



**Queensland  
Government**  
Queensland Health

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**Cairns District Health  
Service**

# **CAIRNS INTEGRATED MENTAL HEALTH RESIDENTIAL REHABILITATION SERVICE**

**Goal : Establish an Integrated Psychiatric Residential  
Rehabilitation Service, based in the Cairns community.**

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## Table of Contents

<b>1. PROJECT DEFINITION:</b> .....	<b>4</b>
<b>SUMMARY</b> .....	<b>4</b>
1.1 <i>Problem Being Addressed</i> .....	5
1.2 <i>Increasing acuity</i> .....	6
1.3 <i>Demand Studies</i> .....	6
1.4 <i>Considerations &amp; Options</i> .....	7
1.5 <i>Proposed Model</i> .....	8
1.6 <i>Objectives</i> .....	12
1.7 <i>Outcomes</i> .....	12
1.8 <i>Scope</i> .....	14
<b>2. BUSINESS CASE</b> .....	Error! Bookmark not defined.
2.1 <i>Resources</i> .....	<b>Error! Bookmark not defined.</b>
2.2 <i>Benefits</i> .....	<b>Error! Bookmark not defined.</b>
2.3 <i>Risks and Barriers</i> .....	15
<b>3. PROJECT PLAN:</b> .....	Error! Bookmark not defined.
3.1 <i>Strategies &amp; Activities</i> .....	<b>Error! Bookmark not defined.</b>
3.2 <i>Timetable</i> .....	<b>Error! Bookmark not defined.</b>
3.3 <i>People</i> .....	<b>Error! Bookmark not defined.</b>
3.4 <i>Consultation</i> .....	<b>Error! Bookmark not defined.</b>
3.5 <i>Communication</i> .....	<b>Error! Bookmark not defined.</b>
3.6 <i>Training</i> .....	<b>Error! Bookmark not defined.</b>
3.7 <i>Related Projects</i> .....	<b>Error! Bookmark not defined.</b>
3.8 <i>Critical Success Factors</i> .....	<b>Error! Bookmark not defined.</b>
3.9 <i>Policy &amp; Legislative Issues</i> .....	<b>Error! Bookmark not defined.</b>
3.10 <i>Evaluation</i> .....	<b>Error! Bookmark not defined.</b>
<b>4. ATTACHMENTS</b> .....	Error! Bookmark not defined.

## 1. PROJECT DEFINITION:

### SUMMARY

Studies and analyses conducted since 1995 have identified a gap in intensive residential rehabilitation services for persons with a mental illness in the Cairns community. This identified need is for both medium to long-term intensive rehabilitation, and short-term transitional care following periods of acute illness.

Projections of significant growth in demand for mental health services in the Cairns community indicate that need for community-based services in this area will double by 2026. Patterns of extremely high use of acute facilities for medium and longer-stay patients suggest gaps in psychiatric rehabilitation services may already be having expenditure implications for Queensland Health.

In December 2003, the Premier for Queensland announced that a 20-bed mental health rehabilitation service ('Residential Community Care Centre') would be established in Cairns. Furthermore this service would resemble the Victorian model of service delivery for people with a mental illness requiring intensive treatment and support.

Current strategic directions toward recovery-oriented models of service delivery, more community integration of rehabilitation services, and more community partnerships in service delivery highlight a need to consider broader models of service delivery to provide intensive support to people recovering from mental illness.

It is proposed herein that in response to the election commitment by the Premier of Queensland, that Cairns Health Service District establish a psychiatric residential rehabilitation service for 20 people, based in the Cairns community.

In brief, that:

A 'transitional' *Prevention and Recovery Care Service* be established, aiming for an average stay of 21 days (8 weeks maximum). This requires 8-10 beds in a cluster residential unit. The focus of the service is to provide short-term transitional residential care and support, which aims to assist people's reintegration into their community following episodes of acute care, and to provide additional intensive short-term support for people who are at risk of relapse.

