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Mental health rehabilitation services in the UK in 2007

AIMS AND METHOD

A survey of UK consultants in rehabilitation psychiatry was carried out to investigate current service provision and changes over the past 3 years.

RESULTS

Most services had undergone multiple changes, with an overall reduction in over half and an overall

expansion in a minority. The proportion with low secure provision had doubled. Around a third reported reinvestment of rehabilitation resources into other specialist in-patient and community services.

CLINICAL IMPLICATIONS

Rehabilitation services are undergoing rapid change with diversion of

resources into services that may lack rehabilitation expertise. This risks an increase in independent sector referrals for in-patient rehabilitation for those with complex needs. Expansion of community services should be balanced against the need for local in-patient rehabilitation services.

In 1999, the *National Service Framework for Mental Health*¹ set targets for the implementation of specialist community mental health services across England (335 crisis resolution, 220 assertive outreach and 50 early intervention services by 2003). Five years later, there were 263 assertive outreach teams employing around 3000 staff, 168 crisis resolution teams employing around 2000 staff and 41 early intervention services employing 174 staff.² Most of these staff moved from existing mental health services into the new teams. These services have succeeded in reducing reliance on in-patient services overall,³ although English assertive outreach services were not shown to be effective in this regard⁴ and a proportion of users of these and other community mental health services still require lengthy hospital admission.⁵

The majority of people requiring lengthy admissions have a diagnosis of schizophrenia complicated by treatment resistance⁶ and/or comorbidities such as cognitive impairment, substance misuse and challenging behaviours.^{7–9} Many do not meet eligibility criteria for specialist community teams since they are unable to manage community living.^{10,11} At any one time it has been estimated that around 1% of people with schizophrenia receive intensive in-patient rehabilitation in order to recover adequate social function to live outside hospital.⁸ Rehabilitation services provide a whole system approach to recovery from mental ill health which maximises 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.¹² Service users tend to be referred for rehabilitation once the National Institute for Health and Clinical Excellence guidance on the treatment of schizophrenia¹³ has proved unsuccessful and other approaches have failed.⁸

Over the past 3 years, the Faculty of Rehabilitation and Social Psychiatry of the Royal College of Psychiatrists has received reports from its members of rehabilitation service reconfigurations and losses. Some, such as the rebadging of 25% of community rehabilitation teams as assertive outreach teams (C. Wright, personal communication, 2009) appear to be a direct consequence of the

implementation of the National Service Framework for Mental Health.¹ In order to investigate these reports further, the Faculty carried out a survey of its members across the UK, coordinated by its regional representatives.

Method

The survey was carried out between October 2006 and March 2007. Consultants were asked to complete a structured proforma, devised by the authors of this paper and based on a previous survey of rehabilitation services in England.¹² Information about any reductions or expansion of in-patient and community rehabilitation services that had taken place in the 3 years since the previous survey or were being proposed was gathered. All regional representatives were requested to disseminate the survey proforma to all consultants in rehabilitation psychiatry in their area. Responses were collated by the Chair of the regional representatives (D.M.) and summarised according to the main changes to services reported and whether any service reconfiguration had resulted in an overall service reduction, expansion or both.

Results

Thirteen (72%) of the 18 regional representatives responded. From a possible 101 regions/trusts/local authority areas, data on 55 services were received (response rate 54%). Of these, four reported that there was no rehabilitation service in that area, five reported that there had been no changes but major service reviews were planned, the detail of which was unknown. A summary of the main types of change reported by the remaining 46 services is shown in Table 1.

Most services reported multiple changes. Ten services (18%) reported closures of whole wards or units, two reported planned ward/unit closures and eight reported planned reductions in in-patient rehabilitation beds. Seventeen (37%) respondents reported cuts to community rehabilitation services comprising closure of seven community rehabilitation teams, eight community

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	Services reporting changes (n = 46) n (%)
Reduction in service: type of service reduction	25 (54)
All areas of service reduced including whole ward/units	5 (11)
Loss of one part of service (e.g. ward, continuing care unit, supported community accommodation unit)	5 (11)
Redesign resulting in transfer of resources to e.g. forensic services, older peoples' service, primary care and voluntary sector	9 (20)
Reduced staffing to manage more complex and disturbed individuals	4 (9)
Reduced service funding	2 (4)
Development or expansion of service: type of service reduction	4 (9)
Substantial investment in all areas	1 (2)
Development through reinvestment of efficiencies achieved through repatriation of out of area treatments	2 (4)
Service redesign leading to greater system coherence	1 (2)
Reduction and development of service: type of mixed service change	17 (37)
Reduction in in-patient services and reinvestment in other services (e.g. early intervention, supported community accommodation, low secure unit, hospital and community rehabilitation units)	10 (22)
Reduction in community rehabilitation services and reinvestment in other parts of non-forensic in-patient and community rehabilitation service	2 (4)
Rehabilitation service resources reduced but service expanded by joining with assertive outreach and intensive home treatment teams and/or increasing remit to cover more clients in supported community accommodation	5 (11)

rehabilitation residential units and four rehabilitation day services. However, taking into account all the changes reported within a service, these were not always considered to have resulted in an overall reduction in service.

