Moving the Focus to Recovery Oriented Services

Recovering a life: the principles and practice of rehabilitation for psychosis

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Empowerment, hope and recovery

From “moral treatment” of the 19th century asylum through the social psychiatry revolution of the 1950s it is known that:

Better outcomes achieved if patients treated with dignity and respect

If treatments based on co-operation rather than coercion

Functional outcomes of personal and societal value are emphasised (e.g Work)

William Tuke c. 1813
Personal Recovery

Building a meaningful and satisfying life despite illness
Believing in oneself & having hope for the future
Taking responsibility and control
Self-management with clinicians as coaches

“A way of living a satisfying, hopeful and contributing life even with limitations caused by illness” (Anthony, 1993)
What is Psychiatric Rehabilitation?

“A whole system approach to recovery from mental ill health which maximizes 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.”

(Killaspy et al, 2005)
Key Concepts in Psychiatric Rehabilitation

• Empowerment, hope and recovery
• Focus on the goals and choices of the patient
• Focus on real-world outcomes (work, friendship etc)
• Focus on building strengths
• Skills training (variously defined)
What outcomes does every clinical service need to measure to focus on recovery?

How do we mainstream recovery oriented services for everyone?

Holistic – Bio-psychosocial / mental and physical health
Shephard et al, 2014; Supporting recovery in mental health services: Quality and Outcomes

The ImROC programme (Implementing Recovery through Organisational Change), DH 2008;

Help local services become more supportive of recovery for those using them/carers

Quality indicators provide the key link between evidence-based practice and improved outcomes (McColl et al., 1998)

Recovery belongs to the people who use mental health services and is embedded in their unique and individual lives

Judgement rests with them; however guidance for clinicians/managers needed

NB Children, Older Adults, different settings; for Adults
The ImROC programme is based on this framework.

10 key challenges

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive user-led education and training programmes
3. Establishing a ‘Recovery Education Centre’ to drive the programmes forward
4. Ensuring organisational commitment, creating the ‘culture’
5. Increasing personalisation and choice
6. Changing the way we approach risk assessment and management
7. Redefining user involvement
8. Transforming the workforce
9. Supporting staff in their recovery journey
10. Increasing opportunities for building a life beyond illness
Box 1: Quality indicators for supporting recovery at an individual level

Staff should aim to: **Facilitate recovery-promoting relationships**

- establish shared values
- demonstrate good, basic relationships skills (empathy, warmth, respect)
- support personal hopes and aspirations
- promote a sense of control (‘agency’).

**Use ‘pro-recovery working’ practices**

- narrative accounts (recovery stories)
- a ‘strengths’ approach
- ‘coaching’ methods
- Personal Recovery Plans (WRAP, STAR)
- self-management; shared decision-making; person-centred ‘safety planning’.
Consider specific approaches which will support recovery not developed from a recovery perspective, e.g.

- Joint Crisis Plans (JCP)
- ‘Housing First’
- Individual Placement and Support (IPS)
- use of ‘personal budgets’ (social and health).
Box 2: Quality indicators for supporting recovery at an organisational level

Has the organisations used any of the following instruments?

- Recovery Oriented Systems Indicators (ROSI) Yes No
- Recovery Self-Assessment (RSA) Yes No
- Scottish Recovery Indicator (SRI) Yes No
- Recovery Promotion Fidelity Scale (RPFS) Yes No
- Developing Recovery Enhancing Environment (DREEM) Yes No

Has the organisation undertaken a self-assessment and attempted service development using the ImROC ‘10 key challenge’ framework? Y/N

Has the organisation co-produced any of the following key recovery supporting, service developments? a) Recovery Colleges Yes No b) Peer Support Workers Yes No; c) Person-centred ‘safety planning’ Y/N d) Applying recovery principles to improve quality & safety on inpt wards
Box 3: Summary recommendations for recovery outcomes measures. Definite:

