

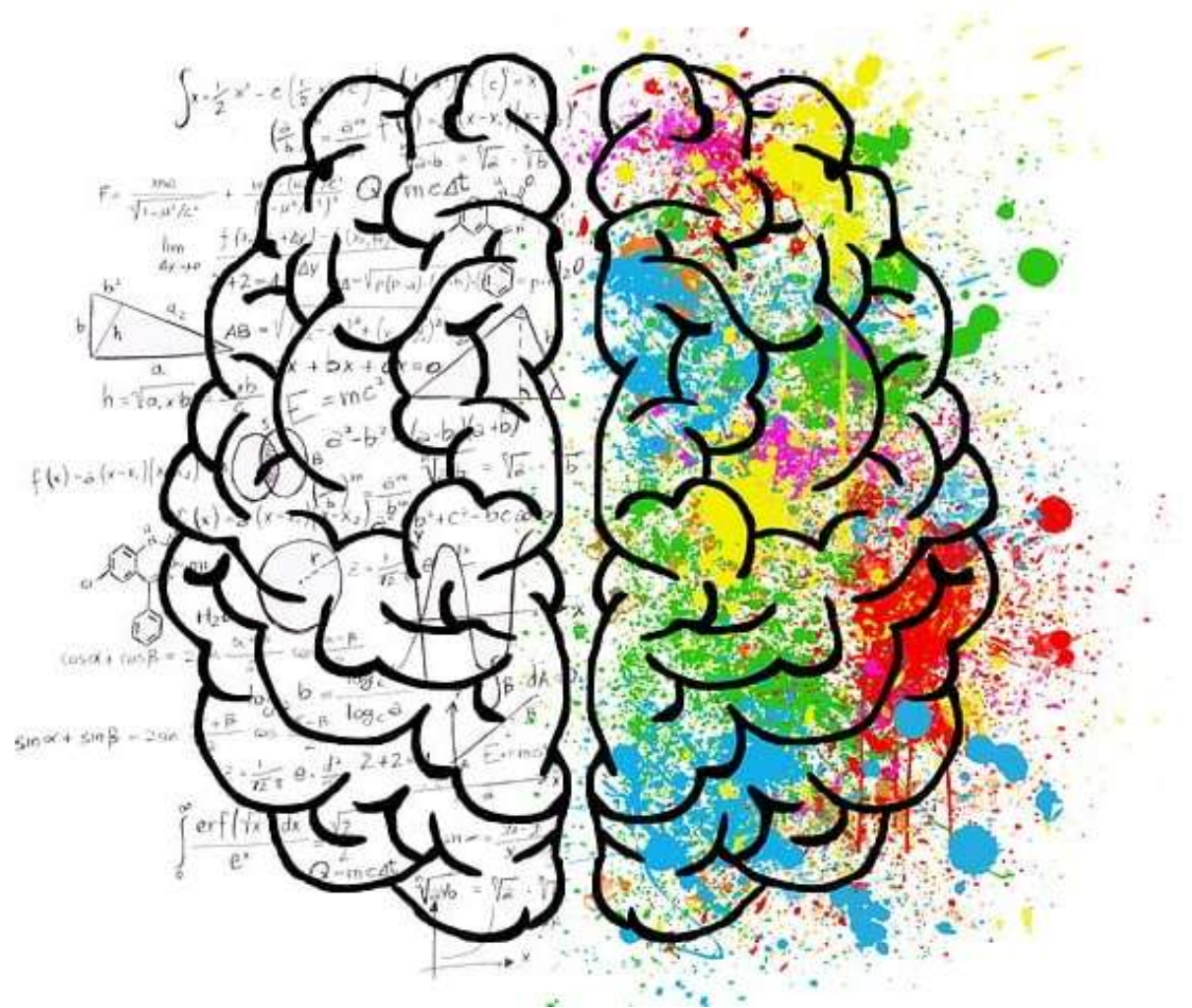
BMHP6029

Psychopathological Classifications and Provisions

Week 5

Rehabilitation and Feeding and Eating Disorders

2026



Structural



**Mental health
rehabilitation**



Recovery model



**Feeding and eating
disorders**

Mental Health Rehabilitation

What it is

Who needs it

UK policy landscape

Workforce and MDT roles

Recovery model

Current debates and challenges

Mental Health Rehabilitation

Mental health rehabilitation supports people with **severe, complex, and long-term mental illnesses** to regain functioning, autonomy, and social inclusion.

Around **80%** of service users have psychosis-related diagnoses such as schizophrenia, schizoaffective disorder, or bipolar disorder (Dalton-Locke et al., 2021; NHS England, 2023).

Rehabilitation may be **in-patient, community-based**, or part of **supported accommodation pathways**.

- NHS England's 2023–2024 *Community Mental Health Transformation* emphasises rehabilitation as a core component of integrated care systems (ICSs).
- The *Long Term Plan* (2019) commits to reducing inappropriate out-of-area placements (OAPs) by improving local rehabilitation capacity.

Who needs Mental Health Rehabilitation?



In sight and in mind report

- Read pp. 5-6 in [in-sight-and-in-mind_rehab-report_25-2-20.pdf](https://www.rcpsych.ac.uk/in-sight-and-in-mind_rehab-report_25-2-20.pdf) ([rcpsych.ac.uk](https://www.rcpsych.ac.uk)) to answer this question





Who Needs Mental Health Rehabilitation?

People who benefit from rehabilitation typically have:

- Persistent symptoms despite standard treatments
- Cognitive or functional impairments
- Repeated or long hospital admissions
- Co-existing conditions (substance use, neurodevelopmental disorders)
- Social isolation or limited support networks

Current debate:

ICSs report rising demand due to **reduced acute bed capacity**, **housing shortages**, and **delayed discharges** (RCPsych, 2023).

When are people referred to rehabilitation service?

- People transitioning from forensic services
- People requiring structured environments to relearn ADLs
- People preparing for independent or semi-independent living

The structured environment on a rehabilitation unit can be very supportive for someone living with complex, severe or chronic mental illnesses.



Aims of mental health rehabilitation

Relearning

- To help patients learn or re-learn life skills.

Confidence Building

- To help patients get their confidence back.

Self-Dependence

- To help them cope better without much help.

