How to set up rehabilitation and recovery services in Ireland

Guide for consultants in rehabilitation psychiatry
produced by the Faculty of Rehabilitation
and Social Psychiatry,
Irish College of Psychiatrists, 2007

Occasional Paper OP64

Irish College of Psychiatrists
Coláiste Síciatraithe na hÉireann

Contents

Members of the Subcommittee of the Faculty of Rehabilitation and Social Psychiatry 4

Executive summary 5

Introduction 7

Developing a service model 9

Service philosophy 10

Defining the target groups of service users based on the needs of the local population 13

Interface between rehabilitation and recovery services and general adult psychiatric services 14

Interface between rehabilitation and recovery services and forensic psychiatric services 15

Guidelines on referral to rehabilitation and recovery services 16

Establishing the multidisciplinary team 18

Assessment of the needs of individual service users 20

Therapeutic interventions 24

Social exclusion and discrimination 29

Training and education programmes 31

Research 36

Service evaluation and audit 32

Conclusion 33

References 35

Appendix: Allied voluntary organisations 39

Members of the Subcommittee of the Faculty of Rehabilitation and Social Psychiatry

This subcommittee was established to develop a policy document for the Faculty of Rehabilitation and Social Psychiatry consultants in rehabilitation psychiatry on how to set up rehabilitation and recovery mental health services in Ireland.

Dr Ena Lavelle Chairperson of Faculty of Rehabilitation and Social Psychiatry, St Ita's Hospital/North Dublin Mental Health Services

Dr Catherine McDonough Secretary of Faculty of Rehabilitation and Social Psychiatry, Cavan/Monaghan Mental Health Services

Dr Michelle Brannigan Tipperary Mental Health Services

Dr Leona Spelman Clare Mental Health Services

Dr Ray Goggins Wexford Mental Health Services

Dr Darina Sloan Waterford Mental Health Services

Dr Michael Reilly Sligo Mental Health Services

Dr Michell Cahill Kildare Mental Health Services

Executive summary

The Irish government's new mental health strategy, *Vision for Change* (Department of Health and Children, 2006), includes in its mandate the development of specialist rehabilitation and recovery mental health services. To date, rehabilitation mental health services in Ireland have been associated with 'resettlement programmes' for long-stay patients with enduring mental illness who resided in psychiatric institutions. These programmes sought to resettle individuals in supported community residential homes but lacked an emphasis on active rehabilitation. Historically, rehabilitation services have developed in an *ad hoc* manner around the closure of large psychiatric hospitals. Consequently, they have been largely inaccessible to the majority of individuals with severe and enduring mental illness, who live in the community. This occasional paper highlights the need to move away from the historical perspective: the focus of modern rehabilitation and recovery services should be on an approach to service development that is centred on service users, that facilitates assessment of individuals' needs and that supports service users' own choices of life goals. Ready access for people with severe and enduring mental illness is crucial to the success of rehabilitation and recovery mental health services. These services should be comprehensive, and promote both social inclusion and movement towards independent living in the community.

The *Vision for Change* strategy incorporates the 'recovery perspective' into the development and implementation of modern mental health services in Ireland. This paper gives a useful definition of rehabilitation; it also outlines the background of the recovery perspective and provides some guidelines on how such a philosophy can be incorporated into a rehabilitation and recovery mental health service, and on how outcomes may be measured.

Rehabilitation and recovery mental health services in Ireland are at various stages of evolution. An important stage of setting up such a service is mapping out existing rehabilitation resources and infrastructures and identifying the various target groups who will need access to the service. Potential groups of service users are described and the interfaces between rehabilitation and recovery services and general adult mental health services and forensic mental health services are discussed. Consideration is given to how such services could work collaboratively together to meet the needs of service users with severe and enduring mental illness. The document includes guidelines for formal referral criteria for rehabilitation and recovery services.

Multidisciplinary rehabilitation teams are poorly developed in Ireland and existing rehabilitation services have been mainly based on a medical/nursing model of service delivery, with a lack of access for service users to interventions based on psychological, social or occupational therapy.

Clearly, rehabilitation and recovery services by their very nature should be based on a holistic approach. The paper includes guidelines on how to set up multidisciplinary rehabilitation and recovery teams, which are based on recommendations laid out in the *Vision for Change* strategy.

A comprehensive assessment of the needs of individual service users is an essential starting point to engaging them in the recovery process. The assessment procedure used in rehabilitation and recovery services is described, as are the most commonly used assessment tools.

There is a broad-based approach in relation to the therapeutic interventions used in rehabilitation and recovery services and these are outlined under the following headings: pharmacological, psychosocial and supported residential programmes.

People with enduring mental health problems commonly experience prejudice and discrimination in accessing employment and housing, which in turn results in social poverty, which further excludes them from society. People with enduring mental illness should have the same rights and opportunities that are available to non-disabled citizens. Promoting access and inclusion is important in improving a person's health as well as social functioning. However, people with enduring mental illness still have difficulty accessing the support they need to avail themselves of housing and employment opportunities. Rehabilitation and recovery services have a key role in helping people with enduring mental illness to gain access to housing, employment and social/leisure activities, through developing formal links with vocational training bodies, employment and housing authorities and linking closely with allied voluntary bodies.

Staff training and education have been identified in the *Vision for Change* strategy as an essential part of the process of improving services. Developing modern rehabilitation and recovery services will involve education and training programmes that facilitate the incorporation of the 'recovery perspective' into clinical practice. It will also require the training of mental health professionals in the various assessment procedures and therapeutic interventions that are relevant to such a service. The development and funding for such training programmes should be established on a secure basis, as outlined in the new mental health strategy.

There are currently no patient data available to inform the planning of comprehensive rehabilitation and recovery services that offer a range of provision, from in-patient, intensive continuing care and short-term rehabilitation to community rehabilitation services, and that meet the needs of the various target populations on a national level. A national survey of long-stay psychiatric patients and new long-stay patients should be undertaken as an aid to planning a comprehensive system of care for people with severe mental illness. This should be supplemented by focused epidemiological studies to identify unmet need in the community, including the need for high-support community residential provision. The Faculty of Rehabilitation and Social Psychiatry of the Irish College of Psychiatrists has set up an academic subgroup which will encourage research relevant to rehabilitation and recovery mental health services.

This occasional paper indicates how rehabilitation and recovery mental health services should evolve in an era when the individual needs of service users with severe and enduring mental illness are pivotal. It provides a template to consultants in rehabilitation and recovery mental health services on how to set up such a service.

Introduction

The Irish government's new mental health strategy, Vision for Change (Department of Health and Children, 2006), incorporates the 'recovery perspective' into the development and implementation of modern mental health services. The Vision for Change strategy includes in its mandate the development of specialist rehabilitation and recovery mental health services; however, there is still a debate about what the role and scope of these services should be, particularly in relation to the interface with service users and carers, generic mental health services and other key stakeholders.

This occasional paper is designed as a guide on how to set up a rehabilitation and recovery service which is evidence based, incorporates the recovery perspective in its implementation, and is based on and adapted to the needs of the local population.

Background to rehabilitation psychiatric services in Ireland

Mental health services traditionally targeted the improvement of illness symptoms and maintaining the stability of the patient; the emphasis was on caring for groups of service users rather than enabling them to make independent choices on how to manage their illness and achieve their individual life goals. To date, community mental health services in Ireland have been based on community out-patient clinics, day hospitals, day centres and supported community residential programmes. However, individuals with severe and enduring mental health illness face challenges both in accessing rehabilitation services and in relation to housing, employment and social integration in their local communities. Many regularly experience social exclusion and discrimination and occasionally are at risk of becoming institutionalised within their own community. In order to address these issues, modern rehabilitation and recovery mental health professionals may need to step back and re-examine how their services are delivered in an Irish context.

