A strategy for rehabilitation for older people in Ireland

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Introduction

A modern healthcare system must do more than just stop people dying. It needs to equip them to live their lives, fulfil their maximum potential and optimise their contribution to family life, their community and society as a whole.

Rehabilitation is a set of interventions designed to optimize function and reduce disability in individuals with health conditions in interaction with their environment (WHO)[1]. This is achieved by focusing on the impact that the health condition or disability has on the person's life, rather than focusing exclusively on their diagnosis. It involves working in partnership with the person and those important to them so that they can maximise their potential and independence, and have choice and control over their own lives.

It is a philosophy of care that helps to ensure people are included in their communities, employment and education. It is increasingly acknowledged that effective rehabilitation delivers better outcomes and improved quality of life and has the potential to reduce health inequalities and make significant cost savings across the health and care system.

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Older people key and largest group requiring rehabilitation

Older people have an increased likelihood of functional decline due to increasing levels of multi-morbidity affecting them in a significant number of ways, which in addition neurorehabilitation includes musculo-skeletal, cardio-respiratory elements, etc, such as:

- recovery from unexpected illness – such as acute admission to hospital following a stroke, surgery, a fall, chest infections and cardiac events
- managing long-term conditions – when people with a long-term medical or conditions affecting function become unexpectedly ill or have an exacerbation, they benefit from rehabilitation intervention to help them regain or maximise their independence
- self-managing conditions – people with a long-term condition are enabled to manage their own health and reduce the risk of developing secondary problems affecting either their mental or physical health, such as loss of strength and cardiovascular fitness, contractures, pressure ulcers, pain, anxiety and depression
- recovery from major trauma – in particular after falls and fractures, rehabilitation helps people to regain and maximise their skills and independence
- maintaining skills and independence – for progressive conditions (such as dementia, motor neurone disease and terminal cancer), early diagnosis, assessment and rehabilitation intervention can help people to maintain their skills and independence for as long as possible
- access advocacy – people who are vulnerable and need support (such as those with cognitive impairment or communication difficulties) are offered advocacy as part of their rehabilitation package

In addition, multi-morbidity and intercurrent illness represent a further degree of complexity in the rehabilitation of older people, as well as an understanding of wider societal issues, such as ageism, which impact on service provision and delivery. There has been an inadequate provision of rehabilitation services for older people to date, arising from a lack of a policy framework for geriatric rehabilitation, a lack of available geriatric medicine, gerontological nursing and health and social care professional (HSCP) resource, and determination of rehabilitation pathways based upon financial considerations rather than patients' needs[2]. There is also evidence that there are significant harms occurring to older people from widespread use of ill-defined 'convalescence/ step-down/post-acute care' with indeterminate staffing, skills and governance[3].

Developing age-attuned rehabilitation

Geriatricians represent the largest group of specialist physicians in Ireland with formal training in rehabilitation, and have prepared this policy document with a view to providing a spectrum of appropriately skilled and staffed rehabilitation services to maximise the health and well-being of older Irish people. In addition, dual training in internal and geriatric medicine equips geriatricians to effectively manage common co-morbidities (pneumonia, heart failure, delirium, diabetes, etc.) commonly accompanying rehabilitation of older people.

Rehabilitation services for this group have suffered from a lack of focus and consistency in official policy, in turn affecting the services and support offered to older Irish people and their families. This is reflected in the continued use of vague and unhelpful terms such as "convalescence/step-down/reablement" for what should clearly be defined as rehabilitation.

This strategy is developed to move beyond this lack of focus and to be consistent with national strategies and policies, including The Years Ahead[4]; the National Positive Ageing Strategy[5]; Sláintecare[6]; national policies for stroke[7], dementia[8], trauma[9] and HSE Health Service Capacity Review[10]; as well international best practice and scholarship. It should be seen to be complementary to the national strategy for the provision of neurorehabilitation services[11].

