Delivering a Whole System Approach to Mental Health Rehabilitation

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Who needs mental health rehabilitation?

- **People with particularly complex problems**
- **> 80% have psychosis**
  - Treatment resistant 'positive' symptoms, severe 'negative' symptoms
  - Cognitive impairments
  - Co-existing problems
    - intellectual disability/developmental disorder/trauma-attachment problems
    - physical health comorbidities, other mental health symptoms, substance misuse problems
- Severe difficulties in social and everyday **function** (ADLs and community)
- Highly **vulnerable** to self-neglect (49-72%) and exploitation (25-41%) (Killaspy et al., 2013; 2016)
- Long periods in hospital and high community support needs
- Absorb up to **50% of mental health/social care budget** (Mental Health Strategies, 2010)
- **15-27% of people with first episode psychosis develop complex problems**

(Craig et al., 2004; Menezes et al., 2006; Friis, 2011)

The 'whole system' mental health rehabilitation pathway

"*A **whole system** approach to recovery from mental ill health which maximizes an individual's **quality of life and social inclusion** by encouraging their skills, **promoting independence and autonomy** in order to give them **hope** for the future and which leads to **successful community living** through appropriate support.*"
(Killaspy et al, 2005)

Complex medication regimes
Physical health
OT – ADLs and occupation
Psychosocial interventions
Recovery orientation
Therapeutic optimism
Long term view

Referrals
Acute inpatient wards (80%)*
Forensic units (20%)

Inpatient and community rehabilitation units

Mental health supported accommodation
Residential care
Supported housing
Floating outreach

Clinical Input
Community Rehabilitation Teams
Primary Care

Greater autonomy

> 10 years

1-3 years

> 5 years

inpatient → **community**

Good evidence for rehabilitation care pathway

Most people with complex psychosis do well when they have access to a rehabilitation pathway (inpatient rehabilitation, supported accommodation services, community teams)

Case control study - Ireland

- **Lavelle et al (2012) – 5 centres**
  - 8 times more likely to be discharged from hospital than controls
  - Greater improvements in social and everyday functioning than controls

Cohort studies - England

- **Killaspy et al (2016) – REAL Study (50 inpatient rehabilitation units, >350 service users)**
  - 57% successfully discharged from inpatient rehabilitation services to supported accommodation within 2 years (+ 14% ready for d/c)
- **Killaspy et al (2018) – QuEST Study (90 supported accommodation services, >600 service users)**
  - 38% progressed successfully to more independent accommodation over 30 months
- **Killaspy and Zis (2012) – North London**
  - 67% sustained successful community discharge over five years
  - NB - only 10% achieve fully independent accommodation

Drivers of better outcomes in mental health rehabilitation

Predictors of outcome	OR (95% CI)	Study
Successful discharge from hospital associated with greater:		
• social skills	1.13 (1.04 to 1.24)	**REAL**
• engagement in activities	1.04 (1.01 to 1.08)	
• recovery orientation of service	1.03 (1.01 to 1.05)	
Successful move on to more independent accommodation associated with greater:		
• human rights promotion of service	1.09 (1.02 to 1.16)	**QuEST**
• recovery orientation of service	1.06 (1.00 to 1.11)	

Recovery orientation domain

Therapeutic optimism
Expected maximum length of stay
Collaborative, individualised care planning
Strengths based approach
Supporting the person to gain/regain ADL skills
Service user involvement in running the service
Ex-service users employed in the service

Human rights domain

Access to legal representative
Access to advocate
Assistance to vote in elections
Privacy/dignity
Confidential case notes
Access to communication (phone, email)
Complaints procedures

QuIRC™
QUALITY INDICATOR FOR REHABILITATIVE CARE
The Measure of Best Practice in Facilities for People with Complex Mental Health Issues

