

Enabling recovery for people with complex mental health needs

A template for rehabilitation services

Faculty report FR/RS/1
Royal College of Psychiatrists
Faculty of Rehabilitation and Social Psychiatry

Edited by Paul Wolfson, Frank Holloway
and Helen Killaspy

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Faculty of Rehabilitation and Social Psychiatry
of the Royal College of Psychiatrists

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DISCLAIMER

Faculty Reports are recommended by the Executive of a College Faculty to its members. They have not received approval by the College's Central Policy Coordination Committee and do not necessarily reflect the policy of the Royal College of Psychiatrists.

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Template for rehabilitation services

This document has been prepared by the Executive Committee of the Faculty of Rehabilitation and Social Psychiatry of the Royal College of Psychiatrists. It sets out in brief our view on what constitutes a comprehensive psychiatric rehabilitation and recovery service and builds on our position statement (Holloway, 2005), which emphasised that although core rehabilitation and recovery principles are relevant to all mental health services, there is a need for dedicated specialist rehabilitation services. It is increasingly understood that expertise in rehabilitation is required within forensic mental health services and the low secure services that have expanded as the traditional mental hospitals have closed and the number of beds within acute mental health services has decreased.

We are deliberately not prescriptive in terms of the numbers of people who might require any particular kind of service in a given catchment area. The precise figures will depend on particular local factors relating to the epidemiology of severe mental disorder, local demography and social capital as well as the range of services that happen to have been developed locally – some forms of provision might well substitute in certain cases for others.

To gather views from stakeholders on what constitutes a rehabilitation service, committee members have held a series of workshops with service users, carers and staff (including managers and commissioners) from six rehabilitation services in the UK (Wolfson & Mountain, 2008). The stakeholder contribution, which punctuates the text of this document, illustrates the diversity of perspectives which need to be considered in a service specification.

We expect our readership to comprise professionals working within the existing network of rehabilitation, recovery and continuing care services that operates across the UK, the wider family of psychosis services that adopt rehabilitation and recovery principles (notably assertive outreach teams, early intervention services, forensic rehabilitation and low secure services), managers within NHS trusts and independent sector providers, service commissioners and policy makers. The document is also a contribution to the Royal College of Psychiatrists' commitment within the Fair Deal campaign to 'press for the formulation of a clear UK policy on the provision of rehabilitation services for people with long-term mental health problems' (Royal College of Psychiatrists, 2008). Effective rehabilitation and recovery services must be developed

as a partnership between statutory agencies, private and voluntary sector providers, carers and service users.

We believe that this template has relevance to rehabilitation services throughout the UK.

WHAT THIS DOCUMENT IS NOT

We have not described in detail some important elements of an effective rehabilitation service, such as advocacy (Harrison & Davis, 2009) and employment services (National Social Inclusion Programme, 2006) because they are a generic component of all mental health services. Nor have we provided in-depth information about the very important therapeutic activities that rehabilitation services must provide if they are to be fully effective, as these are well described in standard texts on rehabilitation and recovery, for example in Pratt *et al* (2007), Corrigan *et al* (2008), Liberman (2008) and Roberts *et al* (2006). Nor have we set quality standards of care for rehabilitation services. This is the subject of a companion document which is in preparation.

1 Introduction

Within the UK there is no nationally agreed service specification for psychiatric rehabilitation. Local provision of rehabilitation services is variable in ways that are not obviously related to need (Killaspy *et al*, 2005; Mountain *et al*, 2009). The consequences of the lack of a policy for rehabilitation services are serious. Many people with the most complex mental health needs now receive long-term care in costly out-of-area hospital placements (Davies *et al*, 2005). These people frequently experience barriers to returning to their locality into more appropriate forms of care. Others are placed in what is sometimes restrictive care in residential and nursing homes that may have little emphasis on the promotion of independent living skills. These people are at risk of living out their lives in these settings. For yet another group of people the lack of access to a local rehabilitation service means remaining at home with their families and being reliant on the care and support of increasingly elderly relatives in circumstances of unacknowledged distress.

UK IN-PATIENT REHABILITATION SERVICES

Although the majority of mental health trusts in England have in-patient rehabilitation services (Killaspy *et al*, 2005), in recent years provision has become increasingly patchy. From 1999, the National Service Framework for Mental Health (Department of Health, 1999) focused investment on other specialist community services (Mountain *et al*, 2009). Of the 233 assertive outreach teams in existence at the time of the National Assertive Outreach Study of Service Organisation in 2004, 30% had previously been rehabilitation teams, a figure that seems to have risen significantly since then (details available from the authors on request). This represents a potentially important reduction in services for people with severe and enduring mental health problems who are not hard to engage and therefore do not meet the criteria for assertive outreach teams (Mountain *et al*, 2009).

OUT-OF-AREA TREATMENTS

Disinvestment in National Health Service (NHS) rehabilitation services has led to a rapid and uncontrolled rise in independent sector provision of so-called 'out-of-area treatments', in what have been referred to as 'virtual asylums' (Poole *et al*, 2002). This has had the effect of displacing service users from

their communities and there are aspects of the quality of care they provide which have been criticised (Ryan *et al*, 2004). They are also expensive: in 2004–5, out-of-area treatments cost the NHS £222 million, an increase of 63% over the previous year (Mental Health Strategies, 2005).

Historically, most placements have been commissioned by primary care trusts, and there may be inadequate systems for monitoring the quality of care and the ongoing need for the level of support provided (Ryan *et al*, 2007). Service users placed in out-of-area facilities have similar profiles in most respects to those placed locally (Killaspy *et al*, 2009). Rehabilitation psychiatrists are increasingly becoming involved in assessing the appropriateness of out-of-area placements and reviewing the needs of people placed in them.

GOVERNMENT SPENDING ON REHABILITATION AND RECOVERY SERVICES

Readers may not be aware of the sheer scale of spending on services providing rehabilitation and recovery. A report commissioned by the Department of Health documented health and social care spending on adult mental health in 2008 (Mental Health Strategies, 2008). Of the £5.5 billion total spend, 19% is on continuing hospital care, residential and housing care and home support services that are of direct relevance to rehabilitation services. Secure and high-dependency care (16%) requires high levels of rehabilitation competency for patient groups with prolonged hospital admissions. Day services, which should be oriented towards rehabilitation and recovery, account for 3.7% of spending. The clients of the 'family' of psychosis services (assertive outreach, early intervention and community forensic services (4.6% of spending) require rehabilitation expertise, as will people on the caseloads of the continuing care elements of community mental health teams and people admitted to acute in-patient beds with enduring mental illness. Indirect costs, overheads and capital charges account for 19% (Table 1, Appendix, p. 42). Well over 50% of the mental health spend is on the treatment and care of people where rehabilitation and recovery is clearly essential to effective practice. Much of this spending on rehabilitation falls within mainstream health and social care services.

