1-1-2011

Establishing a recovery-focused rehabilitation unit: a case example

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Abstract

This study highlights lessons learnt from establishing a new recovery-focused inpatient rehabilitation unit in a typical regional city of New South Wales. We have learnt that the most important aspects are recruitment, retention and training of dedicated staff and a belief that recovery is possible. Strategies employed to meet the challenges of integrating a recovery-based practice into this type of setting may be transferable to other new services or existing services of a similar nature. We have provided a summary of standard outcome measures reflecting the performance of the unit for the first 2 years of functioning.

Keywords

era2015, Establishing, recovery, focused, rehabilitation, unit, case, example

Disciplines

Medicine and Health Sciences

Publication Details

Panesar, N., Valachova, I., Lynch, W. & Pai, N. (2011). Establishing a recovery-focused rehabilitation unit: a case example. The Australian Journal of Rehabilitation Counselling, 17 (1), 46-53.

Establishing a Recovery-Focused Rehabilitation Unit: A Case Example

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This study highlights lessons learnt from establishing a new recovery-focused inpatient rehabilitation unit in a typical regional city of New South Wales. We have learnt that the most important aspects are recruitment, retention and training of dedicated staff and a belief that recovery is possible. Strategies employed to meet the challenges of integrating a recovery-based practice into this type of setting may be transferable to other new services or existing services of a similar nature. We have provided a summary of standard outcome measures reflecting the performance of the unit for the first 2 years of functioning.

Keywords: rehabilitation, recovery, mental health, inpatient

The ultimate goal of a rehabilitation intervention is to enable participation in a meaningful life in the community with the least amount of professional support (Anthony, 1993). Most mental health services operate within a recovery-oriented framework (Shepherd, Boardman, & Slade, 2008). Recovery-oriented rehabilitation services serve to facilitate the functioning of consumers with a mental illness through the provision of specialised services that enhance life skills, role functioning, independence and well-being. However, many mental health professionals have not received training in this paradigm or are strongly influenced by traditional medical models (McLoughlin & Fitzpatrick, 2008). They hold the view that individuals with mental illness would not experience recovery (Harding, Brooks, & Asolaga, 1987). A large international multicentre study has found that global outcomes at 15 and 25 years after a diagnosis of a psychotic illness were favourable for recovery-focused treatment in over half the people followed up (Harrison, Hopper, & Craig, 2001).

There is an increasing demand for recovery-oriented units in Australia that emphasise evidence-based and multidisciplinary individualised care programs. A recovery unit working in close partnership with acute inpatient services, community rehabilitation and adult mental health teams is critical to long-term management of patients with mental illness. In the Australian context, other partners include those for Ageing, Disability and Home Care (ADHC), alcohol and other drug services. Ancillary services are available from general practitioners, private psychiatrists and nongovernment organisations.

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Patient Characteristics

Individuals referred to the unit must have a primary diagnosis of a psychotic or mood-related disorder that prevents them from living independently and working in a competitive employment due to the severity and enduring nature of their functional and cognitive impairments (Framework for Rehabilitation for Mental Health, 2002). Consumers often have a history of multiple and lengthy hospitalisations and poor response or adherence to medication. There is some evidence to suggest that even consumers with severe disabilities or major chronic illness known to be incapable of living outside hospital can make worthwhile gains in levels of social functioning and in quality of life when appropriate help is provided in a specialised rehabilitation unit (Atkin, Meats, & Sincock, 1991).

The concept of being 'involuntary' in a rehabilitation unit poses a philosophical dilemma. Identifying a consumer's personal goals without collaboration is a coercive approach and is not necessarily in keeping with a recovery philosophy. However, some consumers might clearly benefit from an involuntary admission to a rehabilitation unit under the *Mental Health Act 2007* (NSW) that allows for rehabilitation without a consumer's willingness.

The likely success of newly established recovery units depends on careful planning. Critical planning aspects include utilising resources based on well-researched community needs that would remain consumer-centred and recovery-focused. These aspects include decisions about the recovery environment, treating team, consumer, administrative role, and intervention programs.

