BRIEFING

Centre for Mental Health

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51 Long-stay rehabilitation services

Summary

Mental health rehabilitation services provide specialist care to people with complex needs that cannot be met by other mental health services. They provide treatment and support for between 10% and 20% of people with a severe mental illness, both in hospital and in the community.

Centre for Mental Health has explored current provision of rehabilitation services in England by reviewing relevant Care Quality Commission reports and seeking expert opinion. This briefing summarises the current issues facing rehabilitation services and the people who use them.

Rehabilitation services have been marginalised in national mental health policy for many years. As a result, local community and inpatient rehabilitation services have been depleted. This has led to a growth in the number of people admitted to inpatient wards, often away from their local areas.

While many people receive high quality care and support in these services and are discharged successfully back to their communities, a significant minority face very long stays in 'locked rehabilitation' wards that are far from their homes, families and communities. Yet where inpatient and community rehabilitation services work well together, people can achieve and sustain a good life in the community.

There is an urgent need for national policy to support vital investment in local rehabilitation services.

What are rehabilitation services?

This briefing paper seeks to explore and highlight policy and practice issues relating to rehabilitation services in the NHS in England. It is based on a review of relevant literature, a review of Care Quality Commission (CQC) inspection reports of rehabilitation services, and interviews with experts. The Centre would like to thank the CQC for its support in enabling us to carry out this research, the NHS Benchmarking Network for providing relevant data from its adult mental health services reports and the people who generously gave their time and expertise, including Helen Killaspy, Tony Ryan, Rob Poole and Jed Boardman.

Mental health rehabilitation services are intended to "provide specialist assessment, treatment, interventions and support to enable the recovery of people whose complex needs cannot be met by general adult mental health services" (Joint Commissioning Panel for Mental Health, 2016).

They may be the next step in the pathway for people moving on from standard inpatient services or from secure mental health services, where they have longer-term complex needs and have not recovered sufficiently to be discharged home.

Most are commissioned locally by Clinical Commissioning Groups (CCGs). Where they are secure or highly specialist they are commissioned by NHS England. This paper focuses on the former group.

There is no nationally agreed specification or service framework for rehabilitation services. The Joint Commissioning Panel for Mental Health (JCPMH) has identified four types of inpatient rehabilitation services commissioned locally: high dependency (high support) inpatient rehabilitation, community rehabilitation units, long-term high dependency (high support) units and long-term complex care units. It suggests that depending on the type and mode of rehabilitation service, the length of admission may vary between one and ten years. NHS Benchmarking identifies two types of inpatient rehabilitation: high-dependency rehabilitation, and longer-term complex care or continuing care units. The CQC groups all inpatient rehabilitation services into one category: long-stay rehabilitation. CQC inspection reports indicate that, while some services are using the JCPMH terms, others include rehabilitation and recovery units, step-down rehabilitation units and locked rehabilitation units.

Data from CQC showed that in January 2017 there were 47 NHS trusts and 74 services in the independent sector providing some kind of inpatient rehabilitation care (CQC, 2017). NHS Benchmarking has records of 30 NHS trusts providing high dependency rehabilitation and 21 providing longer-term complex or continuing care (personal communication, 2016).

A 2009 survey showed that almost all NHS mental health trusts provided inpatient rehabilitation units, 59% being stand-alone community based wards separate from a hospital campus. There was a mean of two units per trust and 14 beds per unit (Killaspy *et al.*, 2012). CQC inspection reports published between July 2014 and June 2016 show that there is significant variation in provision of long-stay rehabilitation beds across all provider types, with as few as 5 beds and up to 70 beds in a single location in the independent sector (with a median of 24), and between 9 and 137 beds provided by individual NHS trusts (with a median of 38).

