National Mental Health Services Collaborative

Individual Care Planning: Enabling the Paradigm Shift to Recovery Focused Care

Lessons from the National Mental Health Services Collaborative

7th February 2012

Poster Presentation Abstracts
Contents

1. Developing a Structured Approach to Individual Care and Treatment Planning ........................................... 4

2. Using Quantitative Research to Measure Recovery Outcomes in a Mental Health Setting............................ 5

3. Individual Care Planning At Lakeview Unit (Naas General Hospital): Audit as a Tool for Introducing and Maintaining Change .................................................................................................................. 6

4. Written Information Helps Recovery - What Does This Mean In Practice? National Mental Health Services Collaborative Team .................................................................................................................................. 7

5. “Recovery And The Family” The Effectiveness Of The Shine Family Education Course In Improving Carers Sense Of Well-Being And Support ......................................................................................... 8

6. Wellness and Recovery in the Inpatient Setting: Developing a Wellness Card .......................................................... 9

7. Introduction of MDT Recovery/Care Plans and a Defined Model of Key Working With Policy Development to Support the Process. National Mental Health Services Collaborative Team ........................................ 11

8. Core Care Plan- Patient in Seclusion ...................................................................................................................... 13

9. Implementing a Common Assessment Tool and Care and Recovery Plan in a Community Mental Health Team: National Mental Health Services Collaborative Team ........................................................................ 14

10. Collaborative Recovery Care Planning in St John of God Hospital (CAMHS) National Mental Health Services Collaborative Team ........................................................................................................ 15

11. A.C.I.R. Collaborative Care Planning For Recovery ............................................................................................... 18

12. The Evaluation of a Change Management Project Aimed at Improving Service Users’ Perceived Acceptability Regarding Aspects of 1.1 of the MHC Quality Framework (Individualised Care Planning) National Mental Health Services Collaborative Team ............................................................................................................ 19

13. Individual Care Planning and Recovery for Deaf Irish Sign Language Users .......................................................... 20

14. Implementing Recovery: Individual Care and Treatment Planning ........................................................................ 21
15. Individual Care Planning: Changes to Patient Focussed Care – Involvement in the National Mental Health Services Collaborative National Mental Health Services Collaborative Team ........................................ 22

16. Individual Care Planning in St Edmundsbury Hospital (2010-2011): Developing Recovery Focussed Care .......................................................................................................................... 23

17. The Impact of a Structured Recovery Programme .......................................................................................................................... 24

18. The Effect of Training on the Understanding of Recovery Concepts on Hospital Staff ........................................................................ 25

19. Integrated Care Pathways and Pillars of Care - A Forensic Recovery Pathway ......................................................................................... 26


21. ‘I Know That I Have the Right to Ask’: Findings from the Evaluation of the EOLAS Programme ................................................... 28

22. Collaborative Recovery Care Planning in St John of God Hospital (Adult) National Mental Health Services Collaborative Team ......................................................................................................................... 29

23. Implementing A Recovery Orientated Approach Through The Use Of Psycho-Social Interventions In Community Mental Health Practice With People Who Have Experienced Psychosis .................................................. 31

24. The Use of the Recovery Star as a Tool for Planning With Service Users in a Mental Health Rehabilitation Service .................................................................................................................................................. 32

25. PROTECT (Personalised Recovery Orientated Treatment, Education and Cognitive Therapy) – Ensuring Engagement with the Recovery Model in Early Interventions for Psychosis .................................................................................................................................................. 34

26. Developing an Effective Multidisciplinary Individualized Care Plan Programme. National Mental Health Services Collaborative Team .......................................................................................................................... 35

27. Development and Implementation of Individual Service Plans on a Child and Adolescent Mental Health Community Team-Lucan/Adamstown CAMHS. National Mental Health Services Collaborative Team .................................................................................................................................................. 36

28. The Creative Well Programme: A New Prescription for Mental Health Explore creative ways of overcoming emotional difficulties .................................................................................................................................................. 37
29. Recovery Focussed Care; Impact of Assertive Outreach Treatment on hospital stay of Patients with Severe and Enduring Mental Illness in the Sligo Leitrim Mental Health Service .......................... 39

30. Supporting Recovery: Using a Collaborative Learning Approach – Student Nurses and Service Users Working and Learning together in University College Dublin .............................................................. 40

31. Developing a Service User-Centred Quality of Care Instrument ................................................................. 41

32. Recovery from Psychosis: The Outcomes of Recipients of an Early Intervention for Psychosis Model ........ 42

33. Designing, Measuring and Evaluating Individualised Recovery Focused Care Packages within an Anxiety Disorders Program .................................................................................................. 43

34. ‘Care Planning In Mental Health: Promoting Recovery’ .................................................................................. 44

35. The Introduction of Advance Directives in Irish Mental Health Care ............................................................ 45

36. Moving WEST- Cork Mental Health Service in a Recovery Direction .......................................................... 46
1. Developing a Structured Approach to Individual Care and Treatment Planning

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Abstract:
Individual Care and Treatment Planning is a regulatory and quality requirement by the Mental Health Commission. Care and Treatment Planning supports recovery and ensures service-users are partners in their own care. This pilot project describes a quality improvement initiative of Individual Care and Treatment Planning, within a Child and Adolescent Mental Health Service in County Louth, Ireland. The need for a structured and standardized approach for documentation of care and treatment plans was identified through an in-service audit using the Mental Health Commission Quality Framework audit toolkit.

The aim of the project was to develop and implement a consistent and structured approach to planning and documenting care plans for service-users. The Health Service Executive change model was used to guide implementation of the project. A template was designed for documentation of care plan, for completion by the keyworker following clinical assessment.

