NICE National Institute for Health and Care Excellence

NICE guideline

Rehabilitation for adults with complex psychosis

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

Overview

This guideline covers mental health rehabilitation for adults with complex psychosis. 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.

NICE has also produced guidelines on psychosis and schizophrenia in adults and bipolar disorder.

The recommendations in this guideline were developed before the coronavirus pandemic.

? Anti-epileptic medicines: Follow the Medicines and Healthcare products Regulatory Agency (MHRA) safety advice on the use of valproate, valproate use in people younger than 55 years, valproate use in women and girls, valproate use in men and anti-epileptic drugs in pregnancy.

Who is it for?

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

Recommendations

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

Health and social care professionals should follow our general guidelines for people delivering care:

- decision making and mental capacity
- medicines adherence
- medicines optimisation
- multimorbidity
- people's experience in adult social care services
- service user experience in adult mental health
- shared decision making
- supporting adult carers
- transition between inpatient mental health settings and community or care home settings.

In this guideline, 'complex psychosis' refers to a primary diagnosis of a psychotic illness (this includes schizophrenia, bipolar affective disorder, psychotic depression, delusional disorders and schizoaffective disorder) with severe and treatment-resistant symptoms of psychosis and functional impairment.

People with complex psychosis usually also have 1 or more of the following:

- cognitive impairments associated with their psychosis
- coexisting mental health conditions (including substance misuse)
- pre-existing neurodevelopmental disorders, such as autism spectrum disorder or attention deficit hyperactivity disorder
- physical health problems, such as diabetes, cardiovascular disease or pulmonary conditions.

Together, these complex problems severely affect the person's social and everyday functioning, and mean they need a period of rehabilitation to enable their recovery and ensure they achieve their optimum level of independence.

The guideline does not cover people who have a primary diagnosis of a non-psychotic illness. However, rehabilitation practitioners can also provide advice to services outside the rehabilitation pathway on appropriate treatment and support, including specialist placements and tailored support packages, for people with other primary mental health diagnoses or neurodevelopmental conditions, such as personality disorders or autism spectrum disorder.

1.1 Who should be offered rehabilitation?

1.1.1 Offer rehabilitation to people with complex psychosis:

- as soon as it is identified that they have treatment-resistant symptoms of psychosis and impairments affecting their social and everyday functioning
- wherever they are living, including in inpatient or community settings.

  In particular, this should include people who:

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

For a short explanation of why the committee made this recommendation and how it might affect practice, see the rationale and impact section on who should be offered rehabilitation.

Full details of the evidence and the committee's discussion are in evidence review A: identifying people who would benefit most and evidence review D: effectiveness of rehabilitation services.

Other supporting information can be found in evidence review F: components of an effective rehabilitation pathway, evidence review J: rehabilitation approaches, care, support and treatment and evidence review Q: factors associated with successful transition.

1.2 Overarching principles of rehabilitation

1.2.1 Rehabilitation services for people with complex psychosis should:

- be embedded in a local comprehensive mental healthcare service
- be offered in the least restrictive environment and aim to help people progress from more intensive support to greater independence through the rehabilitation pathway
- recognise that not everyone returns to the same level of independence they had before their illness and may require supported accommodation (such as residential care, supported housing or floating outreach) in the long term.

For a short explanation of why the committee made this recommendation and how it might affect practice, see the rationale and impact section on overarching principles of rehabilitation.

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

1.3 Organising the rehabilitation pathway

1.3.1 All local mental healthcare systems should include a defined rehabilitation pathway as part of their comprehensive service.

1.3.2 Use the local joint strategic needs assessment to inform the commissioning of specific service components (see recommendation 1.3.4) that make up the rehabilitation pathway, to match the needs of the local population.

1.3.3 Conduct a local rehabilitation service needs assessment. This should include the number of people with complex psychosis who:

- are currently placed out of area for rehabilitation
- 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 receiving care from early intervention for psychosis services and developing problems that are likely to require mental health rehabilitation services now or in the near future
- are physically frail and may need specialist support in their accommodation
- are young adults moving from children and young people's mental health services to adult mental health services.

1.3.4 The rehabilitation pathway should include the following components, as informed by the needs assessment:

- rehabilitation in the community, providing clinical care from a community mental health rehabilitation team to people living in supported accommodation (residential care, supported housing and floating outreach)

and

- rehabilitation in inpatient settings, such as high-dependency rehabilitation units and/or community rehabilitation units.

1.3.5 Health and social care commissioners should work together with health services, local authorities, housing providers and other partners (third sector and independent sector providers, service users and their families and carers) to ensure that rehabilitation is provided as locally as possible for all those identified in the local rehabilitation service needs assessment.

1.3.6 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.

1.3.7 Ensure that the rehabilitation pathway is designed to provide flexibility, smooth transitions and support over the longer term, that enables people to:

- join and leave the rehabilitation pathway at different points
- move between parts of the pathway that provide higher or lower levels of support according to their changing needs
- spend different periods of time at different stages of the pathway according to need
- have access to more than 1 period of rehabilitation to progress successfully in their recovery and be swiftly referred back to the pathway if their needs increase and they would benefit from further rehabilitation.

The lead commissioner

1.3.8 Health and social care commissioners should jointly designate a lead commissioner to oversee the commissioning of the specific services that make up the defined rehabilitation pathway for people with complex psychosis.

1.3.9 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.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on organising the rehabilitation pathway and the lead commissioner.

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: supported accommodation (recommendation 1.3.2 and 1.3.4); evidence review F: components of an effective rehabilitation pathway (recommendations 1.3.1, 1.3.3, 1.3.5, 1.3.6 and 1.3.7); and evidence review G: integrated rehabilitation care pathways involving multiple providers (recommendations 1.3.8 and 1.3.9).

Joint working

Integrated rehabilitation pathway

1.3.10 The lead commissioner should work together with service providers to deliver an integrated rehabilitation pathway, 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, so that local and regional rehabilitation services meet 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 so that relevant services and agencies can work together in a timely and flexible way, including for transitions between services (see recommendation 1.3.7)
- 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.