Cost benefits of rehabilitation services

Bunyan et al. *BJPsych Bull* 2016; 40:24-28

22 people discharged from inpatient rehabilitation unit

Mean (SE) bed days 2 year prior to inpatient rehabilitation	= 380 (56)	= £66,000/yr
Mean (SE) bed days 2 years after inpatient rehabilitation	= 111 (52)	= £18,000/yr
Mean (SE) bed days on rehabilitation unit	= 700 (385)	= £74,000/yr

Extrapolation

100 people with complex mental health needs

10 year trajectory (3 years before rehab, 2 years in rehab unit, 5 years post rehab)

67/100 do well @ cost ~ **£30m**

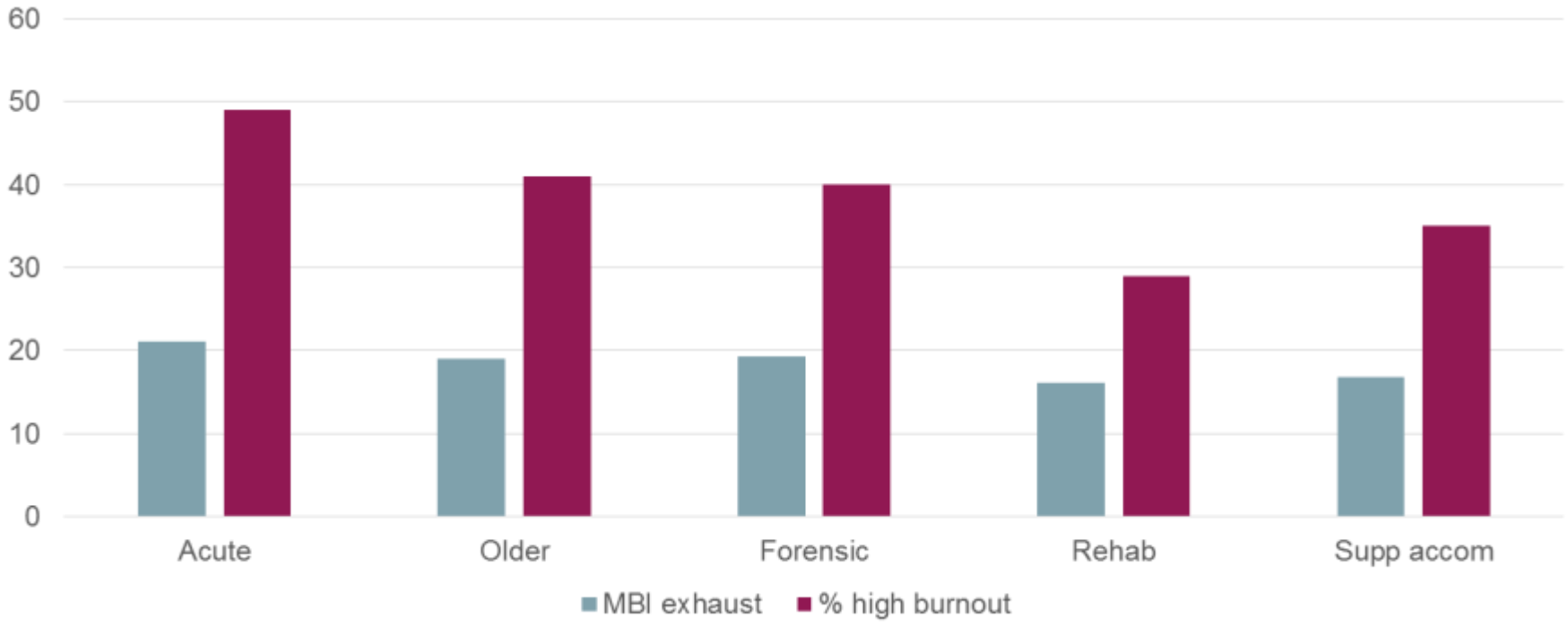
33/100 don't do well @ cost ~ **£22m**

Total cost for 100 people **with rehabilitation services in place ~ £52m**

Total cost for 100 people **with no rehabilitation services in place ~ £66m**

Staff morale: mental health inpatient wards and supported accommodation* staff across England

