

Rehabilitation and recovery now

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Members of the Working Party

Dr Susan Cope	Ladywell Unit, University Hospital, Lewisham High Street, Lewisham, London SE13 6LH
Dr Sarah Davenport	Lancashire Care Trust, Guild Lodge, Guild Park, Whittingham, Preston PR3 2AZ
Dr Laurence Measey	(formerly) The Caludon Centre, Clifford Bridge Road, Coventry CV2 2TE

Executive summary

1. Rehabilitation and recovery services are a rewarding area of psychiatric practice; these services are in a continuing process of development, in response to the changing needs of the target population and to the changing political climate of mental health care delivery.
2. The developmental journey for rehabilitation and recovery services is at a particularly interesting stage and offers many opportunities for psychiatrists to develop new skills over the course of their careers.
3. There are new developments in the way in which services are provided in partnership with service users, their families and other agencies.
4. Rehabilitation and recovery services now provide unique opportunities for the development of longer-term therapeutic relationships with patients and their partners in care, and also offer the rewarding challenge of practical service development.

Most rehabilitation services have a developmental history that bridges de-institutionalisation, re-provision in its many forms, community care and now social inclusion, working to reduce the impact of stigma and to promote recovery. Embracing the concept of recovery, and promoting the recovery ethos throughout rehabilitation service provision, probably represents a clear new direction.

This report describes the philosophy underpinning a modern approach to rehabilitation and recovery. It defines the service user population and gives a description of the range of service provision, together with the guiding principles that inform service development. These principles are based upon:

- enhancing the strengths and resilience of long-term service users and their families
- maintaining optimism for individual growth and recovery
- treating disability with respect and acceptance
- improving the holistic quality of life for those with the most severe disabilities
- reducing stigma and promoting social inclusion
- therapeutic risk-taking to promote personal responsibility.

New ways of working with service users and their carers lie at the heart of the specialty. The journey towards individual recovery while respecting individual disabilities must inform rehabilitation service development. The perspective of service users and their families, together with their many partners in care, can provide a powerful force for development and should be the starting-point for new work.

This report describes how services can be developed, monitored and evaluated, and gaps in services identified through collaborative partnership working.

Assessment, treatments and interventions are described and the need to improve the evidence base for rehabilitation is outlined. Suggestions for an audit focus in local rehabilitation services are made, together with the latest recommendations for workforce planning.

Collaborative work with service users, peer group and inter-agency networking, research, service development and evaluation, and the training of other staff, all offer significant rewards to psychiatrists keen to respond to the challenge of providing a modern rehabilitation and recovery service. These services should lie at the heart of comprehensive community care, responding to the needs of those most at risk of living with severe disability, and aiming to promote their recovery.

Evolution of services

Psychiatric rehabilitation as a subspecialty of general psychiatry is evolving fast. The opportunities for specialist rehabilitation services, and for using evidence-based specific interventions, have continued to expand. It is one of the most attractive career options in psychiatry today.

The early emphasis on social and milieu therapies focused on overcoming the disability associated with institutional care and the sequelae of social breakdown. The first reprovision of institutional care for those with severe and enduring mental health problems shifted the location of care into the community. Alternative models of residential care were adopted, and supported with assertive community treatment. Rehabilitation is now part of community psychiatry. The emphasis is on maintaining service users in the least restrictive environment and ensuring that they have the opportunity to live in a homely setting, with a good quality of life. Rehabilitation involves working within individuals' social networks, working with their families and enabling their access to local 'normal' opportunities such as education, occupation and leisure. It opens up exciting opportunities to forge new partnerships with other organisations, and to create new ways of working with service users.

Rehabilitation continues to focus on a sustained and respectful relationship with individual service users, and on a longer-term response to their needs. It aims for collaboration to enhance the strengths of its service users and to minimise disability. This requires a difference of emphasis and is not based exclusively on working with illness impairments.

Although the older definitions of rehabilitation remain meaningful, the modern focus is on adaptation to and prevention of disability, including early and active rehabilitation and comprehensive treatment programmes for first-episode disorders, and the early detection of psychosis.

A new challenge is on its way, in the form of a second wave of reprovision, as the numbers of long-stay residents in special hospitals are substantially reduced (by 400–600) over the next few years. This will have a significant impact on local services. This second reprovision will need to be informed not only by lessons learned from the first, but also by an awareness of the need to develop a comprehensive range of services for individuals whose level of risk may preclude or compromise their access to mainstream services. This is likely to result in a need for more long-term beds in local service facilities, and an increasing need for redefinition of the relationship between rehabilitation and forensic specialist services.