A focus group of 12 of 15 staff (80%) reported benefits including clarity of treatment plan, ease of prioritization of goals and involvement of clients in the management plan. Challenges reported include time constraints, interference with therapeutic engagement, and streamlining differing goals between a young person and their parent.

An evaluation questionnaire of the change process was completed by 10 of 15 staff (66%). All respondents agreed that ‘there was a clear plan for change’. Most staff were happy with the level of communication prior to (90%) and during the change (80%), while 70% of respondents agreed ‘there was strong and confident leadership of the change’.

Based on findings of this pilot study, the initial template was re-designed and adopted for the service. A structured approach to care planning is now included in the service’s policy. Recommendations for the future include survey of service-users’ views and audit of the new template for rate of completion and content.
2. Using Quantitative Research to Measure Recovery Outcomes in a Mental Health Setting

Presenting Author: Patrick Ryan, DClinPsych, Director, Doctoral Programme in Clinical Psychology, University of Limerick, Ireland.

Recovery has become an increasingly significant concept within the mental health literature. Despite this, few studies have investigated the measurement of recovery and its correlates using quantitative methods. The aim of the current study was to measure recovery in people with chronic psychiatric disabilities using a quantitative tool and to investigate what factors were correlated to recovery outcomes. It was hypothesized that measures that investigated the individual’s subjective sense of well-being would have a stronger correlation to recovery than more traditional clinician-rated scales.

Method:
Participants were 63 people with a chronic psychiatric disability. They were recruited as a convenience sample from community mental health rehabilitation teams in three locations. Using a cross-sectional design, participants completed measures of psychological well-being (Psychological Well-being Scale (PWB)); hope (Adult State Hope Scale) and recovery (Recovery Assessment Scale (RAS)). Health professionals rated participants’ psychosocial functioning using the Multnomah Community Ability Scale (MCAS-R).

Results:
Analyses found that there was no significant correlation between clinician-rated psychosocial functioning scores and participant-rated recovery outcomes. Psychological well-being variables rated by the participants themselves were found to significantly correlate with recovery outcomes. The variables hope, environmental mastery and relationships with others were found to emerge as independent predictors of recovery scores.

Conclusions:
Results underscore the premise that recovery is a distinct construct that is unique to the individual and cannot be fully captured by objective measures of functioning. Implications for practice suggest that services for people with chronic psychiatric disability should utilise recovery focused tools in patient assessment and treatment. Recovery interventions should also focus on the individual’s hope, sense of mastery and relationships with others in order to promote recovery.
3. Individual Care Planning At Lakeview Unit (Naas General Hospital): Audit as a Tool for Introducing and Maintaining Change

Presenting Authors: Dr. Asfar Afridi, Dr. Donal O'Hanlon

Background:
The Mental Health Act 2001 (Approved Centres) Regulations 2006 under article 15, requires the registered proprietor to develop individual care and treatment plan for each resident. The Inspectorate of Mental Health Services following their re-inspection of Lakeview Unit in September 2010 recommended that all residents must have an individual care plan as defined in the Regulations and to adopt a more appropriate individual care plan structure. A revised individual care plan was developed in accordance with Standard 1.1 of the Quality Framework for Mental Health Services, following the Inspectorate recommendation.

Aims/Objectives:
1. To monitor implementation of the revised individual care plan on the Lakeview Unit.
2. To measure aspects of individual care planning and treatment.
3. To provide feedback to respective sector teams.

Method:
The initial audit of individual care planning and treatment was carried out in January 2011 followed by one in March, August and November 2011. The charts from each of the four sector teams and Rehabilitation team were randomly selected. We recorded information about the following aspects of individual care planning and treatment;

1. Functional Analysis of Care Environment (FACE) risk assessment
2. Multidisciplinary Team Care Plan
3. Week one, two and monthly Treatment Reviews
4. Identified Goals
5. Interventions
6. Target date for each goal
7. Patient’s review of plan
8. Discharge plan
9. Inpatient Review Form

Results:
The FACE risk assessment improved from 42% on initial audit to 78% on most recent re-audit in November. During the initial audit in 71% of patients treatment plan was completed within 1st week of treatment, which improved to 94% during the month of November. Goals identification improved from 75% to 89%. The patient's review of care plan figure shows improvement from 24% to 53%. Discharge plan documentation showed marginal improvement from 50% to 53%. The completion of Inpatient review forms improved from 52% to 79%.

Conclusion:
There has been significant improvement in almost all aspects of care planning. Audit cycle is an excellent tool used for attainment of standards and continuous quality improvement.
4. Written Information Helps Recovery - What Does This Mean In Practice?
National Mental Health Services Collaborative Team

Presenting Author: Rose Bennett, Nursing Practice Development Co-ordinator

Authors: Swords Team, ICP Committee

Introduction:
As part of the NMHSC, our team developed a series of initiatives including two information leaflets in order to work collaboratively with service users, their families and carers throughout the pathway of care. The care planning leaflets helps staff ensure that the patient/client journey is client led, with a focus on achieving the client’s person’s aspirations.

Objectives/aims:
- All clients receiving a service from North Dublin Mental Health Service will have a recovery focused Care Plan in place during their involvement with the Mental Health Service.
- Clients will actively participate in the development and implementation of their Care Plans. The information leaflets will be a central component of this care process.

Methods:
- Multi-Disciplinary Team meetings will be held fortnightly. ICP meetings monthly
- Service User Questionnaire (SUQ) will continue to be administered monthly in order to audit the quality of service provided.
- Focus group with service users & families will be used to supplement the SUQ’s as required.
- Learning sets will continue to be used as part of ongoing professional development in relation to recovery focus practice.
- Each team will identify a Lead individual who will champion the implementation of recovery focus care planning.

