

WEST COAST

MENTAL HEALTH

REHABILITATION

SUPPORT SERVICES REVIEW

Final Report

January 2003

Prepared for the West Coast District Health Board by the:

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1 EXECUTIVE SUMMARY

Introduction

The West Coast Mental Health Rehabilitation Support Services Review was carried out by the South Island Shared Service Agency (SISSAL) on behalf of the West Coast District Health Board (WCDHB).

The purpose of the Review was to determine the optimum design for the effective and viable delivery of a specific range of mental health services on the West Coast for adults, children and youth and Maori. These included in-patient rehabilitation beds - including the future of sub-acute beds, residential support services (community residential services), respite care, community support services, local residential alcohol and drug beds and inpatient detoxification services. All within the context of developing a comprehensive rehabilitation service. Impetus for the Review came from the recommendations in the West Coast Mental Health Benchmarking Project (2002).

Information for the service needs analysis was primarily gained from a series of consultation forums held with mental health and alcohol and drug workers, consumers and family members. A project reference group consisting of stakeholder representatives was established to provide expert advice on local needs and to act as a planning forum.

Issues from Consultation Forums

The consultation forums raised a number of key issues including:

- The need to deliver extended care sub-acute services in a clinical rehabilitation framework, preferably separate from the crisis, safety management focus of the acute beds in the inpatient unit.
- The need for a Level IV community residential service with a strong rehabilitation focus.
- The current PACT level III community residential service is largely populated with long term residential clients. Consequently there are access problems for consumers with short to medium term needs who require a rehabilitation focus that enables them to eventually move to independent living.
- The Coast Care Trust day activity centres provide a quality service with the resources available but there is a need to broaden the scope of the service to meet the needs of a wider range of people.
- There is a need to offer greater and more structured vocational training and employment opportunities for consumers.
- Current methods for providing adult respite are working well in general but there is a need for better supervised respite in Buller and for more flexibility in allowing family members to access respite funding when a break for them is the main reason for the consumer receiving respite.
- There is a shortage of suitable carers and facilities for child and youth planned respite and a need for better monitoring of care givers. There are also difficulties with utilising adult mental health services or the paediatric ward for crisis respite in terms of meeting the mental health needs specifically of children and youth.
- No group based day activities are currently provided for children and youth.

- Community residential service needs for children and youth are difficult to meet.
- Intensive specialised residential alcohol and other drug (AOD) treatment cannot be viably provided on the Coast and will need to be accessed from outside the district. However there is a need for a local accommodation service for people waiting admission to residential services elsewhere, needing supported accommodation following intensive residential treatment or for those from outlying areas needing accommodation while attending outpatient treatment.
- Problems with providing inpatient medical detox included a lack of privacy for detox patients, inadequate staff training in medical detox and coordination problems with the A&D Service.
- Overall a need to improve services for Maori was identified including more designated Maori workers, better liaison with runanga for kaumatua/kuia support, the inclusion of whanau in treatment and developing the workforce with regard to culturally appropriate treatment.

Core Recommendations

The overall goal of the recommendations is to enhance the rehabilitation capacity and focus of the West Coast Mental Health Service.

Core recommendations in the Review are as follows:

Adult Medium Term Inpatient, Clinical Rehabilitation and Supported Accommodation Services

1. Establish a residential rehabilitation service in Greymouth consisting of a community residential service linked in partnership with clinical and rehabilitation personnel resources from the Greymouth Community Mental Health Service and Coast Care Trust Greymouth services. Minimum size eight beds.
2. Provide a flexible integrated service that meets a range of client service needs including clinical rehabilitation services, level III and IV community residential services, supported accommodation, pre and post residential alcohol and drug treatment and limited respite options.
3. Facilities: Motel style i.e. a house (4-5 bedroom) with attached 1 or 2 bedroom flats. Enables a range of accommodation from closely supervised beds to individual units which offer greater privacy and less intrusion for service users with reducing support needs.
4. Staffing:
 - a) Minimal 24 hour onsite wake-over supervision by nursing staff (Level IV) with 24 hour crisis backup provided by Greymouth Community Mental Health Service TACT Team.
 - b) Specialist clinical and rehabilitation staff resources provided from Greymouth Community Mental Health Service.
5. Increase the rehabilitation capacity of mental health services in Greymouth by at least one FTE dedicated to specifically servicing consumers using the residential rehabilitation service and associated day activities.
6. Transfer sub-acute patients requiring extended care with significant rehabilitation elements to the community residential service.

7. Increase community support worker resources in each area to assist consumers requiring Level 1 or II community residential services to find suitable independent community accommodation and provide a low level support and monitoring role similar to what a Supported Landlord Service would offer. Recommended increases are 0.6 FTE in Westport and 1.0 FTE for Greymouth/Hokitika.
8. Develop long term residential options in the Buller region such as a Supported Landlord Service or contracted boarding situations if the need becomes apparent.
9. Arrange an independent needs review of all long term PACT clients and medium term community residential clients currently in Seaview to determine the minimum level of accommodation and rehabilitation support necessary to adequately meet their long term care needs.
10. Transfer PACT clients requiring some form of long term residential care to alternative forms of care. These include a Supported Landlord Service operated by PACT, individual rest home care, contracted boarding situations and a long term residential (level III) house.
11. Review the configuration of current community mental health services in terms of staff numbers, location and professional grouping to enhance the rehabilitation capacity of the service overall.
12. Identify the workforce development needs of current DHB and NGO staff at all levels with regard to rehabilitation and the recovery approach and develop an associated training plan.

Adult Respite Services

1. Include opportunities for family members to access respite funding where a break for the family is the primary reason for the consumer requiring respite.
2. Utilise contracted boarding situations as an alternative option for the delivery of crisis respite in the Buller region.

Adult Community Support Services

1. Call a meeting of interested parties to set up a working group to actively explore:
 - a) The development of consumer organised business opportunities that can be used for pre-employment training, vocational rehabilitation and ongoing collective employment opportunities for consumers.
 - b) The establishment of linkages with interested employers to assist with work experience and employment opportunities for mental health consumers.
2. Review the model and scope of day activities currently provided by the Coast Care Trust with the aim of meeting the needs of a wider group of people. Including the provision of more intensive pre-vocational skills development and transitional employment services such as work experience.

Child and Youth Community Residential, Respite, Day Activity and Community Support Services

1. Undertake a recruitment campaign for care givers to provide respite and community residential services for children and young people along with establishing a process for selecting, monitoring and training carers.
2. Trial the provision of community residential services for children and young people and crisis respite for adolescents in contract foster care situations on the West Coast.

3. Develop more intensive day activity services for children and youth including peer support groups, after school activities and weekend camps.

Alcohol and Other Drug Services

1. That limited access (2-3 beds) in the proposed community residential service is available to carefully selected AOD clients requiring some form of supported accommodation services on the Coast including:
 - a) Post-residential alcohol and drug treatment supported accommodation with a rehabilitation focus.
 - b) Consumers with co-existing disorders (MH and AOD) where intensive treatment for AOD problems is not indicated.
 - c) Overnight accommodation for AOD clients from outlying areas receiving outpatient treatment via the West Coast Alcohol and Drug Service.
2. Trial periods of intensive treatment in short term retreats on the Coast in conjunction with other similar initiatives by other districts including short term adventure based residential treatment for groups of young people receiving outpatient counselling if numbers permit.
3. Improve quality of the current medical detoxification arrangements by:
 - a) Developing a separate room with ensuite including shower in the general medical ward that can be used for detox when required.
 - b) Training general ward and mental health acute inpatient unit nurse(s) in medical detoxification.
 - c) Developing protocols between the general medical ward and the Alcohol and Drug Service with regard to the continuity of care for patients requiring detox.

Improving Services for Maori

1. Employ dedicated Maori workers in both the Child and Adolescent Mental Health Service and Alcohol and Drug Service as staff vacancies become available.
2. Work with local runanga to incorporate kaumatua/kuia support for tangata whai ora and whanau members in all mental health services.
3. Review the workforce development needs of staff providing rehabilitation services with regard to providing culturally effective and safe services for tangata whai ora and whanau members.

Timeline

Full development of the proposed residential rehabilitation service is targeted for completion by December 2004 following a two stage process. However if suitable facilities can be found earlier than planned, the completion date may be brought forward. Most other recommendations are targeted for completion by June 2004.

Resourcing the Recommendations

Resourcing the new residential rehabilitation service will occur primarily by a re-configuration of the current Level III community residential contract. This includes:

- a) Achieving cost savings by placing existing residents with long term residential needs in suitable more cost effective alternatives to the current arrangements.
- b) Incorporating beds (and the associated resources) occupied by existing non-long term PACT clients suitable for residential rehabilitation in the new residential service.

Overall the impact is expected to be fiscally neutral as it involves the re-configured use of existing personnel and funding.

2 INTRODUCTION

The West Coast Mental Health Rehabilitation Support Services Review was carried out by the South Island Shared Service Agency (SISSAL) on behalf of the West Coast District Health Board (WCDHB).

Purpose of the Review

To implement the recommendations in the West Coast Mental Health Benchmarking Project¹. Specifically:

- The review (including a needs analysis) of residential services planned for 2002 be carried out to determine the range of residential services before any attempt is made to make up the shortfall.
- The review should include consideration of the need to retain a small number of medium/term beds as well as the need to establish A&D residential services.

And to assist with implementing the following recommendation:

- A broad based rehabilitation service be developed that includes a small number of medium term/rehabilitation beds.

Scope

The Review covers the need for and delivery of mental health in-patient rehabilitation beds - including the future of sub-acute beds, residential support services, respite care, community support services, local residential alcohol and drug beds and inpatient detoxification services. All within the context of a comprehensive rehabilitation service on the West Coast. Reference to other types of mental health services. Eg. Acute in-patient or Needs Assessment and Service Coordination, is limited to the impact on these services of the Review's recommendations for the services covered by the project. Regionally delivered services are not included. For service definitions of those in the scope see Appendix One.

The needs analysis includes the needs of specific population groups. In particular child and youth and Maori.

The future of the fifteen elderly people currently occupying medium term/rehabilitation beds at Seaview hospital is being determined through a separate process external to this Review.

Objectives

- a) To provide the District Health Board with a framework for future service development for in-patient rehabilitation, residential support, respite care, local residential alcohol and drug treatment and community support work.
- b) To assist the development of the mental health section of the West Coast District Annual Plan by providing sufficient accurate information to enable quality planning and funding decisions to be made regarding the services covered by the project.

¹ Elliott, C. (Jan 2002). Mental Health Benchmarking Project for the West Coast District Health Board; Final Report.

- c) To assist future changes in service delivery by encouraging ownership by key stakeholders of any proposed changes through active consultation with stakeholders during the planning process.

3 BACKGROUND

Defining Mental Health Support Services

Mental Health Support Services involve consumer care after or alongside treatment and comprise any efforts to reintegrate people back into their regular lives and to their communities following a severe mental illness. The purpose is to enable people with mental illness to live with maximum independence in the community. Previously called non-clinical services the term has been replaced with the term 'mental health support services' to more accurately reflect the recovery approach.¹

In general Support Services include: Residential Rehabilitation and Supported Accommodation, Community Support Work, Needs Assessment and Service Coordination.

Mental Health Benchmarking Project

The report from the Mental Health Benchmarking Project for the West Coast District Health Board determined the following:

In-patient Services

In-patient mental health services on the West Coast are over the Mental Health Commission Blueprint resource guidelines for both acute in-patient beds (+5.2) and medium term in-patient beds (+20.1). In total there are 34 funded beds, 10 acute and 24 medium term. All the acute beds and five of the medium term are located together at Grey Hospital with the remaining 19 medium term beds at Seaview Hospital.

