NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Rehabilitation for adults with complex psychosis and related severe mental health conditions

Draft for consultation, January 2020

This guideline covers mental health rehabilitation for adults aged 18 and over with complex psychosis and related severe mental health conditions. It aims to ensure people can have rehabilitation when they need it and promotes a positive approach to long-term recovery. It includes recommendations on organising rehabilitation services, assessment and care planning, delivering programmes and interventions, and meeting people's physical healthcare needs.

Who is it for?

- Healthcare professionals
- Social care practitioners and other practitioners providing public services for people with complex psychosis and related severe mental health conditions
- Commissioners and providers of mental health services
- People using mental health services, their families and carers

This draft guideline contains:

- the draft recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect practice.
- the guideline context.

Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the evidence reviews, the scope, and details of the committee and any declarations of interest.

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Contents

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Who should be offered a rehabilitation service?

1.1.1 Offer a rehabilitation service to people with complex psychosis and related severe mental health conditions as soon as it is identified that they have treatment-resistant symptoms and functional impairments that affect their activities of daily living and social participation. This group of people is likely to include:

- people who have experienced recurrent admissions or extended stays in acute inpatient or psychiatric units, either locally or out of area
- people living in 24-hour staffed accommodation whose placement is breaking down.

To find out why the committee made the recommendation on who should be offered a rehabilitation service and how it might affect practice, see rationale and impact.

1.2 Overarching principles of rehabilitation

1.2.1 Rehabilitation services for people with complex psychosis and related severe mental health conditions should:

- provide a recovery-orientated approach with a shared ethos and goals that ensures individualised, person-centred care through collaborative

working and shared decision making with services users and their carers involved

- recognise that not everyone regains the same level of function they had before the illness and may need to stay in supported accommodation in the long term.

To find out why the committee made the recommendation on overarching principles of rehabilitation and how it might affect practice, see rationale and impact.

1.3 Organising the rehabilitation service

1.3.1 The rehabilitation service should be embedded within a comprehensive local mental healthcare system and offer a range of provision, with different levels of support available. The service should form a rehabilitation pathway that includes:

- inpatient rehabilitation, including high-dependency rehabilitation units, and community rehabilitation units **and**
- community rehabilitation, providing clinical care from a community mental health rehabilitation team to people living in supported accommodation (residential care, supported housing and floating outreach).

1.3.2 Health and social care commissioners should jointly commission the rehabilitation service working together with health services, local authorities and other partners (third sector and independent sector providers, service users and their families and carers).

1.3.3 The joint strategic needs assessment should include the number of people with complex psychosis and related severe mental health conditions who:

- are currently placed out of area in rehabilitation services

- have recurrent admissions or extended stays (for example, longer than 60 days) in acute inpatient units and psychiatric intensive care units, either locally or out of area
- live in highly supported (24-hour staffed) accommodation
- are receiving care from forensic services but will need to continue their rehabilitation locally when risks or behaviours that challenge have been sufficiently addressed (for example, fire setting, physical or sexual aggression)
- are frail and may need specialist supported accommodation.

1.3.4 Consider jointly commissioning the most specialised services (including highly specialist rehabilitation units and longer-term high-dependency rehabilitation units) across areas to provide these services at a regional level for people with particularly complex needs.

1.3.5 Ensure that the rehabilitation pathway is designed to provide flexibility and support over the longer term, taking into account that:

- some people need to spend longer at different stages of the rehabilitation pathway than others
- some people need more than 1 period of rehabilitation to progress successfully.

The lead commissioner

1.3.6 Health and social care commissioners should jointly designate a lead commissioner to oversee the commissioning of rehabilitation services for people with complex psychosis and related severe mental health conditions.

1.3.7 The lead commissioner should:

- have in-depth knowledge and experience of commissioning services for people with psychosis and other severe mental health conditions
- have knowledge of local rehabilitation services and partnerships
- be familiar with best practice in rehabilitation.

To find out why the committee made the recommendations on organising the rehabilitation service and the lead commissioner, and how they might affect practice, see rationale and impact.

An integrated pathway

1.3.8 The lead commissioner should work together with service providers to deliver an integrated rehabilitation service, by ensuring that:

- regular communication is supported between senior service managers and senior clinicians across providers of different services within the pathway
- budgets and other resources are shared between local authorities and health services, to develop local and regional rehabilitation services according to the local population's needs
- funding mechanisms support collaboration between service providers and do not create unhelpful or perverse funding incentives that undermine people's progression through the rehabilitation pathway
- clinical records and care plans are shared between providers
- service level agreements are developed to support collaborative working in a timely and flexible way between relevant services and agencies
- services within the pathway are staffed by appropriately skilled staff
- the remit for each of the services making up the pathway (see recommendation 1.3.1) is clearly specified, including the population they cover
- people experience smooth transitions between different services in the pathway and with other parts of the mental health system and health service.

1.3.9 The lead commissioner and service providers should enable people to join and leave the rehabilitation pathway at different points, and move between parts of the pathway that provide higher or lower levels of support according to their changing needs.

1.3.10 The lead commissioner and service providers should ensure that transitions in people's care between mental health teams or primary care:

- are guided by criteria that are clearly defined in local policy
- are agreed with the person and their family or carers (as appropriate) and the clinicians involved in the person's care, at least 3 months before the transition (unless a referral is urgent)
- include an individually tailored period of co-working between services to ensure a smooth transition of care and sharing of all relevant information
- are supported by a local rehabilitation panel, where clinicians can discuss potential referrals and re-referrals and receive advice on appropriate treatment and support
- allow swift re-referral to the rehabilitation service if the person's needs increase and they would benefit from further rehabilitation.

1.3.11 The lead commissioner and service providers should ensure that people have opportunities to visit potential supported accommodation before moving in to help them make an informed choice about the service.

1.3.12 The lead commissioner should consider putting in place a fully integrated system between health and social care teams to improve transitions for people moving on from rehabilitation services and enhance their experiences. This would involve the same multidisciplinary team working across services, using a shared IT and electronic records system and managing care, including for people placed out of area.

1.3.13 For more information on managing transitions, see the NICE guideline on transition between inpatient mental health settings and community or care home settings.

To find out why the committee made the recommendations on an integrated pathway and how they might affect practice, see rationale and impact.

Working with other healthcare providers

1.3.14 The lead commissioner should oversee the agreement of local protocols with primary and secondary physical healthcare providers, for people having inpatient or community rehabilitation. These protocols should:

- promote access to national physical health screening programmes, health promotion, monitoring and interventions (see section 1.10 on physical healthcare)
- ensure there is a system to monitor and report people's access to physical healthcare and outcomes that takes into account the increased physical health risks for specific subgroups, for example the higher prevalence of metabolic syndrome and diabetes in people from black, Asian and minority ethnic groups
- ensure that any physical health conditions are assessed and treated (see section 1.10)
- ensure practitioners in primary care, secondary physical care and rehabilitation services work collaboratively and flexibly, drawing together the necessary expertise and capacity to manage physical health conditions
- ensure that the processes of the Mental Capacity Act (including Court of Protection decisions) do not delay care and treatment.

1.3.15 The lead commissioner should agree local protocols with specialist substance misuse services for people having inpatient or community rehabilitation who have substance misuse problems. These should:

- define local arrangements and the content of care to ensure people have access to support from local substance misuse services
- include in-reach arrangements for people in inpatient rehabilitation services
- monitor and review access to substance misuse services and outcomes.

1.3.16 For people who need clozapine in the community, the lead commissioner should agree a local protocol with the community mental health service for starting or restarting clozapine.

To find out why the committee made the recommendations on working with other healthcare providers and how they might affect practice, see rationale and impact.

1.4 Improving access to rehabilitation

1.4.1 The lead commissioner and service providers should make information available to health and social care practitioners, people who may benefit from rehabilitation and their families and carers, about the local rehabilitation pathway and how it is accessed.

1.4.2 The lead commissioner should work together with service providers to ensure that everyone with complex psychosis and related severe mental health conditions has equal access to rehabilitation services regardless of age, gender, ethnicity and other characteristics protected by the Equality Act 2010, and should actively monitor and report on access at least every 6 months.

1.4.3 If any differences are found in rates of access for specific groups of people (for example, women or ethnic groups) compared with anticipated rates, these should be addressed, for example through:

- providing bespoke services for specific groups, for example women-only services
- providing outreach into other services that work with underserved groups and/or home visiting
- providing tailored information and advocacy.

1.4.4 Services should support people to access legal advice about their immigration status if required.

To find out why the committee made the recommendations on improving access to rehabilitation and how they might affect practice, see rationale and impact.

1.5 Delivering services within the rehabilitation pathway

Multidisciplinary teams

1.5.1 Inpatient and community rehabilitation services for people with complex psychosis and related severe mental health conditions should be staffed by multidisciplinary teams that include:

- rehabilitation psychiatrists
- psychologists
- nurses
- occupational therapists
- social workers
- approved mental health practitioners
- support workers.

1.5.2 The multidisciplinary team should have access to specialist pharmacists, physical exercise coaches, vocational trainers, welfare rights specialists, dietitians and podiatrists.

Size of accommodation

1.5.3 Commissioners and providers of inpatient rehabilitation services and supported accommodation should be aware of the benefits to people of providing rehabilitation in smaller facilities, for example for promoting self-management, autonomy and social integration.

Service quality improvement

1.5.4 Services should consider using tools to support quality improvement such as the Quality Indicator for Rehabilitative Care (QuIRC) for inpatient rehabilitation units, and the QuIRC-Supported Accommodation (QuIRC-SA) for supported accommodation. Also consider joining a peer accreditation or quality improvement forum.

Inpatient rehabilitation

1.5.5 Inpatient rehabilitation units should operate with an expected maximum length of stay (which should be used as a guide rather than an absolute) to reduce the chance of people becoming 'institutionalised'.

1.5.6 Service providers should advise people about the impact of being in inpatient rehabilitation services for an extended period of time on their welfare benefits and the tenure of any existing housing tenancy.

Community rehabilitation

1.5.7 For people with complex psychosis and related severe mental health conditions, living in supported accommodation, specialist clinical care should be provided by a multidisciplinary community mental health rehabilitation team. This team should:

- provide home-based care wherever the person is living
- coordinate the person's care and hold overall clinical responsibility for the person's mental health while the person is living in the community
- oversee the person's progression through the rehabilitation pathway
- liaise with the GP about the person's physical healthcare.

1.5.8 Community mental health rehabilitation teams should operate with a shared team caseload approach, through discussing people's care together at regular team meetings to pool and agree ideas about care and treatment.

Supported accommodation

1.5.9 To prevent unnecessary delays in people's progress along the rehabilitation pathway, staff must be aware that they may need to assess the person's capacity with regard to moving to supported accommodation at the earliest opportunity and follow the necessary steps in the Mental Capacity Act 2005 to enable their move. Also see the NICE guideline on decision making and mental capacity.

1.5.10 Supported accommodation services should:

- give the person stability and avoid unnecessary moves
- be in a familiar location close to the person's social networks if this is clinically appropriate
- include support with tasks such as managing money and activities of daily living while encouraging independence and participation in society
- give the person the option (if they are eligible) to have a personal budget or direct payment so they can choose and control their social care and support (adopted from the NICE guideline on service user experience in adult mental health)
- give the person a safe place that they can personalise and view as their own
- provide support that is matched to the person's mental and physical health needs
- recognise and safeguard individual vulnerability, risk, loneliness and exploitation.