People using rehabilitation services

A 2009 survey found that 80% of people using rehabilitation services in the NHS had been diagnosed with either schizophrenia or schizoaffective disorder. On average, people had been in contact with mental health services for 13 years, with four previous admissions. The length of their current admission was on average 18 months, with eight months spent in a rehabilitation unit, though with considerable variation (Killaspy *et al.*, 2012).

It has been estimated that slightly more than 1% of people with schizophrenia will be receiving inpatient rehabilitation at any one time. They may have severe symptoms of mental illness, including hallucinations and delusions which have not responded adequately to medication; additional symptoms of anxiety or depression; and so-called 'negative symptoms' and cognitive impairments associated with psychosis that impact on motivation and organisational skills, resulting in severe problems managing everyday activities.

The prevalence of self-neglect and vulnerability to exploitation is high (almost 50%) among people in these services and around 25% have a history of self-harm. Although around 20% will have been treated in forensic mental health services within the previous two years, fewer than 10% will have been involved in serious violence. Other comorbidities including learning disability, developmental disorder, personality disorder or substance misuse also contribute to the complex needs of this group (Holloway, 2005).

It is estimated that 10-20% of people newly diagnosed with psychosis will develop complex needs and require such specialist services (JCPMH, 2016). In the UK, mental health rehabilitation services are organised as a care pathway that includes specialist inpatient/community rehabilitation and supported accommodation services. On average, individuals spend 1-3 years in specialist inpatient and community rehabilitation services before progressing to supported accommodation. Individuals often 'graduate' from higher to lower supported accommodation as they gain/regain confidence and skills for community living. The majority of people with complex needs do well with this approach; over a five year period, two-thirds achieve and sustain successful discharge from hospital without readmission, and 10% are able to progress to living in fully independent accommodation. This does, however, mean that one third of this group (or between 3% and 7% of all people diagnosed with psychosis) continue to require specialist and highly supported services longer term. A small minority may require very long term hospital care. The numbers for this group are unclear, but it is likely to be somewhere around 10-12 people at any time in an inner city area with high levels of poor mental health, and fewer in areas with lower morbidity.

Development of rehabilitation since the 1990s

Deinstitutionalisation transformed mental health services, shifting the provision of care from hospital to community based settings. In 1999 the National Service Framework for Mental Health (NSF-MH) provided a strategic blueprint for adult mental health services, aiming to improve quality and reduce variation in provision by setting national standards and defined service models as part of a ten-year agenda. Specialist community mental health services (including crisis resolution, assertive outreach, and early intervention teams) were developed.

The NSF-MH made little mention of rehabilitation services. Around 25% of community rehabilitation teams were rebadged as assertive outreach teams, significantly diminishing provision of specialist rehabilitation services (Health Foundation and Kings Fund, 2015). In 2000 the Department of Health's National Beds Inquiry anticipated that by 2010/11 there would be no NHS long-stay beds, suggesting that the development of psychotropic medications and other treatments would enable reductions in hospitalisations (Department of Health, 2000).

In a 2007 report on the Government's mental health priorities, the Centre observed that there were no current policy initiatives for the development of rehabilitation services, noting that the focus on acute care and risk containment may have been partly responsible for their neglect. Since then, the emergent political and media interest in mental health has continued to focus on conditions affecting large numbers of people, namely anxiety, depression and on people facing acute crises. Care for the smaller numbers of people with very severe mental illness has continued to be squeezed off the agenda.

The disinvestment in local NHS rehabilitation services has led to a rise in provision of beds for people with longer term and complex mental health problems in the independent sector, often outside of people's local areas (Davies *et al.*, 2005).

This type of provision has been referred to as the 'virtual asylum' (Poole, Ryan and Pearsall, 2002). Concerns have been raised about the social and geographical dislocation associated with 'out of area placements' since individuals can be many miles away from family and friends and access to their local care pathway is often disrupted. Some individuals find themselves in settings which provide a higher level of support than they need, and without a proactive rehabilitative focus their independent living skills can be quickly lost, making it increasingly difficult to integrate back into the community. Such patients often end up existing 'under the radar' of commissioners and policy-makers.