In times of increasing constraints on resources it is imperative for local mental health economies that this money is spent effectively. 'Repatriating' people to local services and helping them live as independently as possible is likely to benefit the individual as well as saving money which could be used in more useful ways.

WIDER ACCESS

There is now a compelling case for proper access to rehabilitation services across the whole of England, summarised below in five broad headings.

LOCALISATION

A rehabilitation service is close to its clients, their families and workers who know them. Under local management it is far less likely for people to be 'out of sight, and out of mind'.

PERSONALISATION

A local service can be tailored to the needs of the individuals it is for and respond to a change in need.

CHOICE

A person should be able to remain living in their community of origin if that is their wish.

SOCIAL INCLUSION AND STIGMA

It is hard to find another example in the NHS where a patient has to leave their home town to be resettled many miles away for long periods of time, merely to access a standard treatment environment.

MENTAL HEALTH AND SAFETY

The current culture of throughput that dominates in-patient care pathways can be too optimistic for some service users. There will always be people with complex needs who need longer hospital stays in a more specialist environment for engagement and treatment, sometimes for as long as 2–3 years. In the absence of any local rehabilitation facility, service users are more likely to be discharged prematurely from the acute ward, at arguably greater risk.

2 Contemporary definition of rehabilitation in mental health

Despite its continuing relevance, 'rehabilitation' is an unfashionable term within mental health services where the dominant paradigm is the throughput of individuals along a time-limited care pathway. This stems partly from an erroneous belief that the task of rehabilitation services was completed when the large mental hospitals closed and partly from the phenomenon of 'out of sight, out of mind' in which people with continuing needs are placed out of area or in residential care, or simply ignored.

We use in this document a contemporary definition of rehabilitation which is based on the findings of a national survey of rehabilitation services in England undertaken in 2004 (Killaspy *et al*, 2005):

A whole systems approach to recovery from mental illness that maximizes an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support.

DISABILITY

A simple definition of a psychiatric rehabilitation service is a recovery-oriented service for people with disabilities associated with longer-term mental health problems. Currently, there seems to be a difficulty within UK mental health services in having an open discourse about disability. It is almost as if experiencing some form of disability is such a bad thing that its effects (and how to minimise them) cannot be talked about. Denial of disability has been an undercurrent in UK mental health policy for decades and its consequences have always been felt years later.

Physical illnesses can result in marked impairment in physical and psychological functioning and consequent disability, for example, inability to work. Disability may be short-term (e.g. flu) or long-lasting (e.g. Parkinson's disease). Severe mental illness also results in short- or longer-term disability. Personal reactions to the illness may compound the problem, as will the effects of social stigma associated with mental illness.

Psychiatric rehabilitation services address, very directly, the disabilities of people who have not made a rapid recovery and may experience continuing

difficulties in personal functioning and relating to others. For instance, they may have cognitive impairments that make it hard to plan ahead, or symptoms which make clear communication difficult, or be vulnerable to exploitation by others, or their behaviour may be challenging to others. Professionals working within psychiatric rehabilitation require skills in assessing the extent and the causes of these difficulties. The task then becomes to work collaboratively with the person who is using the service to address these problems in a manner that includes and recognises that person's own wishes and ambitions.

3 Purpose of specialist rehabilitation services

The purpose of specialist rehabilitation services is to deliver effective rehabilitation and recovery to people whose needs cannot be met by less intensive mainstream adult mental health services. The focus is on the treatment and care of people with severe and complex mental health problems who are disabled and often distressed, and who are or would otherwise be high users of in-patient and community services. The aim is to promote personal recovery, 'whilst accepting and accounting for continuing difficulty and disability' (Roberts *et al*, 2006).

What makes rehabilitation services unique is the length of time they expect to work alongside individual service users. They will support people as they gain or regain confidence and skills in everyday activities, a process which can take months or even years. Maintaining expectations of recovery over long periods of time can be difficult for staff and service users alike. A major aspect of the purpose of rehabilitation services is the continuous promotion of therapeutic optimism.

STAKEHOLDER VIEWS

What is the purpose of a specialist rehabilitation service?

Staff:

- to provide an intensive service that is durable and sustainable
- to continue to support people as their needs change
- to adapt the environment to sustain change
- to improve physical health and life expectancy.

Service users:

- to learn life skills
- to get you standing on your feet again
- to be free.

Carers:

- to relieve distress
 - to provide a place of safety for vulnerable people
 - to help make the outside world safer for service users by educating the public.
-

4 Core components of a rehabilitation service

An effective rehabilitation service requires a managed functional network across a wide spectrum of care. Its components (in-patient beds, rehabilitation teams and other resources) should be determined by local need.

IN-PATIENT BEDS

A full range of in-patient services, defined as hospital beds able to care for compulsorily detained patients, should provide access to services across the dimensions listed below. Inevitably, not all dimensions will be provided by local NHS services. Independent providers as well as regional and national services will provide part of the functional network.

The dimensions of function are the expected length of admissions, the functional ability of the residents, the capacity of the settings to manage risk and the degree of specialisation (see Chapter 12, pp. 33–4, for a typology of rehabilitation in-patient settings).

TEAMS WORKING IN REHABILITATION

The core team is a multidisciplinary rehabilitation team which supports in-patient units and/or community clients requiring rehabilitation. By 2005, only half of all rehabilitation services had fully functioning community teams (Killaspy *et al*, 2005). Some services have maintained a limited community service, supporting people in 'placements', or provided a network of supported accommodation. In the absence of community rehabilitation teams, there is a gap in services for those most disabled in the community which cannot be easily filled by mainstream community teams (see Chapter 11, pp. 28–32).

Teams which are part of the 'family' of teams that support people with psychosis are:

- early intervention in psychosis
- assertive outreach

- community forensic, and
- community mental health teams with a longer-term complex case-load.

OTHER ESSENTIAL RESOURCES

Other resources may be part of a rehabilitation service or, more commonly, are available within the wider network of services funded by health and social care budgets:

- a spectrum of locally available supported accommodation to meet local needs
- agencies to help service users to access work and education, ideally in the mainstream; this includes schemes such as supported employment projects, links with local colleges and 'bridge-builder' initiatives which facilitate social inclusion, such as access to mainstream leisure facilities
- access to advocacy services and peer support.