A *Community Rehabilitation and Re-integration Service* be established (medium to long-term 6-9 months average). This requires a four-person central unit and six further units dispersed in the community. This will provide medium-term residential and outreach psychosocial rehabilitation services, to assist people living with psychiatric illness to reintegrate and participate more fully in the life of the community, particularly to achieve their goals toward more independent, functional and socially connected lives.

## 1.1 Problem Being Addressed

There is no residential rehabilitation service in Cairns and very limited intensive non-residential rehabilitation. Case Managers and other stakeholders have identified a demand for 'psychosocial rehabilitation' in people's communities that is not being met within current arrangements/services.

There are currently 51 extended treatment, rehabilitation and dual diagnosis beds in the Northern Zone – 24 beds operating in Townsville and 27 beds in Charters Towers. These beds are funded to provide residential rehabilitation and extended treatment services for Cairns and other districts in the Cairns Mental Health Network. The services operate on the *Model of Service Delivery for Extended Treatment and Rehabilitation Clinical Programs* (June 2003), and provide extended treatment and clinical rehabilitation.

The location of the above services means there is a lack of integration with the Cairns community. The effectiveness of rehabilitation provided at a distant location is frequently questioned. This is borne out by figures indicating Cairns Network usage of these facilities is far below that allocated notionally for the population of the Network. Additionally, the model of service delivery and staffing profiles for these programs mean the focus is largely on provision of extended clinical care. This tends to be particularly so for people from areas outside the centres in which the facilities are based, because it is difficult to maintain functional links with their home communities.

In addition to these longstanding locational and service integration considerations, there have also been a range of needs for community-based rehabilitation and early intervention that have previously not been within the scope of the remote Northern Zone Tertiary facilities. These are summarised more fully in section 1.8, but include greater emphasis on recovery support for existing frequent service users, and for clients early in the course of their illness, and intensive rehabilitation work to facilitate more effective transitions from acute care to community settings.

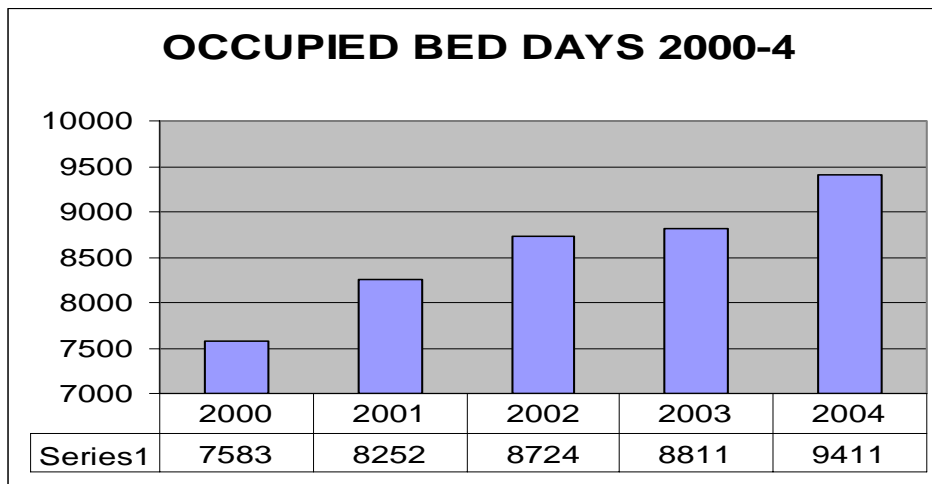
Two major gaps in service have been articulated – transitional 'Prevention and Recovery Care' and medium to long term 'Community Rehabilitation and Re-integration' *in the Cairns Community*. These gaps can result in a lifelong disadvantage for some persons with a mental illness and significant stress on their carers.

This business case argues that the deficiencies created by these gaps not being met are beginning to be seen reflected in patterns of increasing acuity, increasing readmission rates, small numbers of very long tertiary service admissions, and continuing consumer and carer dissatisfaction with service outcomes in these areas of transitional care and rehabilitation. These patterns may well already be having significant cost implications for Queensland Health.

## 1.2 Increasing acuity

The average occupancy rate for the Mental Health Unit Cairns Base Hospital February – May 2004 was 101%. Occupied bed days in the period 2000-2004 have been increasing dramatically.