Results & Conclusion:
- As a result of above Clients will be adequately prepared to benefit fully from participating in MDT meetings.
- The implementation of recovery focused practice will allow clients to make informed decisions about their treatment to the fullest extent possible and will enable clients to inform the MDT about their strengths, hopes and needs.
- Clients and their key worker can use the leaflets to discuss any aspect of the care plan with family and others. Qualitative & Quantitative Data will be monitored to ensure ongoing improvements are a key element in this patient-centred approach to care planning practice.
Providing support to relatives of people with mental illness is a key component of any recovery oriented service. Family education offers an alternative model to psycho education as a means of empowering relatives of people with mental illness because it focuses on relatives needs. The Shine Family education course, “Recovery and the Family”, is based on this model and is co-facilitated by relatives with lived experience.

In partnership with Shine, Mayo Mental Health Recovery Team set about measuring the effectiveness of the Shine Family Education Course using a tool called the Carers Well-being and Support Questionnaire. This tool measures carer’s sense of well-being and support. Well-being was defined based on seven sub domains. These included relative’s feelings about their caring role, their emotional health, their physical health, stigma, safety, and their relationships with family friends and the person they care for. Support was defined by how satisfied relatives are, that they have access to information and advice. It also measures how satisfied relatives were with their involvement in treatment and care planning and how supported they felt by medical or care staff.

We measured the effectiveness of the course by looking at how relative’s sense of well-being and support changed over the duration of the course. The finding show that course participants felt more supported, were more satisfied with the level of support they got from medical and care staff and their satisfaction with the information and advice available to them was improved. The findings however did not show a marked improvement in participants well being. Possible explanations for this are explored further in the research.
6. Wellness and Recovery in the Inpatient Setting: Developing a Wellness Card

Presenting Author: Niamh Casey (Occupational Therapist)

Co-Authors: Christine O’ Byrne (Occupational Therapist)
Sharon Mc Caffrey (Occupational Therapist)
Jonathan Swift Clinic, St James's Hospital

Objectives/Aims:
- The wellness card was a project developed by a client leadership group. The aim was to enable service-users in Jonathan Swift to develop a personal document which listed their day to day coping strategies, the things they can do to feel better & stay well, supports and coping with setbacks.
- The card is integrated into care planning within the Jonathan Swift service. In doing this, the aim is that the service-user remains a key part of the care pathway & therefore they have increased participation in the care planning process.
- It aims to promote living well in the community post discharge.

Methods:
- Originally developed by a client leadership group, the card was then piloted in Jonathan Swift in wellness groups and on 1:1 basis by MDT and care co-ordinators.
- Evaluation of wellness card is qualitative. Interviews with clients, staff feedback and informal interactions with clients after the wellness groups informed the evaluation.
- Clients were also invited to complete an evaluation/feedback form on the wellness group and wellness card. This feedback is discussed formally in an MDT based working group who meet specifically to discuss wellness and discharge planning programs.
- Pilot period revealed that there were changes required to language on the headings: to include language in the card with personal terms such as ‘my supports’, ‘my wellness tools’.
- It was hoped that by doing so that client’s responsibility for recovery is encouraged because it is their personal document.
- MDT provides opportunity to explore client’s wellness card within MDT meeting.
- OT’s from JSC presented wellness group program and wellness card to a national Mental Health Advisory Group run by the Association of Occupational Therapists of Ireland (AOTI). Other clinician’s feedback indicates that the program and card are consistent with current Recovery based guidelines at local and national level. They are an innovative and timely development in mental health and client care.
- Funding was then sought for re-design and professional printing of wellness card from hospital Foundation committee. Considerations for this included re-design of the wellness card in terms of aesthetics and accessibility for clients.
- Working group continues to meet every 2-3 months. Its working long term goal with the establishment of the wellness card in the inpatient service is to integrate it across the service as a whole.
Results & Conclusions

- Wellness card is a personal & practical tool designed for clients to use.
- It benefits clients by increasing understanding of wellbeing therefore improving quality of life. Doing this can reduce incidence of acute mental illness.
- The card is designed to support transition from hospital by identifying strategies to improve wellbeing.
- The Jonathan Swift have liaised with similar inpatient services who have identified wellness group programs & wellness cards as an area of need. Thus, they are a strategic development in inpatient mental health services.
- The card has been integrated into care planning within the Jonathan Swift service. In doing this, the client remains a key part of the care planning & discharge planning process.
7. Introduction of MDT Recovery/Care Plans and a Defined Model of Key Working With Policy Development to Support the Process.
National Mental Health Services Collaborative Team

Presenters: Madge Conboy-Browne, Heather Cronin or Team Members
Baggot St Out Patients Department, HSE Community Mental Health Services, St Vincent’s Hospital.

Aim/Objective:
Our aim was to implement an integrated recovery/care plan supported by a key working and case management system. Our objective was to put in place the processes necessary to improve client satisfaction with the services provided to them at Dublin South East Mental Health Community Services. This necessitated the development and:

- Implementation of Information Booklet explaining a client’s journey through the service,
- Information leaflets on illnesses and medications prescribed that were user friendly and available to all clients as relevant.
- Our final target was the development of introduction of individual recovery/care plans. Our overall objective was to ensure the processes put in place for this team were adaptable and could be spread to all the teams working in Dublin South East Mental Health Services. This is still a continuing process.

Implementation:
A committee was set up comprising of the team members, two service users, one carer representative, and one Irish Advocacy representative. A management representative was invited to attend. Meetings were held every two weeks. Baseline data was obtained using the Mental Health Commission sponsored Service User Questionnaire, audit of the service and process mapping of the client’s journey through the service from presentation to discharge.