Case Example

In 2008/09 South Eastern Sydney Illawarra Area Health Service (SESIAHS) established three new rehabilitation inpatient units as part of the enhancement of non-acute inpatient beds across New South Wales (NSW) as government mental health initiatives. These include Shellharbour and Prince of Wales Hospital Mental Health Rehabilitation Units (MHRU), and Sutherland MHRU, which is youth-focused. This article focuses specifically on the procedures for the establishment of Shellharbour MHRU, which has been in operation since December 2008. While the size, function and general staffing of the units had been predetermined, the service had a rare opportunity to define the model of care and shape the service culture from the outset.

Rehabilitation Environment

The Shellharbour MHRU is a 20-bed inpatient unit for both males and females aged between 18 and 65 years. The unit accepts both voluntary and involuntary mental health service consumers for an intensive rehabilitation program of up to 6 months in duration. The unit is a government-run service located close to the acute mental health inpatient facility on the local general hospital campus. Referrals are accepted from any part of SESIAHS, including acute inpatient units and community teams as well as private psychiatrists. In order to further facilitate the care of consumers, Shellharbour MHRU works in collaboration with local mental health services, local public hospitals, general practitioners and nongovernmental organisations (NGOs).

Preliminary Operational Data

Table 1 presents data on the profile of consumers admitted to Shellharbour MHRU over the past two years (2009–2010). As can be seen in Table 1, the majority of consumers are Australian-born between 19 and 65 years of age. The table also provides an overview of consumers' primary diagnosis and lists the most common comorbidities among consumers between 2009 and 2010. Between 68–85.2% of consumers in 2009–2010 had a primary diagnosis of psychosis and the most frequent comorbidity remains substance misuse at 33.3–44% over the same period.

Preliminary Outcomes Data

Figure 1 presents an overview of length of stay for consumers admitted to the unit during 2009–2010. The average length of stay was 98.9 days in 2009 and 91.6 days in 2010 demonstrating a reduction in the number of hospitalised bed days. The unit was successful in achieving the purpose of rehabilitation by decreasing the readmissions rate at 28 days following discharge from 12% in 2009 to 7% in 2010 ,therefore reducing the readmission rate by almost half over this period (Figure 2). This highlights the success of rehabilitation strategies in reducing readmissions and minimising the 'revolving door syndrome'.

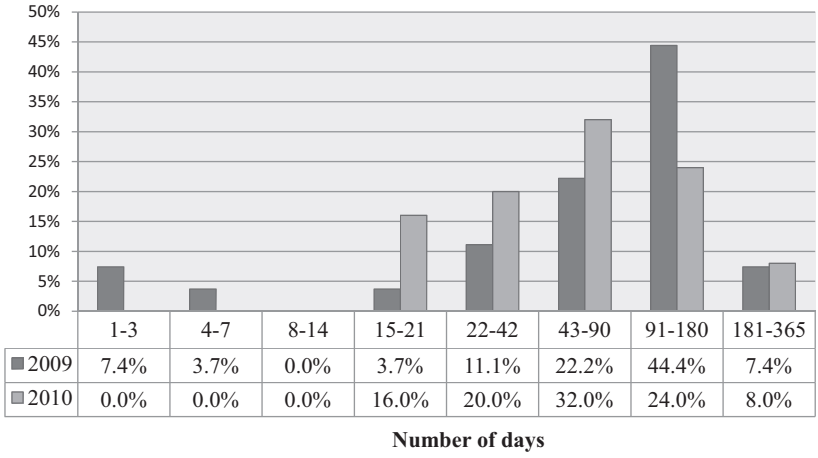
Overall, the unit has noted clinical and functional improvement of consumers in many aspects leading to an improved quality of life at time of discharge. Formal feedback from carers and consumers via the Mental Health Consumer Perceptions and Experiences of Service (MH-COPES) survey shows overall satisfaction with the rehabilitation program.

