

The Forgotten Need for Rehabilitation in Contemporary Mental Health Services

A position statement from the Executive Committee of the Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists

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Summary

1. Rehabilitation and Recovery represent both a set of service principles and a range of specific services. The principles focus on a holistic assessment of the needs of a person experiencing severe mental illness, awareness of the person's social, spiritual and cultural environment and a determination to work with the individual and their carers to achieve the best possible clinical and social outcomes for the individual, with desirable outcomes (as far as possible) set by the person experiencing the illness. These principles are generally accepted by policy makers, practitioners, service users and carers. Paradoxically, despite the contribution of rehabilitation practitioners to the development of best practice within mental health care, including an emphasis on social inclusion and the importance of psychosocial interventions, specialist Rehabilitation and Recovery services are under threat.
2. Rehabilitation is the forgotten need within contemporary mental health services. This is a result of many factors, not least the desire to ignore the uncomfortable fact that severe mental illnesses such as schizophrenia may still lead to considerable distress and disability for the sufferer, even where the new "functional" mental health teams are in operation and best practice interventions are utilised. Most of the large traditional mental hospitals in England have now closed. They have been replaced bed for bed by a "virtual mental hospital", a dispersed and poorly co-ordinated patchwork of hospital, residential and nursing home provision, much of which lies within the independent sector. People placed within the "virtual mental hospital" often receive scant attention from statutory mental health services – out of sight, out of mind. There is little incentive to encourage individuals to move into less restrictive settings. Packages of intensive community support are less commonly used by people with a mental illness than other client groups. As the traditional mental hospital has declined there has been an explosion in the provision of Forensic Mental Health Services, with a marked expansion in medium and low secure beds. Some people spend many months or years as inpatients on acute psychiatric units that are poorly equipped to encourage independence and to address deficits in social functioning.

Rehabilitation: the current situation

3. Although most areas possess some local rehabilitation inpatient beds and many have a Community Rehabilitation Team, these services are available to only a small proportion of people suffering from severe and enduring mental illness. There is a market in Out of Area Treatments (OATs) – placements in largely independent sector hospitals – resulting in people with the most severe disabilities as a result of their illnesses being cared for far from their locality, often at very high cost. The OATs market is expanding very rapidly indeed, with a reported cost to PCTs in 2004/5 of £222m. Failure to invest in local Rehabilitation and Recovery services not only denies individuals of valuable therapeutic interventions but also has significant consequences for local health economies in terms of increasing expenditures on OATs.

Specialist Local Rehabilitation and Recovery Services

4. All mental health services should be adopting rehabilitation principles within their work. However there is a strong rationale for additional local investment into Rehabilitation and Recovery services, as part of a family of specialist services for people suffering from severe mental illness, which includes Early Intervention in Psychosis services and Assertive Outreach Teams.
5. We believe that local specialist Rehabilitation and Recovery services should be available to undertake the following tasks:
 - Provide inpatient rehabilitation in short-term units, focusing on treatment-resistant patients and those with severe functional impairments as a consequence of psychotic illness.
 - Provide continuing, hospital-based, care.
 - Offer care co-ordination for patients being resettled from inpatient rehabilitation units into less dependent settings.
 - Offer expert consultation to acute adult mental health services in the management of treatment resistance.
 - Provide expert assessments for decisions about placements within OATs, residential and nursing home care made by local providers and service commissioners.
 - Provide expert advice on the development of complex packages of community care and support as an alternative to residential and nursing home care.
 - Provide a care co-ordination, monitoring and review function for individuals placed OATs, in residential and nursing home care and in receipt of complex packages of community care.

Providers of long-term inpatient care

6. All services providing long-term inpatient care, whether within the statutory or independent sector and whether designated as "Forensic" or "Non-Forensic", should ensure that staff have competencies in Rehabilitation and Recovery and cultural capability and comply with the provisions of the Race Relations (Amendment) Act 2000.

Broader implications

7. Taking the need for Rehabilitation and Recovery services seriously has implications for local service providers and commissioners, providers of long-term hospital care, the research community and training providers. Local commissioners and service providers should ensure that there is adequate management capacity devoted to rehabilitation services. This capacity should include expertise in epidemiology and needs assessment.