Follow up surveys were carried out to measure progress on two occasions and continuous audits used to monitor progress.

Targets were identified using PDSA cycle. The committee discussed each target. A responsible person was identified to ensure each task was completed prior to the next meeting. All minutes of meetings were circulated to all team members as well as the management team so that they were informed of developments at all times.

Deadlines were set so that unresolved issues could be identified and referred to management for discussion and support to help us attain the goals. Deadlines set by the MHC were adhered to. This allowed us to implement and monitor progress. Service users/clients were involved in developing and reviewing all new documentation prior to implementation.

Recovery/care plans were piloted with a number of clients and any changes that were identified made before it was fully introduced. Introductory letters together with a copy of the proposed Recovery Plan and information booklet were sent to 10 service users explaining the purpose of the recovery/care plan pilot study and asking them to participate.
A post interview survey was carried out with each client involved in the pilot. All staff involved in the pilot also completed a separate questionnaire which elicited their views on using the plan. The results of both surveys were used to make adjustments to the documentation. A finalized version of the recovery/care plan was introduced for general use by that team in April 2011.

A database was set up to facilitate audit of client base. A policy on key working to support the process of Key worker allocation and the guidelines on recovery/care planning for staff was introduced. Audits were carried out to facilitate allocation of clients to key worker. The level of recovery/care planning required by each individual attending the team was identified as part of the audit process, using the CPA approach outlined by Goodwin et al, (2010)

**Outcome:**
An introductory Information Booklet is sent to each individual with their first appointment. This explanatory booklet outlines the client’s journey through the service and has a sample of the recovery plan included as an example for their information.

An individual recovery/care plan is now used in the community mental health service by Dublin 2 & 14 team. All service users attending this clinic have a key worker allocated to them and the level of recovery care required by each service user is identified. Regular audits are carried out to determine admissions and discharges to the team. The level of key working required by each individual using the CPA system is also identified as part of the audit process. Recent audit demonstrate a decline in client base (this may be due to the introduction of prescription charge as much as regular audit)

SUQ survey carried out in November 2010 showed that there was an increase in the number of service users who had an individualized recovery plan. A follow up SUQ survey is planned for January 2012. The project has spread to three other teams in the catchment area. Data bases have been developed for the three teams. Introduction of key working and case management has commenced by the teams. A small number of recovery plans have also been completed.
8. Core Care Plan- Patient in Seclusion

Presenting Authors: Imelda Noone, Nurse Practice Development Co ordinator,
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Assessment Unit, St Brendan’s Hospital, Rathdown Road.

While the authors agree that Seclusion is a safety intervention of a last resort and should be reduced significantly, nonetheless Seclusion must be carried out in accordance with the Rules Governing the use of Seclusion and Mechanical Means of Bodily Restraint. Following the issuing of these rules by the Mental Health Commission in 2006 and the update in October 2009 the authors carried out regular audits to measure compliance in the Special Care Units in St Brendan’s Hospital.

The results of the audits continuously highlighted lack of full compliance. In order to address this and achieve compliance, the authors initiated a draft Core Care Plan encompassing all the rules for Seclusion. This process was assisted by clinical staff using focus groups and constant reviews of working drafts until a final document was agreed on.

The aims of this Core Care Plan are to (a) ensure that a detailed risk assessment is completed, (b) that the approved centre is fully compliant with the Rules and (c) to promote the active review of the episode of seclusion and its effects on the patient. This document was piloted for three months in two units and recommendations from staff were addressed. The final Core Care Plan was introduced in January 2009 and amended in August 2010 and February 2011. This care plan is audited on a six monthly basis and the results continue to highlight full compliance. Also, clinical staff feel that they have a care plan where they had input into the design and it ensures that the quality of care given to patients is of a high standard and is guided by the rules.

The result of the initiative has been very positive and has been validated externally as being successful by the Inspectorate from the Mental Health Commission.
9. Implementing a Common Assessment Tool and Care and Recovery Plan in a Community Mental Health Team: National Mental Health Services Collaborative Team

Author: Ms Kay Cullen
Co-authors: S. Kissane, D. McDonald, H. McGahan, N. O‘Muir, D. Godkin

Aim:
To develop and implement a common assessment tool (CAT) and care and recovery plan with key stakeholders in line with the standards of the Quality Framework for Mental Health Services of Ireland.

Objectives:
To review the service user journey. Develop an information booklet which would outline how services would be delivered from a recovery orientated framework. To develop a multidisciplinary common assessment tool and care and recovery plan.

Method:
The existing literature on assessment and care planning in mental health services was reviewed. Data was obtained through stakeholder focus groups and questionnaires on what should be included within the information booklet and care & recovery plan.

Outcomes:
An Information booklet for service users/families was published. An initial care and recovery plan was developed in collaboration with the service user. This care plan was linked to the common assessment tool and piloted with service users. Multidisciplinary team members received training in the Common Assessment Tool and Care & Recovery planning. All new referrals to the CMHT are assessed using the CAT by a designated MDT member.

Results:
Results from pre-and post questionnaires and focus groups demonstrated an improvement in service delivery. All new referrals receive the information booklet prior to their initial assessment. Waiting time for routine initial assessments has been reduced from 6-8 weeks to 2 weeks. All urgent new referrals are seen on the day. Approximately 30-45 new service users per month are assessed using the CAT and receive an initial individual care and recovery plan at the time of the assessment.

