Do psychiatric rehabilitation services have a role in the current health system?

Introduction

What is psychiatric rehabilitation?

Psychiatric rehabilitation services specialise in working with people with severe and persistent mental health disorders to ensure the highest possible level of social functioning, allowing them to enjoy optimal levels of independence. The individuals at the focus of psychiatric rehabilitation services have usually had a diagnosis of severe mental illness (SMI) for more than 2 years and a pronounced reduction in social functioning (Schinnar *et al.*, 1990). Similar to physical illnesses, SMI can result in short- or longer-term disability greatly affecting the sufferer's life. However, over the last century mental health has been stigmatised with many people mistakenly assuming that people with SMI do not recover. However, it has been shown, through personal account of recovery and clinical evidence, that people with previous or ongoing SMI are able to recover and lead as fulfilling a life as those without an SMI (Deegan, 1993)(Jacobson and Greenley, 2001).

Psychiatric rehabilitation involves a multidisciplinary team working with an individual to produce an individualized programme to integrate the individual back into the community. The process is committed to supporting the individuals needs and aspirations to achieve personally relevant life goals. The individualized approach to psychiatric rehabilitation is central to achieving success as without personally set goals, the individual's vision of what they perceive their optimum quality of life to be may not have been met and a meaningful life in their eye's may still not be achieved (Farkas and Anthony, 2010). Referral to a rehabilitation service can be considered in various circumstances but most commonly it is considered when a person with a SMI is unlikely to benefit from further time on an acute inpatient ward but would be unable to be discharged back to the community to live fully independently. Rehabilitation services usually consist of high support in-patient services and a community rehabilitation service. The goal is usually for a patient to be stepped down from an acute mental health ward to an in-patient rehabilitation service before eventually being moved to a community service where they can receive ongoing support without constant observation. In-patient services focus on helping the individual engage with services and psychological interventions as well as maximising their medication regime and decreasing side effects. Community rehabilitation services continue to provide input once leaving an inpatient service when the service user is living either in a form of supported housing or independently. It is a holistic approach and focuses on helping the individual to gain control over their own life by helping them find employment and housing, but also helping the individual participate in community life by introducing them to community centres and public facilities to build relationships with other members of the community.

A brief history of psychiatric rehabilitation

Psychiatric rehabilitation began in the 19th century during a reform for more humane care of the mentally ill outside of prisons. The idea of rehabilitation for those with SMI was first seen as important, during the moral treatment era when a chaplain at a British asylum recognised 'by obtaining for them a change of scene and air and assisting them to obtain suitable employment entry into social life was possible' (Hawkins, 1871). From 1956 onwards, deinstitutionalisation of mental health services began leading to the integration of those with SMI from asylums or hospitals into the community (Davidson, 2010). Community mental health services were officially established in the British Mental Health Act of 1959 which supported "forms of training and social services which can be given without bringing patients into hospital as inpatients, or which make it possible to discharge them from hospital sooner"; essentially allowing patients to be treated outside of an in-patient setting (Rudolf, 1963). This is where the idea of modern-day

psychiatric rehabilitation started. Since then, psychiatric rehabilitation has become a prominent part of management of patients with SMI with research leading to more refined methods of effective rehabilitation.

This essay will address whether or not psychiatric rehabilitation services have a role in the current health system.

Yes, psychiatric rehabilitation does have a role in the current health system.

The first reason why psychiatric rehabilitation has a role in the current health system is that it has been shown to be effective at improving outcomes for those with SMI and reducing admissions to acute inpatient facilities. A case control study in Ireland found that those with complex SMI who received rehabilitation services were eight times more likely to achieve and sustain community discharge and there was greater improvement in social functioning following rehabilitation (Killaspy, 2014). It is likely that the holistic approach that psychiatric rehabilitation uses is the reason for its success. Employment in those with SMI is staggeringly low, fewer than 16 per cent of people with an SMI are employed, despite between 86 and 90 per cent of this group want to work (Bush *et al.*, 2009). Employment addresses practical needs by encouraging financial independence, but it has also been shown to increase self-esteem and social skills. The reasons employment may be so in those with SMI low is partly be due to stigma surrounding mental health but is likely due to individuals with SMI being removed from society, often due to a period of time on an acute inpatient ward, which dissociates and deskills them. Alongside this, many people with SMI have never had the opportunity to develop the full range of skills necessary for adult functioning, as they became symptomatic prior to developing these skills. For example, those recovering from SMI may undertake tasks such as gaining a job or forming a romantic relationship up to 10 to 20 years later than others, where knowledge and support in these areas is less available (Glynn, 2003). Psychiatric rehabilitation provides support for these individuals, to help their skill bases grow and to navigate the challenges of life. Research has shown that those individuals who gain occupations through psychiatric rehabilitation have reported that their employment helps them manage their symptoms and has reduced their need to use acute mental health inpatient service (Bush *et al.*, 2009). Support with employment is just once example in which psychiatric rehabilitation aids recovery and reduces admission to inpatient facilities. Furthermore, the success of psychiatric rehabilitation in reducing admission leads to a decrease in pressure on acute inpatient facilities. Those requiring admission to acute mental health units is growing, particularly in the upcoming years due to the impact of COVID – 19 on mental health. It has been suggested that 500,000 people will require support for their mental health due to the pandemic (Centre for Mental Health, 2020). Two – thirds of people who will need support will be those who already have existing mental health problems, including SMI. The increased demand for inpatient beds alongside reduced capacity on wards due to social distancing measures exacerbates the existing pressure on in patient services making it even more paramount that every effort is made to reduce the number of admissions, psychiatric rehabilitation can help with this.

