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Community psychosis services: the role of community mental health rehabilitation teams

Faculty Report FR/RS/07
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By Sridevi Kalidindi, Helen Killaspy and Tom Edwards from the Royal College of Psychiatrists' Faculty of Rehabilitation and Social Psychiatry

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Introduction

In the current economic climate, community mental health services for people with a diagnosis of psychosis are under pressure to provide care more efficiently. Around 25% of the total mental health budget in England is spent on rehabilitation services and supported accommodation for people with longer-term and complex mental health needs. This proportion expands to around 50% if the wider family of services that provide for this group are included (Mental Health Strategies, 2010). Much of this spending falls within mainstream health and social care services. In England, the implementation of a tariff-based mental health service appears imminent. Many mental health trusts have already started the process of reconfiguring services to deliver care according to patient diagnosis and complexity using 'care clustering' and 'service line management'. It is expected that specific tariffs will be attached to an episode of treatment according to the care cluster a patient is allocated to and that such treatment will be delivered through the appropriate service line for that cluster. Although the details of the tariff system are yet to be clarified, and this system is not being implemented across the whole of the UK, the reorganisation of mental health services into increasingly specialist subsystems is relevant across all UK countries. It therefore seems timely to reflect on the ethos and skills required of services that deliver care to people with longer-term psychoses in the community; this group includes people with schizophrenia, schizoaffective disorder, bipolar affective disorder and other psychoses.

Historically, community mental health teams (CMHTs) and community rehabilitation teams have provided treatment, care and support for this group. However, CMHTs have also provided treatment and care to people with other diagnoses such as common mental disorders and personality disorders, and to those in acute mental health crisis. Community rehabilitation teams, which exist in 56% of National Health Service (NHS) trusts (Killaspy *et al*, 2012), have provided for people with long-term complex needs and functional impairment secondary to psychosis, many of whom reside in various types of supported accommodation. Across England and elsewhere in the UK, the development of further specialist community mental health services over the past decade (assertive outreach, early intervention, crisis intervention and home treatment teams and, in some areas, specialist personality disorder services) has concentrated the focus of CMHTs on people with severe and enduring psychoses. In addition, there has been an increasing emphasis on the delivery of 'recovery-oriented' services (Shepherd *et al*, 2008) and many CMHTs and community rehabilitation teams have been rebranded as 'recovery' services.

Box 1 gives examples of recent reconfigurations of services for this client group. Given the increased specialisation of community mental health service provision, it seems appropriate to review and clarify the remit of

the teams providing care in the community for people with longer-term psychoses, with a particular focus on the role and remit of community rehabilitation teams.

Box 1 Examples of community services for people with longer-term psychoses

A. In one area of northern England, community psychosis services have been reconfigured as either 'mental health' (providing for people with affective and non-psychotic disorders) or 'mental illness' (providing for people with psychosis). Service users are assigned to one of these according to the assessment of their needs and diagnosis made using the Mental Health Clustering Tool. The 'mental illness' service includes early intervention, crisis resolution and assertive outreach services and a new 'recovery team', and there is a focus on social inclusion across all teams. Despite the reconfiguration, there is flexibility for services to work with individuals who may not easily fit into one diagnostic category, for example assertive outreach services continue to work with people with comorbid personality disorder and psychosis who are difficult to engage. The advantages of the new service configuration include the development of greater specialism, clarity of roles and remits.

B. In another area nearby, reducing the use of in-patient rehabilitation beds has allowed reinvestment into a new community rehabilitation team which functions as a step down for users of the local assertive outreach team whose engagement has improved but whose support needs remain high. The community rehabilitation team also provides time-limited support and interventions to users of other services (such as community mental health teams and in-patient services). These include psychological interventions and support for people making the transition from in-patient care to community living. This team is now joining with a more 'buildings-based' rehabilitation and recovery service provided by the voluntary sector that has expertise in training, education and employment and established links with universities and employers. This service has not previously been able to provide home-based interventions and the new partnership will allow for this. The service will be accessible to all individuals with psychosis and/or complex needs. The development of the community psychosis services over recent years has been facilitated by a gradual, staged and managed transition, leaving some elements undisturbed in the short term.

C. Functional assertive community treatment (FACT) is a Dutch model of flexible intensive case management that is gaining popularity in the UK. It provides something of a hybrid approach between standard case management, crisis intervention and assertive community treatment for people with psychosis who have had difficulties engaging with services. To address the changing needs of a population with psychosis, people 'flow' between less intensive individual case management and more intensive (up to daily) visits from a 24-hour 'whole-team' approach (assertive community treatment) depending on the intensity of their needs. In The Netherlands these teams have case-loads of around 200, and around 20 people at any one time receive the intensive approach. Initial findings suggest that around 80% of individuals on the case-load receive the more intensive input at some time over a 2-year period and there is some evidence of reduced need for in-patient care (van Veldhuizen, 2007). The model has benefits of equity of access and rapidity of response.

Aims and scope of this report

A substantial proportion of people with severe mental illness continue to have significant problems with social and personal functioning many years after diagnosis, despite optimum medical treatment. Most are not so disabled or behaviourally disturbed that they require long-term hospital care, but their problems place them at risk of social isolation, self-neglect, relapse into acute illness, inability to cope and exploitation in community settings. This faculty report aims to provide a useful summary for mental health practitioners, service managers and those commissioning services, of the approach and interventions necessary to deliver good-quality care to people with longer-term psychoses living in the community that promotes their rehabilitation and recovery. It is therefore of most relevance to those who work in, manage or commission CMHTs, community rehabilitation teams, recovery teams and assertive outreach teams. The service user group we focus on are individuals with schizophrenia, schizoaffective disorder, bipolar affective disorder and other psychoses. In areas where care clustering is implemented, the relevant clusters are 11–13 and 16–17 (Box 2). We believe that everyone with longer-term psychosis can benefit from a rehabilitative approach but we aim to clarify when specialist community rehabilitation services are required.