Initially, the best role for specialist rehabilitation services in Ireland may be to provide tertiary mental health services for individuals with severe and enduring psychotic disorders and complex needs which cannot be adequately met at sector level. To date, rehabilitation psychiatry services have been associated with 'resettlement programmes' (i.e. transfer to supported community residential care) of long-stay patients with enduring mental illness who previously resided in psychiatric institutions. However,

many of these individuals have remained in supported community accommodation for prolonged periods and they have limited access to active multidisciplinary rehabilitation programmes in the community. Indeed, only a small proportion have succeeded in moving on into independent accommodation and reintegrating into their local communities. There are also still 'old long-stay' patients residing in psychiatric hospitals who are 'difficult to place' in supported community residential units owing to years of 'institutionalisation'.

Additionally, there is the phenomenon of the 'new long-stay' patient who becomes long-stay within the acute hospital system. Such patients are a heterogeneous group with a range of complex needs; they often exhibit challenging behaviours that make their care outside a hospital setting problematic (Lelliott *et al*, 1994; Holloway *et al*, 1999). New long-stay patients are often inappropriately placed in acute admission units, which are focused on managing acutely ill people and have a rapid patient turnover. These people are at risk of becoming institutionalised in a setting which clearly does not meet their needs. There are also people with severe and enduring mental illness who live in the community but who do not have access to active rehabilitation services. Many of these are also at risk of becoming institutionalised – in their own homes, as a consequence of their negative symptoms, such as self-neglect, social isolation and lack of motivation. These patients sometimes present in an acute crisis following the death of elderly parents or following the family's inability to cope with their illness and associated behaviours in the home.

The phenomenon of new long-stay patient groups has been related to the lack of development of community mental health services, particularly in relation to the development of multidisciplinary community mental health teams and community mental health infrastructure, despite the recommendations laid out in the previous mental health strategy, *Planning for the Future* (Department of Health and Children, 1984). The consequences of a lack of full implementation of that strategy have led to mental health services in Ireland being mainly based on a medical/nursing-led service, with a lack of access for mental health service users to psychological, social or occupational therapies. There is also a lack of access to a range of supported residential programmes for community rehabilitation, particularly in urban areas. Specialist rehabilitation and recovery mental health services are poorly developed in Ireland and have largely evolved in an *ad hoc* manner around the closure of large psychiatric hospitals and therefore these services are largely inaccessible to the majority of individuals with severe and enduring mental illness, who live in the community.

There has been a lack of forward planning with regard to the needs of people with severe and enduring mental illness, who will require access to a range of rehabilitation and recovery therapeutic interventions. There are no data available on the current and future needs of people with severe and enduring mental health illness who live in the community. There has been a lack of involvement with service users on how they would envisage their needs being met in future service development. These issues have to be addressed in order to plan the range of rehabilitation and recovery services that will be required. This occasional paper outlines a way forward.

Developing a service model

Developing a rehabilitation and recovery service model involves setting out a framework for a service plan. The plan should incorporate reviews and stipulate goals for service achievements. There needs to be a flexible approach both within local mental health services and on the part of stakeholders.

Key items in the framework include the following:

- service philosophy
- defining target groups of service users based on the needs of the population area
- interface with other service stakeholders (e.g. general adult services, forensic psychiatry and psychiatry of later life services, allied professional bodies and voluntary groups)
- the formal referral mechanism
- establishing a multidisciplinary team (including community rehabilitation teams, and staff supporting in-patient rehabilitation and supported community rehabilitation residential programmes)
- multidisciplinary assessment of the needs of individual service users
- individual needs-based therapeutic interventions
- advocacy
- team education and training programmes
- research
- service evaluation and audit.

Service philosophy

Developing a service philosophy in a rehabilitation and recovery mental health service is the first stepping stone. This can be done at local level initially, through discussion within the rehabilitation and recovery team, expanding this through input from the overall generic mental health service and in collaboration with service users, carers and other key stakeholders.

Killaspy *et al* (2005) state that a rehabilitation service can be characterised as:

> A whole system approach to recovery from mental ill health which maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support.

The recovery perspective

The recovery perspective was initially advanced by users of mental health services in the USA. The principle of recovery has been best defined by Anthony (1993), who described personal recovery as follows:

> a deeply, personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

These principles have been adopted by many modern mental health services, including those in New Zealand (Mental Health Act Commission, 1998, 2005), the USA (President's New Freedom Commission on Mental Health, 2003), the UK, with the National Service Framework for Mental Health (Department of Health, 1999) and the NHS Plan (Department of Health, 2000), and Ireland, with *Vision for Change* (Department of Health and Children, 2006).

Implementing a recovery perspective is one avenue in which mental health professionals can work alongside mental health service users in a new way, taking on a more individualised approach that includes some of the following components:

- developing hope-inspiring relationships
- facilitating personal adaptation (understanding, acceptance and taking back control)
- promoting inclusion (helping people to access the roles, relationships and activities that are important to them).

There has been criticism of the concept of recovery. What does it mean? Many people with a history of severe and enduring mental illness have fluctuating illness histories and experience significant levels of disability and complex problems which affect various aspects psychological, social and occupational functioning. Therefore, it is helpful to broaden the concept of recovery. A useful way of understanding it is to look at the user-defined model put forward by Repper & Perkins (2003):

- Recovery is not an end-point but a continuing journey – people are not 'recovered', they are 'recovering'.
- Recovery is not the same as 'getting better' – people are not recovering from illnesses, but recovering meaningful and valuable lives, whether or not their problems are eliminated.

Incorporating the recovery perspective at the onset in the development of a rehabilitation and recovery service is a way of focusing provision on a person-centred approach. Rehabilitation services should ideally be delivered in a holistic manner to enable individual service users to identify their strengths and to set out their life goals, taking into consideration their level of disability and associated problems. The delivery of rehabilitation services needs to be flexible and take into consideration the ever-changing needs of individuals with severe and enduring mental illness.

Wolfson & Cupitt (unpublished) adapted the following ten fundamental components of recovery, for the users of a London mental health service, from the national consensus statement on mental health recovery produced by the US Department of Health and Human Services (2006) and it may form a useful template for how to use these concepts in developing rehabilitation and recovery services.

1. People who use mental health services are encouraged to decide their own goals, and how best to achieve them.
2. There are as many pathways to recovery as there are people. The path individuals choose should be based on their strengths as well as their needs, their cultural background and experiences, including past trauma.
3. People who use mental health services need the authority to choose from a range of options and to participate in all decisions, including the allocation of resources that will affect their lives. They may need to be supported in making these choices not just by mental health workers, but by other service users as well, and to learn as individuals and collectively how to influence the way organisations and people respond to them.
4. Recovery involves an individual's whole approach to life, including mind, body, spirituality and community. It includes housing, employment, education, mental and physical health services, friends and family, as determined by the person.
5. Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from the experiences of oneself and others. The first stage is when a person recognises that positive change is possible. This gives a person confidence to take a recovery path.

6 Recovery focuses on valuing the worth of individuals. By building on strengths, a person may decide to take on new roles, such as caregiver, friend, student or employee.

7 Sharing experiences and learning about other people and communities play valuable roles in recovery. Service users can help each other to engage in recovery and provide a sense of belonging.

8 Promoting service users' self-acceptance and respect for others, protecting their rights and fighting stigma are all essential components of enabling recovery.

9 People who use mental health services need to have ultimate responsibility for understanding their experiences and deciding which strategies are most helpful to them in becoming and staying well. It requires effort and understanding to give meaning to their experiences, and courage to try new ways of doing things.

10 Hope is the catalyst of the recovery process. Treating oneself and others in the spirit of optimism is the most fundamental principle of the philosophy of recovery. Everyone reaps the benefits of the diverse contributions individuals with mental disabilities can make, ultimately creating a stronger and healthier community.

Two position papers – *A Common Purpose: Recovery in Future Mental Health Services* (Care Services Improvement Partnership, 2007) and *A Vision for a Recovery Model in Irish Mental Health Services* (Mental Health Commission, 2005) provide further guidelines on the recovery perspective for mental health services.