The mix of acute and rehabilitation/medium term beds at Grey hospital is not considered ideal as the service focus is primarily on those who are most acutely unwell to the detriment of those requiring an intensive rehabilitation service. The report recommends that the five rehabilitation beds are moved from Grey Hospital in the longer term to form part of a broader-based and more comprehensive rehabilitation service that includes residential options as well as daytime and home support. The report suggests that improved service delivery in these areas may reduce demand for acute in-patient beds.

Fifteen of the 19 medium term beds/rehabilitation beds are currently occupied by an increasingly elderly and decreasing population. (eleven are aged over 70 years) and the report recommends that plans be developed to transfer this population to Disability Support Services or a suitable residential or rest home provider be sought to provided these services.

Residential Services

Currently the West Coast is funded for 19 adult mental health residential beds against a Blueprint guideline of 23.1 beds. This leaves an under provision of approximately four beds. Of the 19 beds currently funded they are all funded as level III beds with no Level I/II, IV or Intensive Long Term beds. However three clients requiring level IV community residential services are being cared for in the Huia ward at Seaview hospital in the absence of other suitable services. The remaining residential services are provided regionally.

¹ Ministry of Health. (Nov 2001). Support Services for People with a Mental Illness. Strategic Directions for Future Service Development.

The report recommends that a review of the way current services are provided against actual need should be undertaken before any decision is made about increasing bed numbers.

At present no child and youth community residential services are able to be accessed by the West Coast. The total Blueprint resource guideline for child and youth community residential for the West Coast is 0.6 beds. However resourcing for this service is utilised to provide a community support worker to assist children and young people with life skills training and integration back into the community.

Residential Alcohol and Drug Services

At present all mental health funded alcohol and drug residential services are provided regionally outside the district. The Blueprint resource guideline is 3.2 beds for the West Coast. The report recommends that as they do not need to be regionally provided, the need for alcohol and drug beds be addressed locally as part of the overall need for residential services.

The role of volunteer alcohol and drug residential services on the West Coast should also be acknowledged. In particular a night shelter and a mental health respite service which accepts clients with co-existing disorders, both in Cobden.

Community Support Services

This includes a variety of support services including home-based support (8.1 FTEs), day type activities (7.6 FTEs) and day programmes for child and youth (Nil FTEs). Overall the West Coast is over benchmark for home based support (+3.3 FTEs) and day activities (+1.4 FTEs) but under expending on child and youth day programmes by 1.3 FTE or \$75,000 per annum. The WCDHB Mental Health Benchmarking Project recommends that the over provision remain as it reflects minimum viability levels and that the under-provision in child and youth day activities be filled as a priority.

CAMHS also provides one FTE to work with family members i.e. siblings, parents, children of adult patients.

Respite Care

The DHB Provider Arm manages four \$14,000 contracts for crisis and planned respite. This consists of two youth and two adult contracts which are delivered in a variety of ways with different providers to meet individual needs. Eg. Family care, use of motels, community care agencies.

In the past crisis respite for children and youth has been provided through accessing the Acute Inpatient Service at Grey Hospital or when available, the Christchurch Child and Youth Inpatient Unit. At present access to a bed for 14 years and under in the WCDHB paediatric ward is being finalised for predominantly crisis respite. In addition two families have been found who can offer care for mainly planned respite.

National Developments

In 2000 the Ministry of Health initiated a review of support services for people with mental illness¹. The overall approach is to develop more flexible models of service delivery and funding which move away from the current focus on levels of need. Consultation indicated

¹ Health Funding Authority. (2000) Non-Clinical Services Review Project: A Consultation Document.

strong support for moving to a style of Supported Accommodation. A similar model has been regionally piloted in the southern region with Richmond Fellowship.

4 METHODOLOGY

Review Personnel

Decisions on the Review's recommendations were made by the Project Team in consultation with the Project Reference Group. The reference groups role was to provide expert local advice to the project team on the status of West Coast mental health services and district service development needs, as well as offering a small group forum to work through specific planning issues associated with the project.

A broad consensus was reached by the Project Team and Reference Group on all the key recommendations. However this does not necessarily mean that all reference group members are in full agreement with every recommendation.

Project Team Members

Project Sponsor:	Hecta Williams, General Manager, Mental Health and Primary Care, West Coast District Health Board.
Project Manager:	Paul Rout Service Manager, SISSAL.
Project Supervisor:	Wayne Turp, Manager, Mental Health, SISSAL.

Project Core Reference Group Members

Melanie Penny	Research and Planning Analyst
Geoff Gatward	Inpatient Staff Nurse
Jan Murphy	Former Consumer Advisor
Judith Murphy	Family Advisor
Roger Berwick	Manager Rata A&D Services
Robyn Atkinson	Rehabilitation Nurse, Community Mental Health
Helen Porter	Manager PACT West Coast
Moira Geer	Maori Mental Health Worker

A number of other mental health workers were also consulted by email or telephone regarding the draft recommendations during the planning process.

Data Collection

Quantitative Data

Service utilisation data, in particular regarding occupancy rates for sub-acute beds and details of PACT residents was obtained from the DHB patient database and PACT.

A comprehensive case survey was initiated with case mangers to gain a more extensive needs analysis to estimate demand for a range of existing and potential services along with a basic clientele profile regarding age and ethnicity and barriers faced in accessing mental health

services on the Coast. Insufficient returns were completed in time to include this information in the final report. A summary of the survey results is planned as an appendix to this report once all returns are completed.

Qualitative Data

Thirteen stakeholder consultation forums in total were held to gather information on service needs and proposals for improving service delivery. These were based on a semi-structured questionnaire created for the project. Separate forums were held for adult mental health workers, child and youth mental health workers, AOD workers, consumers including child and youth and AOD and family members.

One individual interview was also conducted with a key district manager and seven questionnaires were returned individually.

Interviews were also conducted with three other providers in other DHB areas to obtain information on other models of service delivery for sub-acute and community residential services in particular. Providers included Pathways, Gateway Housing and Te Toka O Maru O Taranaki Trust.

The first draft of the Review recommendations were presented to a meeting of the mental health forum for initial feedback.

5 RECOMMENDATIONS

Overall Goal: To enhance the rehabilitation capacity and focus of the West Coast Mental Health Service.

A. Adult Medium Term Inpatient, Clinical Rehabilitation and Supported Accommodation Services

Key Recommendations

1. Establish a residential rehabilitation service in Greymouth consisting of a community residential service linked in partnership with clinical and rehabilitation personnel resources from the Greymouth community mental health service and Coast Care Trust Greymouth services. Minimum size eight beds.
2. Provide a flexible integrated service that meets a range of client service needs including clinical rehabilitation services, level III and IV community residential services, supported accommodation, pre and post residential alcohol and drug treatment and limited respite options.
3. Increase the rehabilitation capacity of mental health services in Greymouth by at least one FTE dedicated to specifically servicing consumers using the residential rehabilitation service and associated day activities. This excludes a case management role for the resource.
4. Transfer sub-acute patients requiring extended care with significant rehabilitation elements to the community residential service.
5. Continue to care for sub-acute patients requiring short term extended care with low rehabilitation needs in the acute inpatient unit till discharge.
6. Utilise the acute inpatient unit to accommodate any overflow of sub-acute clients during peak periods of demand for the community residential service. Patients to still attend day rehabilitation activities at residential service.
7. In the interim stages of development of the rehabilitation service, offer basic rehabilitation services as day activities either on the hospital site or off site at a site such as the day activity centres to service users in the acute inpatient unit, PACT houses and at Seaview Hospital who would benefit from more intensive rehabilitation.
8. Increase community support worker resources in each area to assist consumers requiring Level 1 or II community residential services to find suitable independent community accommodation and provide a low level support and monitoring role similar to what a Supported Landlord Service would offer. Especially in the first few months of transition from higher levels of residential care. Recommended increases are 0.6 FTE in Westport and 1.0 FTE for Greymouth/Hokitika.
9. Develop long term residential options in the Buller region such as a Supported Landlord Service or contracted boarding situations if the need becomes apparent.
10. Arrange an independent needs review of all long term PACT clients and medium term community residential clients currently in Seaview to determine the minimum level of accommodation and rehabilitation support necessary to adequately meet their long term care needs. Each client to have an individualised rehabilitation/service needs plan developed by their case manager in conjunction with the consumer, PACT and the needs assessor.

11. Transfer PACT clients requiring some form of long term residential care to alternative forms of care. These include a Supported Landlord Service operated by PACT, individual rest home care, contracted boarding situations and a long term residential (level III) house.
12. In the event that a long term residential (level III) house is required, attempts are made to re-configure current housing arrangements to provide sleepover night staffing only within a single long term residential group home or two homes adjacent to each other as a single service or group of flats (up to 8 beds) to minimise the staffing costs.
13. Provide consumer advocacy support to PACT residents to help ensure their rights are protected and needs reflected in the transfer process.
14. Establish a working party to oversee the development of the residential rehabilitation service and long term residential options within the framework of an agreed memorandum of understanding between the key parties. Membership to include representatives from WCDHB Planning and Funding Division, Provider Arm Mental Health Service, Coast Care Trust, PACT, Consumer Advisor Team, Family/Whanau Advisers and Maori.
15. Give consideration to the current provider of community residential services being nominated as the preferred provider of the new community residential service along with supported landlord services and any ongoing group level III homes for long term residential consumers to ensure an effective and safe transition to the new service structure.
16. Review the configuration of current community mental health services in terms of staff numbers, location and professional grouping to enhance the rehabilitation capacity of the service overall.
17. Identify the workforce development needs of current DHB and NGO staff at all levels with regard to rehabilitation and the recovery approach and develop an associated training plan.

Details of the Proposed Services

Features of the Rehabilitation Service

- a) Development of a comprehensive West Coast recovery-oriented mental health rehabilitation service is the context in which service development is planned.
- b) A rehabilitation model places emphasis on developing a rehabilitation diagnosis (as contrasted with a DSMIV psychiatric diagnosis) which is based on an assessment of an individuals functioning and environmental resources.
- c) The principle goal of a rehabilitation service is to facilitate the recovery of people with mental illness. “Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them (Mental Health Commission Blueprint).”
- d) Aim is to integrate service users as normally as possible into the community in the minimum appropriate time and minimise service dependency in the medium to long term. Clinicians and support workers are discouraged from ‘holding on’ to clients longer than necessary to achieve recovery.
- e) Goal oriented and recovery focused, skill development programme which builds environmental supports. Improving vocational outcomes is a core focus.