Johnson et al, *BJPsych* 2012; *Dowling, PhD thesis (2020)



Reductions in NHS mental health rehabilitation services (Royal College of Psychiatrists' Rehabilitation Faculty surveys)

Since 2003:

- 61% of UK NHS inpatient rehabilitation services report disinvestment
- Around half of all NHS rehabilitation units closed (~75)
- Shift in provision to supported accommodation services with clinical input from community teams
- Increased implementation of community rehabilitation teams (from 15% to 51% of NHS Trusts)
- Expansion of inpatient rehabilitation services in the independent sector

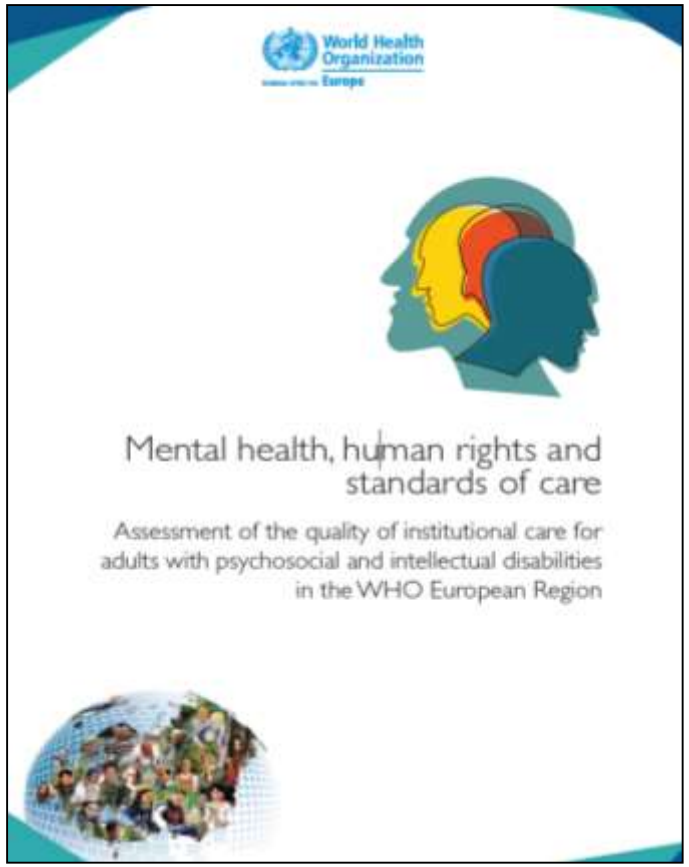
Care Quality Commission, 2018
Comprehensive inspections of all mental health providers 2014-2017

There are a 'high number of people in 'locked rehabilitation wards'. 'These wards are often situated a long way from the patient's home….In a number of cases we found that these hospitals did not employ staff with the right skills to provide the high-quality, intensive rehabilitation care required to support recovery.'

- 5000 rehabilitation beds
- *> 50% in private sector*
- *Total cost > £500m*
- *Length of stay and cost in private sector = **twice** local NHS rehabilitation services*

'Too often, these…rehabilitation hospitals are in fact long stay wards that institutionalise patients, rather than a step on the road back to a more independent life in the person's home community.'