Out-of-area placements

1.5.11 Commissioners should aim to place people locally and limit the use of out-of-area placements wherever possible, except for people with particularly complex needs. This could include:

- people with psychosis and brain injury, or psychosis and autism spectrum disorder, who need treatment in a highly specialist rehabilitation unit **or**
- people who have a clear clinical or legal requirement to remain outside their home area.

1.5.12 Commissioners should only provide an out-of-area placement after a local placement funding panel has confirmed that the person's care cannot be provided locally.

1.5.13 A designated care manager (or 'out-of-area placement review officer'), based within the community mental health rehabilitation team, should review the person's placement after the first 3 months and then every 6 months, to ensure it still meets their needs. This should include:

- reviewing the person's progress with them and the multidisciplinary team at their placement
- agreeing the necessary steps to help the person progress in their recovery so they can transfer to an appropriate placement in their local area at the earliest opportunity.

1.5.14 When people are placed in out-of-area rehabilitation services, the local placement funding panel should explain the following in writing to the person (and their family or carers, as appropriate):

- the reasons for them being placed out of area
- what steps will be taken to return them to their local area
- the support that will be provided to their family or carers to help them keep in contact with each other
- the advocacy support available to help them.

> To find out why the committee made the recommendations on delivering services within the rehabilitation pathway and how they might affect services, see rationale and impact.

1.6 Recovery-orientated rehabilitation services

1.6.1 Staff working in rehabilitation services should aim to foster people's autonomy, promote active participation in treatment decisions and support self-management.

1.6.2 Build on people's strengths and encourage hope and optimism by:

- helping people choose and work towards personal goals, based on their skills, aspirations and motivations
- maintaining continuity of individual therapeutic relationships wherever possible
- providing access to leisure, education, work and other opportunities for meaningful occupation, and building networks through voluntary, health, social care and mainstream resources

- helping people to gain skills to manage both their activities of daily living and their mental health
- providing opportunities for sharing experiences with peers
- encouraging positive risk-taking
- developing people's self-esteem and confidence
- validating achievements and celebrating progress
- recognising that people vary in their experiences and progress at different rates
- improving people's understanding of their experiences and the treatment and support that may help them – for example, through accessible written information, face-to-face discussions and group work.

Supported decision making

1.6.3 Ensure staff in rehabilitation services follow recommendations in the NICE guideline on decision making and mental capacity.

1.6.4 Provide support to people, if they need it, to express their views, preferences and aspirations in relation to their care and support in line with recommendations in the NICE guideline on people's experience in adult social care services.

1.6.5 Local authorities must, in line with the Care Act 2014, provide independent advocacy to enable people to participate in:

- care and support needs assessment **and**
- care planning **and**
- the implementation process and review

where they would otherwise have substantial difficulty in doing so.

Universal staff competencies

These recommendations apply to all staff working in the services described in recommendation 1.3.1.

1.6.6 Ensure that staff training includes an emphasis on recovery principles so that all rehabilitation staff are able to work with a recovery-orientated approach.

1.6.7 Rehabilitation staff should establish and maintain non-judgmental, collaborative relationships with people with complex psychosis and related severe mental health conditions.

1.6.8 Provide support for rehabilitation staff to acknowledge and manage any feelings of pessimism about people's potential for recovery. Support could include helping staff to share experiences and frustrations with each other, for example through supervision, reflective practice and peer support groups.

1.6.9 Ensure that staff have training and competence in delivering non-discriminatory practice and attend appropriate diversity training. They should have an understanding that people from black, Asian and minority ethnic groups may experience stigma arising from both their ethnicity and their mental health condition.

1.6.10 Ensure all staff are trained and skilled in supporting structured group activities and promoting daily living skills.

1.6.11 Staff should be trained and skilled in risk management to an appropriate level for the service they work in. For example, staff in high-dependency units should be able to work with people who have a serious risk to themselves or others.

1.6.12 Rehabilitation services should ensure that their healthcare staff are competent to recognise and care for people with psychosis and coexisting substance misuse.

Maintaining and supporting social networks

1.6.13 Discuss with the person whether, and how, they want their family or carers to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances and should not

happen only once. As the involvement of families and carers can be quite complex, staff should receive training in the skills needed to negotiate and work with families and carers, and also in managing issues relating to information sharing and confidentiality.

1.6.14 Respect the rights and needs of carers alongside the person's right to confidentiality. Review the person's consent to share information with family members, carers and other services during their rehabilitation. Follow recommendations on involving families and carers in NICE's guideline on service user experience in adult mental health services.

1.6.15 Give families, parents and carers information about support services in their area that can address emotional, practical and other needs (this is particularly important if the person is accessing rehabilitation services for the first time).

1.6.16 Advise carers about their right to the following and how to get them:

- a formal assessment of their own needs (known as a 'carer's assessment'), including their physical and mental health
- an assessment of their need for short breaks and other respite care.

1.6.17 Enable the person to maintain links with their home community by:

- supporting them to maintain relationships with family and friends, for example, by finding ways to help with transport
- helping them to stay in touch with social and recreational contacts
- helping them to keep links with employment, education and their local community.

This is particularly important if people are in an out-of-area placement.

To find out why the committee made the recommendations on recovery-orientated rehabilitation services and how they might affect services, see rationale and impact.

1.7 Person-centred care planning through assessment and formulation

Assessment

1.7.1 Offer people a comprehensive needs assessment by a multidisciplinary team within 4 weeks of entering the rehabilitation service.

1.7.2 Include the following as part of the comprehensive needs assessment:

- primary and coexisting mental health problems
- psychiatric history, including past admissions and treatments, responses to treatment, adverse effects to medicines and medicines adherence
- vulnerabilities (including self-neglect, exploitation and abuse) and the person's risk of harm to themselves and others
- physical health and wellbeing through a physical health check (see recommendation 1.7.3)
- developmental history, including birth and milestones; relationships with peers; and problems at school (identifying any problems with social or cognitive functioning, motor development and skills or coexisting neurodevelopmental conditions)
- occupational and educational history, including educational attainment and reason for leaving any employment
- social history, including accommodation history (noting the highest level of independence); culture, ethnicity and spirituality; leisure activities; and finances
- substance use
- psychological and psychosocial history, including relationships, life history, experiences of abuse and trauma, coping strategies, strengths, resiliency, and previous psychological, psychosocial interventions
- current social network, including any caring responsibilities
- current skills in activities of daily living
- current cognitive function

- the person's capacity to give informed consent for their treatment in line with the Mental Capacity Act 2005.

1.7.3 The initial physical health check in the comprehensive assessment should include:

- BMI
- waist circumference
- pulse and blood pressure
- glycosylated haemoglobin (HbA1c), blood lipid profile, liver function tests and thyroid function
- prolactin levels (for people on medicines that raise prolactin levels)
- renal and calcium levels (for people on lithium)
- drug levels where appropriate, for example mood stabilising or anti-epileptic medicines, lithium and clozapine
- electrocardiogram (ECG)
- smoking, alcohol or substance use
- nutritional status, diet and level of physical activity
- any movement disorders
- sexual health
- vision, hearing and podiatry
- oral inspection.

1.7.4 Be aware that people with complex psychosis and related severe mental health conditions:

- are more likely to have multiple comorbidities
- have a higher prevalence of the following conditions (which may contribute to higher mortality in this population):
  - cardiovascular disease
  - chronic obstructive pulmonary disease (COPD)
  - dental problems and poor oral health
  - diabetes
  - metabolic syndrome

- obesity
- osteoporosis
- substance misuse.

Care planning and review

1.7.5 Use the results of the comprehensive assessment to make a formulation to inform treatment and care planning. The care plan should:

- cover the areas of need identified during assessment (see recommendation 1.7.2), including both mental and physical health (for physical healthcare planning, see recommendations 1.10.2 and 1.10.3)
- include the person's personal recovery goals
- clarify responsibilities for staff, the person themselves and their family or carers (where relevant).

1.7.6 Consider using accessible formatting to support development of the care plan with the person.

1.7.7 Review people's progress and care plans with them at multidisciplinary care review meetings at least:

- every month in the inpatient rehabilitation service
- every 6 months in the community.

1.7.8 Incorporate both staff rated and service-user rated measurements of the person's progress into their care plan reviews, so that their support can be adjusted if needed.

1.7.9 Update care plans according to changes in the person's needs after these meetings and between meetings as needed. At every meeting or review, consider and plan with the person their transition to the next step in the rehabilitation pathway.

1.7.10 Ensure that care plans are shared with the person and everyone involved in the person's care (for example, clinicians, supported accommodation staff, and the person's family or carers, if the person agrees) at:

- each review
- each transition point in the rehabilitation pathway
- at discharge from the service.

For more on care plans and assessment before discharge, see recommendations 1.5.20 and 1.5.21 in the NICE guideline on transition between inpatient mental health settings and community or care home settings.

To find out why the committee made the recommendations on person-centred care planning through assessment and formulation, and how they might affect practice, see rationale and impact.

1.8 Rehabilitation programmes and interventions

Daily living skills

1.8.1 Rehabilitation services should develop a culture that promotes activities to improve daily living skills as highly as other interventions (for example, medicines).

1.8.2 Provide activities to help people develop and maintain daily living skills such as self-care, laundry, shopping, budgeting, using public transport, cooking and communicating (including using digital technology).

1.8.3 Support people to engage in activities to develop or improve their daily living skills by:

- working with each person to make a plan to improve these skills that recognises their needs and regularly reviews their goals
- provide activities they enjoy to help motivate them
- providing individualised, risk-managed access to real-life settings (such as kitchens and laundry rooms) where people can practise their skills, wherever feasible.

Interpersonal and social skills

1.8.4 Offer structured group activities (social, leisure or occupational) aimed at improving interpersonal skills. These could be peer-led or peer supported and should be offered:

- daily in inpatient rehabilitation services
- at least weekly in community settings.

1.8.5 Offer regular opportunities for discussion about the choice of group activities, for example, by inviting everyone in the inpatient unit or supported accommodation service to a 'community meeting'.

1.8.6 Offer regular one-to-one sessions with a named member of staff to help the person plan and review their activity programme. The person could be:

- the primary nurse in inpatient rehabilitation **or**
- the person's care coordinator or keyworker in community rehabilitation services.

Engagement in community activities, including leisure, education and work

1.8.7 Programmes to engage people in community activities should:

- be flexible and make reasonable adjustments to accommodate the person's illness and fluctuating needs
- develop structure and purpose in the person's day
- increase their sense of identity and social inclusion
- involve peer support
- be individualised
- recognise people's skills and strengths
- promote a sense of community and belonging.

1.8.8 Offer people a range of opportunities for hobbies and leisure activities that are meaningful to them. These should be tailored to their interests, level of ability and wellness.

1.8.9 Offer people a range of educational and skill development opportunities, for example, recovery colleges and mainstream adult education settings, which build confidence and may lead to qualifications if the person wishes.

1.8.10 For people who would like to work towards mainstream employment, consider referring them to supported employment that uses the Individual Placement and Support approach.

1.8.11 Take into account and advise people about the impact of supported employment on their welfare benefits.

1.8.12 For people who are not ready to return to paid employment, consider alternatives such as transitional employment schemes and volunteering.

1.8.13 Consider providing a cognitive remediation intervention alongside vocational rehabilitation services.

1.8.14 Develop partnerships, for example with voluntary organisations and local employment advice schemes, to increase opportunities for support to prepare people for work or education.