The scope and breadth of rehabilitation for older people

Rehabilitation intervention is provided in the primary care setting, in the acute hospital setting (during an inpatient episode or as an outpatient referral) or in the community. The breadth of rehabilitation means that a range of organisations may contribute to meeting a person's individual needs, including the HSE, local authorities, user-led and community groups, and independent and charitable organisations. This spectrum of activity is well-suited to the roll-out of integrated care across primary and secondary by geriatric medical services in Ireland[12].

Rehabilitation intervention is essential in helping to address the impact of:

- physical or movement problems – such as impaired motor control or loss of limbs;
- reduced balance, strength or cardiovascular fitness; for older people the syndromes of sarcopaenia and frailty are important in this regard
- fatigue, pain or stiffness
- sensory problems – such as impairment of vision or hearing; pain
- loss of or altered sensation of touch or movement
- cognitive or behavioural problems – such as lapses in memory and attention difficulties in organisation, planning and problem-solving
- communication problems – such as difficulties in speaking, using language to communicate and fully understanding what is said or written
- psychosocial and emotional problems – such as the effects on the individual, carer and family of living with a long-term condition. These can include stress, depression, loss of self-image and cognitive and behavioural issues
- medically unexplained symptoms – where a holistic approach is needed to ensure the best possible support for both mental and physical wellbeing
- mental health conditions – such as anxiety and depression, obsessive/compulsive disorders, schizophrenia, post-traumatic stress disorder and dementia
- loss of capacity and vitality
- malnutrition
- swallowing disorders

Although it is often attributed to the end of a treatment pathway, rehabilitation intervention can have significant impact as a preventative measure. For example:

- exercise post-stroke has been shown to reduce the risk of further vascular event
- rehabilitation intervention reduces the risk of coronary heart disease and then reduces the risk of further events

If accessed at an earlier stage in the pathway, prehabilitation intervention (such as prior to surgery) can improve functional outcomes, reduce length of hospital stay and enable timely return to work or occupation. Schemes such as Exwell provide a very appropriate form of socially supportive exercise and stimulation.

Both prevention and prehabilitation are powerful tools for achieving a good outcome for individuals. They also reduce health inequalities, the cost of healthcare and give an increased return on investment in rehabilitation.

Model of rehabilitation

Effective rehabilitation takes a holistic and individualised approach. This is because two people with the same diagnosis may have very different abilities and needs because of a complex interaction between their health conditions, the environments they live in, their values and beliefs, and their aspirations and motivations.

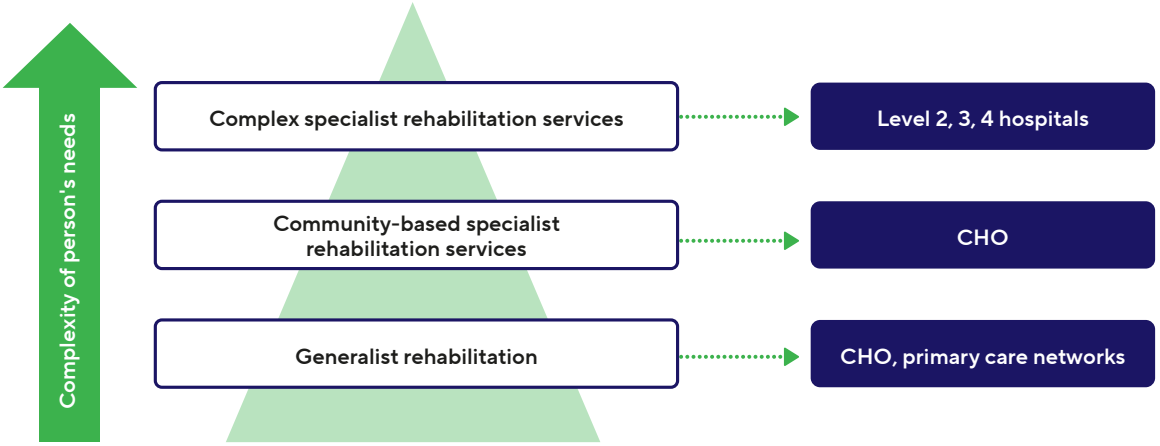
The interaction between an individual's mental and physical health is also key, with one having the potential to significantly affect the other. A "biopsychosocial model" has been developed by the World Health Organisation to capture the complexity of this approach. The International Classification of Functioning Disability and Health (WHO ICF) provides a way of describing and classifying the continuum of human functioning. It should be applied to the clinical approach as a framework for analysing and classifying needs, planning holistic care and monitoring progress and outcomes.