Introduction

The past twenty years has seen a transformation in adult mental health services in England and Wales. In an era of deinstitutionalisation the large mental hospitals have closed and psychiatric bed numbers have dramatically decreased (Holloway, 2004). Long-stay NHS hospital beds have been replaced by a range of accommodation options for people with a severe and enduring mental illness, which now constitute an unacknowledged “virtual mental hospital” (Holloway et al, 2002). We have seen the rise of the Community Mental Health Team, providing comprehensive psychiatric care to a defined catchment area and relating to a local psychiatric inpatient unit. More recently policy and advanced practice has recommended that the CMHT be replaced or supplemented by an array of so-called “functional” community teams. These teams provide Assessment and Brief Treatment, Case Management, Primary Care Liaison, Crisis Resolution/Home Treatment, Early Intervention in Psychosis (EIP) and Assertive Outreach (AOT) (the last four are mandated within the Policy Implementation Guide (PIG) (Department of Health, 2001a)). The Health/Social Care divide has, at last, been bridged by the introduction of integrated mental health services in which staff from the NHS and Social Services work under a joint management, sometimes with pooled budgets.

There have been significant advances in the treatment of mental disorder, notably the emergence of potentially effective psychological and psychosocial interventions, which have been summarised in a continuing series of guidelines produced by the National Institute for Clinical Excellence (NICE) (see www.nice.org.uk). Both the Department of Health and the National Institute for Mental Health in England (NIMHE) have vigorously endorsed the rhetoric, concept and practice of Recovery within mental health care (Department of Health, 2001b; NIMHE, 2004; NIMHE, 2005).

The principles of Recovery have been firmly embraced by the Faculty of Rehabilitation and Social Psychiatry (Roberts and Wolfson, 2004; Royal College of Psychiatrists, 2004). Tackling the social exclusion of people with a mental illness, long a goal of rehabilitation services, has become a cross-Government priority (Social Exclusion Unit, 2004). Rehabilitation practitioners from all disciplines have been at the forefront of the advances in mental health services over the past two decades. They have worked to close the mental hospitals, developed innovative community-based alternatives for the treatment and support of people with severe and enduring mental illness, sought to tackle the social exclusion of people with a mental illness (long before the term was coined) and pioneered psychosocial interventions.

The marginalisation of rehabilitation

Paradoxically, despite the evident success of specialist rehabilitation services over the past two decades, the significant contribution rehabilitation practitioners have made to innovations in treatments and services and the concordance between contemporary mental health policy and acknowledged best rehabilitation practice, many established local rehabilitation services report being marginalised and under threat.

The reasons for this marginalisation are manifold. Here six interlinked factors are discussed in some detail.

(1): Health economies have disinvested in specialist rehabilitation teams and units in order to implement the policy requirements outlined in the initial PIG document (Department of Health, 2001a) and elaborated within Local Delivery Plans (LDPs). These decisions relate to the intensive performance management of LDPs, which has underlined the existence of a range of “must-do’s” that have been implemented irrespective of their opportunity cost. There has been an explicit assumption that a PIG-compliant service would be an effective service, reliably resulting in reductions in inpatient bed days and improving social outcomes for service users. Some effective rehabilitation teams have been rebadged as AOTs, discharging their existing caseloads to the care of the local CMHT or merging two rather different client groups, one characterised primarily by difficulties of engagement and the other by severe social disability requiring intensive support to maintain independent living.

(2): The “virtual mental hospital” that has replaced the traditional asylum has grown in an unplanned fashion, lying at least until recently below the radar of policy-makers and local service commissioners. Both health and social care placements have tended to be spot-purchased from private sector providers, allowing local services to avoid the necessity to

make strategic decisions surrounding the treatment and support of those individuals who require the highest levels of care.

(3): Inpatient facilities offering rehabilitation, which will generally seek purposefully to have extended lengths of stay, fit badly with a managerial ethos focused on admission-avoidance, shortening length of stay in hospital and bed reductions. There will be major technical difficulties in defining appropriate care episodes for inpatient rehabilitation and Forensic spells, which will be required as the *Payment by Results* regime is extended to mental health services.

