Faculty of Rehabilitation and Social Psychiatry

Newsletter

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Chair's Column

Dr Sunil Nodiyal

Welcome to the newsletter for the Rehab and Social Psychiatry Faculty of the Royal College of Psychiatrists! We are thrilled to have you join us as we explore the latest research, trends, and best practices in the field of rehabilitation and social psychiatry.

Throughout this newsletter, you can expect to find insightful articles and resources to support your professional development and enhance your understanding of this important specialty. Whether you are a seasoned practitioner looking to stay up to date on the latest advancements or a student eager to learn more about this field, we aim to provide valuable and relevant content for all. As members of the faculty, we are committed to promoting excellence in the field of rehabilitation and social psychiatry and supporting our members in their professional growth and success. We encourage you to engage with our newsletter, share your thoughts and experiences, and connect with fellow professionals to foster a sense of community and collaboration.

I encourage all of you to attend the annual faculty meeting where like-minded people meet and we can share good or not so good practices in our area. It is a great opportunity to network with other rehab psychiatrists because we know the job can be very isolating at times. I would also request you to look at the vacancies in the faculty and join the exec roles to influence decision making and take on other exciting opportunities as and when they come in form of volunteering for different roles.

Our faculty is facing challenges and with them comes opportunities. The inpatient rehab wards are under pressure following bed reduction and there is proliferation of private beds for rehab services. We should encourage the private providers to engage with the college and get their services accreditation from the college. The role of rehab psychiatrists is also getting lost due to closure of wards, and they are working in non-rehab services and similarly, in some areas, psychiatrists without rehab endorsement are working in these services. We can encourage them to get accreditation with the college.

Thank you for visiting our newsletter, and we look forward to sharing this journey with you. Stay tuned for our upcoming posts and don't hesitate to reach out if you have any suggestions or feedback. Together, we can continue to advance the field of rehab and social psychiatry and make a positive impact on the lives of those we serve.

Our Journey towards Rehab

Rosamond Savege

It is 13 years since my husband, Mark, and I drove south and finally removed our older daughter, Anna, from the room she had been occupying whilst at uni. She left prematurely, as her essays descended into pages of random sentences, and her detachment from the world - which had been apparent for a few years - left her totally incapable of looking after herself. The mess and stench were indescribable, her vulnerability glaringly obvious. We brought her home to our comfortable large house in an equally comfortable village 4 miles from York. Here she has remained apart from 3 quite lengthy stays in our local psychiatric hospital.

It took 4 years before Anna would allow a GP to visit. Then the cavalry - in the shape of an excellent EIP team - arrived. There was a diagnosis – psychosis – care for her, and us, and treatment; surely the end of this traumatic period was in sight? Things were inevitably not that smooth and I have terrible memories of an Easter Bank Holiday weekend when I feared for her, and our, lives. An unsatisfactory response from the crisis team led to us locking the doors, sitting tight, sleeping when Anna slept and watching each other's back. Tuesday brought the lovely care-co to our door at 9.00. "Now, what's been going on?". The relief flooded through me.

Discharge to an over-stretched, poorly managed CMHT led to a gradual unravelling of all the good work that EIP had done. More traumatic weeks (and weekends) followed, but the 2nd and 3rd detentions in hospital (16 weeks in all) finally brought an Outreach Team into our lives. Clozapine's sedating effect has been significant, but Anna is more stable, more communicative, no longer dangerous to herself or us, and is starting to engage better in activities and therapy. Mark and I can relax a bit, leave Anna with my sister for a few days and take her to Northern Spain, where our younger daughter lives.

None of this is easy or risk-free. Day-to-day, we work hard to keep her properly fed and presentable enough to access her activities. We have to get her up, administer her meds, wash her stained clothes, sort all her appointments, negotiate with YORT, social care providers and activity managers, and, above all, be there on the now less rare occasions, when she is happy to open up.

Rehab means hope for the future, as we rapidly approach old age. It means that relationships can be built and trust return. It means that we are not left to sit out terrible weeks alone, but have confidence that the many pieces that need to be in place before Anna can be moved on, are being slowly assembled by others, with our constant input. The future is not clear, but if it brings with it the continuing support from the caring, knowledgeable and accessible bunch of people that is our Outreach Team, then there is a more than a glimmer of light at the end of the tunnel.