Multi-professional, coordinated rehabilitation intervention is essential because it gives improved physical, social and emotional functioning and wellbeing, resulting in the creation of "healthy time".

This strategy aligns with Irish and UK rehabilitation models in proposing an interactive spectrum of services between geriatric rehabilitation services in Level 2, 3, and 4 hospitals, community specialist teams, primary care and general rehabilitation services (Figure 1). It is recognized that certain highly specialized aspects, such as severe brain or spinal cord injuries, or low awareness states, will be referred to the tertiary neurorehabilitation centre. Some community-based programmes are under joint hospital and CHO governance.

FIGURE 1

Rehabilitation services for older people in Ireland



The expectations of good rehabilitation services

1. I have knowledge of, and access to, joined up rehabilitation services that are reliable, personalised and consistent
2. My rehabilitation will focus on all my needs and will support me to return to my roles and responsibilities, where possible – including work
3. My rehabilitation experience and outcomes are improved by being considered by everyone involved with my health and wellbeing working in partnership with me
4. My rehabilitation supports me and gives me confidence to self-care and self-manage, making best use of developing technologies and stops me being admitted to hospital unnecessarily
5. The goals of my rehabilitation are clear, meaningful and measured and there is recognition that my goals may change throughout my life
6. My rehabilitation supports me in my aspirations and goals to reach my potential
7. I can refer myself to services easily when I need to and as my needs change
8. There is a single point of contact available to me where there is the knowledge and skills to help me
9. People who are important to me are recognised and supported during my rehabilitation
10. I am provided with information on my progress as I need it and information is shared, with my consent, with those who I agree are involved in my rehabilitation

Developing complex geriatric rehabilitation – acute hospitals

Frail older people are at an increased risk of functional decline related to acute illness and hospitalization. Some of this decline is already present at hospital admission[13], and as many as 40–50% of frail older people are discharged from hospital with an even greater dependency in Activities in Daily Living than pre-admission[14]: at three weeks some recovery has occurred but they have not returned to baseline[15].

Effective rehabilitation relies on a coordinated strategy, and acute rehabilitation is an important success factor for improved outcomes. For example, geriatricians have been the largest group of specialists engaged in the provision of stroke services in Ireland, with a model that encompasses early rehabilitation alongside hyperacute services, as well as the development of effective early supported discharge[16]. This model is replicated in both general geriatric medical services[17], and orthogeriatric services[18], now seen as a key quality indicator of trauma orthopaedic services.

Given their active clinical input into a range of services requiring rehabilitation – general internal medicine, geriatric medicine, stroke services, orthogeriatrics, surgical and oncology liaison – geriatricians are well placed to coordinate rehabilitation needs arising from the general hospital. Through their expanding integrated multi-discipliinary care services (ICPOP) with the community they are also well placed to coordinate rehabilitation needs arising from the community. Ideally these coordinating roles should be formalized with appropriate clerical/admin support within current CHO/hospital network structures, and in future with any reorganisation arising from Sláintecare.

The transitions will be facilitated by urgent implementation of interRAI, the common assessment tools of needs of older people in community, hospital and residential care setting adopted as a national standard by the Department of Health in 2010, as well as ensuring that the ICT systems in each sector can work seamlessly across the spectrum of care.