(4): More fundamentally, throughout the era of community care there has been a consistent tendency to ignore the disability and social exclusion of people with the most severe disorders. There has been a repeated assumption that advances in service provision and treatment technology have abolished poor social and clinical outcomes for people with psychotic illness. The NICE Schizophrenia Guideline (NICE, 2002) effectively stops when a rather simple menu of treatments and interventions, including clozapine and access to work rehabilitation, is exhausted. In fact the evidence suggests that some important outcomes, such as achieving employment, have got very much worse over the past 40 years (Royal College of Psychiatrists, 2002; Marwaha and Johnson, 2004). Failure to respond to treatment remains common amongst people with schizophrenia (see, for example, Robinson et al, 2004) and, even in the short term, a significant proportion of individuals presenting with psychosis fare very badly indeed (Craig et al, 2004).

(5): Psychiatric rehabilitation, as a discipline, emerged within the traditional mental hospital. Having served, through the hospital reprovision programmes of the 1980s and 1990s, as the mechanism for closing the mental hospitals rehabilitation came to be seen as a redundant concept, irrelevant in the era of deinstitutionalisation. Contemporary evidence suggests that throughout Europe, we are now entering an era of reinstitutionalisation (Priebe et al, 2005). In England the decline in hospital beds now appears to have halted after 50 years.

(6): Finally, and regrettably, the concept of psychiatric rehabilitation, which implies both long-term disability and long-term commitment from services to address this disability, is simply unfashionable. This is at odds with trends in general medical practice, where rehabilitative inputs are seen as increasingly important in reducing the burden of chronic disease.

Reinventing rehabilitation

In an attempt to address this marginalisation, and to reflect changing philosophies of care, local rehabilitation services are commonly rebranding themselves as rehabilitation and recovery services or teams. In part this reflects a genuine conceptual advance that acknowledges the crucial importance of “working with” service users and carers as opposed to “doing to” and the importance of promoting user and carer autonomy and choice. The term “specialist rehabilitation service” is used throughout this paper to include designated community and inpatient rehabilitation, recovery and continuing care teams.

One important consequence of the marginalisation of psychiatric rehabilitation has been a lack of research activity surrounding the topic in recent years. This has led to lacunae in the evidence-base for effective rehabilitation interventions, which in an era of evidence-based health and social care has resulted in a vicious cycle of under-investment. However there is a mass of evidence surrounding the assessment, treatment and community support of people with severe mental illness that is relevant to the design of effective services. The successes and the failures of the mental hospital closure programme provide a rich source of material for service redesign. There is also significant emerging evidence about problems that flow from the structure of contemporary mental health service and in particular the gap between the rhetoric and reality of the new “functional” mental health teams.

Putting rehabilitation services back on the map

Although a wide range of services has now been included within the remit of the PIG (see www.nimhe.org.uk for a compendium) there is no current prospect of a policy document addressing the requirements for a specialist local rehabilitation service. The Early Intervention in Psychosis (EIP) services and Assertive Outreach Teams (AOTs) mandated by the PIG should be adopting a philosophy of care that embraces best-practice rehabilitation principles. However EIP services and AOTs cannot provide a complete response to the challenge of severe mental illness. They should form but two elements of a

family of specialist services treating people with psychotic illnesses that complement the work of the generic CMHT/Primary Care Liaison Team.

This paper seeks to describe the relevance of specialist rehabilitation services to all local mental health economies and makes a preliminary attempt to identify the range of specialist provision that should be available locally. The arguments for specialist rehabilitation services can be simply put: (1) they can offer improved quality of care for individuals experiencing severe mental illness¹; and (2) they can provide cost-effective solutions for the support and treatment of those with the highest levels of disability and distress.

What are the needs?

Rehabilitation and Recovery Now (Royal College of Psychiatrists, 2004) described the heterogeneous nature of the people in contact with specialist local rehabilitation services. The document also emphasised that people receiving rehabilitation services are likely to share the same aspirations as all their fellow citizens for independent living, recreation, employment, social and sexual relationships, material goods, having their religious and cultural needs met and income. This is only partly true: there is, in fact, abundant evidence that these aspirations are eroded over time for people who live impoverished existences, whatever the cause of this impoverishment, in a process described over 40 years ago as institutionalisation. Severe mental illness can also of itself impair cognition, the desire to engage in voluntary purposive activity, which may in at its most extreme result in very marked self-neglect. In addition mental illness is associated with a high level of social stigma, which may be of particular significance to patients from some black and minority ethnic groups.