The negative consequences of out of area placements have been highlighted repeatedly over the past fifteen years. And while such placements are now the focus of considerable national and local attention with regard to acute care (for children and adults) and secure services, there has been less focus on people placed out of area in long-stay hospitals. It is imperative that policy clearly states the need for commissioning of appropriate inpatient rehabilitation services and supported accommodation to provide a local care pathway for people with complex needs.

'Locked rehabilitation'

In the CQC reports published between July 2014 and June 2016, 55 out of 81 referred to whether or not the rehabilitation units they inspected were locked. Half were locked, a quarter were unlocked, and a quarter of services had a mix of locked and unlocked units. Of those in the independent sector, 70% were locked, compared with fewer than a quarter in the NHS, while services in the NHS were more likely to have a mix of locked and unlocked units than those in the independent sector.

Services calling themselves 'locked rehabilitation' have increased over the past few years, predominantly in the independent sector. Such services may have airlocks to enter the unit and are noted in CQC reports to place other restrictions on movement.

The term has not been formally recognised nationally, and guidance from the JCPMH states that it is not recognised as part of the inpatient rehabilitation typology (JCPMH, 2016). Their clinical focus is similar to that of low secure units, and they tend to follow Department of Health guidance on standards for low secure services (Chukwuma, 2014), but unlike low secure units they are not centrally commissioned by NHS England.

The need for a clear definition and statement of purpose for such services, as well as the types and needs of people who should be admitted, is vital to ensure that locked rehabilitation is not just developing out of a need for cheaper low secure care (Dix, 2013; Dye, Smyth, Pereira, 2016).

Costs

The nature of rehabilitation services means that it is expensive care to provide and commission. Although they comprise only 10–20% of those with psychosis, the group with high support needs account for 25–50% of the total mental health budget, even when they are treated in appropriate local rehabilitation and supported accommodation services (Killaspy *et al.*, 2016).

However, the cost of out of area placements inflates the overall cost of rehabilitative care. Most are provided in the private sector, which is more expensive than the NHS. There is a clear market disincentive for early discharge, and a risk that many people remain in higher cost settings for longer than they need (Ryan *et al.*, 2004). It has been found that where placements are out of area, the costs are around 65% higher than local placements (Killaspy and Meier, 2010).

A recent study in Wales identified 26% people as no longer needing the service where they were placed, which the authors found could represent a cost-saving of approximately 20% of the total budget for this client group if people were instead moved to services more appropriate to their needs (Ryan *et al.*, 2016).

It has been suggested that the rise in so-called 'locked rehabilitation' can be attributed to the high cost of low secure services. While the latter are nationally commissioned, the former can be locally commissioned, at a lower cost (Dix, 2013). Locked rehabilitation has been referred to as the 'new low secure' care (Dye, Smyth and Pereira, 2016).

Concerns about rehabilitation services

In conversations with experts we were told that the lack of appropriate provision of local rehabilitation care pathways has led to significant concerns about the care people are receiving in out of area placements. In particular, there is often little care continuity, as people are often moved between institutions without a clear overall plan for their care. When they arrive at a new service the process of building therapeutic relationships has to restart. Linked to this, people's care plans tend to have few clear objectives, with treatment tending to focus on the present difficulties but with little by way of longer term planning. When people do require less intensive support there are often few places for them to step-down to which can sufficiently address their ongoing needs, meaning they can become stuck in overly restrictive settings for much longer than they need. Where there is little local provision, there is also a consequential lack of local expertise for dealing with people's complex needs, which can exacerbate the reliance on out of area placements and create a vicious circle.

Ryan *et al.* (2004) described people who were isolated, vulnerable and powerless to affect their own situations. Their study found informal patients who were effectively detained without Mental Health Act safeguards; fragmented contact between patients, commissioners and care co-ordinators; and very poor care planning, predominantly focused on behaviour management.