Box 2 Mental health clusters and community psychosis services

The majority of people in receipt of in-patient mental health rehabilitation services will be categorised as cluster 13. However, some will be managed in community-based rehabilitation units, or 24-hour supported accommodation, with additional support provided by community mental health services (CMHTs or community rehabilitation teams).

Cluster 13. Complex needs, high support
This group will have a history of psychotic symptoms which are not controlled. They will present with severe to very severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning. They will have possible cognitive and physical problems linked with long-term illness and medication. They may be lacking basic life skills and show poor role functioning in all areas.

As people's symptoms and life skills improve over time, their 'cluster' may be re-categorised to reflect their change in needs. Those who are able to move to less supported accommodation successfully are most likely to be categorised as cluster 12 and will require support from community rehabilitation services and/or other community mental health services to sustain their recovery and accommodation.

Cluster 12. Complex needs, medium support
This group has possible cognitive and physical problems linked with long-term illness and medication. They may have limited survival skills and be lacking basic life skills and have poor role functioning in all areas. This group have a history of psychotic symptoms with a significant disability with major impact on role functioning.

Those who achieve independent living may ultimately be categorised into cluster 11. This group will not need specialist community rehabilitation services in the longer term. Some may continue to be supported by other community mental health services with the aim of eventual discharge to primary care services.

Cluster 11. Complex needs, standard support
This group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near-full functioning. However, there may be impairment in self-esteem and efficacy, and vulnerability.

Assertive outreach teams are most likely to work with patients categorised as cluster 16 or 17 who may be living independently or in less-than-24-hour-supported accommodation.

Cluster 16. Dual diagnosis
This group has enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles and coexisting substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.

Cluster 17. Psychosis and affective disorder, difficult to engage
This group has moderate to severe psychotic symptoms and unstable, chaotic lifestyles. There may be some problems with drugs or alcohol, but not severe enough to warrant dual-diagnosis care. This group have a history of non-concordance with treatment, are vulnerable and engage poorly with services.

Source: Department of Health, 2010. CMHTs, community mental health teams

Clients of community psychosis services

The community psychosis services included in this document are CMHTs, community rehabilitation teams, recovery teams and assertive outreach teams. Community rehabilitation services generally work with people allocated to clusters 13 and 12 and sometimes cluster 11, assertive outreach services work with those allocated to clusters 16 and 17, and other community mental health services such as CMHTs and recovery teams are most likely to work with people in cluster 11 and with those in clusters 12 and 13 where no local community rehabilitation team is in place (see Box 2, page 8, for cluster descriptions). These clusters all represent people with longer-term psychoses, with those in Clusters 13, 12, 16 and 17 having more severe, multiple and complex problems that affect their ability to live safely in the community. These include: non-response to treatment (treatment resistance); difficulties with social functioning and living skills; behaviours that present a risk to others or to themselves, often through self-neglect and vulnerability to exploitation; challenging behaviours; co-occurring substance misuse; co-occurring physical health problems. Despite the development of newer antipsychotic medications and an increased focus on services that intervene at an early stage in the development of psychosis, the number of people with these kinds of complex problems is not reducing. In fact, around 10% of early intervention service clients are referred to rehabilitation services because of the severity of their functional impairment and symptoms (Craig *et al*, 2004). Some patients have multiple mental health problems and do not easily fit into one cluster or diagnostic category (e.g. people with psychosis co-occurring with Asperger syndrome, organic brain injury or personality problems) and are often referred to mental health rehabilitation services because of the complexity of their individual needs.

Simon's story (Box 3) provides an example of the kinds of issues that many people with longer-term psychoses living in the community struggle to deal with.

Simon is likely to be categorised as cluster 11 since he is not living in supported accommodation and he is not 'difficult to engage'. However, his problems are complex and have a very negative impact on his quality of life. He requires specialist interventions to improve his symptoms and social functioning (see the chapter on specialist tasks for community rehabilitation services, pages 17–20). These interventions could, in theory, be delivered by an appropriately resourced and skilled CMHT or recovery team. However, Simon is not presenting as a risk to others or himself and he may therefore not be seen as a priority by a hard-pressed CMHT care coordinator. He requires a rehabilitative approach to help him to progress in his recovery

but at present, CMHTs are not sufficiently resourced or skilled in providing specialist rehabilitation interventions. Simon's case illustrates the 'clinical iceberg' of unattended rehabilitative needs that exist among people with psychosis living independently in the community. He could potentially benefit from the specialist interventions available from a community rehabilitation team and those responsible for commissioning mental health services need to provide adequate investment to ensure that these services are available.

Box 3 Simon's story

Simon is in his early 40s. He has had a diagnosis of schizophrenia for 15 years. He has been admitted to hospital five times, of which three were compulsory detentions. A prominent feature of his illness is his unshakeable conviction that he is under constant surveillance by a government agency; he believes he is followed wherever he goes and frequently sees people who he thinks are working for this agency on the street and in local shops. He also struggles with 'negative' symptoms of his illness such as lacking motivation and he has poor organisational skills. Partly through fearfulness and partly through apathy, he spends most of his time alone in his flat. He takes no interest in his appearance or hygiene and has serious problems managing the upkeep of his flat, on which he owes a considerable amount of unpaid rent. He has not worked for many years.

