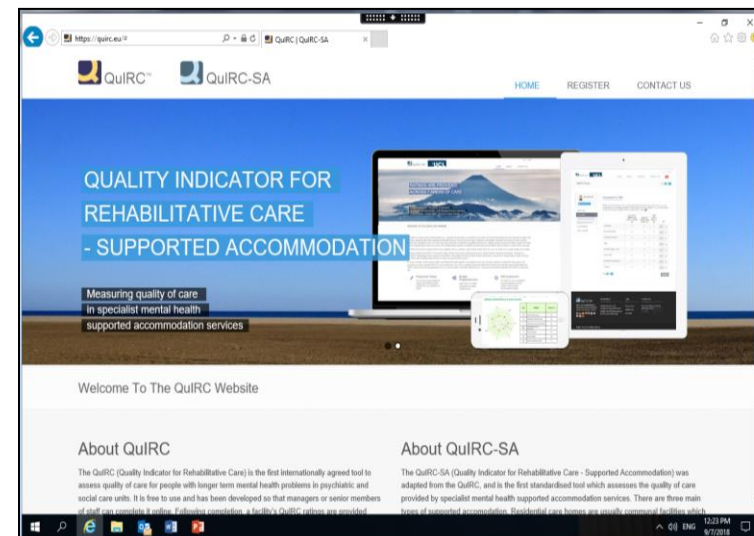
The Quality Indicator for Rehabilitative Care (www.quirc.eu)

>1000 current users;
Australia, Bulgaria, Brazil, Canada, Czech Republic, Germany, Greece, Italy, Ireland, Netherlands, New Zealand, Poland, Portugal, Spain, UK, US





Drivers of better outcomes in mental health rehabilitation

Predictors of outcome	OR (95% CI)	Study
Successful discharge from hospital associated with greater:		
• social skills	1.13 (1.04 to 1.24)	**REAL**
• engagement in activities	1.04 (1.01 to 1.08)	
• recovery orientation of service	1.03 (1.01 to 1.05)	
Successful move on to more independent accommodation associated with greater:		
• human rights promotion of service	1.09 (1.02 to 1.16)	**QuEST**
• recovery orientation of service	1.06 (1.00 to 1.11)	

Recovery orientation domain

Therapeutic optimism
Expected maximum length of stay
Collaborative, individualised care planning
Strengths based approach
Supporting the person to gain/regain ADL skills
Service user involvement in running the service
Ex-service users employed in the service

Human rights domain

Access to legal representative
Access to advocate
Assistance to vote in elections
Privacy/dignity
Confidential case notes
Access to communication (phone, email)
Complaints procedures

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Camberwell Assessment of Need Short Appraisal Scale

Phelan et al., (1995) *BJP, 167:* 589–595; Slade et al., (1998) *Psych Med, 28:* 543–550.

Assesses 22 domains

- 0=no problem (no need)
- 1=no/moderate problem due to help given (met need)
- 2=serious problem regardless of whether help given (unmet need)

- Staff, service user and carer versions available
- Good inter-rater reliability
- Clinicians do not need specific training
- Takes about 10 minutes
- Change in proportion of met: unmet needs over time gives a measure of service's performance
- Useful for care planning

- Food/diet
- Psychotic symptoms
- Accommodation
- Psychological distress
- Looking after the home
- Self-care
- Daytime activities
- Finances/budgeting
- Physical health
- Understanding of mental health problems
- Safety to others
- Safety to self
- Social supports
- Welfare benefits
- Alcohol
- Substances
- Transport
- Relationships
- Sexual expression
- Literacy/numeracy/language
- Child care
- Telephone

Life Skills Profile

Parker G, Rosen A, Emdur N, Hadzi-Pavlov D. The Life Skills Profile: psychometric properties of a measure assessing function and disability in schizophrenia. Acta Psychiatrica Scandinavica, 1991;83:145–52.

- Clinician rated measure
- Developed in Australia for assessment of social function of people with schizophrenia
- 39 items assess 5 sub-scales:
  - Self care
  - Non-Turbulence
  - Social Contact
  - Communication
  - Responsibility
- Each item rated between 1 and 4: total score range = 39-156

- Do not need specific training
- Takes about 10 minutes
- Good psychometric properties
- Used routinely in Australia
- Shorter versions available:

  LSP-20

  LSP-16

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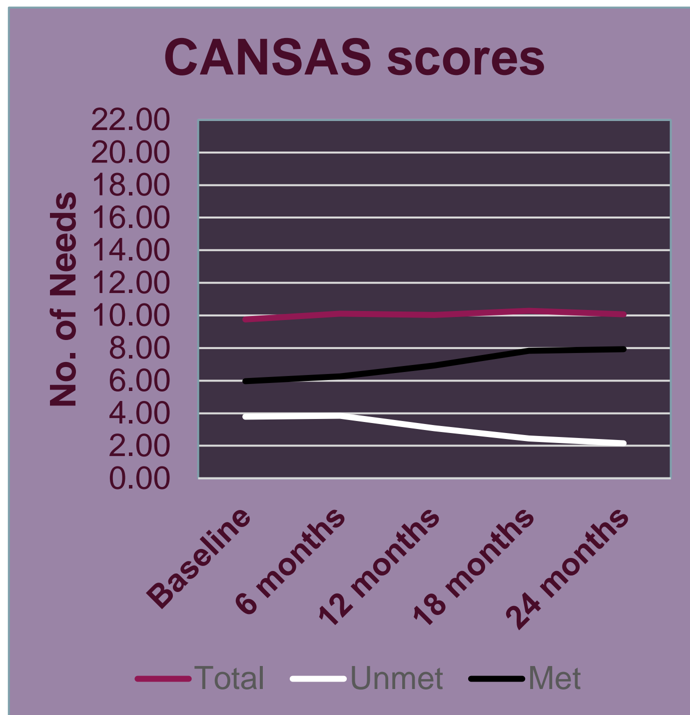
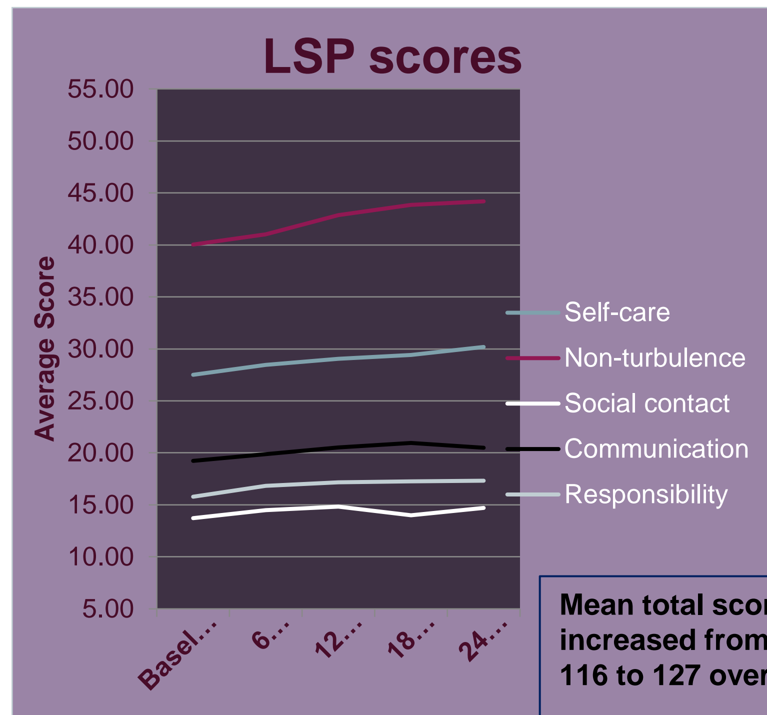
Islington community mental health rehabilitation team – clinician rated routine outcome measures





