Brief guide: inpatient mental health rehabilitation services – discharge

Context
Mental health rehabilitation services work with people with complex psychosis whose needs cannot be met by general adult mental health services (there is a separate brief guide on inpatient mental health rehabilitation services; assessment, treatment and care).

Most (80%) people are referred to inpatient rehabilitation services from an acute inpatient ward and 20% from secure mental health services. The process of rehabilitation often takes many years and individuals may require repeat attempts to progress successfully from one stage to another. Nevertheless, 70% will achieve successful community discharge within 18 months of admission to an inpatient rehabilitation unit. At five-year follow-up, 67% will still be living successfully in the community; 40% will have moved on to less supported accommodation and 10% will be managing an independent tenancy. Rehabilitation services should work closely with other agencies that support service users’ recovery and social inclusion, including supported accommodation, community mental health services, primary care services, education and employment, advocacy and peer support services.

Appendix 1 summarises the main features of the different types of rehabilitation unit and likely length of stay. Having a clear expected length of stay is an important marker of the degree to which a service adopts a recovery orientation. The Royal College of Psychiatrists does not recognise the term ‘locked rehabilitation unit’. Many such units have a similar specification to a high dependency rehabilitation unit but may have a higher level of staffing and greater physical security (similar to a PICU) and focus on people with especially challenging behaviours. Locked rehabilitation units are often provided by the
independent sector due to a lack of local provision of rehabilitation services. People are therefore often admitted as an ‘out of area placement’. This can be socially dislocating.

**Evidence required**

* **NHS core service/trust level (senior service manager)**
  - Awareness of which components of the local whole system rehabilitation care pathway are provided (and which are missing).
  - Awareness of the expected length of stay for each of the different types of unit.
  - Awareness of how many people with complex psychosis are placed out of area.
  - Can explain the processes for agreeing out of area placements and for reviewing them (should be proactive, regular and aim to repatriate to local pathway wherever possible).

* **Unit level (unit manager)**
  - Can name the type of rehabilitation unit they manage - if “locked rehabilitation unit” then ask additional questions to clarify the type of unit using the table in Appendix 1.
  - Can describe the eligibility criteria for new referrals to the service (ask if the unit has a leaflet for referrers - if so, eligibility criteria should be explicitly stated).
  - Can describe the assessment process for people referred to the service, whether there is a waiting list and if so, how this is managed.
  - Can state the expected maximum length of stay on the unit (there should be flexibility for over stayers where *clinically* appropriate).
  - Can describe a clear process regarding discharge planning. This should start within three months of admission and be reviewed regularly at MDT meetings.
  - Once a discharge placement has been identified there should be graduated visits and leave so that the person can familiarise themselves with their new environment. The person’s community care co-ordinator should be proactively engaged in this process (e.g. in making referrals to suitably supported accommodation, applying for appropriate funding for the placement as well as supporting the person to visit their new placement).
  - For people placed in the unit by another borough (an “out of area placement”) the unit should invite their care manager and local care co-ordinator to attend regular MDT review meetings to review progress and agree plans for repatriation.

**Reporting**

Under ‘Multi-disciplinary and inter-agency team work’ describe the quality of engagement between the unit and care managers/coordinators from local service.

Under ‘Access and discharge’ report:
- Lengths of stay people on the unit and how many exceed the time indicated for that unit type (appendix 1), and number of delayed discharges in the past year and reasons.
- The number of out of area placements attributed to the unit/core service (if NHS).
- The quality of discharge planning; including liaison with care managers/co-ordinators.

Under ‘Good governance’ report awareness of local whole system rehabilitation care pathway, expected lengths of stay and management of out of area placements.

**Policy**

**Links to regulations**

* **Regulation 9 (1)(3)(a)** if treatment in care is not recovery orientated.
**Regulation 9(1)(3)(b)** where there is no clear plan of care regarding discharge in place within three months of admission to the unit. Discharge planning should begin on admission.