Transitions

1.3.11 The lead commissioner and service providers should ensure that transitions in people's care between the rehabilitation service and other mental health teams or primary care are:

- guided by criteria that are clearly defined in local policy
- supported by a group of local rehabilitation practitioners, with whom clinicians can discuss potential referrals and re-referrals and receive advice on appropriate treatment and support
- supported by close collaboration, including comprehensive handovers or an individually tailored period of co-working between services
- 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).

1.3.12 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.

1.3.13 The lead commissioner should think about ways to improve the sharing of information and IT systems between health and social care staff, particularly in relation to people placed out of area.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on joint working.

Full details of the evidence and the committee's discussion are in evidence review G: integrated rehabilitation care pathways involving multiple providers (recommendation 1.3.10); evidence review Q: factors associated with successful transition (recommendations 1.3.11 and 1.3.12); and evidence review B: barriers in accessing rehabilitation services (recommendation 1.3.13).

Working with other healthcare providers

1.3.14 The lead commissioner should oversee the agreement of local protocols and service level agreements 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 the section 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 the section on physical healthcare)
- 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 can get 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 The lead commissioner should agree a local protocol with the community mental health service to enable clozapine to be started or restarted in the community. This protocol should:

- be drawn up by, or in consultation with, the community mental health services pharmacist
- include all relevant safety checks
- include informing the person's GP.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on working with other healthcare providers.

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: substance misuse (recommendation 1.3.15); and evidence review H: adjustments to standard treatment (recommendation 1.3.16).

1.4 Improving access to rehabilitation

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

1.4.2 The lead commissioner should work together with service providers to ensure that everyone with complex psychosis has 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, such as women-only services
- providing outreach into other services that work with under-served groups, or home visiting
- providing tailored information and advocacy.

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

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on improving access to rehabilitation.

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

1.5 Delivering services within the rehabilitation pathway

Multidisciplinary teams

1.5.1 Inpatient and community rehabilitation services for people with complex psychosis should be staffed by multidisciplinary teams comprising a range of professionals with skills and competence in mental health rehabilitation,

including:

- rehabilitation psychiatrists
- practitioner psychologists
- nurses
- occupational therapists
- social workers
- approved mental health professionals
- support workers (including peer support workers)
- specialist mental health pharmacists.

1.5.2 The multidisciplinary team should have access to physical exercise coaches, vocational trainers, welfare rights specialists, dietitians or nutritionists, podiatrists, speech and language therapists and physiotherapists.

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 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.

1.5.5 Consider joining a peer accreditation or quality improvement forum.

Rehabilitation in the community

1.5.6 For people with complex psychosis who are living in supported accommodation, specialist clinical care should be provided by a multidisciplinary community mental health rehabilitation team whose work is integrated within an overall framework for the delivery of community mental health services. This team should:

- coordinate the person's care and hold overall clinical responsibility for the person's mental health while they are living in the community
- provide a designated care coordinator for each person but operate with a shared team caseload approach; this involves discussing people's care together at regular team meetings to pool and agree ideas about care and treatment
- make the majority of contacts with the person in their home or community settings rather than where the team is based
- work closely with staff at the person's supported accommodation to tailor people's care plans to their needs (see recommendation 1.7.7) and make clear which staff are responsible for providing different parts of the person's treatment and support as part of their rehabilitation
- support and oversee the person's progression through the rehabilitation pathway by:
  - increasing the intensity of treatment and support during periods of relapse
  - providing ongoing contact and support during any periods of acute inpatient care
  - enabling the person's discharge home at the earliest opportunity
  - adjusting care plans to enable the person to gain the skills and confidence to manage in more independent accommodation
- liaise with the person's GP about their physical healthcare
- liaise with the relevant service when the person is ready to be discharged

from the team to ensure a smooth transition.

1.5.7 Senior clinicians in the community mental health rehabilitation team should work with commissioners and supported accommodation providers to:

- hold an overview of the local mental health supported accommodation services, including current vacancies and the quality of care provided
- ensure that the rehabilitation pathway continues to develop in line with changes in the needs of the local population.

1.5.8 Community mental health rehabilitation teams should include as part of their team the staff who are designated care managers for people placed out of area.

Supported accommodation

1.5.9 Supported accommodation services should:

- provide support appropriate to the person's mental and physical health needs
- promote stability and avoid unnecessary moves
- be in a familiar place close to the person's social and cultural networks, if this is clinically appropriate
- include support with tasks such as managing money and everyday 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 (for more information on personal budgets and direct payments, see the NICE guideline on people's experience in adult social care services)
- give the person a safe place that feels like their own
- recognise and safeguard individual vulnerability, risk, loneliness and exploitation.

Rehabilitation in inpatient settings

1.5.10 Inpatient rehabilitation services should have 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'.

1.5.11 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.

Out-of-area placements

1.5.12 Out-of-area placements should be limited to 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 receive treatment outside their home area.

1.5.13 Out-of-area placements should only be provided after a local placement funding panel (including a rehabilitation practitioner, a senior service manager and local commissioner) has confirmed that the person's care cannot be provided locally.

- 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, provide an

explanation in writing to the person (and their family or carers, as appropriate):

- why they have been placed out of area
- the steps that will be taken so they can return to their local area
- how their family or carers will be helped to keep in contact
- the advocacy support available to help them.

For a short explanation of why the committee made these recommendations and how they might affect services, see the rationale and impact section on delivering services within the rehabilitation pathway.

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, 1.5.6 to 1.5.8 and 1.5.12 to 1.5.15); evidence review F: components of an effective rehabilitation pathway (recommendations 1.5.3 to 1.5.5 and 1.5.10); and evidence review P: supported accommodation (recommendations 1.5.9 and 1.5.11).