Homelessness

Dr Jenny Drife

We have probably all noticed the increasing numbers of people sleeping rough in recent years. In 2023 England's annual street count, undertaken by local authorities on one night each November, found well over 8000 people sleeping rough – an increase of 27% since the year before. This is something that should concern us all, as doctors and as psychiatrists: the mean age of death for a man sleeping rough is 45, and for a woman is 43. And according to the ONS the top three causes of death for homeless people are drug poisoning, suicide, and alcohol related causes. Rates of mental illness are high in people sleeping rough, with one study finding that 25-30% had serious mental illness such as schizophrenia, bipolar disorder, or severe depression.

It's imperative that we all do what we can to prevent people ending up on the streets, and to support people back into accommodation. Housing is often lost when people are becoming unwell and fall out of contact with their treating team. Think about whether your service is accessible to people who are unstably housed (are appointment letters going to the right address?), to those who don't have access to the internet, may not have or keep mobile phones, and may have low levels of literacy. On inpatient wards, if patients say they are going to the streets on discharge, carefully consider whether this is really just an unwise decision or an incapacitous one – experience suggests it is more often the latter.

Many areas now have specialist CMHTs for people sleeping rough. If you are working in one, please get in touch to join our network. My email address is jenny.drife@slam.nhs.uk

Musings

Dr Andrew Molodynski

I've been very fortunate in the last couple of months to be able to travel and meet people in this country and overseas and to talk and listen about mental health services and especially to think about how we can use what we already know to provide the best possible care for people with long term and significant illnesses.

In May I was in Wrexham at a conference focusing on patient friendly mental health services, organised by the teams at Betsi Cadwaladr University Health Board and Bangor University. I was talking about my long-term research and campaign interest, the use of force in mental health care. It is a difficult thing to talk about sometimes without triggering some people and alienating others, but the very mixed audience in Wrexham with a huge proportion of people who have used services and their families engaged in a spirited and thoughtful discussion on the very difficult issues. It was great to hear Lade (Smith- our president of course!) talk about the importance of continuity of care and the crucial need to focus our minds on the care of people with severe and long-term conditions. Hearing also about the Trieste model of care from Roberto Mezzina was inspiring too- while we may not want or be able to do exactly as they have in northern Italy, there are certainly very positive aspects of their services that we can learn from and adopt.

In June I landed up In Dubai at a conference on mental health. It was striking how much of the meeting related to the management of epilepsy and pain and it really brought home to me how much broader the remit of psychiatrists can be in other parts of the world. I was delighted to be able to talk about the positive things we can do that have a strong evidence base for people with psychosis- medication, some forms of talking therapy, individualised employment support, physical health programmes, models of care etc. It's regrettable that here in the UK, one of the wealthiest countries in the world, our ability to do some of these things has become more limited- hopefully by the time you read this change will be afoot. It will take time but at least we can have hope if things begin to move in a positive direction again.

Finally, I was at a very different meeting- the annual meeting of the British Medical Association. In between getting exercised about pay and such matters, there was a huge amount of discussion and worry about the wellbeing of medical students and doctors of all types and level of seniority. We need to be well to look after our patients properly and hopefully the RCPSYCH can take a leading role with the BMA in highlighting the issue and developing strategies to reduce the prevalence of burnout and the damage it does amongst doctors.

Through these seemingly different experiences I felt like there was thread of hope. If we can learn from others and focus on services that are acceptable (or preferably better) to patients and if we can get back on track with resources and systems that help and not hinder us, and

if we can support the workforce, then hopefully mental health services can recover somewhat nationally. If they do, then we will as well and our patients and their families will benefit enormously- a win, win, win situation I'd love to see.

The Garden Project @ Park Road

Owen Baglow

Garden Project @ Park Road: Cardiff and Vale UHB

The Garden Project @ Park Road, initiated in July 2023, has transformed a once-disused area into a vibrant, therapeutic green space. This project, led by Ward Manager Owen Baglow and supported by staff, patients, and community volunteers, features a productive food-growing area and a nature garden. The food-growing area provides fresh, organic produce, promoting healthy eating habits and sustainability. The nature garden, established in January 2024, includes a wildflower meadow, habitat boxes, a pond, and 122 native trees, enhancing biodiversity and providing a tranquil environment for reflection and relaxation.

Patients and staff alike have greatly benefited from this green space. Regular gardening activities and workshops offer therapeutic engagement, reduce stress, and improve mental well-being. The project has also fostered a strong sense of community, bringing together people of all ages and backgrounds to work towards a common goal.

One patient involved in the project, shared, "Working in the garden has given me a sense of purpose. It's incredibly calming and has helped me in my recovery." Another patient remarked, "The garden is a beautiful place to escape to. It has improved my mood and given me something positive to look forward to."