Developing complex geriatric rehabilitation – dedicated rehabilitation units

Liaison onward to rehabilitation units in level 2 hospitals has been an integral part of many of these services, and the staffing benchmarks of the national neurorehabilitation services, as well as national and international guidelines are of assistance in developing staffing guidelines[19].

Patients require ongoing medical, rehabilitation and nursing care following acute hospital admission. It is anticipated that the acute and complex care during their general hospital admission has been stabilized to the greatest extent possible. A significant minority will develop intercurrent illness which requires transfer back to the general hospital[20]. People in these beds require the presence of a multi-disciplinary team, including geriatric medical, ANPs Older Persons, CNS and a HSCP team (at staff, senior and Clinical Specialist levels) including at a minimum physiotherapy, occupational therapy, speech and language therapy, dietetics, social work and pharmacy on at least a consistent 5 day a week basis – admission pathways from both acute and community, as well as robust arrangements for out-of-hours medical cover. The intensity of medical complexity admitted will related to the NCHD/GP out of hours cover. Access and liaison with a range of services is also required, including but not limited to psychiatry of old age, psychology and dentistry.

Rehabilitation is a progressive, dynamic, goal-oriented process, which enables an individual with impairment to identify and reach his/her optimum mental, physical, cognitive and social functional level.

Inpatient rehabilitation for older adults involves multi-disciplinary programme to maximise a person's level of independence prior to discharge and advise on, or arrange the discharge plan. Patients occupying rehabilitation beds should be clinically fit for rehabilitation ie. have the ability to tolerate a structured rehabilitative programme. Outcome is related to the intensity of therapy provided[21].

Patients will be admitted directly from the acute hospital once their acute episode of care is completed, in order to maximise their potential to return home/minimise their readmission to hospital. Medical staffing should be aligned to national and international standards or best practice*[22/23]. There is evidence to show that 15-20% of inpatients in these rehabilitation settings become medically decompensated during their rehabilitation episode. Therefore clinical governance structures with NCHDs under the supervision of a Consultant Geriatrician/ Rehabilitation Physician available through a rota on a 24 hour basis are important in supporting the care of patients in these settings.

The profile of patients who benefit from this service include:

- Those who have a loss of function due to medical illness or decline in health;
- Are at high risk of further functional decline, acute hospital admission or admission to long term care due to this functional loss
- Those that have restorative potential to regain lost function
- Access can be from hospital or home
- Discharge planning will form a major part of the patients care plan to ensure effective and successful discharge processes.

The physical environment should promote a 'Non clinical' ambiance with emphasis on home from home design, dementia friendly environment, single rooms with access to a double room for couple assessment/patient and carer assessment pre discharge and include a access to a rehabilitation gym sufficiently large enough to accommodate the number of patients in the unit requiring rehabilitation, sited in the ward area or immediately adjacent. The gym should have appropriate strengthening, balance and gait equipment, OT kitchen & patient computer, including tablets, laptops and PCs to suit the individual requirements and mimic home, in addition to access to an outdoor area for gait and functional training. Shared dining and social spaces are important in rehabilitation settings to encourage interaction, mobility and reintegration.

Patients should have access to therapy at least 5 days per week for it to be considered rehabilitation in these facilities. Outcome is related to the intensity of therapy provided[24].

* For example, in 2007, GTA Toronto noted 0.5-1.0 WTE physician per 20 beds; Australian guidelines recommend 0.8-1.25 consultant, and associated RMO/junior doctors

Calculating the number of rehabilitation beds required is challenging. One needs to ensure that each geographical area's needs are met. Establishing the number of rehabilitation beds required in each local area requires a specific needs assessment taking into account many factors including; increased life expectancy and the growing number of people living alone.

The MDT should develop a discharge plan within the first few days after admission which will be reviewed by the team at regular intervals of 1-2 weeks to assess progress, revise goals and affect a discharge plan with the family and community services. All disciplines should be included for an effective multidisciplinary team and have access to therapy assistant grade staff, clerical support, ICT and other services where indicated. Rehabilitation may continue post discharge in a more appropriate setting eg. specialist community rehabilitation teams.