Empowerment

- To achieve the things patients want or dream about-like living in their own flat, getting a job or having a family.

Promoting Self-esteem and independent living

- To feel independent and comfortable with life.



Identify how many different professionals are featured in this video?
Note down the key points about mental health support featured in the video.

Mental Health Rehabilitation Services

The rehabilitation team includes psychiatrists, nurses, occupational therapists, psychologists and social workers.

In the UK, just over half mental health rehabilitation units are based in the community with the rest based in hospital sites (In-patient Rehabilitation).

Placements are usually for months or years till the patients feel more confident and their condition improved.



These services assist one to recover, while accepting that some individuals may still have serious difficulties that need continuing help and support (RCP, 2019)

Mental Health Rehabilitation Services

The **Getting It Right First Time (GIRFT) Mental Health Programme (2022–2024)**

emphasises standardised pathways and reducing variation in rehabilitation provision.

[Getting It Right First Time – GIRFT](#)

ICSs now commission **tiered supported accommodation** (high-support, medium-support, floating support).



Mental health rehabilitation in England: what it is & policy landscape

- Whole-system, recovery-oriented care for people with severe, complex and long-term mental illness (predominantly complex psychosis)
 - NHS England (Jan 2024) standardises commissioning of local rehab inpatient services as part of an end-to-end pathway; aim: access close to home
 - GIRFT national rehab report emphasises reducing out-of-provider placements and standardising pathways across ICSs
 - Community Mental Health Transformation embeds rehab within integrated, place-based models
-

Role of Rehabilitation psychiatrists and psychologists



have specialist expertise in the long-term treatment and care of people with severe mental illness and complex needs.



Carry out thorough assessment and treatment

Shared decision-making

Use of outcome measures such as HoNOS, DIALOG+, and ReQoL



Look at long-term possibilities for the patient, not just symptoms of the illness, and work closely within a team of other professionals.



advise colleagues on the diagnosis and management of severe and complex mental health problems for people who are not helped quickly by standard treatments

Support and Treatments Available

Treatments

- Medication Management
- Talking therapies: CBT and specific work with families and carers).
- Digital tools (e.g., recovery apps, remote CBT)

Support and help

- Reduce or stop alcohol and street drug use.
- Manage everyday activities: personal hygiene, laundry and more complex living skills such as budgeting, shopping and cooking.
- Physical health monitoring aligned with **NICE NG181 (2021)** for severe mental illness

Advice and guidance

- Healthy living: diet, exercise and stopping smoking).
- Help with accommodation and social security benefits.
- Legal advice

Role of MHR team

Advise on residential and community support services

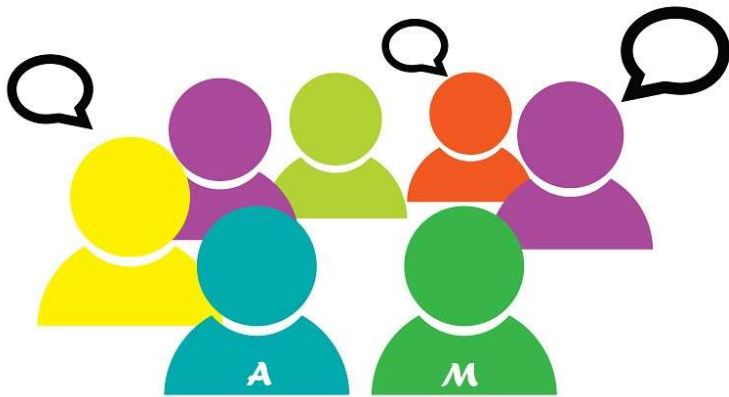
Assist in joint working with voluntary sector agencies that provide supported housing and work opportunities for rehabilitation patients as they recover.

Advice to commissioners about what services should be developed, and how to run high-cost placements





What are indicators of patients ready to transition back into community?



1. For a patient that is getting better, what would you encourage them to do in the community?
2. Which voluntary sector agencies would you engage to provide support and opportunities to enable transition?

Indicators of patients ready to transition back into community

Evidence-based indicators:

- Stable symptoms
- Consistent engagement with treatment
- Ability to manage ADLs with minimal prompting
- Risk management capacity
- Social support networks
- Housing readiness

ICS context:

Local authorities and NHS providers must coordinate **Section 117 aftercare** for eligible individuals.





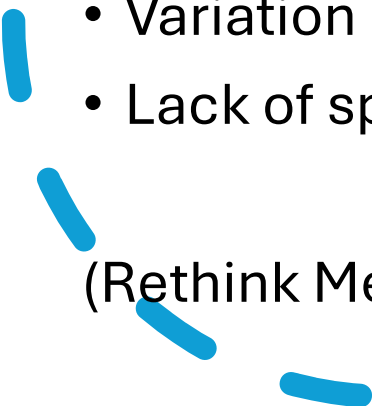
Section 117 after-care: (2024 statutory guidance)

- Joint duty on ICBs and local authorities to arrange free after-care for eligible patients discharged from MHA s3/37/45A/47/48
 - After-care aims to meet needs arising from mental disorder and reduce risk of deterioration/re-admission
 - Jan 2024 DHSC/NHSE statutory guidance clarifies discharge planning principles and annex on sharing budgets/responsibilities
-



Challenges in the provision of mental health in-patient rehabilitation

- Routine out-of-area placements despite their negative impacts on recovery and costing - OAPs remain a major issue despite national targets
- Workforce shortages (nursing, OT, psychology)
- Supported housing crisis
- Variation in ICS commissioning
- Lack of specialist community rehabilitation teams in many regions



(Rethink Mental Illness and the Royal College of Psychiatrists, 2023-24)

Out-of-area placements (OAPs): why they matter in rehab



CQC found in 2018 that ~63% of residential rehab placements were out of area; high cost, longer stays, poorer continuity



NHSE monthly statistics show acute OAPs persist nationally; reducing distance and length of stay remains a key quality & safety goal



Commissioner guidance (2024) expects local access wherever possible and alignment with whole-pathway housing/support