5 When to consider making a referral to rehabilitation services

Referral to rehabilitation services may be considered in various circumstances:

- when a person with major and complex mental health needs cannot be discharged from an acute ward but is unlikely to benefit further from an acute ward environment;
- for assessment of, and engagement with, a person with major and complex mental health problems who has become 'stuck' and non-progressive in their recovery;
- when there has been an erosion of therapeutic optimism within mainstream services towards a person with complex needs, which may be hindering their recovery;
- when a person is facing a transition from a highly supported setting to a less supported placement; this includes people leaving forensic or secure services, people leaving out-of-area placements, or leaving residential care to live in the community;
- when a person needs help in overcoming disabilities associated with severe and complex mental health problems that would benefit from a structured environment and intensive therapeutic programmes that are available on a rehabilitation unit;
- for care, support and treatment in environments which are rehabilitative and may be longer-term;
- for specific advice on assessment, diagnosis, risk, engagement, treatment, placement, care packages, and other aspects of individual care of people with major and complex mental health needs;
- more general advice about the needs of people with long-term conditions such as recovery-oriented practice and service evaluation for this client group.

6 Clients of rehabilitation services

When crisis resolution, early intervention, and assertive outreach teams were set up following publication of the *National Service Framework for Mental Health* (Department of Health, 1999) and the *Mental Health Policy Implementation Guide* (Department of Health, 2001), an important objective was to reduce reliance on in-patient services (Glover *et al*, 2006). In spite of these developments, a proportion of service users still require lengthy hospital admission even when they receive treatment and care from the new 'functional' teams (Craig *et al*, 2004; Killaspy *et al*, 2006).

PEOPLE WITH SCHIZOPHRENIA

People who do not recover quickly on acute wards are often referred to rehabilitation services. Most have a diagnosis of schizophrenia (Killaspy *et al*, 2008) and are referred at the point when it has become clear that following the National Institute for Health and Clinical Excellence (NICE; 2002, 2009) guidelines algorithm has not enabled the service user to leave hospital (Holloway, 2005).

At any time, around 1% of people with schizophrenia receive intensive in-patient rehabilitation (Holloway, 2005). Delayed recovery may be due to treatment resistance, cognitive impairment, severe negative symptoms, substance misuse and challenging behaviour (Wykes & Dunn, 1992; Wykes *et al*, 1992; Green, 1996; Meltzer, 1997; Holloway, 2005; Killaspy *et al*, 2008). In other words, this group has complex mental health needs. There is good evidence that with further treatment in a suitable rehabilitation setting, even those patients whose difficulties are considered to be the most challenging are able to progress to supported community living (Trieman & Leff, 2002).

A relapsing and remitting course of illness with associated risks of suicide, self-neglect and harm to others increases the vulnerability of this client group. Intellectual disability, developmental disorder and personality disorder may also complicate the picture and markedly increase the likelihood of adverse outcomes (Holloway, 2005).

Many people with severe and enduring mental illness also suffer from secondary handicaps due to social stigma. Opportunities and outcomes in terms of employment, income and social relationships are very much worse than for

the general population. People with severe and enduring mental illness are considered to be one of the most socially excluded groups in society (Social Exclusion Unit, 2004).

These examples of poor outcomes for service users have to be offset against some very positive findings from longer-term studies of schizophrenia. One pioneering study (Harding *et al*, 1987) found that half to two-thirds of patients significantly improved or recovered. The criteria for recovery were impressive: no current medications, working, relating well to family and friends, integrated into the community and behaving in such a way as not to betray ever having been hospitalised for any kind of psychiatric problem.

A large international multicentre study found that global outcomes at 15 and 25 years after diagnosis were favourable in over half the people followed up (Harrison *et al*, 2001). The authors concluded that there is evidence of a late recovery effect. This suggests that therapeutic optimism is neither idealistic nor misplaced.

STAKEHOLDER VIEWS

Who should be the clients of specialist rehabilitation services?

Staff:

- those who are vulnerable in an acute ward setting
- clients who have not benefited from mainstream services
- 'Professionals are not very good at predicting who will benefit from rehabilitation, which calls into question exclusion criteria such as "not being interested in moving on" or "not engaging with therapies".'

Clients:

- 'I should have had much more say in whether I came here. It should have been my decision. I would like the decision to be talked about more.'
- 'Long-term hopeless case ward. That's what rehabilitation really is.'
- 'It is good to have role models of people who are improving.'

Carers:

- people with problems with life skills
 - people with problems with relationships.
-

7 Values of rehabilitation services: overcoming disability, recovery and social inclusion

CORE VALUES

A biopsychosocial model has been the underlying principle of clinical practice within rehabilitation services for many years. For any individual client one aspect of the three components may be more or less important at any one time. There is a focus on overcoming disability.

In recent years, rehabilitation services have been closely associated with recovery and social inclusion. These overlapping and complementary approaches are having an increasingly powerful influence on everyday professional practice.

RECOVERY

The concept of recovery emerged from the 'user movement' but also owes a historical debt to the 'moral treatment' pioneered in the 18th century by the Tukes at the York Retreat (Tuke, 1813). Then as now, valuing hope and optimism was at a premium. Low expectations of service users can easily become self-fulfilling prophecy (Harrison & Mason, 1993). The importance of good physical as well as mental health, respect for individuals of all ages and cultures (O'Hagan, 2001) and the right to a life that is not defined by illness or diagnosis (Davidson & Strauss, 1992) are values that underlie all effective rehabilitation practice. Engagement often begins by constructing a detailed narrative base for understanding a person's past – particularly past trauma – and how it impinges on the present. The service user and the multidisciplinary team can then collaborate to develop a personal formulation.

SERVICE USER INVOLVEMENT

Recovery is not just in the gift of mental health workers (Coleman, 1999). People can benefit as much or more from other service users and by marshalling their own resources. Rehabilitation services embrace measures that attempt to capture the direct experience of the service user, and taking part in the process

of rating outcomes often facilitates discussions between staff and service users that identify areas of work on which they need to collaborate further. Such approaches epitomise another core value, service user involvement. This involvement goes beyond collaboration over an individual's treatment. Service users are consulted about the need for service developments, encouraged to provide training for staff and to add a service user perspective to decisions about new staff appointments.

The use of a strengths model of care planning and a positive approach to risk-taking for service users (Deegan, 1996) are ways of embedding recovery values into everyday practice. A recovery-oriented service will involve people in every decision about their care, even in circumstances involving compulsory admission (Roberts & Wolfson, 2006; Roberts *et al*, 2008). This can involve compromise and ingenuity. Warm words about recovery are easy to come by in policy documents; finding a way through the dilemmas that a recovery approach throws up for staff and service users requires a difficult but important struggle.