Additionally, there has been concern that the number of admissions per patient per year is at 1.4. The rate of readmission has risen from 12.66% in 2000 to 17% in 2004. The latter figure represents only part of the picture as patients from Cairns who have been referred to Charters Towers or Townsville do not feature in the readmission figures.



While a number of factors can be brought in to play to maximize access to the acute facility for seriously ill patients, the most useful are:

- Reducing readmissions for patients from the Cairns area
- Reducing lengths of stay
- Reducing the number of new admissions
- Reducing the number of admissions per person
- Strengthening services in the community which sustain a person during a difficult time and, ultimately
- Facilitating the person to live with their disability while fully participating in the life of their community

## 1.3 Demand Studies

Demand for a community-based residential and rehabilitation service in Cairns was systematically identified a decade ago in the Health Service Plan for the redevelopment of Cairns Base Hospital. Following broad-based consultation involving consumers, carers and service providers, the following were identified as 'current' major service deficiencies (in 1995):

.....deficiencies cont.../-

- *Lack of specialised rehabilitation teams*
- *Lack of specialised support, e.g. supported accommodation specifically for mental health clients*
- *Separate inpatient services for children and adolescents*
- *Separate extended care for psycho-geriatric assessment and treatment*
- *Community-based respite or crisis beds*

*The report identified as a priority the establishment of a 7-bed community respite and/or crisis facility separate from the Hospital. This was never established.*

In 1999, the University of Queensland Department of Social and Preventative Medicine in the Cairns *Pathways Home* report recommended: “The volume and range of accommodation and support to address the clinical and life-stage needs of mental health consumers in the community is inadequate.” That report observed “That plans should pay particular attention to the support and accommodation needs of the post-discharge period.”

More recent analysis of trends in population indicates the demand for mental health rehabilitation services in Cairns would have significantly increased since that time, and is likely to continue to increase.

Over the next 2 decades the projected population growth of the Far North will take population to 321,000 people from current estimates of 224,000. Estimates of extended treatment and dual diagnosis ‘beds’ for the Cairns area using the Queensland Health formula in the State Mental Health Strategy are outlined below:

Year	2006	2011	2016	2021	2026
Population	245033	263411	282264	301535	320802
Est. Beds	19.6	21.1	22.6	24.1	25.7

#### 1.4 Considerations & Options

*Community Care Units* have been established in several community sites within Queensland as non-hospital based extended treatment services. This model was developed in Victoria and there are now 20 units in that state with many operating in different ways. The model requires review and is currently under critical examination in a number of centres in Victoria. Queensland’s Community Care Units operate on the same clinical extended treatment and rehabilitation models as E.T.& R facilities, but differ in the Mental Health Act status of the buildings and the status of the ‘residents’, who are not formally inpatients in CCUs.

The concept of *Recovery* is an emerging paradigm. It makes a substantial shift in philosophy from some traditional models of treatment of people with a mental illness. It involves a significant change in beliefs, services, practices, and anticipated outcomes. There is shift of focus in mental health care from symptom control to prevention and recovery. The ultimate goal of recovery, and of recovery-focused psychosocial rehabilitation and treatment, is to overcome the full range of personal, social and functional impacts of mental illness, not just the ‘symptoms’. This places a high priority on the re-establishment of valued roles and activities in the community. Recovery is seen as a framework for more integrated models of psychiatric and social rehabilitation.

Additionally:

- There is an increasing recognition of the importance of *early intervention* (there are two kinds of early intervention – ‘early’ in the course of the illness or ‘early’ in terms of *being there* early to prevent relapse).
- Assessments of Cairns clinical work show that there is a large un-met demand among people with mental illness for rehabilitation and *intensive psychosocial support* in their home community. This is not currently being engaged by the remote rehabilitation services of the Northern Zone or sufficiently by the existing (limited) ambulatory intensive treatment services in Cairns.
- There is a recognition of the complimentary role *non-government organisations* play in delivering practical and innovative services (Review of the Mental Health Community Organisation Funding Program November 2003) and of the necessity of intersectoral partnerships in effectively responding to the needs of people with mental health issues (QH Position Paper on Recovery 2005).
- There is a recognition of the need to develop innovative service modalities to extend the range of service options available (Queensland Mental Health Strategies Plan 2003 – 2008).