1.6 Recovery-orientated rehabilitation services

1.6.1 Staff should 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
- developing and maintaining continuity of individual therapeutic relationships wherever possible
- helping them find meaningful occupations (including work, leisure or education) and build support networks using voluntary, health, social care and mainstream resources
- helping people to gain skills to manage both their everyday activities and their mental health, including moving towards self-management of medication (see the recommendations on helping people to manage their

own medicines)

- providing opportunities for sharing experiences with peers
- encouraging positive risk-taking
- developing people's self-esteem and confidence
- validating people's achievements and celebrating their 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.

Supporting people to make decisions

1.6.2 Staff must meet people's communication needs as set out in the NHS Accessible Information Standard.

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

Universal staff competencies

These recommendations apply to all staff working in the services described in recommendation 1.3.4.

1.6.4 Ensure that staff training emphasises recovery principles so that all rehabilitation staff work with a recovery-orientated approach.

1.6.5 Provide support for 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.

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

1.6.7 Ensure that staff have skills and competence in risk assessment and 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 history of, or currently present with, serious risks to themselves or others.

1.6.8 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

1.6.9 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.

For a short explanation of why the committee made these recommendations and how they might affect services, see the rationale and impact section on recovery-orientated rehabilitation services.

Full details of the evidence and the committee's discussion are in evidence review J: rehabilitation approaches, care, support and treatment (recommendations 1.6.1, 1.6.2 and 1.6.4); evidence review I: collaborative care planning (recommendations 1.6.7 and 1.6.9); evidence review B: barriers in accessing rehabilitation services (recommendation 1.6.3); evidence review K: activities of daily living (recommendation 1.6.6); evidence review A: identifying people who would benefit most (recommendation 1.6.5); and evidence review O: substance misuse (recommendation 1.6.8).

1.7 Person-centred care planning through assessment and formulation

Assessment

1.7.1 Offer people a comprehensive biopsychosocial 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 assessment:

- systematic assessment of primary and coexisting mental health problems
- psychiatric history, including past admissions and treatments, responses to treatment, adverse effects from medicines, and medication adherence
- medicines reconciliation by a specialist mental health pharmacist
- vulnerabilities, including self-neglect, exploitation and abuse, and the person's risk of harm to themselves (including suicide) and others
- physical health and wellbeing through a physical health check (see recommendation 1.7.3)

- developmental history from birth, including 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
- smoking, alcohol and illicit substance use
- psychological and psychosocial history, including relationships, life history, experiences of abuse and trauma, coping strategies, strengths, resiliency, and previous psychological or psychosocial interventions
- current social network, including any caring responsibilities
- current skills in activities of daily living
- current cognitive function, including any communication needs.

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

- body mass index
- waist circumference
- full blood count
- pulse and blood pressure
- glycosylated haemoglobin (HbA1c), blood lipid profile, liver function tests, renal function tests and thyroid function
- prolactin levels (for people on medicines that raise prolactin levels).
- renal function tests 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 and illicit substance use
- nutritional status, diet and level of physical activity
- continence and constipation (particularly if the person is on clozapine)
- any movement disorders
- sexual health
- vision, hearing and podiatry
- oral inspection of general dental health
- any difficulties with swallowing.

1.7.4 Be aware that people with complex psychosis are more likely to have multiple comorbidities, both mental and physical.

1.7.5 Be aware that people with complex psychosis have a higher prevalence of the following mental health conditions (which may contribute to complexity in rehabilitation):

- anxiety (see the NICE guideline on generalised anxiety disorder and panic disorder in adults)
- attention deficit hyperactivity disorder (see the NICE guideline on attention deficit hyperactivity disorder)
- autism spectrum disorder (see the NICE guidelines on autism spectrum disorder in under 19s: recognition, referral and diagnosis, autism spectrum disorder in under 19s: support and management and autism spectrum disorder in adults)
- borderline personality disorder (see the NICE guidelines on borderline personality disorder and antisocial personality disorder)

- cognitive impairments (including acquired brain disorders)
- depression (see the NICE guideline on depression in adults)
- speech, language and communication disorders.

1.7.6 Be aware that people with complex psychosis have a higher prevalence of the following physical health 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.

See the section on care and treatment for physical health conditions for links to other relevant NICE guidance.

Care planning and review

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

- be developed collaboratively with the person
- cover the areas of need identified during assessment (see recommendation 1.7.2), including both mental and physical health (for physical healthcare planning, see the section on responsibilities of different healthcare providers)

- include the person's personal recovery goals
- clarify actions and responsibilities for staff, the person themselves and their family or carers (where relevant).

1.7.8 Consider using accessible formatting to support the person in jointly developing their care plan, regardless of whether or not they have identified communication and information needs.

1.7.9 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.

1.7.10 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.

1.7.11 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.

1.7.12 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 a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on person-centred care planning through assessment and formulation.

Full details of the evidence and the committee's discussion are in evidence review C: prevalence of comorbidity (recommendations 1.7.1 to 1.7.6) and evidence review I: collaborative care planning (recommendations 1.7.7 to 1.7.12).

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 with complex psychosis 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:

- making a plan with each person that focuses on their needs and regularly reviews their goals
- providing activities they enjoy and that motivate them
- enabling them to practise their skills in risk-managed real life, such as kitchens and laundry rooms, wherever possible.

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 to discuss 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
- be individualised
- develop structure and purpose in the person's day
- aim to increase their sense of identity, belonging and social inclusion in the community
- involve peer support
- recognise people's skills and strengths.

1.8.8 Offer people the chance to be involved in a range of activities that they enjoy, tailored to their 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 use (alcohol and illicit substances) 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 service.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on rehabilitation programmes and interventions.

Full details of the evidence and the committee's discussion are in evidence review K: activities of daily living (recommendations 1.8.1 to 1.8.3); evidence review L: interpersonal functioning (recommendations 1.8.4 to 1.8.6); evidence review M: engagement in community activities and evidence review J: rehabilitation approaches, care, support and treatment (recommendations 1.8.7 to 1.8.14); and evidence review O: substance misuse (recommendations 1.8.15 to 1.8.19).