Substance misuse

1.8.15 Ask people about their substance and alcohol use when they enter the rehabilitation service.

1.8.16 Assess people's readiness to address their substance misuse, for example, through motivational interviewing.

1.8.17 Rehabilitation services should work with specialist substance misuse services to support people in line with NICE guidelines on:

- coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings
- coexisting severe mental illness and substance misuse: community health and social care services

- alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence.

1.8.18 Rehabilitation services should offer support and substance misuse interventions that aim to:

- support harm reduction
- change behaviour
- help people develop coping strategies
- improve engagement with substance misuse services
- prevent relapse.

1.8.19 Substance misuse services should provide reasonable adjustments to help people use specialist substance misuse services, for example, by providing in-reach services to people in the inpatient rehabilitation unit.

To find out why the committee made the recommendations on rehabilitation programmes and interventions and how they might affect practice, see rationale and impact.

1.9 Adjustments to mental health treatments in rehabilitation

This section focuses on people with symptoms of psychosis that have not responded well to standard treatment.

1.9.1 For standard pharmacological and non-pharmacological treatments, follow recommendations in these sections of the NICE guideline on psychosis and schizophrenia in adults:

- choice of antipsychotic medication (section 1.3.5)
- how to use antipsychotic medication (section 1.3.6)
- how to deliver psychological interventions (section 1.3.7)
- subsequent acute episodes of psychosis or schizophrenia and referral in crisis (section 1.4).

Also see the NICE guideline on bipolar disorder, in particular section 1.10 on using antipsychotic medication.

1.9.2 Discuss all mental health treatment options with people in line with recommendations on shared decision making in NICE's guideline on patient experience in adult NHS services.

1.9.3 Routinely monitor for and treat other coexisting mental health conditions, including depression, obsessive compulsive disorder, anxiety and substance misuse (for guidance on these conditions, see NICE's web page on mental health and behavioural conditions).

1.9.4 For people diagnosed with a coexisting autism spectrum disorder, follow recommendations in the NICE guideline on autism spectrum disorder in adults.

Psychological therapies

1.9.5 Continue to offer people with complex psychosis and related severe mental health conditions individual cognitive behavioural therapy (CBT) with or without family intervention, as recommended by the NICE guideline on psychosis and schizophrenia in adults. Follow the recommendations on delivery and monitoring in the section on psychological interventions.

1.9.6 Consider additional psychological interventions, especially for people who are not able to engage in CBT. Use psychological assessment and formulation to identify the most appropriate therapeutic intervention, guided by the person's preferences. Interventions could include:

- those focusing on learned behaviours and how context influences behaviour
- mindfulness approaches where people can be supported to focus on and attend to present experiences
- approaches that include a focus on wider systems such as families or ward environments and their impact on the person.

1.9.7 Consider training all rehabilitation staff in low-intensity psychological interventions such as motivational interviewing, positive behaviour

support, behavioural activation, and simple techniques for supporting people who are having troubling thoughts and feelings.

Pharmacological treatments

1.9.8 For people with complex psychosis and related severe mental health conditions whose symptoms have not responded adequately to clozapine alone, consider options such as augmenting clozapine with:

- an antipsychotic[1], for example aripiprazole[2] **and/or**
- a mood stabiliser[3] **and/or**
- an antidepressant[4].

Seek specialist advice if needed, for example from a specialist mental health pharmacist.

1.9.9 If combination treatment is used, consider 2 antipsychotics with different receptor-binding profiles.

1.9.10 Optimise the dosage (as tolerated) of medicines used in the management of complex psychosis (see recommendations 1.9.1 and 1.9.8) according to the BNF and therapeutic plasma levels in the first instance.

[1] Although this use is common in UK clinical practice, at the time of consultation (January 2020), antipsychotics do not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

[2] Although this use is common in UK clinical practice, at the time of consultation (January 2020), aripiprazole did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

[3] Although this use is common in UK clinical practice, at the time of consultation (January 2020), mood stabilisers do not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

[4] Although this use is common in UK clinical practice, at the time of consultation (January 2020), antidepressants do not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

1.9.11 Only use multiple medicines, or doses above BNF or summary of product characteristics limits, to treat complex psychosis:

- if this is agreed and documented at a meeting with a multidisciplinary team and the person (and their family, carer or advocate, as appropriate)
- as a limited therapeutic trial, returning to conventional dosages or monotherapy after 3 months, unless the clinical benefits of higher doses or combined therapy clearly outweigh the risks
- if the medicines are being used to treat specific symptoms (for example, positive and negative symptoms)
- after taking into account drug interactions and side effects
- if systems and processes are in place for monitoring the person's response to treatment(s) and side effects (monitoring may include physical examination, ECG and appropriate haematological tests).

1.9.12 Regularly review medicines used in the management of complex psychosis. If pharmacological treatment is not successful, consider stopping the medicine but be cautious when reducing doses, because people with complex psychosis and related severe mental health conditions may have been on medicines for many years.

1.9.13 If treatment is being reduced or discontinued, this should be:

- agreed and documented at a meeting with a multidisciplinary team and the person (and their family, carer or advocate, as appropriate)
- done slowly over a period of time and closely monitored to allow symptoms of relapse to be detected.

1.9.14 Monitor drug levels to check adherence and guide dosing:

- at least annually and as needed for clozapine and mood stabilising anti-epileptic medicines
- every 3 to 6 months for people established on lithium, following guidance on using lithium in the NICE guideline on bipolar disorder.

1.9.15 Consider monitoring prolactin levels annually if the person is taking a medicine that raises prolactin, and more regularly if they have symptoms.

1.9.16 Monitor thyroid function, renal function and calcium levels at least every 6 months for people established on lithium, following guidance on using lithium in the NICE guideline on bipolar disorder.

1.9.17 Consider annual ECGs for everyone with complex psychosis and related severe mental health conditions in rehabilitation services, and more regularly if they are taking medicines, combinations of medicines or medicines above BNF or summary of product characteristics limits that may alter cardiac rhythm (for example, causing prolonged QT interval).

1.9.18 Be aware that people may be using non-prescription substances (for example, alcohol, smoking, illegal drugs) to cope with their symptoms, which may affect their prescribed medicines.

1.9.19 When treating people with symptoms of psychosis that have not responded well to standard treatment, follow the recommendations in the NICE guideline on medicines optimisation.

Adherence to medicines

1.9.20 Rehabilitation services should promote adherence to medicines in line with the NICE guideline on medicines adherence.

1.9.21 Specific ways to promote adherence could include avoiding complex medicine regimens and polypharmacy wherever possible.

Helping people to manage their own medicines

1.9.22 Offer people the opportunity to manage their own medicines through a graduated self-management of medicines programme if they have been assessed as able to take part. Follow recommendations on self-management plans in the NICE guideline on medicines optimisation.

1.9.23 Be flexible in tailoring the self-management of medicines programme and choice of equipment to the person's needs and preferences. This could

include using monitored dosage systems together with a reminder system (for examples, charts or alarms).

Electroconvulsive therapy

1.9.24 See the NICE technology appraisal guidance on the use of electroconvulsive therapy.

To find out why the committee made the recommendations on adjustments to mental health treatments in rehabilitation and how they might affect practice, see rationale and impact.

1.10 Physical healthcare

Responsibilities for healthcare providers

1.10.1 GPs should develop and use practice case registers to monitor the physical and mental health of people with complex psychosis and related severe mental health conditions in primary care.

1.10.2 For people having community rehabilitation, GPs should assume lead responsibility for the person's physical health needs, including health checks and treatment of physical health conditions, working collaboratively with the community mental health rehabilitation team and other services as relevant.

1.10.3 For people having inpatient rehabilitation, the rehabilitation team should ensure that health checks, treatment of physical health conditions and other healthcare needs are addressed, working collaboratively with primary care.

Coordinating physical healthcare

1.10.4 Nominate a trained healthcare professional from the rehabilitation service to provide continuity of physical healthcare across settings, liaising between the rehabilitation service, primary care, secondary mental health and secondary physical healthcare.

1.10.5 The nominated professional should contribute to physical healthcare plans, ensuring they are informed by the initial physical health check (see recommendation 1.7.3) and include:

- health promotion interventions (see healthy living, below)
- routine screening through the national screening programmes (for example, cervical cancer) if the person is eligible
- monitoring side effects of pharmacological treatments (see the section on pharmacological treatments)
- monitoring of physical health (see monitoring physical health, below)
- monitoring of oral health
- treatment plans for any risk factors or health conditions (see care and treatment for physical health conditions, below)
- any reasonable adjustments needed for healthy living, screening, monitoring or treatments
- the physical healthcare responsibilities for primary care, the rehabilitation service, other secondary mental health services and secondary physical healthcare.

1.10.6 Staff must follow the Mental Capacity Act 2005 when supporting people's physical health, including in primary and secondary physical healthcare screening, prevention, investigations and treatment.

Healthy living

1.10.7 Offer people who smoke help to stop smoking, even if previous attempts have been unsuccessful. Follow recommendations 1.1.3.3 to 1.1.3.5 in NICE's guideline on psychosis and schizophrenia in adults.

1.10.8 Offer people, and proactively encourage them to engage with, a combined healthy eating and physical activity programme by their mental healthcare provider.

1.10.9 Give people clear and accessible information about any health risks related to their:

- medicines (side effects)

- lifestyle, including:
  - diet and physical activity
  - smoking, alcohol or substance use
  - oral hygiene
  - bone health
  - sexual and reproductive health.

1.10.10 Offer annual flu vaccination to people in inpatient rehabilitation services and communal supported accommodation. Explain that family members or carers who support them may also be eligible for free flu vaccination (see the section on flu vaccination in carers in NICE's guideline on flu vaccination).

1.10.11 Support people to maintain good oral hygiene and access dental appointments in line with NICE's guideline on oral health promotion.

1.10.12 Consider providing advice and support for good sleep hygiene and maximise opportunities for healthy sleep. For example, for inpatients, avoid barriers to sleep such as environmental factors or intrusive night-time checks.

Monitoring physical health

1.10.13 Offer people in rehabilitation services a routine physical health check at least annually. The physical health check should include:

- BMI
- waist circumference
- pulse and blood pressure
- HbA1c, blood lipid profile, liver function tests and thyroid function
- ECG if indicated (see recommendation 1.9.17)
- assessment of smoking, alcohol or substance use
- assessment of nutritional status, diet and level of physical activity
- assessment of any movement disorders
- assessment of sexual health
- vision, hearing and podiatry.

For additional physical health checks associated with pharmacological treatments, see the section on pharmacological treatments.

1.10.14 Give people the choice, whenever possible, to have their annual physical health check at their GP practice or by the nominated trained professional at the rehabilitation service (see recommendation 1.10.1).

1.10.15 Ensure a copy of the results of the physical health check is available to the rehabilitation service, primary care, secondary mental healthcare and secondary physical healthcare as appropriate, and record in the case notes. Discuss any important findings with the person.

1.10.16 Be alert to the possibility of infection with hepatitis B and hepatitis C in people who could be at risk, for example because of homelessness, intravenous drug use or a history of sexually transmitted disease. For more information about those at risk and case identification, see the NICE guideline on hepatitis B and C testing.