Specialist services for people who require long-term nursing care or high levels of social care represent a heavy financial burden on mental health trusts. Effective management of the high-support services that have arisen as part of the

network of community services has given a new impetus to the development of specialist rehabilitation psychiatric services.

The new challenge is to set standards for best practice in the care of individuals with long-term disability associated with severe mental health problems. Specialist rehabilitation clinicians have taken on lead roles in service development and planning. They have particular skills in identifying unmet local need for high-support services and identifying gaps in services (e.g. for people with brain damage or autism spectrum disorders). The combination of experience of working with multiple agencies, and the creative mix of interventions and work arising from collaboration with other specialist areas of mental health provision, makes the rehabilitation specialist the key professional in the development of services for those with the most severe disabilities. These services can be extremely costly, so a rehabilitation psychiatrist often has a pivotal role in ensuring the effective and efficient function of services.

Rehabilitation or recovery?

The evolution of the concept of rehabilitation can be traced through the way it has been defined by those writing on this topic over the past decades.

‘The process whereby a disabled person is enabled to use their residual abilities to function effectively in as normal a social situation as possible’ (Bennett, 1978).

‘Psychiatric rehabilitation addresses this dynamic adaptation and attempts to maximise functioning, while at the same time acknowledging the possibility of relatively fixed disabilities and the necessity of providing supportive environments’ (Shepherd, 1995).

‘To enhance personal autonomy and enable the individual to adopt an appropriate social role and lead as fulfilling a life as possible’ (Babiker, 1987).

‘Maximising quality of life’ (Sullivan *et al*, 1992).

The concept of rehabilitation in psychiatric services recognises the importance of quality of life, and the enabling of an individual’s capacity. There is an emphasis on adaptation to live as normal a life as possible, regardless of disability, while at the same time recognising that the long-term disabilities associated with mental health problems fluctuate. There is a recognition that rehabilitation is about long-term – indeed a life-long – commitment to working with individuals. It is not about transient service delivery. Although the new generation of antipsychotic drugs and the reawakened interest in psychological approaches adds a comprehensiveness to service delivery, this must go hand in hand with the acknowledgement that it is not possible to ameliorate all disability. Respectful acceptance is part of the task, without loss of optimism for individual growth and the potential for recovery.

Recovery is an active process through which the service user travels to adapt to living with disability. The professional works with service users to share an understanding of their life story (and often their family story) and helps them to draw upon the resources and skills available in rehabilitation services. Fundamental to this process is work with individuals and their families and carers, to instil and maintain hope.

‘Recovery is an internal, ongoing process requiring adaptation and coping skills, promoted by social supports, empowerment and some form of spirituality or philosophy’ (Campbell, 1997).

‘Recovery is a first-person concept, “I have a problem, but with help I can grow beyond it”’ (Cliff Prior, speech on 1 June 1999).

There is now an emphasis on the shared partnership between service users and service providers, the same philosophy that underpins the National Service Framework for Mental Health for Adults of Working Age. The relevant National Service Framework principles are:

- social inclusion
- user involvement
- carer involvement
- partnership between stakeholders
- evidence-based practice
- meeting agreed standards.

Service user population

Users of rehabilitation services in the past were likely to have spent prolonged periods in institutional care; often they were selected for their suitability for rehabilitation. Today, users of specialist rehabilitation services form a heterogeneous population, varying from district to district depending on the profile of the district served and the nature of the service network. Regardless of these disparities, service users are all likely to have the same aspirations as their fellow citizens for independent living, recreation, employment, social and sexual relationships, and material goods and income.

Users of recovery and rehabilitation services are likely to have some of the following characteristics:

- new long-stay service users (that is, individuals as defined by Lelliot *et al* (1994) who remain as in-patients for prolonged periods)
- their illness is likely to have a relapsing course
- they are reluctant to engage with services
- they have a history of persistent non-adherence with after-care
- significant social disability is present regardless of diagnosis
- their condition is likely to be resistant to treatment
- they may have borderline learning disabilities
- they may have emotional developmental difficulties, with disturbed early life experiences
- comorbid drug and alcohol misuse are often present
- offending behaviour may occur
- the person may present a serious risk to self or others, leading to exclusion from mainstream services.

Modern rehabilitation services have evolved to serve the needs of individuals with complex long-term needs. Such services do not select: instead they aim to include rather than exclude those whose needs are not met by standard community care. However, the assessment of risk for each individual entering a service may lead to the conclusion that the individual cannot be safely managed in that service at that time.