**Is Mental Health
Rehabilitation
available in your *local
area*?**



This Photo by Unknown Author is licensed under CC BY

**Routinely out-of-area placements
are used, despite their potential
negative impacts on recovery and
costing**

- 63% of in-patient placements are in different geographical areas to a patients home address. (CQC, 2018)
- Two thirds of the £535m cost is spent on out-of-area placements
- Out-of-area placements often do not follow recognised service models
- Transitioning between care settings becomes difficult to coordinate
- Distance from family and engaging with local community

Gaps in provision affecting care and outcomes

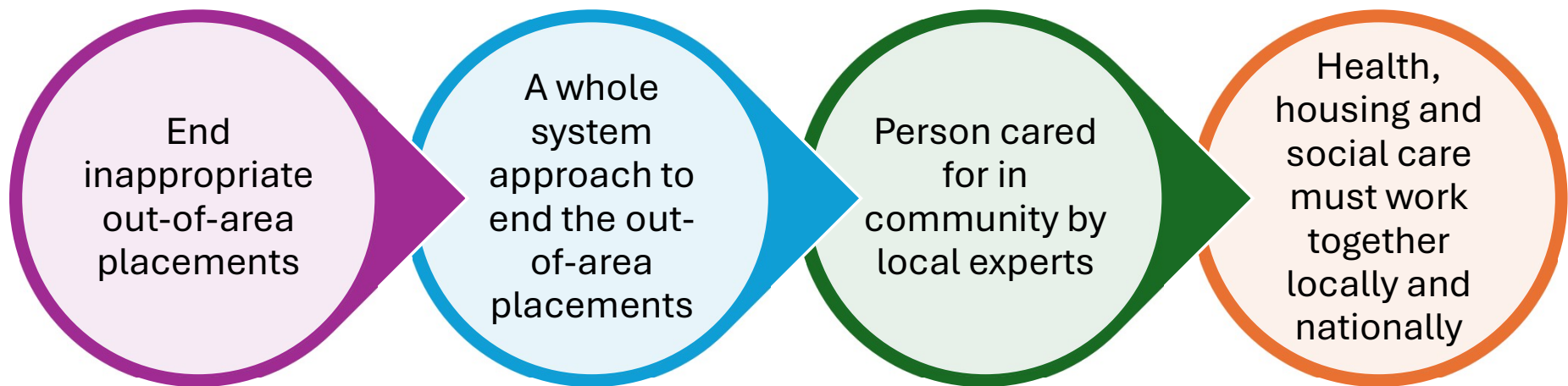
- 333 NHS mental health rehabilitation beds have been decommissioned with further 53 beds planned
- The Doctor magazine found that NHS mental health rehabilitation wards have disappeared entirely from 18 Integrated Care Systems and NHS trusts in England, leaving five million people in those areas reliant entirely on out-of-area private sector provision
- Community rehabilitation treatment is rarely delivered by specialist teams
- Wider challenges around supported housing and social care

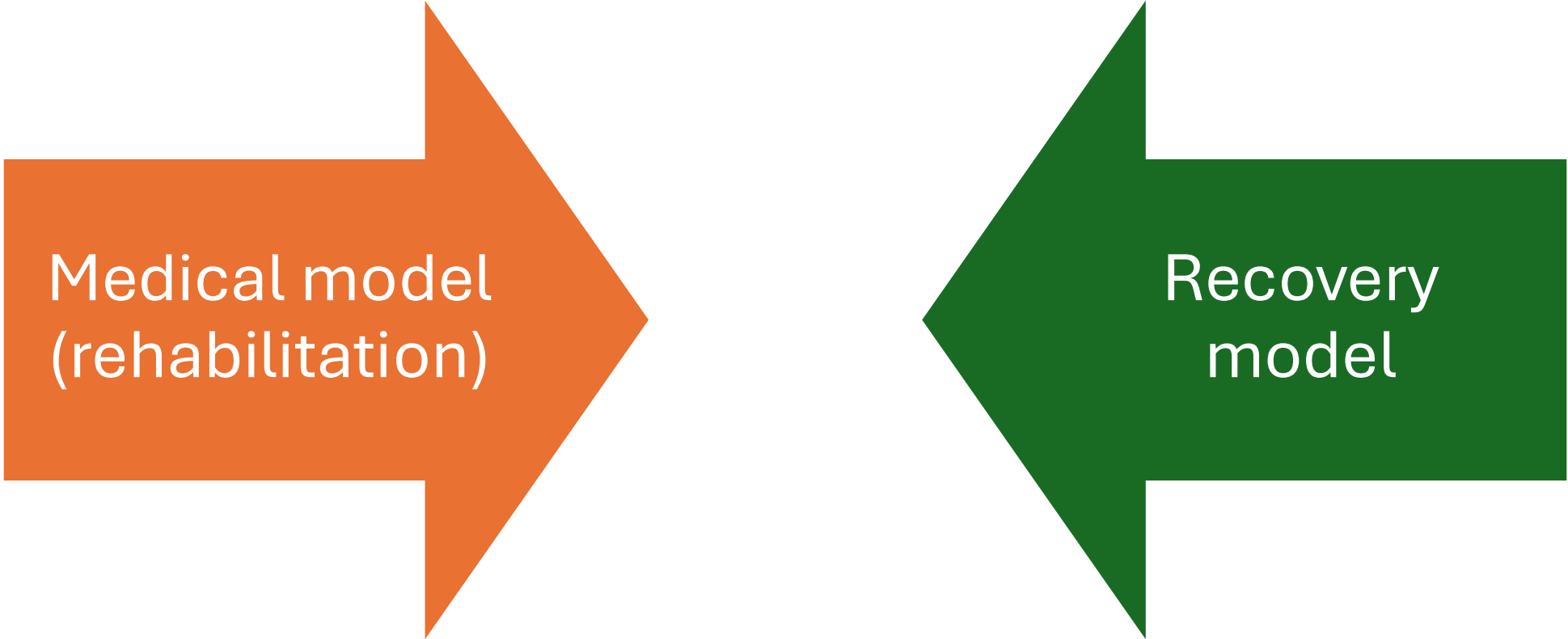


Ensuring the mental health rehabilitation system is fit for purpose requires greater national and local focus

- Currently, there is no national strategy to end out-of-area placements and few local plans
- Currently, there is a lack of routine data on out-of-area placements and no shared definition of when an out-of-area placement is appropriate.