SOCIAL INCLUSION

It would be difficult to imagine how a recovery-oriented service could promote recovery without promoting social inclusion as well. Both:

- focus on improvement in function rather than symptoms
- stress the importance of environmental adaptation to meet service users' needs
- use a 'strengths' model rather than an 'illness' model
- take a long-term view
- promote therapeutic optimism
- support taking therapeutic risks
- assist in developing social and occupational roles for service users
- aim to combat stigma.

SOCIAL EXCLUSION

One obvious contemporary example of social exclusion is the continuing use of out-of-area treatments. They take people away from their families and communities for no good reason. It is particularly unhelpful when the community of origin has a shared language with the service user as well as cultural and ethnic ties. Other examples of social exclusion are neighbourhood opposition to housing schemes for people with mental health problems, unemployment, the benefits trap, social isolation and poverty.

PROMOTING INCLUSION

Practical examples of measures that can promote social inclusion are highly supported flats in the community, school and community-based education, liaison with further education and leisure facilities, and provision for meaningful occupation. Having access to early intervention services, family work, supportive social networks and advocacy can also improve confidence and help reduce stigma.

A 'traffic light' system has been developed (Bates *et al*, 2006) which categorises day services as red (e.g. service users attend a building-based service specifically for them), amber (e.g. attendance at specialist classes for service users within a mainstream setting) and green (e.g. attendance in a mainstream class in a mainstream setting). This simple indicator can prompt mental health professionals to evaluate the most appropriate setting for their client and give a guide for future progression towards a more socially inclusive setting.

STAKEHOLDER VIEWS

What values underpin rehabilitation services?

Rehabilitation service managers:

- working in partnership with service users
- seeing an outcome.

Carers:

- never giving up on people
- valuing carers
- valuing communication with carers.

Service users:

- valuing workers who are 'hands on'
 - getting better
 - making recovery more obviously the objective of care.
-

8 Functions of a rehabilitation service

The main function of a rehabilitation service is to provide specialist treatment in a suitable setting that helps service users gain or regain the skills and confidence to achieve their own goals, such as living in their own flat, getting a job or starting a family.

TREATMENT AND OTHER INTERVENTIONS

The multidisciplinary team has to have the expertise to address the complex and diverse treatment needs of clients referred for rehabilitation. Ideally, some members of the team will provide continuity of care by working across in-patient and community settings.

MEDICATION

Many people are referred for rehabilitation because they have not responded adequately to medications, often including those prescribed for 'treatment resistance'. The ability to find the best medication regime to minimise symptoms without producing distressing side-effects is a key skill for rehabilitation psychiatrists. (For more on what consultant psychiatrists in rehabilitation do, see Chapter 9, pp. 24–5.)

PSYCHOSOCIAL INTERVENTIONS

A range of psychosocial interventions are required, including psychological therapies such as cognitive-behavioural therapy adapted for psychosis, work with families to promote mutual understanding and reduce stress, art therapies and specific interventions for comorbid substance misuse, such as motivational interviewing. Wherever possible, interventions should involve self-management strategies.

HEALTHY LIVING

Guidance and support to improve unhealthy lifestyles (such as exercise, smoking cessation and dietary advice) and monitoring of physical health are essential. A visiting general practitioner can reduce the need for consultations

in accident and emergency departments or long waits for consultant out-patient appointments.

SELF-CARE

Nurses and support workers have a key role in helping service users gain or regain the confidence and routine involved in managing their own self-care, keeping their living space clean and doing their laundry.

COMPLEX LIVING SKILLS

Occupational therapists are required at all stages of rehabilitation to identify specific problems that the service user may have with more complex living skills such as budgeting, shopping, cooking, accessing education and work, and assisting in care planning to address these. All staff should deliver their specialist interventions within the collaborative framework of the recovery approach.

MANAGING IN SOCIETY

Social worker skills are required to advise on access to accommodation, benefits, adult protection procedures, money matters, advocacy and other legal issues.

THERAPEUTIC LIVING ENVIRONMENTS

A range of hospital and community-based units are required to support service users in their recovery. A small number of service users will require in-patient treatment for lengthier periods and both shorter-term (length of stay less than 1 year) and longer-term in-patient units are likely to be required.

All rehabilitation units should provide a safe and homely space that fosters stability and security, avoids institutionalisation and provides the experience for service users of non-abusive relationships.

Continuity of care should be maintained by community care coordinators and care managers throughout the service user's period of rehabilitation, including when this is in an out-of-area placement.

No service user should be assumed to be in a placement likely to suit their needs forever.

LIAISON AND INTERFACES

- Prompt assessment of referrals and practical advice to other services in the management of people with complex needs, comorbid conditions and treatment resistance.
- Developing an overview of the changing needs of local service users and establishing systems for close working with housing providers and commissioners to plan suitable facilities that meet these needs.

- Supporting decision-making by the local placement panel and ensuring there are regular reviews of out-of-area placements.
- Developing strong links with users and carers, organisations, leisure facilities, churches, cafés, educational facilities, advocacy groups, supported employment projects, clubs, voluntary work, support groups, primary care and community police services.

STAKEHOLDER VIEWS

What are the functions of rehabilitation services?

Service users

To provide:

- good nursing staff
- a good night's sleep
- a structure for people to improve
- something which brings an element of joy into a person's life
- a service without too many changes like different doctors and psychiatrists; continuity is very important.

Carers:

- maintain a stable staff team
 - provide a home for life for those who want it
 - help carers access a service that meets the needs of carers who have been traumatised by their role.
-

9 Skills and expertise

People working in rehabilitation services require a wide range of skills and expertise to meet the diverse needs of their clients for treatment and other interventions described in the previous chapter. Team members will need to share relationship, clinical, liaison and advocacy skills (cf. Liberman *et al*, 2001) as well as possessing specialist skills in particular areas. These skills build on core competencies such as the 'ten essential shared capabilities' needed by all mental health workers (Department of Health, 2004a).

RELATIONSHIP SKILLS

Relationship skills should include the ability to:

- work collaboratively so as to empower people, using recovery and person-centred approaches
- use creative and flexible approaches to motivating people who have negative symptoms and cognitive problems
- promote hope and maintain enthusiasm and therapeutic optimism, even when progress is slow.

CLINICAL SKILLS

Clinical skills should include the ability to:

- work with individuals and carers to assess strengths, functional impairments, disabilities and barriers as part of a comprehensive assessment
- work with individuals to identify their personal recovery goals and to agree an approach to attaining them
- help individuals develop or regain skills, often through a series of small steps
- provide psychoeducation and relapse prevention work
- use cognitive-behavioural therapy for psychosis, adapted where necessary for people who have cognitive impairment
- use individually tailored behavioural approaches, where indicated
- prescribe and monitor medication for treatment-resistant schizophrenia
- monitor physical health and advise on how to stay healthy.

