

Why you should read this article:

- To learn about the development of a new community enhanced rehabilitation team during the COVID-19 pandemic
- To understand staff and service users' experiences of a new community enhanced rehabilitation team
- To recognise the importance of a smooth transition process between inpatient and community mental health settings

Service user and staff experiences of a new community enhanced rehabilitation team

Katherine Kidd and Kelly Fenton

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Correspondence

katherine.kidd1@nhs.net

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Abstract

Mental healthcare services have undergone significant changes since the start of the coronavirus disease 2019 pandemic. In Leicestershire Partnership NHS Trust one such change has been the development of a community enhanced rehabilitation team, to support service users who had experienced quicker discharge from inpatient rehabilitation services due to pandemic-related measures with transition into the community.

This article reports the findings of a service evaluation which explored the experiences of service users and staff after the team had been operational for 12 months. Six service users and five staff members participated in individual semi-structured interviews which, following thematic analysis, generated seven themes: developing staff competency; doing 'proper rehab work'; managing anxiety and crisis; good teamwork; mode of working; joining up the pathway; and ideas for the future. The service evaluation supports the continued use of small caseloads to maintain effective rehabilitation care. Further work is required to ensure smooth transition between inpatient and community rehabilitation services.

Author details

Katherine Kidd, clinical psychologist, Leicestershire Partnership NHS Trust, Leicester, Leicestershire, England; Kelly Fenton, consultant clinical psychologist, Leicestershire Partnership NHS Trust, Leicester, Leicestershire, England

Keywords

community, community care, mental health, mental health service users, mental health therapies, patients, patient experience, professional, psychosocial interventions

Background

Leicestershire Partnership NHS Trust mental health rehabilitation service has two inpatient rehabilitation units offering 40 male and female open beds (non-high-dependency beds for people who do not need higher security wards) and eight male high-dependency unit beds. People who use the service have a diagnosis of a severe and enduring mental illness and require rehabilitation support to maximise their functioning and quality of life. The length of stay in the two inpatient rehabilitation units is between three and 18 months.

In April 2020, a community enhanced rehabilitation team was developed in response to the coronavirus disease 2019 (COVID-19)

pandemic, which had led to quicker discharge from the inpatient rehabilitation units. Before the service changes, service leaders identified that moving from inpatient to community settings at this time could cause anxiety, which in turn could result in ineffective community transitions. The aim of the new team, therefore, was to offer time-limited, transitional support with the aim of reducing service users' anxiety, preventing readmission in the early weeks post-discharge and supporting their wider network, including family, friends, carers, accommodation staff and/or support workers, and community psychiatric nurses.

The community enhanced rehabilitation team is a psychology-led service of 12 rehabilitation staff, including nurses,

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healthcare support workers, psychiatrists, occupational therapists and clinical psychologists. Staff were redeployed to the team from inpatient units following ward closures due to the pandemic. While the team was initially developed as a response to the COVID-19 pandemic, it has since been expanded to deliver a service conforming to guidelines set by the National Institute for Health and Care Excellence (NICE) (2014, 2016, 2020) on prevention and management of psychosis and schizophrenia in adults, transition between inpatient and community settings, and rehabilitation of adults with complex psychosis.

This article reports the findings of a service evaluation that explored service user and staff experiences of the new community enhanced rehabilitation team 12 months after its creation.

Rehabilitation pathways

NICE (2020) guidelines on the rehabilitation of adults with complex psychosis state that people should have access to inpatient and community rehabilitation teams, that specialist rehabilitation should be provided to people living in supported accommodation and that a rehabilitation care pathway should be developed which supports people to achieve their optimum level of independence.

A systematic review by Dalton-Locke et al (2021) found that most research on mental health rehabilitation has evaluated individual components rather than whole pathways. The researchers identified components that predicted effective movement through a pathway, for example a pathway from inpatient to community services. These components included the degree to which inpatient and supported accommodation services adopted a recovery approach, shorter hospitalisations before inpatient rehabilitation admission and the promotion of people's human rights. The review also found that higher reported quality of life among users of inpatient rehabilitation services was associated with lower rates of rehospitalisation (Dalton-Locke et al 2021).