1.9 Adjustments to mental health treatments in rehabilitation

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 how to use medication.

1.9.2 Routinely monitor for and treat other coexisting mental health conditions, including depression, obsessive-compulsive disorder, anxiety, substance misuse, and risk of suicide (for guidance on these conditions, see NICE's topic page on mental health, behavioural and neurodevelopmental conditions).

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

Psychological therapies

1.9.4 Continue to offer people with complex psychosis individual cognitive behavioural therapy (CBT) and family intervention as recommended by the NICE guideline on psychosis and schizophrenia in adults. Follow the recommendations on delivery and monitoring in the section of that guideline on psychological interventions.

1.9.5 Consider additional psychological interventions, especially for people who are not ready 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.

1.9.6 Consider training all rehabilitation staff in psychologically informed approaches such as motivational interviewing, positive behaviour support, behavioural activation, trauma-informed care, and simple techniques for supporting people who are having troubling thoughts and feelings.

Pharmacological treatments

Anti-epileptic medicines: Follow the Medicines and Healthcare products Regulatory Agency (MHRA) safety advice on the use of valproate, valproate use in people younger than 55 years, valproate use in women and girls, valproate use in men and anti-epileptic drugs in pregnancy.

1.9.7 For people with complex psychosis whose symptoms have not responded adequately to an optimised dose of clozapine alone, consider augmenting clozapine with the following, depending on target symptoms:

- an antipsychotic, for example aripiprazole for schizophrenia and related psychoses **and/or**
- a mood stabiliser for psychosis with significant affective symptoms **and/or**
- an antidepressant if there are significant depressive symptoms in addition to the psychotic condition.

  Be aware of potential drug interactions and note that not all combinations of treatments may be in accordance with UK marketing authorisations. Any off-licence prescribing should be communicated in writing with the person's GP. Seek specialist advice if needed, for example from another psychiatrist specialising in treatment-resistant symptoms or a specialist mental health pharmacist.

1.9.8 Optimise the dosage (as tolerated) of medicines used to manage complex

psychosis (see recommendations 1.9.1 and 1.9.7) according to the BNF and therapeutic plasma levels in the first instance.

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

- if this is agreed and documented by the 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 that are disabling or distressing
- after taking into account drug interactions and side effects, for example be cautious when adding an antidepressant to clozapine for someone who has experienced symptoms of mania
- if systems and processes are in place for monitoring the person's response to treatment and side effects (monitoring may include physical examination, ECG and appropriate haematological tests).

1.9.10 Regularly review medicines used to manage complex psychosis and monitor effectiveness, adverse effects and drug interactions, including monitoring for constipation for those taking clozapine.

1.9.11 If pharmacological treatment is not effective, consider stopping the medicine:

- following a thorough review of treatment
- after agreeing and documenting the decision at a meeting with a multidisciplinary team and the person (and their family, carer or advocate, as appropriate)
- with caution, particularly if the person has been on the medicine for many years
- by reducing the dose slowly and closely monitoring the person for symptoms

of relapse.

1.9.12 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 recommendations on using lithium in the NICE guideline on bipolar disorder.

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

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

1.9.15 Consider annual ECGs for everyone with complex psychosis 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).

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

1.9.17 Consider referring for a second opinion from a relevant specialist when treating people whose symptoms have not responded well to standard treatment.

Adherence to medicines

1.9.18 Rehabilitation services should promote adherence to medicines. Strategies to promote adherence could include avoiding complex medicine regimens and polypharmacy wherever possible.

Helping people to manage their own medicines

1.9.19 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.

1.9.20 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

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

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on adjustments to mental health treatments in rehabilitation.

Full details of the evidence and the committee's discussion are in evidence review H: adjustments to standard treatment (recommendations 1.9.1 to 1.9.17) and evidence review K: activities of daily living (recommendations 1.9.18 to 1.9.20).

1.10 Physical healthcare

Responsibilities of different 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 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.

Coordinating physical healthcare

1.10.4 Nominate a 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 work in collaboration with a healthcare professional to develop and oversee the physical healthcare plan, ensuring it is informed by the initial physical health check (see recommendation 1.7.3) and include:

- health promotion interventions (see the section on 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 the section on 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.

Healthy living

1.10.6 Offer people who smoke help to stop smoking, even if previous attempts have been unsuccessful.

1.10.7 Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine. Follow recommendations 1.1.2.4 and 1.1.2.5 in the physical health section of NICE's guideline on psychosis and schizophrenia in adults.

1.10.8 Offer people a combined healthy eating and physical activity programme and support them to take part in it.

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 illicit substance use
  - oral hygiene
  - bone health
  - sexual and reproductive health.

1.10.10 Offer annual flu vaccination to people:

- in inpatient rehabilitation services
- in communal supported accommodation
- who have a comorbid physical health condition (such as chronic respiratory disease, chronic heart disease or diabetes) that means they are more likely to develop serious complications from flu (see the section on clinical risk groups in NICE's guideline on flu vaccination).

1.10.11 Explain to people 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).

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

1.10.13 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

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

- body mass index
- waist circumference
- pulse and blood pressure
- full blood count, HbA1c, blood lipid profile, renal function tests, liver function tests and thyroid function
- smoking, alcohol or drug use
- nutritional status, diet and level of physical activity
- any movement disorders
- sexual health
- vision, hearing and podiatry
- oral inspection of general dental health.

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

1.10.15 Give people the choice, whenever possible, to have their annual physical health check at their GP practice or by a trained professional at the rehabilitation service (see recommendation 1.10.5).

1.10.16 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 is recorded in the case notes. Discuss any important findings with the person.

Care and treatment for physical health conditions

1.10.17 Use the annual physical health check in recommendation 1.10.14 to identify at the earliest opportunity people who:

- have or are at high risk of cardiovascular disease (see the NICE guideline on cardiovascular disease)
- have hypertension (see the NICE guideline on hypertension)
- are obese or at risk of obesity (see the NICE guideline on overweight and obesity management)
- have diabetes or are at high risk of diabetes (see the NICE guidelines on preventing type 2 diabetes, type 1 diabetes in adults: diagnosis and management and type 2 diabetes in adults: management)
- are physically inactive (see the NICE guideline on physical activity)
- have COPD (see the NICE guideline on chronic obstructive pulmonary disease).

