

Joint Commissioning Panel for Mental Health

www.jcpmh.info

Guidance for commissioners of
**rehabilitation services
for people with complex
mental health needs**

Practical
mental health
commissioning

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Ten key messages for commissioners

1 Mental health rehabilitation services specialise in working with people whose long term and complex needs cannot be met by general adult mental health services

Rehabilitation services:

- Provide specialist assessment, treatment, interventions and support to help people to recover from complex mental health problems and to (re)gain the skills and confidence to live successfully in the community
- Always work in partnership with service users and carers, adopting a recovery orientation that places collaboration at the centre of all activities
- Work with other agencies that support service users' recovery and social inclusion, including supported accommodation, education and employment, advocacy and peer support services.

2 Rehabilitation services are not the same as recovery services

- A recovery orientation should be at the centre of all health and social care service provision to people with mental health problems and is not limited to rehabilitation services.

3 There is an ongoing need for specialist rehabilitation services

- Despite the investment in community mental health services in recent decades, there remains a group of service users with very complex needs who require specialist inpatient and community rehabilitation. Around 20% of service users presenting to mental health services for the first time with a psychotic illness will go on to require rehabilitation services due to the severity of their functional impairment and symptoms^{1,2}
- Earlier identification of people with complex mental health needs who would benefit from rehabilitation is required. Mental health rehabilitation services require appropriate resourcing to implement early intervention.

4 People using rehabilitation services are a 'low volume, high needs' group

- 80% have a diagnosis of a psychotic illness (schizophrenia or schizoaffective disorder), and many will have been repeatedly admitted to hospital prior to referral to rehabilitation services³
- Many experience severe 'negative' symptoms that impair their motivation, organisational skills and ability to manage everyday activities (self-care, shopping, budgeting, cooking etc.) and place them at risk of serious self-neglect⁴⁻⁶
- Most have symptoms that have not responded to first-line medications and require treatment with complex medication regimes

- Around 20% have co-morbidities such as other mental disorders, physical health problems and substance misuse problems that complicate their recovery further^{7,8}
- Most require an extended admission to inpatient rehabilitation services and ongoing support from specialist community rehabilitation services over many years⁹.

5 People with complex mental health problems often require a large proportion of mental health resources

- Around one half of the total mental health and social care budget is spent on services for people with longer term mental health problems. Half of this (one quarter overall) is spent on rehabilitation services and specialist mental health supported accommodation¹⁰.

6 There is good evidence that rehabilitation services are effective

- Around *two-thirds* of people supported by rehabilitation services progress to successful community living within 18 months of admission to an inpatient rehabilitation unit, two-thirds sustain this over five years *without requiring further hospital admissions*, and around 10% achieve independent living within this period^{9,11}
- People receiving support from rehabilitation services are *eight times more likely* to achieve/ sustain community living, compared to those supported by generic community mental health services¹².

Ten key messages for commissioners (continued)

7 Investment in a local rehabilitation care pathway is cost-effective

- Local provision of inpatient and community rehabilitation services ensures that service users with complex needs do not become 'stuck' in acute mental health inpatient wards¹³
- Historically, where there is a lack of local provision, service users with complex needs have been placed outside the local area in hospital, nursing or residential care. Out of area placements cost around 65% more than local placements, they are socially dislocating for service users and of variable quality¹⁴
- Guidance for commissioners on out of area placements emphasises the importance of provision of local care pathways for people with complex mental health needs to minimise the use of out of area placements¹⁵.

8 Commissioning a 'good' rehabilitation service includes components of care provided by the NHS, independent and voluntary sector. These include:

- Inpatient and community based rehabilitation units – for voluntary patients and those requiring detention under the Mental Health Act (1983)
- Community rehabilitation teams – support service users when they leave hospital and/or move to supported accommodation; assist supported accommodation providers; liaise with providers to ensure that vacancies are matched with clinical priorities; facilitate service users' move-on to less supported accommodation

- Supported accommodation services – nursing/residential care; supported tenancies; floating outreach services. Provide day-to-day support for service users to live in the community
- Services that support service users' occupation and work; advocacy services and peer support services – support service users' social inclusion and rights.

9 Mental health rehabilitation services require multidisciplinary staffing

- Multidisciplinary teams are required in inpatient and community rehabilitation services with the expertise to address their service users' complex and diverse needs including: complex medication regimes; physical health promotion; psychological interventions, arts therapies; self-care; everyday living skills; and meaningful occupation.

10 The quality and effectiveness of rehabilitation service provision can be assessed with simple indicators and standardised outcome tools

This guidance recommends outcome measures and indicators that can be used to monitor: the quality of services, flow through the care pathway and better service user outcomes.

Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, which brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- Service users and carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- Afiya Trust
- British Psychological Society
- Representatives of the English Strategic Health Authorities
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning
- Healthcare Financial Management Association.

The JCP-MH has two primary aims:

- to bring together service users, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, service user and carer experience and viewpoints, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published Practical Mental Health Commissioning¹⁶, a briefing on the key values and principles for effective mental health commissioning
- provides practical guidance and a developing framework for mental health
- will support commissioners of public mental health to deliver the best possible outcomes for community health and wellbeing
- has published a series of short guides describing 'what good looks like' in various mental health service settings¹⁷⁻²⁵.

WHO IS THIS GUIDE FOR?

This guide is about the commissioning of good quality mental health interventions and services for people with complex and longer term problems to support them in their recovery. It should be of value to:

- Health and Wellbeing Boards who have a key role in transforming health and care and achieving better population health and wellbeing through their responsibility for preparing Joint Strategic Needs Assessments which take account of the current and future health and social care needs of the entire population through Joint Strategic Asset Assessments and joint health and well-being strategies
- Clinical Commissioning Groups and Local Authorities as they jointly lead the local healthcare system, including through their local Sustainability and Transformation footprints, Health and Wellbeing Boards and in collaboration with their communities
- Other bodies who, through various contractual forms, take on commissioning and provision of services that span this patient group, such as Multispecialty Care Providers and Primary and Acute Care Systems, as outlined in the NHS Five Year Forward View
- The NHS Commissioning Board which holds to account the work of Clinical Commissioning Groups
- Service providers including those in primary and secondary care, social care, local authorities and third-sector providers of supported accommodation and other services that promote social inclusion, including supported employment and other meaningful occupation

Introduction (continued)

- Public Health England as reducing mental disorder and promoting well-being is an important part of their role and also contributes to a range of other public health priorities
- The Care Quality Commission and NHS Improvement in understanding 'what good looks like' in local mental health services, of which local rehabilitation services are an essential component.

HOW WILL THIS GUIDE HELP YOU?

This guide has been written by a group of mental health rehabilitation experts.

The content is primarily evidence-based but ideas deemed to be best practice by expert consensus have also been included. By the end of this guide, readers should be more familiar with the concept of mental health rehabilitation services and better equipped to understand the:

- policy context for rehabilitation services
- importance of joined up health and social care commissioning of rehabilitation services that take account of service user and carer views
- importance of having a 'whole system approach' when commissioning mental health rehabilitation services
- importance of providing a local rehabilitation care pathway for people with complex mental health needs that includes inpatient care, supported accommodation and vocational rehabilitation services and the range of providers required to deliver this
- key components of a comprehensive rehabilitation service and the need for local tailoring of the rehabilitation care pathway to meet local need.