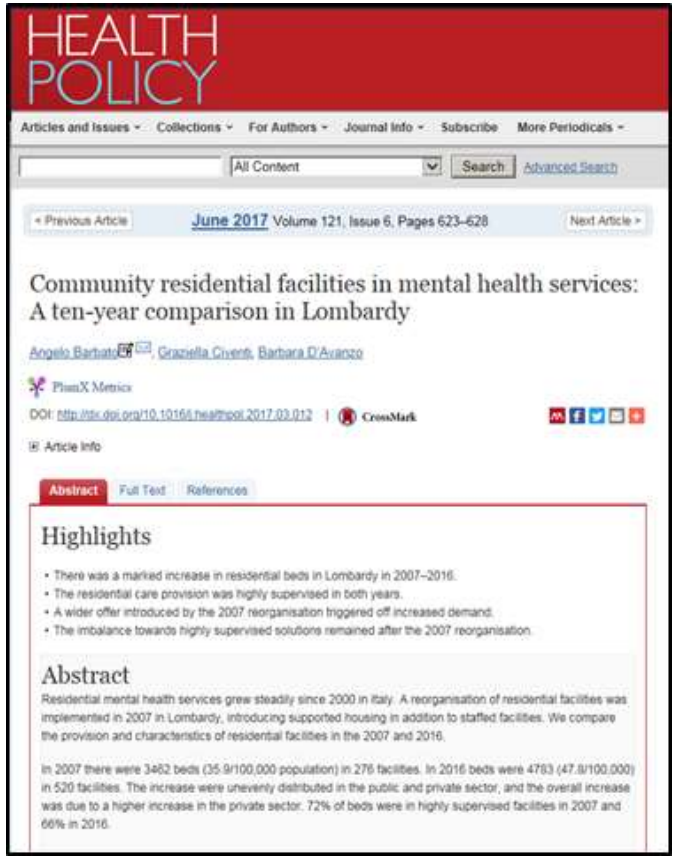
WHO 'Quality Rights' Survey: longer term mental health facilities in 25 European countries (WHO, 2018)



- Lack of knowledge about mental health and the protection of human rights
- Lack of a personalised approach to care
- Lack of rehabilitative activities
- Lack of legal provisions or legal representation
- Lack of community alternatives for move-on

Albania, Armenia, **Austria**, Azerbaijan, **Belgium**, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, **Denmark**, Estonia, **Finland**, Georgia, **Germany**, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, **Luxembourg**, Poland, **Portugal**, Republic of Moldova, Romania, Serbia, Slovakia, Slovenia, **Switzerland**, the former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine

Tendency towards institutionalisation, even in community settings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Community residential facilities in mental health services: A ten-year comparison in Lombardy

Angelo Barbato, Graziella Civenti, Barbara D'Avanzo

PlumX Metrics

DOI: http://dx.doi.org/10.1016/j.healthpol.2017.03.012 | CrossMark

Article Info

Abstract · Full Text · References

Highlights

- There was a marked increase in residential beds in Lombardy in 2007–2016.
- The residential care provision was highly supervised in both years.
- A wider offer introduced by the 2007 reorganisation triggered off increased demand.
- The imbalance towards highly supervised solutions remained after the 2007 reorganisation.

Abstract

Residential mental health services grew steadily since 2000 in Italy. A reorganisation of residential facilities was implemented in 2007 in Lombardy, introducing supported housing in addition to staffed facilities. We compare the provision and characteristics of residential facilities in the 2007 and 2016.

In 2007 there were 3462 beds (35.9/100,000 population) in 276 facilities. In 2016 beds were 4783 (47.8/100,000) in 520 facilities. The increase were unevenly distributed in the public and private sector, and the overall increase was due to a higher increase in the private sector. 72% of beds were in highly supervised facilities in 2007 and 66% in 2016.

Italy: survey of 'community residences' in Lombardy, Italy

(Barbato et al, *Health Policy*, 2017)