Traditionally the client group for psychiatric rehabilitation was defined by referral to and acceptance by a designated rehabilitation service, often operating in a residential setting. People would only receive specialist rehabilitation after a very lengthy psychiatric career, by which time a range of "secondary handicaps" would generally have accumulated (these are the emotional, cognitive, cognitive, social and functional effects of being a patient, particularly in a hospital setting). Relating a need for rehabilitation to contact with a particular local service is clearly not a needs-based approach.

Wykes and Holloway (2000) made an attempt to describe the potential client group for psychiatric rehabilitation thus:

"People defined as having mental health difficulties and fulfilling the following criteria:

- *they have active symptoms (e.g. hallucinations, delusions, high levels of anxiety or depression, negative symptoms of psychosis) and*
- *reductions in social functioning (e.g. breakdown of social relationships, reductions in the capacity for economic support) as a result of a persistent mental illness."*

This broad definition underlines the fact that a large proportion of individuals in contact with specialist mental health services require rehabilitative inputs. People with severe mental illnesses such as schizophrenia experience pre-morbid social difficulties and disadvantages, active symptoms of illness and impairments in cognition and cognition, social stigma and the secondary handicaps consequent on the illness experience. As a result of these problems the opportunities and outcomes for people with severe enduring mental illness in terms of employment, income and social and intimate relationships are very much worse than the general population.

In addition to symptoms and impairments in social functioning, severe mental illness is characterised by a relapsing and remitting course and a range of risk issues. These include risks of suicide, self-neglect and harm to others, all of which are very much commoner

¹ Severe Mental Illness is commonly understood to include all individuals with a diagnosed psychotic disorder (schizophrenia and bipolar affective disorder) and those with other mental disorders whose social functioning is significantly affected by their illness or disorder (which will include some people with a diagnosis of depressive illness, obsessive-compulsive disorder and personality disorder). Schizophrenia is the paradigmatic severe mental illness and the evidence base is strongest for interventions in people with a diagnosis of schizophrenia.

amongst people with a diagnosed psychotic illness (and other mental disorders) than the general population. Co-morbidities such as substance misuse, learning disability, developmental disorder and personality disorder are common and markedly increase the risks of highly adverse outcomes for the individual.

Rehabilitation *within* adult mental health services

The range of needs encompassed within the care plan of a person on Enhanced CPA includes not only needs for psychiatric and psychological treatments but also relationships, accommodation, finances, activity and occupation as well as physical health needs (and, increasingly, spiritual and cultural aspirations). It is a policy requirement that risk issues are addressed in the care plan and that carers' needs are assessed and addressed. CMHTs and the PIG-compliant "functional" mental health teams are expected to address, in a holistic fashion, a wide range of issues aimed at facilitating the effective treatment, rehabilitation and recovery of people with a severe mental illness. PIG guidance has also been published on acute inpatient units and Psychiatric Intensive Care Units (PICUs) and low secure provision (Department of Health, 2002a, b). These facilities have a vital role in rehabilitation and recovery that is often unacknowledged. Effective inpatient services will focus on maintaining their patients' existing social networks (actively working with carers) and will be assessing, maintaining and improving their patients' social and functional skills.

The NICE Guideline for Schizophrenia spells out the pharmacological and psychological treatments that according to the current evidence base should be provided by primary and secondary health services (NICE, 2002): unfortunately the Guideline does not seek to address needs for rehabilitation and continuing care. Similarly, although the term is mentioned under Standard 5 within the National Service Framework for Mental Health (Department of Health, 1999), it is entirely missing from the many PIG publications that have driven the modernisation of mental health services as part of the larger NHS Plan. However, it is clear that policy requires that effective adult mental health services will be working with a range of partners to tackle the social exclusion that is such a feature of experiencing mental illness. These include generic local providers of education and skills training, statutory benefits, employment, leisure and housing services, user-led organisations, advocacy services and specialist agencies offering tenancy support, supported housing and routes back into occupation and employment.

Why specialist rehabilitation services?