For more details of the project, please contact Owen Baglow at owen.baglow@wales.nhs.uk

Reflections on my time as the Rehabilitation Faculty PsychStar

Over the past year, I have been attached to the Faculty of Rehabilitation and Social Psychiatry as part of the Royal College's Psych Star scheme. The Psych Star scheme provides mentorship, funding, and resources to medical students with an interest in psychiatry.

Before joining the programme, I, like most medical students, had not had any exposure to rehabilitation psychiatry. I was assigned two mentors in the faculty, Dr Katie Fergus and Dr Charlotte Harrison, who provided an extremely useful glimpse into the world of rehabilitation.

One of the year's highlights was attending the faculty conference in Leeds, where I was introduced to key ongoing discussions within the field and heard the invaluable perspectives of those with lived experiences. Additionally, the Psych Star scheme allowed me to attend the European Congress of Psychiatry in Budapest and present a poster at the College's International Congress in Edinburgh. The chance to attend these events has broadened my understanding of UK and global practices, as well as future challenges in psychiatry. It has given me the opportunity to meet fantastic people and develop ideas about the kind of career I might want in the future.

I am very grateful for my time as a Rehabilitation Psych Star; it has solidified my passion for mental health and emphasized the importance of holistic, recovery-oriented practices.

Lauren Pereira-Green

RESEARCH IN MENTAL HEALTH REHABILITATION

Professor Helen Killaspy, University College London

Until fairly recently, there wasn't all that much research on mental health rehabilitation services. That situation has gradually improved and there is now consistent evidence demonstrating their effectiveness.

National research programmes in England (such as REAL and QuEST) have shown that around two-thirds of people who are admitted to an inpatient mental health rehabilitation unit can be discharged from hospital within a year, without subsequent readmission or community placement breakdown and over 40% continue to progress well in the community, graduating from higher levels of supported accommodation to more independent settings within three years. However, it's important to note that in one, small cohort study in North London only 10% were living independently at five-year follow-up, suggesting that the majority of people with complex and severe mental health problems will need supported accommodation long term. The national studies also found that rehabilitation services that adopt a more recovery-based approach (individualized, collaborative, hopeful and goal-orientated) are more effective in enabling people to live successfully in the community. Researchers in the Netherlands have developed a model to improve recovery-based practice in mental health rehabilitation services called the Active Recovery Triad (ART) which is currently being evaluated.

A number of 'before and after' studies from the UK, USA and Australia have shown that mental health inpatient service use is reduced when people have access to mental health rehabilitation services, with associated reductions in the costs of care. However, these studies are limited by small sample sizes, short 'before and after' periods, and the absence of comparison (control) groups. Of course, the gold standard randomized controlled trial (RCT) design overcomes these issues, but isn't feasible in well established services like mental health rehabilitation. Indeed, recent attempts to randomise people to different types of supported housing in studies in the UK and Switzerland have proved unsuccessful due to clinician and patient preferences for specific services.

Research that uses routinely collected data, such as healthcare records, might provide an alternative. For example, the Clinical Records Interactive Search (CRIS) system deidentifies and structures electronic healthcare record data for research and has been used in hundreds of studies of mental health services. Nevertheless, there is ongoing debate about the extent to which causality can be inferred from the analysis of these kinds of observational datasets, although there have been some attempts to emulate RCT designs

using them to evaluate medication effectiveness. Whether it is possible to extrapolate these techniques when the intervention is as complex as mental health rehabilitation remains unexplored.

The NICE Guideline on Mental Health Rehabilitation for People with Complex Psychosis also identified a number of areas where we need more research, including: the effectiveness of rehabilitation services for people at an earlier stage of psychosis; the role of peer support; group interventions to improve social skills; the effectiveness of highly specialist rehabilitation services; and the role of the independent sector. A national study in England addressing the last of these is currently underway (the ACER study) but there is clearly plenty of scope for researchers to build on the work that has been undertaken so far to further inform our understanding of how to help people with complex psychosis to optimize their recovery.

One area where we urgently need more research is in regard to community rehabilitation teams. In England there has been a recent increase in the number of these teams that are operating, following investment through the Government's Community Framework programme. However, we don't know how many of these teams there are, where they are, what their eligibility criteria are and whether they offering consistent interventions and treatments. A researcher from University College London, Nikita Singh is currently undertaking an on-line survey of these teams for her MSc project under supervision from myself and Ass Prof Artemis Igoumenou. The study has been approved by UCL's research ethics committee (Project ID: 27177/003).