4 recommendations





The diagram consists of two large, stylized arrows pointing towards each other. The arrow on the left is orange and points to the right. The arrow on the right is dark green and points to the left. The text 'Medical model (rehabilitation)' is written in white inside the orange arrow, and 'Recovery model' is written in white inside the green arrow.

Medical model
(rehabilitation)

Recovery
model

Recovery and hope are the guiding principle of care

(Bradley-Adams, 2020; Killaspy et al., 2020)

- Recovery-focused mental health movement (Anthony, 1993)
 - Closure of large institutes since 1980s
 - Attempts to rehabilitate persons with mental disorder



Social recovery

The chance of living a full and meaningful life in spite of the symptoms is achievable



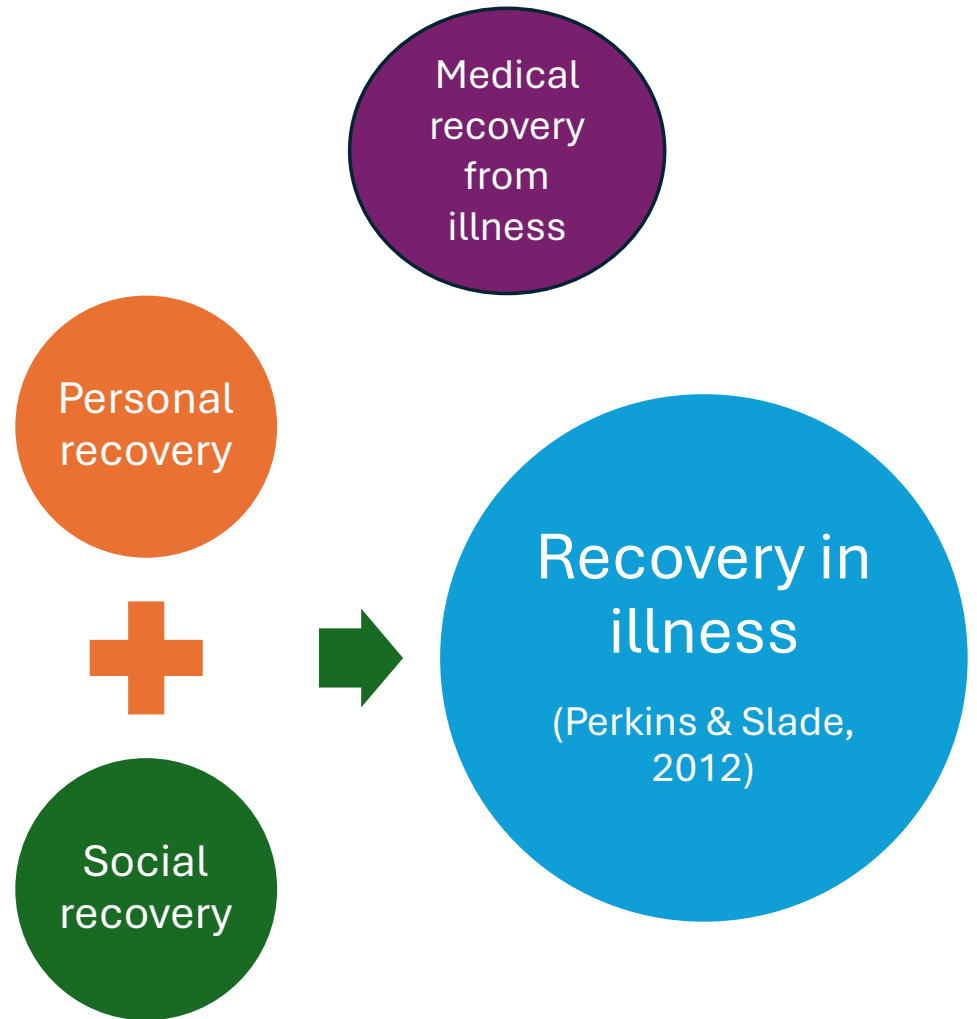
Complete medical recovery and the absence of all symptoms are not achievable for many.