NICE (2020) guidelines recommend that service users should be offered rehabilitation in the community, provided by community rehabilitation teams, but few studies have evaluated this model of care. However, several studies have reviewed the effects of the Illness Management and Recovery (IMR) programme, a manualised recovery-oriented rehabilitation programme for people with serious mental illness (Mueser et al 2002). IMR is tangentially connected to community rehabilitation

interventions in that it is a rehabilitation intervention, but it is not as holistic or varied as the care provided by the community enhanced rehabilitation team discussed in this article, which provides bespoke interventions that focus on an individual's specific identified needs rather than a preset programme followed by all service users.

The IMR programme can be conducted in a group or individual format over 40 or more sessions (Färdig et al 2011). Outcomes of IMR have varied between studies. For example, Färdig et al (2011) conducted a randomised controlled trial of a nine-month IMR intervention in 41 people diagnosed with schizophrenia or schizoaffective disorder; 21 were assigned to an IMR group and 20 to a treatment-as-usual group. Results showed a significant improvement in illness management, psychotic symptoms and coping styles in the IMR group compared with the treatment-as-usual group, but there was no difference in quality of life or perception of recovery. Jensen et al (2019), meanwhile, conducted a larger randomised controlled trial for an IMR intervention with 99 people diagnosed with schizophrenia or bipolar disorder and focused on outcomes one year after programme completion. The IMR intervention was not associated with reductions in inpatient service use, service user functioning and symptoms or emergency department visits at one year follow-up compared with a treatment-as-usual group. It is possible that while service users benefit initially from IMR interventions, this is not sustained at one year follow-up.

Finally, Chan et al (2021), who investigated four-year longitudinal outcomes for service users ($n=193$) of a community rehabilitation team in London, found that 23% ($n=43$) moved to more independent accommodation.

Given the dearth of evidence, high-quality research is needed to investigate the effectiveness of community rehabilitation teams.

Transition from inpatient to community settings

People discharged from inpatient psychiatric care are at a higher risk than the general population of a range of serious fatal and non-fatal adverse outcomes, including all-cause mortality, suicide, non-fatal self-harm and accidental death (Mellesdal et al 2014, Walter et al 2017). Inadequate transition between inpatient and community settings – for example, service users' lack of involvement

in or disagreement with discharge decisions – also has negative effects on people such as urges to self-harm. Therefore, it is important to ensure people are adequately prepared for discharge and that relationships with known mental healthcare staff are maintained (Owen-Smith et al 2014).

One of the main issues that affects transition between settings is the lack of integrated and collaborative working between mental health and social care services, and between inpatient and community practitioners (NICE 2016). NICE (2016) guidelines on transition between inpatient mental health settings and community or care home settings recommend that a person should be supported to prepare for their discharge while in hospital. This includes developing a supportive and trusting relationship between the service user and community practitioner, and the active involvement of the service user's wider care network in discharge planning.

Effect of the COVID-19 pandemic on mental health services

In the UK, COVID-19 pandemic measures resulted in changes to mental health services for service users and staff. For example, the measures led to users of inpatient services being discharged earlier than planned, which Moreno et al (2020) suggested may have put them at risk of relapse, suicidal behaviour, lack of access to medical care and social isolation. Further, Chen et al (2020) found increased rates of death of people who access mental health services – those with and without serious mental illness – during the early part of the COVID-19 pandemic in the UK. In relation to staff, Foye et al (2021) surveyed 897 nurses across a range of mental health inpatient and community settings and found that respondents believed service changes such as remote working and providing phone and video appointments had been adopted too quickly and may have affected quality of care.

These findings indicate the importance of understanding how mental health services have adapted to meet the needs of people with serious mental illness during the pandemic and whether these changes have met this population's needs. Moreno et al (2020) recommended robust and continuous assessment of the rapid changes made to mental health services due to COVID-19 to define 'which practices should be further developed and which discontinued'. Outcome research from health services that have undergone transformation during the pandemic is, therefore, essential to learn lessons for future care provision.

Aim

The aim of this service evaluation was to understand the experiences of service users of and staff working in a community enhanced rehabilitation team developed in April 2020 during the COVID-19 pandemic. The team had been operational for 12 months at the time of the evaluation.