The view of some clinicians is that Simon unfortunately has limited potential to make much additional recovery from the ongoing challenges relating to his mental illness. In the course of Simon's long history of involvement with mental health services, he has received all the usual (and some not so usual) pharmacological and available psychosocial interventions to apparently little effect. Over the past 10 years, the main contact he has received from his community mental health team has been from his community psychiatric nurse, as well as reviews in the out-patient clinics of the two consultant psychiatrists he has been under the care of during this time. His view of conversations he has had with mental health staff has been that they are mainly interested in whether he is taking his medication. Simon has also noticed that the enthusiastic promises of new treatments and new referrals have long since dropped away. Having been out of employment for many years, he does not believe he is able to work or is employable and he cannot see the point of attending a day centre to mingle with strangers or to work without reward. He feels quite powerless to do anything himself and has come to the view that there is little anyone else can do either.

Ethos

Those commissioning and working in community services for people with longer-term psychoses need to recognise that the process of recovery can take many years. They need to hold a long-term view and accept that the path is likely to fluctuate, with periods of remission and relapse being part of the trajectory for many people. Enduring improvements in functioning and stability of symptoms can take many years to achieve. At the same time, they need to hold realistic hope for their service users' recovery. Holding hope and the use of optimistic language have been highlighted as essential in recovery-oriented practice (Andresen *et al*, 2003; Shepherd *et al*, 2008). The evidence from longitudinal studies of the outcomes for people with longer-term psychoses supports this optimism, since around two-thirds experience significant improvement in symptoms and functioning over time and are able to enjoy a high level of independence and quality of life (Harding *et al*, 1987; Harrison *et al*, 2001; Warner, 2004). Sometimes people experience recurrent relapse and failed attempts at community placement before they are able to engage with the support available and sustain progress. It is vital that services do not 'give up' on individuals and that they try to identify the specific interventions that will enable the service user to gain the confidence and skills to manage in a more independent setting. Indeed, it has been shown that even among those considered most 'difficult to place' in the community, the majority are able to progress to less supported settings over time (Trieman & Leff, 2002). Having a recovery ethos is clearly important in instilling this culture of therapeutic optimism. It encourages collaborative partnerships between clinicians and service users that enable the person to gain confidence in their abilities and achieve their potential, rather than fostering dependence on services.

A 'whole-system' community rehabilitation care pathway

Referrals to community rehabilitation services are received from in-patient mental health services (including general adult, rehabilitation and secure services) and from other community mental health services (including early intervention, assertive outreach and CMHTs). Figure 1 shows the components of the whole-system rehabilitation care pathway.

Owing to their complex mental health problems, most clients of community rehabilitation teams reside in supported accommodation of various types provided by health and social services, voluntary organisations, housing associations and other independent providers. These include nursing and residential care homes, group homes, hostels, blocks of individual or shared tenancies with staff on-site, and independent tenancies with 'floating' or outreach support from visiting tenancy support staff. Community rehabilitation services play a key role in supporting service users' transitions through the care pathway, from hospital to community settings and from higher to less supported accommodation. This role ensures that the supported accommodation pathway does not become 'silted up' and that supported accommodation services remain focused on enabling service users to achieve the highest level of independence in the community.

To achieve this, community rehabilitation services are usually involved in the referral of new residents to supported accommodation services, providing liaison between the referring service and the supported accommodation service to ensure a good match between the client's needs and the assistance available at the supported accommodation facility. They facilitate visits for the referred person (and their carer/carers) to the accommodation, accompanying them if they wish and meeting with them afterwards to discuss any concerns or anxieties they may have about the potential move. They provide information to staff in the supported accommodation facility about the needs of newly referred clients and the details of current care plans that could be replicated to manage complex problems.

When agreement has been reached by the facility and the service user (and their carers) for the move, there is often a period of graduated leave to allow the person to familiarise themselves with their new environment and for staff to identify management issues that they may require further help with. Once the service user moves in, the community rehabilitation service staff continue to visit and support the client and the supported accommodation staff on an ongoing basis to help tailor individualised care plans to enable the client to gain skills and confidence for more independent living. They also provide responsive and more intensive support during