Care and treatment for physical health conditions

1.10.17 Use the physical health check in recommendation 1.10.13 to identify at the earliest opportunity people who:

- have hypertension
- have abnormal lipid levels
- are obese or at risk of obesity
- have diabetes or are at risk of diabetes
- have cardiovascular disease
- are physically inactive
- have COPD.

Offer treatment in line with NICE guidance, ideally in primary care.

To find out why the committee made the recommendations on physical healthcare and how they might affect practice, see rationale and impact.

Terms used in this guideline

Behavioural activation

A low-intensity intervention using goal setting and activity schedules to encourage people to engage in activities they have previously avoided due to factors such as low mood or motivation.

Cognitive remediation intervention

A manualised intervention to improve people's cognitive function.

Complex psychosis and related severe mental health conditions

People with a primary diagnosis of a psychotic illness (including schizophrenia, bipolar disorder, psychotic depression, delusional disorders and schizoaffective disorder) plus severe, treatment-resistant symptoms (positive and/or negative) and/or comorbid conditions, which lead to impaired social and everyday functioning.

Commissioners

At the time of writing, the development of integrated care systems, integrated care providers and NHS provider collaboratives is changing the commissioning landscape in the English health and care system. This may be formalised within new legislation. All references to 'commissioners' and 'commissioning' in this guideline should therefore be read in that context, wherever the commissioning function may sit and however it may operate in the future NHS in England.

Community mental health rehabilitation teams

Community mental health rehabilitation teams provide specialist skills and care coordination to identify and address people's rehabilitation needs in the community. These teams can work in all community settings, but commonly work with people living in supported accommodation, often over many years, in order to enable their optimum level of functioning and independence.

Community rehabilitation units

Inpatient rehabilitation units that are set outside of hospital grounds. These units provide the full complement of multidisciplinary treatment and support for people with ongoing complex needs that prevent the person from being discharged from a high-

dependency rehabilitation unit directly to supported accommodation. They build on the progress made in the high-dependency inpatient rehabilitation unit and have a strong focus on promoting independent living skills and community participation. Most referrals come from high-dependency rehabilitation units or acute inpatient units. Community rehabilitation units can only care for detained people under the Mental Health Act if the unit is registered as a ward. If they are not registered as a ward, they can care for people who are voluntary or those subject to a community order (for example, a community treatment order, guardianship, conditionally discharged Section 37/41). The expected length of stay in a community rehabilitation unit is around 2 years.

Floating outreach

Floating outreach services provide support to people living in time-unlimited, usually self-contained, individual tenancies. Staff are based off-site and visit for a few hours per week, providing practical and emotional support, with the aim of reducing support over time to zero.

Formulation

Formulation is a shared understanding of the issues that brought the person into rehabilitation services. It is their story, but draws on information from theory and research, as well as the experiences of the person, professionals and, where possible, others such as carers. It includes factors that made the person vulnerable to developing problems, factors that triggered the problems and factors that keep the problems going. A formulation includes strengths and resources and points to ways that problems can be addressed.

Graduated self-management plan

A process of supporting a person to learn how to take and manage their own medicines. This usually involves them managing 1 day of medicines to begin with, with staff undertaking spot checks before progressing to managing 2 days then 3 days and so on.

High-dependency rehabilitation units

Inpatient rehabilitation units for people with complex psychosis whose symptoms have not yet been stabilised and whose associated risks and challenging behaviours

remain problematic. Units aim to maximise benefits of medication, address physical health comorbidities, reduce challenging behaviours, re-engage families and facilitate access to the community. Most people in high-dependency units are detained under the Mental Health Act. Most (80%) referrals to high-dependency units are from acute inpatient units and 20% from forensic units, with only occasional referrals of people living in the community. The expected length of stay is around 1 year.

Highly specialist rehabilitation units

Highly specialist rehabilitation units are inpatient rehabilitation units for people with psychosis and specific comorbid conditions that require a specialist programme tailored to the person's specific comorbidity (such as acquired brain injury, severe personality disorder, autism spectrum disorder or Huntingdon's disease). Often, the complexity of the coexisting conditions is associated with greater support needs (more challenging behaviours and/or greater risks to self and others) than people having treatment in a high-dependency rehabilitation unit. Referrals come from acute inpatient units or high-dependency rehabilitation units, and the expected length of stay is over 3 years.

Individual Placement and Support approach

A method of supporting people with severe mental health difficulties into work is Individual Placement and Support (IPS). IPS finds people a job quickly and then provides time-unlimited individualised support to keep the job and manage their mental health.

Inpatient rehabilitation units

Inpatient rehabilitation units provide specialist inpatient care to people with complex psychosis and related severe mental health conditions. They can be based within a hospital or in the community.

Joint strategic needs assessment

Joint strategic needs assessment (JSNA) is a process for identifying the health and social care needs of the population in a particular area, and the planning of services to address those needs. The Health and Social Care Act 2012 placed a statutory duty on upper tier local authorities and clinical commissioning groups to prepare a

JSNA together, to commission services taking into account the JSNA, and to refer to the JSNA in the development of the local Joint Health and Wellbeing Strategy. The process is led by local authorities, working with the NHS and other organisations in an area.

Local placement funding panel

A panel not specific to rehabilitation, who agree funding (health, social care or both) for people to receive treatment within area or out of area, for example in a nursing or residential care home, or in an inpatient rehabilitation unit. The panel has a commissioner and senior managers, as well as clinicians (a senior rehabilitation clinician plus possibly a senior clinician who works in general adult care, not specifically rehabilitation).

Local rehabilitation panel

A panel of rehabilitation clinicians who are available to discuss referrals and give expert clinical advice.

Longer-term high-dependency rehabilitation units

Longer-term high-dependency rehabilitation units provide longer-term inpatient rehabilitation for people with high levels of disability due to treatment-refractory symptoms and comorbid conditions, which take more than 1 year to stabilise, and who have ongoing risks to others and/or challenging behaviours. The aims of longer-term high-dependency rehabilitation units are the same as for high-dependency rehabilitation units, and most referrals come from high-dependency rehabilitation units.

Low-intensity psychological interventions

Brief skills-based interventions that can be delivered by any staff member or service user who has had suitable training in the intervention. They include: guided self-help using online resources or workbooks; relaxation or mindfulness; stress workshops and behavioural activation groups.

Motivational interviewing

A person-centred low-intensity intervention that supports behavioural change by helping people explore and resolve ambivalence towards change.

Out-of-area placements

A rehabilitation out-of-area placement occurs when someone receives treatment and support in an inpatient rehabilitation unit or supported accommodation outside the local area where they usually live. The placement may be away from the person's local area because there is no local service available, or because there are clinical or legal reasons that make local rehabilitation inappropriate for their needs, or because they prefer to have treatment outside their local area.

Positive behavioural support

A behaviour management system that seeks to understand the reasons behind problematic behaviours and to find alternative ways to meet goals and needs.

Reasonable adjustments

Reasonable adjustments are changes that are made by organisations such as public service providers, shops and employers, to make it possible for people with disabilities to use a service or do a job. These changes could include things like longer health appointment times or providing a special piece of equipment to do a job. It is a legal requirement under the Equality Act 2010 for organisations to make reasonable adjustments to ensure that as far as this is possible, someone who is disabled is able to receive the same services and job opportunities as someone who is not disabled.

Recovery-orientated approach

There is no single definition of recovery for people with mental health problems, but the guiding principle is the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. In this guideline, it is used to refer to someone achieving the best quality of life they can, while living and coping with their symptoms. It is an ongoing process whereby the person is supported to build up their confidence and skills and resilience, through setting and achieving goals to minimise the impact of mental health problems on their everyday life.

Recovery colleges

Recovery colleges deliver peer-led education and training programmes within mental health services. They provide education as a route to recovery, not as a form of

therapy. The courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals.

Residential care

Residential care homes comprise communal facilities, staffed 24 hours, where day-to-day needs are provided (including meals, supervision of medicines and cleaning), and placements are not time limited. People do not hold a tenancy in a residential care home.

Supported accommodation

Supported accommodation is an umbrella term covering the terms supported housing, residential care and floating outreach.

Supported housing

Supported housing services are shared or individual self-contained, time-limited tenancies with staff based on-site up to 24 hours a day who help the person to gain skills to move on to less supported accommodation. The expected length of stay is around 2 years but only around a third of people manage to move on in that time.

Transitional employment schemes

Transitional employment schemes give people a supported occupation in which to gain pre-vocational work experiences and potentially prepare for mainstream employment. One of the original examples was the ‘clubhouse’ model of psychosocial rehabilitation developed at Fountain House in New York.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Who should be offered a rehabilitation service?

What is the efficacy and cost effectiveness of rehabilitation services versus treatment as usual for people with complex psychosis or related severe mental health conditions, with residual disability, leaving early intervention services?

To find out why the committee made the research recommendation on who should be offered a rehabilitation service, see rationale and impact.

2 Peer-support interventions

How can peer-support interventions be used most effectively to support people with complex psychosis and related severe mental health conditions using rehabilitation services?

To find out why the committee made the research recommendation on peer support interventions, see rationale and impact.

3 Highly specialist and longer-term high-dependency rehabilitation units

What are the service and service user characteristics of highly specialist and longer-term high-dependency rehabilitation units that are associated with better outcomes?

To find out why the committee made the research recommendation on highly specialist and longer-term high-dependency rehabilitation units, see rationale and impact.

4 Structured group activities

What structured group activities are effective at improving interpersonal functioning (social skills) for people with complex psychosis and related severe mental health conditions?

To find out why the committee made the research recommendation on structured group activities, see rationale and impact.

5 Inpatient rehabilitation provided by the independent sector

What is the clinical and cost effectiveness of inpatient rehabilitation provided by the independent sector compared with that provided by the NHS?

To find out why the committee made the research recommendation on inpatient rehabilitation provided by the independent sector, see rationale and impact.

Other recommendations for research

Integrated care system

Is an integrated care system effective at promoting successful progress for people with complex psychosis and related severe mental health conditions to a more independent setting?

Staff training interventions

What staff training interventions are effective at facilitating personal recovery for people with complex psychosis and related conditions?

Coexisting neurodevelopmental and mental health conditions

What coexisting neurodevelopmental and mental health conditions need to be considered when forming a rehabilitation plan for people with complex psychosis and related severe mental health conditions?

Medicines adherence

What interventions are effective to support medicines adherence for people in supported accommodation?

Tailored interventions

What tailored interventions (pharmaceutical and psychological) specific to rehabilitation are effective at equipping people with complex psychosis and related severe mental health conditions with the ability to live in the community?

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice and services. They link to details of the evidence and a full description of the committee's discussion.

Who should be offered a rehabilitation service?

Recommendation 1.1.1

Why the committee made the recommendation

Low to very low-quality evidence from randomised controlled trials of rehabilitation in the community and observational studies of inpatient rehabilitation showed that rehabilitation was effective and cost effective for many people with complex psychosis and related severe mental health conditions. Qualitative evidence also showed that people with severe mental illness value rehabilitation. Although there was moderate quality evidence that people with shorter duration of illness before rehabilitation and lower psychopathology scores were more likely to progress through the rehabilitation pathway, the committee thought that everyone with treatment-resistant symptoms and functional impairments had the potential to benefit. In the committee's experience, people with recurrent or extended stays in acute inpatient psychiatric units, or in a supported accommodation placement that is breaking down, are indicative of people with treatment-resistant symptoms and functional impairments.