In terms of service expansion, 14 (30%) respondents reported development of in-patient services, eight of which were low secure units (six had opened and two were planned). Seventeen (37%) respondents reported investment in community rehabilitation services with twelve detailing development of various residential services and five reporting development of some form of service to review individuals placed out of area. However, taking all the changes reported for each service into account, these developments were considered to have resulted in an overall expansion of only four rehabilitation services.

Discussion

Study limitations

Our data is incomplete since although the majority of regional representatives responded, some had been unable to contact some consultants within their region. Our overall service response rate of 54% is reasonable for a postal survey but clearly non-response bias means that the results must be interpreted with caution. However, in areas where rehabilitation services had already been cut, non-response was inevitable unless the regional representative was able to report this. We therefore cannot report the absolute figures for the number of rehabilitation services that have been completely closed since 2004. Non-response may also have been as a result of potential respondents being too busy to complete the survey (perhaps because of expansion of services) or lacking enthusiasm for the research (perhaps because of service reductions and poor morale).

However, we cannot estimate from our results whether the non-response from services undergoing expansion or reductions were similar.

Potential impact of reductions in rehabilitation services

Bearing this in mind, the results of this survey appear to suggest that there has been a net loss of in-patient rehabilitation services across the UK over recent years and an expansion of low secure provision. In 2004, 15% of rehabilitation services reported having low secure service provision.¹² Our results suggest that since then, a further 15% of services had opened or planned to open a low secure unit.

Services appear to be being reconfigured within small geographical areas without any strategic coherence or reference to the wider mental health system. This has led to patchy provision across the UK, with services in neighbouring areas or within the same trust reporting reductions or expansion, often without recourse to any specified service plan. This lack of coherence renders rehabilitation services vulnerable to cuts when the health economy is under pressure.

The results of this 'snapshot' survey suggest that rehabilitation services are undergoing a period of rapid change. It is unclear what the impact of these changes will be on individual patient care and the wider mental health service. One obvious problem with reductions in local rehabilitation services is that individuals with complex needs and treatment resistance become stuck in acute in-patient settings with no rehabilitation expertise.⁸ This affects the whole in-patient system and increases referrals to the independent sector for in-patient treatment.^{14,15} Although we welcome investment in community rehabilitation services, this cannot be made at the cost of in-patient services since it may only benefit those



with more prospects of recovery and disadvantage those with higher levels of need.

The development of new functional community teams implemented through the National Service Framework for Mental Health may have been at the cost of rehabilitation services. Mental health commissioners, under considerable financial constraints, have focused on targets for the provision of these new services. The lack of emphasis on the delivery of rehabilitation services as part of the National Service Framework for Mental Health may therefore be directly responsible for the current incoherence in provision of these services, at least in England.

The mental hospital closure programme has led to the development of a 'virtual asylum' in the form of independent sector hospital, residential and nursing placements.^{16–19} Individuals with severe impairment of their social and every day living skills who require a high level of support are increasingly being placed in 'out of area treatments' at a cost to the National Health Service of around a quarter of a billion pounds for working age adults alone.²⁰ The cost of out of area treatments is much more than financial: service users are often placed long distances from their area of origin leading to social dislocation from family and other support networks (this is a particular problem for those from black and minority ethnic communities); continuity of care from their local mental health and primary care services is lost; many do not receive appropriate care from their new local mental health services under the care programme approach; care is incompletely or irregularly reviewed leading to 'over support' and increasing institutionalisation as their symptoms and function improve, rather than promotion of independent living skills; care coordinators from the area of origin do not report the outcomes of reviews to commissioners of these services in any regular or coherent manner. These issues clearly undermine the rehabilitation and recovery of service users, leading to increased social exclusion in terms of their local community, family networks, access to appropriate support when they need it and reintegration into mainstream employment, education and leisure activities.

Recommendations

The need to prioritise a coherent service approach for those with complex and long-term mental health needs is therefore obvious and, in order to reverse the current potential loss of expertise in attending to the needs of this patient group, we suggest that commissioners and providers of services support and invest in their own local rehabilitation services rather than promoting an outflow of resource into out of area treatments. Our survey results show that some rehabilitation services have already taken on a specialist role in reviewing out of area treatments and some have reinvested financial flows into local rehabilitation and residential services. We would strongly encourage this approach. In addition, rehabilitation services need to engage in a focused research programme to evidence their effectiveness if they are to survive the vagaries of service reconfiguration.

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Declaration of interest

The authors are members of the Executive Committee of the Royal College of Psychiatrists' Faculty of Rehabilitation and Social Psychiatry.

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