The Care Quality Commission has similarly raised concerns about people with severe mental health problems staying in hospital (largely in the independent sector) for long periods of time, with insufficient focus on their recovery. They found poor discharge planning, a lack of motivating and recovery-oriented activity, a lack of involvement of people in developing their treatment plans, or care that was not person-centred or holistic, and poor assessment and treatment of physical health problems (CQC, 2016).

A further concern has been raised by experts about services where there is an inappropriate patient mix. Often rehabilitation services will provide care both for people with psychosis and those with personality disorders, which require different approaches. People with personality disorders with challenging behaviour tend to be contained in such services where they can't be managed in local services.

A number of these issues are worthy of further discussion:

Isolation and dislocation

Many people are cared for away from their local area, far from anyone or anywhere they know. Out of area placements tend to be used in cases where local services are not able to meet the needs of an individual. However often when the individual improves there is no associated change to the service (Killaspy *et al.,* 2009), meaning that people spend longer in an unnecessarily restrictive (and costly) environment. Care tends to be uncoordinated, people are geographically and socially isolated, and there is a risk of institutional practices (Ryan *et al.,* 2004). Advocacy is attached to services rather than to people, so they will often lose touch over time, or experience a lack of continuity. People receive few, if any, visitors and are dislocated from their local community teams and pathways. Their isolation and exclusion means that their rehabilitation is less meaningful and takes longer, contributing to the higher costs of out of area placements.

One CQC report described this situation in one locality in the south of England:

"Patients from the… area did not have access to a local rehabilitation service. Service managers described challenges in supporting patients… to reintegrate into their local community because of the distances involved. This impacted on patients' ability to travel to their homes and locality and on the frequency of visits from care co-coordinators."

A qualitative study of people relocated to their local area from out of area placements found that most reported increased autonomy and quality of life, but those that moved to

independent living often reported loneliness (Rambarran, 2013). This suggests that a greater focus on social integration is required for anyone admitted to hospital outside their home area.

Lack of meaningful rehabilitation and overly restrictive settings

Concerns have been raised by the CQC and researchers in the field about the over-provision of care to people in settings where they may not need the level of support they are given. A recent assessment of the need for rehabilitation services in Wales concluded that over a quarter of people receiving long-term care in mental health services would have been better placed in residential care, a nursing home, supported accommodation or provided with support at home (Ryan *et al.*, 2016). Over-provision means that people may be inappropriately restricted in what they can and can't do, and as a result lose or not develop the skills they could use in daily life.

This has been a feature of a number of CQC reports, for example:

"Figures provided by the service showed that 23 patients had been identified as not requiring the inpatient hospital care they were currently receiving…. The average length of stay…was eight years which is high compared to similar services."

"Weekly and monthly activity programmes were advertised on all wards, though when we enquired they were not accurate as the activities planned were not taking place and staff did not know why. There was a range of low level activities for patients from walking to weekly cinema trips that were paid for by the ward… We saw no evidence of patients involved in education or high level therapeutic and rehabilitation activities."

"Care was not patient centred. Restrictive practices were in place including locking the cutlery away… A patient had been deskilled, who was previously cooking independently and living in the annex. They had to move back… due to building works, had all meals cooked for them, and were in a hospital with locked doors."

"There was restricted access to outside space… [the] ward's outside smoking space was enclosed in metal mesh fence panels with a metal mesh roof, this could be seen from outside the hospital; there were blanket restrictions in place that applied to patients without individual risk assessment, for example, patients were required to ask for plastic spoons and polystyrene cups; there were no areas outside of a patient's bedroom to store possessions. Not all patients had keys to their room so that they could lock away their possessions securely; staff did not always facilitate weekend activities."