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

1.10.18 Be alert to the possibility of infection with blood-borne diseases 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 guidelines on hepatitis B and C testing and HIV testing.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on physical healthcare.

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 and 1.10.18) and evidence review N: engagement in healthy living (recommendations 1.10.4 to 1.10.17).

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.

Commissioners

At the time of publication, 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 team

Teams providing 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, to enable their optimum level of functioning and independence.

Community rehabilitation units

Inpatient rehabilitation units that are set outside hospital grounds. These units provide the full complement of multidisciplinary treatment and support for people with ongoing complex needs that prevent them 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 1983 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, or conditionally discharged Section 37/41). The expected length of stay in a community rehabilitation unit is 1 to 2 years.

Complex psychosis

In this guideline, 'complex psychosis' refers to a primary diagnosis of a psychotic illness (this includes schizophrenia, bipolar affective disorder, psychotic depression, delusional disorders and schizoaffective disorder) with severe and treatment-resistant symptoms of psychosis and functional impairment.

People with complex psychosis usually also have 1 or more of the following:

- cognitive impairments associated with their psychosis
- coexisting mental health conditions (including substance misuse)
- pre-existing neurodevelopmental disorders, such as autism spectrum disorder or attention deficit hyperactivity disorder
- physical health problems, such as diabetes, cardiovascular disease or pulmonary conditions.

Together, these complex problems severely affect the person's social and everyday functioning, and mean they need a period of rehabilitation to enable their recovery and ensure they achieve their optimum level of independence.

Floating outreach

Services providing 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.

Graduated self-management of medicines programme

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. These 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 1983. 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

Inpatient rehabilitation units for people with psychosis and comorbid conditions who need a specialist programme tailored to their specific comorbidity (such as acquired brain injury, severe personality disorder, autism spectrum disorder or Huntingdon's disease). Often, the complexity of the person's coexisting conditions is associated with greater support needs (more challenging behaviours and/or a greater risk to themselves 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 (IPS) approach

A method of supporting people with severe mental health problems into work. 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

Units providing specialist inpatient care to people with complex psychosis. They can be based within a hospital or in the community.

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 service managers, as well as clinicians (a senior rehabilitation practitioner plus possibly a senior clinician who works in general adult care, not specifically rehabilitation).

Longer-term high-dependency rehabilitation units

These units provide longer-term inpatient rehabilitation for people with high levels of disability due to treatment-resistant symptoms and comorbid conditions that 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.

Motivational interviewing

A person-centred psychologically informed approach that supports behavioural change by helping people explore and resolve ambivalence towards change.

Out-of-area placements

A placement that provides treatment and support in an inpatient rehabilitation unit or supported accommodation outside the local area where a person usually lives, and/or outside the catchment area for the local authority that has responsibility for their housing. 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 behaviour support

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

Psychologically informed approaches

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.

Recovery colleges

Peer-led education and training programmes for mental health service users. 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.

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 refers 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.

Residential care

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

An umbrella term covering residential care, supported housing and floating outreach.

Supported housing

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 intended length of stay is usually about 2 years but in practice, only around one-third of people move on in that time.

Team formulation

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 team formulation includes strengths and resources and points to ways that problems can be addressed.

Transitional employment schemes

These 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.

Trauma-informed care

Care that is built on an understanding that anyone using services could have experienced psychosocial trauma and that this is likely to influence how they engage with care. Key principles include safety and avoiding re-traumatisation; relationship building; peer support; collaboration and mutuality; empowerment and choice; and an awareness of cultural, historical and gender issues.

Treatment-resistant symptoms

Persistent symptoms that have not responded to the range of treatments (including pharmacological treatments) recommended in the NICE guidance for the person's condition.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Who should be offered rehabilitation?

What is the efficacy and cost effectiveness of rehabilitation services compared with treatment as usual for people with complex psychosis with residual disability, who are leaving early intervention services?

For a short explanation of why the committee made the recommendation for research, see the rationale on who should be offered rehabilitation.

Full details of the evidence and the committee's discussion are in evidence review D: effectiveness of rehabilitation services.

2 Peer-support interventions

How can peer-support interventions be used most effectively to support people with complex psychosis using rehabilitation services?

For a short explanation of why the committee made the recommendation for research, see the rationale on engagement in community activities, including leisure, education and work.

Full details of the evidence and the committee's discussion are in evidence review M: engagement in community activities.

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?

For a short explanation of why the committee made the recommendation for research, see the rationale on rehabilitation in inpatient settings.

Full details of the evidence and the committee's discussion are in evidence review A: identifying people who would benefit most.

4 Structured group activities

What structured group activities are effective at improving interpersonal functioning (social skills) for people with complex psychosis?

For a short explanation of why the committee made the recommendation for research, see the rationale on interpersonal and social skills.

Full details of the evidence and the committee's discussion are in evidence review L: interpersonal functioning.

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?

For a short explanation of why the committee made the recommendation for research, see the rationale on out-of-area placements.

Full details of the evidence and the committee's discussion are in evidence review E: comparative effectiveness of different types of rehabilitation services.

Other recommendations for research

6 Integrated care systems

Is an integrated care system effective at promoting successful progress for people with complex psychosis to a more independent setting?

For a short explanation of why the committee made the recommendation for research, see the rationale on transitions.

Full details of the evidence and the committee's discussion are in evidence review R: supporting transitions.

7 Staff training interventions

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

For a short explanation of why the committee made the recommendation for research, see the rationale on engagement in community activities, including leisure, education and work.

Full details of the evidence and the committee's discussion are in evidence review M: engagement in community activities.

8 Coexisting physical health conditions

What is the impact of coexisting physical health conditions on the mortality of people with complex psychosis?