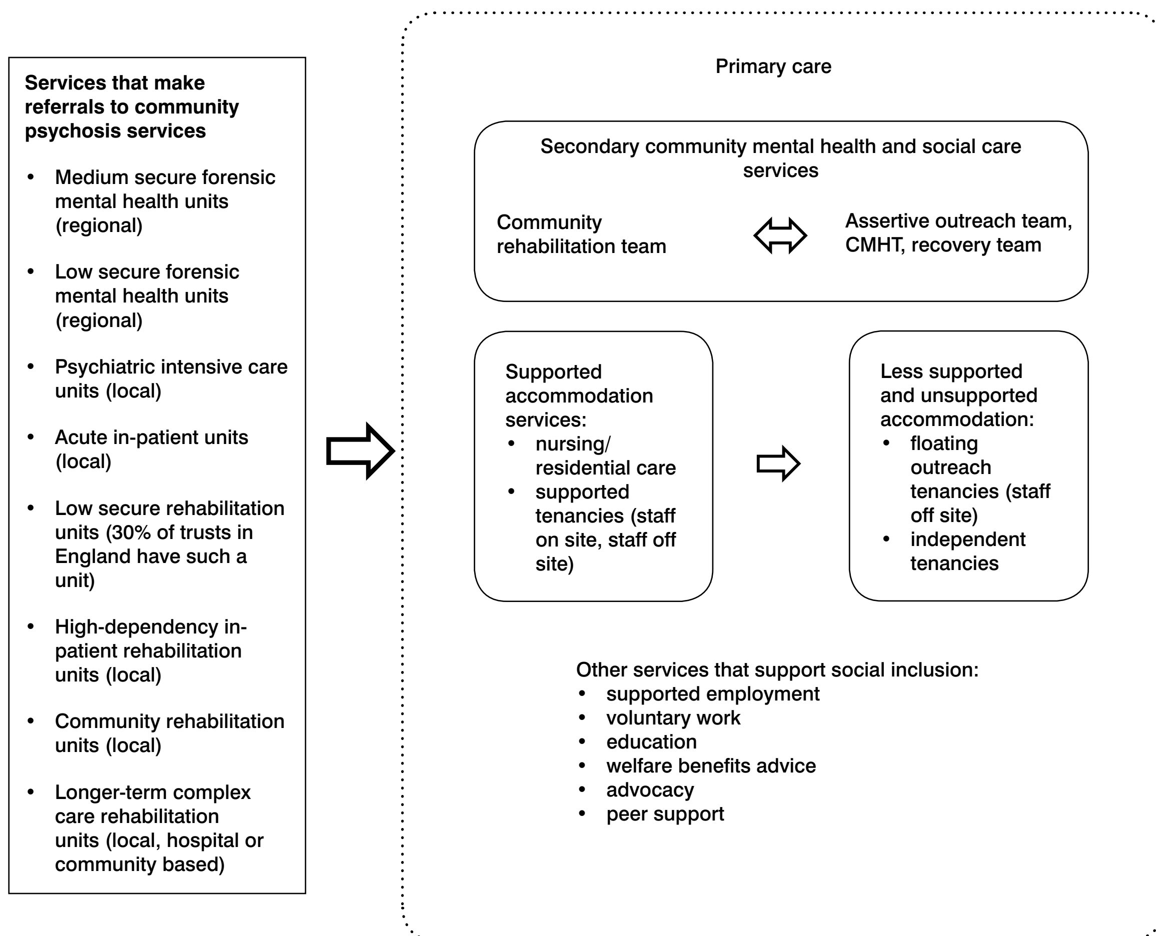

Fig. 1 The whole-system community rehabilitation care pathway.

periods of instability and attempt to avoid placement breakdown or hospital admission wherever possible. This may involve the amendment of care plans and facilitating access to additional mental health support (e.g. the local crisis resolution team).

Focusing on strengths rather than areas of difficulty is important in building up a person's confidence. This work requires skilled mental health staff from all disciplines to encourage service users to gradually take responsibility for their own decisions and to manage their mental health and other aspects of their life to the best of their ability. To be successful, this process usually requires incremental steps, such as graduated self-medication programmes, assistance to improve in daily living skills, and detailed planning and support for a graduated move into less supported accommodation. It also requires sensitive insight-related work, such as the identification and agreement of relapse indicators, and agreement about the interventions and supports that can help during periods of crisis. To test these and progress in helping an individual take on some of the responsibility to remain out of hospital, a degree of 'therapeutic risk-taking' is required. Michael's story (Box 4, page 15) illustrates some of these issues.

It takes a number of years for service users to move successfully through each step of the care pathway owing to the severity and complexity of their mental health needs. They often need to make repeated attempts to successfully make the transition from a higher to a lower level of support. One study found that over a 5-year period, around two-thirds of people in a rehabilitation service were able to sustain their placement or progress to a less supported setting (27% remained in the same placement and 41% progressed to less supported accommodation), but only 8% achieved a completely independent tenancy (Killaspy & Zis, 2012). Community rehabilitation services will work with service users over the longer term, providing continuity of care and holding the memory of what has worked well for the person previously. They will also advocate for service users to have more than one attempt at a move to more independent accommodation.

As well as supported accommodation services, community rehabilitation teams and other community psychosis services liaise and collaborate with a wide range of other providers in the statutory and voluntary sectors, to enable their clients to access services that support their recovery and promote their social inclusion. These include Social Services, housing, vocational rehabilitation, education and employment services, advocacy and peer support services and primary care.

The workload of a community rehabilitation team will vary according to the degree of complexity of clients, the proportion of clients detained under the Mental Health Act (and the associated medico-legal work), as well as the staffing of the rest of the team, including the amount of trainee doctor and specialty doctor time. Furthermore, the geographical spread of workplaces needs to be considered. Taking all of these issues into account, a community rehabilitation team/assertive outreach team with an average case-load of 100, with some clients under a community treatment order, would require 5.0 programmed activities per week from a consultant in rehabilitation psychiatry. This would be to provide direct patient care, home visits, care programme approach (CPA) review meetings, weekly team meetings, Mental Health Act work and clinical administration. Although it is difficult to be exact in these circumstances, it is likely that in areas of average morbidity there should be one whole-time equivalent community rehabilitation consultant per 350 000–400 000 adult population.

This description does not include consideration of consultant responsibilities additional to other components of the rehabilitation service, such as in-patient rehabilitation units, and these would need to be reflected in the job planning process.