What are mental health rehabilitation services?

This guide defines mental health rehabilitation as:

A whole systems approach to recovery from mental illness that 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 leads to successful community living through appropriate support.²⁶

A mental health rehabilitation service provides specialist assessment, treatment, interventions and support to enable the recovery of people whose complex needs cannot be met by general adult mental health services.

These services aim to work with people to help them acquire or regain the skills and confidence to live successfully in the community. They focus on addressing and minimising the symptoms and functional impairment that people may have, with an emphasis on achieving as much individual autonomy and independence as possible.

This includes optimal management of symptoms, promotion of activities of daily living and meaningful occupation, screening for physical health problems, promoting healthy living, and providing support and evidence based interventions to support carers.

Rehabilitation services adopt a 'recovery' approach that values service users as partners in a collaborative relationship with staff to identify and work towards personalised goals. The concept of recovery encompasses the values of hope, agency, opportunity and inclusion, themes that resonate well with the aims of mental health rehabilitation.

Rehabilitation services operate as a whole system that includes a range of inpatient and community services, supported accommodation and vocational rehabilitation services provided by statutory, independent and voluntary sector organisations

The specific components required in any locality will vary according to local psychiatric morbidity and need and are described on pages 12-17.

The skills needed by staff that work in rehabilitation services are described on pages 15-17.

Users of rehabilitation services often have co-morbid physical health problems and close liaison with primary care services and, where appropriate, secondary care medical services is a key role for rehabilitation practitioners.

THE REHABILITATION CARE PATHWAY

People who do not recover adequately after acute admission to a mental health unit to be able to be discharged home are referred to rehabilitation services. As a result of this situation, most referrals therefore come from general adult inpatient services. Rehabilitation services also provide step-down for those patients moving on from secure mental health services who have longer term and complex mental health needs.

Around 20% of people receiving care from early intervention services have longer term and complex needs that will require input from rehabilitation services^{1,2}. Most are inpatients in a general or secure mental health inpatient ward at the point of referral.

Figure 1 (page 8) illustrates a typical rehabilitation care pathway, showing the 'direction of travel' for service users with complex and longer term mental health problems, from inpatient services through to community living. The service components in the rehabilitation care pathway are shown in blue. The specifications of each are described in detail on pages 12-17.

A national survey of inpatient rehabilitation services³ found that almost all NHS Trusts in England have at least one type of inpatient rehabilitation unit accepting referrals from acute admission wards and secure mental health services. Around 60% of these units are actually sited in the community, 11% are wards within a mental health unit and 29% are separate units within the mental health unit's grounds. The exact configuration of inpatient rehabilitation services varies in different localities according to need, with inner city areas tending to have greater need for high dependency inpatient rehabilitation units within the mental health unit, from where service users generally move on to a community based rehabilitation unit in preparation for more independent, but supported community living. Most (57%) people who require inpatient rehabilitation are able to move on successfully to some form of supported accommodation within 18 months¹⁰. Two-thirds are able to successfully sustain their community accommodation five years on (without readmission or placement breakdown)⁹.

Community rehabilitation services ideally take a census approach to all those in both health and social care-funded placements and work with local commissioners and housing providers to ensure the right complement of housing and support is available in their locality, to facilitate the move through to the least restrictive, independent and socially inclusive setting, as close to home as possible at all times. Community rehabilitation services work closely with supported accommodation services, to provide comprehensive support to service users as they continue their recovery in the community. When service users are able to manage with less support they move on to less supported accommodation. Once they are able to manage more independent living, their care is transferred from the rehabilitation service to a standard community mental health service or to primary care. However, only around 10% of service users will achieve and sustain fully independent living within five years of referral into rehabilitation services⁹.

It takes a number of years for service users to move successfully through each

step of the rehabilitation care pathway due to the severity and complexity of their mental health needs. Service users often need to make repeated attempts to successfully transition from a higher to a lower level of support. Those commissioning rehabilitation services need to be aware that a 'long term view' has to be held for this service user group.

WHO USES MENTAL HEALTH REHABILITATION SERVICES?

Despite developments in mental health interventions and services that provide early intervention to people presenting with psychosis, around 20% of people entering mental health services will have particularly complex needs that require rehabilitation and intensive support from mental health services over many years¹. At any time, around 1% of people with schizophrenia are in receipt of inpatient rehabilitation⁷.

A national survey of inpatient mental health rehabilitation services across England found that 80% of those using these services had a diagnosis of a psychotic illness, usually schizophrenia or schizoaffective disorder. Two-thirds of service users were male, reflecting the fact that men diagnosed with schizophrenia tend to have a poorer prognosis than women. On average, service users had experienced mental health problems for 13 years, had been recurrently admitted to hospital prior to referral for rehabilitation and had spent ten months in the acute ward prior to transfer to the rehabilitation unit^{2,3}.

Mental health rehabilitation service users often have prominent 'negative' symptoms that impair their motivation and organisational skills to manage everyday activities^{4,5,6}. This places them at risk of self-neglect. Many also have on-going 'positive' symptoms (such as delusions and hallucinations) which have not responded fully to medication and can make communication and engagement difficult⁷. It is estimated that around one third of people with a diagnosis of schizophrenia do not respond adequately to antipsychotic medication²⁶.

As well as 'treatment resistant' positive symptoms and severe negative symptoms, many people who use rehabilitation services have co-existing problems that make their presentation especially complex and difficult to manage. These include other mental health issues (such as depression and anxiety), long term physical health conditions (such as chronic obstructive pulmonary disease and cardiovascular disease), pre-existing disorders (such as learning disability and developmental disorders including those on the autistic spectrum) and substance misuse. These problems mean that some service users present with challenging behaviours, including aggression to others, and may have difficulties engaging with treatment and support^{7,27}.