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DIALOG

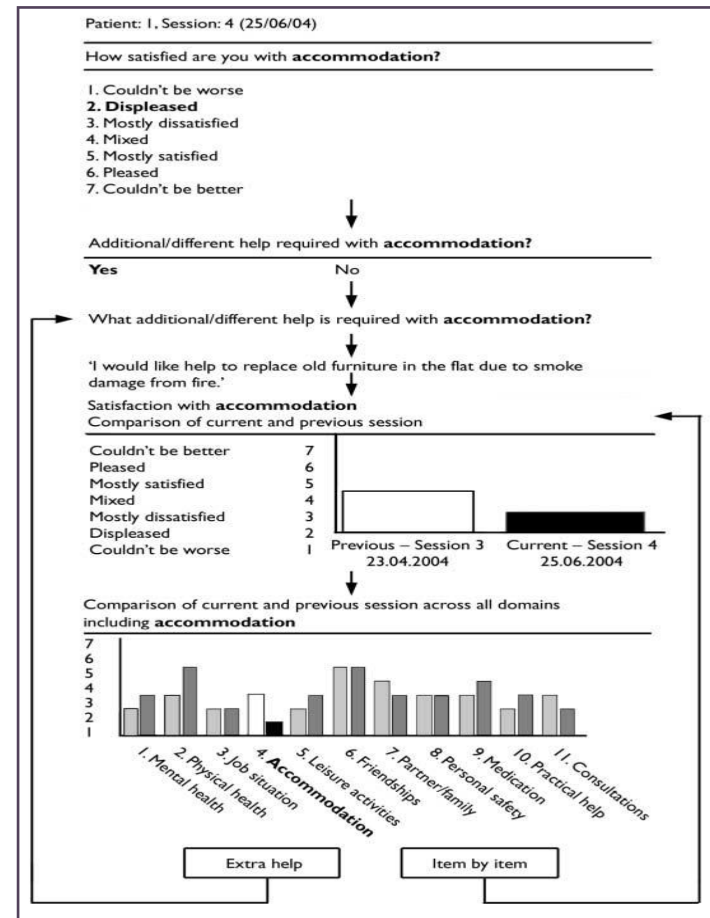
Priebe, S., McCabe, R., et al (2007) Structured patient–clinician communication and 1-year outcome in community mental healthcare: Cluster randomised controlled trial. *British Journal of Psychiatry*, November 2007 191:420-426

- Patient Reported Outcome Measure
- Provides structure for communication between service user and clinician (can be an intervention in itself)
- Minimal training required
- Useful for care planning as well as monitoring change over time
- Electronic (handheld device/app) and paper versions

11 domains

- Mental health
- Physical health
- Job situation
- Accommodation
- Leisure activities
- Family relationships
- Friendships
- Personal safety
- Medication
- Practical help
- Meetings with MH professionals

- Score 1- 7 on each item



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Family and Friends Test

One item from Client Satisfaction Questionnaire; Reichheld, F. F. (2003). The one number you need to grow. Harvard Business Review, 81(12), 46-55.

How likely are you to recommend our services to friends and family if they needed similar care or treatment?

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don’t know

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RCPsych recommended routine quality and outcome metrics for mental health rehabilitation services

Patient Safety

- Number of serious incidents/deaths
- Number (%) service users who receive annual physical health check
- Number (%) of service users with complex psychosis placed out of area

Clinical Improvement

- Length of stay (expected LoS different for different components of rehabilitation pathway)
- Number (%) readmitted within certain timeframe
- Number (%) whose community placement breaks down within specific timeframe
- Number (%) service users discharged to community or move on to less supported accommodation within expected timeframe without readmission/placement breakdown
- Number (%) service users participating in work, education, leisure

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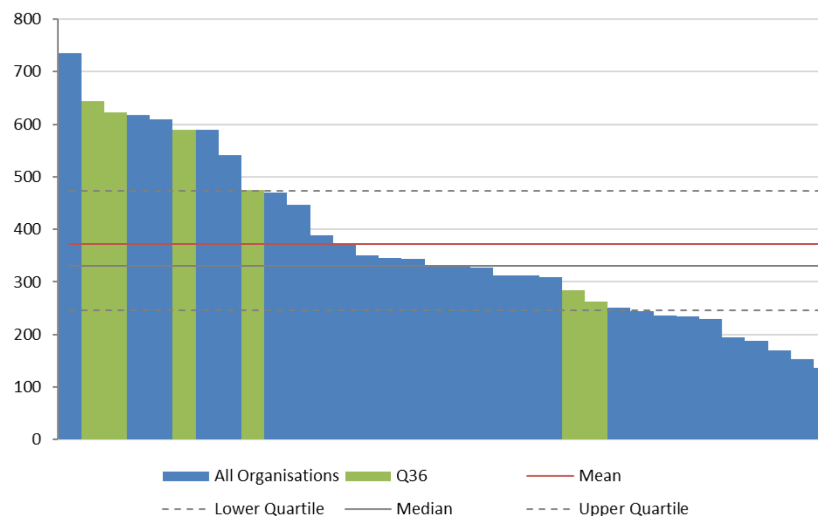
High Dependency Rehabilitation Units – length of stay (2016-17)

- Average 372 days for patients discharged in year

- London units highlighted in green



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Final thoughts

- No getting away from the need to collect and report routine data
- ✓ Make it useful
- ✓ Make it meaningful
- ✓ Make it as simple as possible

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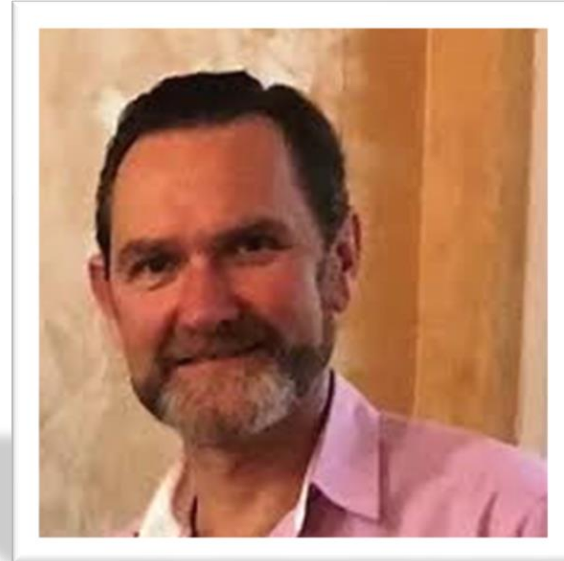
Many thanks for your attention!

h.killaspy@ucl.ac.uk

RANZCP Updates



Dr Nicholas Burns

Director of Forensic Mental Health Services, Orange Health Service

Health

UPDATES

DR NICK BURNS

NICHOLAS.BURNS@HEALTH.NSW.GOV.AU

NSW SUBCOMMITTEE OF THE BINATIONAL SECTION OF SOCIAL, CULTURAL AND REHABILITATION PSYCHIATRY

- Supported by Binational committee and NSW Branch RANZCP
- Some but not all states have a subcommittee
- Informal meetings at this stage until formal College elections in 2021.
- First meeting 2020
- Acting chair
- Meet quarterly, including at College Congress
- Discussion based around education and training, advocacy, partnerships, standards of care
- direct links to NSW Branch of the College and the binational committee

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ADVANCED TRAINING IN REHABILITATION PSYCHIATRY PILOT PROGRAM

- currently being developed by binational committee and the RANZCP
- Thanks to generous seed funding from Ministry of Health through PCLI
- Will form part of a formal advanced training stream in Rehabilitation psychiatry

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- Pilot program to commence in NSW IN 2021, February/March
- 6 months duration
- Initial cohort, 5-10 candidates
- Entry point; seeking volunteers through NSW Branch of the College. For psychiatrists and stage 3 trainees working in the field