Conclusions:
The NMHSC project has had a positive impact on how the service is delivered from both a service user and service provider perspective. The ethos of a collaborative approach is now recognised as essential in the planning and delivery of services within the team.
Collaborative Recovery Care Planning in St John of God Hospital (CAMHS)
National Mental Health Services Collaborative Team

Presenting Author: Ms Sarah Donnelly, Clinical Nurse Specialist (Adolescents),

Co-authors: Dr David McNamara, Child and Adolescent Psychiatrist, Ms Michele Coyle, Senior Psychologist, Ms Yvonne Scanlan, Senior Occupational Therapist, Mr Paul Hawkins, CNM 2, Ms Angela Holden, Senior Social Worker

St John of God Hospital is an independent, not for profit, 183 bedded, psychiatric hospital providing acute psychiatric care nationally and locally. Ginesa Suite is a twelve bedded adolescent inpatient unit. We are a tertiary unit which aims to meet the needs of young people aged 14 to 18yrs with acute mental health needs. We work closely as a multi-disciplinary team, the participants involved are Child and Adolescent Psychiatrist, Senior social worker, Senior Occupational Therapist, Senior Clinical Psychologist, Clinical Nurse Specialist, members of Nursing team, Service users and their parents/guardians.

Motives for Change:
The overall purpose of the project was to review current multi-disciplinary team care planning, its effectiveness in practice and how it relates to the MHA 2001. To adopt best practice and improve team work and systematic care planning. To actively engage and empower young people to be more involved and work collaboratively with the multi-disciplinary team in developing their own care plans. To develop a better understanding of the recovery model and how it can be implemented into care planning. To educate young people and their carers regarding care planning and actively involving them in planning and implementing care. To maintain updated care plans and evidence that care plans are updated on a regular basis.

Aims and Objectives:
- To actively involve young people in the care planning process.
- To involve parents / carers in how we plan and implement care.
- To educate parents and young people about care planning and the recovery model.
- To improve how we document care planning and ensure that there is a record of it being regularly reviewed.
- To review / audit current care planning how effective it is and how it can be improved on.
- As a team to work collaboratively in facilitating goals and objectives.
- Through use of a collaborative Multi-disciplinary Recovery care plan to ensure all team members are aware of young person’s goals and objectives.
- To ensure that the standard set out by the Quality Framework, Mental Health Services in Ireland are being adhered to. Standard 1:1 Criteria 1.1.2. The development of the individual care and treatment plan has input from the service user, the MDT and the family/chosen advocate, where appropriate.

Implementation:
- St John of God Hospital, Adolescent Team accepted the nomination to undertake this project and we obtained approval from the Hospital Clinical Governance Committee.
- We carried out the Plan, Do, Study, Act cycle to develop an updated recovery care plan in collaboration with young people, families/carers, all multi-disciplinary team members.
We reviewed our current care plan and how it could capture young person’s personal goals and views. The overall aim being that the care plan was patient centred.

This involved us meeting as a team on a number of occasions to brainstorm the what, why, how and when.

Meeting with young people as a group to ask them for ideas and what changes they would envisage would be needed for them to be more involved in their care.

Meeting with families/carers regarding how they would like to be involved in the care planning process.

A new format was developed and piloted.

The pilot was central to Ginesa Suite and all team members were actively involved.

Young people, families/carers and staff were instrumental in designing each draft of the Multi – Disciplinary Recovery care plan which progressed through 4 PDSA cycles.

Young people, Families/Carers and staff were involved in the evaluation process.

Evaluation methods included weekly auditing of standards achieved, using the NMHSC audit tool, regular discussions with young people, carers and the team.

We collaboratively evaluated the outcome and contributed to the National Mental Health Services.

When an initial draft was developed we tried this for a period of four weeks. Each young person was allocated a care co-ordinator which involved all Multi-disciplinary team members. The care co-ordinator was responsible for involving the young people with the care plan, bringing their goals and objectives to the team meeting on a weekly basis and discussing it with their families. The team reviewed the Multi-disciplinary Recovery care plans every Thursday, a documented record was kept of this and the care co-ordinator would discuss any changes with the young person and their family. The young person would sign the care plan and a copy would be given to them. Families were met weekly and the Multi-disciplinary Recovery care plan was reviewed and discussed. Young people and families were able to input their point of view.

Following our third audit it became evident that care plans were not being completed and signed as planned. When results of this were presented back to team members it became evident that due to some team members working part time and programme constraints they were unable to meet individually with young people and families on a weekly basis. Young people’s/families points of view and input were being missed.

Following this the format for the Multi-disciplinary Recovery care plan remained however we changed how it was implemented. Within the programme a Care planning group was included on a weekly basis. This involves young people meeting as a group, discussing care planning and recovery. Education is offered to young people regarding recovery and how care planning is important and that their input is central. Young people then individually go through their care plan with a member of the multi-disciplinary team member. Their objectives, goals and points of view are then inputted into the care plan and included in team discussions.

Outcomes:

We audited the involvement of the young people and families in the care planning progress i.e. was there care plan explained, did they receive a copy of their care plan, did they feel involved, did they feel they could influence what was written in their care plan. We also monitored the key worker role, i.e. did they know their key worker, and did they have an understanding of their role. Did they discuss their care plan with their key worker? We audited their contact with the team i.e. did they have an understanding of each team member and their role, did they know how to give feedback to the team regarding the team.
We also regularly monitored the extent to which all fields on the care plan were completed correctly, the identification of the key worker ensuring that young people and families had copies and involvement within the development of the care plan.

Following our last audit of above we reviewed 25 sample care plans. Out of the 25 care plans 17 had been signed by the young person. 1 was offered and refused and the last two were incomplete. All had documented evidence of input from service user, family and MDT members. Young people showed an awareness of their care plans that their key workers were and the team members and their roles.
11. A.C.I.R. Collaborative Care Planning For Recovery

Author: David Green
Co-Author: Martin Doolan

Objective:
South Tipperary Mental Health Service undertook to advance its existing practices to reflect more comprehensively modern best practices, and to ensure a more service-user centred model.