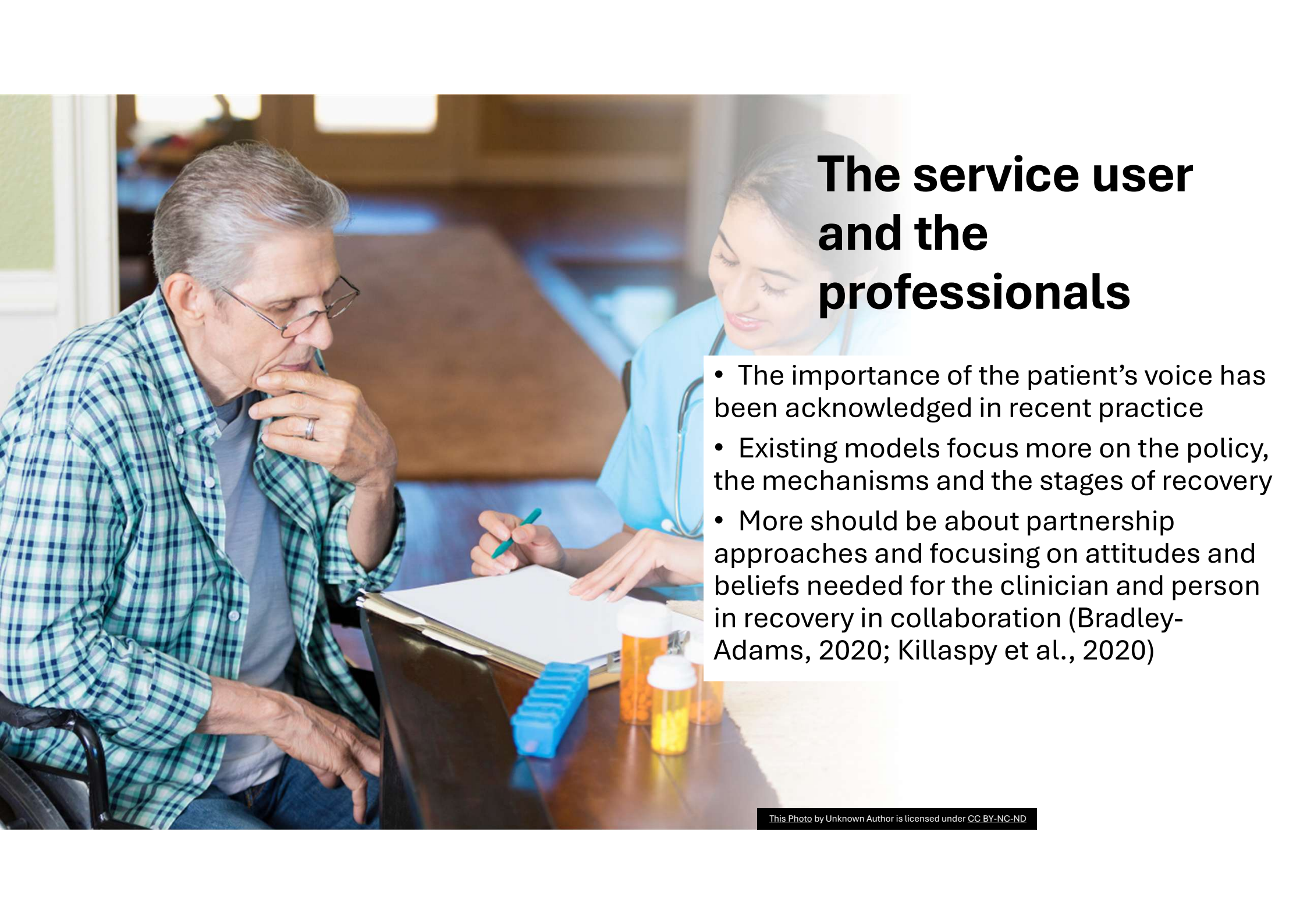


This Photo by Unknown Author is licensed under [CC BY-SA](#)

The person's perception of their relative wellness, living with symptoms and feeling hope and of value (Slade & Wallace, 2017)

As well as living independently and not being a burden, the person also enjoys the meaningful life like others without mental health disorder (Ramon, 2018)





The service user and the professionals

- The importance of the patient's voice has been acknowledged in recent practice
- Existing models focus more on the policy, the mechanisms and the stages of recovery
- More should be about partnership approaches and focusing on attitudes and beliefs needed for the clinician and person in recovery in collaboration (Bradley-Adams, 2020; Killaspy et al., 2020)

Killaspy et al (2020)



Measuring the quality of Supported Accommodation using Quality Indicator for Rehabilitative Care (QuIRC-SA): living environment, therapeutic environment, treatments and interventions, self-management and autonomy, social interface, human rights and recovery-based practice.

Patients 'moving on' was facilitated in services where recovery-based practice was used more and human rights were promoted

Service promotes collaboration between staff and service users in care planning and running of the service

Government set target of 2 years in rehabilitation may lead to some service users' needs not being met as they may need longer term support

However

Recovery can mean different things to different people (Rethinking mental health, n.d.)

Visit [Recovery and mental illness \(rethink.org\)](https://rethink.org) to look up for social prescribing

You will also find more accessible information about personal and social recovery.



Feeding or Eating Disorders

Word association: what 5 words do you associate with eating disorders?



PsychHub

WHAT IS AN EATING DISORDER?



Higher morbidity and mortality rate than other mental health disorders, especially Anorexia Nervosa, due to significant impacts on the physical health.

- Not all disorders are linked to reduced weight.
- Affects both males (25% of cases) and females (75% of cases)



Feeding & eating disorders: classification and current guideline status

- ICD-11 categories include AN (6B80), BN (6B81), BED (6B82), ARFID (6B83), Pica (6B84), Rumination (6B85), OSFED (6B8Y)
- NICE NG69 (2017; last reviewed by exceptional surveillance May 2024) – no update triggered; emphasises early intervention and psychological therapies
- MEED (RCPsych CR233, 2022; updated 2025) provides risk assessment & emergency management incl. refeeding syndrome



Eating disorders: epidemiology & service pressures (England/UK)

At least 1.25 million people in the UK are affected; ~25% are male (recognised under-diagnosis in men)

NHS Digital survey data show increasing eating problems/disorders among children and young people since 2017

Hospital activity and referrals have risen; capacity and workforce constraints impact waiting times

Mortality & medical risk in eating disorders

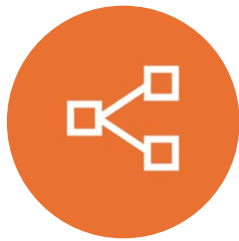
AN has the highest mortality among psychiatric disorders; suicide and medical complications are leading causes

Meta-analysis: SMR ≈ 5.9 for AN; ≈ 1.9 for BN and EDNOS (Arcelus et al., 2011)

MEED guidance: structured risk assessment, higher-calorie refeeding protocols with monitoring for refeeding syndrome

(Micali & Herle, 2023)

Overlaps with other mental health conditions



OCD:



ANXIETY



DEPRESSION



GUILT AND
SHAME

ANOREXIA



Clinicians' perspective

Claudino et al (2019) compared clinicians' diagnosis of different eating disorders between ICD-10 and ICD-11

No difference in AN

Clinicians more likely to classify Binge Eating disorder as Obesity using ICD-10

Treatments and rehabilitation

Differentiated across the subtypes

- Also depend on the severity and impacts on the person's psychological and physical health