Measuring recovery

The DREEM (Developing Recovery Enhancing Environments Measure; still in an unpublished pilot version at the time of going to press) provides a user-led structure that enables services to measure their commitment to and effectiveness in providing recovery-based care. It focuses on service development and enhances collaborative work with service users.

In recent years, the importance of narrative enquiry as a method of research as well as a method of supporting recovery has been highlighted (Roberts, 2000, 2006). Brown & Kandirikirira (2006) described a study that examined over 60 'recovery narratives' in Scotland to establish the factors that helped and hindered recovery, and they highlighted helpful approaches to promote recovery narratives. Roberts (2000) has argued for the importance of narrative alongside and integrated with evidence-based medicine.

Defining the target groups of service users based on the needs of the local population

Rehabilitation and recovery services in Ireland are at various stages of evolution. Some emerged following the closure of large psychiatric hospitals and have a large number of supported community residential units, with groups of service users who are still largely dependent on the mental health services to meet their needs. Other services are still in the stages of closing down large psychiatric hospitals and have a mix of long-stay in-patients remaining in the hospital campus and clients residing in supported community residential units. And some community mental health services are starting up without a large psychiatric hospital base.

Therefore an important stage of setting up a rehabilitation and recovery service is mapping out the existing rehabilitation facilities that have been assigned to the service and identifying the various target client groups who will need access to it.

Wykes & Holloway (2000) described the potential group of service users for psychiatric rehabilitation as fulfilling the following criteria:

- they have active symptoms (e.g. hallucinations, delusions, high levels of anxiety or depression, negative symptoms of psychosis) and
- reductions in social functioning (e.g. breakdown of social relationships, reductions in the capacity for economic support) as a result of persistent mental illness.

Interface between rehabilitation and recovery services and general adult psychiatric services

Identifying the target group of service users is an important aspect of any service development. In general adult psychiatric services, the clinical case-load includes individuals who present with a range of psychotic disorders, and who are effectively managed within these services and the primary care services. Therefore, what role do specialist rehabilitation and recovery services have in relation to the interface with general adult psychiatric services? The answer is that they have a specialist role in addressing the needs of individuals with enduring psychotic disorders and complex problems, whose needs cannot be met at the level of the sector service, for example consultation in treatment-resistant psychotic illness, comprehensive assessment of needs using multidisciplinary input, provision of a range of supported in-patient and community rehabilitation residential places and links with vocational rehabilitation services. Communication and flexibility are key, as they allow fluidity within the various systems, so that people with enduring psychotic disorders can move within the overall generic mental health services in accordance with their needs and levels of disability.

An important aspect of this relationship between general adult mental health services and rehabilitation and recovery services is that individuals with enduring psychotic disorders who have specialist rehabilitation needs can access the rehabilitation and recovery service from the general adult service and in turn can move back to the general adult service when their needs are met, enabling them to remain socially integrated within their local community. It is generally acknowledged that there are individuals with enduring psychotic disorders with more complex needs, who may need to remain longer with the rehabilitation and recovery service. However, in order for specialist rehabilitation and recovery services to continue to be accessible to those with enduring psychotic disorders and complex problems, and who continue to present to mental health services following the closure of psychiatric hospitals, it is important to set up entry and exit care pathways from the rehabilitation and recovery services to the general adult mental health services. This way forward differs from rehabilitation mental health services in the past in Ireland, where once service users were referred and accepted to the rehabilitation mental health service, they usually remained within it.

Interface between rehabilitation and recovery services and forensic psychiatric services

Some service users within the population that an effective rehabilitation service should be targeting exhibit behaviours which constitute a significant risk to others, and some have a history of serious offending, raising the need for a forensic dimension to their assessment and care. Similarly, the population served by the forensic services with treatment-resistant illness and longer-term needs shares many similarities with the population served by rehabilitation and recovery services. Both populations require the skills developed within both rehabilitation and recovery and forensic mental health services to provide them with comprehensive, evidence-based treatment which maximises rehabilitation opportunities, with appropriate consideration of risk.

To date, it has been difficult for rehabilitation and recovery services in Ireland to access therapeutic secure facilities for individuals with severe enduring mental illness and complex needs and significant risk behaviours, particularly in urban areas, where often the need is greatest, because of lack of local provision. There has been an increased demand for residential care for offender patients who have long-term needs and this must be taken into consideration in an Irish context. The development of a regionalised model of forensic mental health services in Ireland with parallel infrastructure (e.g. medium-secure units) would enable access to and movement between forensic mental health services and rehabilitation and recovery services. In the UK, the development of forensic community teams has become the norm. However, community forensic services are not well developed in Ireland. This service gap should be addressed in order to enable a collaborative approach, between community rehabilitation and recovery services and community forensic services, to the provision of services that meet the needs of individuals with severe and enduring mental illness with comorbid forensic histories and complex needs who live in the community. There are clear interface issues here between local rehabilitation and recovery services and forensic mental health services, with a requirement for a sharing of competencies.

Guidelines on referral to rehabilitation and recovery services

The following are guidelines on inclusion and exclusion criteria for rehabilitation and recovery services. The precise criteria will depend on the needs of the target client groups and should be agreed at local mental health service level. Further, these criteria may change or evolve as the rehabilitation and recovery service develops and expands to include other diagnostic patient groups.

Inclusion criteria

People defined as having enduring psychotic disorders as a result of mental illness *and* who fulfil the following criteria.

- Ongoing symptoms (e.g. hallucinations, delusions, high levels of anxiety or depression, negative symptoms of psychosis).
- Reduced social functioning (e.g. breakdown of social relationships, reductions in the capacity for economic support).
- Needs not adequately met at sector level.

Exclusion criteria

- Under the age of 18 years or over the age of 65 years. (The adoption of this criterion in particular may depend on the needs of the local population and the needs of the individual referred.)
- Acutely unwell as a consequence of the mental illness.
- A primary diagnosis of learning disability.
- A diagnosis of dementia.
- A primary diagnosis of illicit substance misuse alone. (It is recognised that individuals with severe and enduring mental illness may have a comorbid diagnosis of illicit substance misuse, and in these cases flexibility may be indicated with regard to their accessing the rehabilitation and recovery service following a period of detoxification and stabilisation.)

Formal referral mechanisms

Specialist rehabilitation and recovery services are tertiary mental health services and therefore in setting one up it is recommended that a formal

referral mechanism is instigated; this can be developed at local level and based on local population needs.

The approach of the providers of rehabilitation services is usually initially focused on developing a therapeutic relationship with the referred service user, who often has a history of experiencing repetitive failures within the mental health services and society in general. For example, many experience frequent relapses in their illness related to a history of treatment-resistant illness with persistent psychotic symptoms, depression and anxiety, episodes of deliberate self-harm, non-adherence with medication, comorbid illicit substance misuse, behavioural problems, and low self-confidence and self-esteem and communication problems. Individuals with severe enduring mental illness also experience discrimination and stigma in accessing housing and employment and in their social interactions with others. They are commonly socially disenfranchised within their own communities. This pattern often leads to frequent prolonged admissions to psychiatric hospitals, which further isolates them from their communities. Therefore, a trusting therapeutic relationship may take a long time to establish, as an individual may not be ready to take that initial step when first referred to a rehabilitation and recovery service.

Psychiatric rehabilitation cannot be imposed. Psychiatric rehabilitation concentrates on the individual's rights as a respected partner and endorses his or her involvement and self-determination concerning all aspects of treatment in the rehabilitation process. These rehabilitation values are also incorporated into the concept of the recovery model (Farkas *et al*, 2005).

Outcomes of the referral process

Once a referral is made, the case should be discussed at multidisciplinary team level and a decision taken, following a period of assessment, on whether: to take up the referral within a rehabilitation service context; to liaise further with the referring team; or not to take up the referral. It is recommended that patients are informed of their referral to the rehabilitation and recovery service, that they understand the nature of the referral and that they give fully informed consent to it. It is also advisable wherever possible to inform the family or carers (with the patient's consent) of the referral.