Method:
- We established the Assessment, Care planning and Integrated Records (ACIR) group. This was a multi-disciplinary body, including Service User representative, to review current practices, international models, and MHC documentation. It consulted widely with all stakeholders. The activity of this group resulted in the design of an Integrated Care Pathway model for the service.
- A new assessment format was designed, with risk and needs assessment incorporated, leading to multi-disciplinary care plan /discharge pathway.
- This model actively engages service users in care planning, recovery, relapse prevention and discharge from the outset.
- The model is multi-disciplinary and whole system – i.e. valid for community and approved centres.
- This development was supported by educational approaches for teams and service users.
- A Pilot of this model was put in place, which was audited over 3/6/12 month intervals leading to minor modifications and evaluation.

Results:
Audit results indicated that the model was successfully adopted.

Evaluation, including staff and service user surveys, demonstrated a high satisfaction with the new model. 70% of service users felt that the changes were an improvement and this was supported by staff comments that service users were “…becoming more involved” and that “[they] report a sense of ownership around their care”.

Conclusion
ACIR stands up well when matched with Quality Framework standards and comparable research. ACIR has proven itself to be robust in placing the service user at the centre of needs based care planning. More recently it has been adopted in the whole extended catchment areas of Carlow/Kilkenny/South Tipperary.
Aims & Objectives:
To improve service users’ perceived acceptability regarding aspects of 1.1 of the Mental Health Commission (MHC) Quality Framework (QF).

Methods:
The perceived acceptability regarding aspects of 1.1 of the MHC Quality Framework, for service users’ receiving care from the multidisciplinary team involved with the national mental health services collaborative (NMHSC), was measured with a questionnaire adapted from the first 9 questions of the MHC/NMHSC Service User Questionnaire (MHC 2010). These questionnaires were conducted pre and post the introduction of interventions from Sept – Nov 2010, aimed at improving service users’ perceived acceptability regarding aspects of 1.1 of the MHC Quality Framework.

The questionnaire was repeated in March 2011 following the implementation of additional interventions to provide direct education to the service users’ aimed at increasing their knowledge and understanding of Individualised Care Planning, Multidisciplinary Team working and Key Working. It was repeated again in November 2011, to assess the effectiveness of on-going initiatives to improve service users’ perceived acceptability regarding aspects of 1.1 of the MHC Quality Framework.

Results:
The results show sustained and significant positive changes in service user perceptions regarding their involvement in the planning of their care and the involvement of their family/carers/advocates. The post-intervention questionnaire results from the original interventions in Sept – Nov 2010, showed a marked anomaly in relation to service user perceptions about their opportunities to sign their care plans. Results were disappointing for this measure, despite the fact that a review of medical records for those involved on the day of the questionnaire showed that all of the service user’s questioned had signed their care plan. This led to the introduction of additional sustained service wide initiatives to provide direct education to the service users’ aimed at increasing their knowledge and understanding of Individualised Care Planning, Multidisciplinary Team working and Key Working. Results from March and November 2011, show this anomaly persists, but there has been some improvement.

Conclusions:
Service users’ perceived acceptability regarding aspects of 1.1 of the MHC Quality Framework has improved, particularly perceived involvement in care planning, but there is a need to maintain service wide initiatives to improve service user knowledge and understanding regarding Individualised Care Planning, Multidisciplinary Team working and Key Working.
13. Individual Care Planning and Recovery for Deaf Irish Sign Language Users

Presenting Author: Dr Margaret du Feu, Consultant Psychiatrist

Co-author: Stephen Browne, Clinical Nurse Specialist

There are at least 5000 people in Ireland who have been profoundly Deaf from early life, and use ISL as their first, preferred or only language.

The Ireland Mental Health and Deafness Service was established by the HSE in September 2005 and has seen nearly three hundred patients. It is mainly a liaison service as the team consists only of a Consultant Psychiatrist, four sessions a week and one full time Clinical Nurse Specialist. The team holds clinics and does visits all over the Republic of Ireland.

The Ireland Mental Health and Deafness service has a complete series of referrals from 2005 and these have been reviewed retrospectively to ascertain the patients who have needed shared care with local mental health teams. These patients have been analysed for route of referral, diagnosis, pathway to shared care and clinical outcomes.

Although referrals may be initiated by the Social Workers with Deaf People, GP’s are always included in the referral process and care planning.

Many Deaf patients have serious long term mental health problems. Co-ordinated care planning needs to include the GP, local Mental Health Teams or Intellectual Disability, Older Adult or Forensic Services, as appropriate and with Social Work and voluntary sector involvement.

The poster will give examples of problems and successes in this process, outcomes and lessons to be learnt. The results show that most have serious long term mental health problems, many with complex needs. Where successful co working has been established the outcome is improvement for the patient. However there have often been difficulties and delays in setting up shared care, and a lack of resources for Deaf patients remains a major issue. The aim of the study is to learn how to improve and build on good practice for this patient group.

Presenting Authors: Tomas Murphy and Dominic Fannon
Recovery Team mayo Mental Health Services

The Mayo Mental Health Recovery Team provides both Residential and Community Services to people who suffer with Severe and Enduring Mental illness within the County. An approach to care using models of concordance and partnership has been emphasized within a new MDT care plan which has been implemented in NOV 2009. To date both the MHC and Service User Forums have advocated its use. The process of design, planning and implementation was Multidisciplinary, having expert advice and input from Medical, Nursing, Social Workers, OT and Advocacy domains.