LIAISON AND ADVISORY SKILLS

Liaison and advisory skills should include the ability to:

- give advice and support to carers and professional colleagues
- give advice on modifying environments or support to enable people to access social, vocational and educational roles
- work in partnership with users, carers and services, and facilitate support networks.

SPECIALIST SKILLS

Individual members of the multidisciplinary team may have specialist skills in particular areas, for example in assessing cognitive functioning, detailed functional assessment, behavioural analysis, motivational interviewing, family interventions, and skills training in work rehabilitation (which may include business and commercial skills).

STAKEHOLDER VIEWS

Skills and expertise

Service users

Staff should:

- try to get patients well, though they may not be able to
- help to overcome side-effects of medication
- not cause unnecessary pain.

Carers

Staff should:

- inspire people
 - be challenging but not overwhelming
 - not talk down to people
 - be streetwise – know what a Klingon is.
-

10 What does a rehabilitation psychiatrist do?

Specialists in rehabilitation psychiatry have expertise in the long-term treatment and care of a client group with severe mental illness and complex needs. They adopt a biopsychosocial approach that embraces recovery-oriented practice and always work within a multidisciplinary team.

They work within a variety of settings that include:

- community rehabilitation teams
- in-patient and community rehabilitation and continuing care units
- functional mental health teams providing early intervention for psychosis and assertive outreach
- tertiary care in-patient units for people with challenging behaviours and complex needs, including low secure, medium secure and high secure forensic settings.

TASKS

Key tasks of the rehabilitation specialist include:

- the detailed assessment of and care planning for people with complex needs, comorbid conditions (notably, comorbid substance misuse) and offending behaviour
- advice to colleagues on the diagnosis and management of patients with severe mental illness who do not benefit sufficiently from standard treatments
- advice to services that are providing residential care and complex community care packages
- management of patients in rehabilitation and long-term hospital settings
- advice to commissioners regarding service development and the management of high-cost placements
- support for joint working with voluntary sector agencies that facilitate social inclusion
- use of leadership skills, experience in conflict resolution and good communication to avoid the powerful dynamics that lead to splitting and scapegoating of other agencies and services (Harrison, 2006)

- review of service users being treated or living in out-of-area placements
- membership of the local placement panel(s).

Specialists in rehabilitation psychiatry have the core competencies of the general adult psychiatrist with additional expertise to undertake the core tasks outlined above.

11 In-patient services

REHABILITATION IN-PATIENT UNIT: GENERAL PRINCIPLES

- 1 A rehabilitation in-patient unit will usually provide part of a pathway from acute and forensic services (including acute and longer-term secure services) to a community residence of some kind. It can also form a pathway from an unsuccessful community placement to a successful placement.
- 2 The starting point of an admission is an assessment of the individual's needs, including their views and wishes, and then the development of a strategy to meet those needs as far as possible, and in partnership with the individual, as far as possible.
- 3 The programme will usually involve the development of needed and wished-for skills, for example traditional cooking or budgeting, using a self-management tool (such as the Wellness Recovery Action Plan (Copeland, 2002)). Psychosocial interventions and psychological therapies should form an integral part of the care package. For some, a key issue will be developing a capacity to live without serious substance misuse.
- 4 Areas where the individual will need support are identified and agreed. Engagement with community services, the social network support of a drop-in centre or an introduction to a bridge builder become a priority as discharge approaches.
- 5 A rehabilitation unit will foster self-esteem, confidence, emotional literacy, optimism for the future and all the other factors which enhance people's self-image and equip them with the courage to challenge themselves. It follows that in-patient units must not be dominated by risk management by professionals; in good units individuals share and eventually own risks. Nor should staff feel it is their role to make the 'right' choices and then inform people of the decisions which have been made on their behalf. This does not mean that rehabilitation units are places where anything goes. A unit culture which promotes respect for others, courtesy and other reasonable expectations on communal living is supportive. The law does not stop being applicable at the door of the unit.
- 6 Rehabilitation plans should be goal-directed and one goal should always be to identify when discharge is suitable and the package of care which is necessary to achieve that discharge. Most people will leave hospital and wish to continue to make further progress towards their other individually preferred life goals. They will need to engage with suitable or preferred community resources before discharge. This can be more difficult to

achieve when a rehabilitation unit is distant from the intended discharge location.

The core principles encompassed within 'recovery' and 'social inclusion' should be apparent in any rehabilitation unit and the operational policy and daily working of the unit should reflect this.

COMPREHENSIVE IN-PATIENT REHABILITATION SERVICES

In-patient rehabilitation services require a range of different facilities that work as part of an interdependent system, a managed functional network rather than stand-alone units.

Only the largest NHS trusts will provide a full spectrum of services. Most will work with other providers in the independent sector or NHS to provide a full service. Very specialist services, for example for people with comorbid conditions such as mental illness and brain injury, can only be provided to large populations. At the other end of the scale, short-term (up to 1 year) rehabilitation units, which may be hospital- or community-based and focused on enabling users to return to independent living, should be available in all but the smallest services.

An in-patient service is a unit with 'hospital beds' that provides 24-hour nursing care. It is able to care for patients detained under the Mental Health Act, with a consultant psychiatrist or other professional acting as responsible clinician. This does not mean that all or even a majority of patients will be detained. All units should have access to the full range of skills of the multiprofessional team (described in Chapter 7, pp. 18–20).

A full range of in-patient services (defined as hospital beds able to care for detained patients) should be provided across the dimensions below. Inevitably, not all dimensions will be provided by local NHS services; units provide over a range of dimensions and independent providers and regional and national services will provide part of the functional network.

- Length of admission: from shorter-term assessment and treatment of 6–12 months, through more prolonged rehabilitation of 1–2 years, to longer-term care over many years.
- Functional ability of residents: from domestic environments concentrating on acquiring and utilising on a daily basis activities of daily living skills for community living through to high-dependency settings with domestic services provided by the unit rather than its residents.
- Risk management, including risks to self, others, health and vulnerability: from open, low-staffed community units, through local higher-staffed (often locked/lockable) units able to manage behavioural disturbance, to secure rehabilitation.
- Degree of specialisation: from local generic rehabilitation units predominantly for patients with treatment-resistant psychosis available in all trusts serving a population of around 300 000, through to highly specialist facilities for people with specific conditions and complex comorbidities, requiring specialist treatment programmes for populations of several million.

