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Contemporary mental health rehabilitation

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Mental health rehabilitation services were established during the era of deinstitutionalisation in the latter half of the last century. Since then, their focus on 'resettlement' of the residents of asylums into community-based settings has evolved, as it became increasingly clear that most individuals had the capacity to gain (or regain) skills that allowed them to live and participate with increased independence in the community. With the gradual expansion and greater specialisation of community-based mental health services over recent decades, contemporary mental health rehabilitation services have increasingly focused on people with more severe and complex problems. However, their remit is not always clear and varies in different settings.

In 2005, UK mental health rehabilitation practitioners were asked what they thought their services were for. Responses were collated into the following definition:

> '*A whole systems approach to recovery from mental illness that 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 to this definition is the need for the various components of the mental health system to work collaboratively to support an individual's recovery, often over many years. In many countries, this 'whole system' includes inpatient and community-based components provided by statutory health and social care services, non-statutory (nongovernmental organisations) and independent providers of health, housing, welfare benefits, education and employment services. The definition emphasises a focus on enabling individuals' function, rather than addressing clinical symptoms and incorporates the crucial need for services to maintain therapeutic optimism – holding hope for recovery when other parts of the system, and the service user themselves, may feel stuck and demoralised.

Whilst often quoted, the definition lacks clarity on exactly who rehabilitation should be for and what exactly it should do. However, Holloway (2005) described this group in detail. Almost by definition, people who are referred to mental health rehabilitation services tend to have symptoms that have not responded to first (and, usually, second or even third) line treatments. Often, they will have such a mix of problems that evidence-based guidance is extremely difficult to apply, or there is simply no evidence-based guidance available that is relevant to their particular situation. The majority have a primary diagnosis of psychosis with severe negative symptoms and the cognitive impairments associated with longer-term psychosis (particularly affecting executive functioning and verbal memory). Some may, in addition, have pre-existing problems, such as personality or attachment difficulties, below average intellectual functioning or developmental disorders (such as those on the autism spectrum). Many will have co-morbid mental health problems (such as depression, anxiety, obsessive-compulsive symptoms) and a significant sub-group will have co-existing substance misuse issues. Physical health problems are highly prevalent such as diabetes, cardiovascular problems and chronic pulmonary disease, due to an array of factors including psychotropic medication side effects, apathy and inactivity associated with the illness itself, lifestyle choices and lack of access to a healthy diet and opportunities for exercise. These problems coalesce at a confluence of complexity that impedes recovery and impacts negatively on the person's social and every day function to such a degree that they often require lengthy hospitalisations and have high support needs in the community. This group is highly vulnerable to exploitation and self-neglect (recent national surveys in England suggest up to three quarters have experienced these kinds of risks) and their difficulties with day to day function, along with societal stigma and discrimination, mean that they remain one of the most socially excluded groups in society (Killaspy *et al*., 2013, 2016*a*).

Nevertheless, positive outcomes have been demonstrated in longer-term studies. Harding *et al*. (1987) showed that half to two-thirds of patients who received mental health rehabilitation had improved or fully recovered 32 years later. We carried out a national research programme evaluating inpatient mental health rehabilitation services across England and found that over half the users of these services were successfully discharged within 12 months, without readmission or community placement breakdown. A further 14% were ready for discharge but awaiting a vacancy in suitably supported accommodation (Killaspy *et al*., 2016*b*). A 5-year longitudinal study of users of inpatient mental health rehabilitation and supported accommodation services in London found that two-thirds progressed successfully to more independent settings over a 5-year period, with 10% achieving fully independent living (Killaspy and Zis, 2013). These results suggest that therapeutic optimism for this group is not misplaced, as long as there are appropriate community services (including supported accommodation) available to support people's ongoing recovery. In addition, whilst all modern mental health services should operate with a recovery orientation, this approach has been specifically identified as a driver of successful progress through the rehabilitation pathway in England in our recent national cohort studies of people using inpatient rehabilitation and specialist mental health supported accommodation services, along with engagement in activities that facilitate the person's daily living and social skills (Killaspy *et al*., 2016*b*).