The committee was aware that some people leaving early intervention services will have complex psychosis or a related severe mental health condition, with significant residual disability in terms of persisting symptoms and functional impairment. However, it was not possible from the evidence to determine whether providing very early access to rehabilitation to people leaving early intervention services could prevent repeated admissions and problems in daily living. The committee therefore made a research recommendation to assess rehabilitation services for people leaving early intervention services.

How the recommendation might affect practice

Earlier access to rehabilitation services should result in people with treatment-resistant symptoms and functional impairments receiving more effective treatment sooner. This should reduce repeated admissions, enable earlier referral to less intensive (and cheaper) services and support more independent living. There may be some resource impact if more units are needed; however, most trusts in England have existing mental health rehabilitation units and half of trusts have community rehabilitation mental health teams (CRMHTs) who work with people after they have left hospital and moved to supported accommodation. In areas without CRMHTs,

community mental health teams (CMHTs) already care-coordinate. There will also be substantial savings from repatriation of people placed out of area.

Full details of the evidence and the committee's discussion are in:

- evidence review A: identifying people who would benefit most
- evidence review D: effectiveness of rehabilitation services.

Other supporting information can be found in:

- evidence review F: required components of an effective rehabilitation pathway
- evidence review J: rehabilitation approaches, care, support and treatment that are valued
- evidence review Q: factors associated with successful transition.

Return to recommendations

Overarching principles of rehabilitation

Recommendation 1.2.1

Why the committee made the recommendation

There was qualitative evidence on the approaches, care, support and treatment that are valued by people using rehabilitation. A recovery-orientated approach was reported in the evidence to be of particular value and there was evidence that services adopting this approach to a greater extent were more successful in supporting people to progress along the rehabilitation pathway. The committee used this evidence along with their clinical knowledge and experience to recommend an overarching set of principles to guide the delivery of rehabilitation services.

Based on the evidence, the committee noted that not everyone with complex psychosis will get better. However, in the committee's experience, everyone with treatment-resistant symptoms had the potential to benefit from rehabilitation, even if they do not regain the same level of function and continue to need a high level of support in the longer term.

How the recommendation might affect practice

The committee agreed that the overarching principles reflect current practice and do not need any additional resources to deliver.

Full details of the evidence and the committee's discussion are in evidence review J: rehabilitation approaches, care, support and treatment that are valued.

Return to recommendations

Organising the rehabilitation service, and the lead commissioner

Recommendations 1.3.1 to 1.3.7

Why the committee made the recommendations

Organising the rehabilitation service (recommendations 1.3.1 to 1.3.5)

The evidence supported having a local rehabilitation pathway that includes a range of services allowing people to progress from high to lower dependency. The committee agreed, based on their knowledge and experience, that different levels of support are needed by people in rehabilitation, and providing only 1 type of service would not accommodate people's full recovery. Both inpatient (high-dependency units and community units) and community rehabilitation services (community mental health rehabilitation teams providing clinical support to people in supported accommodation) would be required. They also agreed that the rehabilitation service needed to be embedded in the local mental healthcare system to ensure integration.

The committee agreed that arranging rehabilitation services at a local level would:

- enable better integration between health and social care (because supported accommodation and housing are arranged at local authority level)
- help to prevent inappropriate care, for example, people being unable to progress from inpatient units or out-of-area placements
- provide options for appropriate aftercare for people who have been detained in hospital (a statutory obligation under the Mental Health Act 1983).

In the committee's view, the commissioning of rehabilitation services needs to take into account the mental health services that are already available and how services

will work together to meet the population's needs. Currently, there is a lack of integration between services and a lack of clarity about who should be funding and commissioning them. The committee considered it essential that health and social care commissioners work together to commission services, to address people's overlapping health and social care needs. They acknowledged that to provide a full range of inpatient rehabilitation services, independent sector providers as well as those in the NHS may need to be involved.

Local authorities are required under the Health and Social Care Act (2012) to perform a joint strategic needs assessment to identify the health and social care needs of their population. The committee identified key groups to be aware of while conducting the needs assessment – people who are most likely to need local rehabilitation services, and those who might need highly specialist or longer-term rehabilitation services – to ensure services can be planned to help meet their needs.

The committee was aware that commissioning highly specialist services at the local level might not be feasible because there may not be enough people with very complex needs to warrant a dedicated unit. Therefore, they recommended local areas could work together to commission these services at a regional level.

The committee highlighted the need for flexibility within the rehabilitation pathway. People with complex psychosis do not always have a linear progression to recovery from needing high support to independence; some people may need continued support in the long term and some people may need more than 1 period of rehabilitation. It should be possible to accommodate this in the pathway.

The lead commissioner (recommendations 1.3.6 and 1.3.7)

Evidence from qualitative studies showed that integration and collaborative working across teams and services was facilitated by a lead champion. This model of a lead commissioner is also recommended by NICE for people with learning disabilities and behaviour that challenges, who similarly have overlapping health and social care needs. Qualitative evidence, along with the experience of the committee, provided a number of attributes that would enable the lead commissioner to effectively perform their role.

How the recommendations might affect practice

Organising the rehabilitation service (recommendations 1.3.1 to 1.3.5)

These recommendations largely reflect current practice in terms of joint commissioning. However, greater emphasis on an integrated rehabilitation pathway will likely see people being referred less often to out-of-area placements and discharged from inpatient rehabilitation to community rehabilitation settings at a faster rate.

Economic evidence from a wider NHS and Personal Social Perspective indicates that there may be a large cost saving from faster discharge rates that are appropriate to a person's illness and reducing inappropriate out-of-area placements. However, there may be a high resource impact for local authorities who are responsible for commissioning the provision of housing for people discharged from inpatient units. To some degree, this resource impact felt by local authorities would be offset by faster transitions to supported housing and floating support. Nevertheless, the overall health benefits of people spending more time in contact with community-based services, and less in inpatient facilities, would offset any additional resource impact.

The lead commissioner (recommendations 1.3.6 and 1.3.7)

An appropriately skilled lead commissioner would facilitate local authorities working together with health and social care commissioners, which is current practice in some areas.

Full details of the evidence and the committee's discussion are in:

- evidence review A: identifying people who would benefit most and evidence review P: features of supported accommodation that promote successful living (recommendation 1.3.3)
- evidence review F: required components of an effective rehabilitation pathway (recommendations 1.3.1, 1.3.2 and 1.3.4)
- evidence review G: integrated rehabilitation care pathways involving multiple providers (recommendations 1.3.6 and 1.3.7).

Return to recommendations

An integrated pathway

Recommendations 1.3.8 to 1.3.13

Why the committee made the recommendations

The qualitative evidence identified a number of barriers to integrating rehabilitation care pathways, which resonated with the committee's own experiences. 'Siloes' of resources were discussed as a key barrier, and the committee noted that collaborations among services are hard to sustain unless they are underpinned by sufficient shared budgets. They also agreed that competitive funding among services is often not in the best interest of people in rehabilitation because it can discourage services from supporting a person to progress through the pathway. The committee agreed that the lead commissioner could also help to address other barriers, for example by ensuring that important information is shared across services, putting in place agreements to support collaboration, and clearly defining staff roles and responsibilities.

The committee agreed that because people with complex psychosis have a fluctuating illness, they need to be able to move between services in the pathway depending on their needs. The committee also discussed the importance of smooth transitions when moving between mental health teams or primary care, and recommended measures, based on consensus, to achieve this.

There was some qualitative evidence that some service users come to services passively because it is simply where they are 'sent to' next. Being able to visit a service before a placement begins, helps people to make their own decisions and to feel more at ease about making the transition.

One randomised controlled trial provided evidence of benefit of an integrated system to support transitions. An integrated system here referred to a team of health and social care practitioners and informal caregivers for each person who met weekly to coordinate care, were able to communicate through a shared IT environment, and were trained to collaborate. Because of the evidence being limited to 1 randomised controlled trial and a lack of detail about what aspects of the intervention were effective, the committee recommended considering integrated care systems as an option rather than strongly recommending them.

How the recommendations might affect practice

Developing an integrated approach to rehabilitation is likely to be costly initially. Resources would be needed to set up services and underpin the collaboration between them (for example, systems to coordinate and communicate between services). However, an integrated rehabilitation pathway is likely to be cost effective in the longer term. Additional costs would be offset by the economic and health benefits of successful transitions and people receiving the correct level of support.

Visiting rehabilitation settings is common in some areas, and should not involve a high resource impact, unless the person needs significant support to attend the visit.

Full details of the evidence and the committee's discussion are in:

- evidence review G: integrated rehabilitation care pathways involving multiple providers (recommendation 1.3.8)
- evidence review Q: factors associated with successful transition (recommendations 1.3.9 and 1.3.10)
- evidence review B: barriers in accessing rehabilitation services (recommendation 1.3.11)
- evidence review R: supporting successful transitions (recommendations 1.3.12 and 1.3.13).

Return to recommendations

Working with other healthcare providers

Recommendations 1.3.14 to 1.3.16

Why the committee made the recommendations

The evidence showed that people with severe mental illness are at increased risk of many comorbid conditions and substance misuse. The committee considered it crucial that healthcare (both mental health and physical health), social care and substance misuse services develop local protocols to ensure people in rehabilitation receive appropriate physical healthcare and substance misuse services if they need them. Based on their knowledge and experience, the committee made

recommendations on what these protocols should cover to ensure consistency across services.

In the committee's experience, some people using rehabilitation services may need to start or restart treatment with clozapine. This requires strict monitoring and at the moment many of these people are admitted to hospital. However, it is possible to provide clozapine in the community with the right level of monitoring through an extended-hours service. The committee agreed that making clozapine available in the community would prevent unnecessary hospital admissions and is an important part of a successful rehabilitation service.

How the recommendations might affect practice

Rehabilitation services should already be working with other providers to meet people's needs for physical healthcare and substance misuse services. However, if services and funding within an area are highly siloed, additional resources may be needed to enable this collaboration.

Although clozapine in the community is not available in all areas, most areas do have a team in place providing an extended-hours service for people with mental illness, for example a crisis resolution home treatment team. It may involve additional costs to fund the extra work for this team to provide clozapine at community level, but it could be balanced by cost savings resulting from better management of psychosis symptoms.

Full details of the evidence and the committee's discussion are in:

- evidence review C: prevalence of comorbidity (recommendation 1.3.14)
- evidence review O: effective interventions in addressing substance misuse (recommendation 1.3.15)
- evidence review H: principles to guide adjustments to standard treatment (recommendation 1.3.16).

Return to recommendations

Improving access to rehabilitation

Recommendations 1.4.1 to 1.4.4

Why the committee made the recommendations

In the committee's experience, many potential users of rehabilitation services and their families and carers are unaware of what services are available and how to access them. This was also reflected in the qualitative evidence.

Qualitative evidence found that factors like age, sex, physical health problems, race and ethnicity were barriers to accessing rehabilitation for many people, because services are often unequipped to meet specific needs associated with these groups. The evidence also found no significant association between successful progress in rehabilitation services and age, gender or ethnicity. The Equality Act 2010 requires services to be accessible regardless of these protected characteristics and the committee agreed everyone with complex psychosis should have access to rehabilitation services. They therefore provided examples for how these access inequalities could be addressed.

The committee recommended supporting people to access legal advice about their immigration status if required, in case people might be concerned about being deported if they access services.