Service provision

Across the whole range of rehabilitation services the following guiding principles pertain:

- Services provide effective treatment and care
- Care planning is based on individual need
- Services promote social inclusion
- Services respect cultural diversity
- Services are committed to working with families and carers
- Services are multi-disciplinary and multi-skilled
- Cross-agency partnership working is common
- Services promote access and participation of service users in mainstream community resources, such as educational services, work opportunities, libraries and leisure facilities
- Services promote choice and competence of service users
- Service users are in receipt of enhanced care programme approach (CPA) with particular recognition of the potential need for long-term commitment to high levels of service input
- Access is provided to regular reassessment of potentially changing needs.

Service range

Network of services

All trusts are required to provide a network of services to meet the needs of the local population. Although it is recommended that specialist rehabilitation services are part of each network, there is likely to remain a diversity of specialist models. In some districts, the functions of a specialist rehabilitation service will be integrated into general community psychiatric services. Most districts will choose to develop high-intensity specialist rehabilitation services for particular target populations.

Residential services

The nature of residential services has evolved. Shared living arrangements are not acceptable to the majority of service users, and supported independent living schemes have replaced hostels. There is also the need for 24-hour nursing care of varying levels of security. Although there remains a need for a range of types of supported accommodation, these two models of provision have become the mainstays of such facilities.

Agreed boundaries

The specialist rehabilitation services need to address the interfaces with other services, notably:

- primary care services
- general adult community services
- psychiatric services for the elderly
- forensic psychiatric services
- psychiatric services for people with learning disabilities
- child and adolescent psychiatry
- substance misuse services.

Boundaries between services need to be negotiated and agreed locally.

The following service range has developed as specialist rehabilitation provision over recent years. Most local specialist rehabilitation services will provide some of these services, but few provide them all:

- assertive outreach community teams, focusing on engagement
- intensive community treatment teams, with low case-loads
- respite and readmission beds

- medium-term assessment and treatment services, either in-patient or community-based
- residential community support services with particular emphasis on flexible support for people in their own homes
- 24-hour nursed care services
- challenging behaviour services
- low secure and medium secure long-term nursed care services, often overlapping with forensic psychiatric services.

In addition, in some areas rehabilitation services may take on a wider continuing care remit.

Development of early intervention programmes for first-episode psychosis may be provided by specialist rehabilitation services. This is likely to be an increasingly important area, as it applies the principles of rehabilitation to the early stages of treatment of major mental illness.

Assessment, treatment and interventions

Assessment

Assessments are primarily based on information gathered from as many sources as are relevant. A detailed life history of the individual is paramount. Assessment tools such as standardised rating scales are used by many services. For many individuals who are identified as having illness resistant to conventional treatment, the psychiatric assessment will need to reconsider the working diagnosis. Assessments undertaken in specialist rehabilitation services cover the following areas:

- functional abilities, including living skills, educational and employment achievements
- social functioning
- psychiatric symptoms, cognitive deficits, neurological impairments, and relapse indicators
- user and carer aspirations and opinions
- history of treatment adherence or resistance and disengagement from services
- risk assessment and management.

The identification and analysis of risk is a fundamental part of the assessment of any person with a mental health problem. Many service users referred to specialist rehabilitation services will have been previously managed in conditions of security. Rehabilitation specialists historically have had an important role in the care of service users with histories of high-risk behaviour. As with assessment of functional ability, the past history of the individual is essential to risk analysis; standardised rating instruments to assist the process are in use by some services, and new measures are being developed.

Rehabilitation psychiatrists have an important role in making decisions about therapeutic risk-taking. In collaboration with forensic services, rehabilitation services aim to ensure that service users are cared for in the least restrictive way that is compatible with meeting their needs and addressing issues of public safety. The safety and vulnerability of the individual service user is also central to the implementation of any risk management plan.

Engagement

Assertive outreach services specifically target those with severe mental health problems who are reluctant to engage with services. Understanding the barriers

to engagement, and developing the skills to make partnerships work, form one of the essential functions of rehabilitation and recovery services.

Interventions

Although adaptation of the social environment remains a major component of rehabilitation and recovery services, the emphasis for treatment is now addressed across all three domains of the biopsychosocial spectrum. The development of atypical antipsychotic drugs, in particular clozapine as a specific treatment for treatment-resistant schizophrenia, has transformed rehabilitation as a specialty. It is now common for local rehabilitation services to develop special expertise in use of the atypical antipsychotics, especially clozapine. Access to the prescribing of these drugs is now an important part of treatment.

Service users want more talking therapies. There is now a considerable evidence base for the effectiveness of cognitive-based psychological treatments and for the effectiveness of family work. These treatments should be available in rehabilitation and recovery services. Therapies available are the cognitive therapies for persistent symptom control, depression, concordance (or adherence) therapy, and cognitive remediation.