Treatment Resistance

Adult mental health services are clearly tasked with providing rehabilitative inputs for their patients/clients/service users. What, then, is the rationale for specialist psychiatric rehabilitation services? At a theoretical level this lies in the existence of *treatment resistance*, which affects a significant proportion of people with severe mental illnesses such as schizophrenia. Treatment resistance is here understood as an individual experiencing continuing symptomatology or social disability, for whatever reason, following an acute episode of mental illness.² The research focus on the response to the treatment of severe mental illnesses such as schizophrenia has been the positive symptoms of psychosis. However, even where treatment is effective in minimising positive symptoms other, less dramatic, problems may persist as enduring affective symptoms or impairments in cognition and conation. Some individuals are, from the onset of their illness, very disabled by their psychotic illness. Others may experience multiple recurrent episodes of acute psychosis. These are often associated with a decision to stop medication that is controlling or minimising positive symptoms of psychosis and frequently lead to increasing social decline. This is of particular significance to people from black and minority ethnic groups who have not been adequately engaged with treatment because of issues such as language needs.

Treatment resistance is not just a matter of failure to implement currently understood good practice. There is good evidence that some people with psychosis do badly even with

² It is important to emphasise that "treatment resistance" no more implies a failure in the patient/client/service user than it would in someone who was not responding to their treatment for tuberculosis, diabetes, cancer or any other medical condition. The failure lies with existing treatment technologies and services (although poor adherence to treatment is a factor, as it is in other conditions).

the best EIP interventions (Craig et al, 2004). Others, later on in their illness career, cannot be safely supported in the community despite the best efforts of effective and active AOT services. Yet other people engage in offending behaviour (which is frequently associated with comorbidities) that leads them to come under the remit of Forensic Mental Health services. (Forensic provision has expanded as traditional, mental-hospital based rehabilitation services have been shrinking.) There is increasing evidence that substance misuse is a significant contributory factor to treatment resistance (Isaac et al, 2005).

Out of Area Treatments

At a more pragmatic level, the need for specialist rehabilitation services is clear from the phenomenon of the "new long stay" patient, who becomes long-stay within a hospital system predicated on brief admissions. The "new long stay" are a heterogeneous group with a range of complex needs, often exhibiting challenging behaviours that make their care outside a hospital setting problematical (Lelliott et al, 1994; Holloway et al, 1999). "New long-stay" patients are clearly inappropriately placed in contemporary acute psychiatric wards, which are geared towards managing acutely ill people and rapid patient turnover, and will generally very appropriately be transferred to alternative provision. This often requires people to be placed outside the local mental health economy. One consequence of placement out of area is that ties with family and other social networks may be disrupted. The David Bennett Inquiry demonstrated that Out of Area placement makes it significantly less easy to meet the individual's specific ethnic and cultural needs (Blofeld et al, 2003).

The lack of capacity of local mental health services to provide appropriate care for people with enduring and complex needs is dramatically underlined by the massive and rapidly increasing expenditure that local health economies are devoting to Out of Area Treatments (OATs) (Ryan et al, 2004). One analysis has put the OATs market in 2004/5 at £222m, an increase of 63% in one year (Mental Health Strategies, 2005): this is likely to be an underestimate as it represents only reported spending by PCTs. Significant numbers of people are being placed in inpatient settings far from their homes because of lack of appropriate local provision. The OATs phenomenon affects both Forensic and General Adult services and represents the most obvious consequence of the rise of the "virtual mental hospital", a dispersed and rather chaotic system of care that has arisen as the mental hospitals have closed. Forensic OATs reflect overspill from traditional medium secure provision as well as patients deemed to require low secure care and (increasingly) long-term medium secure care.

The distinction between Forensic and non-Forensic OATs is, to an extent, arbitrary and contingent on the range of local service provision and local access criteria to Forensic services. People placed in non-Forensic OATs from a local service tend to have very complex needs and to present challenging behaviours (Holloway et al, 1999; Ryan et al, 2004). Although schizophrenia is the commonest diagnosis people may have primary diagnoses of personality disorder, acquired brain injury and degenerative brain disease. Rare, very hard to place, individuals have co-morbid autistic spectrum disorders.

The "virtual mental hospital"

The data shows that over the past 20 years psychiatric hospital beds in England and Wales have been replaced almost bed for bed by residential and nursing home placements, generally within the independent sector (Holloway, 2004). These are provided for people who cannot manage their illness and disability in independent living, in family homes or in housing projects funded by *Supporting People* monies. Residential and nursing home placements are expensive and, in general, are poorly monitored by mental health services: the system provides little incentive for the encouragement of individuals to move into less dependent settings and exercise more autonomy. Placements may not take account of the specific needs of people from ethnic minorities. Alternative ways of helping people with disability to live independently that are well established in other client groups, such as Direct Payments, are not much used within mental health services. Floating support and domiciliary care are also relatively poorly utilised by people with a mental illness.