RECOVERY OUTCOME DOMAIN 1 – Quality of recovery-supporting care
To what extent do service users feel that staff in services are trying to help them in their recovery? Recommended measure: INSPIRE

RECOVERY OUTCOME DOMAIN 2 – Achievement of individual recovery goals
To what extent have goals, as defined by the individual, been attained over time? Recommended measures: Goal Attainment Scaling (GAS), narrative accounts

RECOVERY OUTCOME DOMAIN 3 – Subjective measures of personal recovery
To what extent do individuals feel that their hopes, sense of control and opportunities for building a life beyond illness have improved as a result of their contact with services? Recommended measure: Questionnaire on the Process of Recovery (QPR)

RECOVERY OUTCOME DOMAIN 4 – Achievement of socially valued goals
Has the person’s status on indicators of social roles improved as a result of their contact with services? Recommended measures: Relevant items from Adult Social Care Outcomes Framework (2013b), Social inclusion web.
Possible

RECOVERY OUTCOME DOMAIN 5 – Quality of life and well-being
Has the person’s quality of life and well-being improved?
Recommended measures: MANSA, WEMWBS

RECOVERY OUTCOME DOMAIN 6 – Service use
As a result of their recovery being supported, has the person made an appropriate reduction in their use of formal mental health services?
Recommended measures: Relevant items from the NHS Outcomes framework, and the Mental Health Minimum Data Set (but beware!)
Rehabilitation Psychiatry

- 85% Psychosis – longer term conditions
- Treatment resistance
- Negative symptoms
- Comorbidities, psychiatric and physical health
- Functional impairments
- Challenging behaviour
- Difficult to engage
- Risk

(Holloway, 2005)

- 10% of those in secondary care, account for 25 – 30% of the annual UK mental health and social care budget (MH Strategies 2010)
- The principles of rehab are relevant to all Mental Health services
ICD-10 multi-axial diagnoses;
- Axis I: Clinical Disorders, Mental and general medical conds
- Axis II: Disabilities (personal care; occupational functioning; functioning with family; broader social functioning)
- Axis II: Contextual factors (interpersonal & other psychosocial and environmental problems)
- Axis IV: quality of life (primarily reflecting patient’s self-perception)

Clinician Reported Outcome Measure (CROM)
- Health of the Nation Outcome Scale (HONOS)
- Social & Occupational Functioning Assessment Scale (SOFAS)
- Camberwell Assessment of Need Short Appraisal Schedule (CANSAS)
- Global Assessment of Function (GAF)

Patient Reported Outcome Measure (PROM)
- Warwick-Edinburgh Mental Well-being Scale (Stewart-Brown et al)
- Manchester Short Assesment of Quality of Life (MANSA; Priebe et al 1999)
- DIALOG (Priebe et al)

Patient Reported Experience Measure (PREM)
- Friends & Family Test

Showing the value of Mental Health Rehabilitation Services & Further Developing Best Practice
National Rehabilitation Psychiatry Outcomes

- **Process outcomes**
  - Length of stay - by bed type (PICU, LSU, acute, physical health bed)
  - Number of occupied bed days 2 years before rehab intervention and afterwards
  - Crisis Resolution / Home Treatment Team usage

- **Enabling factors/standards to achieve good outcomes**
  - **Recovery oriented**
    - Good interface working between acute care to ensure earlier Rehab intervention
    - Transition, systematic processes in place, linking in with the right time, right place, right care
  - OATs management systems
  - Appropriate service development - including appropriate supported housing
  - Census approach - all in funded placements
  - Advice to others eg panel surgery, to maintain or stop breakdown of a placement
  - Multi-agency teams; support & skill up others
  - Whole system approach, including **Community Rehab teams** - 'pull through' to least restrictive, most socially inclusive (and usually less expensive) setting
Premature Mortality: 15-20 years early in those with severe mental illness (SMI)