Rehabilitation and recovery services provide family education, support and behavioural family interventions. There is also increasing interest in the development of packages of psychological treatments informed by psychodynamic and systemic models. It is likely that rehabilitation and recovery services will lead the way in developing the evidence base for these packages.

Both training and support in practical living skills, social skills and budgeting continue to be provided. However, if assessment suggests that an individual might not have the capacity to gain such skills, it is now accepted that offering support in helping the individual adapt to disability is a valid alternative.

Activity and work for users of services

Assessment of the vocational skills and leisure interests of service users is fundamental to rehabilitation and recovery services. Individuals are helped to join mainstream recreational, leisure and educational services as far as possible. Nevertheless, there remains a place for specialist day care. Specialist pre-vocational training is provided by some rehabilitation services. Supported work projects for individuals with severe mental health problems along with social firms have now become a preferred model of providing employment opportunities for service users, although sheltered work is still provided in some areas.

Residential services

Assessment for high-support residential placements remains a specialist function within rehabilitation. Specialist rehabilitation services are usually the gatekeepers

for access to the most highly supported 24-hour nursed care settings. Rehabilitation services often provide staff education, support and/or training in these settings. There is often a managerial function to ensure effective and efficient use of budgets for these expensive local services.

Rehabilitation services develop important local knowledge of alternative facilities provided by both statutory and independent sectors; they may act as a pivot for the development of partnership services.

The emphasis in modern residential care is now for service users to consider that they have a home for as long as they need it. All residents of supported living schemes or supported independent living schemes should have regular reviews to consider the appropriateness of the support provided. Residents should also be offered choices regarding the options for moving on if progress is made. For many individuals, however, the challenge is to support staff to accept the value of maintaining function within an appropriate environment, rather than aiming for a move to a setting of lower dependency.

Other interventions relating to normal expectations

Modern rehabilitation and recovery services address access to welfare rights and advocacy. Access to physical health care is another area that requires a proactive approach from rehabilitation services, as comorbid physical health problems have a high prevalence.

Training

Psychiatrists in training

The Royal College of Psychiatrists has published the MRCPsych syllabus, which contains a Section on Rehabilitation. The new Core Competencies for Consultant Psychiatrists provides guidelines for training. Senior house officer posts in rehabilitation are accepted as general psychiatry experience. Higher training in a specialist post with a recognised trainer for 1 year leads to an endorsement in rehabilitation; this is expected of those who will take up specialist posts in rehabilitation.

The speciality is particularly attractive to those who value getting to know their patients in depth, enjoy the challenge of complex problems and are stimulated by the creativity of service development. This is an expanding field, and higher trainees are encouraged to take up training opportunities in psychotherapies for psychosis.

Other disciplines

Although the disciplines of nursing, psychology, social work and occupational therapy continue to provide specialist professional training, it is also expected that multi-disciplinary training, in accordance with National Health Service Executive plans for review of workforce planning, is likely to develop rapidly in the rehabilitation field.

Initiatives involving service users in staff training have been developed in several centres. Rehabilitation services are increasingly aware that to empower service users effectively, staff too must feel valued and empowered. Access to training for staff at all levels is recognised as a core method of achieving this goal.

Evidence base

One of the major challenges for specialist rehabilitation is to strengthen the evidence base and to ensure that evolving practice is informed by evidence. Although there is a significant evidence base for some psychosocial interventions, there is weaker evidence for service models. This is likely to remain the case, as complex interventions do not lend themselves to robust research methodology.

Health service and biological research, as well as the development of user involvement in planning and executing research and audit, should become integral in directing future service developments in rehabilitation.

Setting standards for local specialist rehabilitation services

Local rehabilitation and recovery services will vary in different areas. Local services will need to consider standards for audit around three domains:

- I Service provision, including access to, and implementation of different treatments. Staff training, and the provision of residential and vocational services.
- II User and carer focus to services provided, including access to advocacy, user-centred care planning, and user involvement at all levels of service provision, planning and monitoring.
- III Integration with other services, including shared definitions and strategies across agencies, and policies about boundaries with other services.

Workforce planning

The current recommendation for specialist rehabilitation consultant psychiatrists is 0.4–0.8 whole-time equivalent per 100 000 age-adjusted population, depending on the scope of the responsibility of the post concerned. Where specialist rehabilitation services include assertive outreach or low secure units in addition to high-support residential services, the higher figure is appropriate.

The development of a modern rehabilitation service is both stimulating and challenging. Rehabilitation is a growth specialty with opportunities for rewarding collaborative work with service users, peer group networking, research, service evaluation and training.

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