If you are working in a community rehabilitation team in the UK, please take a few minutes to complete thr survey which can be accessed at this link:

https://qualtrics.ucl.ac.uk/jfe/form/SV_efBngnbC6JjaOEK

You may have received an email about the survey previously and is so there is no need to complete it again. Only one response per team is needed.

We will report the findings in a future Faculty Newsletter.

The Mental Health Act: A Patient Perspective

I am certain that the majority of my fellow service users agree that for medical, social and indeed humane reasons there is a place in society for the Mental Health Act, especially in cases of preventing harm to the self or harm and violence towards others. Even in cases where there is no risk of harm, many service users see a place for the application of the mental health act as a process whereby mentally ill people who may be unaware that they need help are rescued from the nightmare of psychosis. Psychosis itself is coercive – so when psychosis is deciding for the individual it may be ultimately preferable for the reality of the mental health act to intervene however drastic these measures may seem at the time.

For some – like myself – we can accept with hindsight that coercive intervention was a necessity to recovery, especially in my case as I was not aware that I was mentally ill or that I needed help. I have learnt to conclude that the mental health act is something positive for most service users as it ensures a path way *out* of hospitalisation rather than a way into prolonged and interminable incarceration within an institution. However, the majority of service users would ask that detention under the mental health act is only applied after all other possibilities have been explored and that medical professionals should use all possible measures to promote voluntary admission. Voluntary treatment should be a primary option wherever this is possible. Indeed, the mental health act Code of Practice states that compulsory admission powers should only be exercised as a last resort. Human rights law states that no one should be deprived of their liberty because of their disability.

At the time it is happening assessment and detention is a traumatic and frightening crisis that exacerbates the already terrifying experience of psychosis. People who are suffering from the very common psychotic delusion that there is a conspiracy against them can believe that such contact with police and professionals substantiates and reinforces this delusion into a terrifying truth and this can distort reality even further.

The process of assessment and detention whereby basic freedoms are suddenly snatched away from the individual is an experience that makes it difficult for the service user to believe the mental health act has benefits. Detention under section can create for the service user a barrier to the acceptance of and compliance with treatment and to developing a therapeutic relationship with mental health professionals. The service user will focus more on the loss of basic human rights and on the struggle to have these rights reinstated. Therefore, the necessarily firm focus on recovery from the psychosis that has brought him/her into being detained becomes secondary and almost unimportant. Treatment ceases to be collaboration between service user and medical professional and becomes an acrimonious power struggle to regain social freedom, autonomy and inclusion in the normal

world. Detention may seem an interminable sentence and the service user may feel that he/she is being punished. In some cases, one would consider prisoners to have more rights than the detained service user who may be denied access to fresh air, sunshine and freedom of movement – not to mention the no smoking policy.

So, what can help to make for a sympathetic and supportive application of the mental health act and improve the experience of being sectioned? Patients can only ask that when it comes to such a harrowing situation the professionals assessing and detaining - wherever practical and possible – proceed with sympathy and respect giving supportive explanations and reassurances from the very start that there *is* light at the end of the tunnel. Above all they should try and preserve the patient's dignity and attempt to dispel feelings of fear, humiliation, crisis and downfall. If professionals are heavy-handed in a mental health act situation, the resulting trauma can influence the progress of treatment and recovery. Bad memories of heavy-handedness remain with you for the rest of your life. Above all, the possibilities of a voluntary admission should be promoted and explored exhaustively and at all costs wherever the situation allows: coercion should always be a last resort.

The mental health act may help people out of crisis, especially when they lack capacity to realise that they need help or indeed that they are unwell: how ever incomprehensible and unacceptable it may seem at the time the mental health act seems to have a place in many people's journey to recovery. However, the implementation of such coercive treatment is distressing and traumatic, because it means loss of choice and freedom: the mental health act is socially excluding and stigmatising - service users can find it difficult to help themselves to be socially included again after such experiences. Being subject to the mental health act is always a bitter medicine which could be made more palatable if psychiatrists can be trusted to maintain their awareness of the negative side of such treatment and act accordingly to improve the experience. All we can hope for is that psychiatrists can be trusted to apply the mental health act only after all other alternatives have been considered so that coercion under the mental health act is always a last resort.

Implementing Open Dialogue into a Community Rehabilitation Team[9]

Authors: Jonathon Whyler, Liji Premlal Puliparambil, James Bancroft, Amrith Shetty

Open dialogue is gaining interest within the field of Psychiatry globally and features a psychological intervention within a specified service delivery centred around a person's psychosocial network (Freeman et al., 2019; Tribe et al., 2019). This therapeutic strategy originated in Finland, where the practice was first developed around supporting patients during acute crisis periods and as a treatment approach for psychosis. A therapeutic conversation, named 'Dialogic Practice' is incorporated into network meetings (Olson et al., 2014; Seikkula et al., 2001), and there are key elements of Dialogic Practice, which include using a relational focus during the intervention. Specific interactions and communication styles are outlined as part of the delivery including around responding and reflecting, and the therapists also reflect between themselves as a conversation observed by the network (Olson et al., 2014). This practice results in open, honest, and transparent interactions.