TYPOLOGY OF IN-PATIENT REHABILITATION UNITS

COMMUNITY REHABILITATION UNIT

- Client group and focus: many people, although not needing an acute admission ward or intensively staffed services, need time to recover from a psychotic episode, to optimise medication and reduce side-effects to a minimum. There is a focus on engagement with services, psychological interventions and activities of daily living skills.
- Recovery goal: to develop skills and support packages that include families and carers, for a successful return to community living with variable degrees of support.
- Site: ideally, this is community-based, with a focus on developing practical activities of daily living skills in a domestic environment close to a person's home community.
- Length of admission: usually up to 1 year.
- Functional ability: domestic environments concentrating on acquiring and utilising on a daily basis activities of daily living skills for community living.
- Risk management: generally low-staffed open units which may have some specialist risk assessment skills.
- Degree of specialisation: local generic rehabilitation units predominantly for patients with treatment-resistant psychosis should be available in all trusts serving a population of around 300 000.

HIGH-DEPENDENCY REHABILITATION

- Client group and focus: people who need this kind of facility will be highly symptomatic, have several or severe comorbid conditions, significant risk histories, and a high proportion will be detained and have 'challenging behaviours'. Often they will have had forensic admissions or spent periods of time in psychiatric intensive care units. The focus is on thorough ongoing assessment, medication, engagement, supporting clients in managing their behaviour and re-engaging with families and communities.
- Recovery goal: usually involves a move on to other facilities in the rehabilitation service before community living or residential care.
- Site: usually hospital-based to benefit from support from other units and out-of-hours cover.
- Length of admission: 1 to 3 years.
- Functional ability: domestic services provided by the unit rather than its residents, although participation in domestic activities with support encouraged as part of therapeutic programme.
- Risk management: higher-staffed (often locked/lockable) units able to manage behavioural disturbance.
- Degree of specialisation: should be available in all trusts serving a population of around 600 000 to 1 million; has a major role in returning patients from secure services and out-of-area placements.

LONGER-TERM COMPLEX CARE

- Client group and focus: patients will usually have high levels of disability from complex comorbid conditions, with limited potential for future change and

associated with significant risk to their own health and safety or to others. In addition to mental health problems, comorbidity with serious physical health problems will be common and will require ongoing monitoring and treatment.

- Recovery goal: other rehabilitation options will usually have been explored; disability and risk issues remain but a more domestic setting that offers a high level of support is practical. The emphasis is on promoting personal recovery and improving social and interpersonal functioning.
- Site: usually community-based, sometimes on a hospital campus.
- Length of admission: several years.
- Functional ability: domestic services provided by the unit rather than its residents, although participation in domestic activities with support encouraged as part of therapeutic programme.
- Risk management: higher staffed units but with emphasis on unqualified support staff; risk management based on relational skills and environmental management, for example low expressed emotion.
- Degree of specialisation: should be available in all trusts serving a population of around 600 000 to 1 million.

SECURE REHABILITATION

- Client group and focus: this group has diverse needs but have all have been involved in offending behaviour. They will all be detained under the Mental Health Act 1983 and the majority under Part 3 of the Act. Levels of security will be determined by Ministry of Justice requirements and a key task will be the accurate assessment and management of risk. Residents will have varying levels of functional skills and are likely to require therapeutic programmes tailored to their offending behaviour in addition to their mental disorders.
- Recovery goal: to leave hospital with the probability of close supervision by a local community forensic team or assertive outreach team.
- Site: usually a hospital campus.
- Length of admission: 2 years plus; variable, depending on the nature of the offending behaviour and psychopathology.
- Functional ability: domestic services provided by the unit rather than its residents, although participation in domestic activities with support encouraged as part of therapeutic programme.
- Risk management: higher-staffed units able to manage behavioural disturbance with full range of physical, procedural and relational security and specialist risk assessment and management skills.
- Degree of specialisation: low secure for populations of 1 million plus to high secure for populations of around 15 million.

HIGHLY SPECIALIST SERVICES

- Client group and focus: these units cater for people with very particular needs, for example acquired brain damage, severe personality disorder, comorbid autism-spectrum disorder. Psychological approaches to treatment and management predominate. Often, nearby step-down units will be required that allow people to move on but maintain contact with the specialist expertise they require. Very active liaison with referrers is an essential aspect of the working of these services.

- Recovery goal: for patients to move on to more independent settings often with complex care packages developed with the advice of the specialist service.
- Site: within hospital complexes or in stand-alone units.
- Length of admission: 1 to 3 years, but highly variable depending on the nature of the conditions and specialist treatment programmes.
- Functional ability: variable, but hopefully covering a range from full domestic services to high levels of patient participation in activities of daily living.
- Risk management: varies with risk profile and treatment needs.
- Degree of specialisation: highly specialist facilities for people with specific conditions and complex comorbidities, requiring specialist treatment programmes for populations of several million.

A recent survey of Rehabilitation and Social Psychiatry Faculty executive members and regional representatives received returns from services covering a total population of 7.5 million in the UK and the Republic of Ireland (6 million from England). Levels of rehabilitation in-patient services were highly variable, but universally felt to be inadequate. Many units were trying to span a variety of functions described above, limiting their effectiveness for certain groups. Major service gaps were in high-dependency and low secure rehabilitation and supported accommodation for patients to move on to.

STAKEHOLDER VIEWS

In-patient rehabilitation units

Staff:

- separate gender space, own bedroom and bathroom
- forensic rehabilitation units must have single-sex accommodation
- a large outdoor space, plenty of space, smoking space
- a gym, an occupation therapy kitchen
- homely features, flexible health and safety rules
- fresh food, cooked on the premises
- a good location, close to local amenities.

Service users

Much of the above plus:

- vegetarian meals and cooking facilities
- TV, internet access
- activities on site and in the community
- should be nice and clean
- consider contact with animals/pets.

Carers:

- a room for relatives to meet with residents that is neither their bedroom nor a communal area.
-

12 Community rehabilitation teams

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, nor so difficult to engage or so high-risk as to require assertive outreach, but they remain at risk of social isolation, self-neglect, relapse into acute illness, inability to cope and exploitation in community settings.

Community rehabilitation teams can provide a consistency of input and focus on rehabilitation and recovery which is not always possible for generic community mental health teams. This client group will have been referred from a variety of sources:

- early intervention team clients who have ongoing disability
- assertive outreach team clients who are well-engaged but with rehabilitative needs
- community mental health teams clients who need a more structured and intensive approach to rehabilitation
- people leaving in-patient rehabilitation units, low secure services or highly supported placements, both local and out of area, who are moving to a less supported setting. This group of clients often require specialist and intensive community follow-up which is no longer available in many services. Without the support of a community rehabilitation team, the gap in provision between an in-patient unit and a supported housing scheme can be very difficult to manage.