Method

Recruitment and participants

The community enhanced rehabilitation team members were approached by a clinical psychologist who works in inpatient services, while service users were approached by their care coordinator. Inclusion criteria for service users were having received transition interventions from the team, for example emotional and practical support to meet the person's goals, and having capacity to consent to an interview. Six service users participated in phone interviews lasting approximately 15 minutes. Eleven of the 12 community enhanced rehabilitation team members were invited to take part (one team member conducted the evaluation and was not therefore eligible to participate) and five staff interviews were conducted, each of which lasted around 60 minutes. Staff participants included team leaders (nurses), nurses and healthcare support workers.

Measures

Semi-structured interview schedules were developed by a clinical psychologist in the rehabilitation service and quality reviewed by two other clinical psychologists from the service. Table 1 details the interview schedule for staff and service users.

Procedure

Interviews with staff and service users were conducted by phone due to COVID-19 restrictions. Before each interview the interviewer read the information sheet and consent form to the participant. Consent was gained verbally as outlined by the NHS Health Research Authority (2019). Responses were typed verbatim by the interviewer.

Ethical approval

As it was a service evaluation, review by a full ethics committee was not required, therefore the evaluation was approved by Leicestershire Partnership NHS Trust's quality improvement programme (Further resources) on 20 June 2020.

Key points

- A holistic, person-centred model of care can contribute to service users' positive experience of community rehabilitation
- Multidisciplinary team working, small caseloads and regular contact with managers can enhance staff experience of working in a community enhanced rehabilitation team
- Face-to-face contact should be the primary mode of contact with service users in community rehabilitation teams
- It is important to develop close links between inpatient and community mental health teams to support transition between the two settings

Analysis

Analysis of interview data followed Braun and Clarke’s (2006) thematic analysis procedure. Thematic analysis was chosen because it enables a flexible approach to the data and outlines the main themes of the interviews. A critical realist perspective was taken during the analysis. Critical realism states that although reality exists, an individual’s perceptions of it are influenced by their knowledge and experience (McEvoy and Richards 2006, Fletcher 2017).

Service user and staff interviews were analysed together to develop a comprehensive understanding of the community enhanced rehabilitation team. Each interview was coded individually and themes for each interview were considered. The themes were then considered across all interviews and areas of overlap and difference were identified. The interview data were consulted in an iterative process to ensure that the themes represented the data accurately.

To test data saturation, the sixth service

user interview was conducted after analysis to identify whether further interviews would add to the identified themes. No new themes or subthemes were identified, indicating that satisfactory data saturation may have been met. With regard to staff, no further recruitment was possible following the five interviews because all potential participants had been approached.

Findings

Seven themes were generated from analysis of the interviews: developing staff competency; doing ‘proper rehab work’; managing anxiety and crisis; good teamwork; mode of working; joining up the pathway; and ideas for the future.

Developing staff competency

Staff described their experiences of joining the community enhanced rehabilitation team when redeployed from inpatient wards, which was initially a stressful change:

‘It was quite nerve wracking to begin with ward closures.’ (Staff member 2)

Some were concerned about their competence given the team’s lack of experience of community work, with comments including:

‘It’s been a big change going from inpatients to community.’ (Staff member 1)

‘I feel there is a gap from community leadership.’ (Staff member 4)

However, several discussed enjoying the community work once they settled into it, stating that:

‘I was really lucky to be reallocated to this team.’ (Staff member 2)

‘It’s been good. It’s a change from the ward. I don’t think I could go back to the ward.’ (Staff member 3)

Experiences of the training provided when staff joined the team were variable, with some reporting they had undergone a lot of training and others that they had none. Some identified further training needs in relation to community working:

‘Supporting staff members to attend training related to the community [would be an improvement].’ (Staff member 4)

Staff discussed using informal supervision to develop their competence and clarify areas of uncertainty:

‘As the community aspect is new to us, we take a collaborative approach to managing care and risk.’ (Staff member 4)

This was regarded as useful by many staff, one of whom stated:

‘Clinical support has been excellent.’ (Staff member 1)