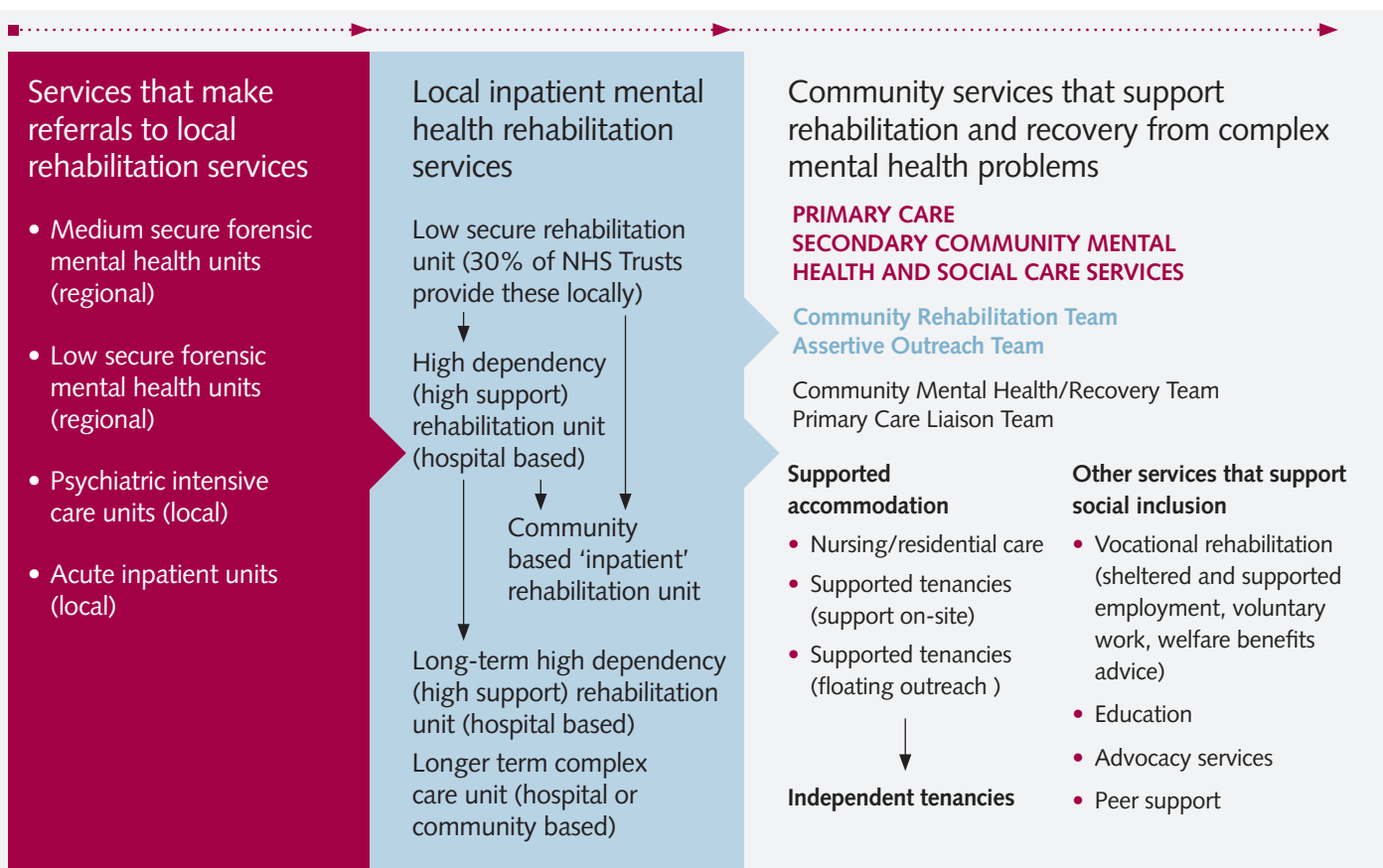
Most have considerable disability and impaired mental capacity to make everyday decisions. They can be vulnerable to exploitation and abuse by others and may require safeguarding.

In short, mental health rehabilitation service users are a '**low volume, high need**' group.

It is likely that, in addition to those patients that receive support from mental health rehabilitation services, there is a larger group of people living in the community, diagnosed with schizophrenia, who have not been adequately supported to achieve their full recovery potential. Sometimes these people will be receiving support from general adult mental health services but considered 'stable'. Some may not be receiving care from secondary mental health services but are known to their GP. A large 'clinical iceberg' of under-treatment is suspected. There is good evidence that clozapine, a medication prescribed for people with 'treatment resistant' symptoms, is underused in the community. It is likely that community mental health teams have not been able to focus on this group due to many other competing priorities. Improving access to appropriate multidisciplinary and multi-provider resources, including rehabilitation services, is needed to maximise recovery for this group.

What are mental health rehabilitation services? (continued)

Figure 1: Components of a 'whole system' rehabilitation care pathway

**WHICH 'CLUSTERS' ARE RELEVANT?**

With reference to the Mental Health Clustering Tool (HoNOS)²⁸, the majority of people in receipt of inpatient mental health rehabilitation services are likely to be categorised as Cluster 13:

Cluster 13:
Complex needs, high support

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

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

Cluster 12:
Complex needs, medium support

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

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

Cluster 11:
Complex needs, standard support

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

Assertive Outreach Teams (AOTs) are most likely to work with patients categorised as Cluster 16 or 17 who may be living independently or in supported accommodation. AOTs are specialist community teams that offer intensive support to people living in independent or low support tenancies. They comprise an important component of the local care pathway for people with longer term and complex mental health needs. Many are commissioned and managed as part of the local rehabilitation service, hence their inclusion in this guide.

**Cluster 16:
Dual diagnosis**

“This group has enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyle and co-existing substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired”.

**Cluster 17:
Psychosis and affective disorder,
difficult to engage**

“This group has moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable & engage poorly with services”.

**HOW EFFECTIVE ARE MENTAL
HEALTH REHABILITATION SERVICES?**

Due to the complex nature of their problems, mental health rehabilitation services often work with their clients over many years, enabling them to gain/regain confidence and skills in everyday activities and in managing their mental health symptoms.

Maintaining expectations of recovery over long periods of time can be difficult for staff, service users and carers. A major aspect of the ethos of rehabilitation

services is the continuous promotion of therapeutic optimism.

Longer term studies of people with a diagnosis of schizophrenia have shown that half to two-thirds significantly improve or recover over time^{29,30}. There is also good evidence that even amongst those with complex problems, with appropriate rehabilitation, the majority (two-thirds) are able to progress successfully to supported community living within eighteen months and around 10% will achieve independent living within five years^{9,11,31}. This suggests that therapeutic optimism is neither idealistic nor misplaced.

A prospective cohort study carried out in Ireland that compared service users in receipt of mental health rehabilitation services with those receiving care from general adult mental health services who had similar levels of complex needs and were wait listed for rehabilitation services, found that those receiving treatment and support from rehabilitation services were eight times more likely to achieve and sustain successful community living eighteen months later¹².

A five-year programme of research, funded by the National Institute for Health Research and led by a team at University College London, investigated the clinical and cost-effectiveness of mental health rehabilitation services in England (the ‘REAL’ study – Rehabilitation Effectiveness for Activities for Life). This included a national survey of inpatient rehabilitation services which found that the quality of services was positively associated with service users’ experiences of care and autonomy³. Over half of those admitted to an inpatient rehabilitation unit were successfully discharged to the community within 18 months (and a further 14% were ready for discharge but were awaiting suitably supported accommodation) with reductions in the associated costs of care. Factors associated with successful discharge were the degree to which the unit embraced a recovery

orientation, as well as service users’ social skills and engagement in activities¹¹.

**HOW DO MENTAL HEALTH
REHABILITATION SERVICES WORK
WITH OTHER AGENCIES?**

Rehabilitation services operate as a whole system that includes a range of other agencies and organisations. Collaborative and partnership working is key to this. It helps ensure the provision of a holistic and comprehensive care pathway that can support service users to make incremental improvements in their everyday and social functioning, and to successfully take on increasing levels of responsibility in managing as many aspects of their own life as possible.

Rehabilitation services and the wider network of services with which they work develop strong links with local community resources to facilitate service users’ social inclusion.

Similarly, productive partnerships with users and carers are needed to ensure that local provision is adequate to enable recovery and to assist informal support networks. Integrated health and social care commissioning is therefore required to ensure that the local rehabilitation care pathway is appropriate for the local population, that there are functional and productive partnerships between providers to inform this provision, and it is appropriately used to enable people to move on smoothly between services.