The staffing for 20 bedded units should include:

We recommend that current national recommendations should mirror those for 20 bed post-acute specialist rehabilitation unit in the national strategy for the provision of neurorehabilitation services[11]:

Staff in WTE	2012 NCPOP in-patient rehabilitation[25]	Recommended revised 2022 ISPGM
Consultant		2
Medical		1.5
Nursing		As determined by Nursing Hours Per Patient Day (Safe Staffing Framework)[26]
ANP		1
CNS		3.7
Physiotherapy	2 Senior, 2 Basic	5.5*
Occupational Therapy	2 Senior, 2 Basic	5.5*
Speech and Language Therapy	1 Senior, 1 Basic	2.5*
Social Work	Access	2*
Clinical Nutrition	1 WTE	1*
Pharmacist		0.5
Podiatry	1 WTE	
Clinical Psychology		2*
Discharge planner/bed-manager		
Arts/music therapist		
Total	20.7	55

*a combination of clinical specialist, senior, staff grade and assistant staff as services evolve.

Other supports

Important linkages for the Rehabilitation Team include Old Age Psychiatry, Palliative Care, Podiatry, Orthotics, Audiology, Optometry and Dentistry.

Community Geriatric Rehabilitation Teams

Geriatric rehabilitation is a continuum of services and supports that will require appropriate responses at local and national level. Rehabilitation is a dynamic and critical component of the therapeutic continuum and one that is essential if patients are to regain or maintain their life roles and quality of life after serious illness or injury. It can improve health outcomes, reduce disability and improve quality of life. Specialist rehabilitation is the total active care of patients with a complex, disabling condition by a multi- professional team who have undergone recognised specialist training in rehabilitation, led or supported by a consultant trained and accredited in geriatric medicine medicine, with consistency in staffing and skilling in each form of service.

Generally, patients requiring specialist geriatric rehabilitation are those with complex disabilities. Such patients typically present with a diverse mixture of medical, physical, sensory, cognitive, communicative, behavioural and social problems, which require specialist input from a wide range of rehabilitation disciplines (e.g. gerontologically-trained nurses, physiotherapy, occupational therapy, speech and language therapy, psychology, dietetics, orthotics, social work etc.) as well as specialist medical input from consultants trained in geriatric medicine, old age psychiatry, rehabilitation medicine, neuropsychiatry and other specialities.

Community based specialist geriatric rehabilitation teams (CGRTs) require a degree of specialisation and training that will enable them to provide services to people with complex presentations, such as:

- those who require a degree of specialised input beyond that available from a primary care team;
- those who require a level of intensity of therapeutic input that is not possible from a primary care team;
- those who do not require in-patient facilities, but do require high-intensity geriatric rehabilitation inputs;
- those who need to transition from hospital to home (who have geriatric rehabilitation needs), and in particular developing the concept of appropriately supported discharge to assess schemes.

This model of practice for community geriatric rehabilitation teams has been developed upon review of existing models currently operational across the country and ideally governance is integrated closely with the in-patient geriatric rehabilitation services. While there may be variance across some CHO's with respect to how these models of practice are implemented, the general principles should not be subject to interpretation, these are;

- Interdisciplinary team working
- Moderate to high intensity rehabilitation inputs
- Individualised rehabilitation programmes based of service users identified goals
- Measurement of outcomes
- Service based on assessed need

It should be noted that recommendations made in this document are made with the following assumptions in mind;

- An appropriately resourced PCT with universal access i.e. not dependent on age/ medical card etc
- Access to essential supports including; Respite (at home or institutional), Residential services, Day services, Family/carer supports, Self management supports, Public Health Nursing
- The links to these services need to be explicitly described within each CNRT
- Links with mainstream services need to be developed for example, local gyms etc to support maintenance of function and capacity, and community integration, or services such as Exwell
- Links to diagnostic services also need to be explicitly described

It is important to also recognise that the CGRT represents just one element of the pathway of care for those with geriatric rehabilitation needs and their effective operation is contingent on the availability of specialist community geriatric rehabilitation services, as well as appropriately resourced primary care and disability services. In addition, the development of other specialist services with the managed geriatric rehabilitation network (MGRN) including acute and post-acute inpatient rehabilitation services is critical to enable CGRTs to operate effectively within a continuum of care.