Table 1. Interview schedule for staff and service users	
Interview schedule - staff*	Interview schedule - service users*
1. What has been your experience of working for the community enhanced rehabilitation team?	1. Can you tell me about how you were feeling about your discharge?
2. Are there any good things about the work completed by the team? If so, what are they?	2. Did you think the discharge happened at the right pace for you?
3. Are there any things that could be improved about the work completed by the team? If so, what are they?	3. How have you found the support provided by the team?
4. Do you have any suggestions for how to improve the patient care given by the team?	4. Were there any good things about the support provided by the team? If so, what were they?
5. Do you have any suggestions for how to improve staff experience of working for the team?	5. Were there any things that could be improved about your support from the team? If so, what were they?
6. Are there any resources that would have been helpful in supporting you to complete your work for the team?	6. Have you got any suggestions for how the team could be improved?
7. What was your experience of supervision while working for the team?	7. Did the team provide care that focused on what was important to you?
8. Can you tell me about how it felt working from home and providing care remotely?	8. Is there anything else that you would like to share with me about your experience of the team?
9. Is there anything else you would like to say about your experience of the team, or the care provided by the team?	
*Interviews were semi-structured therefore follow-up questions may have been used	

Several staff participants likened informal clinical support to clinical supervision, with one stating that:

'How people view supervision is a meeting set up called "supervision", but actually in the team we get a lot of supervision, there is always someone to talk to.' (Staff member 1)

Overall, no negative experiences of clinical support were reported by staff; however, experiences of formal supervision were mixed with some participants praising the quality of supervision and others commenting that they did not have time to participate.

One service user participant reported that staff were 'very professional' and that 'they know their job and they do their job well' (service user 3), which indicated that they believed staff were competent. This was a sentiment reflected in many of the service user interviews.

Doing 'proper rehab work'

Staff demonstrated a passion for rehabilitation work, with comments including:

'It is a really needed service, so it is exciting.' (Staff member 1)

'I feel really lucky to... be able to work doing rehab and that's what I love doing.' (Staff member 2)

Rehabilitation work included practical and emotional interventions. For example, one service user said:

'They have really helped me. [Healthcare support worker] has helped me to put the curtain poles up.' (Service user 4)

Staff also emphasised the importance of practical support, commenting that:

'My colleague has skills where he can support with cooking or activities of that nature that can help with rehab.' (Staff member 3).

Service users described times when interventions helped them to develop coping skills:

'[The psychologist] treating me with CBT over the phone [has been helpful].' (Service user 6)

'They reminded me of coping mechanisms that I learned.' (Service user 3)

One staff participant stressed the importance of psychologically informed interventions:

'What was nice about this team is that it is more psychologically led.' (Staff member 3)

Service user and staff participants described completing rehabilitation work with a person-centred approach. For example, one service user described the genuine interest taken in them by the team:

'They seemed like they really wanted to help... it made me feel good. Like there are

some people out there who really do care.'

(Service user 2)

One staff member demonstrated a person-centred attitude, commenting that:

'I feel my work has been more trying to understand the person from their perspective.'

(Staff member 3)

Having enough time to complete interventions was important to service users and staff. Service users described times when their worker went the 'extra mile for me' (service user 1), while others described team members as follows:

'Doing everything they can to help me in the community and it be a success.'

(Service user 3)

'I don't think they could do any more.'

(Service user 5)

Staff, meanwhile, commented that it was 'good to have more time with service users' (staff member 1), and described interventions for which intensive support was needed, for example when going into the community, 'It can take three hours... if you do intensive or time-consuming interventions' (staff member 2), or when supporting a person in crisis, 'The chap who was in crisis, that took all day' (staff member 3).

Having more time was also associated with enhanced outcomes, with one staff member stating:

'[Having more time] means a better outcome for service users, I think they feel that there is a route to recovery.'