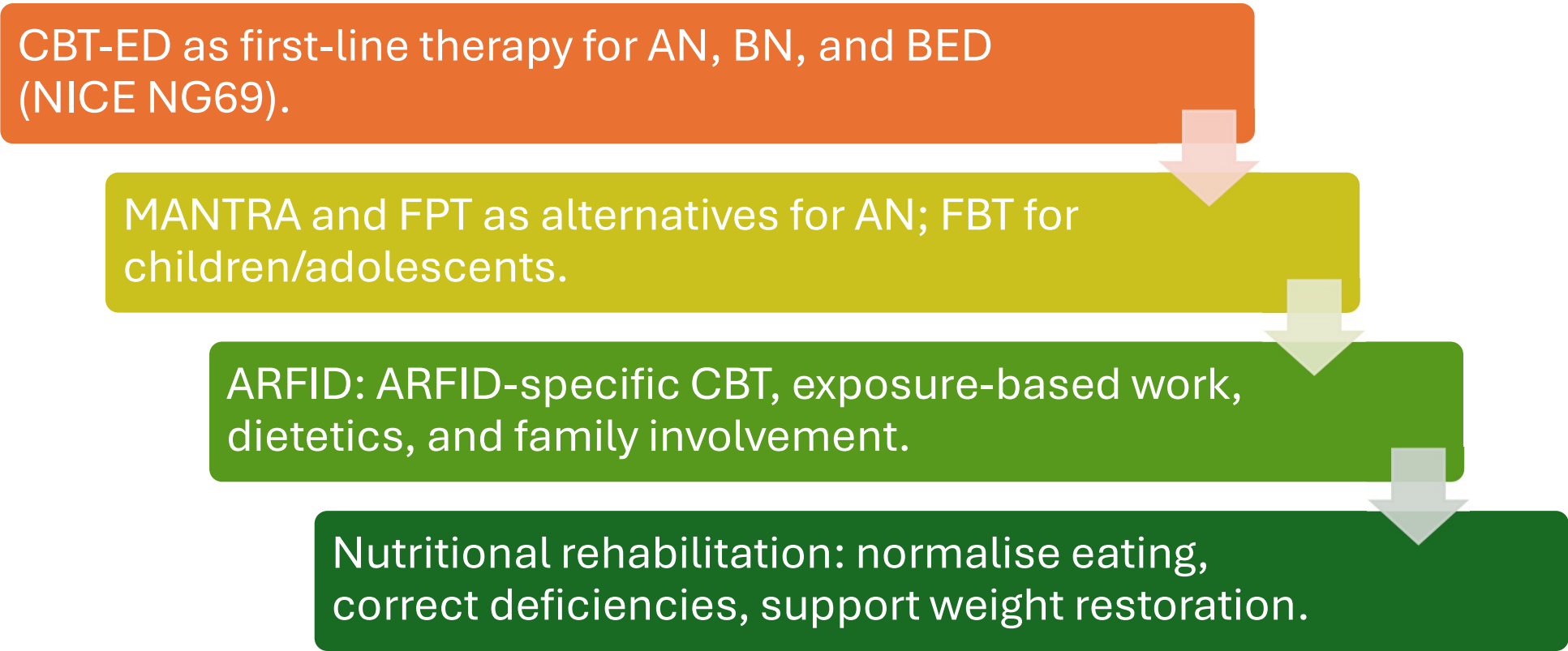
In severe cases, medical interventions may be risky as the body been worn down by malnutrition or acid damaged

Core Principles of Treatment (ICD-11 & NICE)

- Early intervention improves outcomes across ICD-11 eating disorders.
 - Multidisciplinary care: psychology, psychiatry, dietetics, paediatrics, nursing.
 - Medical risk–led approach using MEED (Medical Emergencies in Eating Disorders).
 - Care should be age-appropriate, culturally aware, and tailored to developmental needs.
- 

Psychological & Nutritional Treatment Approaches

CBT-ED as first-line therapy for AN, BN, and BED (NICE NG69).



```
graph TD; A[CBT-ED as first-line therapy for AN, BN, and BED (NICE NG69).] --> B[MANTRA and FPT as alternatives for AN; FBT for children/adolescents.]; B --> C[ARFID: ARFID-specific CBT, exposure-based work, dietetics, and family involvement.]; C --> D[Nutritional rehabilitation: normalise eating, correct deficiencies, support weight restoration.];
```

The diagram consists of four colored rectangular boxes arranged in a descending staircase pattern from top-left to bottom-right. The boxes are orange, yellow-green, green, and dark green. Each box contains text describing a treatment approach. Downward-pointing arrows connect the bottom-right corner of one box to the top-right corner of the next box below it.

MANTRA and FPT as alternatives for AN; FBT for children/adolescents.

ARFID: ARFID-specific CBT, exposure-based work, dietetics, and family involvement.

Nutritional rehabilitation: normalise eating, correct deficiencies, support weight restoration.

Medical Monitoring, MEED & Inpatient Care



Medical monitoring (vitals, ECG, hydration, electrolytes)



Refeeding syndrome prevention (monitor phosphate, potassium, magnesium)



MEED traffic-light system to identify medical instability.



Indications for inpatient/day patient care: medical risk, suicidality, failure of outpatient care.

Find out more about feeding or eating disorders

- Each group focuses on one feeding or eating disorder
 - What is the prevalence in the UK ?
 - What rehabilitation and care is available?
 - What is the recovery rate ?
 - Can you locate any Case study or personal experience/account?
- Where would be a good starting point for the above information?
- Report back to the whole class



Causes of feeding or eating disorders

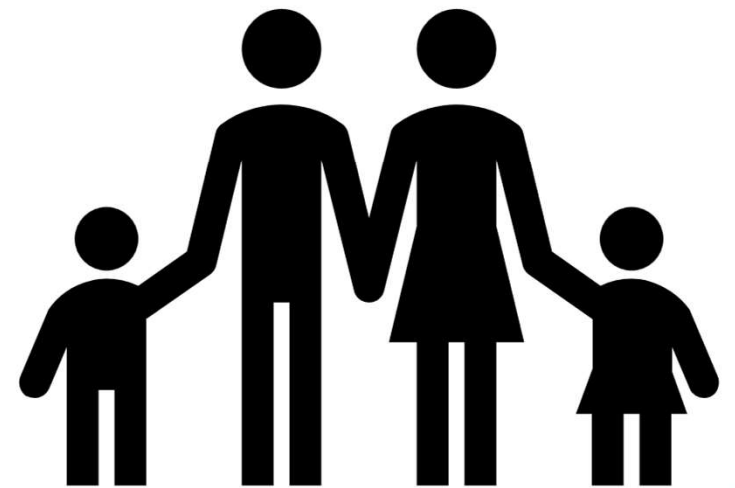
- The reasons explored on the following slides have been put forward as causes of feeding or eating disorders
 - Some are more specific to a particular subtype.
 - Past literature focused more on females with eating disorders therefore some of the causes likely to be gender specific.