Key Features of a Community Geriatric Rehabilitation Team

- The multi-professional team has undergone recognised specialist training or with significant clinical experience in geriatrician-led or supported by a consultant trained and accredited in Geriatric Medicine.
- Smaller caseload allowing for more intensive input
- Clinically led with clinical and professional supervision
- A co-ordinated inter-disciplinary team-working towards an agreed set of goals
- Take patients who initially have more complex rehabilitation needs than non-specialist services
- Clinical data as defined by interRAI, the national standard for needs assessment for older people, are routinely collected and reported annually for all patients
- Meet the national standards for specialist geriatric rehabilitation services as developed by the Integrated Care Clinical Programme for Older People.
- Support local rehabilitation teams in hospital and community
- Have a recognised role in education, training in the field of rehabilitation.
- Access to clinical space (i.e. rehabilitation gym with appropriate equipment) for delivering rehabilitation interventions.

Therapeutic programmes are typically interdisciplinary and of moderate intensity for patients with an identified need for specialist rehabilitation. Community specialist geriatric rehabilitation teams form a critical link in the care pathway by facilitating early discharge and continuity of therapy from acute and post-acute rehabilitation facilities; may also assess and making recommendations on vocational options such as returning to work, educational and occupational activities, and liaison with rehabilitative training services, given increasing occupational activity among older people.

There is a wide breadth of services delivered in the community which play an essential role in maintaining the health & wellbeing of those with conditions causing loss of function in later life and ensuring that the gains made through engagement with clinical services are maintained and generalised into their everyday life. The role played the Voluntary Organisations and Primary care is paramount in this regard.

Community Geriatric rehabilitation teams and those providing community geriatric rehablitation supports should work in tandem with clear lines of communication and clear referral pathways to ensure each patient receives the supports they require across the continuum of care in a coordinated collaborative way.

Geriatric Rehabilitation Continuum of Care

The multi-tier model of levels of complexity of need forms the basis for the provision of specialist rehabilitation services in the UK and Ireland (Figure 1). It is a model that translates well into the Irish context.

Every service provided within this continuum of care play an essential role in the rehabilitation and ongoing support of the individual with a geriatric rehabilitation needs. The success of each intervention is in many ways dependent on the appropriate flow through the continuum of care and availability of services at each level.

The community geriatric rehabilitation team plays a critical role in this continuum of care, however it is acknowledged that the intervention of such teams is for a relatively short period of time in the life time of the individual with the geriatric rehabilitation needs. Without appropriate links to longer term services, for many, the full benefit of the intervention of the CGRT may not be sustained over time.

It is for this reason that the Integrated Care Clinical Programme for Older People recommends to linkage with Integrated Care Programmes within each CHO with representation from all those providing geriatric rehabilitative supports. This forum should play a key role in;

- Triaging of referrals
- Joint assessment of need
- Identification of appropriate services & prioritization in relation to need
- Coordination of services to support smooth transition between and across services

Rehabilitation Setting;

- Home
- Health centre
- Residential setting

Each CGRT should have access to appropriate facilities to discharge their services including;

- Co-location of team to support MDT approach
- Access to appropriate equipment/appliances/aids to assess patients
- Administrative support
- Appropriate IT infrastructure including telemedicine/telehealth opportunities, with seamless integration of interRAI.

Hours of Service

The CGRT provides five days-a-week (Monday through Friday), 9am to 5pm treatment and care. Some services are available outside these times by pre-arranged appointment.