Psychiatric rehabilitation services play a major role in moving service users who are placed in high-cost, out-of-area treatment (OAT) services to appropriate services which are local to them. An OAT is a unit which admits those individuals with SMI who no longer need acute inpatient care, to a location that does not form part of the individual's local network of services. The first problem with OATs is the referrals are often not appropriate and beneficial for the individual. From the 1st September 2020 to the 30th September 2020, out of 630 OaT placements that were active, 600 were inappropriate (NHS, 2020). As stated previously, a major aspect of psychiatric rehabilitation is building links with the patient's community, being placed out of area displace services users from their communities and families and often means the individual is unable to be visited regularly by their care co – ordinator, disrupting continuity and therefore quality of care. Communication between distance OAT services and local services can be poor and often

OAT services are no longer necessary, but this is not identified swiftly and service users may be in inappropriate and expensive OAT services that are of no benefit to them, delaying their reintegration into society. This phenomenon has been referred to as the 'virtual asylum' since there is little attention paid to the review and assessment of the needs of these patients. Under local management in a psychiatric rehabilitation service, the service user is able to have regular contact with their care co – ordinator, maintaining continuity of care which in itself has been widely shown to improve patient outcomes (Cabana and Jee, 2004). The second benefit of psychiatric rehabilitation, in relation to OATs, is the lower cost of psychiatric rehabilitation in comparison. Out of area placements cost around 65% more than local placements (Joint Commisssioning Panel for Mental Health, 2016). This is due to the number of NHS beds for those with SMI dropping significantly due to lack of funding resulting in a higher demand for private OATs; a significant cost to the NHS. From the 1st to 30th September 2020, OATs incurred a cost of £10,025,929, most of this cost is incurred from the longer than necessary stays in these more expensive facilities (NHS, 2020) . It is therefore in the interest of reducing cost to the NHS to invest more in psychiatric rehabilitation than OAT services.

No, psychiatric rehabilitation does not have a role in the current health system.

Whilst proven to be effective in a large proportion of those with SMI, it has been shown that those with attempted suicide or self-harm, or had been on forensic in-patient wards, were less likely to benefit from psychiatric rehabilitation. A case control study carried out by Bredski et al. (2011) examined which factors predict discharge from an inpatient rehabilitation facility to a community rehabilitation team. It found that after a year of rehabilitation within an inpatient rehabilitation services there was no significant improvement in the social functioning of individuals that have attempted suicide or self-harm or been on forensic in – patient wards, largely due to the prevalence of challenging behaviours in these individuals. This means that these individual's never progress to supported or independent community living; the end goal and overarching purpose of psychiatric rehabilitation. However, it may be a case that these patient's simply need more time and a slower pace of rehabilitation. It has been shown in one study that after five years in a slower stream patient rehabilitation, there was a significant reduction in challenging behaviours within certain individuals and 40% of the patients were able to be discharged to the community (Trieman and Leff, 2002). Although the slower pace of rehabilitation of stay is in no doubt costly, the consequent saving of money in the long term due to the step down of the patients to the community no doubt justifies the investment (Hallam and Trieman, 2001).

One of the main arguments that psychiatric rehabilitation may not have a place in the current health system is because of the lack of resources currently available. As previously mentioned, psychiatric rehabilitation is a multidisciplinary approach in nature, requiring large numbers of specialists including social workers, mental health nurses and psychiatrists. However, research carried out by Rethink Mental Illness and the Royal College of Psychiatrists has shown that only 12 of 50 trusts that responded to a Freedom of Information (FOI) request, provided a specialist community mental health rehabilitation team whilst others provided rehabilitative care but through generic community mental health teams (CMHT) (Royal College of Psychiatrists, 2020). People suffering with SMIs need more specialist teams due to their complex needs and CMHTs are already being overrun with patients who have fewer mental health needs. Furthermore, there is a lack of supported housing for those people who are able to be stepped down from inpatient rehabilitation units. There will be an estimated shortfall of 47,000 beds in supported accommodation by 2024/25, with the largest gap in provision is for those requiring longer term stays due to mental illness. The decline in the availability of beds in supported accommodation makes effective rehabilitation extremely difficult as service users get stuck in in-patient facilities, or even discharged straight back to the community, both of which are detrimental to recovery.