(Staff member 1)

This requirement on their time led to staff members stressing the importance of smaller caseloads, with one commenting:

'We don't want big caseloads for each individual nurse.' (Staff member 3)

Two staff described how the community enhanced rehabilitation team provided a service that had a distinct function and remit compared with community mental health teams (CMHTs). One said it was 'very different from a CMHT' (staff member 2), while another was concerned about it becoming 'like a CMHT and becoming overrun with paperwork' (staff member 3). This suggested that team members valued being able to offer a different type of service from CMHTs and wanted to retain their unique function.

Managing anxiety and crisis

Service users described overwhelmingly positive experiences of how the team supported them to feel safe when they were feeling anxious. They also talked about staff members' positive interpersonal styles, 'The way they spoke to me and looked after me was calming'

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(service user 3), and how team members spent time listening to them, 'It's been very good to have someone who can listen to your problems' (service user 5), which led to them feeling better, 'It was reassuring with my anxiety. It reduced my anxiety' (service user 1).

One staff participant discussed the benefits of having 'someone to ease anxiety and get through the worries they might have when they are first discharged' (staff member 1). Participants also discussed management of crisis situations. For example, one service user described how the team's interventions '... helped me get through the crisis without me going back into hospital... they helped calm me and helped me deal with it.' (service user 3)

One staff participant described helping '... some people through crisis and they have come out the other end without needing hospital admission' (staff member 1), while another commented that managing a patient crisis was '... a bit... anxiety-provoking' but that 'we got through and he didn't go into hospital' (staff member 3).

Good teamwork

Staff participants said the community enhanced rehabilitation team worked well together, was very supportive and had good communication. They also valued members' different areas of expertise, with one stating that:

'In this team we get listened to if we have our own point or issues or raise a concern.' (Staff member 5)

Several staff participants discussed team members as having 'varying expertise and knowledge' (staff member 5), and talked positively about working with colleagues who 'all bring a particular set of skills' (staff member 3).

Others described the team leaders as 'approachable' (staff member 2) and 'really good at supporting us' (staff member 3), and felt 'encouraged to contact senior members of staff if you are unsure' (staff member 1).

Having leaders with different expertise was also appreciated, with one commenting:

'They all have different areas they can help with.' (Staff member 2)

Mode of working

Staff participants preferred face-to-face working for a number of reasons, for example: because it enabled better assessment, 'It's very difficult to assess if you're not going into a patient's property' (staff member 2); developed better relationships, 'It's got to be face-to-face contact to show someone

you actually care' (staff member 5); and prevented situations escalating to crisis point, 'Face-to-face visits will really improve things and will stop people from coming into crisis' (staff member 1).

However, face-to-face contact was not always possible due to COVID-19 restrictions, which generated comments such as:

'We have to follow policy.' (Staff member 2)

Service users did not discuss whether they had received care face-to-face or remotely.

Staff had mixed experiences of working remotely, for example: working from home reduced distractions, 'You can get completely engrossed in what you are doing' (staff member 2); increased the availability of team leaders, '[The team leaders] have been more accessible for advice' (staff member 4); and reduced commuting time, 'I like not having to commute' (staff member 1).

However, working from home also had disadvantages, for example: having children around and the lack of differentiation between work and home, 'If someone did commit suicide, that's in your home. That's not healthy' (staff member 3); a lack of connection with team members, 'Staying at home in a small office can feel like a lonely experience' (staff member 3); and a lack of physical activity, 'It gets to the end of the day and I'm like, have I even got up?' (staff member 1).

Joining up the pathway

Service users' experiences of transition between inpatient and community services within the pathway varied. Two service users stated that transition was 'very sudden', with one commenting, 'I got annoyed because it kept being put back... I didn't know why' (service user 2), and the other saying, 'I would have liked to... know what support would be carrying on' (service user 1).