- f) Individualised assessment and rehabilitation plans are developed in conjunction with the service user with regular review and monitoring.
- g) Utilises ‘strengths’ model of identifying a person strengths and actively creating situations where success can be achieved and the level of personal strength enhanced.
- h) ‘Whole of life’ focus. Reflects the four cornerstones of Whare Tapa Wha:
 - taha wairua (spiritual health)
 - taha hinengaro (mental and emotional health)
 - taha tinana (physical health)
 - taha whanau (whanau health)
- i) Does not seek to replicate existing community resources but supports and advocates for individuals to access these services for themselves.
- j) Flexible and responsive support as required by the consumers clinical and rehabilitation needs at any point in time is the key to achieving goals and preventing relapse.
- k) Incorporates culturally based programme components to meet the needs of tangata whai ora. Including cultural assessment, input from Maori mental health case managers, links with Kaupapa Maori community services, networking with local runanga and kaumatua/kuia support.
- l) The safety of consumers whose mental health may be at risk of deterioration, is ensured by harnessing family/whanau members, local communities, other health professionals and consumer peers to monitor the individuals wellbeing and to inform the Community Mental Health Team if an individual is at risk of relapse. The corollary of this is the need for mental health services to be responsive and accessible to people when required.
- m) Success of the service overall relies on a strong and active collaborative partnership between NGO service providers, consumer organised support services, DHB mental health teams, the community and the consumer and family that is based on a shared vision and effective leadership.
- n) Different levels of need are addressed by varying the level of clinical and rehabilitation support provided in association with the accommodation options.
- o) Consumers are involved in the planning, implementation and evaluation at every level of the associated services to ensure they are responsive to the needs of the individual service user.
- p) The role of the family in assisting the consumer towards recovery is valued.
- q) Family/whanau are involved in the planning, implementation and evaluation of the service components.

Features of the Community Residential Service

- a) Encompasses target groups requiring the following services:
 - Sub-acute/medium term with intensive inpatient rehabilitation.
 - Clinical rehabilitation service.
 - Community residential level III and IV.
 - Respite options.
 - Day rehabilitation activities.
 - Post-residential alcohol and drug treatment supported accommodation with a rehabilitation focus.
 - Consumers with co-existing disorders (MH and AOD) where intensive treatment for AOD problems is not indicated.
 - Overnight accommodation for AOD clients from outlying areas receiving outpatient treatment via the West Coast Alcohol and Drug Service where other options are not available.

- Short term supported accommodation for AOD clients awaiting admission to residential treatment elsewhere.
 - Social detox for medically low risk AOD consumers.
- b) The site is also used as a networking base for day rehabilitation services for people living in their own homes or sub-acute patients unable to access the community residential service.
- c) Capacity: Minimum eight beds with possibly up to an additional four beds if demand indicates a need. However initial demand may require a minimum of ten beds due to a backlog of clients requiring rehabilitation.
- d) Dedicated access to service of two beds for alcohol and drug clients. Total access will depend on the availability of beds and the priority compared to other clients needs. Consumers actively engaged in hazardous alcohol and/or other drug use which poses a significant risk to themselves or others would be excluded. Alcohol and other drug consumers without co-existing disorders would be required to be engaged and self-motivated for change.
- e) The availability of individual units could permit mothers with babies to be accommodated in the service and provide respite options for children and adolescents if respite sleepover staff were able to be provided.
- f) Clients currently occupying level III PACT beds or beds in Seaview Hospital who could eventually live independently following a period of residential rehabilitation would be given priority in the new service.
- g) Facilities: Motel style i.e. a house (4-5 bedroom) with attached 1 or 2 bedroom flats. Enables a range of accommodation from closely supervised beds to individual units which offer greater privacy and less intrusion for service users with reducing support needs. If respite option for solo parent with children is offered this would require use of one of the separate flats (two to three bedrooms) with fenced play area.
- h) Overflow of sub-acute patients at periods of peak demand continue to be accommodated in the acute inpatient unit.
- i) Location: Greymouth
- j) Staffing:
- Minimal 24 hour onsite wake-over supervision by nursing staff (Level IV) with 24 hour crisis backup provided by Greymouth Community Mental Health Service TAC Team.
 - Specialist clinical and rehab staff resources provided from Greymouth Community Mental Health Service. The level of intensity of rehabilitation services able to be offered will be limited by the overall ability of community mental health services to employ enough appropriately skilled staff.
 - Additional one rehabilitation full time equivalent required to support residential rehabilitation service clients (E.g. Occupational Therapist &/or Rehabilitation Nurse)
- k) Number of case managers involved with clients in residential service is minimised to facilitate an effective relationship between the NGO provider and Community Mental Health Service in meeting the needs of the service users.
- l) The management of the service as a whole, including decisions on the admission, internal transfer within units and discharge of service users, is overseen by a joint management co-ordinating group consisting of staff representatives from both the Community Residential Service provider and Community Mental Health Team along with a consumer advocate. The management group should include both clinical and rehabilitation personnel.

- m) Service is as self sufficient as possible with residents responsible for cooking, shopping, cleaning, care for grounds, gardening etc, with support and supervision of staff as required.
- n) Opportunities for employment or fundraising initiatives are attached to service Eg: vegetable growing.

Long Term Residential Options

- a) The transfer of current PACT clients with long term residential needs to suitable more cost effective residential options is critical if resources are to be freed up to allow the establishment of a residential rehabilitation service.

Options include:

- Rest home care for over 65s - Individual mental health contracts with rest homes to meet the mental health care needs of clients. Particularly for people who are likely to have increasing aged care disability issues.
 - Long term level III community residential home(s) –Level III group homes with staff sleepover similar to present. Preferred facilities are those which allow more cost effective staff-client ratios. Eg. Increased bedroom number houses, two houses adjacent to each other, groups of flats. A location close to the residential rehabilitation service could also offer some further staff backup resources for each service.
 - Contracted boarding situations – Selected individuals in the community are contracted, trained and monitored to provide care in a host boarding situation.
 - Supported Landlord Service – Individuals who do not require intensive support live independently together in a shared flat with daily input and help from a PACT community support worker (0.4 FTE) to monitor wellness and assist with things such as paying the rent etc.
- b) The transfer needs to be based on an independent needs assessment, involve the consumer in the planning process and respect the individuals concerns and ability to cope with change.

Recommended Funding Method

Capacity funding of Community Residential Service and Long Term Residential Supported Landlord Service. Community residential service agreement specifies range of types of residential care levels to be provided and indicative volumes. However considerable flexibility to vary the service within the resources available according to the needs of clients at any one point in time is permitted. Specified minimum occupancy rates are recommended at 90%.

Comprehensive West Coast Mental Health Rehabilitation Service (Adult)



Residential Rehabilitation Service

COMMUNITY RESIDENTIAL SERVICE

Encompasses:

- Sub Acute requiring rehab component
- Clinical rehabilitation service
- Community residential level III and IV
- Respite option
- Day rehabilitation activities
- AOD supported living/rehab
- Coexisting disorders requiring low to medium intensive AOD treatment
- Short term AOD awaiting transfer to Res. treatment or while receiving outpatient
- Low risk social detox
- Respite

Location: Greymouth

Facilities: Motel style - 10 to 12 beds

Staffing: Minimum 24 hour onsite supervision (Level IV)

LONG TERM RESIDENTIAL OPTIONS

(Homes for Life)

Principally meets needs of existing long term PACT residents

Encompasses:

- Rest home care for over 65
- Long term level III community residential home(s)
- Contracted boarding situations
- Supported Landlord Service – shared flats

Location: Westport, Greymouth, Hokitika.

Capacity: 17 beds

INDEPENDENT LIVING

Encompasses:

- Living in own home
- Boarding
- Private rest home care

Community support to find accommodation and monitor progress and stability especially during transition period from community residential service.

COMMUNITY MENTAL HEALTH SERVICES AND DAY ACTIVITY CENTRES

Re-configured for increased rehabilitation capacity and focus

Additional 1.0 FTE to provide increased rehab capacity for residential rehabilitation service

Additional community support workers - 0.6 FTE for Westport. - 1.0 FTE for Greymouth/Hokitika incl LTR Supported Landlord Service

- Clinical Support
- Rehabilitation Support
- Other residential support - Home based support services, Community support work, Support for independence
- Consumer Peer Support

B. Adult Respite Services

Key Recommendations

1. Include opportunities for family members to access respite funding where a break for the family is the primary reason for the consumer requiring respite.
2. Utilise available single units in the proposed community residential service as another option for planned and crisis respite.
3. Utilise contracted boarding situations as an alternative option for the delivery of crisis respite in the Buller region.

C. Adult Community Support Services

Key Recommendations

1. Call a meeting of interested parties to set up a working group to actively explore:
 - The development of consumer organised business opportunities that can be used for pre-employment training, vocational rehabilitation and ongoing collective employment opportunities for consumers.
 - The establishment of linkages with interested employers to assist with work experience and employment opportunities for mental health consumers.
 - This would involve accessing WINZ resources and potentially assistance from the West Coast Development Trust.
3. Review the model and scope of day activities currently provided by the Coast Care Trust with the aim of meeting the needs of a wider group of people. Including the provision of more intensive pre-vocational skills development and transitional employment services such as work experience. Consideration to be given to 'best practice' examples such as the 'Clubhouse or Fountain House' model - site based programs where members are actively involved in operating the day-to-day business of the club.
4. Increase the level of community support work available to assist with the transition from residential rehabilitation to independent living especially for those who would otherwise occupy level I or II beds. Volumes: 0.6 FTE for Westport and 1.0 FTE for the Greymouth/Hokitika areas. Part of this increase would also act as the support mechanism for long term residential clients in a Supported Landlord Service in either Greymouth or Hokitika and as such funded as part of that service.
5. Explore options for developing paid consumer peer support as an alternative mechanism for providing ongoing community support.

D. Child and Youth Community Residential, Respite, Day Activity and Community Support Services

Key Recommendations

1. Undertake a recruitment campaign for care givers to provide respite and community residential services for children and young people.
2. Trial the provision of community residential services for children and young people in contract foster care situations on the West Coast.

3. Where suitable services are not available on the Coast, consider purchasing access to adolescent community residential and crisis respite services in Nelson/Marlborough or Christchurch.
4. Support the development of beds in the paediatric ward specifically for child crisis respite.
5. Establish a process with associated criteria for selecting, monitoring and training respite carers for children and youth.
6. Explore the possibility of utilising the 'Time out Carers' organisation to undertake the recruitment, selection and training of carers for respite and community residential services.
7. Develop more intensive day activity services for children and youth including:
 - Peer Support Groups – Consumer led group(s) with staff assistance, that provide opportunities for peer to peer support and social activities with a recovery focus.
 - After School Activities – Built around rehabilitation needs identified with consumers.
 - Weekend Camps – Offers opportunities for peer to peer support activities, intensive group work, planned respite along with mental health education and relapse prevention work.
8. Utilise contracted and trained foster situations for adolescent crisis respite as an alternative to the use of adult inpatient services.

E. Alcohol and Drug Services

Key Recommendations

Residential Treatment Services

1. That intensive and specialised residential alcohol and drug treatment continue to be accessed from regionally provided services delivered outside the West Coast.
2. That limited access (2-3 beds) in the proposed community residential service is available to carefully selected AOD clients requiring some form of supported accommodation services on the Coast including:
 - Post-residential alcohol and drug treatment supported accommodation with a rehabilitation focus.
 - Consumers with co-existing disorders (MH and AOD) where intensive treatment for AOD problems is not indicated.
 - Overnight accommodation for AOD clients from outlying areas receiving outpatient treatment via the West Coast Alcohol and Drug Service.
 - Short term supported accommodation for AOD clients awaiting admission to residential treatment elsewhere.
 - Social detox for low risk AOD consumers.
3. Funding of the above is mainly from general mental health service resources.
4. Maximum length of stay for AOD clients in the proposed service would normally be three months.
5. Trial periods of intensive treatment in short term retreats on the Coast in conjunction with other similar initiatives by other districts.
6. Offer short term adventure based residential treatment for groups of young people receiving outpatient counselling if numbers permit.