Establishing the multidisciplinary team

The *Vision for Change* strategy (Department of Health and Children, 2006) outlines in its mandate recommendations for the core staffing of a rehabilitation adult mental health service. These teams should include the following:

- one consultant psychiatrist
- 10–15 psychiatric nurses for assertive outreach nursing teams (with a maximum case-load of 12 service users to one nurse)
- mental health support workers, sufficient for the numbers of service users who require such support, who can provide peer support and advocacy
- two occupational therapists
- two social workers
- two clinical psychologists
- one cognitive–behavioural therapist/psychotherapist
- one addiction counsellor
- additional staff
  - domestic skills trainer
  - creative/recreational therapists
  - administrative supporting staff associated with day centres and community residences.

The *Vision for Change* strategy recommends that three multidisciplinary teams be provided in a mental health catchment area of 300 000 (i.e. 1 per 100 000 population). A minimum of 39 teams are therefore needed nationally. Reallocation of existing staff to rehabilitation and recovery teams must ensure that the required training is provided to equip them with an understanding of the philosophy and the specialist skills embodied in a recovery-oriented service model.

The strategy further states that it is essential for a range of specialist resources to be made available to these teams and that the dedicated community mental health teams are required to coordinate and optimise the use of these resources. Each team should have a clearly identified clinical leader, team coordinator and practice manager. Since the core principle of rehabilitation and recovery is to help individuals reach their maximum level of independence, rehabilitation mental health services must be strongly person centred, with the needs of the individual service user always at the centre of the working team.

There are some key principles underpinning the functioning of a rehabilitation and recovery team outlined in the *Vision for Change* strategy:

- *Assertive outreach*. The central principle is the provision of individualised, focused and proactive care to service users, to minimise the risk of disengagement and to maximise involvement in the recovery process.
- *Person centred*. A person-centred, realistic recovery orientation should be evident in detailed individual assessments and carefully formulated care plans.
- *Practical*. The members of the rehabilitation and recovery team have a role to play in offering practical help to service users, particularly those with severe illness. In meeting the objective of returning people to valued life experiences, care should be taken to offer this help in a way that empowers the user, rather than encouraging passive dependence.
- *Key worker designation*.
- *Liaison*. Liaison with other agencies, both statutory and voluntary (e.g. housing and employment agencies), is required to access maximum support for service users.

While these principles are welcome and they offer a template for how to set up the components of a rehabilitation community mental health team, the reality is that, currently, rehabilitation teams are poorly developed in Ireland and existing rehabilitation services lack a true multidisciplinary input. Further, general adult community mental health services lack comprehensive community mental health teams. Developing community teams in Ireland requires a fundamental cultural change to community mental health services themselves, as well as the training of staff members. The development of the rehabilitation community mental health teams should be based on the needs of the local target population groups with severe and enduring mental illness; the precise nature of these needs will depend on whether the locality served is rural or urban, and on sociodemographic indexes.

Assessment of the needs of individual service users

Principles of assessment

A comprehensive assessment is an essential starting point to engaging an individual in the recovery process. To carry out an adequate assessment, a lot of information must be elicited and recorded. Thus it is helpful to use structured assessment instruments that are multidisciplinary in context and reflect the principles of rehabilitation and recovery. It is desirable that the assessment process embraces the concepts of recovery services, such as the special attention to individual strengths, thus facilitating empowerment. People who experience persistent and significant difficulties as a consequence of psychotic illness have complex and multiple needs. A 'need' here can be defined as a circumstance that requires some course of action. As unmet and unrecognised needs are common in individuals referred to rehabilitation services, the assessment of need is a core skill for professionals working in the specialty.

Service users' and carers' opinions and views must be incorporated, thus making assessment truly collaborative. Further, the assessment procedure must be continually ongoing and measure outcomes.

What should be assessed

It is essential to assess the following areas:

- *Diagnosis*. An accurate diagnosis is essential in order to engage the service user in evidence-based pharmacological and psychological treatments and to inform prognosis.
- *Comorbidity*. Under-recognition of comorbid disorders such as affective disorder, anxiety disorder, substance misuse, personality disorder, intellectual disability, organic brain injury and autistic spectrum disorder may hinder rehabilitation programmes and compromise recovery. Identification of comorbid disorders can inform appropriate treatment as part of the recovery plan.
- *Risk*. All rehabilitation psychiatrists should be competent in the assessment of a service user's risk to self or others. Risk assessment that collates relevant information should lead to a formulation of the risk issues and identify the factors that can be modified to decrease the probability that adverse events will occur. Thus, risk assessment can inform therapeutic risk taking.

- *Functional and occupational skills*. It is essential to assess activities of daily living and social functioning within the environment in which the service user will be living. Occupational skills assessment should measure strengths as well as deficits and include personal goals.
- *Recovery factors*. A comprehensive assessment should cover personal goals, hopes, aspirations, engagement with service and motivation for self-management.
- *Cognitive functioning*. It is essential to screen all service users for cognitive deficits owing to the association with poor functional outcomes. More detailed neurocognitive assessment may be required if deficits are highlighted.
- *Psychological well-being*. It is useful to gather information about early life experiences, vulnerabilities, stressors, core beliefs about self and the world, coping strategies, emotional and behavioural consequences of the illness, relapse indicators and support networks.
- *Physical health*. An assessment of the patient's physical health, done in collaboration with primary care, is essential, as the physical health of people with psychotic illnesses is frequently poor. Side-effects of medication also need to be monitored. Specialised assessment using neuroimaging – magnetic resonance imaging (MRI), computerised tomography (CT) or positron emission tomography (PET) – may be desirable.
- *Quality of life*. Subjective assessment of quality of life can help measure outcomes and satisfaction with a recovery programme over time. This assessment can highlight areas of importance and significance for the service user, thus ensuring a person-centred approach.
- *Assessment of need*. Identifying met and unmet needs is essential to formulating the care/recovery plan.
- *Carer assessment*. This area of assessment should include burden of care, quality of life, unmet needs, and hopes and aspirations for their loved one.

Adapting the above assessment schedule should lead to a comprehensive and thorough assessment of individuals and their needs while acknowledging personal strengths. This then becomes the basis for the development of a person-centred, holistic and evidence-based recovery plan for each individual service user. How such a comprehensive assessment process should be implemented requires further elaboration.

Assessment tools

A recent survey of rehabilitation services in Ireland (M. O'Reilly, unpublished at time of going to press) showed that teams were using standardised structured assessment instruments such as the Camberwell Assessment of Need (CAN) and Functional Assessment of Care Environment (FACE – recording and measurement systems) (see below). These assessment tools have been developed to standardise direct observations and interviews and have a number of benefits:

- they act as an *aide-mémoire* and provide a standard checklist
- they are reliable and measure outcomes over time to demonstrate the effect of rehabilitation inputs/programmes
- they assist in the planning of a recovery programme
- training programmes can be used to standardise the use of a scale across professional groups
- they allow comparisons to be made between individuals and in an individual over time
- they facilitate communication between services and the conduct of collaborative research.

There is a plethora of assessment instruments and rating scales that provide measurements in all areas. Each service needs to decide on its package of assessment tools and how these should be used. It would be prudent to have a basic assessment package for all service users being assessed for rehabilitation programmes and to use more specific assessment tools (e.g. of neurocognitive functioning) judiciously, according to individual need.

The following are the most commonly used assessment tools.

Camberwell Assessment of Need (CAN)

The adult CAN (Slade *et al*, 1999) is a family of questionnaires for assessing the wide range of problems that can be experienced by a mental health service user with severe mental health problems. It covers 22 different areas of life, and can be used to assess the perceptions of the service user, a carer and a mental health professional working with the service user. Three versions are available – a clinical version (CAN-C), a research version (CAN-R) and a short version (CANSAS).

The CAN-C is an in-depth assessment of the 22 areas. It assesses what sort of help the service user is currently receiving and how much help he or she needs. It also provides space for recording his or her views about what help should be offered, and for a care plan. The priority of the adult CAN is to identify serious needs. Once the need has been identified, specialist assessments can be conducted in specific areas.