3 STAGE PROCESS

STAGE 1

- Online educational package for completion at candidate's own pace
- 15 topics with key references provided
- Online survey to assess candidate's knowledge
- Survey will form part of evaluation, with before and after scores

STAGES 2 AND 3

- Designed as ‘Entrustable Professional Activities’
- Topics taken from stage 3 of general adult stream and drug and alcohol stream
- In line with Royal College of Psychiatrists’ advanced training scheme

STAGES 2 AND 3

- 1-2 topics per stage
- Work based activities
  - Either case-based discussion or journal club-style presentation reviewing key literature
- 6 times 2 hour sessions, in groups of 5 to 10
- Expert preceptors from across Australia, NZ and the UK (Dark, Harvey, Killaspy)

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- Not accredited yet
- No badge of honour (not a certificate)

alamy stock photo

EVALUATION PROCESS IN 2021

- Hoping to attract ongoing funding through the College

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WHITE BOARD KEY ISSUES

ACTIONING THE KEY ISSUES WE HIGHLIGHTED FROM OUR MEETING IN MARCH 2020

THE QUESTIONS WE DISCUSSED

- **Are the existing systems for complex care working?**
- **Where are they working well?**
- **What can we do better?**
- **What is needed to support rehabilitation psychiatry as a specific field in NSW?**
- **How can the College (RANZCP) assist?**

7 KEY AREAS OF CONCERN

1) TREATMENT AND MODELS OF CARE

- **Defining complex care and who is part of this remit**
- Early detection of people needing rehab
- Individualized care plans, not one size fits all
- Providing continuity of care, planning for the long term
- Looking at the evidence for what works, practice guidelines and models in other jurisdictions
- Promoting early use of clozapine
- Symptom control vs function
- Length of stay, should it be prescribed?
- Don't expect linear progress

7 KEY AREAS OF CONCERN

2) REFLECTIVE PRACTICE

- **Encouraging research, including outcomes research**
- Bench marking (eg staffing skills and mix, use of evidence-based practices)
- Fostering links to academic institutions

7 KEY AREAS OF CONCERN

3) ADVOCACY AND EQUITY

- **Improving how we deal with complex cases at a state-wide level**
- Service mapping; Identifying gaps in service across the state
- Sharing the burden, capacity for community to cope with intensive services such as forensic services
- Access to NDIS
- Connectivity across the state, working as a state-wide network
- Differing types of service needed, eg community/residential/subspecialty units forensic

Response to how to further action the key area:
"Use of consumer/carer feedback;
settling on outcome measures statewide;
adoption of statewide rehab framework;
rehab services being vulnerable to cannibalisation;
need for local leadership, to protect and enhance turf;
knowing what services are where;
development of statewide network"

7 KEY AREAS OF CONCERN

4) CAPACITY BUILDING

- **Developing specialist clinical skills and specialist clinicians**
- Maintaining standards of care. Links to best practice guidelines and benchmarking
- Developing a specialist training scheme in rehabilitation psychiatry

7 KEY AREAS OF CONCERN

5) FOSTERING STRONG PARTNERSHIPS

- **Improving relationships with non-health sector services, such as NDIS and housing agencies**
- With other specialist health services, especially drug and alcohol services
- Housing services and improving access to good housing, looking at different models for supported housing

7 KEY AREAS OF CONCERN

6) STRONG LEADERSHIP

- **Developing links to high level policy development**
- Ensuring we have a voice at all levels of management; LHD, college, ministry
- Organizing groups such as binational committee and subcommittee, will provide direct link to college and ministry bypassing LHDs
- Joining other organizations such as World Rehab Association
- Presenting at college conferences
- Processes for developing strong leadership

7 KEY AREAS OF CONCERN

7) SERVICE USER VOICE

- **Acknowledging and incorporating marginalized sectors of the population; eg homeless people, prisoners**
- Accommodating diversity in our services

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LHD Presentations: Modes of Care / Measurement

Comment shared in the chat:
"It is great to hear the presentations. so, THANK U!"

NSW GOVERNMENT | Health

Dr Justine Hoey Thompson
North Coast Area Health Service

What services do you have in your LHD that provide rehabilitation or non-acute care?

- 20 bed subacute mental health unit
- Byron Central Hospital
- 28 day programme though 3-6 months rehab also available
- Staff- 0.8 Clin Psych, 2x OT, 0.6 SW
- 2 peer support workers
- 0.5 exercise physiologist
- Mix of RNs and ENs
- 3 reg's, 2 psychiatrists- 0.6, 0.4.
- Admin full time

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What is/are the model(s) of care of those services?

- "Step up/step down" 28 day short stay subacute unit
- Principles pf recovery focused, person centred and trauma informed care
- Can provide rehab for 3-6 months- recovery based treatment and rehabilitation to people whose needs cannot be met by less intensive community based adult mental health services
- For residents of NNSWLHD
- Primary diagnosis of a moderate to severe mental illness
- Core age group 18-64
- No longer at acute risk to self and/or others
- With stable physical health not requiring acute medical or surgical intervention
- Expected patients have identified goals as part of admission
- Should demonstrate a willingness to engage in individual and group therapeutic activities
- Legal status voluntary of involuntary
- Exclusion also those with a primary diagnosis of intellectual disability, substance abuse, dementia, ABI, Borderline PD

a) What are the strengths of your services?

- Strong, enthusiastic multidisciplinary team- including peer support, exercise physiology
- Attractive, new ward- single rooms and bathrooms
- Linked in well with CMO and employment agencies
- In-reach with A&D
- Trauma informed care and treatment

b) What are the challenges or outstanding service needs?

- Outstanding needs- cognitive remediation for major mental illnesses, and also lack dietician and physicians- unable to have people here with eating disorders.
- Challenges- Pressures to take people with borderline PD due to lack of access to care in community

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Sydney Local Health District

Mobile Assertive Treatment Team (MATT)

Assertive Outreach Team (AOT)

Dr Kerri Eagle

Comment shared in the chat:
"Great services Kerri. Wonder to what extent such services are entrenched across other LHD's"

Rehabilitation/Non-acute Services

- Community assertive MH services (MAT/AOT)
- Inpatient MH rehabilitation units: CCMH Kirkbride/Broughton
- Buduwa, step-down care, short term recovery focussed residential support
- MATT:
  - Located at Camperdown CHC
  - Camperdown, Redfern, Marrickville catchment areas
  - 100 patients:
    - Mental illness, enduring and severe
    - Multiple admissions, lengthy admissions +/-
    - Unable to be supported with standard CORE services
    - Functional disability
    - At risk accommodation
  - Staff:
    - 0.6 Staff Specialist
    - 1.0 Registrar
    - 1.0 Team Leader
    - 11 FTE MH clinicians
    - 1.0 Peer Support Worker
- AOT:
  - Located at Croydon CHC: Croydon and Canterbury catchment
  - 80 patients: 0.4 SS, 1.0 registrar, 1.0 Team Leader, 8 FTE MH clinicians, 2.0 peer support

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MATT cont

- Assertive CC and psychosocial support (7 days week, 8am to 9pm)
- MDT:
  - Psychologist
  - Social workers
  - Nurses
  - OT
- Medical supervision, new virtual medication supervision trial
- Supported accommodation (Camperdown flats 24/7 support; Lilyfield drop in support) and housing needs
- Outreach clinics (Common Ground)
- Functional support/vocational support, establishment of NDIS, oversight of implementation of additional supports
- AOD liaison, dedicated AOD worker to be employed
- Inreach to inpatient units
- Collaboration with AOT
- Clinics/groups/digital literacy

Strengths/Challenges

- Strengths:
  - Commitment to assertive community treatment
  - MAT/AOT well established teams
  - Stable relationships with inpatient teams and collaboration/inreach
  - Flexible, MDT, responsive MH care
  - Highly skilled teams
- Challenges:
  - Limited integrated AOD support
  - Acute bed pressure
  - Insufficient supported accommodation options
  - Long term (non forensic) inpatient and residential facilities for the high risk cohort with SMI

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NON ACUTE SERVICES WSLHD

Prepared by Dr Pradeep Jarabandahalli
Director-Rehabilitation services
Cumberland Hospital

November 2020

Health
Western Sydney
Local Health District

Services

110 Non Acute beds at Cumberland

-40 contained beds

-70 cottage beds.