Details of Proposed Short Term Treatment Options:

- a) Permits an intermediate position between full residential and outpatient counselling.
- b) Provides a practical alternative to day programmes which would not otherwise be viable on the Coast.
- c) Use camp sites or other suitable facilities.
- d) For young people this could include outdoor adventure camps for several days.
- e) This is also an option for mental health services in general for young people and could combine treatment and respite options.
- f) Resourced by re-configuration of existing outpatient staffing and or financial resources. Link with other community and regional resources E.g. Child, Youth and Family resources for youth offenders, Ministry of Education etc.

Medical Inpatient Detox

1. Improve quality of the current arrangements by:
 - Developing a separate room with ensuite including shower in the general medical ward that can be used for detox when required.
 - Training general ward and mental health acute inpatient unit nurse(s) in medical detoxification.
 - Developing protocols between the general medical ward and the Alcohol and Drug Service with regard to the continuity of care for patients requiring detox.
2. Continue to utilise Kennedy Detox Service in Christchurch for the small number of high risk people requiring specialist medical detox services.

F. Improving Services for Maori

Key Recommendations

1. Employ a dedicated Maori mental health worker as part of the Child and Adolescent Mental Health Service as staff vacancies become available.
2. Employ a dedicated Maori AOD worker as part of the Alcohol and Drug Service as staff vacancies become available.
3. Work with local runanga to incorporate kaumatua/kuia support for tangata whai ora and whanau members in all mental health services.
4. Review the workforce development needs of staff providing rehabilitation services with regard to providing culturally effective and safe services for tangata whai ora and whanau members.

6 TIMELINE

Key Objective	Target Completion Date
A. Residential Rehabilitation Service	
1. Establish working party to oversee residential developments.	1 Jul 03
2. Develop initial implementation workplan.	31 Aug 03
3. Complete independent needs review for long term PACT residents.	30 Sept 03
4. Transfer initial group of four to Supported Landlord Service shared flat.	30 Nov 03
5. Establish stage one i.e. minimum of five bedroom house for community residential service.	30 Jun 04
6. Employ additional one rehabilitation FTE to increase rehab input for sub-acute clients in interim.	30 Nov 03
7. Transfer sub acute clients to new residential rehabilitation service.	30 Jun 04
8. Complete transfer of remaining long term PACT clients to alternative options.	30 Jun 04
9. Establish stage two i.e. additional attached individual accommodation units (up to seven beds in total).	31 Dec 04
10. Review rehabilitation staff configuration of current community mental health services.	30 Sept 03
11. Develop a workforce development plan for DHB and NGO staff with regard to rehabilitation skills, the recovery approach and culturally effective treatment.	30 Sept 03
<p>Note: The timeline for the residential rehabilitation service is indicative only and is dependent on a number of variable factors. It assumes that a facility will need to be built by building additional units alongside a large house. If full facilities can be obtained sooner the timeline may be able to be shortened.</p>	
B. Community Mental Health Support Services	
1. Review the day activities provided by the Coast Care Trust.	30 Sept 03
2. Hold an initial meeting of interested parties to progress the development of consumer organised employment activities.	31 Dec 03
3. Employ additional community support and/or peer support workers.	30 Nov 03 (Grey/Hoki)
	30 Jun 04 (Buller)

- | | | |
|----|---|------------|
| 4. | Develop a plan for the recruitment, training, contracting and monitoring of community caregivers for providing community residential and respite services for children and adolescents. | 30 Sept 03 |
| 5. | Establish a pilot mental health peer support group for children and adolescents. | 31 Jul 03 |
| 6. | Trial more intensive day activities including after school programs and week end camps for children and adolescents. | 31 Dec 03 |

C. Alcohol and Other Drug Services

- | | | |
|----|---|------------|
| 1. | Trial short term intensive AOD treatment weekend retreats for adults. | 30 Jun 04 |
| 2. | Trial short term intensive AOD intervention adventure camp for adolescents. | 30 Jun 04 |
| 3. | Develop an agreement with the General Manager Hospitals for providing some form of suitable facility for medical detox in the general medical ward. | 30 Sept 03 |
| 4. | Develop protocols between the General Medical Ward and the Alcohol and Drug Service regarding the management of medical detox patients. | 30 Sept 03 |
| 5. | Train two ward nurses in medical detox practice. | 30 Sept 03 |

D. Services for Maori

- | | | |
|----|--|---------------------|
| 1. | Employ a dedicated CAMHS Maori mental health worker. | As vacancies permit |
| 2. | Employ a dedicated Alcohol and Drug Service Maori worker. | As vacancies permit |
| 3. | Formally approach local runanga to develop a joint plan for establishing kaumatua/kuia support for mental health services. | 31 Jul 03 |

7 RESOURCING OF RECOMMENDATIONS

Resourcing new service developments will occur from the following options:

1. Primarily by a re-configuration of the current Level III community residential contract. This includes:
 - Achieving cost savings by placing existing residents with long term residential needs in suitable more cost effective alternatives to the current arrangements.
 - Incorporating beds (and the associated resources) occupied by existing non-long term PACT clients suitable for residential rehabilitation in the new residential service.
2. Accessing current respite funding for people who use the new community residential service for respite purposes.
3. Using unspent Alcohol and Drug Service funding allocated for accessing inpatient medical detox services outside the region.
4. Re-configuration of existing community mental health services with regard to rehabilitation capacity. (Additional FTE is on top of this).
5. Under-utilised staff capacity in the acute in-patient unit on an ad hoc basis during periods of lower demand.
6. Retraining existing AOD service staff to assist with short term treatment options.
7. Using any funding that may be attached to up to three residents currently in Seaview who may be suitable for the community residential service.
8. WINZ benefit contributions from residents.
9. Utilising resources allocated to the unfilled 0.5 FTE position for child and youth community support worker.
10. WINZ and other community resources for vocational employment opportunities.
11. Joint funding with Child and Youth and Family for AOD services that work with young offenders.
12. Community housing section of Housing NZ in terms of capital investment in facilities. Then leased to provider.

Notes:

Initial cost planning indicates that it is possible to fully fund the annual operating cost of the residential rehabilitation service development, including the additional rehabilitation FTE, through a re-configuration of existing resources alone. However there are a number of risks and variables for the proposal which will depend on two factors in particular. Firstly the cost and method (e.g. lease or purchase) of obtaining suitable facilities and secondly the final outcome of the independent needs review with regard to the ability to transfer long term PACT clients to cheaper forms of care. There will also be additional transitional costs associated with the development including staffing and set up expenses.

A detailed two or three year revenue and expenditure budget for the residential rehabilitation service will need to be developed as part of the implementation process.

All recommendations have been developed with the aim of having a fiscally neutral impact on DHB expenditure.

Priority for available funding is the development of the residential rehabilitation service. Additional funding to be used to contribute to service development initiatives for child and

youth and alcohol and drug services followed by increasing the overall level of rehabilitation staff resources in all districts over and above the increases recommended.

8 SERVICE UTILISATION DATA

Sub-acute Beds

The exact utilisation of sub-acute beds is difficult to estimate due to problems with incorrect coding of patients in the patient information system and the fact that service users can be on leave for significant periods of time while recorded as admitted. In measuring actual occupancy rates, because sub-acute patients are often not coded in the DHB database as moving from acute status to sub-acute status, it has been necessary to set an arbitrary time limit to define sub-acute status. In this case all patients in the inpatient unit who have been admitted for longer than 25 days.

WCDHB Sub-acute Data: All Mental Health Inpatients with Length of Stay Greater than 25 Days Between 1 Nov 01 And 31 Oct 02	
Total number of patients	26
Total number of female	11
Total number of male	15
Total number of discharges	34
Average length of Stay (including time on leave)	92
Minimum length of stay	26
Maximum length of stay	365
Total number of bed days including leave	3124
Estimated number of leave days	371
Estimated number of occupied bed days	2753 (5 beds)
Average age of patients	49
Youngest patient	23
Oldest patient	85
Number aged between 20-44 years	14
Number aged between 44-65 years	7
Number aged over 65 years	5
Number of Maori	3

PACT Level III Community Residential Service Long Term Clients

Out of the 19 PACT beds the majority are occupied by long term ex-Seaview residents who joined the service three years ago. Figures are as at 21 October 02.

Total number of long term clients	16
Youngest long term client	38
Oldest long term client	79
Average age of long term clients	59.4 years

9 SUMMARY OF INFORMATION GATHERING CONSULTATION FORUM RESULTS

Medium Term and Extended Inpatient Services

What Works Well About the Current Arrangements for Sub-Acute/Medium Term/Extended Care Beds

Both consumers and mental health workers viewed the inclusion of sub-acute beds in the inpatient unit with acute clients as having few strengths. Positive aspects included:

- Sub acute beds close to intensive treatment if required.
- Sub-acute patients propping up acute inpatient unit in terms of feasibility.
- Current nurse specialising arrangements for long term sub-acute patients who are reintegrated into a PACT house have been successful.

What Doesn't Work Well

Consumers and workers were adamant that having sub-acute/extended care beds in the acute inpatient unit was an unsatisfactory means of delivering medium term beds for the following reasons:

- Focus in the inpatient unit is on safety and crisis management of patients with higher levels of acuity, not rehabilitation. Having sub-acute patients in with acute patients potentially reduces safety for acute patients.
- Acutely ill people were often disruptive and exhibited disturbing behaviour. Eg. Disturbed others sleep and could be aggressive. Long term patients react negatively to acute psychosis and can learn bad behaviours. Conversely long term clients exhibiting strange behaviour can frighten acutely unwell people. The setup was seen as negative for both groups.
- Sub-acute beds not always available if there was excess demand for acute beds.
- Encouraged institutionalisation of people.
- The locked in /fenced in environment was distressing for extended care patients.
- Consumers argued there was nowhere indoor to smoke.
- Physical facilities and focus of unit not suitable for rehabilitation activities and did not encourage independent recovery.
- No psychologist was available.

Staff identified the following deficits in the acute facility:

- Lack of a whanau room for visiting relatives especially for Maori.
- Access to emergency on-call staff including orderlies trained in calming and restraining techniques.
- Specialist alcohol and drug training for staff in regard to detoxifying patients.

Westport mental health workers stated that TACT was not available in Buller so this tended to increase the need for medium term beds.

Ways the Effectiveness of Current Arrangements Could Be Improved

If the sub acute/extended beds remained in the acute unit consumers and workers argued for the following improvements:

- More physical separation between acute and medium term beds in the unit.
- Separate day facilities on site or in the community for rehabilitation day activities. E.g. Social club rooms. Facilities would need to include a kitchen, gardening, gym equipment, art and craft activities. Consumers wanted a more peaceful tranquil environment.
- More in-depth rehabilitation in the inpatient unit. This would require additional rehabilitation nursing and OT. One manager viewed attaching rehabilitation activities to the acute unit as helping breakdown rehabilitation barriers in the unit.
- Dedicated sub acute staff.
- Westport workers advocated for clearer client based criteria for using the sub-acute service. They favoured lowered levels of medication with increased use of alternative non-pharmaceutical therapies ie. greater rehabilitation and less of a medical focus.

Gaps for Medium Term Inpatient Services on the West Coast

Both consumers and workers identified the following service gaps:

- Clinical rehabilitation services for sub-acute/extended care. Most preferred a community based setting that could be linked to a Level IV community residential service.
- A stepdown halfway house between the inpatient unit and independent living.
- A need for a service in Westport.

The issues for sub acute/extended care inpatient beds were not that there was a service gap, but that the means of delivery needed to change and availability issues needed to be addressed.

Estimate of Number of Medium Term Beds Required for the Coast.

Estimates varied from five to twelve but most considered five beds to be about right. However a backlog of clients at the moment due to the absence of clinical rehabilitation services could impact on future demand if rehabilitation services were developed.