An example of the work of one community rehabilitation team is given in Box 5 (page 16).

Box 4 Michael's story: responsive support and therapeutic risk-taking

Michael is a 24-year-old man who had been diagnosed with schizophrenia when he was 17. Before his first contact with mental health services, he had been using a variety of drugs for a number of years and had often come into contact with the police for public order offences, which were prompted by his belief that people were saying derogatory things about him. Initial attempts to engage him in the community had proven difficult and this ultimately led to him being admitted involuntarily. After a 3-month stay in hospital, he was discharged back to his parents' home but his engagement with the community mental health team and his adherence to medication were poor. Eventually, his mental state deteriorated and he became aggressive towards his parents, who evicted him. This led to another admission to hospital and a referral to a community rehabilitation unit, where he stayed for 9 months. He was commenced on clozapine as he had difficulty tolerating typical antipsychotic medication and showed partial response to olanzapine. On discharge, he moved to supported community accommodation and received follow-up from the community rehabilitation team.

Unfortunately, a month after discharge, it appeared that his mental state was deteriorating and he admitted to sometimes forgetting to take his medication. At a meeting with his care coordinator and community consultant psychiatrist, he again expressed beliefs that people were 'talking about him'. On further discussion, he was willing to accept that this might have been a symptom of his mental illness and admitted that he did not want to be aggressive to people if they were not talking about him. A contingency plan was drawn up such that his support workers visited him at medication times. He appeared to improve as a result, but after 3 weeks his mental state again deteriorated. He was again reviewed by his care coordinator and consultant psychiatrist, who were concerned about his worsening mental state and the possibility of a further admission to hospital. They reiterated that they wanted to support him to stay in his accommodation and ensure that those around him were safe. Michael had some insight into his symptoms and still had motivation to avoid acting on them. The question was therefore put to him as to what he could do to reassure those supporting him that a risk management plan could be put in place which supported him to remain living in the community at that time.

The contingency plan was rewritten for the second time, as Michael had lost his copy. He planned to stay at home for the next few days after the review. He agreed to ask the support staff to go shopping with him later, so that he had someone with him to check out what he was experiencing and reduce the chance of him acting on his beliefs. It was also agreed that his dose of clozapine would be increased. A crisis plan was discussed as to what support staff should do if they felt his mental state was deteriorating. Michael agreed that he would try to communicate to them when they should contact the hospital and seek further professional support. Over the following 2 weeks, Michael's mental state improved, although he did telephone the out-of-hours service several times to seek support for his psychotic symptoms. He also made use of his as required (PRN) medication on a few occasions and found this beneficial. He reported that he found it helpful that he was made aware of how concerned the team were about him and that plans to maintain his safety were shared between him and the team. Michael felt this was much better than his previous experiences of being admitted to hospital under the Mental Health Act, when decisions were made for him.

Box 5 Example of a community rehabilitation team

This community rehabilitation team has been in existence for almost 10 years and serves a mixed urban/rural environment of about 27 square miles, with a population of approximately 260 000. The team developed from one community nurse post, originally employed to review and support clients placed in supported accommodation out of area. Income earned by the in-patient rehabilitation service for extracontractual referrals funded a second member of staff and reinvestment of resources from the closure of an NHS community rehabilitation unit was also used to expand the team. The team now has six members (four full-time nurses and two part-time support workers) who support and coordinate the care of 50 clients living in supported community accommodation provided by the voluntary sector. The team works closely with the supported accommodation staff and has access to a psychiatrist, a psychologist and an occupational therapist as well as an employment support service.

The team accepts referrals from the in-patient rehabilitation service, early intervention service and assertive outreach team and provides regular support (if necessary, more than twice weekly) to help clients maintain their health, develop their independent living skills and access community resources. The team has a client-centred, recovery ethos and aims to enable clients to identify and achieve their goals and maximise their independence in the community. As clients progress, some have been referred to community mental health teams or back to primary care, while others continue to benefit from the support of the service in the longer term.

In-reach work within the in-patient rehabilitation units helps to foster positive relationships with clients, actively encouraging a greater community focus and providing continuity and support when they move out of hospital and into the community. This close relationship with the in-patient services is particularly helpful in supporting the team to gain an in-depth understanding of the complex needs of the individuals referred.

The relatively small number of staff and clients enables sufficient familiarity for therapeutic engagement, careful monitoring and support, but also allows flexibility for different members of staff to address the different needs of the clients. The team works office hours but there is flexibility to allow for evening and occasional weekend activities. The team also works closely with the crisis/home treatment service should clients require ongoing support out of hours.

Specialist tasks for community rehabilitation services

All community psychosis services identify and address the particular needs of their service users with regard to symptoms, functioning (activities of daily living, social relationships and activities/occupation) and risks (self-harm or self-neglect, risk to others and the risk of vulnerability to exploitation). Although the responsibility for coordination of tasks and interventions generally falls to a named individual within the service (in UK countries that use the CPA, the care coordinator), the varied skills of other members of the multidisciplinary team are required for a comprehensive assessment of needs and for specific treatments and interventions. Each discipline has its own system for training and continuing professional development (CPD) and it is not our intention to duplicate information on the specific competencies that each discipline is expected to have. However, having an appropriate range of staff (psychiatrists, psychologists, nurses, occupational therapists, social workers and support workers, including support, time and recovery (STAR) workers) with the skills and competencies to assess a person's needs and deliver evidence-based and other recommended interventions for people with psychoses is clearly of paramount importance. These interventions are detailed in individualised care plans that are drawn up in collaboration with service users to enable recovery and social inclusion and include medication, psychological and social interventions in line with guidance from the National Institute for Health and Clinical Excellence (NICE; 2009).