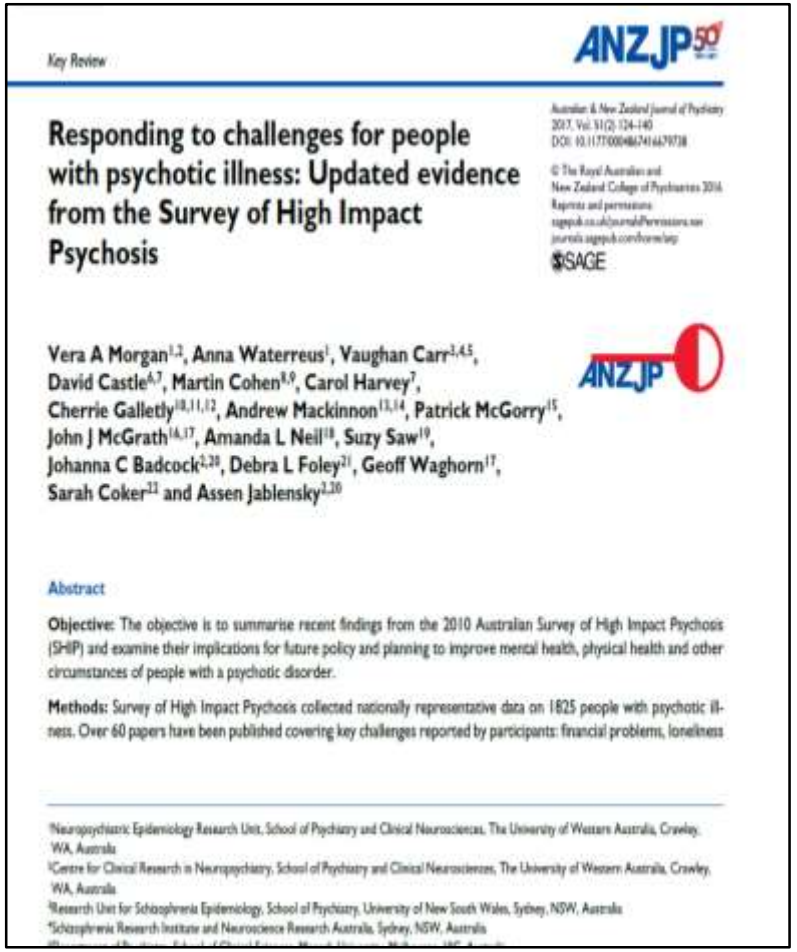
- Last 10 years - 88% increase in community residences (276 to 520) and 38% increase in number of places (from 3462 to 4783)
- Most expansion in private sector (care vs treatment)
- Concerns about lack of rehabilitative and recovery ethos

Inadequate community care

Australia - Survey of High Impact Psychosis

(Morgan et al, *ANZJP*, 2016)

- Few inpatient services, increasing involvement of NGOs in providing community care
- Sub-optimal treatment
  - Polypharmacy (63%)
  - Under use of clozapine, employment support and other evidence based psychosocial interventions
  - Poor physical health and low access to physical healthcare
  - High rates of social isolation
  - Increasing levels of homelessness



Key Review

ANZJP 50

Responding to challenges for people with psychotic illness: Updated evidence from the Survey of High Impact Psychosis

Australian & New Zealand Journal of Psychiatry 2017, Vol. 51(2) 124-140
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ANZJP

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Abstract

Objective: The objective is to summarise recent findings from the 2010 Australian Survey of High Impact Psychosis (SHIP) and examine their implications for future policy and planning to improve mental health, physical health and other circumstances of people with a psychotic disorder.

Methods: Survey of High Impact Psychosis collected nationally representative data on 1825 people with psychotic illness. Over 60 papers have been published covering key challenges reported by participants: financial problems, loneliness

