Commentary re:

Clinical Strategy and Programmes Division: Rehabilitation Medicine Programme, Model of Care for the Provision of Specialist Rehabilitation Services in Ireland Version 0.18 (2nd substantive draft)

The Faculty of Liaison Psychiatry, College of Psychiatrists of Ireland wish to highlight the unmet need in relation to Psychiatry (and specifically Neuropsychiatry) services that will be essential for optimal care and outcome of those with complex Rehabilitation needs. The RMP as proposed does not address this unmet Psychiatry need.

- The proposed National Rehabilitation Medicine Programme (RMP) acknowledges the general unmet need in relation to acute, post-acute and continuing care Rehabilitation Medicine services in Ireland and presents a model of improved care for patients with such needs. Rehabilitation care takes place in acute hospitals (acute specialist rehabilitation), in post-acute settings (National and Regional Specialist Rehabilitation Units) and in the Community (Community-based Specialist Rehabilitation services) delivered by multidisciplinary teams. A hub and spoke model of National Tertiary Centre (NRH) and 6 Regional Centres is planned.

- The RMP model of care is based on that of the British Society of Rehabilitation Medicine (BSRM: Standards for Rehabilitation Services, 2009). In the BSRM model and standards, there is clear recognition of the need for higher proportion of mental health staff including Consultant Neuropsychiatrist for those cases with more complex rehabilitation needs. This need is also identified in relevant National Care pathways from Scotland (SIGN 130. Brain Injury rehabilitation in adults, 2013) and Northern Ireland (Regional Acquired Brain Injury Implementation Group: Acquired Brain Injury Inpatient Care Pathway: Neurorehabilitation. Health and Social Care Board). The majority of those requiring a service by the National Tertiary Centre (ie NRH) as well as a sizeable minority of those in the Regional Specialist Rehabilitation service will have complex needs and therefore will required defined access to a Consultant Neuropsychiatrist.

Clinical Neuropsychiatry services lie at the interface between Neurology, Rehabilitation Medicine and Psychiatry

- 'Neuropsychiatry is the specialty that provides for the mental health needs of persons with brain and Nervous system disorders. Clinical neuropsychiatry is a subspecialty of psychiatry devoted to the assessment and management of mental and behavioural problems in nervous system as well as unexplained neurological symptoms. Typical clinical presentations requiring the specialist skills of neuropsychiatry services include brain injury sequelae, early-onset dementia, psychological morbidity related to epilepsy and other neurological disorders and psychogenic non-epileptic seizures. A key role of

Neuropsychiatry services is the assessment of these complex cases, which are often beyond the skills and service remit of general adult mental health services.' (Vision for Change, Department of Health and Children, 2006)

- 'Neuropsychiatry services work closely with other neuroscience and mental health services and have expertise provided by neither service alone. Neuropsychiatry services see patients with conditions such as young onset dementia including Huntington"s disease, movement disorders, neuro-developmental disorders, epilepsy, sleep disorders, and acquired brain injury for example from head injury, cerebral tumours or a cerebrovascular accident. These patients are usually seen because of cognitive, behavioural or psychiatric symptoms. Other patients are seen because of neurologically unexplained symptoms or altered states of consciousness or mental symptoms of uncertain aetiology. Specialist neuropsychiatric activity includes: inpatient and outpatient assessment for complex conditions presenting with psychiatric symptoms; access to clinical and nursing expertise, including neuropsychological assessment and brain scanning facilities and assessment of physical function; intensive nursing care in specialist units and within community teams; links with neuropathological centres; access to detailed genetic investigations and counselling.' (Manual for prescribed specialised services.' Specialised Services Commissioning Transition Team, NHS Commissioning Board; November 2012)

The unmet need for Neuropsychiatry is endorsed by Neurological Alliance of Ireland, National Mental Health Policy, the existing National Rehabilitation Medicine service as well as relevant quality improvement literature in the UK

- The Neurological Alliance of Ireland (the national umbrella body representing over thirty not for profit organisations including Headway and Acquired Brain Injury Ireland, working with people with neurological conditions (including acquired brain injury, stroke, spinal injuries) and their families) endorses the need for Neuropsychiatry services. '*The continued lack of specialist neuropsychiatric services continues to impact significantly on the quality of care and treatment of people with neurological conditions in Ireland.'* This organisation is recognised as a key partner in informing and shaping the response to the needs of people with neurological conditions and their families in Ireland. (Submission to second independent monitoring group: A vision for change. Neurological Alliance of Ireland, 2010).
- Current National Mental Health Policy (Vision for Change, Department of Health and Children, 2006) has clarified the case of unmet need for clinical Neuropsychiatry services in Ireland. A year after traumatic brain injury, approximately 20% of people will have diagnosable mental disorders and 40% will have neurobehavioral problems. These figures estimate a neuropsychiatry need in traumatic brain injury of approximately 80 cases per 100,000 population. Neuropsychiatric needs are also present in service users with acquired brain injury from encephalitis, meningitis, subarachnoid haemorrhage and anoxic brain as shown in the experience at National Rehabilitation Hospital (NRH). Similar estimates are available for epilepsy (600–1,500 cases per 100,000 population), early-onset dementia (50 cases per 100,000 population age 46-64), unexplained Neurological symptoms including non-epileptic seizures and motor conversion disorders

(300 cases per 100,000 population) and other disorders. Taken together, these estimates suggest that it is reasonable to expect 30–35 new referrals to specialist neuropsychiatry services per 100,000 population per year whose needs cannot be met by local mental health services. This policy has also specifically drawn attention to the need for Neuropsychiatry services to work in collaboration with Rehabilitation Medicine to meet the often complex continuing care needs (including challenging behaviour) of patients with acquired brain injury.