Lack of oversight

There is no definitive knowledge of how many people are in long term rehabilitation services, which makes planning and oversight difficult. Regulation focuses on the service rather than individuals, so there is no clear way of assessing how this group moves through the system. Out of area placements tend to be long term, so even if people were placed appropriately to begin with, that knowledge will be lost over time as individuals in commissioning organisations change. At a local level, care coordinators with high caseloads are not able to give people the attention they require over time, particularly when risk tends to be greater for people living in the community, rather than in settings with 24 hour staffing. One survey found that less than 60% of individuals had a care coordinator from their area of origin (Ryan *et al.,* 2007). A considerable amount of information was not known to a significant proportion of commissioners of services, particularly legal status, diagnosis and ethnicity, all of which could have been used to inform future commissioning strategies and the development of local service systems (Ryan *et al.,* 2007). There is little understanding of how long people have been in the system, as often people will be in touch with inpatient services for a very long period of time, though short-term discharges mean that their stay is recorded as multiple spells of care.

CQC report examples:

"Initial feedback showed there was a lack of meaningful engagement between staff at

the hospital and people involved in planning patient care. Staff were not routinely sharing information relating to patient care with commissioners. This made it difficult for commissioners to adequately monitor the placement. We were provided with a care and treatment review for one patient prior to our inspection. Staff had not made attempts to contact the appropriate teams to ensure they were provided with a copy of the review. This meant that staff could not act on findings and recommendations relating to patient care."

"We looked at all the patients' care plans. There was no evidence of discharge planning. One patient had lived there for 15 years and other patients had been there for several years each. There was no evidence that the service sent progress reports to the Clinical Commissioning Groups (CCG) who were responsible for the placement and funding of the patients' stay. The CCG told us they had not requested these until this year."

Very long stay cohort

For the small cohort of people who require very long-term rehabilitative care, there is little recognition that they are a distinct group with particular needs which might be better met in a different kind of setting. Instead, they tend to be dispersed within the system, with one or two people per rehabilitation unit.

At a national level there is limited acknowledgement that some people with very complex psychosis may require very long term specialist inpatient care. This cohort is expensive (and investment in appropriate services may be unappealing). It has been suggested that a focus on short-term outcomes for this group (such as a lack of serious incidents) undermines the need for longer term investment in appropriate interventions that can support recovery, creating an unhelpful tension between containment and rehabilitation (Poole, 2016).

As a result, people may end up living very narrow and barren lives, with an embedded poverty of aspiration. They tend not to fight the system or their circumstances, as their expectations are low. For some, their lives become a series of minor struggles for a degree of autonomy in the face of an institutional system around them.

We reviewed 82 of CQC's reports on long-stay rehabilitation services published between July 2014 and June 2016. Just under half (39) provided information about the longest length of stay for a patient at that service, and of those a quarter (10) reported that it was over five years. In many cases, people who had been in those services for very long periods of time were residing with people who were expected to be discharged much sooner.

For example:

- Three patients in a 13-bed independent sector unit had been there for over 12 years, where the average length of stay should have been 18-24 months.
- In an 18-bed NHS unit, one patient had been on the ward since 2007 (nine years at time of inspection), where the average length of stay was 20 months.
- In a 30-bed independent unit with 22 current patients, two patients had recently been discharged: one of whom had been there for 16 years and the other for eight years.
- At one NHS unit, of the patients who had not been discharged in the last year, the average length of stay was over seven years, and one patient had been there for 20 years. For those who had been discharged, the average length of stay was under 3 years.
- In a 13-bed independent unit, the "majority" of patients stayed for many years, some for the remainder of their lives. The last patient had been discharged in 2011 to hospital, and prior to that to live in their own flat in 2008. Inspectors found that there was no proactive approach to patient

rehabilitation or focus on this pathway, care plans did not include detailed discharge planning, and patients were rarely discharged from the hospital.