- 20 Sub Acute beds at Blacktown hospital.
- 24 Medium Secure Forensic beds Cumberland

Health
Western Sydney
Local Health District

Models of Care

- Current review and submissions for Non acute care MoC
- Sub acute MoC-existing with KPI of 90 day stay

Health
Western Sydney
Local Health District

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Strengths

- A comprehensive set up with access to wide range of Rehabilitative settings
- Brand new Pavilion opened for activities and by Dec 3rd we will move one unit of 20 beds to a brand new unit
- PCLI has a prominent presence.594 years worth transition.
- Supported by PCLI resources

NSW GOVERNMENT | Health Western Sydney Local Health District

Challenges/Reviews

- PCLI/NDIS transitions and flow through creating bed base especially in cottages
- Current-We are right bang in the middle of PLR construction site!

Health
Western Sydney
Local Health District

Dr Ness McVie
Clinical Director Forensic Psychiatry
Hunter New England LHD

- SLA with JHFMH to provide 30 inpatient beds to forensic patients (at Morisset Hospital)
- Currently about 30 forensic patients on Conditional Release managed by Community Mental Health teams in HNELHD

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MORISSET HOSPITAL

Health
Hunter New England
Local Health District

- Located on the south western shores of Lake Macquarie
- 91 bed non-acute mental health facility for adults with enduring mental illness
- High Support Unit (HSU) (Rosella) 14 beds
- Clinical Support Unit (CSU) 32 beds within cottage-style accommodation.
- Clinical Rehabilitation Unit (CRU) (forensic) 15 beds within the cottage-style accommodation.
- Medium Secure Unit (MSU) Kestrel Unit: 30 beds.

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Profile of Patients

- Forensic
- Civilian – can be difficult to manage mainly due to aggression, drug use, or absconding issues
- Majority with Dual Diagnosis
- Majority with Treatment Resistant Schizophrenia

NSW GOVERNMENT | Health
Hunter New England
Local Health District

What is the model of care of those services?

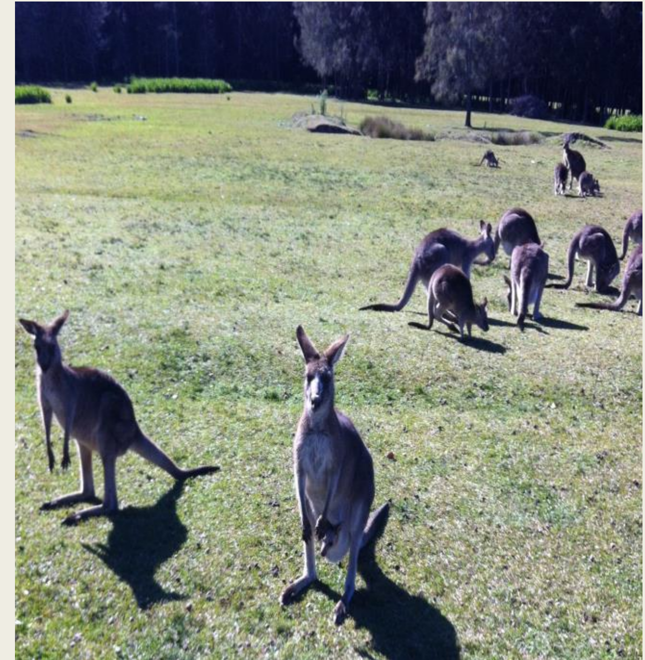
- Individual care plan
- Recovery focussed
- Aim to mobilise input from community services as early as possible to facilitate transition – community programs, housing, NDIS, CMHS
- Specialised Program – One door – programs and supervised day leave
- CCR 12 weeks; MDT 2-3 weeks

Rehab Programs include:

- Breakfast Club
- Toastmasters
- Tuesday bus trips
- Personal item shopping (escorted from Kestrel)
- Computer training
- Gym
- Car wash
- Social skills
- Ward jobs
- drug and alcohol
- Managing my mental illness
- Men’s health

a) What are the strengths of your services?

- Location
- Dedicated staff



b) What are the challenges or outstanding service needs?

- Location
- Outdated facilities
- Cottages accommodation
- Patient mix (risk vs health optimisation & least restrictive care)
- Lack of access to paid employment

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NEWCASTLE HERALD

VOICE OF THE HUNTER

$1.60 INC GST

Psychiatric Services

Psychiatric Rehabilitation Services

Adult General Psychiatry

Psycho-Geriatrics

Neuropsychiatry

Forensic Services

MORISSET HOSPITAL

Unit of the Hunter New England Health Service

NO CASUALTY UNIT

MENTAL HEALTH UNIT MURDER CHARGE

STABBED IN THE NECK

A MENTAL health patient allegedly plunged a knife into the neck of a fellow patient on the Morisset Hospital campus on Monday night, then threw the weapon into Lake Macquarie as the victim died from the single stab wound. Thomas Dillan Stone has been charged with the murder of the man he shared a cottage with in the low-security rehabilitation program, while Hunter New England Health has announced it will conduct its own investigation into the incident.

DAN PROUDMAN reports, P2

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Leesa Brown
Hunter New England LHD

Comment shared in the chat:
“Thanks Leesa. Absolutely the same case in WSLHD. The pace of discharges has resulted in more acute patients transferred to Rehab units. Acute units have become semi forensic units due to Silverwater catchment and weekend court and Rehab units have become more acute”

What services do you have in your LHD that provide rehabilitation or non-acute care?