Within Cheshire and Wirral Partnership NHS Foundation Trust (CWP), the Mental health Intensive Support Team (MhIST) is a community rehabilitation service which supports patients presenting with complexity. This can include patients with severe mental disorders and impaired social, interpersonal, and occupational functioning, as well as a history of substance misuse and neurodevelopmental disorders. The current patient cohort consists of many patients who have experienced long periods of hospitalisation, including those who have been away from their community and support networks in out-of-area placements. An important function of the rehabilitation team is to assist patients in regaining their independence and capacity for functioning and this includes a focus on social aspects.

MhIST is a relatively new specialist team, and the first patient was supported in 2021. The team has grown and developed since then and has included the incorporation of open dialogue as the team's philosophy of care. To our knowledge, MhIST is one of the first teams in the United Kingdom to offer this programme within rehabilitation services, which has now become an integral part of the clinical model of care and treatment plan for MhIST patients.

Typically, patients will attend for network meetings fortnightly or less frequently if required. In keeping with a flattened hierarchy, all team members can participate in meetings. As part of the service delivery, team members also engage in regular team reflection to support and enhance the level of clinical practice. Open dialogue facilitates rehabilitation by fostering a supportive environment and safety net, where the patient can

explore their experiences and challenges without judgement. This approach also recognises the impact of social factors within the rehabilitation process.

The intervention appears to be well received by patients so far. Data from our cohort was previously presented in a semi-qualitative cross-sectional study in which feedback was captured from both patients and their networks. Themes identified in the analysis including patients feeling understood and improvements in communication and engagement. Open dialogue sessions helped patients feel better supported, improved communication and honesty within their social network, and helped them to understand their mental illness (Puliparambil et al., 2023).

Open dialogue represents a change towards a more relational, network-based approach, and by integrating the principles of this intervention into rehabilitation psychiatry, there is potential for more effective and compassionate care that considers psychosocial factors and dynamics in addition to enhancing knowledge, communication, and participation of social networks. Although we have introduced open dialogue as part of a community-based intervention, there may be scope for this intervention to be offered at various junctures in the rehabilitation pathway, including inpatient services, and research is warranted into the evidence-base for open dialogue within rehabilitation services including longer term outcomes and follow-up.

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RCPsych Membership Survey

The college launched the membership survey at the recent Congress

There are opportunities for members to win free tickets to Congress 2025 in Wales by completing this survey.

Closing date: 26/07/2024

For further information please visit this link- Membership Survey 2024

The feedback will help the college to improve services for our members. It will bring feedback into a central place for us to analyze and understand within the contexts of members locations and career stages. The results will translate into a deliverable action plan and will help keep us accountable to members suggestions

How important is the patient's environment in psychiatric rehabilitation?

Jessica Sinyor

Winning essay of the faculty essay prize

Introduction

Charting the history of rehabilitation and recovery, Dr Gavin Francis describes how – even when there is no cure for illness or disability – "it can still be possible to 'recover' in the sense of building towards a life of greater dignity and autonomy" (1). Key to rehabilitation, argues Francis, is where it takes place; it is imperative to "optimise the environment around the patient to make it more conducive to healing" (1). Psychiatric rehabilitation, which aims to maximise the quality of life and social inclusion of people with severe mental illness (SMI), takes place in a range of environments including inpatient units and supported housing (2). These services stand in contrast to the institutional approach to managing psychiatric illness that endured into the twentieth century (3). This essay will ask whether the environments in which psychiatric rehabilitation currently takes place succeed in "fostering self-esteem, confidence, emotional literacy" and promoting social inclusion (2). Using the biopsychosocial model, I will assess the importance of the environment in psychiatric rehabilitation for individuals' biological, psychological and social wellbeing and explore how aspects of the patient's environment may be exploited to aid recovery.

What is rehabilitation psychiatry?

Psychiatric rehabilitation serves patients with a diagnosis of severe and enduring mental illness resulting in functional impairments that require long-term care. The ultimate purpose of rehabilitation is to re-integrate the individual into the community. Clients of rehabilitation services most commonly have a diagnosis of schizophrenia, although intellectual disability, personality disorder and physical health challenges may further complicate the picture (2). Referrals to rehabilitation services are often made when an individual with SMI is unlikely to benefit from further time in an acute ward environment, but cannot be discharged into the community.