**Regulation 9 (1)(3)(a)** when not collaborating with patients or a person lawfully acting on their behalf. Consider **Regulation 12(1)(2)(i)** Where providers are not working collaboratively with partners to assess and meet the needs and preferences of patients.

**Regulation 10(2)(b)** Where the service does not promote the autonomy of the patient and their independence or to develop those skills as part of their recovery. Where involvement in the community is not being facilitated.

**Regulation 17(2)(a)** where systems are not in place to enable the provider to understand the rehabilitation care pathway and improve the quality of services provided to patients including length of stay and out of area placements.
### Appendix: Types of inpatient rehabilitation unit

<table>
<thead>
<tr>
<th>Client group</th>
<th>High Dependency</th>
<th>Community</th>
<th>Complex Care</th>
<th>Low Secure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client group</strong></td>
<td>Severe symptoms, (multiple) co-morbidities, significant risk histories, ongoing challenging behaviours. Most detained under MHA ~ 20% previous forensic admission.</td>
<td>People who cannot be discharged directly from high dependency to supported accommodation due to ongoing complex needs. Most referrals come from high dependency rehab or acute inpatient services. Can only take detained patients if registered as a ward. Can have CTO/S41 patients if not registered as a ward.</td>
<td>People who have not progressed from high dependency rehab unit. High levels of disability and risk. Co-morbid serious physical health problems are common. Mix of detained and voluntary patients.</td>
<td>History of offending and/or severe challenging behaviour. All detained under the Mental Health Act (usually Part 3). <strong>Key task</strong> - accurate assessment and management of risk. <strong>Commissioned by NHS England</strong>.</td>
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<tr>
<td><strong>Focus</strong></td>
<td>Thorough assessment, engagement, maximising benefits from medication, reducing challenging behaviours, re-engaging with families and communities. Step down for forensic services and repatriation of people from out-of-area placements to local services.</td>
<td>Facilitating further recovery, managing medication (self-medication programmes), engagement in psychosocial interventions (CBT, family work), gaining skills for more independent living including ADL skills and community activities (leisure, vocational).</td>
<td>Longer term rehabilitation That provides interventions as described for high dependency and community rehab units.</td>
<td>Thorough assessment, engagement, maximising benefits from medication, reducing offending/challenging behaviours, encouraging ADL skills.</td>
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<tr>
<td><strong>Recovery goal</strong></td>
<td>Move on to community rehabilitation unit or supported accommodation.</td>
<td>Move on to supported accommodation.</td>
<td>Most move to supported accommodation or residential care.</td>
<td>Most move to another component of the rehabilitation pathway, often high dependency or community rehab.</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Usually hospital based</td>
<td>Community based</td>
<td>Hospital campus or community</td>
<td>Hospital based regional secure services</td>
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<tr>
<td><strong>Length of stay</strong></td>
<td>1-3 years</td>
<td>1-2 years</td>
<td>5-10 years</td>
<td>2+ years – highly variable</td>
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<td><strong>Functioning</strong></td>
<td>Domestic services provided, but ADL skills encouraged through OT.</td>
<td>Self-catering, cleaning, laundry, budgeting etc. with staff support.</td>
<td>Domestic services provided and ADL skills encouraged through OT.</td>
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<tr>
<td><strong>Risk management</strong></td>
<td>Often locked or can be locked. Higher staffed, full MDT.</td>
<td>“Open” units, Staffed 24 hours by nurses and support workers with regular input from MDT.</td>
<td>Not locked but controlled access. Higher staffed with MDT input, but more support staff than nurses compared to high dependency rehab unit.</td>
<td>Locked. High-staffing, MDT. Physical, procedural and relational security, specialist risk assessment and management skills.</td>
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<td><strong>Provision per population</strong></td>
<td>Every Trust. One unit per 600,000 to 1 million.</td>
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<td>Regional. One unit per 1 million.</td>
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