Internationally, the adult CAN is the most widely used needs assessment approach.

Functional Analysis of Care Environment (FACE)

The FACE recording and measurement system (Clifford, 1999) encompasses multiple areas of mental health assessment. Version 5 of the Core Assessment and Outcomes Package for Mental Health Services introduces the concept of a fully integrated suite of documentation for mental health services. The assessment tool has been developed over 15 years with the involvement of hundreds of practitioners across health and social care. The package encompasses all domains of health and social functioning, including psychological, physical, activities of daily living, social and occupational functioning, interpersonal relationships, risk and subjective quality of life. The completed assessment highlights key areas of need while also indicating

possible strengths. The system aims to engage the service user and carers, and measures outcomes from the perspective of both the practitioner and the service user.

Social Functioning Questionnaire

The Social Functioning Questionnaire (Clifford & Morris, 1983) is an eight-item self-report instrument which provides a rapid and robust measure of perceived functioning.

Process of assessment

The assessment process involves the assimilation and conceptualisation of many variables pertaining to the individual service user. The outcome of the assessment should be a recognition of needs. The identified needs highlight the necessary interventions required. The measurement of outcomes identifies the progress of individuals and the appropriateness of interventions within the service. The process of assessment must always be ongoing in order to facilitate individual recovery plans and inform service delivery and development.

Key steps in assessment

- *Review of history*. Specialist rehabilitation teams should receive a thorough background history on individuals who are referred to their service. This should include clarification of diagnosis, comorbidity, risk and potential barriers to engagement. Direct contact with professionals previously involved in a service user's care is essential. Increasing the number of sources of information leads to greater reliability.
- *Engagement of service user and carer/family*.
- *Multidisciplinary assessment*. The skills and knowledge of different professional groups must be incorporated into the assessment process. An assessment conference can identify key issues and highlight the need for more specialist assessments. Longitudinal assessment and follow-up are important.
- *Development of formulation*. A bio-psychosocial perspective promotes a shared view of a service user's difficulties and acknowledging strengths creates a holistic, person-centred formulation. This should lead to planning of interventions and the development of clear and realistic goals.

Therapeutic interventions

Pharmacological interventions

Rational pharmacotherapy for individuals with severe and enduring mental illnesses is a prerequisite for successful rehabilitation. However, in the past, treatment decisions were often incompatible with the recommendations of modern literature, such as polypharmacy, higher than necessary usage of anticholinergic agents and giving psychotropic drugs in inconveniently divided doses. The under-investment in quality systems of care, and the failure to routinely provide intensive and comprehensive psychosocial interventions to complement drug therapies, have resulted in a very limited improvement in functioning and quality of life for individuals with enduring mental illness.

The emergence of the novel antipsychotic agents, for example clozapine, has changed the scope of treatment options, and expectations for recovery and reintegration are now much higher. There is minimal evidence that novel agents are more efficacious than conventional antipsychotic medications in the acute treatment of positive symptoms, although they do seem to be more effective in relapse prevention (Csernansky *et al*, 2002). There are also some data indicating greater efficacy for negative and neurocognitive symptoms (Purdon, 1999). Atypical antipsychotic agents are better tolerated and produce fewer motor side-effects, including tardive dyskinesia. However, some of the newer drugs have potentially serious side-effects of their own, especially endocrine and cardiac side-effects, weight gain and impaired glucose tolerance, which will temper their long-term use. There may still be a place for conventional antipsychotic drugs when all novel options are exhausted, especially in relation to when depot use can be justified; however, long-acting atypical agents are now available.

Polypharmacy of other kinds, such as combinations of an antipsychotic agent, a mood stabiliser and a benzodiazepine or an antidepressant may be fully justified by comorbid symptoms, which are common in psychotic disorders. Baseline CT or MRI scan, neuropsychological assessment, neurological examination for neurological abnormalities and movement disorders, electrocardiography (ECG), height and weight (for body mass index), a screen for illicit drug use, and determination of the lipid profile and fasting serum blood glucose (and/or HbA1c) level are all part of optimal initial assessment (Marder *et al*, 2004; American Diabetes Association *et al*, 2004).

The pros and cons of pharmacological interventions should be discussed with the patient and psychosocial support provided (Lambert & Nader, 2004).

Psychosocial interventions

Psychosocial interventions (McGorry, 2004) such as behavioural, psycho-educational and family interventions, cognitive–behavioural therapy, cognitive remediation and vocational rehabilitation have augmented treatments for individuals with enduring mental illness. Although the advent of antipsychotic medication has led to greater improvement for a higher proportion of people with regard to symptoms of their illness, many of these people did not make gains in the personal, occupational, social or self-care domains of their lives.

Psychosocial interventions should be relevant to the needs of the individual and informed by an understanding of the social and cultural context. They require well trained clinicians with specific expertise in the following areas.

Family interventions

Families benefit from an intervention that offers knowledge about the illness, as well as its effects on the person with it and on the family, and provides an avenue of support for them. Families also help each other. Psychosocial family interventions have a number of aims, including developing an alliance with carers, reducing emotional distress, creating or recreating a positive family atmosphere, problem solving, maintaining realistic expectations of patient performance, helping to set limits and appropriate relationship boundaries.

Psycho-education interventions

Psycho-education programmes (McGorry, 2004) for people with enduring mental illness improve adherence to treatment and lead to better outcomes, better management of subsequent relapse, lower readmission rates and a greater sense of well-being. Psycho-education initially focuses on supporting patients and families, and educating them about the illness. As patients recover, the subject matter may evolve to more general topics, such as life skills and adapting to the changes necessary to manage their illness.

Cognitive interventions

Cognitive–behavioural therapy added to standard care has been shown to reduce relapse of schizophrenia relative to standard care alone (Cormac *et al*, 2004). Another cognitive intervention, cognitive remediation, aims to address cognitive impairments such as distractibility, memory problems, lack of vigilance, attentional deficits, and limitations in planning and decision making. Since these deficits correlate more closely with functioning than do symptom levels, addressing them may enable the patient to engage in and benefit from other interventions and consequently function better in social and other domains (Hayes & McGrath, 2004).

Social skills training

Social skills training (also called life skills training) addresses issues relating to the development of social skills, intimate relations, occupational skills and

skills for independent living. Social skills training improves social adjustment, and enlarges and enhances the person's social network.

Vocational rehabilitation

Traditionally in Ireland, vocational rehabilitation training has been funded and operated separately from the mental health services. Funding is usually tied to rigid time frames, which do not necessarily take into consideration the needs of individuals with severe and enduring mental illness, who experience a course of relapsing illness with associated high levels of disability and who may need longer time frames and more flexibility to move towards social inclusion and reintegration into their local communities. Vocational literature has indicated that if efforts to promote inclusion are to be successful, then they must be integrated into the clinical work of the team rather than being a separate problem for distinct services. Rehabilitation and recovery services have a key role to play in linking in with allied rehabilitation vocational training bodies (e.g. National Learning Network, Eve Ltd and local rehabilitation vocational training bodies), so as to establish a collaborative approach to the provision of rehabilitation vocational services that meet the needs of individuals with severe and enduring mental illness.

Supportive residential programmes

To date in Ireland, rehabilitation services have been based on resettlement programmes following hospital closure programmes. Providing sheltered housing in the community for the long-term patients of large psychiatric institutions was one of the first steps of deinstitutionalisation. Most long-stay patients can successfully leave psychiatric hospitals and live in community settings (Barbato *et al*, 2004).

The *Vision for Change* strategy states that:

> the majority of new service users with severe mental illness will not require community residential facilities, but will need varying degrees of support to live in individualised independent accommodation. The statutory responsibility to provide this housing is not within the remit of the mental health services or the HSE [Health Service Executive]. Close cooperation with relevant housing authorities is required to ensure this obligation towards people with severe and enduring illness is honoured. The standard and quality of these facilities should be closely monitored and recorded by the CMHT [community mental health team]. (Department of Health and Children, 2006)

There is a lack of patient data on the unmet needs of people with severe and enduring mental illness in Ireland, particularly in relation to the new generation who are being referred and who live in the community. Community mental health services are not well developed with regard to the availability of early intervention, assertive outreach and continuing-care community mental health teams. Specialist rehabilitation and recovery services are still poorly developed on a national level. Therefore it may be too early to discount the need for supported community residential units, and the number of high-support 24-hour staffed residences required would be more appropriately determined by needs of the local target population, which may vary from urban to rural areas and which also depend on sociodemographic issues.