It is important to note that this is very unlikely to represent the full picture in terms of total length of stay. People are often discharged for short periods of time between longer admissions, meaning that their total length of stay looks considerably shorter than it actually is. It would nonetheless appear that in many units, small numbers of patients with the most complex needs are staying for very long periods alongside those who move through more quickly.

Good practice

Detailed standards of good practice in commissioning and providing rehabilitation services are available from the Joint Commissioning Panel for Mental Health guidance for commissioners (2016), the Royal College of Psychiatrists' 2009 position statement, and the subsequent standards developed by their Quality Network for Mental Health Rehabilitation Services (2016).

They state that services should be provided locally, with a combination of inpatient rehabilitation units and supported accommodation for people to move on to.

Staffing should be made up of multidisciplinary teams. Services should have a recovery focus, and provide meaningful rehabilitative activities, focused on skills development and social inclusion. When people move between services there should be effective care coordination to ensure that gains people have made are not lost in the new placement. Care plans should include discharge planning, and inter-agency working with advocacy, housing and other social care services is needed to ensure that people can step-down to less supported services or accommodation as they recover.

CQC examples of good practice include:

"There was a team of social inclusion workers whose role was to help patients bridge the gap between hospital and community by using a wide range of services and facilities in the local community. This team was integrated into the ward staff group and provided a graded reintroduction to community involvement for patients. They were involved in quarterly inter-agency network meetings which were attended by a range of community services including; district councils, housing providers, colleges, community centres, specialist employment support, volunteer services, the job centre and citizens advice bureau."

"Patients had access to a rehabilitation kitchen where they could cook their own meals and this was encouraged at least once a week. Patients living in the bedsits had a kitchen in their own room and did all their own cooking. In the outdoor area there was a space where patients were growing their own vegetables, which could also be used in their cooking. The service was a good example of social inclusion and there was a big emphasis on patients engaging in activities in the local community. This included a college course called "back on track", which consisted of short six week courses on English and maths."

"Staff planned discharge arrangements in conjunction with their commissioners and identified move-on services. Some patients stayed locally and others returned to their home areas. The hospital had developed good links with local housing providers, which meant that patients could remain in the local area if they wanted to [...] When there had been a delay because of a local funding problem, the service had found innovative ways of supporting a patient to move into the community, which included staff visiting the patient every day after they had moved out of the hospital. The service considered discharge planning throughout the admission, with the acknowledgement that some patients would move through the service more quickly than others, based upon individual need and context of their illness, history and recovery."

Alternative service types

Alternative types of services for the long-stay cohort are being developed in some areas, though there is a need for independent evaluation. We were made aware of two as part of this research:

- Alternative Futures in the north-west: people receive care in independent hospitals, but medical support and Mental Health Act governance is provided by the NHS. Beds are block contracted by the local commissioner, and only people local to the area are accepted (e.g. CQC, 2015).
- Tile House in London, a collaboration between One Housing Group and Camden and Islington NHS Foundation Trust which provides supported housing with clinical input from the NHS (One Housing Group, 2015).

Recommendations

For local commissioners and providers:

- **Local authorities and CCGs** should ensure that Joint Strategic Needs Assessments and Sustainability and Transformation Plans quantify the number and type of inpatient rehabilitation services needed for their population, and that they subsequently invest in local rehabilitation services as appropriate. This may require commissioners from geographically bordering areas to come together, enabling economies of scale and allowing people to better step up or down to services as appropriate for their needs at the time. Local services will decrease the need for costly out of area placements, and allow people to remain connected to their local area and contacts.
- **NHS trusts and CCGs** should ensure that the numbers of people they have placed out of area, and the costs of doing so, are reported to CQC and other bodies (such as NHS Digital or NHS Benchmarking) as appropriate.
- **CCGs** should ensure that they receive regular data from providers about the people they are commissioning inpatient rehabilitation care for, and be able to assure themselves that individuals are in the most appropriate placement for their needs.
- **Providers** should improve their data collection, particularly identifying people who have not made progress after a few years of inpatient rehabilitation. The data collection should identify the numbers of people, their location, the type of care they are receiving and the commissioners who are responsible for meeting their needs.
- **Sustainability and Transformation Plans** should consider the needs of people using rehabilitation services and particularly those experiencing long hospital stays, in order to redesign services to meet their needs at a larger scale than is possible currently, especially in areas with lower morbidity with fewer people who require long-term support.