## 1.5 Proposed Model

It is therefore recommended here that:

1. A ‘transitional’ *Prevention and Recovery Care Service* be established, aiming for an average stay of 21 days (8 weeks maximum). This requires 10 beds in a cluster residential unit. The focus of the service is to provide short-term transitional residential care and support, which aims to assist people’s reintegration into their community following episodes of acute care, and to provide additional intensive short-term support for people who are at risk of relapse.

- ‘A facility providing short-term intensive early intervention and recovery-focused ‘transitional’ rehabilitation and reintegration’
- A cluster residential – 8-10 beds
- Buildings provided to ‘normal everyday’ design.
- 24-hour cover (intensive during day, maintenance at night).
- Linkages to both inpatient and community service systems.
- Offer a safe, organized, supportive place for service users.
- Brings together clinical, non-clinical and community services in a place where these can be centred around the person’s needs.
- Contribute to the development of coordinated, inter-agency approaches to care planning, case management and discharge planning.



2. A *Community Rehabilitation and Re-integration Service* be established (medium to long-term 6-9 months average). This will provide medium-term residential and outreach psychosocial rehabilitation services, to assist people living with psychiatric illness to reintegrate and participate more fully in the life of the community, particularly to achieve their goals toward more independent, functional and socially connected lives.

- A medium-term (6 to 9 months average) residential service providing recovery-focussed psychosocial rehabilitation in the community, in staffed residential settings and as outreach to selected clients living at home.
- A Residential Unit, with a 4-bed central unit and 6 units located in dispersed community settings. Intensive support in these facilities and for limited periods in transition.
- Buildings may not necessarily be purpose built (may purchase and renovate).
- ‘Service’ provided across the 10 places. 24-hour cover always at the four bed central units, intensive flexible cover at the satellite units tailored to client needs. Always intensive clinical support available (24-hours).
- Linkages to both Mental Health case management, Crisis Care and Intensive Treatment, and to community service systems.
- Bring together clinical, non-clinical and community services in a place where these can be centred around the person’s needs.
- Daily operations would be a mix of direct service provision of rehabilitative functions which would be linked to intensive mental health clinical ‘in-reach’ in the form of enhanced crisis and case management services.
- Staffing would be a mix of clinical and trained rehabilitation workers. Active case management and clinical responsibility by the Mental Health service would be retained.
- Contribute to the development of coordinated, inter-agency approaches to care planning, case management and discharge planning.

### *General Principles of Care*

Both the proposed Cairns services will be based on the following:

- Provision of professional rehabilitation support
- Fostering hope, expectations of recovery, and appropriate challenge
- Developing natural social support systems

- Focussing on the development of practically-oriented skills (not only the absence of symptoms, since it is skills, that are the determining factor in rehabilitation outcomes)
- Take a holistic approach to care and remain mindful of clients' capacities, vulnerabilities, needs and rights.
- Recognise the priority to foster and maintain clients' links to their community and ongoing care networks during transition from periods of difficulty and illness.
- Where appropriate, and possible, families should be included in the care so that they increase their skills in dealing with problems.
- Maximise the independence and dignity of clients, and provide care appropriate to their needs and strengths.

*Service features:*

- Services should be flexible, and program-based, not facility-based. Facilities provided are part of the program.
- The Program should be centred in the community, and link with natural community settings whenever possible.
- Operate within a rehabilitation framework that recognises participants potential for personal growth and the right to opportunities which support growth.