The statutory authority for these community high-support residential units should come under the remit of the mental health services and the HSE, in order to meet the needs of the target client group who have enduring mental illness with significant levels of disability.

The emphasis in the *Vision for Change* strategy document in relation to developing rehabilitation and recovery services is currently on community rehabilitation services. While this is welcome, there is a lack of planning, based on the needs of target populations, for in-patient provision for patients with severe enduring mental illness with complex needs who need a longer-term approach to their case management. In developing rehabilitation and recovery services there is a need to provide a comprehensive range of services, from in-patient intensive rehabilitation/continuing care and short-term rehabilitation to community-based rehabilitation services.

The phenomenon of new long-stay patients residing on acute admission units for prolonged periods has attracted attention in the UK for the past 30 years. Little is known about the nature of the new long-stay population in Ireland. The UK experience is that, following deinstitutionalisation, new long-stay patients are a heterogeneous group of individuals with a range of complex needs, who often exhibit challenging behaviour that makes their care outside the hospital setting problematic (Lelliott *et al*, 1994; Holloway *et al*, 1999). These patients are clearly disenfranchised and are often inappropriately placed on acute admission units, where the focus of treatment is towards managing acutely ill patients and rapid patient turnover.

There is clear evidence from the UK that, because of a lack of planning and provision for continuing care following the resettlement programmes with the closure of large psychiatric institutions, a significant number of people with severe and enduring mental illness with complex needs were reallocated to 'out of area treatments'. A consequence of this was that ties with families and local communities and social networks were disrupted, with people being placed in in-patient settings far from their homes because of lack of local provision (Department of Health, 1984). Without investment in appropriate local provision, there is a danger of a similar phenomenon emerging in Ireland.

Critics of supported residential programmes have contended that they do not always meet the varying and fluctuating needs of persons with serious mental illnesses and do not account for individual preferences and choices. Greater flexibility is needed to enable individuals with enduring mental illness to move through the residential programme towards independent living in the community, depending on their individual needs and taking into consideration their varying levels of disability and complex problems. Some may need a longer time in in-patient rehabilitation units before they can progress to community living, while others may need the option of moving back into an in-patient rehabilitation setting from the community during a period of illness relapse.

The following list indicates the range of supported rehabilitation residential programmes that should be provided, at both in-patient and community level, based on the needs of the target client population:

- in-patient intensive rehabilitation unit
- continuing-care unit
- high-support community unit (24-hour nursing care)

- medium-support community unit (care assistant at night, supported by community rehabilitation team during the day)
- low-support/group home unit (with input from the community rehabilitation team during the day, but no staff at night).

The focus in rehabilitation is on encouraging client groups to pursue the same avenues for accommodation needs as everyone else in the community. Staff often have a role in providing an advocacy service or in linking clients with other advocacy services in the community. One model that has been successful is where formal 6-monthly meetings take place between the rehabilitation service and local county council housing authorities, to update them about identified housing needs. The importance of a multidisciplinary team is evident here; for example, the social worker can advise about allowances available and the occupational therapist can help people with activities of daily living.

Social exclusion and discrimination

Among the key issues that were to be addressed in the new mental health strategy were social exclusion and discrimination.

> Though a simple aspiration for most people socially isolated by mental illness, the sense of belonging to a community with all that this can imply for mutuality and participation, remains stubbornly exclusive in spite of community care. (Morris, 2001)

If mental health services are to assist the recovery of those who use them, then the way in which these services operate is important. However, such services, and the people who work in them, cannot be separated from the broader social context in which they exist. People with enduring mental health problems commonly experience prejudice and discrimination, for example in accessing employment and housing, and this in turn can result in social poverty, which further excludes them from society. People with mental health problems should have the same rights and opportunities that are available to non-disabled citizens.

The outcome for the users of mental health services is largely centred around symptomatic improvement and discharge. However, this is perhaps a narrow outlook and should be expanded in a holistic way to encourage service users to secure jobs or college courses, to have a place of their own, and to engage in social and leisure activities. Further, services should provide information and support to relatives, so they, too, feel included and supported.

Promoting access and inclusion is important in improving health as well as social functioning. Social functioning, psychological well-being and physical and mental health are intimately linked. For example, the absence of social supports and social networks is detrimental to mental health (Simmons, 1994). The absence of employment has been linked with increased general health problems, including premature death (Brenner, 1979; Smith, 1985; Beale & Nethercott, 1985; Bartley, 1994) and there is a particularly strong relationship between unemployment and mental health difficulties (Smith *et al*, 1993; Warr, 1987; Warner, 2000). Unemployment is associated with increased use of mental health services (Brenner & Bartell, 1983; Wilson & Walker, 1993; Warner, 1994; Steward, 1996) and is known to increase the risk of suicide (Platt & Kreitman, 1984; Moser *et al*, 1987; Philippe, 1988; Lewis & Sloggett, 1998). Vocational literature has also indicated that if efforts to promote social inclusion are to be successful, then they must be integrated into the clinical work of the team rather than being a separate problem for distinct services (Bond *et al*, 1997, 2001).

A large Irish study (Whelan *et al*, 1991) that examined unemployment, poverty and psychological distress found the effects of poverty and unemployment to be cumulative, with unemployed people in poor households

being five times more likely to have psychiatric symptoms. Another Irish study (Keogh, 1997) also reported links between family burdens in mental illness and poverty. Poverty is also closely associated with greater use of mental health services. For example, there is an eight-fold difference in psychiatric admission rates between professional and unskilled groups in Ireland (Daly *et al*, 2004). The 2000 Labour Force Survey in the UK revealed that unemployment among those with mental health problems is high, at 84% (Burchardt, 2000; see also Crowther *et al*, 2001), higher than that among people with physical and sensory impairments (Mueser *et al*, 1998). They also show that people with mental health problems are nearly three times more likely to be in debt, and that people with mental health problems carry more than double the risk of losing their jobs than those without.

Research evidence on employment has repeatedly shown that if provided with the support they need, as many as 60% of people with more serious mental health problems can gain and sustain open employment (Bond *et al*, 1997, 2001; Crowther *et al*, 2001). Similar research has shown that, with support, the majority of people with such difficulties can live independently (Mueser *et al*, 1998). In addition, a range of initiatives have shown that they can equally successfully access education (Unger *et al*, 1991) and a range of social and leisure opportunities.

However, people with mental health problems still have difficulty accessing the support they need to avail themselves of such opportunities. Rehabilitation and recovery services have a key role in providing support to people with enduring mental illness to gain access to housing, employment and social/leisure activities through, for example, developing formal links with vocational training bodies (National Learning Network, Eve Ltd) and employment and housing authorities, and linking closely with allied voluntary bodies, such as Schizophrenia Ireland, the Irish Advocacy Network, STEER and Mental Health Ireland (see Appendix).

Training and education programmes

Staff training and education have been identified in the *Vision for Change* strategy (Department of Health and Children, 2006) as being an essential part of the process of improving services. Recommendations set out in that strategy include the following:

- Education and training should be directed at improving services as a primary goal and must have the welfare of service users as their ultimate objective.
- Training programmes should emphasise the acquisition of skills that are clinically meaningful, should train personnel for leadership and innovation roles, and should foster an attitude of critical enquiry and self-scrutiny in relation to service delivery.
- There should be centralisation of the planning and funding of education and training for mental health professionals in new structures, to be established by the HSE in close association with the National Directorate of Mental Health Services. This centralised education and training authority should be constituted to represent stakeholder and service user interest, as well as education and training bodies representing all disciplines.
- The HSE should commit itself to adequate, rational and consistent funding of education and training. However, the accreditation of courses should remain the responsibility of the respective professional bodies.
- Funding of HSE-sponsored training courses should be established on a secure basis, to allow for expansion and development of these courses and to ensure workforce requirements in mental health services can be met in coming years.

