Brief guide: inpatient mental health rehabilitation services – assessment, treatment and care

Context
Mental health rehabilitation services are an essential element of a comprehensive mental health care system. They work with individuals with complex psychosis whose needs cannot be met by general adult mental health services. Over 10% of people newly diagnosed with psychosis will develop complex problems and require rehabilitation services. On average, people referred to rehabilitation services have been in contact with mental health services for over thirteen years and have had repeated admissions. The problems they experience include hallucinations and delusions that have not responded to medication, severe ‘negative’ symptoms that affect motivation and organisational skills, and co-existing physical and mental health problems that further impair their recovery and can result in challenging behaviours.

Rehabilitation services provide specialist assessment, treatment and support to stabilise the person’s symptoms and help them gain/regain the skills and confidence to live successfully in the community. They should provide specific interventions in accordance with NICE guidance. Staff should work in partnership with service users and carers. Services that adopt a recovery orientation, and place collaboration at the centre of all activities, are more likely to achieve successful community discharge. Other services may have lost hope for the person’s recovery before referring them for rehabilitation. It is therefore vital that those who work in rehabilitation services maintain therapeutic optimism.

A multidisciplinary team should deliver individualised, collaborative care planning and work with service users to help them develop self-management skills and strategies. The team should have access to regular group and individual supervision to share concerns and problem solve.

Medication: the team should include a designated rehabilitation psychiatrist who has a clear clinical leadership role within the team and acts as the Responsible Clinician role for all detained patients. Management of complex medication regimes (often including clozapine) and side effects are key skills.

Psychological interventions: as well as evidence based psychological therapies (such as cognitive behaviour therapy for psychosis and family interventions), clinical psychologists may also facilitate reflective practice sessions with the team to develop psychological formulations which support therapeutic rapport and optimism. They 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.
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 skills to live successfully outside hospital (e.g. managing their medication, self-care, housework, laundry, shopping, budgeting and cooking). They also support service users to access and engage with leisure activities and vocational rehabilitation activities in the community (e.g. education, training and employment). Occupational therapists often organise and facilitate individual and group activities on the unit 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.

Healthy living: all members of the team should provide guidance and support (such as exercise, smoking cessation and dietary advice) and monitoring of physical health. Medical team members lead on physical health assessment and appropriate referral and treatment for co-morbid physical health problems; especially in relation to regular screening for known side effects of medication. As individuals progress towards community living, liaison with general practitioners becomes increasingly important to ensure that adequate monitoring and treatment of physical health problems continues following discharge.

Evidence required

Needs assessment and care planning (interview with unit staff and review of care records):
- detailed assessment of service users’ needs within the first month after admission that includes input from MDT (there may be separate medical, nursing, psychological and OT assessments or these different assessments may be collated into an overall assessment)
- process for reviewing people’s needs regularly (e.g. monthly/quarterly MDT care review meetings)
- evidence of collaborative care planning involving service users as well as MDT and any carers.

Staffing (based on a 14-bed high dependence rehabilitation unit):
- Psychiatrists – 0.5 wte consultant in rehabilitation psychiatry; 1wte core trainee or equivalent
- Occupational therapist - at least 1 wte
- Clinical psychologist - at least 0.4 wte
- Nurses - at least two qualified per day shift, one per night shift
- Support workers - at least 4 wte per day shift and at least 2 wte per night shift

A similar sized community rehabilitation unit or complex care unit could have fewer wtes but should still have a full MDT represented. The unit manager must justify the staffing to ensure it is adequate for type of unit, number of beds and number of detained service users.

Recovery orientation and therapeutic optimism (interview with unit staff and review of care records):
- Recovery orientation may be explicitly stated in unit’s mission statement
- Staff use language that is optimistic in relation to service users and are able to clarify what is meant when they use the word “recovery”
- The service has a specific expected length of stay (but there is flexibility for over stayers to continue to receive treatment on the unit)
- Evidence of support to engage service users in activities that aim to assist them to gain skills for community living (e.g. cooking activities, self-medication programmes)
- Evidence of goal setting in care plans and/or group/individual sessions
- Evidence of staff making links with community resources (leisure and vocational rehabilitation).

**Reporting**

- Under ‘**assessment of needs and planning of care**’, describe the quality of assessment and care plans and the extent to which they are recovery oriented (state the number of care plans you reviewed and the proportion that were of a good quality); including whether a thorough physical examination has been undertaken and there is regular monitoring of physical health.
- Under ‘**best practice in treatment and care**’, state the evidence that the service provides the range of interventions listed above and that staff follow NICE guidance, describe the quality of physical healthcare and health promotion, state which assessment/outcome tools are used and whether the staff engage in meaningful clinical audit.
- Under ‘**skilled staff to deliver care**’, list the membership of the MDT and state whether staff are provided with both individual and group supervision.
- Under ‘**multi-disciplinary and inter-agency team work**’, describe the extent to which the individual members of the MDT collaborate in delivering the care plan.
- Under ‘**the facilities promote recovery, comfort and dignity and confidentiality**’, describe the range of social and leisure activities available; including in evenings and at weekends.

**Policy**

**Link to regulations**

**CQC should take action under:**

- **Regulation 9 (1)(3)(a)** where providers/staff are not working collaboratively with the patient to develop and deliver the care plan.
- **Regulation 9 (1)(3)(a)** if best practice in treatment in care is not being used to facilitate a recovery orientated approach.
- **Regulation 9 (1)(3)(a)** if physical health care examinations are not taking place or regular monitoring of physical healthcare is not taking place
- **Regulation 15(1)(c)** where the facilities do not promote recovery, privacy and dignity. Or consider **Regulation 10(1)(2)(a)(b)**
- **Regulation 12(1)(2)(i)** where a full MDT is not in place with the right skills and therefore the needs of the patients are not being met.
- **Regulation 18(2)(a)** where staff are not provided with individual and group supervision.