PRS Morisset Hospital

ISMHU

Community Rehab

STEPS

Rehab Strea m

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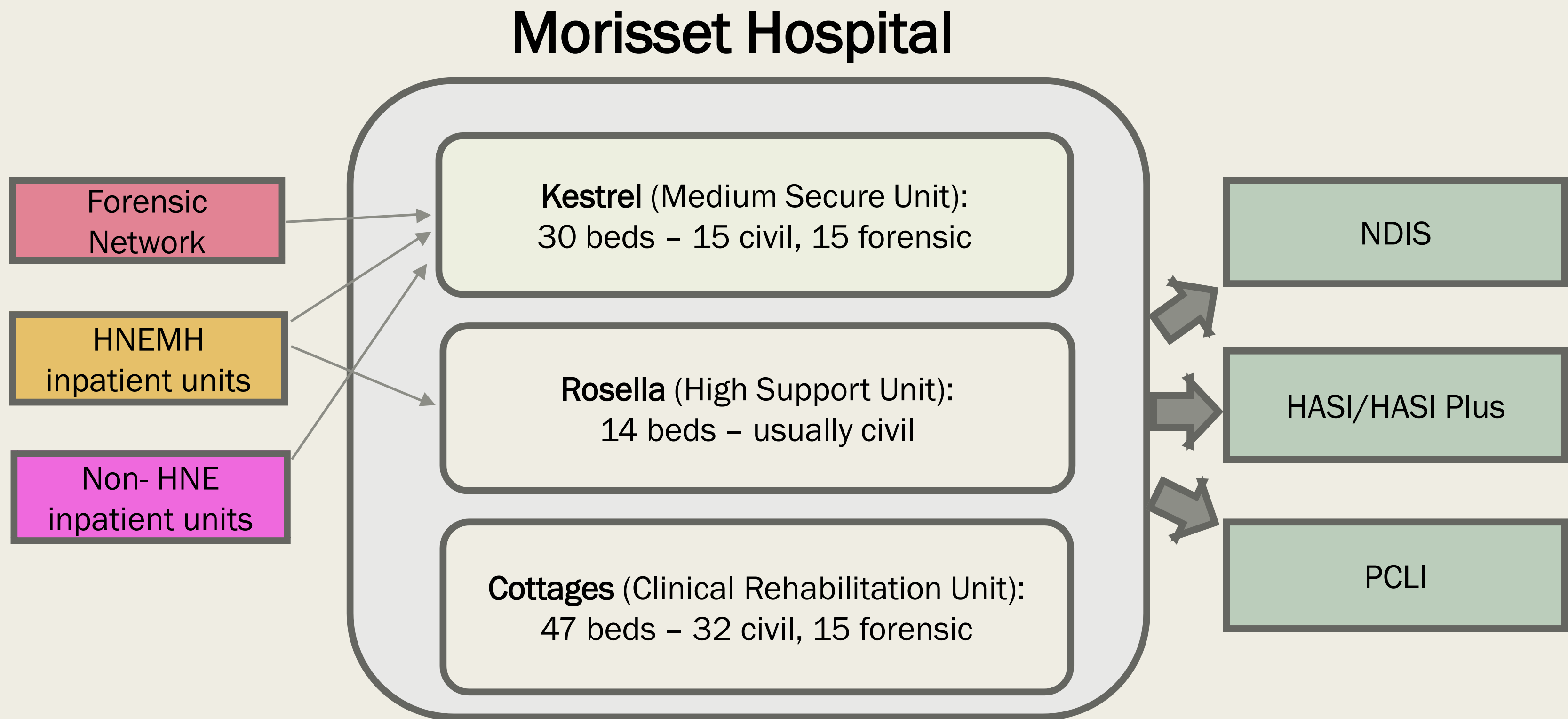
What is/are the model(s) of care of those services?



Morisset Hospital – Strengths, Challenges

- Model of Care - work in progress for last 4 years
- Strengths:
  - *High risk civil patients*
  - *Recovery focussed*
  - *Dramatic increase in discharges, short wait list*
  - *PCLI – Community Transition Team*
- Challenges:
  - *Outdated physical environment*
  - *Stand alone hospital*
  - *Physical health – dietitian, exercise physiologist, smoking, etc.*

ISMHU (Intermediate Stay Mental Health Unit)

- One of the 20 bed nonacute units
- Recovery focus, offering evidence-based interventions. 6 week program (shorter than other NAIPU)
- Accepts referrals from HNEMH inpatient units and community e.g. early psychosis service, CMHT, eating disorders service.
- Not in acute phase of illness, no current substance use
- Model of care being reviewed, may increase length of stay
- Challenges:
  - *Stand alone, no after-hours medical cover*
  - *Overflow from acute system*

Dr Maryanne O'Donnell,
Eastern Suburbs MHRU, SESLHD,

- Consultant lead in Eastern Suburbs MHS MHRU, 0.5FTE position
- Supported by 0.5FTE Reg
- Nursing staff NUM, CNC, RNs/ENs 2-3 on shifts/nights/rotation
- Allied health
  - *1.0 FTE Clin psych and students*
  - *1.0 FTE OT*

    1.0 FTE SW
- Peer Support/Peer Stoc
- Exercise Physiology student

What services do you have in your LHD that provide rehabilitation or non-acute care?

- ESMHS
  - *14 bed in patient rehab unit*
  - *Community Rehab- several rehab clinicians on each of 5 community teams*
  - *Rehabilitation Coordinator across service trying to integrate services more effectively*

- SGH/Sutherland
  - *20 bed inpatient rehab unit*
  - *Community rehab*

What is/are the model(s) of care of those services?

- Models of care
  - *Recovery focused*
  - *Person centred*
  - *Strengths based*

a) What are the strengths of your services? b) What are the challenges or outstanding service needs?

- **Strengths**
  - *Reasonable environment/Open ward/Peer support*
  - *Programs focused on reintegrating patients to community*
  - *Work closely with NDIS/NGOs/CMs*
  - *Physical health care-exercise physiology student*
- **Challenges**
  - *Rotation of nursing staff (inc NUMS, CNCs, care coordinators, casual staff)*
    - Difficulty with maintaining strengths based approach
    - Completing and adhering to care plans
    - Role of care coordinators
  - *Bed pressures*
    - Overflow from Acute units
    - Involuntary v voluntary rehab
    - Covid -19 disruption- Unit utilsed for subacute services, struggling to re-establish program
  - *Providing consistent group and individual programs*
    - Developing Cog Rem capacity
    - Intense SW/OT assessment for services; inhibits family therapies
  - *Need to improve organisation of rehab pathway, assessment processes and the delivery of our services*

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What are the **strengths** that you are experiencing in the non-acute care system in your district?

Live Poll Outcomes

“Great multidisciplinary team who are enthusiastic and work well together. We work closely with NDIS.”

“PCLI - community transition team.”

“Motivated and committed MDT”

“Well staffed with experienced people broad range of skills, great environment, Inreach from AOD, CMOs”

“We have a full fledged team of specialists and allied health staff”

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What are the **challenges** that you are experiencing in the non-acute care system in your district?

Live Poll Outcomes

"Bed pressure- transfer of inappropriate patients to the ward resulting changing the dynamics on the ward; Physical environment is unsuitable with no courtyard; Patients have no leave at the moment due to COVID 19 restriction which restricts community access; We don't have an exercise physiologist, who would be a great addition to the team. Model of care changed a few times and current one is under review - this has resulted in a lot of confusion around the referrals."

"Major issue with staffing."

"Overflow bed pressures, pressure to take people with borderline PD against evidence base, no cognitive rehab"

"Physical healthcare."

"Limitation is how intermediate stay unit is used sometimes for bed flow management"

"Wonder if short term rehabilitation units have a challenge in establishing clear roles within the service or they run a risk of becoming a sub-acute unit for a 'prolonged' acute admision and hence, the basic roles change."

"There is some work to be done in defining "intermediate/short – stay" and Sub acute vs non acute vs Rehab. Some answers hopefully will come from Benchmarking and advocacy of this forum."

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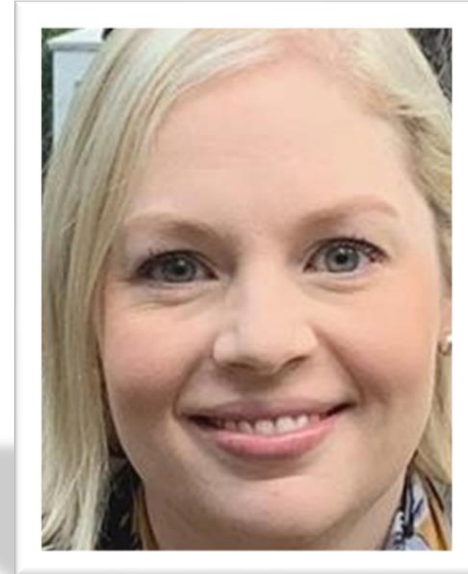
Non Acute Benchmarking



Jo Sharpe
Manager, Clinical Measurement & Benchmarking

NSW GOVERNMENT | Health

The Royal Australian & New Zealand College of Psychiatrists
New South Wales Branch

Non Acute Benchmarking

24 November 2020

Jo Sharpe
Manager, Clinical Measurement & Benchmarking
InforMH, System Information & Analytics Branch
NSW Ministry of Health

Have you attended a benchmarking event before?

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Online Poll: All responses received

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How do you feel about data?