- **Mortality from physical health conditions:**
  - Diabetes
  - Cardiovascular disease
  - Respiratory disease
  - **Risk Factors:**
    - Hypertension
    - Obesity – diet and lifestyle
    - Dyslipidemias
    - Smoking
Killaspy et al 2009

Measure of quality of residential care

10 European countries

7 Domains Living Environment
  • Therapeutic Environment
  • Treatments & Interventions
  • Self-management/ Autonomy
  • Social interface
  • Human rights
  • Recovery based practice

Higher quality based on more recovery oriented, better outcomes

Scores as % of possible maximum
Therapy Interventions
Interventions: General Principles

An ideal service provides a comprehensive, continuous, collaborative and person-centred approach with positive expectations of service users.

As far as possible interventions should be working with people *in vivo* – in real life environments that make real-life demands on them.

Multi-disciplinary Teams necessary; Shared formulations.

Interventions should be targeted to help people define and then achieve their personal goals.

Intervention goals should include long-term aspirations (eg living independently and having a job) and short-term targets.

Medication:

- Never assume treatment resistance until a thorough scrutiny of diagnosis (affective symptoms, co-morbidity, organic disease), medication history (what, how much and how long) and adherence

- Clozapine probably the most helpful drug when others fail

- Optimise standard treatments before moving on to judicious use of adjunctive strategies

- Remember many adjunctive strategies have a limited evidence base (e.g. clozapine + citalopram / amisulpride).
Modifying the Environment

- A Job to do
- A home of one’s own
- Making and maintaining friendships
- Accessing leisure pursuits
Social intervention: Employment support

Sheltered workshop

Clubhouse: TEP

IPS

Pre-vocational = ‘train and place’ assumes patients' deficits must be addressed before work placement is possible.

TEP: transitional employment. Real jobs but contracted by clubhouse and distributed among patients as shared and part-time.

IPS (Individual placement and support) = ‘place and train’. Open employment in real job with support.
Competitive Employment in IPS

*Bond et al 2008*

At 18 months IPS vs prevocational ‘not in work’ RR 0.82 [0.77 to 0.88]
NNT 7
Also spend longer in competitive employment
Supported employment: conclusions

Mainly entry level jobs
Average tenure per job is short (eg. 17 weeks in Drake et al 1999)
Best predictor of success is previous employment
No impact on clinical outcomes
A home of one’s own

c. 1950-1990

Tooting Bec With It’s Population Of 3,000
Costs Over £750,000 A Year To Run
Shops, Cinema, Chapel and Recreation Grounds

Group living
Live in support
Home for life
‘Virtual asylum’

2009-???

Independent living
Flexible support when needed
A Home of One’s Own?

Ordinary housing

Support appropriate to need (still mainly group living)

Core and cluster best balance

No guarantee against poor quality care
Little research evidence of best practice

The Rehab & Social Psychiatry Faculty is working with the Department of Health on this
Recognising housing as a mental health intervention

The provision of supported housing can...

- Reduce hospital admissions
- Reduce the costs related to out-of-area placements
- Reduce the risks associated with tenancy breakdown
- Reduce transfer delays from hospital to home

Leisure activity and personal relationships

Restricted social networks even before onset
Symptom severity a poor guide to ability to maintain friendship
Most valued friendships with fellow sufferers
Stigma and the reaction of other people are the major barriers
Closure of ‘drop in’ and social facilities in the interest of improving social inclusion is misguided.
Clubhouse: an overlooked resource

Fountain House NY

Why a ‘club’?

Why a ‘work ordered day’?