Commissioners and providers also need to take account of the personalisation approach within social care. A full description is beyond the scope of this document, but in short, personalisation aims to ensure that social care services are tailored to the needs of every individual, rather than delivered in a one-size-fits-all fashion. For further information on personalisation in social care, please see: <http://www.scie.org.uk/topic/keyissues/personalisation>

Why are rehabilitation services important to commissioners?

People with especially complex mental health needs cannot be adequately managed by general adult mental health services, since their particular needs require specialist assessment and treatment (see pages 14-15).

This group often require lengthy admissions and ongoing intensive support from rehabilitation and other mental health services to live in the community successfully after discharge. Despite being a relatively small group, they absorb around 25-50% of the total health and social care budget for people with mental health problems¹⁰.

As described earlier, a case control study in Ireland found that people with complex mental health needs were eight times more likely to achieve and/or sustain successful community living if they were supported by mental health rehabilitation services as compared to general adult mental health services¹¹.

Investment in local rehabilitation services can reduce 'out-of-area' treatment costs:

- Disinvestment in NHS rehabilitation services after the publication of the *National Service Framework for Mental Health*³² led to a rapid and uncontrolled rise in provision of 'out-of-area placements' in hospital, nursing and residential care homes in the independent sector for people with longer term and complex mental health problems who could not be discharged from acute admission wards^{33,34}.
- This phenomenon has been referred to as the 'virtual asylum' since, until recently, there was little attention paid to the on-going review of these individuals' needs and their potential for recovery and progress to more independent living³⁵.

- Out-of-area placements displace service users from their communities and families. Furthermore, there have been criticisms of the quality of care and lack of rehabilitative ethos in some wards³⁶.
- Out-of-area treatments are expensive, costing, on average around 65% more than similar local services¹⁴. In 2008-9, out-of-area placements cost the NHS and social services around £330 million¹⁰ and there are often inadequate systems for monitoring the quality of care and the on-going need for the level of support provided³⁷.
- Service users placed in out-of-area facilities have similar profiles in most respects to those placed locally³⁸. Rehabilitation psychiatrists and other experienced rehabilitation clinicians should be involved in assessing the appropriateness of making individual out-of-area placements and reviewing the needs of people placed in them in order to clarify whether local services could provide a better alternative³⁹.
- General adult mental health services are unlikely to have the appropriate skills to assess and review people placed out-of-area with a view to repatriation. 'Out-of-area reviewing officers', supported by rehabilitation psychiatrists and other clinicians are required for this role. Without them, many individuals become 'stuck' in placements unnecessarily with no clear care pathway back to their local area³⁹.
- Lack of clarity about commissioning and housing responsibility when individuals wish to settle in an 'out-of-area locality further complicates the situation. It highlights the importance of integrating commissioning between health and local council social care and housing resources for this group.
- 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.
- As stated in the Five Year Forward View⁴⁰ for Mental Health and the Commission on Acute Adult Psychiatric Care¹³, the provision of local care pathways for people with complex mental health needs is essential in order to minimise the use of out of area placements, unless clinical complexity is such that local provision would be unfeasible.
- Since there is geographical variation in sociodemographic characteristics and psychiatric morbidity, the exact components of the rehabilitation care pathway that will be required in different areas are likely to vary.
- More details on which components of the rehabilitation care pathway should be provided locally and which are more likely to be required at a regional level are given on pages 12-17.
- Commissioning of a local rehabilitation care pathway will be informed by the local Joint Strategic Needs Assessment for mental health, which should include data on individuals currently residing in out-of-area placements due to their complex mental health needs.
- Successful joint strategic commissioning of health and housing for this group will require good co-operation between commissioners, enhanced and supported by Health and Wellbeing Boards, and the alignment of resources from Clinical Commissioning Groups and local authorities to enable people to achieve their maximum level of independence⁴¹. Thinking more innovatively with housing providers can also produce good results in this regard.

What do we know about current mental health rehabilitation services?

While the Royal College of Psychiatrists' Faculty of Rehabilitation and Social Psychiatry has produced a template for mental health rehabilitation services (upon which this commissioning guidance is based)⁴², there is no nationally agreed service specification within the UK. Nevertheless, almost all NHS Trusts have at least one high dependency inpatient or community based rehabilitation unit and over half have a community rehabilitation team³.

Around 25% of the total mental health budget is absorbed by rehabilitation services and supported accommodation for people with longer term and complex mental health needs. This proportion expands to around 50% if the wider family of services that provide for this group are included (including standard general adult services). Much of this spending on rehabilitation falls within mainstream health and social care services¹⁰.

The importance of providing a local rehabilitation care pathway to minimise the use of out-of-area placements has been emphasised in a number of policy documents including:

- Guidance produced by the National Mental Health Development Unit for the Department of Health⁴³
- Mental Health and the Economic Downturn; national priorities and NHS solutions⁴⁴.

The implementation guide to the mental health strategy; *No Health Without Mental Health*³³ strongly supports investment in rehabilitation services:

"Commissioning rehabilitation services for people with complex, severe enduring mental illness: CCGs should work towards developing a local rehabilitation care pathway for people with complex mental health needs, which includes a range of rehabilitation inpatient care facilities. Such service developments would also aim to reduce the subsequent use of expensive out of area placements (OATs) and promote the social inclusion of these people closer to home."

Similarly, the supporting document to the mental health strategy, *The economic case for improving efficiency and quality in mental health services*⁴⁵, also emphasises the need for local investment in a rehabilitation care pathway to reduce the need for out of area placements.

The Mental Health Five Year Forward View⁴⁰ highlights that:

"People want care in the least restrictive setting that is appropriate to meet their individual needs, at any age, and is close to home. People living with severe mental health problems, such as schizophrenia or personality disorder, should not be held in restrictive settings for longer than they need to be. The NHS should expand proven community-

based services for people of all ages with severe mental health problems who need support to live safely and well, as close to home as possible. More 'step-down' help should be provided from secure care, such as residential rehabilitation, supported housing and forensic or assertive outreach teams".

These are very clearly key tenets of good rehabilitation psychiatry services as discussed. Achieving good interfaces with other parts of psychiatric services is essential.

A national survey of acute admissions was undertaken as part of the Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, and found that 16% of patients could have been treated in alternative settings. Rehabilitation services were identified as the most common alternative¹³.

The implementation plan of the Five Year Forward View for Mental Health⁴⁶ states that NHS England will be working with partners to develop evidence-based treatment pathways with the supporting infrastructure required to enable their implementation. Each of the pathways will be designed to span the journey from 'referral to recovery' and, from 2017-2019, evidence-based treatment pathways for community mental health care (encompassing referral to recovery pathways for psychosis, personality disorder, bipolar affective disorder and severe and complex common mental health problems) will be developed. Mental health rehabilitation services will be a key part of those pathways⁴⁶.

What would a good mental health rehabilitation service look like?

An effective rehabilitation service requires a managed functional network of services across a wide spectrum of care, the exact components of the care pathway provided should be determined by local need. These comprise:

- Inpatient and community based rehabilitation units
- Community rehabilitation teams
- Supported accommodation services
- Services that support service users' occupation and work
- Advocacy services
- Peer support services
- Robust arrangements for liaison with primary and secondary care services to monitor and manage physical health comorbidities.

Some of the components of the rehabilitation care pathway may be provided by independent and third sector organisations. Pathways through these services should be as seamless as possible, which will be dependent on good working relationships between the components. Commissioners play a key role in facilitating these relationships.