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Online Poll: All responses received

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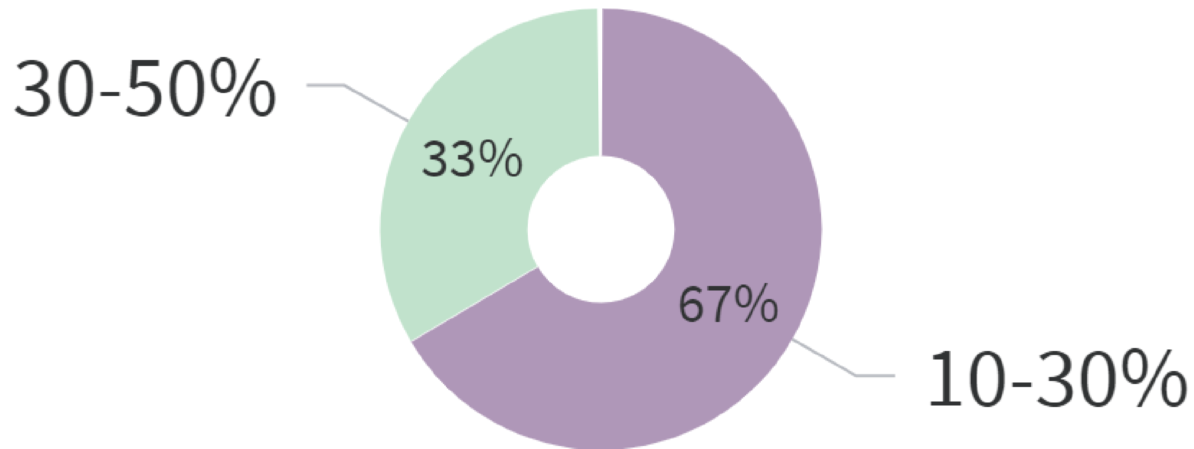
What proportion of beds are in our non acute services?



Correct answer: 33% (approximately)

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Online Poll: All responses received

Overview

- What is benchmarking?
- Non Acute Data Sources
- Clinical benchmarking in NSW
- Non Acute Peer Groups
- Previous benchmarking indicators

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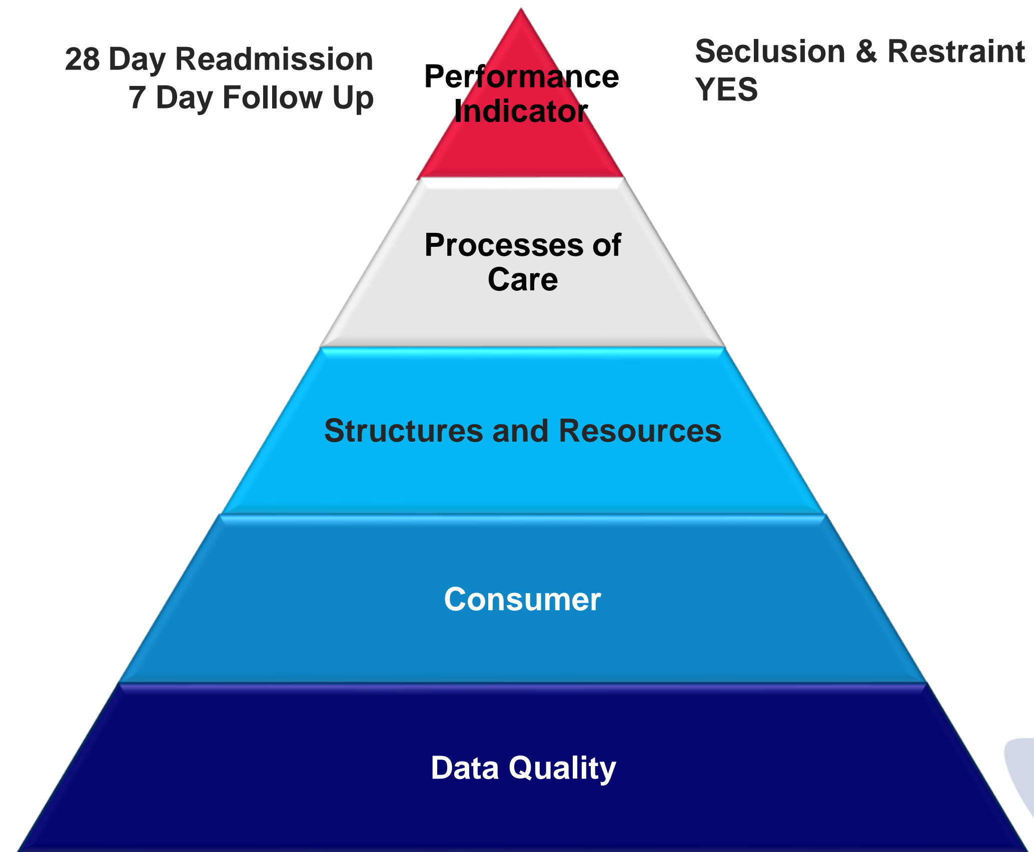
What is benchmarking?

"Using data to reflect on practice… understand variation between services … explore areas for best practice … foster a sense of **respectful enquiry and collaboration"**

- Feeding back and examining data about current practice
- Using data to understand similarities and differences in care
- Prompting and supporting service improvement



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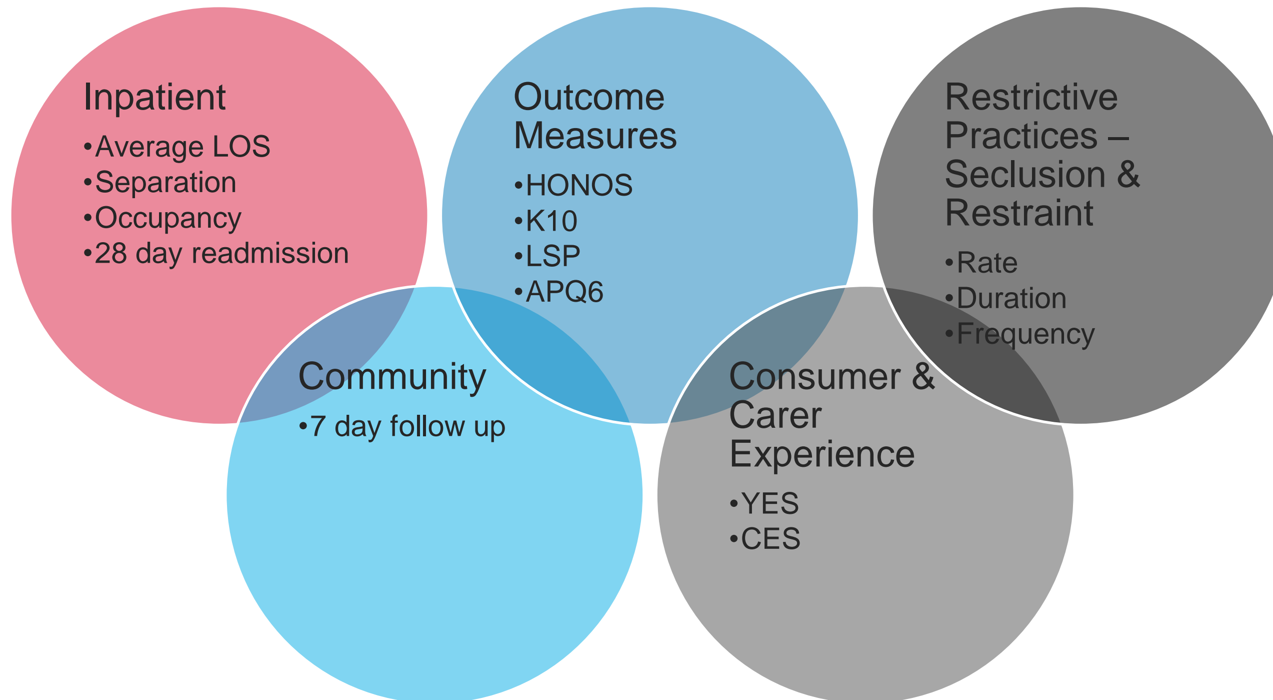
This information is provided to NSW public Mental Health services to support benchmarking. It is not for circulation outside of this purpose.