Other service users were unsure why certain decisions had been made about their transition. However, some discussed enhanced transition experiences, with one stating:

'It was the right time for me to leave because I could cope.' (Service user 4)

Another described good communication during transition:

'It was made quite clear I wouldn't be sent out on my own.' (Service user 5)

Staff, meanwhile, emphasised the importance of 'integrating into the inpatient wards to offer continuity and to ensure smooth transition of the patients' rehab journey' (staff member 4), while another staff member reported:

‘There have been a couple of really good examples where we have had the referral come in, attend discharge CPA [care programme approach] and we have had good communication throughout, and it makes a really big difference [but] there could be better communication between the wards and our team.’ (Staff member 1)

Another staff member acknowledged that communication between inpatient and community services was a joint responsibility:

‘It is a two-way thing.’ (Staff member 1)

Ideas for the future

Staff discussed other interventions the team could use including group work, ‘conversation cafes’, working on an allotment and driving service users to appointments. They also discussed having more team members because, as one staff member stated:

‘... if we’re starting to feel we’re pressurised and rushing I think we’re going to lose what the team is all about.’ (Staff member 3)

Staff members also discussed how having enough staff to dedicate time to complete intensive rehabilitation would ‘benefit the patient and a lot of them appreciate the work that you will put in’ (staff member 2). Another staff member believed that working weekends would improve the support offered, stating that:

‘Some patients just feel lost at the weekend.’ (Staff member 5)

Another said they would appreciate having more team members with varying expertise and knowledge.

Although clinical support was described as good, staff believed having a physical base would improve this and help them feel more ‘part of a team’ (staff member 1). One staff member stated that having a base would offer ‘the opportunity to meet up with other colleagues within the team to discuss anything that you want to’ (staff member 2), adding that it could also improve informal supervision:

‘It’s for those little niggly things, so it’s not enough for an email.’ (Staff member 2)

With regard to the future, staff participants hoped for ‘a real focus on engaging carers and families in discharge/recovery plans’ (staff member 4), and ‘teaching sessions for carers’ (staff member 3).

Most service user participants stated that nothing could have been improved from their perspective, variously commenting that: ‘Everything was great’ (service user 1); ‘I can’t think of an area where they need to improve’ (service user 3); and ‘I’m not just saying this... I’ve not had any bad experiences’ (service user 6).

Discussion

Overall, service users and staff reported positive experiences of the community enhanced rehabilitation team. Service users were complimentary about the new service and the care they received and appreciated having staff who attended to their emotional and practical needs. People who access mental health rehabilitation services have complex intervention needs which extend beyond symptom reduction (van der Meer and Wunderink 2019).

Service users in this service evaluation had a range of needs for which they required support, for example emotional support for anxiety or practical support to manage a crisis, and their interview responses indicated that this model of person-centred care met those needs. They reported greater satisfaction with the services they were offered because they perceived them as being focused on their individual needs.

Staff reported that having supportive colleagues and managers improved their experience of working for the team and they valued being able to deliver ‘proper’ intensive rehabilitation work. They discussed the need for appropriate resources to deliver holistic care, including a range of skills in the team, small caseloads to enable adequate time to deliver interventions and approachable managers who could be contacted easily in an emergency. The latter point is consistent with Foye et al’s (2021) recommendation for strong clinical leadership in mental health teams.

The findings indicated that staff preferred face-to-face rather than remote contact with service users, and that they found undertaking assessments and developing relationships more challenging to achieve remotely.

NICE (2016, 2020) guidelines emphasise the importance of smooth transitions between inpatient and community care within a rehabilitation pathway. The findings of this evaluation suggest that communication between different stakeholders in this aspect of the pathway could be improved, with some service users reporting uncertainty about why care decisions had been made.

Finally, staff discussed areas of future expansion for the team, including introducing interventions to connect service users with carers, acquire new knowledge and skills, and connect with the natural environment.

Limitations

The evaluation took place in one service during the unique changes required in response to the COVID-19 pandemic, which may limit

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the generalisability of the findings to other community mental health services.

Service user participation was voluntary, therefore those with positive experiences of the team may have been more likely to volunteer, which may have skewed the findings. However, these service users still offered constructive criticism about the transition process, which suggests that although some had more challenging experiences, they were willing to share these.

Conclusion

This service evaluation explored the experiences of service users and staff of

a community enhanced rehabilitation team developed during the COVID-19 pandemic. Service users and staff discussed positive experiences of the care provided by the team, as well as how service users' experiences could be improved by enhanced communication between community and inpatient services, and by having more control over the transition process and the speed of transition.

Future plans include evaluation of service users' experiences of the transition process with the aim of providing specific recommendations to improve this aspect of the rehabilitation pathway.

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