Forensic mental health services

The expansion of Forensic mental health services has coincided with the rundown of the traditional mental hospital. First medium and then low secure bed numbers have increased rapidly, both in the NHS and the OATs sector. The need for longer-term medium secure

provision has been made more urgent by the rapid retraction of the high secure sector, within which patients frequently resided for many years. There is therefore a strong argument for the adoption of a rehabilitation ethos within longer term high, low and medium secure services (Abbott, 2005), to ensure that services promote symptomatic and social recovery for patients whilst effectively managing risk. Without this ethos the prospects for moving people through the system are damaged, which is bad not only for the patients caught up in the system but for local health economies. Forensic OATs represent a major financial risk for PCTs.

Forensic community teams have become the norm (Judge et al, 2004). With them has come an increased demand for residential care provision for offender patients who have long-term needs. There are clear interface issues between local specialist rehabilitation and recovery services and the local Forensic mental health services, with a requirement for a sharing of competencies.

Specialist rehabilitation services

A contemporary definition of rehabilitation in mental health services

Following a national survey of rehabilitation services Killaspy et al (2005) have provided a contemporary definition for rehabilitation:

"A whole system approach to recovery from mental ill health which maximises 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 which leads to successful community living through appropriate support."

The definition underlines the aspirations of contemporary rehabilitation services in terms of recovery and the promotion of the autonomy of service users and a reluctance to use the language of disability. It contains an important statement of principle: effective rehabilitation requires a whole system approach. Specialist rehabilitation services are but one element of the system that will deliver good rehabilitation and recovery outcomes for individuals with a mental illness. However, although the definition demonstrates the philosophy underlying contemporary services, it does not allow us to identify the elements of a specialist local rehabilitation service.

Current provision

Despite a perception that specialist rehabilitation services are under threat a recent national survey in England identified designated rehabilitation services to local authority areas covering 31 million people (Killaspy et al, 2005) (the response rate from Trusts was 89%). On average a local authority area of 330,000 had 13 short-term rehabilitation beds and 12 longer-term beds, with an average turnover of 13 patients per annum. Units might be on hospital sites or, equally commonly, be free-standing. Although almost all of the rehabilitation units accepted detained patients services rarely had specific local provision for challenging behaviour or low security, which is in line with the data on the OATs market.

Killaspy et al (2005) identified a total of 2200 NHS rehabilitation beds in the Trusts responding to the survey. The National Adult Mental Health Service Mapping Exercise (www.dur.ac.uk/service.mapping/amh/queries/), which undoubtedly contains inaccuracies, reported 2900 rehabilitation beds for the whole of England. The true figure for rehabilitation beds in England probably lies between 2500 and 2900. It represents a significant investment in rehabilitation services: rehabilitation bed numbers should be compared with the NHS adult acute provision, 14380, and secure unit bed numbers of 1950 (this data relates to 2000-1, the latest year for which Department of Health figures are available). We do not have accurate data on the diagnoses of residents of rehabilitation units, but the vast majority will be suffering from schizophrenia or another form of psychotic illness, such as bipolar affective disorder. It can be estimated that slightly more than 1% of people in England with a diagnosis of schizophrenia (some 150,000 individuals – assuming a point prevalence of 3 per 1000) will be receiving inpatient rehabilitation at any one time.

A majority of services with rehabilitation inpatient units also had a Community Rehabilitation Team, although patients would commonly be discharged to the care of the local CMHTs even where a Community Rehabilitation Team was in place. Killaspy et al (2005) found that in some areas the local AOT service was formally part of the community

rehabilitation services, although the vast majority of AOTs lie separately within the local management structure. Detailed data on the functioning of Community Rehabilitation Teams is lacking. The National Adult Mental Health Service Mapping Exercise (www.dur.ac.uk/service.mapping/amh/queries) for 2003 reported that of 175 Local Implementation Teams (mental health economies based on local authority boundaries) 63 had Community Rehabilitation Teams, with an average of 100 clients per team (range 6 to 706!) (again, there are inaccuracies in this data with the caseload of some services being exaggerated and other active teams known to exist not being included in the return). In 2003 possibly 3% of people suffering from schizophrenia in England were in receipt of support from a Community Rehabilitation Team, although there is clearly a very wide range of provision across the country.