How the recommendations might affect practice

The recommendations might have some resource impact, depending on how developed services are in this respect across different areas. For example, some extra resources may be needed if outreach is needed to improve accessibility for minority groups. However, equal access and reasonable adjustments are requirements of the Equality Act 2010 and so should be standard practice and already considered in budgeting.

The recommendation to support people to access legal advice about their immigration status could require access to costly legal specialists; however, the committee noted this is currently being done in practice.

Full details of the evidence and the committee's discussion are in evidence review B: barriers in accessing rehabilitation services.

Return to recommendations

Delivering services within the rehabilitation pathway

Recommendations 1.5.1 to 1.5.14

Why the committee made the recommendations

Multidisciplinary teams (recommendations 1.5.1 and 1.5.2)

There was some evidence that supported providing community rehabilitation through a multidisciplinary team and this was in line with the committee's own experience. The committee also considered multidisciplinary working to be effective in inpatient rehabilitation services, so they recommended it for both inpatient and community settings. They used their own expertise to recommend the core roles that should be included in the team, and the other health professionals the team should have access to, to provide sufficient mental and physical healthcare during rehabilitation. Input from specialist pharmacists would be required because of the complex medicines being taken by people with complex psychosis. This is also a group with high levels of physical health comorbidity so input from physical exercise coaches, dietitians and podiatrists would help promote physical health. Input from welfare rights specialists would also be important because people with complex psychosis will be on welfare benefits and are likely to need advice on their income.

Size of accommodation (recommendation 1.5.3)

The evidence suggested that for every additional bed in an inpatient rehabilitation unit, there was an associated small decline in people's quality of care (as rated by Quality Indicator for Rehabilitative Care [QuIRC] on living environment, therapeutic environment, promotion of self-management and autonomy and promotion of social integration). The committee agreed this finding was also relevant to supported accommodation. The committee could not specify the optimal size of inpatient units or supported accommodation because no absolute optimal size was indicated in the evidence, and units of varying size may be appropriate for different areas with different needs.

Service quality improvement (recommendation 1.5.4)

There was evidence that the quality of rehabilitative care (as measured using QuIRC for inpatient units and QuIRC-SA for supported accommodation) was associated with

better outcomes of rehabilitation, autonomy, experience of care and satisfaction for people using the service. This evidence came from inpatient units, community units and supported accommodation. The committee agreed that measuring the quality of rehabilitative care using currently available tools would help rehabilitation units to identify areas for improvement and ultimately lead to better rehabilitation services. They also recommended services consider joining a peer accreditation or quality improvement forum because rehabilitation services often exist in isolation, so it is important for them to share good practice with other practitioners.

Inpatient rehabilitation (recommendations 1.5.5 and 1.5.6)

Evidence showed that rehabilitation units with an expected maximum length of stay were associated with better quality of care. The committee agreed that having an expected maximum length of stay could help prevent delays when people are ready to move on through the rehabilitation pathway. However, they also agreed this should not be treated as absolute; services need to be flexible and provide appropriate treatment and support tailored to each person's needs.

The committee noted that accepting a placement in inpatient rehabilitation could affect people's eligibility to receive particular benefits (for example housing benefit) and could affect people's existing tenancies with local authorities. The committee wanted providers to be aware of and advise people about these issues.

There was a lack of evidence about the characteristics of effective highly specialist or longer-term high-dependency inpatient services. People with particularly complex comorbid conditions whose care cannot be managed in less specialised settings often spend very long periods of time (sometimes many years) in highly specialist or longer-term inpatient rehabilitation services. The Care Quality Commission has raised concerns about quality of life for people in this group. It is important to understand the characteristics of services and service users that support successful progress through rehabilitation, so the committee made a research recommendation.

Community rehabilitation (recommendations 1.5.7 and 1.5.8)

The committee used their expertise to extrapolate from the evidence showing multidisciplinary community team management increased participating in activities of daily living, to recommend how community mental health rehabilitation teams should

provide care and work together to support people in community rehabilitation. However, they acknowledged that this team's remit may vary in different areas depending on how other community-based services are organised.

Supported accommodation (recommendations 1.5.9 and 1.5.10)

The committee noted from their experience in practice that issues with mental capacity can cause delays to people moving to supported accommodation. They agreed it was necessary to highlight the need for staff to follow steps outlined in the Mental Capacity Act 2005 so that people can progress through the rehabilitation pathway.

The committee used qualitative evidence to highlight features of supported accommodation that are valued by people, such as having stable accommodation with privacy and a sense of belonging, being able to live in an area where they already have roots, and having the support they need to live the life they want to live as independently as possible. The committee discussed the importance of supporting people to have autonomy, including to make potentially risky decisions, while still maintaining reasonable safety and helping people to avoid exploitation. The committee believed that in the long term, these recommendations would allow service users to live more sustainably and independently in the community, with fewer stressors and mental health relapses that lead to hospitalisation.

Out-of-area placements (recommendations 1.5.11 to 1.5.14)

Health economic modelling showed that providing rehabilitation locally was less costly than using out-of-area placements, which are often provided by the independent sector. Although no clinical outcomes were found in the accompanying systematic review, the model included data from the Care Quality Commission, which showed that people placed in out-of-area inpatient wards have a longer average stay on such wards than those placed in local wards. There is a large hypothetical overall cost saving from a wider NHS and Personal Social Services perspective which, in the model, is driven by a reduction in the rate of out-of-area placements and faster discharge rates to supported accommodation that enable more independent living.

The committee acknowledged that there were no relevant clinical outcomes or utility data to compute quality-adjusted life years, although they were of the view that a person in supported accommodation would typically have improved activities of daily living in these settings. Therefore, the committee believed that reducing out-of-area placements would result in more people being appropriately discharged to supported accommodation, which would reduce costs and improve quality of life.

The committee was aware of evidence suggesting that for many people in out-of-area placements, it could be appropriate to offer rehabilitation in local units. Being in a local unit also makes it easier for people to maintain contact with their families, communities and local support networks or activities, such as peer support groups.

The committee shared anecdotal reports of people being in out-of-area placements for many years, without clinical oversight from the person's local area. To avoid this, they made recommendations to ensure that out-of-area placements are offered only when care cannot be provided locally, and that people should return to their local area as soon as possible. In the meantime, people should be supported to maintain contact with friends and family. The committee also agreed that service users and their families and carers (as appropriate), should receive written information about their out-of-area placement, so they have this information to hand and know their rights about the placement.

There was a lack of comparative evidence between services provided by the independent sector and the NHS. The committee acknowledged that the independent sector is an important provider of rehabilitation services; however, the services they provide are often a long way from where people live, and from the local area that funds their placement. Many independent units are locked, and lengths of stay are considerably longer (and therefore costlier) than in equivalent NHS services. There is little systematic and reliable evidence on the characteristics of users of these services or the effectiveness of these units, to establish if the longer stays are necessary. Given the potential for significant cost savings if the effectiveness in the two sectors were found to be the same, the committee made a research recommendation.

How the recommendations might affect practice

The recommendation for the multidisciplinary team to have access to additional health professionals may have a resource impact for those teams without this access currently. However, because some teams already have access to these specialties, the committee did not think this would be a significant resource impact.

Not all supported accommodation services currently use the QuIRC-SA so the recommendation may lead to a moderate change in practice. This tool is web-based, free to use and completed annually by a unit manager or senior staff member in around 90 minutes. Further investment may be required to rectify deficiencies identified by these quality measures; however, the committee considered this would be justified by improved experience of care and better rehabilitation outcomes for service users.

The recommendation to advise on the impact of rehabilitation placements on tenancies could require access to welfare rights specialists (as in recommendation 1.5.6), which could have a resource impact for services without this access currently.

The committee recognised that in some regions, the implementation of the recommendations about supported accommodation may require local authorities to invest significantly in improving the quality and variety of supported accommodation they offer. Nevertheless, local authorities often commission the provision of supported accommodation and therefore are able to set quality of accommodation as quality components when tendering to providers, and can control budgets.

There is likely to be some service reconfiguration required by the recommendations on out-of-area placements as people move back to local units. New rehabilitation units may need to be commissioned locally and there could be a substantial initial investment. The committee argued that this 'investment' is currently already being spent on out-of-area placements so would not constitute additional funding.

The recommendation for a designated care manager may represent a change in practice in some areas. For areas that don’t currently perform regular clinical review of people being sent out of area, this could represent an additional resource;

however, if the review leads to people being brought back within area to a more cost-effective placement, this resource could be offset.

Full details of the evidence and the committee's discussion are in:

- evidence review E: comparative effectiveness of different types of rehabilitation services (recommendations 1.5.1, 1.5.2, 1.5.7, 1.5.8 and 1.5.11 to 1.5.14)
- evidence review F: required components of an effective rehabilitation pathway (recommendations 1.5.3 to 1.5.5)
- evidence review P: the features of supported accommodation that promote successful community living (recommendations 1.5.6 and 1.5.10).
- evidence review R: supporting successful transitions (recommendation 1.5.9).

Return to recommendations

Recovery-orientated rehabilitation services

Recommendations 1.6.1 to 1.6.17

Why the committee made the recommendations

Recommendations 1.6.1 and 1.6.2

Qualitative evidence showed that service users value a recovery-orientated approach to their care. This means helping people to work towards their aspirations and make the most of their abilities, while giving them support and encouragement wherever needed. The evidence suggested several key areas including activities of daily living, hobbies and interests, and vocational goals, where service users believed that services could build their aspirations towards recovery and put this orientation into practice.

Supported decision making (recommendations 1.6.3 to 1.6.5)

Working collaboratively with people with severe mental health conditions to produce a care plan can be challenging because of diminished communication and capacity. However, despite these challenges, planning care in collaboration with the service user is expected practice in UK mental health services and is established within existing mental health guidelines. For this reason, the committee reviewed the existing NICE guidance for mental health and adopted recommendations, rather than

conducting a review of the evidence. The committee identified recommendations in existing NICE guidelines about capacity and communication barriers.

The offer of independent advocacy is a key aspect of collaborative care planning, so the committee adopted a recommendation from NICE's guideline on people's experience in adult social care services that they agreed was relevant to people using rehabilitation services.

Universal staff competencies (recommendations 1.6.6 to 1.6.12)

The committee considered training and knowledge in recovery orientation to be essential to deliver an effective, recovery-orientated rehabilitation service. They also agreed that recovery can only be facilitated by developing collaborative and non-judgemental relationships with people using the service. There was qualitative evidence, however, that staff sometimes lack optimism or are overly risk-averse about the prospect of rehabilitation for some people, and that this can negatively affect a person's recovery. To address this, the committee recommended ways to encourage positive attitude changes among staff (such as peer support groups and reflective practice) that aim to help them retain hope and optimism, while acknowledging that not everyone will achieve full independence.

Qualitative evidence was supported by the committee's experience that service users from minority groups may experience language barriers and unconscious prejudices related to mental illness and also to their minority ethnic status. The combination of this may produce its own unique barriers within services. In line with the evidence, the committee agreed it was important for staff to be aware of the additional barriers to using services faced by people from Black, Asian and minority ethnic groups, because of additional cultural and language barriers, or racial biases and prejudices.

Based on limited evidence and committee consensus, structured group activities were seen as a key aspect of rehabilitation (see recommendation 1.8.4) that all staff should be able to support, not just specific staff such as occupational therapists. The committee also discussed safeguarding and risk, and agreed that all staff need to be trained to deal with risks relevant to the setting they are working in.