Non Acute Data Sources



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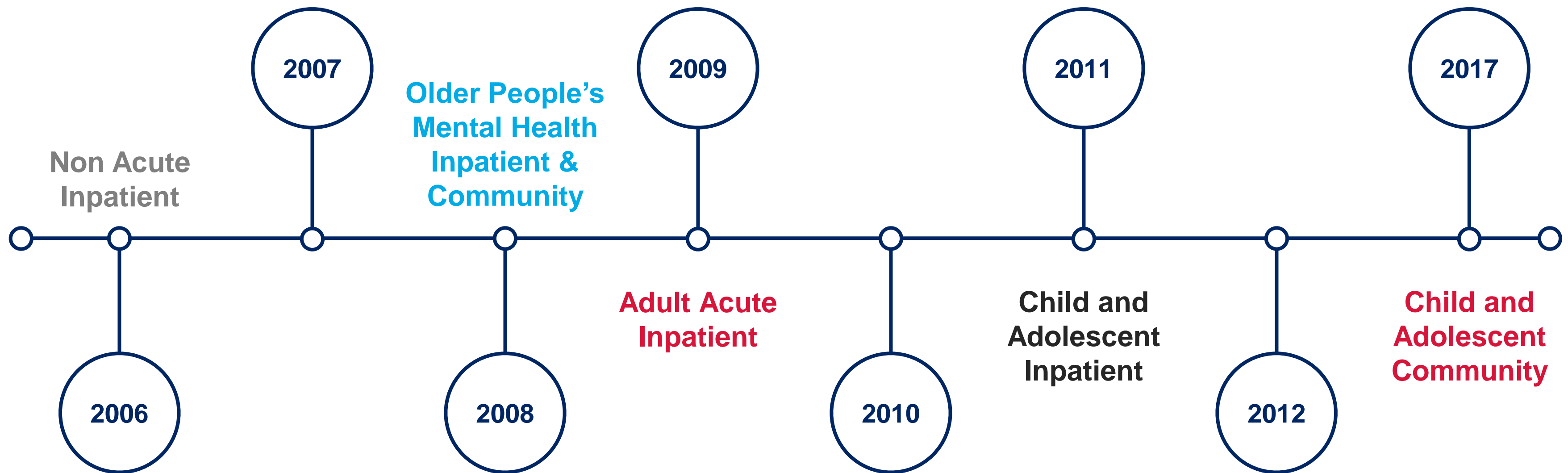
Clinical Benchmarking in NSW



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Previous Benchmarking Indicators for Non Acute

Indicator	Target		Data Source
	Rehab	Longer Stay Rehab	
Length of stay	150 days		InforMH
Readmissions within 28 days to a mental health unit	10%	10%	
Proportion of Overflow Patients	10%	10%	
Change in HONOS			
Follow up by CMHT within 7 days	100%	100%	
Proportion of patients staying >500 days	0%	<65%	
Staffing FTEs per bed			LHD
Staff trained in Recovery Oriented approach	90%	90%	
Staff trained in Substance Misuse interventions	70%	70%	
6 monthly MHCOPES action meetings*			

*Replaced by YES and CES monthly reporting

The indicators for non acute services need updating

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
100%				

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Online Poll: All responses received

Non Acute Peer Groups

Sub Acute	Rehabilitation	Longer Stay Rehabilitation	Non Acute Forensic
▶ Blacktown: Subacute ▶ Broken Hill: Rehab ▶ Dubbo: MH Rehab ▶ Liverpool: Subacute ▶ Shoalhaven: Subacute ▶ Byron: Tuckeroo Sub Acute ▶ Wagga: MH SUBA	▶ Coffs Harbour: Coffs Rehab ▶ HNE Mater: ISMHU ▶ Orange: Manara ▶ Orange: Turon ▶ POW: MH Rehab ▶ Shellharbour: MH Rehab ▶ Sutherland: Non-Acute ▶ Kenmore: Ron Hemmings	▶ Concord: Broughton ▶ Cumberland: Acacia ▶ Cumberland: Banksia ▶ Cumberland: Boronia ▶ Cumberland: Waratah ▶ Cumberland: Willow ▶ Liverpool: MHU North ▶ Macquarie: Bridgeview ▶ Macquarie: Cottages ▶ Macquarie: Figtree ▶ Macquarie: Hamilton ▶ Macquarie: Henley ▶ Macquarie: Manning ▶ Macquarie: Tarban ▶ Morisset: CRU ▶ Morisset: Rosella ▶ Orange: Castlereagh ▶ Orange: Lachlan ECU	▶ Morisset: Kestrel ▶ Cumberland: Bunya ▶ Orange: Macquarie ▶ Forensic: Clovelly ▶ Forensic: Dee Why ▶ Forensic: Elouera

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My service is in the peer group I expect it to be

Response	Percentage
Strongly agree	22%
Agree	44%
Neither agree nor disagree	22%
Disagree	
Strongly disagree	11%

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Online Poll: All responses received

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Peer Grouping of Non Acute Services

Peer Group	Separations (N)	Average available beds (N)	Occupancy (%)	Avergae LOS (days)	LOS over 365 (%)	Average leave days (N)	Male (%)	Average age (N)	Primary Diagnosis Psychosis (%)
Longer Stay Rehab	303	402	82%	403	42%	38	74%	41	91%
Rehab	536	135	85%	93	3%	8	60%	39	70%
Sub Acute	1058	115	78%	35	1%	3	43%	39	31%
Non Acute Forensic	57	153	91%	537	63%	67	95%	39	93%

Based on separations data from 1 July 2019 – 30 June 2020

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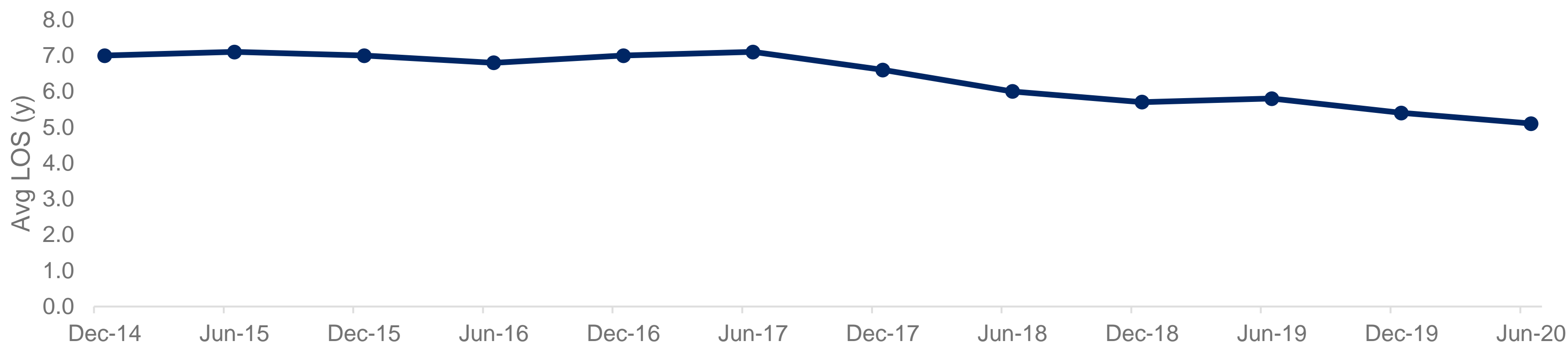
Pathways to Community Living Initiative (PCLI)



	Dec-14	Jun-15	Dec-15	Jun-16	Dec-16	Jun-17	Dec-17	Jun-18	Dec-18	Jun-19	Dec-19	Jun-20
People	387	360	364	365	350	319	304	319	317	309	308	260
Total LOS (Yrs.)	2,720	2,561	2,554	2,500	2,461	2,294	1,997	1,917	1,817	1,805	1,527	1,335
Avg LOS (y)	7.0	7.1	7.0	6.8	7.0	7.1	6.6	6.0	5.7	5.8	5.4	5.1

This data excludes (1) People under 18; (2) Designated forensic units in Justice Health, HNE, WNSW and WS LHDs; (3) People who are administratively admitted but have had 365 days of overnight leave in the previous year.