Despite these encouraging results, there is no consensus on the specific care that inpatient and community mental health rehabilitation services should provide. As a result, there is considerable heterogeneity in approach and many individuals across the world do not receive adequate support to facilitate their recovery and maximise their independence. Worse, in recent years, it has become clear that a process of reinstitutionalisation of those with more complex mental health needs is taking place, even in countries that were at the forefront of deinstitutionalisation. For example, in Italy, concerns have been raised about the growth of 'community residences' provided by the independent sector that provide care to this group but do not offer a rehabilitative approach (de Girolamo *et al*., 2002; Barato *et al*., 2017). In Australia, where provision of community mental health care has increasingly shifted from statutory to non-statutory services, inadequacies in the treatment available to people with more severe psychosis, including underuse of clozapine and lack of evidence-based psychosocial interventions such as supported employment have been identified, along with reports of increasing homelessness (Morgan *et al*., 2017). The hospital inspectorate for England and Wales, the Care Quality Commission, recently reported major concerns that, due to disinvestment in local rehabilitation services, many people with complex mental health problems are placed in unnecessarily restrictive hospital settings in the independent sector, often many miles from their home area, with no clear discharge plans (Care Quality Commission, 2017). Across Europe, it has long been noted that the reduction in inpatient psychiatric beds associated with 'deinstitutionalisation' has been more or less matched by a rise in the number of beds in the forensic system and other forms of institutional care (Priebe and Turner, 2003).

These issues are, at least in part, due to the significant economic constraints facing health systems. Providing longer term, specialist inpatient care and supported accommodation is expensive. In the UK, it has been estimated that people with complex mental health needs absorb up to half the resource allocated to mental health by the whole health and social care sector (Mental Health Strategies, 2010). It is perhaps no surprise then that some of the inadequacies in the 'care pathways' for people with complex problems described above are due to rather cynical processes that shunt the costs of care from one provider or sector to another, as well as actual disinvestment in rehabilitation services. In addition, investing in longer-term services to support the recovery of people with severe and complex mental health problems does not fit well with current policy, with its focus on population-based strategies to promote mental health and well-being with the aim of preventing the development of mental illness, and early intervention to improve the prognosis of those who do (WHO, 2013; European Commission, 2016). However, there is now robust evidence from long-term cohort studies that one-fifth to one quarter of people newly diagnosed with psychosis who have received early intervention will still go on to develop the kinds of severe and complex needs that will require specialist rehabilitation services (Menezes *et al*., 2006; Friis *et al*. 2011). Furthermore, many of the factors associated with this are not amenable to population-based or early intervention strategies (e.g. being male, insidious onset of symptoms, prominent negative symptoms) which could explain the recently reported lack of sustained benefits from longer-term trials of early intervention for psychosis (Albert *et al*., 2017). It is, therefore, abundantly clear that there will be an ongoing need for specialist mental health rehabilitation services and it is imperative, from a political, clinical and economic perspective, that we improve our understanding of the most effective approaches, models of care, treatments and interventions that they should offer.

Two editorials in this edition address this agenda further. Professor Tom Craig explores the origins and evolution of mental health rehabilitation services with an emphasis on the crucial importance of maintaining a focus on social factors and social interventions in order to deliver effective rehabilitation (*Social Care: an essential aspect of mental health rehabilitation services*). Dr Lisette van der Meer and Dr Charlotte Wunderink review the international evidence for specific mental health rehabilitation programs and psychosocial interventions for those with more complex mental health needs (*Contemporary approaches in mental health rehabilitation*). These complementary perspectives illustrate the impressive extent of research in this field and help to clarify the aspects of treatment and care that require ongoing investment and those that require further evaluation. We already know a great deal about what works for people with complex mental health problems. Our biggest challenge is getting the message across that specialist services for this group are still needed and will continue to be needed for the foreseeable future.

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