The multidisciplinary team (which must have the expertise in treatment and other interventions described in Chapter 7, pp. 18–20) will make a holistic assessment and work with the client to formulate a care plan. This will be aimed at slow reintroduction to social environments, learning environments, family and friends and community support agencies, as well as promoting the client's coping skills and recovery. It may also involve befriending services, mental health day centres, community centres, other public facilities and training/employment agencies. The aim is to widen the individual's own social networks and gradually reduce dependence on the team.

In many areas community rehabilitation teams focus specifically on supporting people who have been placed in residential or nursing home care, working with the care home providers to ensure that people's care plans allow for further rehabilitation and recovery with the eventual aim of moving towards

living independently or in lower support settings. Increasingly, the community rehabilitation team will need to become engaged with the personalisation agenda that will see people with continuing disabilities resulting from their long-term condition provided with an individualised package of support that maximises independence.

13 Family of psychosis services

Assertive outreach teams and early intervention services complete the spectrum of services dedicated to the rehabilitation of people with psychosis. Like rehabilitation teams, they take a biopsychosocial approach, provide dedicated input to a specific population, and promote recovery and social inclusion. In England, the *Mental Health Policy Implementation Guide* (Department of Health, 2001) set out in detail how local health services should implement both assertive outreach teams and early intervention services, and over subsequent years their development has been strongly performance-managed.

EARLY INTERVENTION IN PSYCHOSIS

Since the 1990s, enthusiasm for earlier and phase-specific interventions for people with schizophrenia has grown (Edwards & McGorry, 2002). Long delays in accessing treatment, leading to social and psychological disadvantage and disability, and the apparent association between duration of untreated psychosis and poor outcome (Norman & Malla, 2001) suggest that investment in earlier effective treatment should reduce longer-term disabilities and possibly the cost of services.

Early detection involves the identification and treatment of people who may be considered to be in the prodromal stage of psychosis, as well as those with an early psychotic episode who have not received adequate treatment. Phase-specific treatment is directed at reducing the progression to psychosis in people with prodromal syndromes, as well as promoting recovery in those who have recently experienced a first episode of psychosis.

Teams aim to provide a targeted and specialised service to younger people (aged 14–35 years) for a specified length of time, currently up to 3 years. With an emphasis on recovery and social inclusion, family interventions and efforts to engage young people with services, they have much in common with rehabilitation services. In practice, the service may sit within community mental health teams, rehabilitation teams or stand alone, the last being the preferred model in the UK.

ASSERTIVE OUTREACH AND THE ASSERTIVE OUTREACH TEAM

Stein & Test (1980) observed that following the closure of mental hospitals people with severe mental health problems were finding the complex network of community care harder to access than the old institutions. The aim of assertive outreach was to bring together all the services people required into one team, with an emphasis on practical support. In the UK, the assertive outreach team has evolved into a model for supporting people who find it hard to engage with standard care. The client group is typically people with severe mental illness and complex needs who are high users of services. These individuals have a range of psychosocial difficulties, including significant drug and alcohol misuse, comorbid personality disorder, homelessness, joblessness, forensic histories, and are characteristically treatment avoiders.

It should be noted that assertive outreach is a platform from which to provide a range of treatments, rather than a treatment in itself. The model is intended to promote engagement in order to provide treatment that would not otherwise be possible. It aims to provide the range of acute and rehabilitative services from within the team as opposed to brokering services from other agencies. Care is provided explicitly in the community, although hospital admission is a relatively common event.

Case-loads are capped (typically to 10–15 per care coordinator) to allow more intensive working and frequent contact. A core element is that a team approach is adopted; that is to say that a range of, if not all, team members will be involved in a person's care with shared responsibility within the team. Assertive outreach teams typically stand alone and interface predominantly with in-patient, rehabilitation and forensic services, although the majority of referrals will come from acute, community mental health and rehabilitation teams. Service users are likely to remain with the team for the medium to long term, with a target discharge rate of 10% of the case-load in any one year (Burns & Firn, 2002).

14 Accommodation

A comfortable, safe place to call home is a primary human need and it is important for mental well-being (Dunn, 2008). We choose where we live to be close to the people and places which matter to us. We furnish our home with objects that have meaning for us. The same principles should inform the provision of accommodation for people with severe mental health needs.

PRINCIPLES

- 1 Accommodation should be as close as possible to where people want to live.
- 2 There should be a wide range of accommodation to meet different individual needs and facilitate choice.
- 3 Accommodation should be of high quality and well-maintained.
- 4 It should be safe and secure, and should feel like home.
- 5 There should be sufficient flexibility to allow people to move on to higher or lower support at a time when they are ready.
- 6 Developments in accommodation should take into account the experience of local service users and their families.
- 7 Rehabilitation services need to work with accommodation providers to facilitate the recovery of service users. This includes formalised joint working arrangements (Department of Health, 2004b) as well as supporting individuals. Experience shows that that third-sector/non-statutory providers can better support people with the most complex needs when working closely with rehabilitation services.

RANGE OF ACCOMMODATION

The exact number of places and how they are provided will vary depending on local need and arrangements, but all areas should have access to a full range of provision (Macpherson *et al*, 2004; Wolfson, 2006). During earlier hospital closure programmes, the principle was to provide a home for life for every resident. With time, this has evolved into what is often a gradual move through various types of accommodation with different levels of support to match the changes in the skills, confidence and autonomy of the service user. Alongside this provision a range of services are available to support the recovery process.

- Depending on the need, the degree of support can vary from 24-hour staffing to daytime staffing with out-of-hours telephone cover, to out-of-hours cover provided by the generic on-call service for emergencies only.

- The staffing can range from a full NHS multidisciplinary team to third-sector or private providers.
- Supported housing with support from an outreach team (sometimes called floating support) or a specialist housing scheme with a warden. A Cochrane review concluded that research evidence for the superiority of either arrangement is weak (Chilvers *et al*, 2006).
- Core and cluster housing: staff are based in the core setting that houses residents with the greatest support needs. Satellite (cluster) housing accommodates other residents grouped by needs for support.
- Family placement: the service user becomes part of the family. This may particularly suit people with educational under-achievement or cognitive impairment.
- Adult placement (also known as supported lodgings): a private landlord provides support to tenants renting rooms in a house; inexpensive, but often the tenants have few rights when things go wrong.
- Group home: generally for older people providing mutual support for those who value it.
- Dispersed intensive supported housing (Howat *et al*, 1988): a specialist form of supported housing with support provided over extended hours as an alternative to residential care.
- Access to mainstream accommodation, facilitated by close collaboration with local housing providers. Urgent applications can be delayed or turned down on the basis either that the service user lacks the capacity to manage a tenancy or that they are too able to merit special priority for housing. The margin between these two extremes can seem uncomfortably small. It is important to stress in the application that services will provide adequate support to the applicant.