Referral pathway

Referrals are received from;

- Acute hospitals
- Other rehabilitation units
- Stroke rehabilitation services
- Primary Care
- GP
- Voluntary Service Providers
- Self-referral
- Neurologists
- National Rehabilitation Hospital

Admission Criteria

The person being referred must:

- Have a diagnosis for their loss of function that is acquired or progressive
- Be determined as having to potential to benefit from specialist geriatric rehabilitation
- Have rehabilitation needs which can be met by the CGRT.
- Be able to benefit from and participate in an intensive period of rehabilitation
- Be medically stable
- Be able to access transport to attend the service (if being treated in a centre)
- Be in agreement with the referral to the team
- Be able to attend at least twice a week for up to a maximum of 12 weeks

Discharge Criteria:

Discharge from the CGRT will be progressed when;

- The person is deemed to have received maximum benefit from the CGRT on completion of the rehabilitation programme
- The person has improved to the projected functional level that will allow discharge to PCCC or other specified environment or service
- The person experiences major intervening surgical, medical and/or psychological problems that precludes further benefit from a continuing with an intensive rehabilitation programme.
- The person is no longer willing to be an active participant in their rehabilitation programme.

Re- referral to the service:

Re-referral is treated as a new referral and acted on accordingly. If the referral is appropriate for the CNRT it can be open to primary care until a position becomes available in the CNRT. A screening questionnaire is sent to the client to determine goals for second period of rehab if they have attended before. If this is not returned, the referral may not be accepted.

If the previous rehabilitation period was not completed (e.g. due to illness) a new period of rehabilitation will be offered. Referral criteria apply as above.

Services provided for the patient

Case management/care coordination

- A case manager/care coordination is best described as the person who engages with and assists the person in coordinating appropriate environmental interventions and supports so that their activity and societal participation are optimised. The goals of case management/care coordination are to support the provision of quality health care along a continuum, decreasing fragmentation of care across many settings and enhancing the client's quality of life.
- It is proposed by the ICPOP that case management/care coordination is the approach required to complete the network of services for the population of individuals with specialist rehabilitative needs.
- The ICPOP sees a case manager/care coordinater as being a dedicated, distinct role within the Interdisciplinary Team. The case manager/care coordinater for those with specialist rehabilitation needs will have an overarching role in facilitation and co-ordination but with specialist education and training with respect to geriatric rehabilitation and those with complex needs following gerontological syndromes or illness.

- Assessment of physical, psychosocial and cognitive /perceptual skills through interview, observation, standardised assessment and liaison with family/carers and other members of the geriatric rehabilitation team
- Dedicated case manager
- IDT intervention which provides individualized evidence based patient focused therapy programmes which incorporate functional activities aimed to maximise independence and participation in the community
- Activities of daily living (ADL) assessment and training
- Specific task focused interventions
- Cognitive rehabilitation
- Physical Rehabilitation
- Community reintegration
- Coping with and adjustment to disability support
- Dysphagia assessment and management
- Independent living skills assessment & training
- Nutritional counselling and management
- Patient education, training and counselling
- Psychosocial assessment and psychotherapeutic intervention
- Safety awareness and training
- Self management supports
- Wheelchair assessment and seating provision
- Driving assessment
- Adaptive equipment and technology
- Podiatry
- Specific assessment for educational supports
- Linkage to Dental services

Services provided for the family/carer

- Education/training about management of condition causing loss of function/illness (formal education, printed resource material, instruction and practical skills training)
- Psychological support services
- Information about community support, advocacy, accommodation and assistive technology resources.

Discharge outcomes & environments/ essential supports

- Patients are discharged to the care of their General Practitioner and/or disability manager.
- The General Practitioner is invited to refer the patient back as outlined previously and patients encouraged to self-manage and request re-entry to rehabilitation as required.

Ongoing management of their condition can be through community rehabilitation supports such as those provided by the PCCC, Day Services, and Voluntary Organisations.

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