The delivery of *rehabilitation* is to be through *Individual Personal Plans* which will provide the basis for each person's participation in the program. These are developed collaboratively with participants, focusing on needs, desired futures and personal strengths. A range of individual and/or group activities that respond to the needs and goals of individual participants will be offered. These may focus on:

- Learning or relearning the skills required for life
- Maintaining and increasing independent self-care and social functioning (The live-in environments will be homelike with a focus on the responsibilities and tasks of normal living)
- Support to develop or re-develop vocational, leisure, and personal relationship skills in real everyday contexts
- Support and help accessing educational or employment opportunities
- Help to make important links to community, both generic services and individuals that may lead to independence from 'service-system' support
- Peer support
- Exploration of the self and illness through creative pursuits
- Provision of other opportunities and support to 'live well' in spite of ongoing symptoms and illness<sup>1</sup>

The proposed new services will operate in line with principles outlined in recent NSW and QLD statements of best practice in rehabilitation:<sup>ii</sup>

*.....The essentials of rehabilitation are described as individualised care, attention to strengths, aiming to restore hope, addressing vocational potential, encouraging a full array of social and recreational activities, and involving people in their own care. Services also need to be flexible and responsive to changing needs.*

(NSW Framework for Rehabilitation)

Similarly, the following excerpts from Queensland's recently revamped *Model of Service Delivery for Extended Treatment & Rehabilitation Programs* highlight the high degree of congruity:

*As mentioned previously, recovery is not a “service” that is “graduated to”. It is a personal journey that belongs to the consumer. The role of mental health and community service providers is to assist the recovery process, but not dictate its direction. In relation to the service provider this means a shift from caring for, to working with. Through this, service providers work in a manner that stimulates wellness and focuses on strengths rather than concentrating symptoms and deficits.*

*To facilitate the promotion of recovery-orientated service provision in both mental health services and the non-government sector, a set of underlying principles have been developed. These are as follows:*

- *Services work within a framework of recovery and incorporate philosophies of hope, consumer empowerment and partnership into practice*
- *Services understand people in the context of their whole selves, not just their illness*
- *Services ensure consumers set their own goals and measure their own success*
- *Services enable people to take on competent roles*
- *Services focus on consumer strengths rather than concentrating symptoms and deficits*
- *Services facilitate and aid natural support networks and look outward to assist people to find and use other more appropriate community services, supports, and resources (adapted from Blueprint for Mental Health Services in New Zealand, 1998)*

## 1.6 Objectives

- Provide evidence-based treatment, clinical rehabilitation, and supportive care in residential community based settings for clients who have significant and prolonged psychiatric symptomatology and/or associated disability.
- Provide a program that assists people to achieve their goals toward more independent and satisfying living.
- Help people to participate more fully in the life of the community, including economic and social participation.
- Provide support and resources for people on their individual journeys of recovery.
- Assist people to understand and come to terms with their illness in personal, spiritual and biomedical terms.
- Ensure access and linkages to generic community services and resources and sources of natural support.
- Provide services to allow people to ‘live well’ within the community in spite of their illness, as they would define ‘wellness’.
- Work to enhance quality of life, self esteem and sense of wellbeing as goals in themselves.
- Provide support to family members and other carers and appropriate involvement in individuals’ lives.
- Ensure comprehensive exit planning to facilitate reintegration after use of residential facilities.

## 1.7 Outcomes

- Distress caused by mental illness is reduced.
- The optimal level of functioning achieved for each client.
- Each client achieves their optimal level of functioning capacity that facilitates maximum reintegration into the community.
- Increased capacity among clients to meet life and vocational goals, achieve significant life enhancement, and gains in self-esteem and self-confidence, and to become contributing members of the community.
- Improved crisis prevention and crisis resolution, relapse prevention and reduction, and more effective discharge from inpatient care.

- Significant reduction in the need for costly mental health and emergency services as people who experience psychiatric symptoms effectively take responsibility for their own wellness and stability.
- Greater connection with and effective use of natural support networks of family members, friends, generic health care professionals (GPs), and non-specialised community contacts.
- Contribute to reducing the burden of care experienced by carers in supporting people at home.
- Inter-sectoral and inter-district links ensure continuity of care for client before, during and following inpatient care.

## 1.8 Scope

### Potential Target Groups

Recent analyses of Cairns services suggest that there are a range of needs centering around intensive rehabilitation and transitional support that are being poorly met at present by either the Zonal tertiary facilities or the existing array of community services in Cairns.