After referral, inpatient management is multi-disciplinary and aims to "maximise an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future" (4). This involves addressing any physical health needs, optimising medical regimens and working with patients to improve their self-care and life skills to prepare them for transfer to community services.

Where does psychiatric rehabilitation take place?

The rehabilitative environment has undergone major changes since the second half of the twentieth century. The establishment of asylums in the early nineteenth century reflected

a more humane impulse to house people with mental illness in environments more conducive to recovery and care than prisons (5). However, by the turn of the twentieth century, the ambitions of the first asylums – grand buildings constructed away from industrialised areas – had given way to overcrowded institutions (6). These conditions precipitated the closure of mental hospitals in favour of treating patients in the community, a move heralded by the Mental Health Act of 1959 which abolished the Lunacy and Mental Treatment Acts (1890-1930) and the Mental Deficiency Acts (1913-1938). From the 1960s onwards, large asylums were closed down and inpatient bed numbers were slashed as patients were integrated into the wider hospital network or managed in the community (7). The environments in which psychiatric rehabilitation now take place should, according to NICE guidelines, follow a step-wise model of decreasing intensiveness and restrictiveness correlated with improvements in the patient's condition (8). A typical pathway may involve moving from an acute ward to a high-dependency unit to community rehabilitation in supported housing (9).

While there is consensus that the de-institutionalisation of mental healthcare was overdue, the services which replaced it are not without criticism. Out of area placements may entrench social isolation; the lack of range in services results in patients residing in unnecessarily restrictive environments; and the importance of cultivating independent living skills may be overlooked (10). Indeed, some have argued that we are witnessing "re-institutionalisation" in which patients are confined to overly interventionist inpatient care due to the absence of follow-up services (6, 10). The question of the environment – inpatient and community-based – is central to assessing the effectiveness of psychiatric rehabilitation to facilitate the recovery of the patients it serves.

The environment in psychiatric rehabilitation

What is the importance of the environment in psychiatric rehabilitation? The place where an individual lives is both a causative and a complicating factor in the development of mental health problems. Poor quality housing, overcrowding, lack of daylight and a neglected physical environment are all associated with poor mental health (11). Compared to those without mental health problems, individuals with SMI are twice as likely to be unhappy with their housing and four times as likely to report that their housing worsens their health (12). Given this association, it is key, as Dr Steffan Davies argues, that the influence of the clinical environment on wellbeing is "considered and managed in the same way as any other aspect of treatment" (13). I would extend this argument to community services and to the transitions between different care settings. Each environment may influence the patient's outcome: it is not just what is done to support an individual, but *where* it is done. Because rehabilitation involves sustained periods in wards, units or supported accommodation, it is particularly important to ensure that the patient's environment best facilitates their recovery. Indeed, one study of patients in the West Midlands found that only one in ten users of rehabilitation services were living in independent accommodation within 10 years of admission to an inpatient unit (14).

To assess the importance of the environment in psychiatric rehabilitation, a holistic evaluation is essential. The biopsychosocial model of illness is used here to provide a framework for investigating the influence of the patient's environment on their biological, psychological and social wellbeing (15).

Biological

As Šprah *et al*. describe, "comorbidity between mental and physical disorder conditions is the rule rather than the exception" (16). In addition, physical comorbidity is associated with readmission for psychiatric patients, with diabetes, cardiovascular disease and liver disease among the health conditions linked to a higher risk of hospitalisation (16, 17). The relationship between physical and mental illness is exacerbated by the adverse effects of many psychotropic medications, including weight gain, obesity and associated sequelae (18).

It is therefore key that care plans for individuals with SMI take a "whole systems approach" that acknowledges and alleviates the influence of poor physical health on psychiatric rehabilitation and overall quality of life (4). One benefit of the intensive rehabilitative setting that may be required at the outset of an individual's care is the opportunity to support them to better their physical health. However, recent evidence shows that the standard of physical healthcare provided in rehabilitation units requires improvement, with premature mortality remaining a pressing issue for this patient group (14).

Psychiatric rehabilitation must provide a setting in which to monitor and treat physical health conditions and make lifestyle interventions such as smoking cessation and dietary advice (8). The advantage of the inpatient environment should be in facilitating multi-disciplinary input, allowing different specialties to collaborate. Effective management of physical health conditions is key to giving patients the tools for long-lasting recovery and preventing readmission. If services can succeed in integrating care of the body as well as the mind, there is a strong case for the importance of the inpatient rehabilitation environment in addressing the 'biological' aspects of wellbeing.