PLACEMENT PANEL

The placement panel:

- approves and monitors out-of-area and specialist placements
- ensures that every placement provides enough support to be safe for the service user, but is not an overprovision
- ensures that the client's views and those of their relatives have been sought
- avoids unnecessary delay by having the authority to make clinical and financial decisions on the spot when supported by evidence of need.

MAKING AN APPLICATION TO A PANEL

- 1 Following discussion with the client, family and multidisciplinary team at a review, the care coordinator formulates a housing care plan.
- 2 The care coordinator submits a report to the panel, including a brief history, risk assessment, the agreed housing recommendation and the degree of urgency.
- 3 The report also provides the multidisciplinary team's view of the likely consequences of the recommendation not being available or not being accepted by the panel.
- 4 The care coordinator should present the report in person to the panel to allow detailed questioning of the suitability of the placement. A decision is then made by the panel.

15 Peer support, service users as staff members and user-led provision

One key principle of contemporary practice in rehabilitation and recovery is that of empowering the service user – moving away from the paradigm of services doing things to people towards the service acting in a facilitative role. An important practical way of doing this is to encourage peer support, the employment of service users within mainstream mental health services and the development of service-user led provision (Repper & Perkins, 2003).

These approaches are much better developed in the USA than in the UK (Corrigan *et al*, 2008). Approaches include user-run mutual self-help groups (some of which reject the paradigms employed by mainstream mental health services, others working cooperatively with services), the employment of current or former service users as case managers or befrienders and larger-scale user-run programmes offering housing, vocational rehabilitation or day care.

The significance of the day-to-day support that service users provide to one another is often overlooked (as noted in the service user's account below).

From a service user

The following is based on my own experience of relationships with other service users while receiving in-patient treatment. This is very different from the friendships service users may form in the community, when they have reached a certain stage of recovery, have left the ward and have the choice of who they associate with. It can be very rewarding when service users give each other support and encouragement through shared experience, but the in-patient experience can also be very negative.

PEER SUPPORT – THE NEGATIVE SIDE

Psychosis is a very frightening experience and the fear is generally exacerbated by admission to the psychiatric ward – especially if the patient is detained under a section of the Mental Health Act. An in-patient's fear and psychosis can be further exacerbated by the behaviour of other patients whose symptoms are disturbing, especially as everyone is thrown in together in spite of being at different stages of mental illness or mental health. This is true of the formal group activities organised by therapists – such activities can be very intimidating, disturbing and frightening because of the psychotic behaviour of some patients. It is no wonder that other patients shun being involved in such activities and would rather remain by themselves – medical professionals may then blame

those who do not wish to participate for their own peace of mind as being 'stand-offish' or 'loners' – as if the patient was at fault.

In spite of the formal efforts of mental health professionals to make the in-patient feel that they are in a safe and comfortable place, the way in which patients relate to one another informally can make the ward a terrifying nightmare jungle where patients can be the victims of others' hostility, bullying and harassment – not to mention being witness to the disturbed psychotic thoughts of others. In the worst cases, crimes of assault, theft and criminal damage to personal property are an everyday experience.

Sadly, the victims of these crimes may receive very little sympathy or support from medical professionals who can actually make the victim feel that they have brought crime upon themselves. Where a male patient is assaulted by a female patient, medical professionals can make the male victim an object of mirth and ridicule. Very often crime goes without redress and police proceedings are very rare – in fact non-existent. Crime is an accepted part of psychiatric ward culture. I have to leave aside the common experience of witnessing the use of illegal substances altogether as this is not in my article's scope.

In short, the way in-patients relate to one another can be a hindrance to recovery rather than an advantage as they can relate in a savage and brutal way that would be unacceptable in any other sort of social situation. Doctors and nurses can turn a blind eye to this.

PEER SUPPORT – THE POSITIVE SIDE

Perhaps in-patients have more support to offer each other during the transition period when symptoms of psychosis are reduced or better managed and discharge is in sight. It is then that they can help each other by relating more like they would in the community. These relationships are very helpful for recovery and medical professionals should encourage them, whether in an informal setting – say at meal times – or in more formal activity and talking therapy groups. During this stage some in-patients develop long-lasting friendships which they can carry beyond discharge and into the community – another important factor in being eased into discharge which can sometimes be just as traumatic as admission.

This may be the place to mention the value of sexual relationships in the in-patient setting, although this is a highly controversial area among medical professionals that provokes strong views. However, I feel that open sexual relationships between consenting adult in-patients can have many benefits in assisting recovery.

To conclude, it is unrealistic to expect that because in-patients find themselves in similar circumstances, they are automatically going to give each other positive support. As with any social situation, there is both a positive and negative side to the way people relate to one another.

Appendix

Table 1 Reported adult mental health expenditure in England 2007–8 (health and social care)

Direct costs	Expenditure	
	£, 000	Proportion of total costs, %
Secure and high-dependency provision ^a	859 460.29	16.0
Community mental health teams	666 983.54	12.1
Acute in-patient services	611 189.53	11.1
Continuing care ^a	497 800.31	9.0
Housing and residential care ^a	429 364.52	8.0
Crisis resolution/home treatment teams	213 734.78	3.9
Day services (including NHS) ^a	202 085.51	3.7
Psychological therapy services	161 378.39	3.0
Assertive outreach teams ^a	124 946.73	2.3
Psychiatric out-patient clinics	103 780.19	1.9
Home support services	108 587.11	2.0
Specialist mental health services	77 160.47	1.4
Early intervention in psychosis services ^a	69 178.99	1.3
Community services for mentally disordered offenders ^a	50 368.94	1.0
Carers' services	23 114.76	0.4
Accident and emergency mental health liaison service	20 065.11	0.4
Personality disorder services	15 642.20	0.3
Mental health promotion	4 215.71	0.1
Direct payments	8 715.69	0.2
Other direct costs	226 002.76	4.1
Indirect costs	418 190.68	8.0
Capital charges	165 859.68	3.0
Overheads	440 068.73	8.0
Total	5 512 262.49	100

a. Services that broadly fall into the category of rehabilitation services.

Source: Mental Health Strategies (2008)

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