Introduction:
Person Centred
MDT format
International best practice
Guided by MHC & Vision for Change
Based on models of concordance
Active participation of clients within process

Implementation:
November 2009
Staff information and education sessions
Changes in practice –plan for Audit
MDT approach to care planning
Use of care co-ordinators

Evaluation:
Implementation of computer based care plan
All clients to have identified Care Co-ordinators
Development of specialist Team Co-ordinator role
Formation of Recovery Information Pack
Implement Early Intervention Care Planning Process
Care-co-ordinator roles encouraged

Future Ambitions:
Ongoing Audit
Increase Participation of NGO’s within care Plans.
Objectives:
The objective was to align the multidisciplinary team approach to providing care to an inpatient population with that of the Organisations vision by incorporating the perspective of a service user to ensure a more patient centred approach.

Methodology and Implementation:
A review of the Organisations vision was conducted and self reflection of the multidisciplinary team on its own aims was conducted to generate a shared vision. A service user perspective was obtained by results from survey work conducted by the Consumer Council on patient experiences of their care. A service audit tool kit was used to analyse team work and how effectively the team functions in the first cycle. In the second cycle, a service user’s journey process map was identified and analysed with service user interviews to highlight areas that needed change.

Results:
Areas of change or improvement that were identified included:
- A standard was needed at a service level agreement for a predetermined time period between referral and the time of assessment by a department. It was determined that a three day waiting period would be an organisational standard and generate a higher level of efficiency in delivering patient care.
- Pre and post intervention assessments were conducted showing an improvement in four key areas.
- Increased awareness of the service user on their referral to a therapeutic service.
- Improvement in waiting times to meet a staff member from a therapeutic service.
- Improvement in information regarding waiting times to access a therapeutic service.
- Improved level of understanding about the purpose and content of a therapeutic service.

Conclusion:
The team identified that a cohesive approach that was in line with the Organisations vision and incorporated feedback from a service user perspective was necessary to provide a better multidisciplinary approach to current in-patient care.
16. Individual Care Planning in St Edmundsbury Hospital (2010-2011): Developing Recovery Focussed Care

Presenting Author: Michael Finn, Assistant Director of Nursing, St Edmundsbury Hospital

Authors: Michael Finn ADON, Julie Moran, In Patient Services Coordinator, Sally McCahey, CNM, Programme Manager. Stephen Douglas, Nurse Development Coordinator. Dr Noel Kennedy Consultant

Objectives:
Emerging data suggests that services developing a Recovery Focussed System of Care deliver better outcomes for service users and lead to greater involvement in treatment planning and satisfaction among service users and staff. Clinical managers in St Edmundsbury Hospital sought to introduce Recovery Focussed Care through Individual Care Planning and service development in accordance with Mental Health Commission (MHC) Quality Framework between 2010-2011.

Methods:
Recovery Focussed Individual Care Planning was introduced by (1) allocating individual Key Workers for each service user holding formal admission/discharge treatment planning meeting, organizing treatment delivery and advocating for service users, (2) ensuring more direct service user input into Multidisciplinary Meetings, (3) enhancing Advocacy and service user information within the Hospital, (4) producing an information book to orientate service users on admission, (5) enhancing psycho educational programmes to be more Recovery Focussed, (6) appointment of Inpatient and Day patient coordinators to develop individual programmes and focus on individual needs of service users, (7) appointment of a Ward Based Pharmacist to attend multidisciplinary meetings and discuss drug treatment options, including side effects, with treating physicians and service users, (8) enhanced documentation of Individual Care Plans in line with MHC Regulations. Service user satisfaction, level of Recovery Focussed care and documentation were repeatedly audited during 2010-2011.

Results:
Individual Care Planning improved in delivery and documentation during this process, as was evidenced by ongoing Audit. Multidisciplinary team members described increased satisfaction with the Recovery Focussed Care and service user understanding and satisfaction with this model of care were high. The Hospital achieved full compliance with all the MHC Regulations after MHC visits in 2010.

Conclusions:
The development of Recovery Focussed Individual Care Planning (2010-2011) has led to high level of service user and staff satisfaction and interaction in addition to much improved documentation of care planning in St Edmundsbury Hospital.
17. The Impact of a Structured Recovery Programme

Presenting Author: Edel Fortune, Clinical Manager, Wellness and Recovery Centre, St Patrick’s University Hospital

Introduction:
The experience of individual’s recovery journey was measured using the Stages of Recovery Instrument (STORI) (Anderson et al 2003). The self-report instrument measures five stages of recovery; Moratorium- a stage of hopelessness and self-protective withdrawal. Awareness - the realisation that recovery and a fulfilling life is possible. Preparation - the search for personal resources and external sources of help. Rebuilding - Taking positive steps towards meaningful goals. Growth - a sense of control over one’s life and looking forward to the future.

Respondents:
The respondents were all undertaking a five week structured recovery programme at St Patrick’s University Hospital. They were from ten different programmes and the questionnaires were completed at three stages; day one of the programme, at the end of the programme and at six months follow up. There were 46 respondents at day one and at the end of the programme and 14 at the six month follow up stage. Those who only completed one questionnaire were excluded.

Results:
The cumulative score of the 46 individuals that completed the first two questionnaires indicated that the programme resulted in an overall improvement of 21% in the participant’s psychological recovery and personal growth.
The cumulative score of the 14 individuals that completed all 3 questionnaires indicated that the improvement between stage 1 and 2 was 23% and at six month follow up it had returned to 15% above the original baseline.
The programme continues to show encouraging results.