For Government and Arm's Length Bodies:

- **Department of Health and NHS England** should provide clear direction and support for the development of local integrated services, working across the health and social care economy and bringing in the third sector.
- **Department of Health** should facilitate the development of national guidance for rehabilitation services, clearly setting out specifications for services supporting people with different levels of needs, and clarifying terminology and the need for local rehabilitation care pathways.

- **Department of Health** should commission a comprehensive survey of the numbers of people using rehabilitation services, both inpatient and community-based, locally and out-of-area, in NHS and independent sector services, including those who are experiencing long stays in hospital.
- **NHS England** should hold commissioners to account for appropriate commissioning of services for people with severe mental illness.
- **The CQC** should ensure that inspection reports feature key information needed for oversight of the system, including specificity around the type of rehabilitation being provided, information about any out of area placements, the people being cared for, and focus given to the small cohort of very long-stay patients. Ratings limiters should be applied where services are not providing truly rehabilitative services, and working towards relocating people to their local area, where they are in an out of area placement.
- **Department of Health and NHS England** must recognise and give attention to the small cohort of people who may require highly supportive care throughout their lives. Consideration should be given to how best to improve their quality of life if they are going to remain in an inpatient setting for a very long period of time. While this is unlikely to lead to significant savings, or improvement in people's condition, it will stop wasteful expenditure on inappropriate services, and prevent associated deterioration. Services should be designed specifically for people with long term care needs: for example highly supported tenancies based in a community setting would have flexibility to cater for people's fluctuating needs over time, with a safety net of allowing them to become an inpatient in a familiar facility if needed, lessening the potential for a significant relapse.

Conclusions

There has been a succession of missed opportunities to meaningfully develop effective long-term rehabilitative care, from the NSF-MH in 1999, through subsequent national strategies and programmes, to the 2016 Five Year Forward View for Mental Health.

The vulnerabilities of people in long-stay mental health rehabilitation services are not dissimilar to those experienced by people with learning disabilities in long-stay hospitals, and the risks of institutionalised practices are high. Although CQC has not found the flagrant abuse in the rehabilitation services it has inspected comparable to that experienced by people with learning disabilities living at Winterbourne View, it has found care of a standard far below what people should be able to expect in some services.

The focus of the Transforming Care programme for people with learning disabilities - of providing care in the community, more innovative options to meet individual needs, and ensuring that people who do need inpatient care only receive it for as long as they actually need it - should apply equally to people with longer term mental health needs.

Similarly, although this group did not receive significant focus in the Five Year Forward View for Mental Health, in the context of step-down from nationally commissioned secure care the Forward View has called for a programme of work to support people who have severe mental health problems and significant risk or safety issues, in the least restrictive setting and as close to home as possible. This programme aims to increase the provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and trialling new co-commissioning, funding and service models (Mental Health Taskforce, 2016). This work should equally focus on the needs of people who may not have had contact with secure services, but who have similar needs for local rehabilitative care.

From a purely economic perspective, providing long-term care in hospitals, particularly outside of people's local area, is highly expensive and often cost-ineffective. While the group needing a high level of support will continue to be more expensive than people with less complex needs, the money would be better invested in improving local services that have a better chance of maximising a person's recovery and autonomy.

From a moral and social perspective, it is unacceptable that there is a group of vulnerable people who have been allowed to remain isolated and powerless for decades, with little hope for change in their circumstances. It is imperative that progress is made for this group in the next three to four years and they are not left behind once again.

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