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Questions

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Comment shared in the chat:
"HNE has quite robust data on Clozapine and ECT"

Comment shared in the chat:
"I think there is a need to benchmark clozapine data across the state"

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Breakout Activity – Round 1

- **DATA:**
  - What are the burning questions we want answered by examining the data?
  - What indicators do you think we should be collecting that are relevant to your service and other non acute care settings?

GROUP FEEDBACK

“We have to start by understanding the current landscape of rehab units. There seems to be wide variation in LOS and even the definition of peer groups – that makes comparison difficult. There are range of measures we can make use of, but there is lack of standardisation. Data around physical health is will be quite important. Also, data which can help with cost-effectiveness, evidence based treatment, improve quality, reduce variation in care”

“Data collected is not reflective of care provided; Impact of NDIS and PCLI on data; Need to ensure data collected trickles down to service providers to compare between services; Need to agree which outcome measures best measure care provided so it can be used across the state and collected meaningfully”

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Breakout Activity – Round 2

- **PRACTICE CHANGE**:
  - How do the data we provide to your service feed into quality improvement in your service?
  - How do we want to engage with other clinicians?

GROUP FEEDBACK

"Collected from INFORMH has been useful to feedback to clinicians and reduce their anxiety, reflect on the positives and look at room for improvement"

"Not much data filters through to the coal-face clinicians. Easily digestible reports need to be made available. Want to relate to clinicians working in similar units; regular zoom link ups and formal/informal"

"We do have a monthly "Scorecard" that is circulated to all MH Clinicians. It is for standard KPIs, not specific to Rehab"

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Reflecting on our identity:

What do you see is the purpose of us getting together?

Live Poll Outcomes

“Defining best practice in Rehab psychiatry, collaborating on shared goals including measurement-based care and improving outcomes for our consumers”

“To improve the quality of care for our patients by providing evidence-based care”

“Sharing ideas, learning from each other, combating nihilism through peer-to-peer resilience and inspiration”

“Collaboration, benchmarking and Rehabilitation psychiatry as a recognised sub speciality”

“Attempting to ensure that quality rehab is available to all who need it.”

“Having standards including models of care that can be shared and used across the state”

“Peer support. Learning from each other. Benchmarking. Establish ourselves as a specialist area.”

“Reduce isolation, networking, start to advocate for our services”

“Define and calibrate our identity”

“Having a voice for rehab psychiatry”

General feedback shared:
"This is a great platform for learning and support. Thanks a lot for organising"

Comment shared in the chat:
"This Forum is a great opportunity to engage with clinicians in other settings/services"

NSW Rehabilitation Psychiatry Network

Evaluation Survey

General feedback shared:
"Enjoyed the day, was well organised and coordinated, Zoom worked well, great option for rural and remote clinicians"

General feedback shared:
"It was good to hear the presenters and liked the new innovative format though I think this cannot replace face to face meetings but useful as an adjunct"

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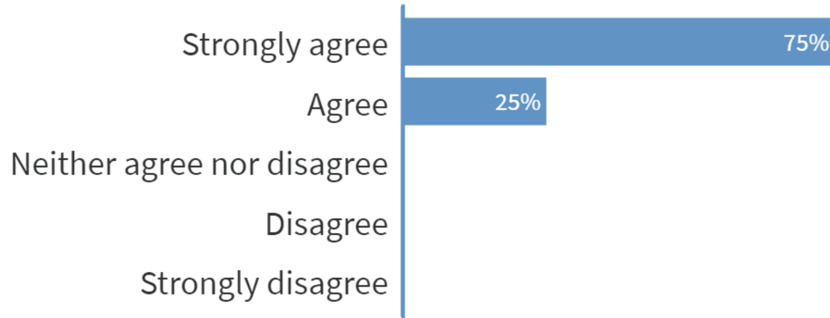

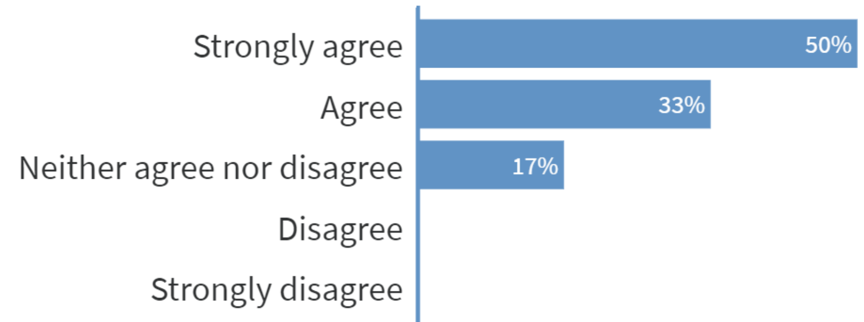

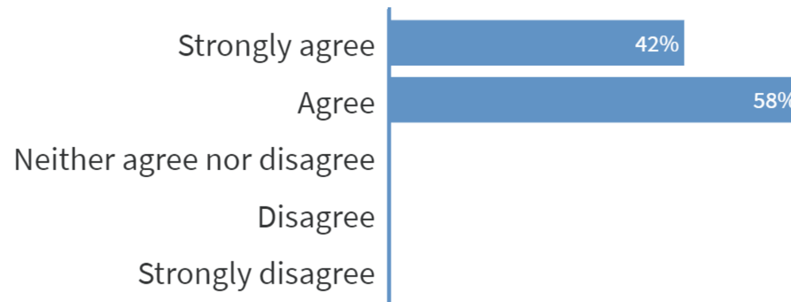

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New South Wales Branch

Evaluation Survey Questions: All responses received

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What is one thing that you would like to influence / do differently in your role as a result of today's workshop?

"Collect more specific rehabilitation data"

"Engage better with the other psychiatrists in the catchment of this Rehab Unit in regard to trying to facilitate better longitudinal care of our shared patients"

"More tuned to the growth of rehabilitation psych."

"Use some of the things learnt from the NICE guidelines"

"Promote rehab as significant sub-specialty and advocate for resources to meet clinical need and evidence"

"Use measurement based care within my clinical practice"

"Take the learning back to my Team"

"Be more engaged in the Benchmarking processes - and apply this in the practice"

"Have a structure for the EPA on Treatment Resistant Conditions which trainees do during their rotation in sub acute unit"

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Evaluation Survey Question: Sample of responses received

What topics would your service be interested in hearing about in future meetings?

"Developing shared outcomes"

"Length of stay in comparison to other similar units - with staffing being compared"

"New evidence-based rehabilitation interventions"

"Use of standardised tools across various LHD making it easy to compare"

"Developing shared outcomes; looking at specific interventions and ways to standardise use in rehab settings"

"How the model of care differs between different settings such as subacute, rehab and long stay"

"Scholarly presentation; Cognitive remediation"

"Both service and clinical issues in rehabilitation psychiatry"

"More information on effectiveness of different programs"

"Benchmarking"

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Evaluation Survey Question: Sample of responses received