In relation to education and training programmes in specialist rehabilitation and recovery services, the following modules are recommended:

- recovery philosophy and practice for the rehabilitation team
- formal induction for the rehabilitation team
- multidisciplinary team-building
- the use of structured assessment schedules
- family therapy
- cognitive–behavioural therapy
- the Wellness Recovery Action Plan (WRAP), a self-management plan
- user involvement.

Research

The *Vision for Change* strategy (Department of Health and Children, 2006) promotes in its mandate research in mental health services. Mental health service research can help with:

- the provision of the information needed for effective service planning
- ensuring that services are effective and of high quality
- driving service development
- driving staff development.

The report *Mental Health: New Understanding, New Hope* from the World Health Organization (2001) outlined four areas of mental health research that are vital to improving mental health services:

- epidemiological research
- outcome research into the treatment and prevention of mental ill health, and the promotion of mental well-being
- policy and service research
- research on the economics of mental health services.

The Faculty of Rehabilitation and Social Psychiatry will promote research relevant to the area of rehabilitation and recovery psychiatry. The Faculty has established an academic group and it is envisaged that this will provide a useful networking and support forum for research development.

Service evaluation and audit

In Ireland, the 1994 health strategy *Shaping a Healthier Future: A Strategy for Effective Health Care in the 1990s* (Department of Health and Children, 1994) included quality as one of its main underlying principles. The current health strategy, *Quality and Fairness: A Health System for You* (Department of Health and Children, 2001), is guided by four principles: equity, people centredness, accountability and quality. The *Vision for Change* (Department of Health and Children, 2006) mental health strategy places a firm emphasis on recovery and facilitating active partnerships between service users, carers and mental health professionals.

The Mental Health Commission's (2006) report *Quality Framework: Mental Health Service in Ireland* outlines a framework to serve as a useful resource for supporting continuous quality improvement. It comprises 8 themes, 24 standards and 163 criteria. The themes are as follows:

1. the provision, by a multidisciplinary team, of a holistic, seamless service and the full continuum of care
2. respectful, empathetic relationships between people using mental health services and those providing them
3. an empowering approach to service delivery for the benefit of both the people using the service and those providing it
4. a high-quality physical environment that promotes good health and upholds the security and safety of service users
5. access to services
6. the involvement and support of the patient's family and/or chosen advocate
7. staff skills, expertise and morale, as key influences in the delivery of a high-quality mental health service
8. systematic evaluation and review of mental health services underpinned by best practice, to enable providers to deliver high-quality services.

The implementation of the quality framework includes monitoring and evaluation in the following areas:

- *Service users and their families*. The standards inform service users, their families or chosen advocates and the general public about what to expect from a mental health service. There is opportunity for service users to provide feedback on standards, which should be incorporated into the service planning process.

- *Mental health service quality improvement*. A mental health service should use the standards as a guide to good service delivery and quality improvement. The framework will help mental health services to monitor their own performance against the standards.
- *The use of modern quality and safety methods for continuous improvement*. The framework encourages mental health services to train their staff and to support staff in using modern quality methods.
- *Development of mental health services*. The standards provide a framework for the development of a mental health service, which can be used to change existing services or in establishing new services.
- *Monitoring by the Mental Health Commission*. The Mental Health Commission will be using the standards and associated criteria to monitor the delivery of mental health services in the public, independent and voluntary sectors.
- *Implementation by mental health service providers*. Health service providers should incorporate the standards into service-level agreements for the provision of mental health services and regularly monitor progress in relation to compliance.
- *Profile of mental health services*. The Mental Health Commission will use the quality framework as a platform for increasing the profile of mental health services in terms of national policies and priorities.

The quality framework will include self-assessment by the mental health services and external assessment of the standards and criteria by the Inspector of Mental Health Services as part of the inspection process for approved centres and mental health services. An audit toolkit has been designed to assist mental health services in auditing their own service to determine levels of attainment of the standards and also to help staff understand what needs to be done to achieve them. The meeting of the standards itself is not an end-point but should be viewed as part of a process of continuous quality improvement. This process will take place over time (the implementation of the *Vision for Change* strategy is stated as taking place over a 7- to 10-year period).

It has been recommended that the quality framework for mental health services be costed by the Mental Health Commission in association with mental health service providers as a matter of priority, so that realistic, time-bound action plans are developed and implemented. It is recommended that, as matter of quality corporate governance, mental health service budgets are devolved, so that the necessary decisions regarding expenditure are made at the most appropriate levels within the health system.

The Faculty of Rehabilitation and Social Psychiatry also suggests that more time is needed to pilot the audit toolkit in the mental health services, so that it is both meaningful and implementable and takes into consideration the diversity with regard to specialisation within the mental health services.

Conclusion

Rehabilitation and recovery mental health services are at varying stages of development in Ireland. This occasional paper includes references to existing templates for recommendations for service development and includes guidelines on how to incorporate the recovery perspective into the service model. Services need to move away from the historical focus on resettlement programmes and instead incorporate a more holistic, user-centred approach, with assessment of individuals' needs and their active participation in choice of life goals. These services should incorporate a range of rehabilitation interventions, and promote both social inclusion and movement towards independent living in the community. The paper provides a template for consultants in rehabilitation and recovery mental health services for the setting up of such a service.

It is envisaged that the Faculty of Rehabilitation and Social Psychiatry will work on further projects, with themes taken from this paper, in order to elaborate concepts of rehabilitation and recovery service development.

References

American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists & North American Association for the Study of Obesity (2004) Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetic Care*, **27**, 596–601.

Anthony, W. A. (1993) Recovery from mental illness: the guiding vision of the mental health system in the 1990s. *Psychosocial Rehabilitation Journal*, **16**, 11–23.

Barbato, A., D'Avanzo, B., Rocca, G., *et al* (2004) A study of long stay patients resettled in the community after the closure of a psychiatric hospital in Italy. *Psychiatric Services*, **55**, 67–70.

Bartley, M. (1994) Unemployment and ill-health: understanding the relationship. *Journal of Epidemiology and Community Health*, **48**, 333–337.

Beale, N. & Nethercott, S. (1985) Job-loss and family morbidity: a study of factory closures. *Journal of the Royal College of General Practitioners*, **35**, 510–514.

Bond, G. R., Drake, R. E., Meuser, K. T., *et al* (1997) An update on supported employment for people with severe mental illness. *Psychiatric Services*, **48**, 335–346.

Bond, G. R., Becker, D. R., Drake, R. E., *et al* (2001) Implementing supported employment as an evidence based practice. *Psychiatric Services*, **52**, 313–322.

Brenner, M. H. (1979) Mortality and the national economy: a review of the experience of England and Wales. *Lancet*, *ii*, 685–699.

Brenner, S. & Bartell, R. (1983) The psychological impact of unemployment. A structural analysis of cross-sectional data. *Journal of Occupational Psychology*, **56**, 129–136.

Brown, W. & Kandirikirira, N. (2006) *Recovering Mental Health in Scotland. Report on Narrative Description of Mental Health Recovery*. Scottish Recovery Network.

Burchardt, T. (2000) *Enduring Economic Exclusion: Disabled People, Income and Work*. Joseph Rowntree Foundation.

Care Services Improvement Partnership (2007) *A Common Purpose: Recovery in Future Mental Health Services*. Royal College of Psychiatrists and Social Care Institute for Excellence.

Clifford, P. I. (1999) The FACE recording and measurement system: a scientific approach to person-based information. *Bulletin of the Menninger Clinic*, **63**, 305–331.

Clifford, P. & Morris, I. (1983) *The Social and Functioning Questionnaire*. Research and Development for Psychiatry.