There is a high prevalence of alcohol and substance use problems among the rehabilitation population. The committee thought it was essential that all staff are able to identify these problems and provide the right support, so they adapted a recommendation from NICE's guideline on coexisting severe mental illness and substance misuse for the rehabilitation population.

Maintaining and supporting social networks (recommendations 1.6.13 to 1.6.17)

Involving family members and carers in decision making can reduce isolation and increase support for people having rehabilitation. However, for people with severe mental illness, it can be complex to involve family members and carers. Previous relationships may have broken down during the person's illness, or the person may find it difficult to form new relationships, and they may need additional support to assist them. A person's capacity or their wishes about other people's involvement can also change during their illness. Laws and established NICE guidelines are already in place related to these topics and so the committee agreed it was appropriate to review these rather than conduct an evidence review. With these points in mind, the committee adopted:

- recommendation 1.6.13 from the NICE guideline on service user experience in adult mental health
- recommendations 1.6.14 and 1.6.15 from the NICE guideline on transition between inpatient mental health settings and community or care home settings.

The committee adopted further recommendations about ensuring families, parents and carers get the support that they need, and on enabling people to maintain relationships with their home community and networks. They adopted:

- recommendation 1.6.16 from the NICE guideline on dementia
- recommendation 1.6.17 from the NICE guideline on transition between inpatient mental health settings and community or care home settings

How the recommendations might affect practice

The recommendations on staff competences may have a resource impact where services do not currently provide training. However, any additional resources needed

may be offset by the benefits to service users of establishing a recovery-orientated rehabilitation service. Helping people with complex psychosis to engage with their family members or carers may be more resource intensive than for people with less severe disease, because of the functional and communication problems people with complex psychosis may face. But these recommendations are derived from other NICE guidance so should reflect current practice.

Full details of the evidence and the committee's discussion are in:

- evidence review J: rehabilitation approaches, care, support and treatment that are valued (recommendations 1.6.1, 1.6.2 and 1.6.6)
- evidence review I: collaborative care planning (recommendations 1.6.3 to 1.6.5 and 1.6.13 to 1.6.17)
- evidence review B: barriers in accessing rehabilitation services (recommendations 1.6.7 to 1.6.9)
- evidence review K: interventions to improve activities of daily living (recommendation 1.6.10)
- evidence review A: identifying people who would benefit most (recommendation 1.6.11)
- evidence review O: effective interventions in addressing substance misuse (recommendation 1.6.12).

Return to recommendations

Person-centred care planning through assessment and formulation

Recommendations 1.7.1 to 1.7.10

Why the committee made the recommendations

Assessment (recommendations 1.7.1 to 1.7.4)

The committee used evidence about rates of physical and mental health conditions and substance misuse in this population to recommend what to consider as part of the initial assessment when people enter the rehabilitation service. The committee drew on their experience to provide details about what a structured comprehensive

needs assessment should cover in order to assess people's complex needs and specific comorbidities.

The committee agreed that the baseline investigations before starting antipsychotic medicines recommended in the NICE guidelines on psychosis and schizophrenia in adults and bipolar disorder should form the core of the initial physical health check for people in rehabilitation services because most would be receiving antipsychotic medicines. They therefore adapted this recommendation.

The committee also drew on the evidence identifying the most common physical comorbidities so that they could highlight the conditions that rehabilitation staff need to be alert for because these may contribute to higher mortality in this population.

Care planning and review (recommendations 1.7.5 to 1.7.10)

The committee agreed that using the initial needs assessment to identify comorbid health conditions and assess other common needs, such as personal recovery goals, could contribute to a healthcare plan that would reduce morbidity and mortality, and improve people's function and quality of life.

Quantitative evidence suggested that detailed and regularly updated care plans prompt actions to be taken that lead to better service user outcomes, especially when developed within a multidisciplinary team. The committee used this evidence, their own experience, and other NICE guidelines to make further recommendations on good care planning. They recommended reviews every month in inpatient rehabilitation, and every 6 months for people having community rehabilitation, to provide a balance between keeping a plan relevant without being overly invasive.

The committee was aware that the NICE guideline on transition between inpatient mental health settings and community or care home settings made recommendations on a full list of considerations for a care plan at discharge. The committee referred to these recommendations because they apply to the population in this guideline.

How the recommendations might affect practice

An initial needs assessment is already standard practice, but changes might be needed to align with recommendations on what the assessment should include.

Physical health checks should also be standard practice, but the committee noted that monitoring and treatment of coexisting health problems was variable in this population so the recommendations should improve consistency of practice.

The recommendations on care planning should not have substantial resource implications. In some areas, additional staffing and training might be needed to enable more regular and thorough review, but in the long term these costs will be offset by more effective treatment, improved recovery and a reduced need for crisis teams, hospital beds and other services.

Full details of the evidence and the committee's discussion are in:

- evidence review C: prevalence of comorbidity (recommendations 1.7.1 to 1.7.4)
- evidence review I: collaborative care planning (recommendations 1.7.5 to 1.7.10).

Return to recommendations

Rehabilitation programmes and interventions

Recommendations 1.8.1 to 1.8.19

Why the committee made the recommendations

Daily living skills (recommendations 1.8.1 to 1.8.3)

Based on evidence suggesting that interventions could improve activities of daily living, and given the importance of activities of daily living in recovery and quality of life, the committee recommended that interventions to improve these activities should be promoted as highly as other interventions. In the committee's experience, this does not always happen in practice.

Based on their own experience, the committee agreed that individualised support could improve activities of daily living. For example, committee members discussed providing activities that people enjoy and motivate them. If a person is motivated, they might be more likely to engage in activities of daily living such as personal care or going out on public transport. Having access to areas such as kitchens and laundry was also agreed to be key to practising skills.

Interpersonal and social skills (recommendations 1.8.4 to 1.8.6)

There was evidence from qualitative studies that people in rehabilitation value structured group activities, and a randomised controlled trial found that taking part in structured group activities improves interpersonal functioning. This was in line with the committee's views, so they recommended providing these activities in both inpatient and community settings. Based on their clinical experience, structured group activities need to be offered daily in inpatient settings and at least weekly in community settings to be effective, and people should have choice in what they are offered. Although there was no evidence on peer-supported activities, committee members had found these to be effective and agreed they could be an option.

Structured group activities are routinely provided by rehabilitation services, but the evidence base is fairly limited. The committee thought that more specific detail on the structured activities, and their efficacy, could help further inform practice. They therefore made a research recommendation for structured group activities.

Engagement in community activities, including leisure, education and work (recommendations 1.8.7 to 1.8.14)

The committee wanted to emphasise the importance of meaningful occupation and work in promoting recovery and helping to promote community inclusion, based on their own experience and the preferences expressed in the qualitative evidence. The committee highlighted a number of aims of community activities, and recommended a range of hobbies and leisure activities, as well as skill development opportunities.

Evidence from randomised controlled trials showed that Individual Placement and Support (IPS) increases engagement in employment for those interested in work, and this was supported by cost-effectiveness evidence from a health economic model. There was also evidence that adding cognitive remediation can increase the effectiveness of vocational rehabilitation. The committee recommended consideration of both these interventions. They agreed, however, that some people may not be ready for competitive employment and would benefit from alternatives to IPS such as transitional employment schemes.

The committee also discussed the role of partnerships with other organisations such as voluntary organisations and employment advice schemes. They agreed these could be an important route to engagement with employment or education.

The committee discussed peer-support interventions for engaging in community activities. Although peer-support interventions were widely valued by the committee, there was no directly relevant research to guide the development of peer support for community activities in complex psychosis and rehabilitation services. The committee therefore made a research recommendation in this area.

Substance misuse (recommendations 1.8.15 to 1.8.19)

The prevalence of alcohol and substance use problems among the rehabilitation population is high. Because of limited evidence, the committee made recommendations based mainly on consensus and existing NICE guidance. They wanted to prevent a situation where problematic substance use was occurring but rehabilitation staff viewed it as being outside their remit. The committee agreed that questions about substance misuse should be routine when people enter the rehabilitation service and that rehabilitation staff needed to know what their role should be in supporting people and providing substance misuse interventions.

How the recommendations might affect practice

The committee noted that providing access to real-life settings to support people to engage in daily living skills might be challenging in some services, because of the range of people's needs and risks within the service.

Structured group activities such as playing board games and watching DVDs do not have a high resource impact, but activities outside of the rehabilitation setting could be costlier, depending on the support needs of the group. Providing a named person to support engagement is unlikely to have significant resource impact, because an existing key worker or support worker might take on this role if it isn't being done already, and no external provision would be needed.

The committee agreed that relatively few people with complex psychosis in rehabilitation services are ready to engage in paid employment so the recommendations for individual placement and support would have little impact on

current IPS services. Cognitive remediation is not routinely added to vocational rehabilitation and this could lead to a change in practice in for some centres.

The recommendations call for greater awareness among rehabilitation staff about identifying and managing substance use, which could be incorporated into general training for all staff.

Full details of the evidence and the committee's discussion are in:

- evidence review K: interventions to improve activities of daily living (recommendations 1.8.1 to 1.8.3)
- evidence review L: interventions to improve interpersonal functioning (recommendations 1.8.4 to 1.8.6)
- evidence review M: interventions to improve engagement in community activities and evidence review J: rehabilitation approaches, care, support and treatment that are valued (recommendations 1.8.7 to 1.8.14)
- evidence review O: effective interventions in addressing substance misuse (recommendations 1.8.15 to 1.8.19.

Return to recommendations

Adjustments to mental health treatments in rehabilitation

Recommendations 1.9.1 to 1.9.24

Why the committee made the recommendations

Recommendations 1.9.1 to 1.9.4

The committee focused this section on people with symptoms of psychosis resistant to standard treatment because this population is representative of people using rehabilitation services. The committee recommended adjustments to standard treatments for psychosis described in other NICE guidance listed in recommendation 1.9.1.

The evidence showed there were benefits and harms to each treatment option, so the committee agreed that treatment options should be discussed with the person.

They referred to the recommendations on shared decision making in other NICE guidance.

The committee was also aware that comorbidities, including other mental illnesses, and autism spectrum disorder, can affect outcomes in people with complex psychosis, and so recommended treating these comorbidities in line with the relevant NICE guidance.

Psychological therapies (recommendations 1.9.5 to 1.9.7)

There was some evidence from randomised controlled trials showing that for people with treatment-resistant psychosis, cognitive behavioural therapy (CBT) decreased psychosis symptoms (positive) compared with pharmacological therapy alone. Based on this evidence and their experience that people with complex psychosis are often too unwell to engage with CBT at earlier contacts with the rehabilitation service, the committee recommended that it should be continued in this treatment-resistant population.

In the committee's experience, some people in rehabilitation services are not able to engage with CBT. The committee discussed the importance of providing additional psychological interventions but could not recommend a specific intervention because of the lack of evidence. Instead they recommended possible interventions to consider and emphasised that these should be based on psychological assessment, formulation and consideration of each person's preferences.

The committee also wanted to acknowledge the importance of low-intensity psychological interventions. Despite the lack of evidence from trials, the committee decided that the option of providing all staff with skills in delivering these interventions should be considered in rehabilitation settings.