For a short explanation of why the committee made the recommendation for research, see the rationale on assessment.

Full details of the evidence and the committee's discussion are in evidence review C: prevalence of comorbidity.

9 Medicines adherence

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

For a short explanation of why the committee made the recommendation for research, see the rationale on adherence to medicines and helping people to manage their own medicines.

Full details of the evidence and the committee's discussion are in evidence review K: activities of daily living.

10 Tailored interventions

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

For a short explanation of why the committee made the recommendation for research, see the rationale on interventions tailored to people in rehabilitation.

Full details of the evidence and the committee's discussion are in evidence review H: adjustments to standard treatment.

11 Risk of blood-borne virus infections

What are the risks that predict the development of blood-borne virus infections in people

with complex psychosis in the UK?

For a short explanation of why the committee made the recommendation for research, see the rationale on care and treatment for physical health conditions.

Full details of the evidence and the committee's discussion are in evidence review C: prevalence of comorbidity.

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice and services.

Who should be offered rehabilitation?

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. Qualitative evidence also showed that people with severe mental illness value rehabilitation.

There was moderate quality evidence that people who experienced a shorter duration of illness before rehabilitation, and who had lower psychopathology scores, were more likely to progress through the rehabilitation pathway to greater independence. However, the committee thought that everyone with treatment-resistant symptoms and functional impairments had the potential to benefit from rehabilitation, and that this applied regardless of whether they were living in inpatient or community settings.

The committee also highlighted the groups of people who, in their experience, are likely to have treatment-resistant symptoms and functional impairments.

The committee was aware that some people leaving early intervention services have significant residual disability, with persisting symptoms and functional impairment. However, it was not possible from the evidence to determine whether providing very early access to rehabilitation to these people could prevent repeated admissions and problems in daily living. The committee therefore made a recommendation for research on who should be offered rehabilitation.

How the recommendation might affect practice

Earlier access to rehabilitation should deliver 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 mental health rehabilitation teams who work with people after they have left hospital and moved to supported accommodation. In areas without these teams, community mental health teams already coordinate care. There will also be substantial savings from the repatriation of people placed out of area.

Return to recommendation

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 to be particularly valued 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 overarching 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 their experience, rehabilitation can be beneficial for everyone who has treatment-resistant symptoms, 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 will improve consistency of best practice and do not need any additional resources to deliver.

Return to recommendation

Organising the rehabilitation pathway, and the lead commissioner

Recommendations 1.3.1 to 1.3.9

Why the committee made the recommendations

Organising the rehabilitation pathway (recommendations 1.3.1 to 1.3.7)

The evidence supported each locality having a defined rehabilitation pathway with access to a range of service components in different settings to provide the appropriate treatment and support that people need. The committee agreed that different levels of support, and usually both inpatient and community services, are needed to support people's full recovery. They noted it was important that these services were provided as locally as possible. The committee agreed that this 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 that need to be included through a complementary local rehabilitation service 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 1.3.8 and 1.3.9)

Qualitative evidence 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 perform their role effectively.

How the recommendations might affect practice

Organising the rehabilitation pathway (recommendations 1.3.1 to 1.3.7)

These recommendations largely reflect current practice in terms of joint commissioning. However, greater emphasis on an integrated rehabilitation pathway will likely see fewer people being referred 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 shows that there may be a large cost saving from faster discharge rates that are appropriate to a person's illness and reduce 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.

Providing more local inpatient facilities could potentially increase capital costs for some commissioners in the short term if those facilities do not currently exist. In the longer term, this would involve replacing costs incurred out of area with those incurred locally, so the move to more locally available services is expected to be cost neutral over time. Overall, the health benefits of people spending more time in contact with community-based services, and less in inpatient facilities, would offset any initial additional resource impact.

The lead commissioner (recommendations 1.3.8 and 1.3.9)

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

Return to recommendations

Joint working

Recommendations 1.3.10 to 1.3.13

Why the committee made the recommendations

Integrated rehabilitation pathway (recommendation 1.3.10)

The qualitative evidence identified barriers to integrating rehabilitation care pathways, which resonated with the committee's own experience. '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 additional areas to highlight in the recommendation where the lead commissioner could help to address barriers to integration.

Transitions (recommendations 1.3.11 to 1.3.13)

The committee agreed that because people with complex psychosis have a fluctuating illness, they need to be able to move seamlessly between services in the pathway depending on their needs. Based on consensus, the committee recommended measures 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 study showed benefit of an integrated system to support transitions. The integrated system was a team of health and social care practitioners and informal carers for each person who met weekly to coordinate care, were able to communicate through a shared IT environment, and were trained to collaborate. Because the evidence was limited to 1 randomised controlled trial and there was no detail about what aspects of the intervention were effective, the committee could only recommend exploring ways to improve the sharing of information and IT systems.

To find out more about whether an integrated system involving a multidisciplinary team might help improve transitions and people's progress through the rehabilitation pathway towards greater independence, the committee also made a recommendation for research on integrated care systems.

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.

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 services for mental and physical healthcare, social care and substance misuse develop local protocols to ensure appropriate services are available to people in rehabilitation. Based on their knowledge and experience, the committee recommended what these protocols should cover.

In the committee's experience, some people using rehabilitation services may need to start or restart treatment with clozapine. This requires strict monitoring and currently 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.

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 inequalities in access 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, 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.

Return to recommendations

Delivering services within the rehabilitation pathway

Recommendations 1.5.1 to 1.5.15

Why the committee made the recommendations

Multidisciplinary teams (recommendations 1.5.1 and 1.5.2)

There was some evidence to support providing community rehabilitation through a multidisciplinary team and this was in line with the committee's 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 experience to recommend some of the core roles that would need to be included in the team. They also recommended other health professionals the team should have access to in order to meet the mental and physical healthcare needs of people with complex psychosis during rehabilitation. Input from welfare rights specialists was also thought to be important because people with complex psychosis will be on welfare benefits and are likely to need advice on their income. Speech and language therapist input would be needed to deal with the additional communication needs that can be experienced by this group. Physiotherapists would be needed to help people with mobility issues to engage in more physical activity to mitigate the physical health impact of a more sedentary lifestyle.