TABLE 1

Consumer Characteristics in Percentage

	2009 %	2010 %
Age		
19–30 years	33	20
31–45 years	41	44
45–64 years	22	36
65–74 years	4	0
Ethnicity		
ATSI*	0	8
Born outside Australia	4	28
Born in Australia	96	64
Primary diagnosis		
Psychotic disorder	85.2	68
Affective disorder	14.8	28
Personality disorder	0	4
Comorbidity		
Substance misuse	33.3	44
Personality disorder	3.7	4
Developmental disability	7.4	4

Note: *Aboriginal and Torres Strait Isander



	1-3	4-7	8-14	15-21	22-42	43-90	91-180	181-365
2009	7.4%	3.7%	0.0%	3.7%	11.1%	22.2%	44.4%	7.4%
2010	0.0%	0.0%	0.0%	16.0%	20.0%	32.0%	24.0%	8.0%

FIGURE 1
Length of stay profile.

Workforce

The bed capacity of Shellharbour MHRU increased from 16 to 20 beds in December 2009. In February 2010 the unit achieved a full staff establishment through recruitment and this has been maintained. Due to their lack of experience in rehabilitation, the focus was initially on training and education in rehabilitation and the recovery process. Further staff education includes training in Mental Health Outcomes Assessment Tools (MHOAT) outcome measures, clinical supervision for nursing staff, Journal Club, staff in-service program and mandatory training.

Treating Team Role

In psychiatric rehabilitation, many interventions must be implemented simultaneously in different settings by different supporters in a consumer's social network. Only

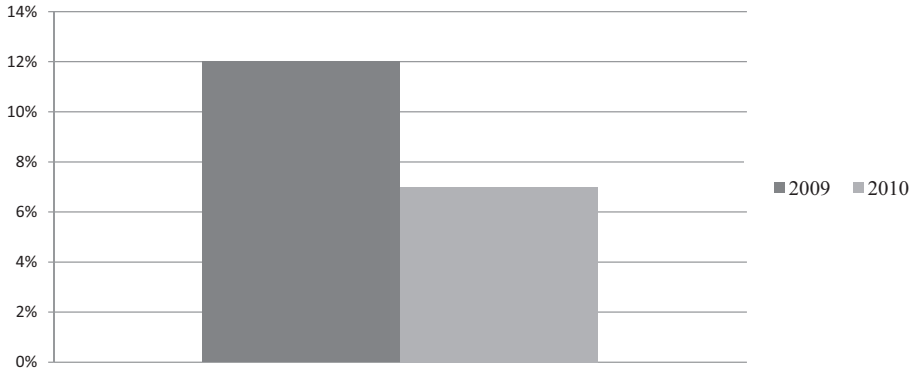


FIGURE 2
Percentage of readmissions within 28 days of discharge.

a multidisciplinary team can sustain an efficient and productive range of services (Liberman, Hilty, Drake, & Tsang, 2001). In setting up and grounding Shellharbour MHRU we were aware that challenges in establishing a multidisciplinary team include recruitment, retention, education and training of competent and conscientious staff members.

Recruitment

Recruitment and retention of appropriately experienced staff was one of the most significant challenges encountered. The majority of staff recruited did not have experience working in a rehabilitation setting and required training in working within a recovery philosophy. Initially, there was a limited range of therapeutic interventions available due to a lack of trained staff. A comprehensive rehabilitation education program was therefore established as a central component of the biopsychosocial approach. However, following recruitment and training of dedicated staff, the MHRU was able to offer a broad range of rehabilitation programs.

While comprehensive training and orientation in these areas were provided, there was initially no staff experienced enough to take on a clinical guidance and leadership role on the unit. This was resolved through the appointment of an overseas psychiatrist experienced in leadership and rehabilitation to the position of full-time Clinical Director. Similarly, a newly recruited Nurse Unit Manager (NUM) with experience in guiding the clinical staff was employed. This combination provided the unit with senior leadership with a focus on recovery outcomes.

Coordination Function

Another challenge in individualised psychiatric rehabilitation lies in the special competencies required from team members who deliver a care coordination model. Such a model requires a rehabilitation assessment with provision of clinical rehabilitation interventions in conjunction with collaborative goal-setting. A number of strategies have been established and implemented to educate and guide staff to promote their confidence and knowledge in psychiatric rehabilitation. Strategies have included internal and external training with supportive initiatives provided by individuals with expert knowledge in rehabilitation. The training of newly recruited allied health staff (Social Worker, Occupational Therapist, Diversional Therapist, Clinical Psychologist) and nursing staff (inclusive of NUM) facilitated development of the multidisciplinary model of care currently endorsed on the rehabilitation unit.