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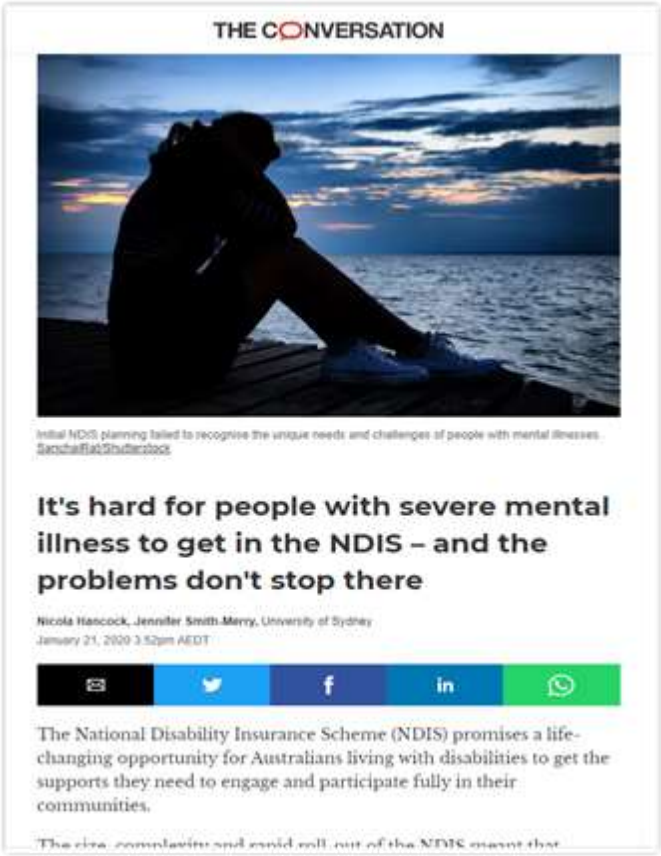
Discriminatory welfare benefits systems

UK Govt data on 327,000 people who switched from DLA to PIP between 2013 and 2016: People with a mental health condition were 2.4 times more likely than those with diabetes, back pain or epilepsy to lose their entitlement.



Key drivers for delivering whole system mental health rehabilitation

1. **Supportive policy**
2. **Guidelines**
   - Commissioners are accountable for commissioning services that can deliver the treatments and interventions recommended by NICE
   - Service providers are responsible for delivering them
   - Commissioners and providers can be challenged about threats to existing services and lack of local provision
3. **Service planning principles**
   - Mental health systems should include **local** rehabilitation services for those with the most complex needs
   - Rehabilitation takes time - need **long term service planning** for this group
   - Systems must **avoid perverse incentives**/financing structures that lead to institutionalisation and marginalisation
4. **Integrated systems (health, social care and voluntary sector)**

1. Policy

- Recent mental health policy has focussed on **public mental health promotion** and **early intervention -** most factors associated with developing more complex needs are not amenable to this focus (pre/perinatal 'soft' brain injury, male, younger age of onset, insidious onset, severe negative symptoms, multiple co-morbidities)
- Lack of acknowledgment of this group in policy has been **highly detrimental**
- By definition, those with complex needs require **longer term, specialist** approach
- **NHS policy 2020** (NHS Long Term Plan): New integrated models of primary and community mental health care will include '***maintaining*** *and* ***developing new services*** *for people with the most complex needs*'

2. The first NICE Guideline for Mental Health Rehabilitation

Rehabilitation in adults with complex psychosis and other severe mental health conditions

In scope

- Primary diagnosis of psychosis **plus**
- Severe, treatment refractory symptoms (positive and negative) **and/or**
- Comorbid conditions (mild/borderline ID, developmental disorders, other mental health conditions, physical health conditions, substance misuse) **and**
- Impaired function - ADLs, interpersonal and occupational

Out of scope

- Primary diagnosis of common mental disorder (depression without psychosis, anxiety), personality disorder, obsessive compulsive disorder, eating disorder, substance misuse problems, or moderate to severe ID