In some areas rehabilitation services not only provide inpatient care and community follow-up but are large-scale direct providers of housing. This historical model derives from the resettlement element of hospital closure programmes completed during the early 1990s. It runs against subsequent policy initiatives requiring a mixed economy of care.

The majority of specialist rehabilitation services in England adopt a “tertiary flow” model of provision (Killaspy et al, 2005). Patients move into the service from acute or other inpatient wards by entering a short-term rehabilitation unit. They may then move on to a longer-term unit or be discharged to non-hospital provision. On discharge patients may leave the rehabilitation service, to be supported by CMHTs or AOTs or may receive support from the Community Rehabilitation Team. Some Rehabilitation Teams also accept direct referrals from CMHTs of patients living in the community.

The family of psychosis services

In addition to designated rehabilitation and continuing care provision within the NHS and a very patchy presence of Community Rehabilitation Teams across England there is now near-universal availability of AOTs. By 2003 more than 9000 people were on AOT case-loads, with perhaps 5% of people suffering from schizophrenia in receipt of AOT. These operate along a highly prescriptive service specification, set out in the PIG (Department of Health 2001a), that is in turn based on the Assertive Community Treatment model favoured in the USA (see Burns and Firn, 2002 for a detailed description). EIP, also mandated by the PIG, is now available throughout England, but in most areas the capacity of the local EIP team is far less than local demand for treatment of incident psychosis. By 2003 only 1000 people were being supported by EIP services (much less than 1% of individuals with schizophrenia). Significant investment is required to ensure that EIP services are able to offer specialist care to all new cases of psychosis.

Rehabilitation and continuing care inpatient facilities, Community Rehabilitation Teams, AOTs and EIP services together form a family of specialist psychosis services that complement the work of CMHTs³ and acute inpatient units and Forensic mental health services in supporting people with a severe mental illness. To this family of specialist psychosis services may be added service-wide initiatives to provide Psychosocial Interventions (PSI) for psychosis, putting the evidence-based psychological treatment technologies espoused in the NICE Schizophrenia Guideline (NICE, 2002) into local clinical practice (Brooker and Brabban, 2004).

What specialist rehabilitation provision is required?

Existing models of specialist rehabilitation service generally address only some of the needs outlined above, by providing slow-stream hospital-based care for a restricted number of individuals with severe mental illness, most commonly schizophrenia, together with limited follow-up of patients discharged from specialist units. It can be estimated that less than 5% of individuals with active schizophrenia are in contact with specialist rehabilitation services in England. Specialist rehabilitation services do not, in general, offer their expertise to the wider potential client group of people with severe mental illness and treatment resistance. Neither do they participate in the assessment and review of people being placed in residential care or OATs.

³ In some areas CMHTs are divided into assessment and treatment teams and continuing care teams: the latter are clearly undertaking functions that require rehabilitation expertise.

Specialist rehabilitation services should be **locally** available to undertake the following tasks⁴:

- 1) Provide inpatient rehabilitation in short-term units, focusing on treatment-resistant patients and those with severe functional impairments as a consequence of psychotic illness.
- 2) Provide continuing, hospital-based, care.
- 3) Offer care co-ordination for patients being resettled from inpatient rehabilitation units into less dependent settings, having taken steps to assess and meet religious and cultural needs.
- 4) Offer expert consultation to acute adult mental health services in the management of treatment resistance.
- 5) Provide expert assessments for decisions about placements within OATs, residential and nursing home care made by local providers and service commissioners.
- 6) Provide expert advice on the development of complex packages of community care and support as an alternative to residential and nursing home care.
- 7) Provide a care co-ordination, monitoring and review function for individuals placed OATs, in residential and nursing home care and in receipt of complex packages of community care.

In addition specialist rehabilitation expertise is required within all services providing OATs, which generally are located in the independent sector. Specialist rehabilitation expertise is also required within high, medium and low secure Forensic provision. Forensic and specialist rehabilitation services should work closely together in the development and delivery of complex, high-dependency mental health care. Specialist rehabilitation services need to be competent in managing commonly occurring comorbidities, in particular the comorbid substance misuse that is such a common feature of people who are treatment-resistant.