A rehabilitation service was expected to reduce demand for the acute unit by reducing the number of people recycling through it.

Suggestions for Alternative Means of Delivering Medium Term/Rehabilitation Inpatient Services on the West Coast

There was strong support from both workers and consumers for a new community residential service that included sub-acute, clinical rehabilitation and level III/IV needs but with a rehabilitation focus.

A ‘motel’ style facility (house plus individual units) was favoured that permits people to receive high to low support but without shifting accommodation. The facility would require a garden, kitchen, quiet room gym etc.

Suggestion that because of limited resources, could split the accommodation component to be provided by a community provider and the clinical input to come from specialist MH teams.

Support was expressed from several workers for the Timaru ‘Strengths Model’ which emphasises client centred individual needs assessment and goal setting.

A number of workers wanted more intensive clinical and rehabilitation support for people in their own homes. Some wanted this as the preferred means of delivering rehabilitation compared to residential options.

Community Residential Services

What Works Well About the Current Arrangements for Delivering Community Residential Level III Beds

Most people interviewed thought the current PACT level III homes were run well with a nice home-like atmosphere.

What doesn’t work well

- In effect most clients are residential long term clients with many from Seaview. As a consequence there is a problem accessing PACT for community residential level III services.
- The lack of rehabilitation activities was considered an issue.
- Some staffing difficulties.

How Could the Effectiveness of Current Arrangements Be Improved

Suggestions included:

- Some consumers wanted more consumer consultation.
- Greater rehabilitation focus in service for true level III clients.
- Staff need better training around mental illness, the recovery approach and rehabilitation methods.

Gaps for Community Residential Services on the West Coast

Community Residential Level I/II

Workers thought level I/II could be provided in the community with support from TACT and community mental health teams for people living in their own homes.

Workers and consumers identified a need for some short term accommodation before returning to home after inpatient care.

There was support for group flats or grouped individual flats including supported landlord service and a contracted boarding situation with stringent vetting of the host.

Hokitika workers indicated that most needs at this level were met by clinical staff who could better be used elsewhere.

Community Residential Level III/IV

Several workers and consumers identified a need for a level IV facility on the Coast particularly for clients with more complex needs Eg. Psychosis, aggressive behaviours, those requiring detox.

Accessing level IV services outside of Coast was seen as stressful for client.

Consumers and workers identified a gap for a level III/IV community residential house in Westport.

Residential Intensive Long Term

PACT was currently seen as providing this through level III houses. But level III was not considered the best way of providing care for many long term clients who needed a different setting.

Suggestions for Alternative Means of Delivering Community Residential Services on the West Coast

Consumers and workers supported a proposal for a motel style facility for community residential level IV/III with a structured rehabilitation focus and client centred care. There was support for including these needs as part of a broader service for clients requiring sub-acute/extended inpatient care with a rehabilitation focus. Suggested features of such a service included:

- Vary clinical and rehabilitation support to provide different levels of care.
- Support from groups such as Alcoholics Anonymous.
- Also use for day programme rehabilitation services.
- Includes therapies such as life skills and anger management.
- Locate close to base hospital.
- Estimates of the total number of beds needed for the whole service ranged from eight to twenty.

A number of issues regarding such a service were raised including:

- There was some debate around ability to take people with co-existing disorders (AOD and MH) and AOD clients in general in a mixed service. But recognition there was a need for all these groups.
- There was concern different levels of age and disorder would not mix well.
- Need for stability, consumers didn't want to be shunted from home to home as levels of need changed.
- One manager believed that Greymouth Community Mental Health Services had the capacity to pick up a higher level of work in support of model.

There was support for level I/II community residential services being delivered as supported landlord services, contracted boarding situations or by more intensive support for people in independent living.

Consumers and workers identified a gap for community residential services in Westport.

It was suggested that long term residential needs be funded separately to free up resources for true clinical rehabilitation and community residential services.

A rehabilitation service would mean that clients returned to the community better equipped and therefore less likely to relapse and require inpatient care.

Other Community Residential Services

Limited time prevented significant discussion regarding the following services apart from the comments noted. In general the ability to provide highly specialised services was seen as problematic on the Coast in terms of viability.

Forensic – community residential, recovery support and education

Limited access in Westport.

Mother and Babies – respite services or intensive home support

Significant gap for people and families involved.

Family member suggested linking with other social services e.g. Homebuilders to provide better support.

Head Injury or Neurological with Behaviour Problems

Little local support is a problem.

Community Support Services (Including Respite Services)

What Works Well About the Current Arrangements for Community Support (Excluding Respite)

All workers reported that community support was easy to access, meets needs, is effective and provides flexible individualised care from dedicated professionals. Has a rehabilitation focus but caseload overwhelms. Keeps people out of hospital and provides social support and assistance with integration into the community.

Consumers spoke highly of support in the community especially in Westport and reported support was responsive to changing needs. Day activities at the Coast Care Trust offered a variety of opportunities for friendship, recreation and positive activities.

What Doesn't Work Well

Workers reported that the Coast Care Trust activity centres did not suit everyone especially non-smokers and those who 'outgrow' the centres. Often this reflects the need for more intensive educational and vocational training and skill development. Westport workers reported that the Activity Centre did not like people attending who were 'symptomatic'.

Coast Care Trust has an unsuitable Hokitika facility – mostly young men – women don't like the environment. But staff do a good job.

Westport workers saw utilising needs assessment services to access community support as an unnecessary duplication of what the community mental health teams could do.

Inflexible for short term needs e.g. 4 weeks –clients tend to end up in IPU as a consequence.

One manager believed there needed to be a clearer plan for withdrawal of support when a person is able to function normally. Other workers saw ongoing support having a preventative effect in terms of being able to monitor risk of relapse.

Gaps for community support services on the West Coast

Other residential Support. Including:

- *Home Based Support Services*
- *Community Support Work*
- *Support for Independence*

Hokitika - Support workers need more guidance and support from MH nurses.

Lack of after hours support in Westport e.g. by TACT.

Supported Landlord Service

Happens informally in Westport

Work Rehabilitation/ Employment and Educational Support Service

This service was identified as needed.

Employment opportunities are improving on the Coast with the economic investment.

Gap especially for young people in Westport.

Coast Care Trust has this role. Activity centres do OK with resources.

Activity Based Rehabilitation Service/Day Activity and Living Skills

Need to broaden scope of what activity centres provide.

Suggestions for Improving Community Support Services on the West Coast

Other residential Support. Includes:

- *Home Based Support Services*
- *Community Support Work*
- *Support for Independence*

Higher level of clinical and rehabilitation support for people living in their own home. More clinical input would enable more rehabilitation to be undertaken for people in independent living.

Greater rehabilitation focus that proactively promotes wellness required rather than focus on keeping people out of hospital.

Supported Landlord Service

Consumers supportive but wanted careful screening.

Support for the concept from workers.

Work Rehabilitation/ Employment and Educational Support Service

Suggestions included:

- More employers willing to take on people required.
- Need to look at subsidised employment by WINZ.
- Workbridge liaison person.
- Greater rehabilitation focus with more intensive educational and vocational programmes.
- Set up a motel that could be used for community residential service with additional rooms used as a working motel with consumers employed as workers.
- Support was expressed for the 'Clubhouse' model.

Activity Based Rehabilitation Service/Day Activity and Living Skills

One person suggested that this could be delivered by other community groups also.

What Works Well About the Current Arrangements for Respite?

Generally workers believed arrangements for respite worked well with a range of options that were sufficient to meet individual needs. Funds were sufficient.

Consumers reported current arrangements for respite were useful, prompt when required and offered good support.

Other observations included:

- Includes meals on wheels as an option.
- Putting people in motel with family for short period useful.
- Have found that family or friends don't require payment when utilised.
- High level of assertive outreach in Hokitika means less need for inpatient care and respite care.

What Doesn't Work Well

Works well for planned respite in Westport, but limited options for crisis respite apart from unsupervised support in a motel.

Consumers reported people in outlying areas sometimes had trouble accessing care and there was sometimes conflict between the family, service user and clinician as to what was required for the service user.

One family member believed needs assessors were over worked and not everyone who needed respite was therefore getting it.

Costs not monitored well.

One case manager found the amount of associated paper work excessive.

Suggestions for Improving Respite Arrangements

Crisis Respite

Motels useful to keep families together.

Some funding could go to families for care.

Option of respite for carer should be considered.

Consumers suggested the option of staying at home with intensive support.

Provide supervised support for individuals receiving respite in Westport.

Better way for solo mothers with kids to access respite in the community other than via Inpatient Unit.

Planned Respite

Sometimes more useful to offer respite to the family and let the service user stay at home. E.g. Solo parents if respite available for children to get break.

Need to keep up to date with needs assessments.

Child and Youth Community Residential, Respite and Day Activity Services

What Works Well About the Current Arrangements for Children and Youth for These Services

Young consumers thought planned respite offered a good break away from hassles at home. Workers viewed planned respite as providing a welcome break for both families and the young person.

Young consumers reported what worked well for them in assisting their recovery in the community was having someone to talk to about issues such as getting on with their family or school. Especially someone who is not connected to school or family and will keep things confidential.

Workers viewed the community support services available for children and young people as a very valuable service that improved the individuals independence, motivation and skills but was under utilised.

What Doesn't Work Well

Planned Respite

No monitoring in the system of planned respite care - need to have safety checks in place.

No measurable way to test effectiveness of child's care.

Hard to find caregivers – shortage especially in outlying areas.

Would like greater access.

Not integrated well with overall service provision.

Crisis Respite

The use of one bed in the Parfitt paediatric ward is being finalised. Workers indicated it was difficult to access the ward as Parfitt are reluctant to keep child there, as they don't have suitable staff. There are also safety issues for the child and other children in ward.

Child and youth workers considered it inappropriate to have an adolescent (>14) in the mental health adult inpatient unit as they learn 'bad habits' from adults and there are no activities for the young person in the ward. Staff are not trained and inappropriate friendships can be formed with other patients which can be burdensome on the young person.

16-17 year olds too old for paediatric ward and too young for the adult inpatient unit who are not equipped to deal with them.

Difficulties in accessing TACT who are reluctant to deal with child and youth.

Difficulties are compounded by the absence of a consultant child and youth psychiatrist.

Community Support Work

Service not available Coast wide.

Doesn't deal with mild to moderate levels of mental health problems. Not preventative in approach.

Suggestions for Improving Arrangements for Child and Youth Respite on the West Coast

Workers sought the following improvements:

- More caregivers, with appropriate screening for motive and ongoing monitoring. A promotional drive to recruit was suggested.
- More information for the caregiver re type of child the caregiver is dealing with.
- Training for staff in the adult inpatient unit to deal with families who look after child.
- Better coordination. An effective regional agreement would help.

Gaps for Child and Youth Services on the West Coast

Community Residential Services

No service is available on the Coast and accessing Christchurch services is difficult.

Planned Respite

Access gap in general – especially for mild to moderate needs.

Need for siblings to access respite.

Gap for youth with AOD problems who want to give up and need to distance from an unsupportive family environment.

Places for children of solo parents with mental illness.

Crisis Respite

Gap with TACT/emergency services being unavailable.

For AOD youth, especially those needing emergency respite from family situation. One AOD consumer reported there was no respite facility for her child who had co-existing disorders and had been suicidal.

Day Activity Services

Child and youth workers noted the Coast wide gap for group day activities. Only individual support is currently offered.

Other gap identified included a youth AOD day programme.