High cost of maintaining supported accommodation tends to by why the number of beds is decreasing, however, the consequences of a growing shortfall of these beds has been shown to be even more costly. Firstly, if a person with SMI has to live in accommodation without the support they need they may end up using more health or criminal justice services, shifting the cost to other public services. Furthermore, the costs incurred from resulting to patients remaining in in-patient services (which are more expensive than supported housing) would increase. For example, in 2015/16 it would have cost over £128m to meet the deficit in supported accommodation beds but the consequence of not meeting the gap led to a cost of £361m to the taxpayer (The National Housing Federation: London., 2017) . With no action taken, it has been shown that in 2020/21, the cost to the taxpayer could increase to £668m (The National Housing Federation: London., 2017). This research has shown that the cost of setting up more supported accommodation for mental health rehabilitation saves money, rather than spends it.

Conclusion

This essay has analysed whether psychiatric rehabilitation services have a role in the current health system. In conclusion, I believe that they do. Not only has rehabilitation been shown to be effective at reducing admission to acute in-patient psychiatric facilities, but it has also been shown to be cost effective. The main obstacle facing incorporation of psychiatric rehabilitation is the lack of resources available due to underfunding, both in terms of labour, in the form of specialist community mental health rehabilitation team and infrastructure, in the form of beds in supported accommodation. However, the cost of reducing the number of beds in supported accommodation has actually be shown to be more expensive due to those with SMI being placed in unsuitable housing leading to pressure on other public services such as acute inpatient facilities and criminal justice services. Therefore, looking to the future, it is important that resources are distributed appropriately, and the importance of psychiatric rehabilitation is not overlooked.

Bibliography

Bredski, J. *et al.* (2011) 'The prediction of discharge from in-patient psychiatric rehabilitation: A case-control study', *BMC Psychiatry*. doi: 10.1186/1471-244X-11-149.

Bush, P. W. *et al.* (2009) 'The long-term impact of employment on mental health service use and costs for persons with severe mental illness', *Psychiatric Services*. doi: 10.1176/ps.2009.60.8.1024.

Cabana, M. D. and Jee, S. H. (2004) 'Does continuity of care improve patient outcomes?', *Journal of Family Practice*.

Centre for Mental Health (2020) *Covid-19 and the nation's mental health*.

Davidson, L., Rakfeldt, J. & Strauss, J. (2010). *The roots of the recovery movement in psychiatry: Lessons learned*.

Deegan, P. E. (1993) 'Recovering our sense of value after being labeled mentally ill.', *Journal of psychosocial nursing and mental health services*. doi: 10.3928/0279-3695-19930401-06.

Farkas, M. and Anthony, W. A. (2010) 'Psychiatric rehabilitation interventions: A review', *International Review of Psychiatry*. doi: 10.3109/09540261003730372.

Glynn, S. M. (2003) 'Psychiatric rehabilitation in schizophrenia: Advances and challenges', *Clinical Neuroscience Research*. doi: 10.1016/S1566-2772(03)00016-1.

Hallam, A. and Trieman, N. (2001) 'The cost effectiveness of specialised facilities for service users with persistent challenging behaviours', *Health and Social Care in the Community*. doi: 10.1046/j.1365-2524.2001.00322.x.

Jacobson, N. and Greenley, D. (2001) 'What is recovery? A conceptual model and explication', *Psychiatric Services*. doi: 10.1176/appi.ps.52.4.482.

Joint Commisssioning Panel for Mental Health (2016) *Guidance for commissioners of rehabilitation services for people with complex mental health needs*.

Killaspy, H. (2014) 'The ongoing need for local services for people with complex mental health problems', *The Psychiatric Bulletin*. doi: 10.1192/pb.bp.114.048470.

NHS (2020) 'Out of Area Placements in Mental Health Services September 2020'.

Royal College of Psychiatrists (2020) *In sight and in mind: Making good on the promise of mental health*.

Rudolf, G. D. M. (1963) 'Mental Health Act 1959', *British Medical Journal*, 1(5335), p. 950. doi: 10.1136/bmj.1.5335.950.

Schinnar, A. P. *et al.* (1990) 'An empirical literature review of definitions of severe and persistent mental illness', *American Journal of Psychiatry*. doi: 10.1176/ajp.147.12.1602.

The National Housing Federation: London. (2017) *Strengthening the case for supported housing: the cost consequences,*.

Trieman, N. and Leff, J. (2002) 'Long-term outcome of long-stay psychiatric in-patients considered unsuitable to live in the community: TAPS Project 44', *British Journal of Psychiatry*. doi: 10.1192/bjp.181.5.428.