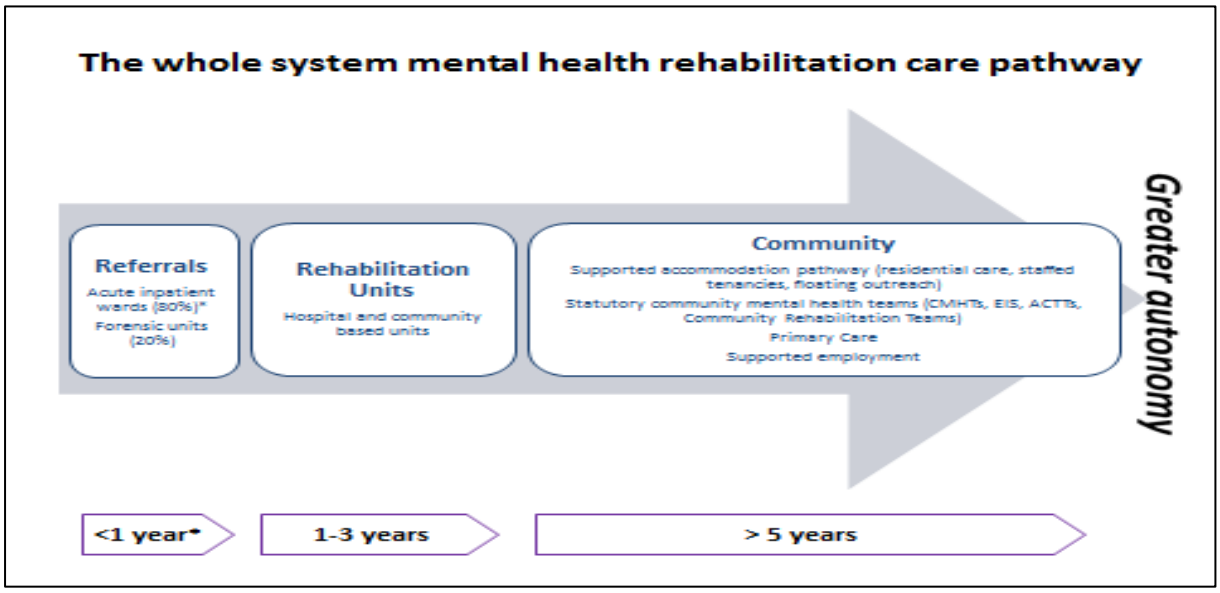
Brief guide on inpatient mental health rehabilitation services: access and discharge

Context

Mental health rehabilitation services are an essential component of the mental health system. They work with people with **complex psychosis and related conditions** (see 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. 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 standard or longer term high dependency rehabilitation unit but may have a higher level of staffing and greater physical security and higher staffing if they focus on people with especially challenging behaviours. Over half the rehabilitation units in England are provided by the independent sector due to a lack of local NHS provision. People are therefore often admitted as an '**out of area placement'**, which can be socially dislocating (see Brief Guide '*Out of area placement in rehabilitation units*.'). As well as the units shown in Appendix 1, there are some 'Highly specialist inpatient rehabilitation units' 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 regional or national level and are likely to be commissioned by NHS England. However, some are provided by the independent sector and individual places can be agreed by the local Clinical Commissioning Group.

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 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 usually 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. 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 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:
  - The usual length of stay and how many individuals currently exceed the expected timeframe for that unit type (Appendix 1); number of delayed discharges in the past year and reasons.
  - The number of out of area placements attributed to the unit/core service.
  - 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.

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 1. Types of inpatient rehabilitation unit

	High Dependency Rehabilitation Unit	Community Rehabilitation Unit	Longer Term High Dependency Rehabilitation Unit	Highly Specialist Inpatient Rehabilitation Unit	Low Secure Rehabilitation Unit
Client group	Severe symptoms, (multiple) co-morbidities, significant risk histories, ongoing challenging behaviours. Most patients detained under MHA. Most referrals (80%) come from acute inpatient units, and 20% from forensic units.	Ongoing complex needs so cannot be discharged directly from high dependency rehab unit to supported accommodation. Most referrals from high dependency rehab unit or acute inpatient unit. Can take detained patients if registered as a ward (may have CTO/S41 patients if not registered as ward).	High levels of disability from treatment refractory symptoms and/or complex co-morbid conditions that require longer inpatient rehabilitation to stabilise. Significant associated risks to own health/safety and/or others. Most patients detained under MHA. Most referrals from high dependency rehab unit.	Specific co-morbidties that require very specialist approach e.g. psychosis plus traumatic brain injury, degenerative neurological disorder or autism. Challenging behaviour is often a significant issue.	History of offending and/or severe challenging behaviour. All patients detained under the Mental Health Act (usually Part 3). Most referrals from medium secure or other components of forensic system.
Commissioned by	Local Clinical Commissioning Groups (CCG)	CCGs	CCGs	NHSE (individual places can be commissioned by CCGs)	NHS England.
Focus	Thorough assessment, engagement, maximising benefits from medication, reducing challenging behaviours, psychosocial interventions, re-engaging with families and communities. Step down for forensic services and repatriation of people from out-of-area placements.	Facilitating further recovery, managing medication (self-medication), psychosocial interventions (CBT, family work), gaining skills for more independent living including ADL skills and community activities (leisure, vocational).	To stabilise symptoms adequately such that function improves and move on to a less supported component of the rehabilitation pathway becomes feasible. Interventions as for high dependency and community rehab units in a highly supported setting.	To stabilise symptoms and challenging behaviours adequately. Managing challenging behaviours and physical aspects of co-morbidities is key.	Key task - assessment and management of risk alongside engagement, maximising benefits from medication, reducing offending/challenging behaviours, encouraging ADL skills.
Recovery goal	Move on to community rehabilitation unit or supported accommodation.	Move on to supported accommodation	Move on to community rehabilitation unit or supported accommodation.	Move on to a specialist, long term supported accommodation facility.	Move on to high dependency rehabilitation unit, community rehabilitation unit or supported accommodation.
Location	Usually hospital based	Community based	Usually hospital based	Hospital based	Hospital based regional secure services

Length of stay	Up to 1 year	1-2 years	1-3 years (can be longer – variable)	2+ years	2+ years – highly variable
Functioning	Domestic services provided, but ADL skills encouraged through OT	Self-catering, cleaning, laundry, budgeting etc with staff support	Domestic services provided, but ADL skills encouraged through OT	Domestic services provided. Physiotherapy, speech and language therapy and OT provided to improve all aspects of functioning	Domestic services provided and ADL skills encouraged through OT
Risk management	Controlled access ('locked'). Higher staffed, full MDT	"Open" units. Staffed 24 hours by nurses and support workers with regular input from MDT.	Controlled access. Higher staffed, full MDT May have air lock and higher staffing than standard HDRU if target client group require this.	Usually controlled access. Higher staffed, full MDT plus physiotherapy and SALT. Unlikely to need airlock.	Controlled access with air lock. High staffing with MDT. Specialist physical, procedural and relational security skills and facilities.
Provision per population*	Every Trust. One unit per ~300,000.	Every Trust. One unit per ~300,000.	Every Trust. One unit per ~600,000	Regional One unit per ~1m	Regional. One unit per ~1m