Faculty Report
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Rehabilitation services in the UK and Ireland: current status and future need.

This paper is a report of two workshops led by Frank Holloway and Debbie Mountain at the Faculty of Rehabilitation and Social Psychiatry Annual Conference held in November 2007. The aims of the workshops were for participants to share information on the current status of local rehabilitation services across the UK and Ireland, to describe key changes that had taken place and to identify issues for further development.

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There were 27 participants: 1 user and 26 doctors, of whom 24 were Consultant Psychiatrists, 1 a clinical assistant and 1 an SpR (of the 24 Consultants 15 defined themselves as Consultants in Rehabilitation). All worked in NHS/HSE[1] except for 1 consultant who worked in the independent sector.

Settings

Not all questions were fully completed, but of those describing the services in which they worked, 18 worked in inpatient and community settings, 6 worked in inpatient settings only and 1 in the community only. Respondents reported their local catchment areas as ranging between 82,000 and 750,000 with a mean of 315,000. The total catchment population represented by the attenders was 6,922,000.

Elements of the local rehabilitation service

23 catchment areas had access to inpatient beds: 7 had short term beds only, 15 had short term and continuing care beds and 1 had slow stream beds only. Seven catchment areas had access to low secure beds. One catchment area had no inpatient area.

Within the community, 16 catchment areas had a wide range with supported accommodation and access to AOT/crisis services and 6 catchment areas had access to supported housing only. Only 6 catchment areas reported having community rehabilitation teams and in only 2 areas were community rehabilitation teams expanding.

[1] The HSE is the equivalent to the NHS in Ireland

Services referred to should people require more intensive input or more supervision than that available locally

Respondents from 16 catchment areas reported that they would need to refer out-of-area for low secure/forensic provision and in 7 catchment areas this was noted to be private sector provision. One catchment area reported referring out-of-area for inpatient rehabilitation and 2 reported referring to challenging behaviour units.

Changes in the last 2 years

Respondents reported many changes to local practice and provision. Only one respondent reported a clear local strategic direction for rehabilitation and continuing care services: in general changes that occurred appeared ad hoc and reactive to circumstance.

Those working within acute services reported within a context of acute bed reductions increasing pressure to discharge rapidly "chronic" patients with an increased risk profile.

Within rehabilitation services a mixed picture was reported. Three short-term inpatient rehabilitation units had closed with in two cases revenue being used to develop a community rehabilitation team. One area reported the loss of a rehabilitation inpatient service to the independent sector. One area opened a community unit and one area extended their rehabilitation service. One area noted increased pressure where the longer term aspect of care was lost.

Retractions in long-stay rehabilitation/continuing care provision were described. Beds had been reduced in three areas with in two instances the revenue being used to develop assertive outreach. There was in general decreased access to long stay hospital provision, with an emphasis on discharging long stay patients to residential care. However low secure had expanded in one area with another area in advanced planning. One area reported decreasing dependence on out of area placements and another a reduction in funding to the independent sector while another catchment area was commissioning more out of area placements! One catchment area was building a woman's secure unit.

Changes to community support were very variable. Four areas reported an extension in the role of supported accommodation. Another area described the development of intensive support packages for individuals. In one area hostels were closing and residents were moving towards independent living. Two catchment areas reported reductions to/closure of the local community rehabilitation team, in one instance to develop the CMHT.

There were a variety of changes within Assertive Outreach services. One area had reduced the caseload and in another area AOT had taken over the community rehabilitation team. One area had linked AOT to rehabilitation and another had created new teams which separated AOT from rehabilitation.

Desired developments in Rehabilitation Services

Many people wished to see the development of high level planning for those services that work with people who require rehabilitation in the absence of national policies in the UK – it was noted that such a policy exists in Ireland (Department of Health and Children, 2006). There was a request that the Royal College of Psychiatrists set minimum standards for care of "chronic" patients and agree service definitions that would allow clarification of the roles of various teams. There was a parallel call for the development at a local level of a coherent service approach with clear direction within a defined management structure.

There appears to be an increasing awareness of the need to provide care for those with more complex needs. Although these needs were not described in detail, many identified service developments which they thought would address these needs, such as redevelopment of inpatient rehabilitation including short and long term rehabilitaton wards and low secure care. More provision for "new long stay" patients including small local continuing care units, more NHS supported staffed accommodation and more long term hostel wards to support more disabled patients were all considered to be necessary. A need for increasing provision for community support with more hostel places, better access to step-down community beds and a greater variety of supported accommodation was also noted. In addition respondents noted that it was vital to provide resources to support employment and improve vocational training.

Many people discussed the development of the community rehabilitation team to fulfill a range of tasks including in-reach to the acute wards. Respondents identified a need for better liaison and partnership working between agencies including housing providers, the independent sector, the local authority and the voluntary sector. It was felt that clear pathways to and from the rehabilitation service would result in a more efficient and effective pattern of care.

It was noted that staffing within rehabilitation services required more investment by expanding the consultant and psychology workforce and effectively resourcing staff in rehabilitation and recovery teams. Investing in training in recovery concepts and recovery-orientated practice was mentioned by a number of respondents.

Conclusions

Psychiatrists attending the workshop described the current pattern of dedicated rehabilitation provision available to nearly 7 million people. The average catchment area was in excess of 300,000 population (very similar to that reported by Killaspy et al, 2005). The commonest pattern of dedicated NHS/HSE rehabilitation service was a combination of short- and long-term inpatient provision with an apparent increase in access to local low secure/challenging behaviour provision to that reported by Killaspy et al (2005). The pattern of community care available was very variable and there was evidence that community rehabilitation teams were both less common than identified by Killaspy et al (2005) and under continuing threat.

The single most significant change respondents identified as a priority was for improved strategic direction for recovery, rehabilitation and long-term care services. Whilst Ireland has a clear policy supporting the development of these services (Department of Health and Children, 2006) there is no such policy within the UK. As a result it is impossible to identify a coherent theme in the service changes that the respondents reported. The Faculty of Rehabilitation and Social Psychiatry (2005) has previously identified this policy gap and made initial suggestions about the core elements of an effective local recovery and rehabilitation service. Responses by experts in the field would suggest that further work to this end is clearly needed.

References

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