- The National Rehabilitation Hospital has advocated for a dedicated Challenging Behaviour Unit. 'It has been a view of the NRH that Ireland needs a challenging behaviour unit similar to services of this type provided in the UK. Since the NRH set up its Neurobehavioural clinic, where patients are reviewed by Neuropsychiatrists, neuropsychologists and rehabilitation Medicine brain injury specialists, it has become concerned about the overlap in challenging behaviour care with the forensic mental health services. There appear to be a number of brain injury patients whose frontal lobe disorders have led to challenging behaviour and subsequent incarceration in prison. It would appear more appropriate that patients with challenging behaviour due to brain injury are rehabilitated in a non-custodial challenging behaviour unit rather than in a prison. Neuropsychiatry should have a key role in any proposed challenging behaviour unit for patients with acquired brain injury'.
- Agrawal et al (2015) Provision of neuropsychiatry services: variability and unmet need. BJPsych Bull.;39(6):297-301; Bhattacharya et al (2015) Commissioning neuropsychiatry services: barriers and lessons. BJPsych Bull. 39(6):291-6.

<u>Specific Comments re:</u> Clinical Strategy and Programmes Division: Rehabilitation Medicine Programme, Model of Care for the Provision of Specialist Rehabilitation Services in Ireland Version 0.18 (2nd substantive draft)

- **P9.** In the Executive Summary, it is stated that the Rehabilitation Medicine Programme (RMP) has aligned its objectives with several other HSE Clinical Strategy and Programmes Division (CSPD) programmes including Neurology, Stroke, Older Peoples', Psychiatry and Rheumatology. P18: Links with other National Clinical Programmes gives some information on how these are aligned but there is not mention of how the objectives of this programme are aligned with those of Psychiatry?
- **P28.** It is stated in the Aims and Objectives of the RMP that costs will be reduced by: Reduced length of stay (LOS) in acute hospitals and reduced length of stay (LOS) in complex specialist rehabilitation hospitals. There is clear evidence that Specialist Psychiatry services in acute hospitals achieve this. In an independent economic evaluation by the London School of Economics (Parsonage M and Fossey M. An economic evaluation of a liaison psychiatry service. London School of Economics and Centre for Mental Health. 2012), Specialist Psychiatry services in acute hospitals have been clearly shown to reduce costs of medical care by reducing length of stay by 4£ for every 1£ invested in service.
- **P70-71.** Chapter 12. Requirements for service delivery: Implementation of the Neurorehabilitation Strategy; Personnel and Workforce planning. Neuropsychiatry is included as a key activity of Tertiary Specialist Neurorehabilitation service. This is

welcome and consistent with National Mental Health Policy (Vision for Change, 2006) which has recommended national Neuropsychiatry in collaboration with Neuroscience Centre and Rehabilitation Medicine. Regional Specialist Neurorehabilitation teams will also need clinical Neuropsychiatry resource given their key activities: Ie Level 2 patients with complex neurorehabilitation needs. This is also consistent with National Mental Health Policy (Vision for Change, 2006) which recommended defined resources in Regional Centres.

- **P82-83.** Minimum Staffing Provision for specialist in-patient rehabilitation services (BSRM National Guidelines for rehabilitation following acquired brain injury). These figures were adapted and updated by the BSRM in April 2015 (Specialist Neurorehabilitation services: providing for patients with complex neurorehabilitation needs) and include inpatient activity and associated outreach work (excluding community rehabilitation work). In this updated BSRM document specialist services for patients with more complex needs require a higher proportion of Psychology / Counselling staff; consultant Neuropsychiatrist support; a proportion of registered mental health nurses and sufficient staffing levels to provide a safe environment for high risk patients, including 1:1 supervision where needed. There should therefore be a recognition in the draft RMP model of care that recognises this increased Neuropsychiatry and mental health staffing need in those with complex behavioural needs.
- **P104:** Appendix 1: Polar Pathway. Amputees experience a range of mental health issues including PTSD, Depression, body image difficulties that will impact on outcome following amputation. In the acute and post-acute phase there needs to be access to Psychiatry and Psychology here.
- **P105:** Appendix 2: Spinal Patient Pathways. A range of mental health issues may emerge in patients with Spinal Injuries that require Specialist Psychiatry input in addition to the core Rehabilitation MDT ie in the acute hospital this will be Liaison Psychiatry; in the post-acute setting (Tertiary or Regional Rehabilitation Unit) this will be General Psychiatry, Liaison Psychiatry, or Neuropsychiatry. No mention of this is Psychiatry need is made here.
- **P107:** Appendix 3: ABI patient pathways. A range of acute mental health issues may emerge in patients in the acute hospital following acquired brain injury. Acute challenging behaviour in delirium/PTA following brain injury is most common as a reason to refer to Liaison Psychiatry whose expertise is needed in addition to the core Neurosurgical/Rehab Medicine MDT. For patients with ongoing complex rehabilitation needs following ABI, specialist Neuropsychiatry will be required to facilitate discharge planning, transition to post-acute rehabilitation setting and follow-up. No mention of this is Neuropsychiatry need is made here.
- **Alcohol-related Brain Damage:** No mention is made of the rehabilitation needs for these patients who, following WKS-type brain injury have significant capacity for recovery and have ongoing rehabilitation needs. There is no formal care pathway from the acute hospital for this cohort who are a COMMON reason for delayed discharge. (Alcohol and brain damage in adults. With reference to high-risk groups. College report CR185. Royal College of Psychiatrists, Royal College of Physicians London, Royal College of General Practitioners, Association of British Neurologists. 2014).