In partnership with the Area Family and Carer Team the multidisciplinary team have commenced intensive work with consumers and their families and carers. Working closely with carers and family members is an essential aspect of facilitating a consumer's recovery (Glynn, Coohen, Dixon, & Niv, 2006). This is because recovery can be defined by functioning in the family, work, friendship and residential settings (Liberman & Kopelowicz, 2002). A team selected for their personal skills, positive attitudes and eagerness to learn is one of the most important requirements in establishing a newly functioning team (Liberman, Hilty, Drake, & Tsang, 2001).

The multidisciplinary team promotes evidence-based biopsychosocial approach in management of consumers. Due to complex consumers' needs and severity of illness preventing them from seeking appropriate resources, the inpatient rehabilitation team follows the assertive community treatment (ACT) model. ACT delivers comprehensive services in a coordinated fashion by all members of a single team

(Essock & Kontos, 1995; Stein & Test, 1980). Adequate skill mix within the team provides a variety of interventions such as psychosocial interventions, psychoeducation and psychological treatment. In addition, the local team has strong links with other mental health services and a good general knowledge of local resources. Work with each consumer starts with multidisciplinary assessment including a cultural component. Each consumer is assigned a Care Coordinator, providing overall responsibility for ensuring appropriate assessment, care and review by themselves and others in the team. Staff know and work with all consumers and continuity of care is provided by the whole team.

Consumer Role

Suitability of individual consumers for an admission to MHRU depends on their rehabilitation goals and willingness to engage in the rehabilitation process. The consumer's willingness and ability to engage in a range of hospital-based mental health rehabilitation assessments and program is a prerequisite for treatment. Consumers requiring admission to MHRU are likely to benefit through improved response to medication and adherence to treatment.

Administrative Role

The rehabilitation unit is linked to existing mental health information initiatives including MHOATs and the Mental Health Information Development Project, providing easy access to relevant, timely and comprehensive databases of information. Facilitation of reliable documentation and transfer of information between service providers and consumers is achieved by all staff trained in information technology data entry (NSW Department of Health, 2011).

Evidence-Based Intervention Programs

Currently available programs include cognitive–behavioural therapy, family intervention, social skills training, life management skills, healthy living, psychoeducation, illness self-management, drug and alcohol education, and relapse prevention. In addition to the standard activities, consumers also have opportunities to join spiritual sessions, meditation, gymnasium and yoga. Consumers participate in community-based leisure activities such as tenpin bowling, fitness program and swimming. Based on an individual's goals, rather than goals identified by clinicians, the team propose individualised treatment plans incorporated with the strength model. This model emphasises the engagement between the team and the individual to identify their strengths and develop a plan focused on goals identified by the individual, rather than those identified and prescribed by clinicians (Chopra et al., 2009; Rapp & Goscha, 2006). The unit is also in the process of introducing cognitive remediation, prevocational rehabilitation and supported employment on the unit as these programs are currently available to our consumers through the community rehabilitation team.

Future Prospects

A greater number of recovery units are likely to be established in the next decade, with demand for such services driven by the needs of people with complex, recurring and ongoing nonacute mental health issues in the community. Shellharbour MHRU is one of 10 new rehabilitation units established in NSW with a recovery-focused strategy. The unit is now accredited for training and a junior medical officer and a

psychiatry registrar are full-time members of the team. In addition, the unit provides training to medical students from the Graduate School of Medicine, University of Wollongong and to undergraduate nurses from across the state.

Conclusion

While establishing a new inpatient rehabilitation unit, we learnt the following factors were necessary to provide effective care: (1) a comprehensive and assertive recruitment strategy, and (2) a clear model of care and external expertise to guide the implementation process. Having recruited dedicated senior staff to lead and monitor the implementation effort, they had to provide consultations and lead training, including in-vivo clinical supervision. This helped clinicians transfer their clinical skills into rehabilitation practice. As this is a newly established unit, improvements in the delivery of recovery-oriented rehabilitation programs are ongoing. Recovery is possible for all consumers.

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