Side-by-side working

A subtle therapeutic community

Belonging and meaning

In and out-reach and peer support

Clubhouse international
Psychosis: common prejudices

Can never do anything with your life
Can’t make decisions
Nothing sufferer can do to recover...all their fault and could if they were less lazy/tried hard enough
Can’t work
Part 2: Service configurations
Policy and disinvestment

National Service Framework for Mental Health (DH, 1999) and NHS Plan (DH, 2001) led to investment in specialist community mental health services (EIS, AO, Crisis Resolution)

Disinvestment in rehabilitation services (Mountain et al., 2009):

- Reduction in resources in >50% services
- 33% reported reinvestment of rehabilitation resources into other specialist inpatient and community services:
  - 25% community rehabilitation teams rebadged as AOTs; most AOTs now closed
  - 30% had low secure unit (doubled since 2004)
Whole system approach to mental health rehabilitation services

Services that make referrals to local rehabilitation services

- Medium secure forensic mental health units (regional)
- Low secure forensic mental health units (regional)
- Psychiatric intensive care units (local)
- Acute inpatient units (local)

Local inpatient mental health rehabilitation services

Low secure rehabilitation unit (30% of NHS Trusts provide these locally)
High dependency rehabilitation unit (hospital based)
Community based “inpatient” rehabilitation unit
Longer term complex care rehabilitation unit (hospital or community based)

Community services that support rehabilitation and recovery from complex mental health problems

- PRIMARY CARE
- SECONDARY COMMUNITY MENTAL HEALTH AND SOCIAL CARE SERVICES
  - Community Rehabilitation Team
  - Assertive Outreach Team
  - Community Mental Health/Recovery Team
  - Primary Care Liaison Team

Supported accommodation

- Nursing/residential care
- Supported tenancies (support on-site)
- Supported tenancies (floating outreach)

Independent tenancies

Other services that support social inclusion

- Vocational rehabilitation (sheltered and supported employment, voluntary work, welfare benefits advice)
- Education
- Advocacy services
- Peer support
- Cultural/leisure services
Specialist skills of rehabilitation services
A National Strategy
(reinforcement necessary)

National commissioning Guidance (2012)

- Waxing and waning rehabilitation services nationally
- Out-of-Area Treatment (OATs); Winterbourne
Consequences of disinvestment in mental health rehabilitation services

- People with complex needs become stuck on acute admission wards (delayed discharges)
- Increased use of local low secure units
- Increased use of out of area placements - the “virtual asylum”
  - Forensic beds
  - Private hospital beds (“locked rehabilitation”/low secure)
  - Nursing/residential care beds
  - More expensive, poor rehabilitative culture, social dislocation
    (Poole et al, 2002; Priebe et al., 2003; Killaspy and Meier, 2011)
- Increased use of private beds for acute patients
- Supported housing pathway gets blocked (no move-through)
- Clinical iceberg in community of people with negative symptoms and treatment resistant symptoms
Specialist Rehabilitation Services in the UK

Patchy provision across the UK (Killaspy et al 2005)

**Rehabilitation inpatient units:**
- medium-stay (average length of stay 1 year)
- continuing care (average length of stay 2+yrs)

**Medium secure, low secure and challenging behaviour inpatient services**

**Community Rehabilitation Teams**
- role in supporting people in residential and nursing home placements (the “virtual asylum” that has replaced the traditional large mental hospital)
Out of Area Treatments

c 3000 beds in the Independent Sector
(for profit and not-for-profit) in Out of Area Treatments

People in OATs are diagnostically very heterogeneous: co-morbidities (e.g. autistic spectrum disorders, acquired brain damage, learning disability) are common

Very undesirable: Expensive, far from home and costly
What rehabilitation can achieve: case study
Examples of Excellence in Practice

- Nottingham
- Devon
- Croydon Rehabilitation & Recovery Service / personality disorder service
- Whole system approaches – including housing
- Clubhouse model
- Co-production
- Recovery Colleges
- Peer support workers;
- Experts by experience
Concluding comments

Rehabilitation & Recovery principles are relevant to all mental health services

Specialist rehabilitation services work with a small minority of people with severe mental illness

Good care and recovery oriented practice can improve outcomes for people whatever their apparent level of disability

With thanks to Professor Tom Craig for some of the slides
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The principles and practice of rehabilitation psychiatry

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