Mental Health Rehabilitation NICE Guideline - areas covered

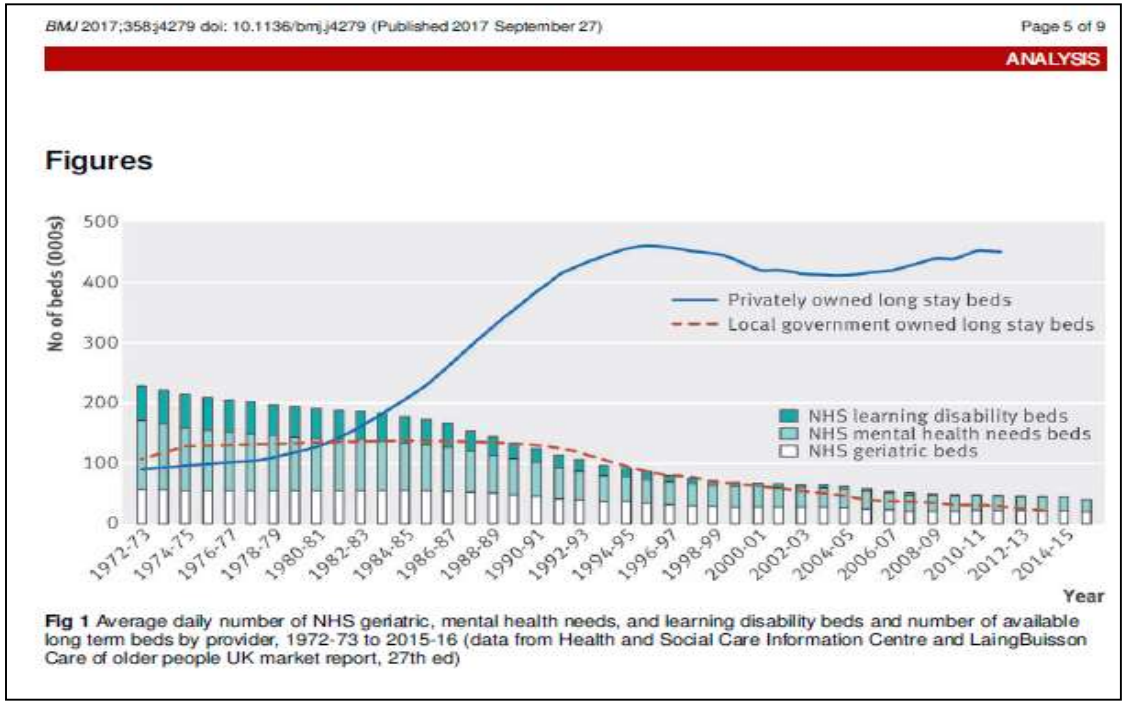
- **Identifying people** who would benefit most from mental health rehabilitation services
- **Organisation, function and structure of services** (inpatient and community rehabilitation units and community rehabilitation teams, supported accommodation)
- **Delivering optimised treatments** for people with complex psychosis and other severe mental health conditions to help recovery and prevent relapse
- **Collaborative care planning** and improving **service user and carer experience**
- **Therapeutic programmes specific to rehabilitation**:
  - activities of daily living (self-care, cooking, cleaning, shopping, budgeting, maintaining a tenancy)
  - interpersonal functioning and social skills
  - vocational rehabilitation (leisure, education and work)
  - healthy living (diet, weight, exercise, sleep, oral health, health monitoring, accessing health services, self-medication programmes, cessation programmes for smoking and substance misuse)
- Types of **supported accommodation -** features that promote successful community living
- Criteria and processes relating to **transition from rehabilitation services** to other parts of the mental health system or primary care

3. Service planning

- Beware market forces
- Resist economic pressures to cut
- Adjust procurement cycles -

  support investment in longer term care pathways
- Avoid fashionable trends –

  need both inpatient and community services i.e. balanced care model (Thornicroft & Tansella, 2004)



Sutaria, Roderick, Pollock et al, *BMJ*, 2017, 358; j4279

4. Integrated systems

- Integrated Care Systems are all the rage in England!
- Aim to encourage localism and adapt resources to community needs
- Mental health services are more advanced with regard to integrated systems than physical health services
- Organisational level – shared vision/strategy, shared health and social care budgets – shared financial risks.
- Service level – much less clear but key operational elements:
  - Clarity regarding each partner's remit and responsibilities
  - Regular interface meetings to discuss individual service users' transitions through the pathway, avoid silo thinking, build on the shared vision, avoid boundary disputes and cost shunting, support each other

Integrated rehabilitation service models – the way forward or a fashionable trend?