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.

Service quality improvement (recommendations 1.5.4 and 1.5.5)

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.

Rehabilitation in the community (recommendations 1.5.6 to 1.5.8)

There was evidence that multidisciplinary community team management increased participation in activities of daily living. The committee used their experience to extrapolate from this 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 (recommendation 1.5.9)

The committee used qualitative evidence to highlight features of supported accommodation that are valued by people, 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.

Rehabilitation in inpatient settings (recommendations 1.5.10 and 1.5.11)

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 recommendation for research on highly specialist and longer-term high-dependency rehabilitation units.

Out-of-area placements (recommendations 1.5.12 to 1.5.15)

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 it was their view that a person in supported accommodation would typically have improved activities of daily living. Reducing out-of-area placements would therefore lead to 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 inpatient 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 with the aim of reducing out-of-area placements wherever possible, providing better support while people are in these placements and bringing them back to their local area as soon as possible. This included recommending time frames for reviewing out-of-area placements, which were based on committee consensus.

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 2 sectors were found to be the same, the committee made a recommendation for research on inpatient rehabilitation provided by the independent sector.

How the recommendations might affect practice

The recommendation for the multidisciplinary team to have access to additional healthcare 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 needed to address gaps 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 people about the impact of rehabilitation placements on

their tenancies could require access to welfare rights specialists, which could have a resource impact for services without this access currently.

The committee recognised that local authorities in some regions may need to invest significantly in the quality and variety of their supported accommodation to implement the recommendations on supported accommodation. However, the recommendations do recognise that commissioning decisions should be based on a local rehabilitation service needs assessment to reflect the needs of the local population. Nevertheless, local authorities often commission supported accommodation and therefore can specify quality metrics when tendering to providers.

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. However, in the long term, this would be expected to be largely cost neutral with respect to capital costs, as out-of-area facilities are replaced by local ones. Therefore, the committee argued that this 'investment' is currently already being spent on out-of-area placements so would not constitute additional funding in the long term. The committee did note though that any investment should be based on a local rehabilitation service needs assessment based on the needs of the local population.

The recommendation for a designated care manager may represent a change in practice in some areas. For areas that do not 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.

Return to recommendations

Recovery-orientated rehabilitation services

Recommendations 1.6.1 to 1.6.20

Why the committee made the recommendations

Recommendation 1.6.1

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 help them work towards recovery.

Supporting people to make decisions (recommendations 1.6.2 and 1.6.3)

Working collaboratively with people with complex psychosis to produce a care plan can be challenging because of diminished communication and mental capacity. Despite these challenges, planning care in collaboration with the service user is expected practice in UK mental health services. Guidance on mental capacity and communication needs is already provided in other NICE guidelines but the committee also agreed it was relevant to highlight the legal obligation to follow the NHS Accessible Information Standard when working with people in rehabilitation.

Universal staff competencies (recommendations 1.6.4 to 1.6.8)

The committee considered staff training in recovery orientation to be essential to deliver an effective rehabilitation service. There was qualitative evidence that staff sometimes lack optimism or are overly risk-averse about the prospect of rehabilitation for some people, which can negatively affect a person's recovery. To address this, the committee recommended ways to encourage positive attitude changes to help staff retain hope and optimism, while acknowledging that not everyone will achieve full independence.

The committee made the recommendation on supporting structured activities based on limited evidence combined with consensus. They saw structured group activities as a key aspect of rehabilitation (see recommendation 1.8.4) and agreed that all staff, not just certain staff such as occupational therapists, should be able to support these activities.

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 substance misuse among the rehabilitation population. The committee thought it was essential that all staff are able to identify these problems and provide the right support.

Maintaining and supporting social networks (recommendation 1.6.9)

Involving family members and carers in decision making can reduce isolation and increase support for people having rehabilitation. However, this can be complex for people with severe mental illness. 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 with this. 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 that cover involving family members and sharing information, as well as supporting families and helping people keep in contact with their home communities.

How the recommendations might affect practice

The recommendations on staff competencies may have a resource impact in services that do not currently provide training. However, any additional resources 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.

Return to recommendations

Person-centred care planning through assessment and formulation

Recommendations 1.7.1 to 1.7.12

Why the committee made the recommendations

Assessment (recommendations 1.7.1 to 1.7.6)

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 also drew on their experience to provide details about what a structured comprehensive biopsychosocial needs assessment should cover to assess people's complex needs and comorbidities.

The committee agreed that 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.

The committee also drew on the evidence identifying the most common physical and mental health comorbidities to highlight conditions that staff need to be alert for because these may contribute to higher mortality or complexity in rehabilitation in this population. The committee also agreed that more understanding is needed about the likely impact of physical comorbidities on mortality among people with complex psychosis, so they made a recommendation for research on coexisting physical health conditions.

Care planning and review (recommendations 1.7.7 to 1.7.12)

The committee agreed that the comorbid health conditions and other needs identified in the needs assessment could be used along with people's recovery goals to 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 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 decided that monthly reviews in inpatient rehabilitation, and 6-monthly reviews for people in community rehabilitation, would keep care plans relevant without being overly invasive.

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.

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 daily living skills and, given the importance of these skills in recovery and quality of life, the committee recommended promoting interventions to improve these activities as highly as other types of interventions. In the committee's experience, this does not always happen in practice.

Based on their experience, the committee agreed that individualised support could improve daily living skills, for example by choosing activities that people enjoy and that 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 important so that people can practise their skills.

Interpersonal and social skills (recommendations 1.8.4 to 1.8.6)

There was qualitative evidence that people in rehabilitation value structured group activities, and a randomised controlled trial found that taking part in them improves interpersonal functioning. This was in line with the committee's views, so they recommended these activities in both inpatient and community settings.