Genetic factors

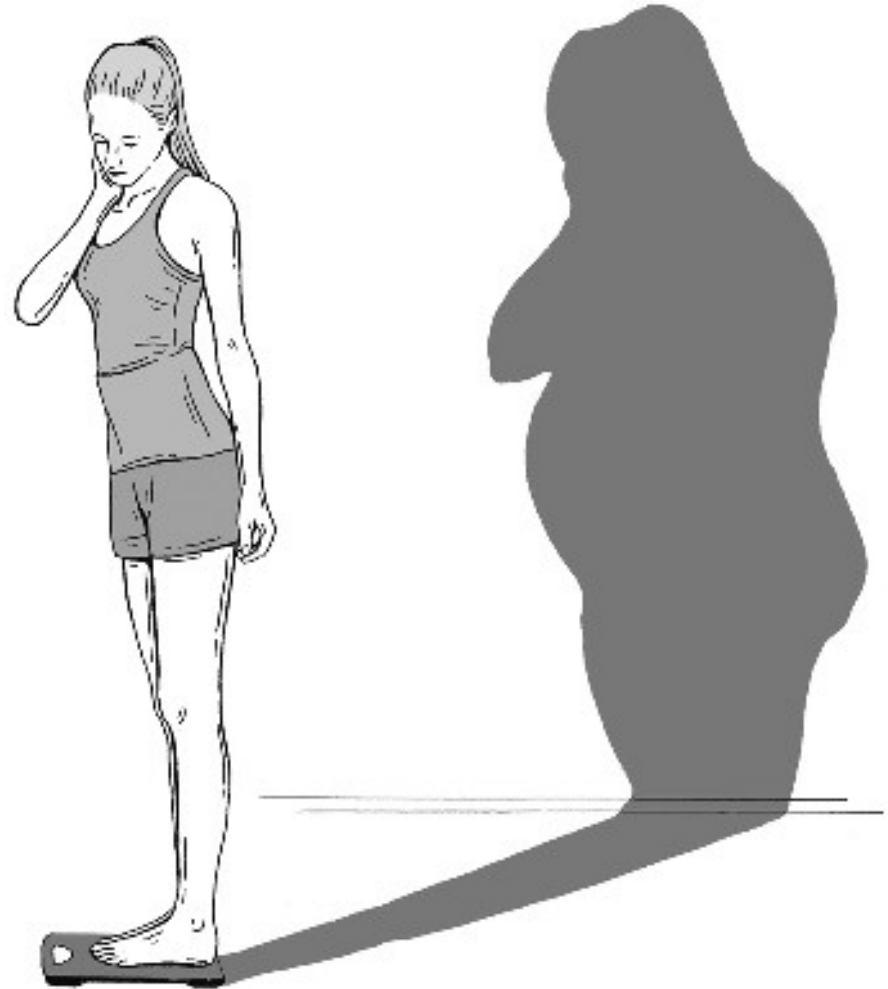
Family links:

- Anxiety and compulsion/obsessive elements commonly shared in family members with eating disorders, OCD and autism.



[Secretly starving: inside the virtual world of anorexia \(telegraph.co.uk\)](http://telegraph.co.uk)

Distorted perception of body image



Measuring perception of body image

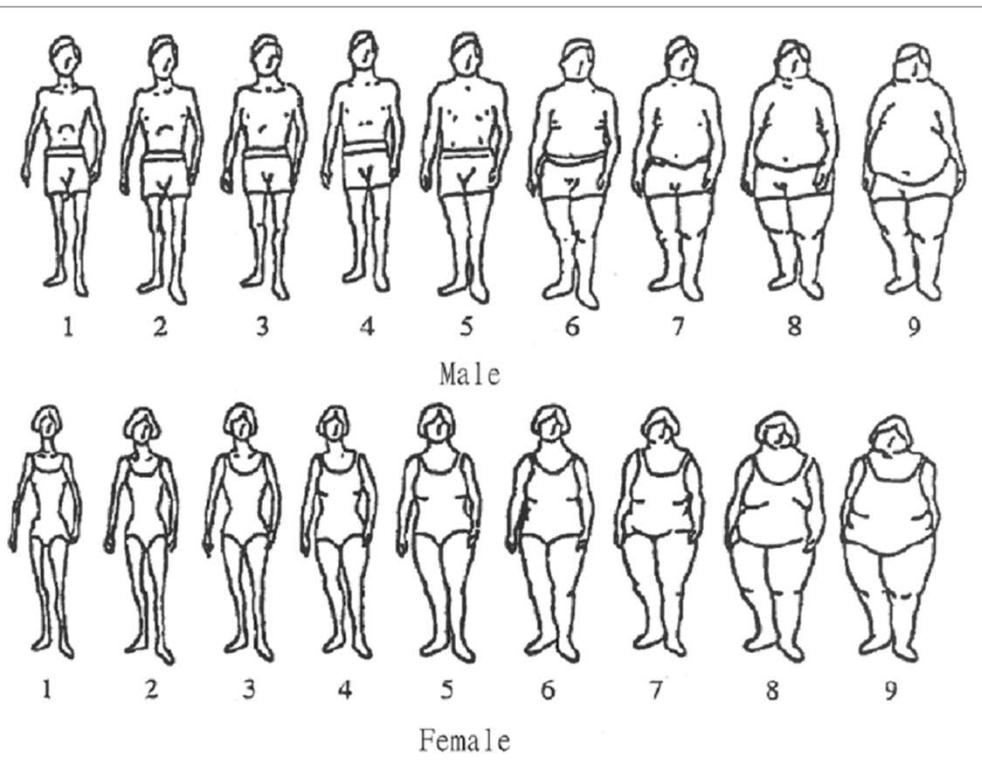
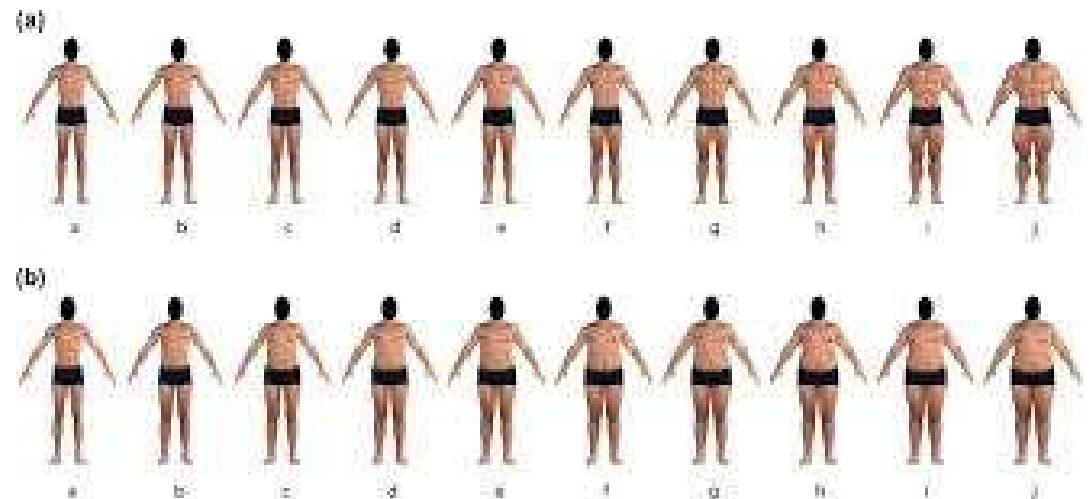