Psychological

The environment can support the psychological factors involved in an individual's recovery in two ways. First, physical aspects of the environment can be engineered to promote psychological wellbeing. Second, inpatient units and community services provide safe spaces in which to adjust medical regimens and involve patients in psychological therapies.

"New hospitals," observes Dr Gavin Francis, "have much in common with airports and supermarkets: low plastic ceilings, little natural light, retail forecourts, windows that don't open, and views, where they exist, giving on to car parks" (1). These physical characteristics may mean that opportunities to diminish distress and cultivate optimism creating better spaces that make use of the continuity between wellbeing and the environment are lost. Where possible, environments should be optimised to enhance patients' psychological wellbeing. As NICE advises, this includes avoiding barriers to sleep, such as noisy wards and non-essential night-time checks (8). Bringing the outdoors into units, for example using plants and artwork, and ensuring that spaces are well-lit are evidence-based recommendations for enhancing the ward environment (2, 19).

The psychiatric rehabilitation setting is also psychologically important because it provides an opportunity to "find the best medication regime to minimise symptoms without producing distressing side-effects" (2). The patient's residence in an inpatient environment for several weeks or months affords clinicians greater oversight over treatment efficacy and any adverse effects, allowing them to tweak medications and engage patients in shared-decision making that cultivates "self-esteem [and] confidence" (2). The patient's

residence in a specialist unit also means that they may be more likely to see the same staff. The environment may therefore facilitate better continuity of care that enhances the quality of the doctor-patient relationship, a key factor in treatment adherence which, when poor, increases the risk of worse long-term outcomes for people with SMI (20).

Of course, pharmacological treatment is only one part of psychological management. The environment can further support psychological aspects of rehabilitation by providing a space in which to access psychological therapies including Cognitive Behavioural Therapy (CBT), family intervention and group therapy, for which the presence of other patients would be instrumental. As with medical interventions, the intensive rehabilitation environment means that staff can monitor the impact of therapies on patients and support them if therapies provoke troubling thoughts or feelings. However, it is also essential to psychological wellbeing that when patients are ready to move on from intensive facilities, community-based services are available to them. Patients report that the more 'normal' their living environment, i.e. the least restrictive and smaller-scale their accommodation, the higher their quality of life (21). For patients still residing in inpatient settings, the sense that there is somewhere for them to progress to is critical to fostering "hope for the future" (4). As I will discuss later in this essay, this, unfortunately, is not consistently the case.

Social

The environment is particularly instrumental to individuals' social recovery and wellbeing. Social exclusion is a key issue for people with SMI: they are more likely to lack sources of support and struggle to maintain relationships (22). The exclusion people with SMI face is characterised both by individuals having smaller social networks and by the isolation engendered by lack of an independent life that includes, for example, work (23). In terms of occupation, the employment rate of people with a mental health condition is 10-15% lower than those without (24). Rehabilitation psychiatry therefore has two levers for achieving its tenet of social inclusion: first, to cultivate skills geared toward helping people to lead fulfilling, independent lives and second, to support individuals to build connections with others.

To prepare an individual to lead an independent life after discharge, inpatient services must encourage patients to "acquire or develop the skills and confidence to live successfully in the community" (25). It is essential that the inpatient environment is exploited to equip patients with the means to cope with activities of daily living (such as cooking, self-care, budgeting and laundry) and meaningful activities, training and education that may help them to gain supported or sheltered employment. Art therapy, for example, has been successfully used to complement pharmacological interventions in people with mental illness, helping individuals to develop communication skills that will aid life after discharge (25, 26). However, art therapy has not been consistently delivered in rehabilitation units (4). To allow patients to graduate to greater autonomy, psychiatric rehabilitation services must deliver on their ambition of skills development.

Encouraging social inclusion does not stop at helping patients to develop the skills and confidence essential to life in the community. A "whole systems approach" acknowledges that the connections we share with family, friends, colleagues and the wider community "fulfil many of our immediate and personal needs and contribute to our well-being" (4, 27). Inpatient care necessarily extracts an individual from the place where they are living and surrounds them with unfamiliar faces, compounding the isolation often created by mental

illness. To mitigate this, it is essential that patients remain embedded in some sense of community, crucially by being able to receive visitors. Allowing patients to be treated in an environment in which they can also maintain connections with close contacts may make rehabilitation more effective; family engagement with a patient's treatment, for example, is associated with better outcomes for people with psychotic disorders (28).