INPATIENT REHABILITATION SERVICES

An inpatient 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 involuntarily. All units should have access to the full range of skills of a multi-professional team and have strong links to a range of meaningful activity, which builds the person's confidence and skills, both on site and in the community.

As most rehabilitation service users will require lengthy inpatient treatment, 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.

Inpatient rehabilitation services require a range of different facilities that work as part of an interdependent system, rather than stand-alone units. Only the largest NHS Trusts will provide a full spectrum of inpatient rehabilitation services. Most will work with other providers in the independent sector or NHS to provide a comprehensive inpatient care pathway. Very specialist services, for example units for people with co-morbid conditions such as mental health problems and brain injury or autism spectrum disorders, can only be provided supra-regionally whereas those offering rehabilitation in high dependency and/or community rehabilitation units should be available locally.

A full range of inpatient services should be provided across the dimensions and types described below.

Typology of inpatient rehabilitation units: services commissioned by Clinical Commissioning Groups

High dependency (high support) inpatient rehabilitation

- Client group and focus: people who need this kind of facility will be highly symptomatic, with multiple or severe co-morbid conditions, significant risk histories and challenging behaviours. Most will be detained under the Mental Health Act. Around 20% will have had forensic admissions. The focus is on thorough ongoing assessment, maximising benefits from medication, engagement, reducing challenging behaviours and re-engaging with families and communities. These units have a major role in repatriating patients

from secure services and out-of-area placements to local services and, ultimately, to local community living.

- Recovery goal: to move on to community rehabilitation unit or to supported community living.
- Site: ward usually based in the local mental health unit to benefit from support from other wards and out-of-hours cover.
- Expected length of admission: up to 1 year*.
- Functional ability: domestic services provided by the unit, 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. One unit is needed for a population of 600 000 to 1 million.

Community rehabilitation units

- Client group and focus: people with complex mental health needs who cannot be discharged directly from hospital to an independent or supported community placement due to their ongoing high levels of need. The focus is on facilitating further recovery, optimising medication regimes, engagement in psychosocial interventions and gaining skills for more independent living.
- Recovery goal: to achieve a successful return to community living. Most people will move on to a supported tenancy.

* Where a local rehabilitation pathway provides either a high dependency unit or a community rehabilitation unit (rather than both), the expected length of stay may be up to 3 years.

- Site: local, community based unit providing a domestic environment that facilitates service users' confidence and abilities in managing activities of daily living (self-care, shopping, engagement in community based activities/vocational rehabilitation). Community rehabilitation units vary in whether or not they are designed to accept people detained under the Mental Health Act.
- Expected length of admission: 1-2 years.
- Functional ability: domestic environments that facilitate service users to acquire everyday living skills in preparation for more independent community living.
- Risk management: staffed 24 hours by nurses and support workers with regular input from other members of the multidisciplinary team. Specialist risk management skills are essential.
- Degree of specialisation: should be available in all Trusts. One unit is needed for a population of around 300,000.

Around one third of patients do not progress adequately to be able to move on to a community rehabilitation unit or supported accommodation. They will require transfer to a long-term, local high dependency or complex care unit to continue their rehabilitation.

Long-term high dependency (high support) units

- Client group and focus: high levels of disability from treatment refractory symptoms and/or complex co-morbid conditions that require a longer period of inpatient rehabilitation to stabilise. This group has significant associated risks to their own health and/or safety and/or to others.
- Recovery goal: to stabilise symptoms adequately such that function improves and move on to another component of the rehabilitation pathway becomes feasible. The emphasis is on promoting personal recovery and improving social and interpersonal functioning over the longer term.

- Site: ward based in the local mental health unit.
- Length of admission: up to 5 years.
- Functional ability: domestic services provided, although participation in domestic activities with support encouraged as part of therapeutic programme.
- Risk management: staffed to at least the same level as high dependency rehabilitation unit; risk management based on relational skills and environmental management.
- Degree of specialisation: should be available in all Trusts. One unit is needed for a population of around 600,000.

Long-term complex care units

- Client group and focus: patients will usually have high levels of disability from complex co-morbid conditions, with limited potential for gaining skills required for supported community living, and have associated, significant risks to the health and safety of themselves and/or others. Co-morbid serious physical health problems are common and will require ongoing monitoring and treatment.
- Recovery goal: other rehabilitation options will usually have been tried unsuccessfully; 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 over the longer term.
- Site: usually community-based, sometimes on a hospital campus.
- Length of admission: 5-10 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.
- Degree of specialisation: should be available in all Trusts. One unit is needed for a population of around 600,000.

Typology of inpatient rehabilitation units: services commissioned by NHS England at a regional or national level

Low secure rehabilitation units

- Client group and focus: this group has diverse needs but have all been involved in offending or challenging 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. Clients 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 move on to a high dependency or community rehabilitation unit.
- Site: hospital ward or unit within a hospital campus.
- Length of admission: at least 2 years; variable, depending on the nature of the offending or challenging 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: one unit is needed for a population over 1 million.

What would a good rehabilitation mental health service look like? (continued)

Highly specialist units

- These units provide specialist treatment programmes for people with very particular and complex mental health needs and co-morbidities (e.g. acquired brain injury, severe personality disorder, autism spectrum disorder).
- They are usually provided at a super-regional or national level and are therefore likely to be commissioned by the NHS England. However, some are provided by the independent sector and individual places can be agreed by the local Clinical Commissioning Group.
- A placement funding panel, comprising senior clinicians and representatives of the local Trust and Clinical Commissioning Group should agree such placements and ensure regular reviews are carried out to monitor ongoing need and identify individuals for repatriation to the local rehabilitation care pathway at the earliest opportunity³⁸.

NB. 'Locked rehabilitation units'

- The term 'locked rehabilitation unit' has not been formally specified and is not recognised as part of the typology of inpatient rehabilitation units described above. Commonly, such units are provided in the independent sector and most closely resemble a high-dependency rehabilitation unit.

COMMUNITY MENTAL HEALTH REHABILITATION SERVICES

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 treatment. Around 20% of service users presenting with a psychotic illness will go on to require rehabilitation services due to the severity of their functional impairment and symptoms^{1,2}.

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 their problems place them at risk of social isolation, self-neglect, relapse into acute illness, inability to cope and exploitation in community settings.

Over half the NHS Mental Health Trusts in England have a community rehabilitation team³. The skills of these teams ensure an ability to support service users with complex mental health and associated needs, to live successfully in the community, by correctly placing service users into the right provision for them, in close collaboration with them and their carers as to their wishes, in a personalised manner. Community rehabilitation teams provide a key 'WD40' role in keeping the whole system of supported accommodation moving, by supporting clients and supported accommodation providers to enable through-put. The teams' input to providers of accommodation often involves supporting them to maintain the service user in the community, despite risks and times of deterioration in mental health, in that setting. This can include direct training of the staff within supported housing in psychological and behavioural approaches to a range of behaviours and issues, including how to support activities of daily living in an incremental manner, medication management and monitoring and minimising risk effectively, in close liaison with clinicians. It is this triumvirate of the right physical space in the right place in the community, along with the right supported housing staff and skill set, along with proactive specialist rehabilitative secondary mental health care input, that leads to successful community living and on-going rehabilitation to step down further into more independent settings for service users. Supported housing staff often have very good

methods of linking service users into community, by supporting socially inclusive activities that further the service users' own goals.