Tile House - an innovative partnership between statutory and non-statutory services

- 24 hour supported accommodation (sleeping night staff)
- Building and support staff provided by voluntary organisation
- 12 individual, self-contained one bedroom flats
- Clients have tenancies and pay rent through housing benefit
- Clinical staff provided by NHS mental health Trust:
  1.0 nurse, 0.025 psychiatrist, 0.2 psychologist, 0.4 OT
- Clinical staff employed by NHS Trust (protects their pension and employment rights, access to CPD etc)

Tile House

Benefits

- Promotes common values and language
- Complementary staff skills and strengths
- Shared learning
- Greater and broader collaborative care planning with service users
- Enables clients with very complex needs to live successfully outside hospital
- Part funded by repatriation of people placed in out of area beds
- Economically efficient?

Challenges

- Gatekeeping – who decides?
- Tensions between clinicians and non-clinicians in agreeing appropriate response to challenging behaviour
- Tensions in understanding the boundaries/remit of each others' roles
- Practical issues – lack of access to NHS electronic records
- Isolating for clinicians
- Expensive
- Lack of move-on and many relapses

Alternative approach - community rehabilitation teams

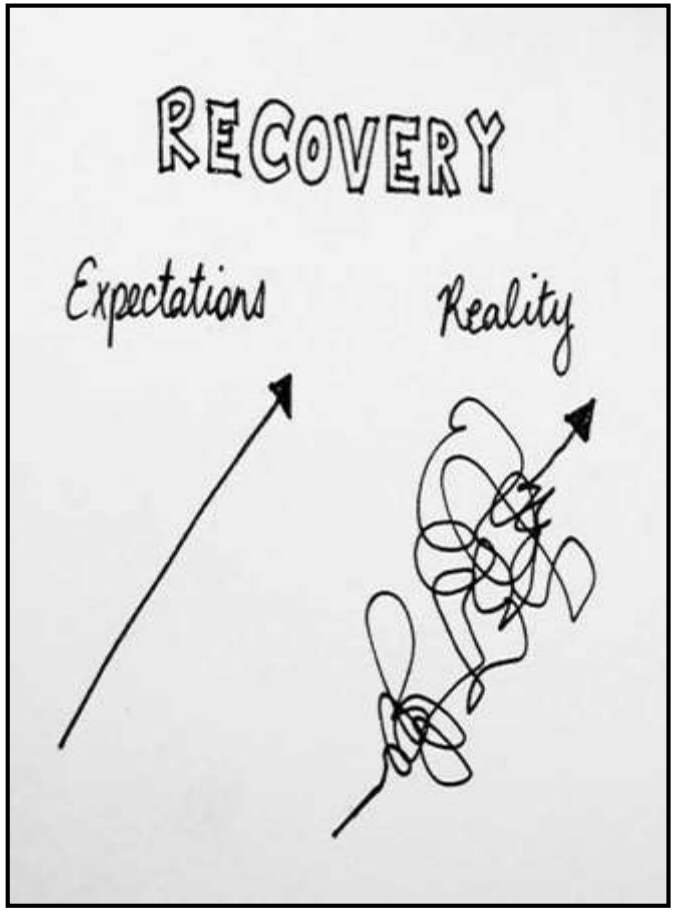
MDT with specialist rehabilitation skills and clear remit

- Care co-ordination of people with complex psychosis
- Hold health and social care statutory responsibilities – Care Programme Approach, S117 Aftercare, Safeguarding etc
- Proactively engage with inpatient, forensic and out of area services
- Liaison and in-reach to supported accommodation services
- In vivo working with service users (and carers)
- Support supported accommodation service staff
- Liaison with primary/secondary physical health
- Facilitate ‘move-on’ through the whole rehabilitation care pathway

Conclusions

Delivering a whole system approach to mental health rehabilitation requires

- Acknowledgment of the fact that some people have complex needs
- Commitment to providing adequate, appropriate, longer term services that can support people's recovery
- Inpatient and community based services
- Health, social care and voluntary sector to work together
- Appropriately trained and supervised, recovery orientated staff
- Hypervigilance on everyone's part to avoid institutionalisation (systems and practices)



Don’t forget to hold the long term view!

Many thanks
for your attention

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