Pharmacological treatments (recommendations 1.9.8 to 1.9.19)

There was some evidence from randomised controlled trials supporting augmentation with the agents in recommendation 1.9.8 for reducing psychosis symptoms in people with schizophrenia refractory to clozapine. The evidence was limited by small sample sizes and information on adverse events was very sparse. However, given the lack of treatment options, and considering that current

prescribing for this population is inconsistent, the committee decided that augmentation should be considered an option. In general, the committee recommended classes of drug rather than individual drugs, but they specifically mentioned aripiprazole as an example while recommending augmentation with antipsychotics. The committee noted that amisulpride is more commonly prescribed than aripiprazole, but the evidence did not show a change in psychosis symptoms following amisulpride, while there was some evidence regarding the effectiveness of aripiprazole in reducing total psychosis symptoms. Although the evidence also showed that ziprasidone decreased psychosis symptoms, this drug is not licensed or available in the UK.

Given the safety profiles of these drugs and their potential interactions when combined, the committee recommended seeking advice from a specialist pharmacist if needed.

The committee made recommendations on dosing, combination treatments and interactions with other substances based on their experience and knowledge about the safety of various therapeutic options. They also agreed it was important to measure drug levels regularly to assess adherence and guide dosing. There was a lack of evidence on how frequently this should be done, so the committee used their own knowledge and experience, as well as drawing on NICE's guideline on bipolar disorder for monitoring of people taking lithium.

The committee also agreed it was important to monitor the effects of specific medicines; however, again there was no evidence on how frequently to do this. Some antipsychotics increase prolactin, raising the risk of hyperprolactinaemia, and the committee discussed whether prolactin should be measured: before starting treatment with a drug that raises prolactin (as is common practice, and recommended in NICE's guideline on psychosis and schizophrenia in adults); only if a person has symptoms for hyperprolactinaemia; or at regular intervals. The consensus view was to consider monitoring prolactin annually and more regularly if the person is symptomatic.

The committee also wanted to highlight the importance of electrocardiogram (ECG) monitoring. Antipsychotic medicines can cause cardiac abnormalities, for example

lengthened QT interval on electrocardiography. Although the NICE guidelines on psychosis and schizophrenia in adults and bipolar disorder recommend ECGs only when starting antipsychotic medicines, the committee recommended ECGs annually (and more frequently for people with complex antipsychotic regimens or doses above BNF levels). They agreed this was warranted for this population, many of whom have been on medicines long term, or combinations of medicines that may alter cardiac rhythm, or both. It is already common practice to perform ECGs if exceeding BNF limits for antipsychotics.

Adherence to medicines, and helping people to manage their own medicines (recommendations 1.9.20 to 1.9.23)

Evidence showed that medicines adherence was associated with successful progression in the rehabilitation pathway to more independent living. However, there was no evidence on specific interventions to improve adherence in people using rehabilitation services. The committee noted that people with a severe mental illness may find polypharmacy and complex regimens difficult to manage and so recommended avoiding these if possible.

Acknowledging the importance of self-management of medicines in people's recovery, the committee recommended opportunities to do this for those assessed as able to take part.

Electroconvulsive therapy (recommendation 1.9.24)

The committee was aware of other NICE guidance on electroconvulsive therapy and agreed it was appropriate to cross-refer to this.

How the recommendations might affect practice

The recommendations on psychological therapy reflect current practice and should not involve additional resources. The recommendations on pharmacological treatments will help to standardise practice across the NHS. The recommendations may lead to an increase in the prescription of aripiprazole as augmentation therapy, though this will not have a resource impact because the associated resource use and unit costs are marginally less costly than amisulpride. The recommendations on increased monitoring of prolactin levels follows current practice. There may be some resource impact from an increase in ECG monitoring, though the committee noted

the Maudsley Prescribing Guidelines suggest that an ECG should be offered at least yearly. Therefore, any resource impact would likely be small.

However, the recommendations on increased monitoring (prolactin levels and ECGs) compared with other NICE guidance may involve some resource impact.

The overall impact of avoiding complex medical regimens and polypharmacy could be cost saving if adherence is improved and could lead to more successful transitions through the rehabilitation pathway.

Full details of the evidence and the committee's discussion are in:

- evidence review H: principles to guide adjustment to standard treatment (recommendations 1.9.1 to 1.9.19)
- evidence review K: interventions to improve activities of daily living (recommendations 1.9.20 to 1.9.23).

Return to recommendations

Physical healthcare

Recommendations 1.10.1 to 1.10.17

Why the committee made the recommendations

Responsibilities for healthcare providers (recommendations 1.10.1 to 1.10.3)

In the committee's experience, access to physical healthcare services is variable depending on the rehabilitation setting and they agreed it was crucial that people did not miss out on monitoring or treatment of their physical health. So the committee outlined the role that inpatient rehabilitation teams should play in physical healthcare, and also adapted existing recommendations on GP responsibilities (recommendations 1.10.1 and 1.10.2) from the NICE guideline on psychosis and schizophrenia in adults. These adapted recommendations were consistent with the evidence about physical comorbidities that the committee looked at.

Coordinating physical healthcare (recommendations 1.10.4 to 1.10.6)

Combining the limited evidence with their experiences of health promotion in rehabilitation services, the committee agreed that a single trained health professional

should coordinate people's physical healthcare. The committee did not specify the role of the health professional (for example, a doctor, nurse or healthcare assistant) but the key point was to have a named person to maintain continuity.

The committee recommended the items that should be considered in physical healthcare plans based on their experience, and the evidence on comorbidities in people with severe mental illness.

Healthy living (recommendations 1.10.7 to 1.10.12)

The committee agreed that smoking was one of the most important modifiable risk factors in this population. They noted that people with complex psychosis using rehabilitation services may find accessing standard smoking cessation programmes difficult. Given the lack of evidence for a specific intervention in rehabilitation, and the need to be mindful of potential drug interactions, the committee agreed that the smoking cessation guidance in the NICE guideline on psychosis and schizophrenia in adults was applicable to the rehabilitation population.

They also agreed that recommendation 1.1.3.1 about combined healthy eating and physical activity programme from the NICE guideline on psychosis and schizophrenia in adults was relevant for this population and was broadly supported by the evidence they looked at.

The committee made the recommendation about providing information on physical health risks based on both their knowledge and experience and evidence of the prevalence of comorbidities. Adverse lifestyle factors that may be more prevalent in people with complex psychosis, for example, they may be less physically active, could place them at a higher risk of physical health problems such as obesity, cardiovascular disease, metabolic syndrome and diabetes. They may have difficulty maintaining oral hygiene due to poor self-care and may be at higher risk of substance abuse, smoking, alcohol abuse, and sexual and reproductive health problems.

The committee also discussed the importance of good sleep for overall physical health and recovery. Although there was no evidence of specific interventions to improve sleep in the evidence or other NICE guidance, the committee agreed it

would be good practice to provide advice and support for maintaining sleep hygiene, and practitioners should avoid environmental barriers that may hinder sleep.

Monitoring physical health (recommendations 1.10.13 to 1.10.16)

The committee recommended (recommendation 1.10.13) an annual physical health check for people in rehabilitation services using elements based on the physical health checks in NICE's guidelines on psychosis and schizophrenia in adults and bipolar disorder. They also added assessments of sexual health, vision, hearing and podiatry, smoking, alcohol and substance use and thyroid function. These additions were based on both their clinical knowledge and experience, and the evidence on comorbidities.

To increase uptake of this health check and improve access, the committee agreed it could be done either at the rehabilitation service by a nominated professional, or at the person's GP practice. Adapting recommendations from NICE's guideline on psychosis and schizophrenia in adults, the committee recommended (recommendation 1.10.15) discussing the results of the physical health check with the person and relevant practitioners.

The recommendation to be alert to possible hepatitis infection was based on evidence about the relatively high prevalence of hepatitis in inpatients with severe mental illness. The committee agreed this may be related to homelessness, intravenous drug use or a history of sexually transmitted disease.

Care and treatment for physical health conditions (recommendation 1.10.17)

The committee agreed that risk factors and physical or mental health conditions identified during the initial health check should be managed according to existing NICE guidance. For the treatment recommendation, the committee listed the same conditions as NICE's guideline on psychosis and schizophrenia but added chronic obstructive pulmonary disease (COPD) because of the high proportion of COPD in the population.

How the recommendations might affect practice

Limited evidence indicated that coordination of physical healthcare by a trained professional could be cost effective.

If the recommendations on physical health checks result in more people having these checks, there may be a resource impact. However, these costs may be offset in the longer term by the prevention of morbidity and future illness. Although the health checks are within existing NICE guidance and so should be common practice, the National Cardiac Audit Programme 2017 audit found that most patients had not been assessed for all 5 cardiovascular health risk factors in the last year.

Treatment of physical health conditions according to NICE guidance should be current practice; however, the National Cardiac Audit Programme 2017 audit found many patients with identified risk factors had not received appropriate interventions.

Full details of the evidence and the committee's discussion are in:

- evidence review C: prevalence of comorbidity (recommendations 1.10.1 to 1.10.3)
- evidence review N: interventions to improve engagement in healthy living (recommendations 1.10.4 to 1.10.17).

Return to recommendations

Context

Over 80% of people who are referred for mental health rehabilitation have a primary diagnosis of schizophrenia, schizoaffective disorder or other psychosis, around 8% have bipolar affective disorder, and the remaining 11% have other diagnoses. Around two-thirds are male. Although people who need mental health rehabilitation have varied primary diagnoses, a common feature is the complex problems they experience. These have a severe, negative impact on the person's day-to-day functioning, including managing everyday activities and social, interpersonal and occupational functioning. These problems often make it impossible for people to be discharged from acute mental health inpatient care back to the community. Some people with these difficulties struggle to manage in the community and may benefit from mental health rehabilitation services.

The problems people may experience include 1 or more of the following:

- treatment-resistant symptoms (for people with a primary diagnosis of psychosis, this may include 'positive' symptoms such as delusions and hallucinations and/or severe 'negative' symptoms that lead to problems with motivation)
- specific cognitive impairments associated with severe psychosis that have a negative impact on organisational and social skills
- coexisting mental health problems, such as severe anxiety, depressive or obsessive compulsive symptoms, or substance misuse
- coexisting physical health problems, such as diabetes, cardiovascular disease or pulmonary conditions
- pre-existing neurodevelopmental disorders, for example autism spectrum disorder.

Rehabilitation is essential to address these complex problems. For the vast majority of people, mental health rehabilitation leads to successful and sustained discharge from hospital and a meaningful, rewarding community life.

Although the mental health rehabilitation care pathway includes both inpatient and community services, there is significant national variation in how they are provided. In areas where there is a lack of local NHS rehabilitation services, people may receive treatment through the NHS or independent sector in the form of 'out-of-area treatments'. Since 2012, there have been many closures of NHS inpatient rehabilitation units across England and only half of trusts have a community rehabilitation team. Given that the users of these services have complex psychosis and related severe mental health conditions as described above, this suggests that many people do not have access to the specialist rehabilitation services they need, either locally or elsewhere.

This guideline covers adults (aged 18 and older) with complex psychosis and related severe mental health conditions. This includes people with a primary diagnosis of psychosis, including schizophrenia, bipolar disorder, psychotic depression, delusional disorders and schizoaffective disorder.

It covers the following areas:

- who should be offered a rehabilitation service

- organising a rehabilitation service
- improving access to rehabilitation
- delivering services
- working collaboratively with people using rehabilitation services
- assessment and person-centred care planning
- rehabilitation programmes and interventions
- mental health treatments
- physical healthcare.

Finding more information and resources

To find out what NICE has said on topics related to this guideline, see our web page on mental health and behavioural conditions.