Community rehabilitation services ideally take a census approach to all those in both health and social care funded placements and work with local commissioners and housing providers. This will ensure the right complement of housing and support is available in their locality and will facilitate a move through to the least restrictive, independent and socially inclusive setting, as close to home as possible at all times.

Referrals to community rehabilitation services are received from:

- Early intervention services
- Assertive outreach teams for clients who are now well engaged but have on-going problems with everyday living skills
- Community mental health teams for clients whose functional needs are too severe to be managed by general adult services
- Inpatient (general adult, rehabilitation, low and medium secure services), nursing and residential care homes (both local and out of area) for clients who are ready to move to a less supported, community based setting.

The main functions of community rehabilitation services are to:

- Co-ordinate care – around 15% of community rehabilitation teams provide full CPA care co-ordination²⁶, or this function is provided by the local community mental health team. The care co-ordinator provides continuity of care, and will often have known the service user for many years. They remain in contact if the service user is admitted to hospital and are involved in making referrals to appropriately

- supported accommodation prior to discharge, facilitating the person's access to appropriate welfare benefits, adult protection procedures, other legal issues including use of the Mental Health Act and Mental Capacity Act where necessary, and in all aspects of care planning required on discharge to the community.
- Use expertise in assessing to provide the right placement and care packages such as self-directed support, which facilitate sustained community living for service users with multiple, complex needs.
 - Provide support to service users and successfully manage the transition, as they move from hospital to supported accommodation and from higher to less supported accommodation.
 - Enable service users to gain confidence in their everyday living skills, their self-management of their illness and medication, and their day to day life.
 - Widen service users' social networks.
 - Support service users to build 'meaningful occupation' into their daily routine.
 - Promote therapeutic optimism in service users and plan for a potential move to a more independent setting. No service user is assumed to be in a placement likely to suit their needs forever.
 - Build and maintain partnerships with local providers of supported accommodation, education and vocational rehabilitation services, other community resources.
 - Work closely with commissioners to scope and review the ongoing supported accommodation needs of the local population.
 - Have expert knowledge of the availability, referral and funding processes required to access supported accommodation.
- Keep clear discharge criteria to ensure ongoing access for new service users.
 - Review service users placed out of area and work with other care teams and the service user, to understand their pathway and wherever possible, repatriation to their own locality.
 - Provide expert opinion and knowledge for service users with complex needs who are being supported by other teams. This might take the form of an 'in-reach' service to an acute admission ward or a liaison service where other mental health professionals can present their clients for advice about appropriate interventions and referral to supported accommodation services.
- The specific interventions provided by community rehabilitation services include:
- Holistic multidisciplinary assessment and formulation of individualised, collaborative care plans that enable recovery and social inclusion.
 - Clinical interventions to minimise symptoms (e.g. psychological interventions and support with medication management).
 - Practical support to enable service users to maintain their placement/tenancy (e.g. access to appropriate welfare benefits, help with budgeting, paying bills, assistance with activities of daily living such as shopping, cooking and cleaning).
 - Supporting service users to:
 - access appropriate physical and dental health care, including attending primary and secondary medical care appointments
 - access social, cultural and leisure activities, as well as education and vocational resources
 - (re)engage with family and friends
 - access personal budgets as appropriate to support their individualised recovery goals.
- Providing support to:
 - service users' families and other informal carers
 - staff in supported accommodation to increase their confidence in managing people with complex mental health problems.
- Out of area placement review**
- This can be effected through a dedicated team, or individuals within a community rehabilitation service, depending on the number of clients placed out of area³⁹.
- The aims of the review are to:
- Ensure that the placement continues to meet the person's needs.
 - Identify an appropriately supported, (ideally more independent) placement for the service user to move-on to in the future ideally in their area of origin (where desired and clinically indicated).
 - Identify with the service user and the staff of the out of area placement clear goals for progression through the pathway being identified (e.g. managing medication more independently, self-catering, budgeting).
 - Facilitate assessment by the potential move-on accommodation provider at an appropriate time.
 - Liaise with all parties, including family members, and support the service user and family practically and emotionally through the assessment and move-on process, including visits, transitional leave and final move.
 - Continue to review the new placement if out of area, or hand over case to local community mental health/rehabilitation service after an appropriate settling period.

What would a good rehabilitation mental health service look like? (continued)

TREATMENTS AND INTERVENTIONS DELIVERED BY INPATIENT AND COMMUNITY MENTAL HEALTH REHABILITATION SERVICES

Mental health rehabilitation inpatient and community services are staffed by multidisciplinary teams with the expertise to address the complex and diverse treatment needs of their service users. Ideally, some staff provide continuity of care by working across inpatient and community settings. All staff deliver their specialist interventions within the collaborative framework of the recovery approach. Given the complexity of the client group, the team should have access to regular group and individual supervision to share concerns and problem solve. Wherever possible, specific interventions are delivered in accordance with NICE guidance⁴⁷. Several chapters in the second edition of *Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry (2nd Ed)* detail effective, evidence-based interventions in this service user group⁴⁸.

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 or physically harmful side-effects is a key skill for rehabilitation psychiatrists. Special expertise in the use of clozapine, other atypical antipsychotic medications and mood stabilisers and the use of a combination of therapies is a key competence. Their expertise in managing treatment resistant conditions means that rehabilitation psychiatrists are also called on to review patients in other parts of the service and to advise colleagues on treatment. They also identify when referral to a tertiary service for very specialist advice and treatment is required (such as the National Psychosis Unit, South London and the Maudsley NHS Foundation Trust).

Psychological interventions

Psychological therapies (such as cognitive behaviour therapy for psychosis and family interventions) promote communication and understanding of an individual's mental health problems and identify strategies that can be helpful in reducing distress and unhelpful interaction patterns. Individual 'timelines' or 'life charts' are useful tools to help service users, professionals, and family carers gain a deeper understanding of an individual's personal experience and the triggers that have precipitated relapses. This information can be usefully incorporated into individualised care plans and Wellness Recovery Action Plans. Clinical psychologists also offer consultation to the staff team to develop psychological formulations of the service users' difficulties, which support positive relationships between staff and service users, therapeutic optimism and creative interventions. Whenever possible, staff work with service users to help them develop self-management strategies. Clinical psychologists may also provide training and supervision to other staff to provide 'low intensity' psychological interventions, such as behavioural activation, anxiety management and relaxation techniques, relapse prevention, and motivational interviewing for co-morbid substance misuse (ref chapter 8 in the *Enabling Recovery* textbook)⁴⁸.

Arts Therapies

Arts Therapies (art, drama, music, dance) are delivered in around one third of inpatient rehabilitation units across England²⁶. Arts therapies combine art and psychotherapeutic techniques to enable service users' communication, expression and understanding in the context of an interpersonal therapeutic relationship as part of the recovery process. Arts Therapies for the treatment of negative symptoms of schizophrenia are supported by NICE Guidelines⁴⁷.