In addition, community rehabilitation services provide specialist expertise in the management of severe and complex psychoses. Examples are given below.

Roles of community rehabilitation services in the management of severe and complex psychoses

Biological interventions

- Identification of treatment-resistant illness (limited response to an adequate trial of treatment).
- Expertise in the prescription of complex medication regimes (including clozapine, adjuncts to clozapine and alternatives to clozapine if clozapine is not effective or cannot be tolerated because of serious side-effects) for treatment-resistant psychoses and comorbid mental health conditions.

- Expertise in the prescription of medications for negative symptoms of psychosis.
- Liaison with pharmacists with specialist knowledge of complex medication regimes.
- Strategies to maximise adherence and response to treatment (e.g. supervision of medication administration, use of depot medication, soluble and crushed formulations, use of plasma levels to identify changes in adherence and metabolism).
- Supporting service users to develop skills to self-manage their medication through graduated self-medication programmes.
- Routine physical health screening in keeping with guidance for patients on different medication regimes.
- Referral and support to access dental care, primary care and secondary medical services as required.

Psychological interventions

- NICE-recommended 'high-intensity' psychological interventions for psychoses (e.g. cognitive–behavioural therapy (CBT), family interventions, arts therapies).
- 'Low-intensity' psychological interventions for psychoses (e.g. relapse prevention, insight-oriented work, anxiety management, motivational interviewing, family work).
- Promotion of recovery orientation of services involved in supporting service users (e.g. use of the Wellness Recovery Action Plan (WRAP) and other tools to improve service users' involvement in their own care planning, self-management and identification of recovery goals).

Social interventions

- Managing activities of daily living (e.g. personal care, laundry, shopping, cooking, cleaning, budgeting, paying bills).
- Accessing community activities and vocational rehabilitation services to improve social and occupational functioning (leisure, education, work).
- Accessing appropriate social security benefits (welfare benefits advice).
- Accessing personal budgets to enable recovery goals and community activities.
- Referral to appropriately supported/independent accommodation.
- Practical and emotional support with moving into new accommodation.
- Support to engage (or re-engage) with family and friends.

Interventions related to legal frameworks

- Use of appropriate mental health legislation for people subject to formal community supervision or who relapse in the community and require involuntary admission.

- Use of formal management of finances/assets for people who lack capacity and/or are vulnerable to financial exploitation (e.g. appointeeship).
- Assessing individuals' mental capacity regarding making decisions about moving accommodation and following the protocols in place for those deemed to lack capacity.
- Adhering to Deprivation of Liberty Safeguards (DoLS) where appropriate.
- Implementation of guidance on safeguarding adults and children where risks are evident.

Supporting the client's wider support network

- Families and informal carers.
- Staff in supported accommodation.

In addition, community rehabilitation services:

- **manage transitions** as the service user moves between different settings (e.g. from forensic services to general services, from the in-patient ward to the community, from higher to less supported accommodation, from secondary to primary care)
- **hold therapeutic optimism** for service users whom other services may consider 'hopeless cases'
- **hold a long-term view** and work with service users over many years
- pay close attention to the **social context** in understanding the person's problems and consider adjustments to their social/living environment as well as more 'traditional' evidence-based interventions.

Senior members of community rehabilitation services provide a 'WD-40' function to prevent silting of the supported accommodation care pathway through a number of varied interventions.

- **Identifying gaps** in local supported accommodation provision and working closely with those commissioning and providing supported accommodation services to address these by developing new or reconfiguring existing services.
- **Membership of the local placement funding panel,** ensuring that placements are matched to individuals' needs and that out-of-area placements are only used when no appropriate local provision is available.
- **Developing systems** for regular, detailed review of people placed in supported accommodation (locally and out of area) with a view to moving on to less supported accommodation or repatriation at the earliest opportunity.
- **Managing service users' transitions** between placements. This helps to ensure safe transitions, reducing the risk of placement breakdown or illness relapse; planning across a locality identifies the ongoing and future accommodation needs of the local population.

Supporting service users' transitions to less supported accommodation also releases financial flows that can be reinvested into the local mental health service economy, an important consideration during the current economic downturn, when maximum cost efficiencies are necessary. The move to a supported flat of one's own after many years of living in residential care homes and hospitals can be incredibly positive and life-changing for many, when managed well.

These lists are not exhaustive, but illustrate the broad range of skills, interventions and tasks that are necessary to enable a person's recovery from a longer-term and complex psychosis. However, the level of skill required is not so easily described. For example, where it may seem obvious to suggest that somebody with treatment-resistant psychosis should receive clozapine, the process by which community rehabilitation services engage that person in discussion about this and manage the practical logistics in a community setting are much more challenging than treatment guidelines suggest, as illustrated by Frank's story (Box 6).

Box 6 Frank's story

Frank was diagnosed as having schizophrenia when he was in his late teens. Over the years he had tried many medications with limited benefit. When he was in his early twenties, for several months clozapine had led to a significant improvement in his symptoms and functioning. However, he then stopped taking it. His functioning gradually deteriorated to the point where he required 24-hour supported accommodation. He remained unwell, with persistent thought disorder, auditory hallucinations and obsessional thoughts. He spent most of the day in his bedroom smoking, and required support and prompting to manage his self-care and environment. He had little regard as to where ash and cigarette stubs were discarded.