Suggestions for Improving the Delivery of Child and Youth Services

Community Residential Services

Some workers proposed a combined respite and residential service but most agreed there were insufficient numbers to make a community residential service for children and youth viable on the Coast.

Contracted foster situations was presented as an alternative option.

Young consumers wanted a place like home but quieter, safer and confidential that they could go to anytime. Views differed about who with. Some wanted it with people that didn't know them or their family while others would prefer to be with a friend. They were open to living with a family in a boarding situation but would prefer a group home with other young people.

Planned Respite

A joint venture was proposed to pool resources of different groups/organisations E.g. A weekend house.

Offer training to suitable people who may be interested but don't feel fully equipped to deal with them.

Weekend residential.

Appoint a liaison worker between caregivers and the CAMH service.

Run a recruitment campaign for caregivers.

Make family respite available. i.e. for the whole family.

Crisis Respite

Similar suggestions as for planned respite.

Young consumers preferred a setting which had other children and young people to talk to. Knowing the staff 'were there for you' was important. They also wanted a choice of when their family was there. They did not like the prospect of being in an adult ward as they would feel uncomfortable and out of place. 'You would think you were going crazy'.

Workers supported utilising the Parfitt ward and some wanted access to the Youth Speciality Service in Christchurch.

Young consumers wanted a place they could go to sometimes when things were not going well at home.

Day Activity Services

Young consumers wanted a peer support group that could also provide support while young people were in hospital. Support group concept was backed by workers.

Holiday camps/ programmes were identified as an option for periods of more intensive activities for children and youth. Young consumers were positive about weekend activity/adventure camps (at camp sites) as a way of getting more intensive treatment and short term respite.

A joint venture with other organisations to pool resources was proposed e.g. Youth centre – one stop shop.

Alcohol and Other Drug Services

What Works Well About the Current Arrangements for Detox Services

Use of Morice ward ensures medical help is available.

Consumers reported case workers worked hard to assist with travel to the Kennedy medical detox unit in Christchurch and to simplify access when required.

What Doesn't Work

Consumers reported the following problems:

- Accessing beds can be delayed.
- Embarrassment and distress when significant detox symptoms displayed in front of other patients.
- Stigma issue about acknowledging why in hospital. Ironically other patients query why someone is there when no symptoms are evident.
- Problems in accessing Christchurch relate to transport difficulties and isolation from family and obtaining childcare.
- No place to smoke indoors.
- Staff untrained in detox lack empathy for the patient.
- Not enough post detox follow up.

Workers reported the following problems:

- A lack of understanding of detox by untrained staff means inappropriate clinical decisions are sometimes made.
- There is an expectation that A&D Service staff will co-ordinate detox but nursing skills required are not available to do so effectively.
- Morice ward only suitable for alcohol detox. More support is required for opioids.
- Clients can sometimes be disruptive in the ward.
- Lack of co-ordination with A&D Service staff.
- Out of district transport of patients to Christchurch uses significant supervising staff resources to accompany the individual.

Ways to Improve the Effectiveness of Current Arrangements for Detox

Consumers suggested the following:

- Provide privacy for medical detox in the Morice ward. Preferably a separate room with ensuite shower and toilet
- Better support following detox in Morice ward.

Workers suggested the following:

- Need designated detox staff in Morice ward.
- Formalise detox arrangements.
- Provide more expertise with regard to detox in ward.
- Better co-ordination with AOD workers.
- Train a person in Morice ward and/or TACT team re detox. Training a TACT worker would be useful for co-existing disorders.
- Combine detox with some type of rehabilitation for co-existing disorders.

Gaps for Detox Services on the West Coast

Availability of beds an issue in Morice ward.

No social or home detox.

Need for safe space for engaging/motivating people with high and complex needs before undertake rehabilitation.

Suggestions for Alternative Means of Delivering Detox on the West Coast

Medical Inpatient Detox

Consumers wanted a bed in Westport.

Community Social Detox

Consumers wanted a bed in Westport.

Consumers and workers wanted to include social detox in either an AOD treatment house facility or as part of a proposal for a residential rehabilitation service.

Work with Te Whai Ora to provide a 24 hour monitoring service for people detoxing at home in Greymouth.

Peer support while detoxing at home.

What Works Well About the Current Means of Accessing AOD Residential Treatment Services

Everyone agreed there was access to a good range of specialised regional services.

Removal from the local environment can assist treatment and maintain privacy better.

What Doesn't Work

Consumers and workers experienced delays in accessing residential treatment. Delays can affect motivation and increase risk of relapse.

Separation from family can cause hardship and reduce support.

Length of programme at Odyssey resisted by clients. More positive PR needed for this programme.

No youth residential service in the South Island.

AOD Residential Needs Not Being Effectively Met for West Coasters

Consumers and AOD workers identified the following needs:

- Youth AOD residential service.
- Pre-treatment accommodation between assessment and admission to specialist regional residential treatment on the West Coast.
- Post residential support on the West Coast and supported accommodation while undertake outpatient treatment.
- Respite care for women with children in recovery.
- Services for co-existing disorders.

Residential AOD Services That Could Be Effectively Provided on the West Coast

There was support from a number of consumers for the development of a 24 hour staffed 4-5 bedroom house that could be used as an AOD facility for social detox, supported accommodation while waiting for admission to treatment elsewhere, and as a halfway post-residential treatment house.

Some AOD workers proposed a similar house or structured AOD accommodation hostel that could offer accommodation for the range of needs outlined above, plus long term recidivist clients who were non-compliant with treatment goals. Clinical support provided from mental health and AOD services. AOD workers differed in their view of the extent such a service could accommodate a range of service users. Several considered it not suitable for both male and female or young people.

Incorporating mental health clients also was suggested as a means of improving feasibility.

Others considered a separate AOD facility as not viable on the Coast, but supported dual diagnosis, pre-treatment support and post residential rehabilitation clients being included in a proposal for a residential rehabilitation mental health service. However views differed with regard to the ability to mix mental health and AOD clients in such a service.

Some support for a child and youth residential service based on the Coast. Workers supported the use of short term intensive treatment using outdoor pursuits. This would not require the establishment of special facilities but would use existing campsite facilities. Could be linked with other organisations running similar programmes to improve viability. Young people were positive about a model involving outpatient counselling followed by an outdoor adventure camp if there were others they knew.

Treatment flow could be smoother if young person completes treatment closer to home in some sort of supported accommodation.

Link youth AOD residential services on Coast with other one stop residential services offered by other agencies to improve viability.

Proposal is currently under discussion for a youth night shelter in Westport focusing on young people who are intoxicated at the weekend. Potential for the A&D service to offer

assessment, outpatient counselling and follow up for young people depending on the service model developed at the shelter.

There was also some support for intensive outpatient treatment in a weekend camp setting for adults. E.g. over four weekends. This would also offer respite for the family.

One worker suggested AOD supported living services for youth and women in particular were a priority.

Services for Maori

How the Cultural Needs of Maori Could Be More Effectively Met in the Delivery of Services

Suggestions offered by mental health workers included:

- Ensuring appropriate cultural treatment is part of any new development and guided and delivered by Maori. The Four Cornerstone bio/social/psychological/spiritual model was promoted by Maori staff along with quality cultural assessment. Tangata whai ora are often uncomfortable with 'mental illness' concept because of stigma.
- The importance of whanau inclusion and support for tangata whai ora was stressed. Particularly the need to ensure whanau involvement is optimised in rehabilitation and that facilities permit this. E.g. Whanau room. The utilisation of whanau support staff for Maori would assist.
- Liaison between hospital and Maori in community – links with runanga and kaumatua for input.
- Consultation/collaboration with Maori service users.
- Support for staff including Maori staff offering consult/liaison services and cultural awareness and treaty training for staff.
- Involve Maori mental health workers in care for Maori undergoing detox.
- Dedicated detox service for Maori delivered by Maori.
- Workforce promotion for more Maori mental health workers.
- Dedicated Maori child and youth mental health worker.
- Dedicated Maori AOD position outlinking to local Maori communities. Could lead to outreach programme on a marae or other suitable venue.
- Maori AOD/mental health worker for youth.

The Rehabilitation System

Barriers the West Coast Faces in Ensuring a Comprehensive and Effective Mental Health Rehabilitation Service is Provided

Barriers identified included:

- Geography i.e. small population dispersed over a wide area.
- Service gaps – Level III Pact homes offering homes for life.
- Caseloads too high for rehabilitation.

- Limits of Blueprint resource guidelines.
- Funding and staff resourcing limits.
- Underestimation of the need for residential services when Sefton closed.
- Insufficient rehabilitation staff and services.
- Lack of suitable housing and other social agencies.
- Coast attracts itinerant high need population.
- Lack of understanding of rehabilitation model in the mental health service.
- Lack of qualified mental health staff.
- Restricted entry criteria – no service for mild to moderate (Ambulance at bottom of cliff approach fostered through 3% focus).
- No primary mental health for child and youth – kids referred by schools (teachers), parents and other agencies.
- Attitudes of IPU and TACT to working with child and youth. Will not assess if CYF and youth justice status.

Ways to Improve How Clinical Services, Community Residential Services, Community Support Work and Respite Services Work Together

Co-ordinated rehabilitation approach.

Dedicated assertive outreach team for Greymouth and Hokitika which would permit a clinical/medical/rehabilitation mix of staff on a mobile basis.

Improved communication and co-operation between teams. Need for inter-team case meetings with the client that are attended by all key workers along with individualised rehabilitation plans, clearer client goal setting and review, and clearer role responsibilities for staff.

Focus on needs identified by clients and their family.

Adopt the 'Strengths' model.

Collaboration not competition.

Youth leadership.

Better understanding of realities of child and youth MH work ie. not just behaviour or parenting issue.

Priorities for Service Development

The main priority identified was the development of a residential rehabilitation service incorporating clinical rehabilitation and community residential level III/IV services.

Other priorities stated were:

- Better rehabilitation support of people in independent living.
- Development of individualised rehabilitation plans.
- Better crisis respite in Buller region.
- Vocational rehabilitation services.

Other Comments

The need to focus on normalising treatment and support for service users was highlighted.

One person suggested mental health services should focus on intervention for serious illness and early intervention to prevent relapse only.

10 DISCUSSION OF SERVICE DEVELOPMENT OPTIONS

The following discussion outlines some of the issues raised in considering options raised by stakeholders within the scope of the Review and the reasoning behind the recommendations.

Sub Acute/Clinical Rehabilitation Beds

Option 1: Retain sub-acute beds in acute inpatient unit but improve rehabilitation facilities and resources.

Includes: Providing some physical separation within current ward or by extending current ward.

Having patients sleep in the acute ward but attend a separate day rehabilitation programme/activities centre either on site or off.

Provide some staffing specifically with a rehabilitation focus.

Discussion

The advantages of this option are that it is less expensive than developing a new service such as in option 2 and it continues to utilise the acute unit resources for accommodation and clinical care for sub-acute clients. It would also mean that patients are not faced with another facility shift before returning to independent living. However the option would require additional staff with a rehabilitation focus to support sub-acute clients.

This option had little support from any stakeholders and was not recommended for the following reasons:

- Most people believed a strong rehabilitation culture could not easily be built in the inpatient service because of the acute focus, and therefore a new service was required.
- It would not be easy to provide more physical separation in the ward and there were limits to the facilities available to provide intensive day rehabilitation activities on or off the hospital site.
- There were feasible more effective options for developing a structured residential rehabilitation service that included sub-acute/extended care patients.
- A community based option would be less institutional in nature and more appropriate to achieving rehabilitation goals.
- A revamped community residential level III/IV service would be most viable with a residential rehabilitation service for sub-acute clients attached.