Healthy living

Guidance and support to improve unhealthy lifestyles (such as exercise, smoking cessation and dietary advice) and monitoring of physical health are an essential component of a high quality rehabilitation service. All members of the team may be involved in promoting healthy living. A coaching approach or motivational interviewing style may be most helpful in enabling self-management of physical health. Psychologists can also provide interventions specifically to facilitate improved physical health e.g. where there is a psychological barrier such as fear of a procedure or relational issues in terms of engagement in physical health professionals. Medical team members lead on physical health assessment and appropriate referral and treatment for co-morbid physical health problems. This is especially relevant in relation to regular screening for known side effects of medication. As individuals progress towards community living, liaison with general practitioners and agreement about which doctor (primary or secondary care physician) will undertake routine physical health monitoring, and how results will be shared between services is crucial to ensure early identification and treatment of any physical health issues. Robust arrangements should be established between longer term community based rehabilitation units and local primary care services to assess, manage and monitor physical health.

Self-care, everyday living skills and meaningful occupation

Nurses, support workers and occupational therapists are key to helping service users gain/regain the confidence and routine involved in managing their medication and activities of daily living (self-care, keeping their living space clean, laundry, shopping, budgeting, cooking). They also support service users to access and engage with community leisure activities

(e.g. cinema, sport) and vocational rehabilitation activities (e.g. education, training and employment). Occupational therapists can identify specific functional problems that the service user may have and contribute to care plans to address these. They will often organise and facilitate individual and group activities on inpatient and community rehabilitation units and develop links with local resources to facilitate community based activities. Techniques such as motivational interviewing and behavioural programs, supervised by clinical psychologists, can be particularly helpful in assisting staff to engage clients with severe negative symptoms who struggle with motivation. Individuals may also require specific psychological or pharmacological interventions to address comorbidities, such as anxiety or agoraphobia, in order to facilitate their progress in gaining living skills and engaging with meaningful community activities.

SUPPORTED ACCOMMODATION SERVICES

People with mental health problems need good quality housing and appropriate support to facilitate their recovery and improve their ability to manage independent living in the future. People with mental health conditions are twice as likely as those without to be unhappy with their housing and mental ill health is frequently cited as a reason for tenancy breakdown. Housing problems often contribute to the stresses that lead to relapse of mental health problems and admission to hospital, and lack of availability of suitably supported accommodation often contributes to delayed discharges. A national survey of inpatient rehabilitation services found that 14% of people were ready for discharge but awaiting a vacancy in suitably supported accommodation¹¹.

The provision of supported housing is therefore an important factor in enabling the social inclusion of this group.

In England it is estimated that around 60,000 people live in some form of specialist mental health supported accommodation. However there has been little empirical research to clarify the most effective models to support people in their recovery.

Most supported accommodation pathways are designed for service users to move to more independent settings as their skills improve. This allows for graduated 'testing' but many users dislike repeated moves. Recently, there has been increased investment in supported flats rather than group settings since many services users prefer their own independent living space, though some service users and family members have reported that independent tenancies are socially isolating.

A national survey of acute admissions, undertaken as part of the Commission on Acute Adult Psychiatric Care¹³, found that, on average, 16% of patients could have been treated in alternative settings, with rehabilitation services being named as one of the most common alternatives. Also on average, 16% of patients per ward were identified as delayed discharges, due most commonly to issues with housing and transferring service users to rehabilitation services and community capacity/ resources. Thus housing is an issue for service users on acute wards too as is access to the often rationed resource of rehabilitation wards.

In the absence of a clear evidence base, most localities provide a spectrum of supported housing designed to meet local needs. These need to be developed in partnership with health, local authorities, independent and third sector providers and in reference to the Joint Strategic Needs Assessment and will include:

- Nursing and residential care homes.
- Supported housing; group, shared or individual tenancies with staff on-site.
- Floating outreach services that provide visiting (off-site) support to individuals in independent tenancies.

Further guidance on commissioning local specialist mental health supported housing services will be published in 2017.

SERVICES THAT SUPPORT OCCUPATION AND WORK

Supporting people with mental health problems to access meaningful occupation and work is important in helping to maximise their recovery, since occupation forms an important part of everybody's personal and social identity. Although occupation is often equated with work, employment rates for people with severe mental health problems are very low. This is due to many reasons including the functional impairments associated with the illness, discrimination by employers, and the 'benefits trap' that can make part-time and graduated working financially unviable. A major focus of rehabilitation services is the facilitation of service users' meaningful occupation, including hobbies, leisure activities and social engagements, through to educational and vocational courses, voluntary, supported and paid employment. Occupational therapists play a key role here in making links with local community resources (e.g. cinemas, gyms, colleges and employment organisations) and, along with nursing staff, support workers and activity workers, in supporting service users to access and engage with these. It is vital that occupational care plans are developed with service users to reflect their interests and goals and that there is recognition that not all service users are able, or wish, to work.

What would a good rehabilitation mental health service look like? (continued)

There are two main types of vocational rehabilitation service – prevocational training and supported employment. The National Institute of Clinical Excellence recommend that supported employment programmes should be provided for people with schizophrenia who wish to return to work or gain employment. However, they should not be the only work-related activity offered when individuals are unable to work or are unsuccessful in their attempts to find employment⁴⁹.

- **Individual Placement and Support (IPS)** aims to get people with mental health problems into competitive employment through training and support on the job. Some IPS services also help clients develop their CVs, conduct mock interviews (including 'how to' disclose a mental health problem), and provide longer term support such as mentoring and coaching, whereas in other areas these supportive functions are carried out by other specialist employment services for people with mental health problems⁵⁰.
- **Prevocational training programmes** provide preparatory work training in a sheltered environment to help service users become re-accustomed to working and to develop the skills necessary for later competitive employment. Some services (particularly the 'Clubhouse' model) offer transitional employment schemes which provide time limited work experience in a mainstream employment setting.
- **Welfare benefits advice services** should be available to provide independent and free benefits advice to address service users' concerns about the impact on their benefits of entering into employment, and to ensure they are claiming all the benefits they are eligible for. Access to debt advice can also be beneficial for some service users.

- **Volunteering services** can also assist people in getting back into employment through part-time, flexible posts that help them learn new skills, gain confidence and reduce social isolation.

ADVOCACY SERVICES

These provide independent advice and support to people with mental health problems to get their voice heard and have their rights protected. Advocacy can be paid for or provided voluntarily. It can be provided on an individual, one to one basis, or through self-advocacy, group or peer advocacy. Some people who are subject to either the Mental Health Capacity Act or Mental Health Act are entitled to access formal advice from an Independent Mental Capacity Advocate (IMCA) or Independent Mental Health Advocate (IMHA).

PEER SUPPORT SERVICES

This involves the use of people with experience of mental health problems to provide individualised support and expertise about treatment and care to people with mental health problems. This is an evolving field which is recognised within policy as having the potential to transform the outcomes of people with mental health problems, and where a number of services are already reporting positive experiences⁷. The evidence base for peer support reflects the fact that this is an initiative in its early stages in the UK, with some studies concluding that peer support may lead to a reduction in admissions and health improvements⁵¹.

ASSESSING THE EFFECTIVENESS AND QUALITY OF MENTAL HEALTH REHABILITATION SERVICES

Metrics that can be used to assess the demand for mental health rehabilitation services and the quality of response to referrals, include the number of referrals, time from referral to assessment and time from acceptance to transfer to a mental health rehabilitation facility.

Length of stay in each component of the inpatient rehabilitation care pathway and supported accommodation will help assess whether the whole system is working effectively. Similarly, readmissions and placement breakdowns will identify where discharge plans have not provided adequate support.

