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

Context

Up to 25% of people newly diagnosed with psychosis will develop complex problems and require mental health rehabilitation services. Most will have been in contact with mental health services for many years with recurrent admissions. They often experience 'positive' symptoms (hallucinations and delusions) that have not responded to medication, severe 'negative' symptoms that affect motivation and organisational skills and physical health problems. Some have co-existing developmental problems (e.g. Asperger's, ADHD) or substance misuse. Most have poor day to day functioning and some will have 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. Rehabilitation services that adopt **a recovery orientation** are more likely to achieve successful community discharge, including individualised, collaborative care planning to help individuals develop self-management skills, positive risk taking and therapeutic optimism. The team should have access to regular group and individual supervision to share concerns and problem solve.

The brief guide (*Inpatient mental health rehabilitation services – discharge planning*) describes the different types of rehabilitation unit. The **staffing below refers to a 14-16 bed high dependency rehabilitation unit.** Other types of unit may have different WTEs but should have a full MDT represented. The unit manager must justify the staffing to ensure it is adequate for the type of unit, bed number, number of detained patients etc.

The team should include a designated **rehabilitation psychiatrist** (0.5 WTE) who acts as the Responsible Clinician for all detained patients. Management of **complex medication regimes** (often including clozapine) and side effects are key skills. All team members should provide guidance and support on **healthy living** (exercise, smoking cessation, diet) and monitoring of physical health. Medical team members lead on physical health assessment and appropriate referral and treatment for co-morbid physical health problems. **Psychological interventions** (CBT for psychosis, family interventions) should be delivered by a **clinical psychologist** (0.4 WTE) who may also facilitate team reflective practice sessions to develop psychological formulations which support therapeutic rapport and optimism. They may provide training and supervision to other staff in "low intensity" psychological interventions (e.g. behavioural activation, anxiety management, relapse prevention, motivational interviewing). **Nurses** (2 WTE per day shift, 1 WTE per night shift), **support workers** (4 WTE per day shift, 2 WTE per night shift) and **occupational therapists** (1 WTE) are key to helping service users gain/regain the confidence and skills to live successfully outside hospital (e.g. **self-medication**, **self-care, housework, laundry, shopping, cooking and budgeting**). They also facilitate their access and engagement with leisure and vocational activities (e.g. education, training and employment) in the community. OTs often facilitate individual and group activities on the unit and develop links with local resources for community based activities.

Brief guide (BG019): Inpatient mental health rehabilitation service: assessment, treatment and care V3, June 2019
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Evidence required

Needs assessment and care planning (interview with unit staff and review of care records):

- Detailed multidisciplinary assessment of individual's needs within first month
- Process for reviewing needs regularly (e.g. monthly/quarterly MDT care review meetings)
- Evidence of collaborative care planning involving service users/carers as well as MDT

Recovery orientation (interview with unit staff and review of care records):

- May be explicitly stated in unit's mission statement
- Staff use language that is optimistic in relation to service users and can clarify what they mean by "recovery"
- The unit has a specific expected length of stay (but there is flexibility for over stayers)
- Evidence of support to assist service users 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)
- Under '**best practice in treatment and care'**, state the evidence that the service provides the range of interventions above, describe the quality of physical healthcare and health promotion, state which assessment/outcome tools are used and whether the staff engage in relevant clinical audit.
- Under 's**killed 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 evenings/ 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.