One of the issues for the acute unit in any change proposal, is that the minimum staff resources required to operate the unit will not alter if significant numbers of sub-acute patients are removed. Therefore no cost savings are realised from such a move. This raises issues as to the best use of the inpatient unit resources in the future if it has significant spare capacity. It is important that this does not create pressure to fill beds with clients who could be more appropriately treated in community settings from a clinical and rehabilitation point of view. Work will need to be undertaken as to how inpatient unit staff resources can be used to support services such as the proposed residential rehabilitation service during periods of low demand.

Option 2: Include the sub acute beds in a community based clinical residential rehabilitation service.

- Includes:
- Strong rehabilitation and recovery focus with individualised rehabilitation plans.
 - Rehab/clinical input provided from provider arm mental health staff resources and varied to meet individual support needs.
 - Physical facilities of a large house/hostel with attached flats. Motel style.
 - Encourage use of community resources as much as possible.
 - Incorporates clinical rehabilitation services with community residential level III/IV services.

Discussion

Most people supported moving the sub-acute beds into a community based residential rehabilitation service because of the unsuitability of the acute focus of the inpatient unit and the desire for a rehabilitation approach for extended care patients. There was an expectation that a structured rehabilitation programme would equip service users with better skills to live independently and therefore reduce the risk of relapse and the need to re-enter the inpatient unit in the future.

There are successful examples nationally of sub-acute services being delivered in a community residential setting. To be successful the service requires clinical and medical support to be available as needed. On this basis it is crucial that the proposed service is able to readily access clinical support from community mental health teams and Grey hospital when required, including for emergency or crisis situations. A location relatively close to the base hospital in Greymouth would be the preferred location.

Ideally the optimum model would be a service partnership between an NGO provider and the provider arm. To service sub-acute needs the minimum staff supervision for the facility would need to be 24 hour wakeover clinically trained staff. This would be the equivalent of community residential level IV staffing specifications.

Ultimately the decision as to which patients would be suitable for the proposed residential rehabilitation service would be based on clinical criteria. The spare capacity retained in the inpatient unit would enable clinicians to continue to utilise the unit for sub-acute patients requiring more intense medical supervision. This would not preclude these patients attending the rehabilitation service for day activities.

Community Residential Services

Option 1: Provide a comprehensive level I to IV service within a new model.

- Includes:
- Strong rehabilitation and recovery focus with individualised rehabilitation plans.
 - Separate the accommodation component from the clinical rehab/support functions.
 - Provide stable accommodation options for people and vary the clinical/rehab input alongside as a means of addressing levels of need issues.
 - Combine with clinical rehabilitation service for sub-acute clients.

Physical facilities include: large house with flats close by (onsite or in locality) or motel complex with house plus smaller units.

Include clients with co-existing disorders (AOD and MH).

Located in Greymouth.

Option 2: Provide a comprehensive level IV/III service within a similar model but deliver level I/II support via community support workers in peoples homes or with a supported landlord service.

Discussion

While some need for Level I/II beds was identified as a service gap, it was generally concluded that these services could be best provided through a supported landlord service or by community support services for people living in their own homes. This reflects national trends towards service delivery which encourages normalisation of living circumstances with provision of this level of community residential service. Consequently only level III/IV residential beds are recommended to be incorporated into the proposed model.

Operating one community residential level III/IV facility that also incorporates sub-acute beds improves the viability of services because the minimum staffing levels do not change up to about ten to twelve beds. However to avoid constructing another institutional style facility a motel style model is recommended. This would have a large house for those residents requiring closer supervision and individual units which would give clients with lower support needs more independence and privacy.

The clear need for any future developments of community residential services is to significantly increase the rehabilitation focus of the service.

The differing needs of specific individuals is catered for in the model by varying the level of clinical and rehabilitation input provided. The advantage of this model is that it permits a range of needs to be accommodated in one facility without moving people between different facilities as their needs change.

The estimated need in terms of number of beds varies and is difficult to quantify exactly. General agreement is that the minimum number of beds required for both clinical rehabilitation/extended care/sub-acute and community residential level III/IV is about eight beds with some additional bed space for AOD clients and for use as a respite facility. One problem is that in the absence of a residential rehabilitation service a backlog of service users has accumulated that may mean a higher demand in the short to medium term.

Westport, Hokitika and Greymouth all wanted to see a community residential service house in their locality. This is not considered viable within the current proposal. However options of supported landlord services and extra community support for transition to independent living need to be considered for all areas.

Option 3: Transfer the care of existing PACT clients with long term residential needs into alternative long term services.

- Includes:
- Supported Landlord service operated by PACT as a group flat.
 - Rest home care for older individuals
 - Contracted boarding situations
 - A reconfigured level III house if required with sleepover staff.

Discussion

The future care of the long term and largely older clients currently in the PACT community residential level III houses is critical to the review for two reasons. Firstly these clients are tying up funding resources needed to develop residential rehabilitation services and secondly they are occupying community residential service beds that are needed by consumers who require supported accommodation for a period before moving to independent living.

The Review advocates for reassigning these clients as residential long term and finding less costly but suitable ways to provide that long term care. Initial estimates are that there are a minimum of four current residents who could live successfully in a supported landlord service operated by PACT in the form of a group flat with daily input from a community support worker. An independent needs review of all long term clients is recommended to ensure services offered match the level of care needed.

If a level III long term house is required, ways need to be explored to reduce the overall cost of the service without compromising care. E.g. Having sleepover staff and maximising the number of bed in one house to minimise staffing costs.

Any service configuration will require good will from all parties including PACT and the DHB. It is therefore important that a 'good faith' change process underpins the implementation of the recommendations.

Alternatives payment methods for funding the new residential rehabilitation service were considered. Traditionally services have been funded by purchasing a number of different levels of care with specified bed numbers for each. Current practice for multi-level services is to 'block' fund the service and let the provider vary the level of care as required. The Review supports this approach as it offers greater flexibility to meet service user needs. Because of the relatively small size of the proposed service and the need to ensure security for the provider over time, capacity funding is recommended, but occupancy rates will need to be closely monitored.

Community Support Services

Option 1: Provide intensive mobile clinical and rehab support for people in independent living situations as an alternative to residential services.

Includes: Alternative to inpatient or community residential services.

Up to 24 hours per day if required.

Discussion

Some workers advocated for the provision of much higher levels of community support to people in their own homes as an alternative to residential services. This could include providing 24 hour care if required. In general there was a view that more intensive and assertive support would decrease the need for both acute, sub acute and community residential services.

While it was agreed that intensive support in peoples own homes was the ideal model, it was considered prohibitively resource hungry especially in a district such as the Coast where many people live in isolated communities. Implementing such a model of care in full depends considerably on the community itself taking responsibility for the care of people with mental disorders. In practice there are still a number of discrimination and stigma barriers to overcome before the community is willing to accept this level of responsibility.

However this option does emphasise the important principle of ‘normalisation’ in caring for consumers and that the goal of the service overall is to enable service users to function as effectively as possible in the community. It also emphasises the need to maximise community based resources for assisting people to gain and maintain wellness in independent living.

Option 2: Provide more intensive vocational rehabilitation and develop employment opportunities for consumers.

Includes: More structured vocational training and work experience opportunities through the Coast Care Trust Activity centres.

Including vocational rehabilitation as a core component of any new residential rehabilitation service.

Recruiting suitable employers for work experience and work opportunities

Setting up consumer operated businesses to offer work experience and employment for consumers.

Vocational rehabilitation is a core activity of a rehabilitation service. The Coast Care Trust activity centres offer basic work skills training in areas such as woodworking and gardening but there is a need to provide more structured and organised vocational training, work experience and employment programmes in conjunction with agencies such as WINZ. Historically employment opportunities for mental health consumers have been sparse but the recent economic investment on the West Coast is creating an increased demand for workers along with business opportunities.

The establishment of provider and/or consumer organised businesses for work experience and employment has been an exciting development nationally and represents a major opportunity on the Coast to enhance the status of peoples recovery.

Option 3: Review the current provision of activities provided by the Coast Care Trust to serve a wider group of clients.

Discussion

Most people interviewed in the consultation forums believed the Coast Care Trust did a good job with the resources available. However it was noted that it could meet the needs of a wider range of people and needs. With the further development of rehabilitation services on the Coast it was seen as an optimum time to review the services offered.

It is expected that the Trust will play a key role in future rehabilitation service development.

Adult Respite Services

Option 1: Enable family members to access respite funding where a break for the family is the issue.

Option 2: Utilise contracted boarding situations as an alternative for crisis respite in Buller.

Option 3: Utilise spare capacity in the proposed residential rehabilitation service as an option for respite care.

Discussion

Few problems were identified with the current means and level of respite services for adults. The above options were all supported as useful additions to what was available that would increase the flexibility of care provided.

Allowing family members to access respite would need to be carefully monitored to ensure there was not a blow out in expenditure and still needs to be driven by what is best for the consumer.

Contracted boarding options would require the careful recruitment, training and monitoring of carers but has potential if suitable people can be found.

Utilising the proposed residential rehabilitation service motel type facilities for respite would increase the viability of the service. Respite funding would be used to provide additional staff as required.

Child and Youth Services

Option 1: Use contracted foster situations for community residential services and adolescent crisis respite.

Option 2: Organise a recruitment, training and monitoring programme for private respite carers.

Discussion

The Child and Adolescent Mental Health Service has struggled to provide respite care for children and adolescents given the lack of specialist inpatient child and youth services in a small DHB district and the care and protection issues which need to be taken into account.

There was a broad consensus from child and youth mental health workers that better recruitment, selection and monitoring of individual respite providers needed to be undertaken. It may be more useful to utilise an organisation such as Timeout Carers to undertake this process rather than setting up something new. Any system needs to achieve a balance between quality care and avoiding extra burdens on care givers which would dissuade them from being involved.

Option 3: Develop more intensive day activities for children and youth.

- Includes:
- A peer support group.
 - After school and/or holiday programmes.
 - Weekend camps and adventure activities.

Discussion

Current activities with children and adolescents are primarily individually based. Delivering significant ongoing comprehensive day programmes will be difficult on the Coast given the small numbers overall and the dispersed nature of the population. An alternative approach is to operate intensive activities on a periodic basis such as after-school or holiday programmes.

Weekend holiday camps offer an opportunity for intensive therapy and rehabilitation activities in a group and/or family setting without setting up expensive facilities or additional

personnel resources. It could also offer a form of planned respite for children and young people.

Young people interviewed were adamant that they wished to have more peer-to-peer activities and wanted to see opportunities such as a support group set up to offer peer support for each other.

Alcohol and Other Drug Services

Option 1: Intensive treatment provided in services outside the district but a specialist supported AOD accommodation service be offered on the Coast.

Includes: Target groups including:

- Clients waiting admission to residential treatment elsewhere.
- Clients requiring a halfway house supported accommodation/rehab following residential treatment.
- Clients requiring social detox.
- Clients who could be treated in outpatient services if they had suitable accommodation.
- Clients requiring short term respite.

Mix of paid and volunteer staff.

Joint DHB / community funding project.

Offer day activities/ drop-in for outpatients.

Facility – 5 bedroom house.

Discussion

It was agreed that a separate AOD residential facility for the target groups proposed was ideal but the proposal was not recommended for two reasons. Firstly the cost, estimated at a minimum of \$200,000 per annum, was prohibitive and secondly that AOD workers were not convinced that there would be sufficient demand to maintain a viable occupancy rate.