Use of the ICD-10 diagnoses is important to record and understand the co-morbid conditions and the interplay between them, on admission to rehabilitation services and on discharge. This must include both mental health and physical health diagnoses, in order to ensure needs are adequately met to support ongoing successful rehabilitation and recovery.

In addition to the Health of the Nation Outcome Scale (HoNOS), and service user satisfaction scales used across all mental health services (the 'Family and Friends Test'), two Clinician Rated Outcome Measures (CROMs) are recommended by the RCPsych's Faculty of Rehabilitation and Social Psychiatry. Both are free to use:

A The Camberwell Assessment of Needs Short Appraisal Schedule (CANSAS)⁵²

This is a widely used, brief and easily completed measure which has good psychometric properties. It reports on met, unmet and total needs in 22 domains and may be especially important for rehabilitation services to evidence the degree to which they are addressing service users' complex problems (i.e. by increasing the

proportion of met to unmet needs) even when total needs do not change (as is often the case for people with complex needs).

B The Life Skills Profile (LSP)⁵³

This is a widely used, standardised measure of social function with good psychometric properties. It is completed by a member of staff who knows the client well and takes around 10 minutes to complete.

The Joint Commissioning Panel recommends **DIALOG⁵⁴** as the main Patient Reported Outcome Measure (PROM). This is a standardised, seven item tool that assess quality of life on seven domains. It has been developed to be completed collaboratively through discussion between the staff member and the service user and can thus be used to feed into care planning. An app is also being developed to facilitate data collation and feedback at the individual and team level.

Further details of the metrics and outcome measures recommended for mental health rehabilitation services can be found in the Rehabilitation Faculty's forthcoming Occasional Paper on Recommended Outcomes.

SERVICE QUALITY

The Royal College of Psychiatrists' Centre for Quality Improvement has an established accreditation programme for inpatient mental health rehabilitation units, which functions similarly to its other 'AIMS' (Assessment of Inpatient Mental Health Services) Programmes. The **AIMS Rehab⁵⁵** programme provides a comprehensive quality assessment of units registered with them, that includes assessment of quality standards agreed by an expert reference group through review of policies, processes and protocols, interviews and assessments with staff, service users and carers and a visit by

a peer assessment team (rehabilitation practitioners and service users from another organisation). The Care Quality Commission increasingly note AIMS accreditation as a key part of the evidence in their assessment of inpatient units.

The Quality Indicator for Rehabilitative

Care (QuIRC) is a web based self-assessment tool for mental health rehabilitation wards and community based rehabilitation facilities that provide 24-hour support to people with longer term mental health problems^{56,57}. It is completed by the manager of the facility and has been validated against service user experiences of care. It has excellent psychometric properties, is free to use and takes 45-60 minutes to complete. It provides a printable and accessible report of the unit's performance showing its percentage scores, and those of similar units across England, on seven domains of care (Living Environment; Therapeutic Environment; Treatments and Interventions; Self-management and Autonomy; Human Rights; Social Inclusion; Recovery Based Practice). The QuIRC has been incorporated into the AIMS Rehab programme and was used in a recent national programme of research into inpatient mental health rehabilitation services across England. Thus, national quality benchmarking data are now available for inpatient mental health rehabilitation units.

Supporting the delivery of the Five Year Forward View for Mental Health

The Five Year Forward View for Mental Health sets out the steps that are needed for a transformation of NHS mental health care with a particular focus on tackling inequalities at local and national level, for those who are disproportionately affected by mental health problems, including those who already face discrimination. Commissioning that leads to the effective planning and management of mental health rehabilitation services will support the delivery of the Five Year Forward View for Mental Health⁴⁰.

Commissioning for prevention and quality care

Rehabilitation services work with patients to improve their ability to manage their own lives, build stronger social relationships, have a greater sense of purpose, have the skills they need for living and working, have improved chances in education, better employment rates, and a suitable and stable place to live. Commissioning high quality rehabilitation services will help achieve this priority, since more people with complex mental health needs will be properly cared for in appropriate settings with good physical health care as well as good mental health and social care.

Good quality care for all 7 days a week

A coordinated system that can provide appropriate rehabilitation for people with the most severe mental health problems results in gradual recovery and successful community living. Commissioning high quality rehabilitation services will help achieve this objective, as people will receive recovery-oriented care in settings which are appropriate for their level of need and as close to home as possible.

This guide describes the outline of a comprehensive pathway and quality standards for rehabilitation psychiatry, as recommended in the Five Year Forward View for Mental Health⁴⁰.

Innovation and research to drive change now and in the future

It is essential that as future models of mental health and integrated service provision are developed, that the place and role of rehabilitation services are not omitted from policy and service planning, as has been the case historically. The development of new models of care and a more integrated approach to mental and physical healthcare, social and healthcare and primary and secondary care (triple integration) is currently underway.

Strengthening the workforce

Ensuring there is qualified and appropriately trained mental health rehabilitation staff will strengthen the NHS workforce. Mental health rehabilitation services require multidisciplinary staffing, with a team that has the expertise to address their service users' complex and diverse needs including: complex medication regimes; physical health promotion; psychological interventions, arts therapies; self-care; everyday living skills; and meaningful occupation.

A transparency and data revolution

The quality and effectiveness of rehabilitation service provision can be assessed with simple indicators and standardised outcome tools. This guidance recommends outcome measures and indicators that can be used to monitor the quality of services, flow through the care pathway and better service user outcomes.

Incentives, levers and payment

Sustainable services that enable access to mental health rehabilitation services will have payment models that incentivise quick access, high quality care and good outcomes, and will help to reduce avoidable crises.

Fair regulation and inspection

Commissioning high quality rehabilitation services will help achieve this objective, as it requires systems to be in place which continually monitor the appropriateness of care settings and treatments.

Leadership inside the NHS and across Government

Leaders should ensure rehabilitation services are commissioned across the NHS, to ensure patients benefit from effective and responsive treatment that will enable them to have the best possible outcomes and reduced health and social care costs.

A rehabilitation approach is essential for the successful treatment and outcomes of people with longer term complex psychoses and for the whole psychiatric system to work well. This guide has described how commissioners and service providers need to develop a whole-system approach for patients with complex psychosis, which delivers effective and efficient rehabilitation services.

Rehabilitation Mental Health Services Expert Reference Group Members

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Development process

This guide has been written by a group of rehabilitation mental health service experts, in consultation with patients and carers. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts. Final revisions to the guide were made by the Chair of the Expert Reference Group in collaboration with the JCP's Editorial Board (comprised of the two co-chairs of the JCP-MH, one user representative, one carer representative, and technical and project management support staff).

Resources

Quality Indicator for Rehabilitative Care (QuIRC) www.quirc.eu

National Mental Health Development Unit – toolkit to reduce the use of out-of-area mental health services www.rcpsych.ac.uk/PDF/insightandinmind.pdf

Social Care Institute for Excellence – personalisation resources www.scie.org.uk/topic/keyissues/

Royal College of Psychiatrists – Accreditation for Inpatient Mental Health Services: rehabilitation www.rcpsych.ac.uk/quality/qualityandaccreditation/psychiatricwards/aims/whygetaccredited/aims-rehab.aspx

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