Consideration also needs to be given to the potential role of local specialist rehabilitation services in the assessment, treatment and support of emerging client groups, particularly adults with autistic spectrum disorders and in the management of people who present challenging behaviours in the context of severe personality disorders or severe neurotic illnesses. Taking on a role in supporting these client groups should only occur after an assessment of local need and with adequate investment in training and other resources to ensure the task can be done well. In some areas other services, for example the local learning disability service for autistic spectrum disorders and the psychotherapy department for people with a severe personality disorder, may be best placed to take on the role.

Rehabilitation: the way forward

This paper has set out to define the case for specialist rehabilitation provision within contemporary, deinstitutionalised, recovery-oriented mental health services. If the arguments it sets out are agreed, the paper has implications for local mental health economies, providers of long-term hospital care, the research community and training providers.

Local mental health economies

- 1) Commissioners and providers of local mental health services should review existing specialist rehabilitation provision against a template of best practice. This will require an assessment of local needs for all forms of culturally appropriate high-support care, including inpatient provision, residential and nursing home care, supported housing and community support options for people with a severe mental illness.
- 2) Services should review their capacity to provide best-practice interventions for psychosis (following NICE Guidelines) and their ability to offer high quality interventions to people with established or emerging treatment resistance.
- 3) At a minimum there should be locally available inpatient provision for both short-term rehabilitation and longer-term inpatient care ("continuing care"). The scale of provision

⁴ HASCAS has developed an external programme to undertake some of these functions for local mental health economies. Their approach emphasises the whole system response to need within an area and the requirement to assess the needs of people placed in OATs and the options for repatriation (see www.healthadvisoryservice.org/adults/oats.htm)

should be based on an assessment of local need, which will depend substantially on the local incidence and prevalence of psychosis.

- 4) Practitioners with expertise in rehabilitation and recovery should be available to provide community support for individuals moving on from specialist rehabilitation inpatient care. Similar expertise should be available in the assessment, placement, support and review of individuals moving into residential and nursing home care and in receipt of complex domiciliary care packages. Local commissioners and providers should consider the potential for these functions to be undertaken by a Community Rehabilitation Team. The Community Rehabilitation Team could also be the focus for local expertise in the management of treatment resistance.
- 5) Local mental health services should consider the value of bringing specialist rehabilitation services, AOTs and EIP services under an integrated management structure. This structure might also include management of service-wide interventions aimed at facilitating the availability of evidence-based psychosocial interventions for severe mental illness and, potentially, local low secure provision.
- 6) Within local mental health economies close working relationships should be established between Forensic mental health services and specialist rehabilitation services that include opportunities for skill sharing and co-working.
- 7) All OATs should only be agreed following assessment by local practitioners skilled in psychiatric rehabilitation, who may either work within the local Community Rehabilitation Team or in close association with this team. Additionally all OATs should be closely monitored by rehabilitation practitioners. OATs providers must meet the provisions of the Race Relations (Amendment) Act 2000.
- 8) Mental health economies should explore options for the joint commissioning of the provision of inpatient services for uncommon client groups and patients with particularly challenging behaviours with neighbouring health economies so that all provision is as local as possible.
- 9) Local commissioners and service providers should ensure that there is adequate management capacity devoted to rehabilitation services. This capacity should include appropriate expertise in epidemiology and needs assessment.

Providers of long-term hospital care

- 1) All providers of long-term hospital care, whether in the NHS or independent sector, should have a focus on rehabilitation and recovery within a culturally sensitive framework.
- 2) Providers should ensure that clinicians working within these settings should have demonstrable competencies in the practice of psychiatric rehabilitation.

The Research Community

- 1) Investment is required in exploring specific rehabilitative interventions, the management of "treatment resistance" and the impact of service configurations on the long-term outcome for severe mental illness.
- 2) Specific attention is required into researching models of treatment and service provision who present challenging behaviours as a consequence of non-psychotic disorders, such as severe personality disorder, autistic spectrum disorder and severe neurosis.

Training providers

- 1) All staff working within mental health services should be aware of the potential impact of mental illness on the life chances of someone suffering from mental illness and have an understanding of the basic principles of rehabilitation and recovery.
- 2) The workforce implications of ensuring that practitioners working within both adult mental health services and specialist rehabilitation and recovery services have the required competencies to deliver rehabilitation interventions must be addressed.
- 3) The training of people working within the social care sector with people with a severe mental illness should include a sound understanding of the nature of mental illness, cultural competency and principles of rehabilitation and recovery.

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