Unfortunately, many people's psychiatric rehabilitation involves not only being moved out of their current living situation but also being moved miles away from their local area in an out of area placement (OAP) (29). OAPs undermine efforts to enhance patients' social inclusion, distancing them from family, friends and the local services from which they have been referred and to which they should eventually be discharged. While OAPs may be unavoidable in cases where the complexity of an individual's needs cannot be met by local services, many patients are sent out of area not because facilities do not exist, but because demand consistently outstrips capacity. 91% of OAPs at the end of December 2021 were considered inappropriate, meaning that the OAP was due to a local bed being unavailable (29). The consequences of OAPs for patients may be devastating, including diminished contact with usual support networks, lack of opportunity to reintegrate gradually into their local community and ultimately rehabilitation that is "less meaningful and takes longer"(10). For refugees and migrants, cultural and language dislocation can compound feelings of alienation (30). An inpatient unit can be engineered to support rehabilitation, but if the environment in which *that* environment is located alienates an individual from their support network – i.e. if the unit is out of area – social exclusion is likely to endure.

Transfers between environments and an integrated model for psychiatric rehabilitation
This essay has examined psychiatric rehabilitation environments discretely. In this final section, I will look briefly at the transitions between environments and the challenges they present. I will also suggest that psychiatric rehabilitation can look to another clinical model – palliative medicine – for an example of an integrated service that co-ordinates patient care across a number of specialist and community-based environments.

Psychiatric rehabilitation requires a "total system approach" that allows patients to move smoothly through stages of rehabilitation (31). Better transitions can be achieved by involving patients in decisions about next steps, by the effective transfer of information between teams, and by accommodating the patient 'in area' to allow for greater flexibility between inpatient and community-based services (32). If a patient needs to be re-admitted, the aim should be to find a bed within the local area, to lessen feelings of displacement and afford some continuity in clinical and personal relationships.

The "smooth transitions" for which NICE advocates cannot be achieved without addressing the "serious lack of a range of appropriate residential settings" (31). Psychiatric rehabilitation requires a dynamic approach to an individual's care plan: the next step in their rehabilitation pathway should be finely tuned to their current level of need. Environments need to be more adaptive to the changing capabilities of an individual as they begin to regain skills, confidence and autonomy. Research has shown that a dearth of appropriate move-on accommodation is frequently cited as a reason for people being kept in "overly restrictive settings for much longer than they need", risking greater institutionalisation rather than fostering independence (10, 31). If individuals cannot move on when they are ready to – an essential part of their recovery – how can rehabilitation psychiatrists realistically aim to "promote hope and maintain enthusiasm and therapeutic

optimism" (2)? It is vital that there is renewed investment in additional step-up and step-down services that broaden the range of environments in which care is offered.

While the outcome for patients in psychiatric rehabilitation is, of course, very different to those receiving palliative care, the co-ordination between specialist units (hospices), general hospitals and community-based treatment demonstrates a flexible approach that adapts to changing individual needs and preferences (33). In addition, the attention to physical space in the modern hospice movement exemplifies good practice in exploiting the influence of environment on wellbeing (34). In aiming to address an individual's "total pain", including psychosocial and spiritual distress, palliative medicine research has shown that a "home-like environment" lessens patients' physical, emotional, social and spiritual suffering (19). Aspects of environmental design in the modern hospice movement, including allowing access to nature (e.g. through a window or indoor plants), displaying artwork, providing natural light, giving people privacy and hiding medical equipment, have been shown to improve symptoms (19). This approach, which promotes the kind of treatment setting evoked earlier in this essay, should inform the psychiatric rehabilitative space and encourage practitioners to harness the power of the environment to improve quality of life.

Conclusion

This essay has argued that inpatient and community environments are crucial to psychiatric rehabilitation. Exploring the biological, psychological and social aspects of wellbeing and recovery, I have sought to show how important the environment is, and how important it is to get the environment right. Inpatient services allow clinicians to address a patient's needs with an intensive, multi-disciplinary approach. Equally important are the provision of community-based care to which a patient may progress and the transitions between environments. To return to Dr Gavin Francis, the thread that must run through each environment is the "continuity between the body we inhabit and the environment that sustains us" (1). Poor quality accommodation and out of area placements negatively influence the wellbeing of those they should sustain. The environment should present a therapeutic opportunity to be maximised. For patients with SMI who spend such prolonged periods in services, it is particularly important to make use of this opportunity. As I have argued, taking care over the environment's physical and geographic aspects can enhance patients' dignity, optimism and autonomy, and ultimately hasten their return to the community

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