Figure rating scale (Stunkard, 1983)

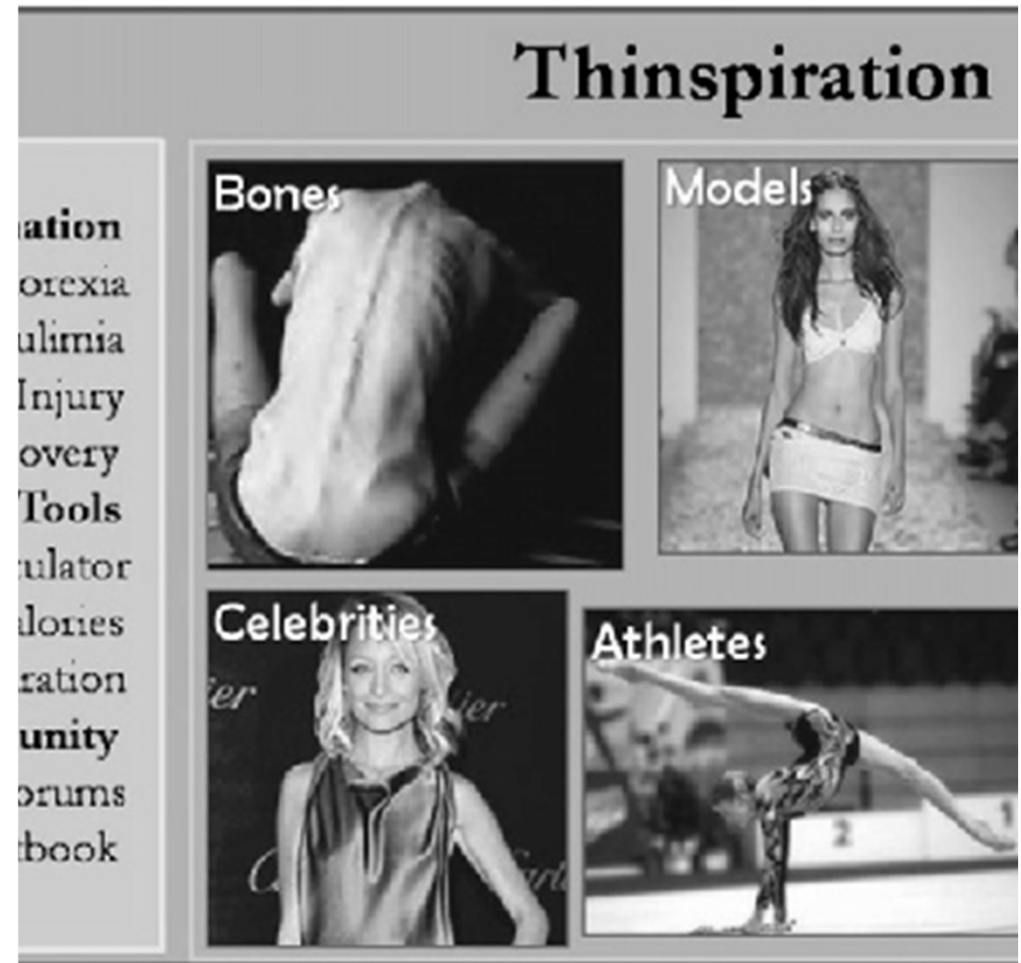
Stunkard's Figure rating scale (1983) has been used to measure perception of body image. Tendency to over rate body shape on the larger side



Visual Body Scale for Men (VBSM) (Talbot, Cass & Smith, 2019)

Media influence

- Often individuals in the media are publicly praised or shamed depending on their body size and dimensions.



Sense of control

- Associated with a tendency for perfectionism
- Counting and controlling calories intake
- Holding off puberty and entering adulthood



This Photo by Unknown Author is licensed under CC BY-SA

Emotional regulations

- Eating not triggered by hunger
- Emotional eating is related to obesity
- Vicious circle in comfort eating, feeling worse after eating and further eating



Is ICD-11 more inclusive or too expansive?

ICD-11 shifts many patients who were previously “residual/restrictive ED (rrED)” into full-threshold diagnoses, especially AN or ARFID.

Concerns include:

- whether this reduces diagnostic specificity
- whether it improves access to treatment
- whether it inflates prevalence artificially.

Search for information and present your findings to the class



Key sources (policy & guidance)

- NHS England (2024) Commissioner guidance for adult mental health rehabilitation inpatient services
- GIRFT: Mental health – rehabilitation national report & programme pages
- DHSC/NHSE (Jan 2024) Discharge from mental health inpatient settings – incl. Annex on Section 117 after-care

Key sources (clinical & epidemiology)

- NICE NG69 Eating disorders (2017; exceptional surveillance May 2024)
- RCPsych CR233 MEED (2022; updated Dec 2025)
- Beat Media Centre statistics; NHS Digital 'Mental Health of Children and Young People in England, 2023 – Part 5'
- Arcelus et al. (2011) meta-analysis on mortality in eating disorders; Micali & Herle (2023) editorial



This Photo by Unknown Author is licensed under CC BY-NC