After a detailed review of his history and treatments, the community rehabilitation team felt it appropriate for Frank to have another trial of clozapine. Frank, however, was not keen and declined to attend the local day hospital, where other patients tended to be initiated on clozapine in the community. Over the following several weeks the subject was discussed with him and he eventually agreed to the necessary physical review and blood tests, which were carried out by the community rehabilitation team junior doctor, but still he remained reluctant to agree to start the new tablets. The community rehabilitation team and supported accommodation staff continued to meet with him to discuss the potential benefits of clozapine and, after a further few weeks, he agreed to a re-trial of clozapine. Nurses from the community rehabilitation team visited Frank twice daily initially to review his basic observations (temperature, pulse and blood pressure) and the supported accommodation staff were informed about possible side-effects of clozapine to look out for. The community rehabilitation team doctor visited him weekly and took the necessary blood tests, reviewed his mental state and physical health. Frank made good progress on clozapine, with improvement in his symptoms and functioning, such that he was able to move to a more independent community placement 2 years later.

Out-of-area placement review

As mentioned in the previous chapter, a particular role for community services that focus on people with longer-term and complex needs is the review and support for repatriation of those placed out of area (see pages 19–20). Disinvestment in NHS rehabilitation services after the publication of the *National Service Framework for Mental Health* (Department of Health, 1999) led to a large increase in the number of people placed out of area in hospital, nursing and residential care homes (Davies *et al*, 2005; HM Government, 2011). Out-of-area placements displace service users from their communities and criticisms have been made of the quality of care and lack of rehabilitative ethos in some (Ryan *et al*, 2004). Out-of-area treatments are expensive, costing on average around 65% more than similar local services (Killaspy & Meier, 2010).

Service users placed out of area have similar profiles in most respects to those placed locally (Killaspy *et al*, 2009). Specialists in rehabilitation should be involved in assessing the appropriateness of making individual out-of-area placements and reviewing the needs of people placed in them in order to clarify whether local services could provide a better alternative. In many trusts, 'out-of-area reviewing officers', supported by rehabilitation psychiatrists and rehabilitation services, carry out this role. Without them, many individuals become 'stuck' in placements unnecessarily, with no clear care pathway back to their local area.

The purpose of the review is to:

- assess whether the placement continues to meet the person's needs
- identify an appropriately supported (ideally, more independent) placement for the client to move on to in the future, ideally in their area of origin where clinically indicated
- identify, with the client and the staff at the out-of-area placement, clear goals for progression through the pathway (e.g. managing medication more independently, self-catering, budgeting)
- facilitate assessment by the potential future accommodation provider at an appropriate time
- liaise with all parties and support the client practically and emotionally through the assessment and moving-on process, including visits, transitional leave and final move
- continue to review the new placement if out of area, or hand over the case to a local CMHT or community rehabilitation team after an appropriate settling in period.

Recent guidance for commissioners on out-of-area placements has been drawn up by the National Mental Health Development Unit and

published by the Royal College of Psychiatrists (National Mental Health Development Unit, 2011). This stresses the importance of provision of local care pathways for people with complex mental health needs to minimise the use of out-of-area placements to the specialist circumstances where clinical complexity is such that local provision would be clearly unfeasible.

Box 7 gives two examples where systematic and creative partnership working between commissioners, statutory and non-statutory services has facilitated the reinvestment of resources spent on out-of-area placements into better local services.

Box 7 'Invest-to-save' initiatives for people with longer-term, complex mental health needs

A. In 2004, an 'out-of-area reviewing officer' post was funded by Islington Primary Care Trust, London, hosted within the local mental health trust's accommodation team to review all clients in out-of-area placements. From 2004 to 2011, 79 people were reviewed, of whom 45 (56%) were assessed as potentially appropriate to move to less supported accommodation. Of these, 41 were supported to move, most of whom (over 80%) returned to Islington. Re-investment of financial flows funded four new, high-specification local supported accommodation projects providing 24-hour on-site support to people living in tenancies. All four are provided by voluntary sector organisations with additional support from local community mental health services. Evaluation of the process has highlighted the social and clinical benefits for clients, many of whom have reconnected with family and improved their independent living skills. Over half have made a further move to a less supported tenancy and a third have progressed to an independent tenancy.

B. In Croydon services, part of the South London and Maudsley NHS Foundation Trust, a specific piece of work has successfully enhanced the transition of people with coexisting psychosis and severe personality disorder from higher to lower levels of support. By attaching specialists to an existing community rehabilitation team to focus on these clients, it has been possible to successfully step-down to community placements several such clients who had experienced extended stays in acute in-patient and secure settings. An important component has been in-reach working across the care pathway, to the hospital ward and supported accommodation facilities, to support staff in providing a consistent approach in response to the person's behaviour. This process has attained good outcomes for the clients and a significant saving in placement funds has been achieved. This transitions service will now be extended across the trust. There is potential for other specific diagnostic groups to be supported in a similar way, for example those with a psychotic disorder and autism spectrum disorder leading to challenging behaviour. They are a group of clients who have specific needs and who often occupy high-cost placements, again for extended periods of time and at huge cost to local health and social care budgets, and for whom a step-down to a more local, more independent setting has not been possible owing to the lack of a joined-up and specialist rehabilitation approach.