Cormac, I., Jones, C., Campbell, C., *et al* (2004) Cognitive behaviour therapy for schizophrenia. *Cochrane Library Issue 1*. Wiley.

Crowther, R. E., Marshall, M., Bond, G. R., *et al* (2001) Helping people with severe mental illness to obtain work: systematic review. *BMJ*, **322**, 204–208.

Csernansky, J. G., Mahmoud, R. & Brenner, R. (2002) A comparison of risperidone and haloperidol for the prevention of relapse in patient with schizophrenia. *New England Journal of Medicine*, **346**, 16–22.

Daly, A., Walsh, D., Moran, R., *et al* (2004) *Activities of Irish Psychiatric Services 2003*. Health Research Board.

Department of Health (1984) *The Psychiatric Services – Planning for the Future. Report of a Study Group on the Development of Psychiatric Services*. Stationery Office.

Department of Health (1999) *National Service Framework for Mental Health: Modern Standards and Service Models*. Department of Health.

Department of Health (2000) *The NHS Plan: A Plan for Investment, A Plan for Reform*. Department of Health.

Department of Health and Children (1994) *Shaping a Healthier Future: A Strategy for Effective Health Care in the 1990s*. Stationery Office.

Department of Health and Children (2001) *Quality and Fairness: A Health System for You*. Stationery Office.

Department of Health and Children (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Department of Health and Children.

Farkas, M., Gagne, C., Anthony, W., *et al* (2005) Implementing recovery oriented evidence based programs: identifying the critical dimensions. *Community Mental Health Journal*, **41**, 141–158.

Hayes, R. L. & McGrath, J. J. (2004) Cognitive rehabilitation for people with schizophrenia and related conditions. *Cochrane Library Issue 1*. Wiley.

Holloway, F., Wykes, T., Petch, E., *et al* (1999) The new long stay in an inner city service: a tale of two cohorts. *International Journal of Social Psychiatry*, **45**, 93–102.

Keogh, F. (1997) Family burden and mental illness in Ireland. Unpublished PhD thesis, Trinity College, Dublin.

Killaspy, H., Harden, C., Holloway, F., *et al* (2005) What do mental health rehabilitation services do and what are they for? A national survey in England. *Journal of Mental Health*, **14**, 157–166.

Lambert, M. & Naber, D. (2004) *Current Schizophrenia*. Science Press.

Lelliott. P., Wing J. & Clifford P. (1994) A national audit of new long stay psychiatric patients, 1: Method and description of cohort. *British Journal of Psychiatry*, **165**, 160–169.

Lewis, G. & Sloggett, A. (1998) Suicide, deprivation and unemployment. Record linkage study. *BMJ*, **317**, 1283–1286.

Marder, S. R., Essock, S. M., Miller, A. L., *et al* (2004) Physical health monitoring of patients with schizophrenia. *American Journal of Psychiatry*, **161**, 1334–1349.

McGorry, P. (2004) *Royal Australian and New Zealand College of Psychiatrists' Clinical Practice Guidelines for the Treatment of Schizophrenia and Related Disorders*. Royal Australian and New Zealand College of Psychiatrists.

Mental Health Act Commission (1998) *Blueprint for Mental Health Services in New Zealand – How Things Need to Be*. Mental Health Act Commission.

Mental Health Act Commission (2005) *Te Tahuhu – Improving Mental Health 2005–2015. The Second New Zealand Mental Health and Addiction Plan*. Mental Health Act Commission.

Mental Health Commission (2005) *A Vision for a Recovery Model in Irish Mental Health Services*. Discussion Paper. Mental Health Commission.

Mental Health Commission (2006) *Quality Framework: Mental Health Services in Ireland*. Mental Health Commission.

Morris, D. (2001) Citizenship and community in mental health: a joint national programme for social inclusion and community partnership. *Mental Health Review*, **6**, 21–24.

Moser, K. A., Goldblatt, P. O., Fox, A. J., *et al* (1987) Unemployment and mortality: comparisons of the 1971 and 1981 longitudinal study census samples. *BMJ*, **294**, 86–90.

Mueser, K. Y., Bond, G. R., Drake, R. E., *et al* (1998) Models of community care for severe mental illness: a review of research on care management. *Schizophrenia Bulletin*, **24**, 37–74.

Philippe, A. (1988) Suicide and unemployment. *Psychologie Medicale*, **20**, 380–382.

Platt, S. & Kreitman, N. (1984) Trends in parasuicide among unemployed men in Edingburgh 1968–82. *BMJ*, **289**, 1029–1032.

President's New Freedom Commission on Mental Health (2003) *Achieving the Promise: Transforming Mental Health Care in America*. President's New Freedom Commission on Mental Health.

Purdon, S. E. (1999) Cognitive improvement in schizophrenia with novel antipsychotic medications. *Schizophrenia Research*, **35**, 51–60.

Repper, J. & Perkins, R. (2003) *Social Inclusion and Recovery: A Model for Mental Health Practice*. Baillière Tindall.

Roberts, G. (2000) Narrative and severe mental illness: what place do stories have in an evidence-based world? *Advances in Psychiatric Treatment*, **6**, 432–441.

Roberts, G. (2006) Understanding madness. In *Enabling Recovery. The Principles and Practice of Rehabilitation Psychiatry* (eds G. Roberts *et al*). Gaskell.

Simmons, S. (1994) Social networks: their relevance to mental health nursing. *Journal of Advanced Nursing*, **19**, 282–289.

Slade, M., Thornicroft, G., Loftus, L., *et al* (1999) *The Camberwell Assessment of Need (CAN)*. Royal College of Psychiatrists.

Smith, J., Birchwood, M., Cochrane, R., *et al* (1993) The needs of high and low expressed emotion families: a normative approach. *Social Psychiatry and Psychiatric Epidemiology*, **28**, 11–16.

Smith, R. (1985) 'Bitterness, shame, emptiness, waste'. An introduction to unemployment and health. *BMJ*, **291**, 1024–1028.

Steward, A. (1996) Unemployment and health. 1. The impact on clients in rehabilitation and therapy. *British Journal of Therapy and Rehabilitation*, **3**, 360.

Unger, K. V., Anthony, W. A., Sciarappa, M. P. H., *et al* (1991) A supported education programme for young adults with long term mental illness. *Hospital and Community Psychiatry*, **42**, 838–842.

US Department of Health and Human Services (2006) *National Consensus Statement on Mental Health Recovery*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

Warner, R. (1994) *Recovery from Schizophrenia. Psychiatry and Political Economy* (2nd edn). Routledge.

Warner, R. (2000) *The Environment of Schizophrenia, Innovations in Practice, Policy and Communications*. Routledge.

Warr, P. (1987) *Unemployment and Mental Health*. Oxford University Press.

Whelan, C. T., Hannan, D. F. & Creighton, S. (1991) *Unemployment, Poverty and Psychological Distress*. General Research Series, No. 150. Economic and Social Research Institute.

Wilson, S. & Walker, G. (1993) Unemployment and health. A review. *Public Health*, **107**, 153–162.

World Health Organization (2001) *The World Health Report 2001. Mental Health: New Understanding, New Hope*. WHO.

Wykes, T. & Holloway, F. (2000) Community rehabilitation: past failures and future prospects. *International Review of Psychiatry*, **12**, 197–205.

Appendix: Allied voluntary organisations

- Irish Advocacy Network, c/o Health Care Unit, Rooskey, Monaghan. Tel: 047 38918 or 047 72863. http://www.irishadvocacynetwork.com/
- Mental Health Ireland, Mensana House, 6 Adelaide Street, Dun Laoghaire, Dublin. Tel: 01 284 1166. http://www.mentalhealthireland.ie/
- Schizophrenia Ireland, 38 Blessington Street, Dublin 7. Tel: 01 8601620. Helpline 1890 621631. http://www.sirl.ie/
- STEER, 1st Floor Office, 15 The Diamond, LondonDerry BT48 6HW. Tel.: 028 7127 9995. http://www.steermentalhealth.org