It is not expected that the West Coast will ever be in a position to provide the specialist intensive treatment services that are accessed currently from out of district due to the relatively small numbers and diverse range of needs.

Option 2: The target groups in option one are included in the proposal for a community based residential rehabilitation service.

Discussion

The inclusion of the AOD target groups in the proposed residential rehabilitation facility was considered the most viable option. However this raises issues regarding the ability of the service to respond to a wide range of mental health and AOD needs in the same facility. The motel style facility enables some separation for specialist needs such as AOD, but the safety of all residents will need to be considered in admitting AOD clients especially for individuals engaging in hazardous drinking or drug use.

Option 2: Offer periods of intensive treatment in short term retreats on the Coast.

Includes: Use camp sites for facilities.

For young people this could include outdoor adventure camps for several days.

Discussion

This option permits an interim position between full residential and day programmes and can be operated as required without setting up expensive additional services. A day programme over several weekends where accommodation is available may be a means of offering more than individual counselling.

Some workforce development of existing AOD staff may need to be undertaken around group therapy models.

Medical Inpatient Detox

Option 1: Improve facilities in current arrangements for medical inpatient detox.

Includes: Having a separate room available with shower.

Training a nurse in medical detox.

Developing treatment protocols between the Morice ward and the AOD Service.

Discussion

It was commonly agreed that specialist medical detox services were not viable on the Coast, rather the issue was about improving the use of the Morice ward for detox purposes as recommended.

Services for Maori

Option 1: Increase the number of designated Maori mental health workers.

Includes: In AOD service and child and youth mental health services.

Option 2: Improve the quality of mainstream services to Maori.

Includes: Kaumatua/kuia support for tangata whaiora.

Whanau involvement in care.

Utilising cultural treatment and support models.

Discussion

Any future development of mental health services must strive to meet the cultural needs of tangata whai ora more effectively. A small population size precludes most stand alone kaupapa Maori options. Instead the focus needs to be on improving the standard of care

within the mainstream service. This will require the active participation of Maori in service planning and review, an increased number of designated workers for Maori and the involvement of whanau and kaumatua/kuia in the care of tangata whai ora.

Developing this will require the establishment of an effective working relationship with local runanga by the mental health service overall.

General Discussion on Developing a West Coast Rehabilitation Service

Barriers to Service Development

The West Coast faces a number of significant barriers to developing an effective and comprehensive mental health rehabilitation service that supports the service user's recovery.

A small population spread over a large geographical area with little public transport presents significant challenges to caring for people with mental illness in their own communities. This barrier to service delivery is compounded by a number of other factors such as the following:

- Very little new funding for mental health services is likely to be available on the Coast because of the relatively high level of population based funding compared to other districts.
- The cost of providing services is higher on the Coast because of the amount of travel and spread of facilities required to service a dispersed population. In addition a minimum level of staffing and resources is required to deliver an effective and safe service independent of the level of need. This means that services such as the Inpatient Unit tend to offer a greater number of beds than the Mental Health Commission Blueprint resource guidelines would indicate were necessary. One consequence of this can be that beds are filled because they are available rather than because inpatient care is clinically indicated as the best option for the client.
- The historical transfer of long term institutionalised clients to Seaview Hospital from other regions has resulted in the tying up of resources through caring for a higher number of older people who require long term residential care than would normally be expected for a population the size of the West Coast.
- There is a limited potential workforce pool from which to draw on for recruitment.

Overcoming these barriers has a number of implications for the delivery of services on the Coast:

- Any new developments need to be funded primarily by a reconfiguration of existing services.
- It is not possible to have the same range of separate specialist services or staff as in a larger population district.
- Services need to be able to assist a diverse mix of needs and people within the same service.
- Innovative alternative means of delivering services need to be developed to meet the needs of small sub-populations.
- It may not be viable to locate certain services in all three main population centres even if ideal.

- Some services will never be viable in the district and will need to be accessed from other DHBs.
- Inter-sectoral collaboration in service delivery offers opportunities for increased viability of services for some groups.

Building an Effective Mental Health Rehabilitation Service

This report advocates for the strengthening of the rehabilitation focus and recovery orientation of the mental health service as a whole and sets this as the context for any proposed service developments. The development of an effective rehabilitation service is not just a matter of new service development but requires the continuing evolution of the West Coast mental health service culture as a whole. This will require:

- Effective clinical leadership and service management at all levels in both the provider arm and NGO sectors.
- The active participation of consumers/tangata whai ora and family/whanau members in the planning, delivery and evaluation of service delivery.
- A shift from a medical focus on psychiatric diagnosis and symptom alleviation to a rehabilitation diagnosis and recovery focus.
- A partnership between the mental health worker, family/whanau and community in providing comprehensive care.
- Client centred treatment planning and delivery.
- Appropriate recruitment, selection and workforce development policies and practice to ensure a suitably skilled workforce is available to provide rehabilitation services.

11 APPENDICES

Appendix One:

National Mental Health Service Specifications Service Type Descriptions

Service	Function
Medium Term Inpatient (beds)	
Sub Acute/Extended Care Inpatient Beds	To provide inpatient care for eligible persons in the acute stage of psychiatric illness, but whose acute illness is slow to settle and who are not yet well enough for care in the community. General hospital setting.
Clinical Rehabilitation Services	To provide a service that enhances skills and functional independence of Service Users, with a recovery focus. The service is for people who are assessed as requiring inpatient rehabilitation because of diagnostic and treatment complexity, insufficient response to treatment and a continuing need for a high level of ongoing supervision and support.
Community Residential (beds)	
Community Residential Level I	To provide a community based residential rehabilitation and support service for people with psychiatric disabilities, where brief daily support from experienced non-clinical staff is sufficient to meet individual needs.
Community Residential Level II	To provide community-based residential rehabilitation and support service for eligible people with psychiatric disabilities, where 24-hour support (which may include sleepovers) provided by non-clinical staff is required to meet individual needs.
Community Residential Level III	To provide a community based residential rehabilitation and support service for people with psychiatric disabilities, where 24-hour support (with sleepover) provided predominantly by non-clinical staff (but with some professionally qualified clinical staff available in-house) is required to meet individual needs.
Community Residential Level IV	To provide community based residential rehabilitation and support service for people with psychiatric disabilities, where 24-hour intensive support provided by a mix of clinical (professionally qualified) and non-clinical staff is required to meet individual needs.
Residential Intensive Long Term	To provide a service for people with complex needs that require 24-hour supervision and active support over a very long term.

Forensic – Community Residential Care	To provide 24-hour residential care as a transitional facility for individuals moving from higher levels of support and supervision toward care within a community setting.
Mother And Babies – Respite Services or Intensive Home Support	The provision of a home based or residential service as an option for women during pregnancy or in the post-partum period who would otherwise require admission to acute inpatient mental health services for treatment of acute episode of illness.
Head Injury or Neurological with Behaviour Problems	No service specification.
Community Support (FTE)	
Other residential Support. Includes: <ul style="list-style-type: none"> • Home Based Support Services • Community Support Work • Support for Independence 	To provide individual support and rehabilitation services for Service Users who are living independently, but not necessarily alone, in the community.
Supported Landlord Service	To provide community-based, affordable, furnished or unfurnished flats with low-key regular social support for people with psychiatric disabilities. Tenants will have security of tenure and social supports will be minimally intrusive.
Adult Crisis Respite	The provision of a home based or residential service as an option for people who would otherwise require admission to acute inpatient mental health services.
Adult Planned Respite	The provision of a home based or residential service as planned to avoid exacerbation of the risk of need for admission to inpatient mental health services, for people under the care of community mental health teams.
Work Rehabilitation/ Employment and Educational Support Service	To provide employment and educational support services which will assist Service Users to gain meaningful employment.
Activity Based Rehabilitation Service/Day Activity and Living Skills	To assist Eligible Persons with psychiatric disabilities to improve their life skills and overcome social isolation.
Child and Youth Mental Health Services	
Community Residential Services-Child & Youth	The service provides a home-like 24-hour residential rehabilitation service for children, adolescents and youth with serious mental disorders that result in complex and ongoing high support needs related to their activities of daily living.
Child and Youth Crisis Respite	The provision of a home-based or residential service as an option for people who would otherwise require admission to acute inpatient mental health services.

Child and Youth Planned Respite	The provision of home-based or residential services as planned events to avoid exacerbating the risk of needing admission to inpatient mental health services for people under the care of community mental health teams.
Child and Youth Day Activity Service	To assist young people with serious mental health problems and high support needs to improve their life skills, overcome social isolation and to meet their developmental, educational and pre-vocational needs.
Alcohol and Other Drug Services	
Medical Inpatient Detox	An inpatient programme that provides a controlled and safe withdrawal from alcohol and drugs, including high levels of nursing and medical support to manage clinical risks.
Detoxification – Residential (Social)	To provide programmes that allow a controlled and safe withdrawal from alcohol and drugs within a non-hospital residential setting.
Alcohol and other Drug Residential Treatment	To provide treatment services for people who have particular requirements that are unable to be met in less structured or supported settings. This includes provision of services to people with needs for ongoing medication prescribed as part of a comprehensive management plan.
Child and Youth Alcohol and Drug Community Residential Services	The service provides a home-like 24-hour residential rehabilitation service for children, adolescents and youth with serious alcohol and drug problems that result in complex and ongoing high support needs related to their activities of daily living.
Alcohol and other Drug Supported Living Services	To provide individual support and rehabilitation services for Service Users who have alcohol and drug dependency and who are living independently, but not necessarily alone, in the community.
Mental Health and A&D Community Residential Services	To provide a community based residential service, which will provide accommodation and treatment interventions for people who have coexisting mental health problems with alcohol and drug dependency.

Appendix Two:

Definition of Psychiatric Rehabilitation

The following is an extract from a paper¹ prepared by Laurie Curtis for the NZ Mental Health Commission. The paper contains a wide range of useful information on rehabilitation and recovery principles and international examples of service best practice.

“Psychiatric rehabilitation (also known as psychosocial rehabilitation and bio-psychosocial rehabilitation) is the process of assisting people to acquire and to use, the internal and external skills, supports, and resources necessary to be successful and satisfied living, learning, and working in the environment(s) of their choice. At its most basic level, psychiatric rehabilitation seeks to help people to determine and prioritise their goals, to identify paths for achieving these goals, and to develop the needed skills and supports to achieve these goals.

Derived from concepts from physical rehabilitation, psychiatric rehabilitation focuses on the disability or impairment resulting from an individual's psychiatric disorder which affects the person's ability to fulfill role expectations. The goal of psychiatric rehabilitation is to help individuals to function "despite" their disability -- to compensate for or to eliminate deficits in functioning, interpersonal barriers, and environmental barriers created by the disability, and to restore ability for independent living, socialisation, and effective life management. Perceived deficits frequently fall into several categories: daily living skills, social interactions, accommodations, vocational productivity, and problem solving (cognitive processes).

Psychiatric rehabilitation services offer 1) skill development, and 2) environmental resource development, in order to help individuals capitalise on their personal strengths, to develop effective coping strategies, and to develop supportive environments so that they may function as independently as possible. Service and support activities are designed to be integrated with the real activities one engages in daily. Rehabilitation services may be offered in a facility setting or "off-site" in the community-at-large or in an individual's home. Rehabilitation services may be offered parallel to, independently of, or integrated with psychopharmacology and other forms of psychiatric treatment.”

¹ Curtis, L, C. (1997). *New Directions: International Overview of Best practices in Recovery and Rehabilitation Services for People with Serious Mental Illness*. NZ Mental Health Commission.