Some of these are as follows:

- A recent snapshot survey of Acute inpatient units in Queensland asked clinicians if a range of hypothetical supports and services were available (including short-term transitional support) could a patient be discharged *today*. The Cairns results indicated 30% of people in the acute unit were clinically well enough to leave, if appropriate supports and services (including forms of residential support) were available to help them reintegrate into the community.
- Clients are currently getting less than optimal forms of existing ‘sub-acute’ care through case management or CATT after ‘early’ discharges, or in vulnerable circumstances. At times when there is intense pressure on bed availability in Cairns, some of the 30% of people mentioned above are discharged into the community (A Salvation Army hostel in Cairns has estimated that up to 50% of its clients have mental health issues and are receiving little by way of trained or skilled residential support. Similar figures are quoted by the Cairns Night Shelter).
- Case Managers have identified potential new rehabilitation clients currently being poorly or inadequately serviced (‘invisible demand’). These are people in ‘holding patterns’ in the community, who would not be able to be referred to existing rehabilitation facilities because of the long lead time for referrals, or because aspects of their circumstances made rehabilitation at distant facilities not the best option. In many instances, case managers continued to try to provide intensive rehabilitation and support in the community, with consequences for Cairns community team resourcing, while funded tertiary beds remained empty or were used by other districts.
- Increasing patterns of illicit substance use, and recognition of the importance of early diagnosis and treatment, mean that there is significant demand for intensive treatment and support for young clients with severe illness needing intensive intervention early in the course of the illness. This is much better done in the home community in *least restrictive ways*.
- Cairns community teams have identified significant numbers of clients with ‘chronic’ illness who may not be reaching their full potential, but do not meet the criteria for extended admissions to Zonal extended treatment facilities. Their lives are significantly impaired by illness, but they remain sufficiently out of scope of services as to not be considered for referral. Sometimes these clients were living intermittently with families, who were acutely stressed and dissatisfied with service provision. In other circumstances families were broken down or disrupted by the load due to inadequate support.

- Particular client groups who need individualised, intensive rehabilitation for varying periods specifically in their home community eg. Persons returning from long stay facilities elsewhere who need intensive support to help with re-integration.

### Target Area

It is proposed that the services funded here are provided primarily for the Cairns Mental Health network, which is that group of Health Service Districts who currently access the Cairns Acute Mental Health Unit (Cairns, Tablelands, Innisfail, Cape York and Torres.) It is also feasible that the services could be accessed by Zonal Tertiary services as part of a range of supports and options made available to facilitate reintegration of people returning from Extended Treatment care in Townsville or Charters Towers.

## **1.9 Risks and Barriers**

A range of risks and barriers have been identified:

- The identification of and recruitment of suitably-skilled staff.
- Development of an acceptable staffing profile to suit the operational model.
- Training, development, and culture-change issues in developing recovery-oriented services.
- Maintenance of leadership within the Cairns IMHP to develop the vision of the new services.
- Relations between service sectors in CIMHP, and development of appropriate referral and assessment processes in keeping with the proposed service model.
- Acquisition and/or construction of suitable residential properties in the community.
- Sufficient infrastructure and resources in the community to provide options for people working on rehabilitation in community settings.
- Quality of inter-sectoral links for the carrying out of community-based rehabilitation in partnership.
- Capacity and skill depth among potential NGO partners.

To address these risks, several strategies are being pursued:

- Identification of current best practice in staff training and recruitment practices for community-based psychiatric rehabilitation services
- Facilitation of an inter-sectoral community steering group for the project
- Research visits to a range of successful sites throughout Queensland, NSW and Victoria
- Engagements with Capital Works (QH) to ascertain and evaluate suitable properties
- Further collaboration and developmental workshops on proposed service model within Cairns IMHP.
- Capacity-building activity with potential partner organisations.

## 2.

<sup>i</sup> Closely paraphrased from the Victorian PDRSS Guidelines.

<sup>ii</sup> NSW Framework for Rehabilitation for Mental Health. NSW Health 2002.