Based on the committee's 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 do. 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 recommendation for research on 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 considering both of these interventions. They agreed, however, that some people may not be ready for mainstream 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 these 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 recommendation for research on peer-support interventions.

The committee also discussed staff training interventions to mediate improvements in daily living skills, interpersonal skills and engagement in community activities, which are key areas of personal recovery in rehabilitation. However, no trials were found that assessed these interventions, so they made a recommendation for research on staff training interventions.

Substance misuse (recommendations 1.8.15 to 1.8.19)

There is a high prevalence of alcohol and substance misuse among the rehabilitation population. Because of limited evidence, the committee made recommendations based mainly on consensus and existing NICE guidance. They wanted to prevent a situation where substance misuse was occurring but rehabilitation staff viewed it as being outside their remit. The committee agreed that questions about substance use 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 for people to practise their 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 the rehabilitation setting could be more costly 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 is not 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 misuse, which could be incorporated into general training for all staff.

Return to recommendations

Adjustments to mental health treatments in rehabilitation

Recommendations 1.9.1 to 1.9.21

Why the committee made the recommendations

Recommendations 1.9.1 to 1.9.3

The committee focused this section on people with symptoms of psychosis that are resistant to standard treatment because this population represents people using rehabilitation services. The committee recommended adjustments to standard treatments for psychosis described in other NICE guidance.

The committee were aware that comorbidities, including other mental health conditions and autism spectrum disorder, can affect outcomes in people with complex psychosis. These comorbidities need to be identified and treated in line with NICE guidance.

Psychological therapies (recommendations 1.9.4 to 1.9.6)

There was some evidence from randomised controlled trials that for people with treatment-resistant psychosis, cognitive behavioural therapy (CBT) decreased positive psychosis symptoms 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 are not ready 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 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 1.9.7 to 1.9.17)

There was some evidence from randomised controlled trials supporting augmentation with the agents in recommendation 1.9.7 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 when 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 on 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 psychiatrist specialising in treatment resistance or a specialist mental health pharmacist if needed.

The committee made recommendations on dosing and interactions with other substances based on their experience and knowledge about the safety of various therapeutic options. They recommended therapeutic plasma levels because this may be useful in checking non-adherence or to confirm toxicity or pharmacokinetic drug interactions.

The committee 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 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 considering ECGs annually (and more frequently for people with complex antipsychotic regimens or doses above BNF levels). They agreed this consideration 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 1.9.18 to 1.9.20)

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. Because of the lack of evidence on specific interventions to improve medicines adherence, they also made a recommendation for research on medicine adherence for people in

supported accommodation. They agreed that people in supported accommodation are likely to receive less support with taking medication than those in inpatient rehabilitation.

Interventions tailored to people in rehabilitation

The committee noted that having psychological and pharmacological interventions specifically for people in rehabilitation, could improve their ability to live in the community. However, the existing evidence was not specific to rehabilitation settings and did not include all relevant outcomes, so the committee made a recommendation for research on tailored interventions.

Electroconvulsive therapy (recommendation 1.9.21)

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. They may lead to an increase in the prescription of aripiprazole as augmentation therapy, but this will not have a resource impact because the associated resource use and unit costs are marginally less costly than amisulpride.

The recommendation 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 annually. Therefore, any resource impact would likely be small.

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

Return to recommendations

Physical healthcare

Recommendations 1.10.1 to 1.10.18

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 1.10.5)

Combining the limited evidence with their experiences of health promotion in rehabilitation services, the committee agreed that a single professional should coordinate people's physical healthcare. The committee did not specify the role of the professional (for example, a doctor, nurse, healthcare assistant or care coordinator) 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 1.10.6 to 1.10.13)

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.

Adverse lifestyle factors may be more prevalent in people with complex psychosis, for example they may be less physically active, which could place them at a higher risk of physical health problems such as obesity, cardiovascular disease, metabolic syndrome and diabetes. They therefore agreed that recommendation 1.1.3.1 about a combined healthy eating and physical activity programme from the NICE guideline on psychosis and schizophrenia in adults was also relevant to include for this population and was broadly supported by the evidence they looked at.

Given that adverse lifestyle factors may be more prevalent in people with complex psychosis, 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. The committee also noted that people with complex psychosis may have difficulty maintaining oral hygiene due to poor self-care and may be at higher risk of substance misuse 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 1.10.14 to 1.10.16)

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

To increase uptake of this health check, 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 discussing the results of the physical health check with the person and relevant practitioners.

Care and treatment for physical health conditions (recommendations 1.10.17

and 1.10.18)

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.

The recommendation to be alert to possible blood-borne diseases was based on evidence about the relatively high prevalence of hepatitis and HIV in people with severe mental illness. The committee agreed this may be related to homelessness, intravenous drug use or a history of sexually transmitted disease. They also agreed that more understanding is needed about the risks predicting blood-borne virus infection in this population so that strategies can be developed to address these, so they made a recommendation for research on the risk of blood-borne virus infections.

How the recommendations might affect practice

Limited evidence showed that it could be cost effective for physical healthcare to be coordinated by a nominated professional.

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 people 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 people with identified risk factors had not received appropriate interventions.

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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 men. 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
- physical health problems, such as diabetes, cardiovascular disease or pulmonary conditions
- pre-existing neurodevelopmental disorders, for example autism spectrum disorder or attention deficit hyperactivity 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 placements. 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 as described above, this suggests that many people do not have access to the specialist rehabilitation services they need, either locally or elsewhere.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on mental health, behavioural and neurodevelopmental conditions.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

Update information

Minor changes since publication

April 2025: We removed references to valproate from individual recommendations and replaced them with a link to relevant safety advice on anti-epileptic medicines from the Medicines and Healthcare products Regulatory Agency (MHRA).

August 2024: We have simplified the guideline by removing recommendations on general principles of care that are covered in other NICE guidelines (for example, the NICE guideline on service user experience in adult mental health).This is a presentational change only, and no changes to practice are intended.

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