The future of community rehabilitation services

This faculty report has described the particular knowledge, skills, ethos and approach that enable people with longer-term and complex mental health problems to achieve greater well-being, recovery and social inclusion. Although some aspects of this work can be undertaken by other community mental health services, the specialist expertise of community rehabilitation teams is needed for those with the most severe and complex problems. As well as providing specialist assessment, interventions and support, these teams work across the multiple systems of care providing support to this group of service users and their carers. They also work closely with those who commission services for people with severe and complex mental health problems to ensure that their needs are not overlooked and that gaps in service provision are addressed.

Profound changes are upon us in the way services are commissioned, organised and delivered to people. The implementation of tariff-based mental healthcare ('payment by activity'/'payment by results') in England will oblige services to provide more standardised and evidence-based care than before. Services will have to provide data on clinical outcomes specific to care clusters and pathways. This will be helpful in assessing how effective the specific interventions and support delivered by services are, and could potentially help inform the reconfiguring of services where outcomes need to be improved. It may assist with our understanding of the effectiveness of interventions and models of support for people with more complex mental health problems, and bolster investment in research to further this evidence base. Staff will need to have appropriate training and skills to deliver the assessments, interventions and support that this greater specialisation will bring. Community rehabilitation services are well placed to further refine their expert skills and provide cost-effective services to assist individuals who have historically been seen as having exhausted all treatment options and/or become institutionalised to achieve their potential.

Use of personal health budgets, currently in its infancy in mental healthcare, will gather momentum in coming years. Service users will be able to choose the provider they wish to oversee their care and there will be a decommissioning of 'block contracts' in supported accommodation. Care coordinators will be tasked with more detailed needs assessments of their clients to inform the budget awarded to meet these and help them manage individualised contracts with providers. Current providers of mental healthcare will need to market themselves effectively to gain this custom. Continuity of care will be affected if different services are used and this will be especially pertinent in the care of people with complex

needs who may need multiple services. Community rehabilitation services will continue to have a key role in assisting with the forecasting of ongoing need for supported accommodation in a locality and in providing objective assessments of the performance of supported accommodation and other service providers in the support and recovery focus they give to clients.

Collecting and providing data about the inputs and outcomes of our work is imperative to evidence their clinical and cost effectiveness, but this needs to be presented in the context of the whole system within which individual components operate. The monitoring of standards of care is increasingly stringent with the aim of driving quality of care up and ensuring value for money, but intelligent commissioning and performance management of whole-care pathways are required to ensure that service users are supported effectively throughout their recovery without unnecessary discontinuities in care. This includes better access to secondary mental healthcare services when needed, and easier access to supported accommodation and other services that promote social inclusion at discharge. To achieve this, a collaborative approach by all stakeholders is required. This will be something of a challenge given the economic context within which mental health services are currently operating and the encouragement by government and policy makers of a competitive mental healthcare 'marketplace'. However, there is nothing like a good crisis to make people think creatively and constructively. Our final vignette shows how one service used a creative approach to providing community rehabilitation in the midst of an economic downturn (Box 8, page 25).

Box 8 Creative use of community rehabilitation services in an economic crisis

The rehabilitation service in north Dublin was set up in 2001 and evolved as part of the closure programme for the local hospital. In the midst of an economic crisis, it has not been possible to deliver the planned investment in Irish mental health rehabilitation services envisaged in the government's *Vision for Change* report (Department of Health and Children, 2006). The lack of investment in community mental health services, including early access to community rehabilitation services and supported accommodation, means that it is difficult for service users to access rehabilitation interventions which would enable and support them to progress towards independent community living. The community rehabilitation multidisciplinary team was established in 2004 to address this service gap and provides specialist assessment and treatment for people with longer-term complex mental health needs, with significantly impaired social and everyday functioning. The service covers a mixed urban/rural area with a population of approximately 230 000. There is no psychologist but all other disciplines are represented. The medical staff, occupational therapist and social worker work across the in-patient and community services.

The team provides a proactive community liaison service to general adult services, advising them on the kinds of rehabilitative interventions that may be beneficial to their clients while they are awaiting the rehabilitation service. It also supports the transition of clients from higher levels of supported accommodation to less supported settings, working beyond the original remit to support more people in independent tenancies and low-support settings. This is to release capacity in supported accommodation while ensuring that clients maintain the good progress they have made in the rehabilitation service. The team provides support and education to families to enhance clients' existing social networks. It makes strong links with other community agencies (e.g. those providing vocational training, advocacy, home care, 'meals on wheels', pharmacy) and primary care services to capitalise on the network of community resources that can assist in clients' maintaining and furthering their progress.

A recently completed study found that service users receiving rehabilitation services in Ireland were eight times more likely to achieve and/or sustain community living successfully compared with service users with similar needs under general adult services (Lavelle *et al*, 2012).

Conclusions

We hope that this faculty report has demonstrated the ongoing need for the specialist skills of community rehabilitation teams. These include the ability to work with service users with very complex and longer-term mental health needs in an incremental and holistic way, holding hope for and working collaboratively towards their ongoing recovery and independence. As well as key clinical skills, this process involves good liaison and partnership working within a complex system of providers of mental healthcare, and with commissioners of services and colleagues in primary care. Community rehabilitation teams have been previously noted to be an integral component of a ´whole-system´ care pathway for this service user group, including those placed out of area. This faculty report provides a useful reference guide for the promotion of this type of service, especially in the face of increasing scrutiny of mental health service delivery in the present economic context.

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