Are rehabilitation services in mental health effective?

In this article...

- The background to mental health rehabilitation services
- The current evidence base for mental health rehabilitation
- Benefits of these services

Serious mental ill health (SMI) affects 1-2% of the population (Mind, 2011) and people with SMI have an average lifespan that is 12.5 years shorter than the general population (Chang et al, 2011).

These people need to access services that are not only effective in treating their mental health but also increase their awareness of lifestyle choices and promote autonomy and independence, thereby reducing their need for inpatient services.

Mental health rehabilitation (MHR) aims to promote the personal recovery of people who have serious mental ill health. MHR services have undergone many changes and redesigns over the past decade to deliver evidence-based care. After it was suggested that mental health services had shifted away from rehabilitation (Holloway, 2005), MHR services have attempted to develop a template for service provision, and to generate a body of research evidence about these services.

What is MHR?

Mental health rehabilitation services began in the 1960s and 1970s as an attempt to deinstitutionalise service users and integrate them into the community (Killaspy et al, 2009). It is a whole-systems approach to recovery from mental illness that maximises quality of life and social inclusion by encouraging service users’ skills, and promoting independence and autonomy. This gives them hope for the future and leads to successful community living through appropriate support.

Services focus on a psychosocial model of care rather than a medical approach to empower and promote independence and recovery (Roberts et al, 2006). The aims of MHR services are set out in Box 1, while a standardised template for services published in 2009 provides a framework of how MHR services operate and how to measure their performance (Wolfson et al, 2009).

Patient perspectives

MHR services have for many years worked to recovery principles. These aim to put service users in control of their care through the provision of knowledge and meaningful choices, resulting in work opportunities (Perkins, 2006). MHR researchers have begun to explore this area to identify its underlying principles.

Turton et al (2010) undertook an international Delphi study exploring recovery principles and interventions. They recruited 447 participants (advocates, service users, carers and professionals) from 10 European countries. Participants found all interventions equally important in the service user’s journey. Not only did they need recovery approaches such as being treated with respect and dignity, afforded meaningful life opportunities and support to attain these goals, but they also recognised the benefit of formal medical treatments and psychological therapies.

Killaspy et al (2008) conducted a survey of 141 service users in MHR services in inner London. They found that participants were more likely to have money and accommodation needs than psychological distress, indicating that service users’ mental health recovery needs were being met. However, the location of the survey in inner-city London makes it difficult to generalise the findings to other areas.

Effect of therapeutic intervention

Bredski et al (2011) conducted a quantitative case control study that examined the factors that may predict discharge from an MHR facility. The sample consisted of service users admitted to an MHR facility within a six-year period; 34 were admitted and discharged and a second group of 31 were admitted but not discharged.

The study found that service users who had attempted suicide or self-harm or had previous care from the forensic team were less likely to be discharged. It also found a positive correlation with discharge in service users who were admitted to MHR services within 10 years of receiving a diagnosis of SMI.

5 key points

1. Serious mental ill health affects 1-2% of the population
2. Mental health rehabilitation services focus on a psychosocial model of care rather than a medical approach
3. These services reduce hospital length of stay and readmission rates
4. They have a positive effect if used within the first 10 years of a diagnosis of serious mental ill health
5. More research is needed to demonstrate their effectiveness

Discussion

Mental health rehabilitation services have been available for over 50 years but there is a lack of robust evidence to support their effectiveness.

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Odes et al. (2011) examined whether a focus on social, cognitive and task-oriented functions founded on recovery principles for patients before they were discharged from a mental health hospital affected readmission rates. The qualitative study had a sample of 71 clients with a diagnosis of schizophrenia without comorbidity such as personality disorder, substance misuse or learning disability.

It found that readmission rates were lower in clients with increased function on discharge. For example, those who were able to engage with the recovery-oriented therapy had improved readmission outcomes. However, limitations to the study including its small size make it difficult to generalise their findings to other areas.

Cost effectiveness

Petrie and Mountain (2009) assessed whether MHR was an effective use of resources by retrospectively examining readmission rates, length of stay and Mental Health Act use following admission to MHR. They reviewed data on a convenience sample of 35 service users, and found statistically significant results before and after MHR admissions:

- The mean number of occupied bed days decreased from 478 to 115 days;
- Mean Mental Health Act use decreased from 2.09 to 0.46;
- Number of readmissions decreased from 2.51 to 1.17.

This study was limited by its small sample size and the use of a single location. Changes to mental health inpatient areas – such as the introduction of crisis teams – may have contributed to the reduction in use of beds, which further reduces the validity of these results.

MHR services have been involved in moving service users who have needed to be placed in private high-cost, out-of-area treatment (OAT) services to gain access to appropriate treatment or safe environments. To assess the efficacy of OATs, Killaspy et al. (2009) compared 51 service users in private placements with others in NHS MHR services. They assessed whether OAT service users could be moved to local MHR facilities and highlighted gaps in local provision.

This study found that 63% of OATs service users were inappropriately placed and were subsequently moved, which resulted in significant cost savings. However, despite the practical and financial success found in the study, there were limitations as service user groups were assessed by different professionals over different time periods, which may have introduced an independent variable that could influence outcomes.

Conclusion

Research is being undertaken exploring a quality indicator tool for MHR, with a view to standardising how we measure these services (Killaspy et al., 2011). It is hoped this will produce data that can be used across the UK.

MHR services have been shown to be effective in reducing hospital length of stay and readmission rates and to have a positive effect if used within the first 10 years of a person being diagnosed with a SMI. They are also being used to reduce costs by moving OAT service users back to the NHS. However, purchasers may not yet be convinced by this apparent efficacy.