Limitations:
The limitations of this study included; no supporting qualitative data, some of the questionnaires were incomplete, only 14 individuals completed all 3 questionnaires.
The Effect of Training on the Understanding of Recovery Concepts on Hospital Staff

Presenting Author: Edel Fortune, Clinical Manager, Wellness and Recovery Centre, St Patrick’s University Hospital

Introduction
In an effort to address the many challenges posed by the introduction of a recovery ethos to an established mental health service, recovery training was offered to all staff, not only those involved clinically.

Aims:
- To investigate mental health service staff baseline knowledge and attitudes about recovery.
- To investigate the impact of a half day structured training programme on staffs attitudes and knowledge about recovery.
- To identify future training needs for staff about recovery.

Respondents:
Those who partook of the training included staff from the following departments; catering, switchboard, maintenance, human resource management and administration. Also included were staff from a variety of clinical disciplines, nursing, medical, social work, occupational therapy.

Results:
Two self report questionnaires were used, pre and post training, with 35 staff. The questionnaires were RKI-202 and RAQ-73.
There were improvements in knowledge demonstrated in all of the following four domains:
- Roles and responsibilities in recovery
- Non linearity of the recovery process
- The roles of self definition and peers in recovery
- Expectations regarding recovery

This demonstrated that a short education session can be a first step in altering the attitudes and beliefs of all staff within a mental health service. It is also useful as a guide when planning future training.

Limitations:
The limitations of this study included; the training was only 2.5 hours in duration. There was a difference between the base line knowledge of clinical and non-clinical staff.
19. Integrated Care Pathways and Pillars of Care - A Forensic Recovery Pathway

Presenting Author: Pauline Gill

Authors: Harry Kennedy, Paul Braham, David Timmons, Paul McKenna, Johnny Thompson, Pauline Gill, Helen O’Neill, Andrea McNulty

Objectives/ Aims:
At the National Forensic Mental Health Service for Ireland we have developed a comprehensive system for the delivery of an assessment, treatment and recovery-oriented care pathway through a secure forensic mental health service. The use of structured professional judgement tools, in particular the HCR-20, SRAMM and CANFOR across the service, prior to this process led to recognition of the need to systematically address identified risks as unmet needs. It also allowed us the opportunity to identify low risk items and ‘met need’ as service user strengths.

Methods:
An iterative process was used to obtain feedback from service users, carers, frontline staff, peer advocates and senior managers. This evolved into a process of action research so that the intended users of the ICP process had ownership and commitment at all stages. The creation of the integrated care pathway as an action research process provided a shared understanding of key standards among clinicians, service users and carers that are necessary to implement a quality care pathway involving all stakeholders.

Results:
Five pillars of Care were identified - (i) physical health, (ii) mental health, (iii) substance misuse, (iv) harmful behaviour and (v) social, family and occupational function. These pillars map a pathway of care and became central to the tenet of recovery within our service, where strengths as well as needs and risks are identified.
We have developed two structured professional judgement instruments, the DUNDRUM-3 programme completion instrument which is closely related to the pillars of care outlined above, and the DUNDRUM-4 recovery instrument which is specific to considerations in forensic mental health settings.

Conclusions:
These measures meet the criteria for validation suggested by the RMAS and appear to predict both positive and negative moves along the recovery pathway.
 Equality of Presence and Equality of Participation: Lessons from the EOLAS Collaborative Research Project

Presenting Author: Fiona Boyd

Full authorship:
Fiona Boyd, Paul Hogan, Alison O’Brien, Dara Lakes, Marianne Breen, Danika Sharek, Padraig McBennett, Caroline O’Connor, Pat Gibbons, Liz Gregan, Deirdre Brassil, Susan McFeely, David Hevey, Agnes Higgins, School of Nursing and Midwifery, Trinity College Dublin and Kildare/Wicklow Mental Health Services

Aim:
The aim of the poster is to report on service users’ experiences of involvement in a collaborative research project. The aim of the research study was to develop, implement and evaluate a peer and clinician led educational intervention on recovery problems for service users and family members, on recovery from enduring mental health problems. Service users and family members were involved in all stages, from steering group to being members of the research team.

Methods:
Drawing on Sherry Arnstein’s model of participation in decision-making from a community development perspective, this poster explores some of the lessons learned from the perspective of the service users and family members involved. Arnstein’s model conceptualises participation and involvement in terms of levels on a ladder, ranging from level one (no participation) to level eight (citizen power).

Results and Conclusion:
Involving service users and family members as equal partners in the research process is a relatively new development in the Irish context. The Arnstein model was a useful benchmarking tool for examining user participation within the study and assisted the team in highlighted strengths and weaknesses of the collaborative process. Findings from the study indicated that although the involvement of peers (users and family members) was valued by all and appeared to foster new understandings, due to a variety of reasons, including insufficient preparation of facilitators on occasion, traditional power dynamics prevailed within the group. Recommendations to ensure full engagement include providing education on strategies to overcome the inherent power differentials between clinicians and peer facilitators and incorporating awareness raising exercises on the valuable contribution peer facilitators bring to programme delivery.
21. ‘I Know That I Have the Right to Ask’: Findings from the Evaluation of the EOLAS Programme

Presenting Author: Marianne Breen

Full authorship: Marianne Breen, Fiona Boyd, Paul Hogan, Alison O’Brien, Dara Lakes, Danika Sharek, Padraig McBennett, Caroline O’Connor, Pat Gibbons, Liz Gregan, Deirdre Brassil, Susan McFeely, David Hevey, Agnes Higgins, School of Nursing and Midwifery, Trinity College Dublin and Kildare/Wicklow Mental Health Services

Aim:
The aim of the research was to develop, deliver and evaluate an information programme for service users and family members on recovery from mental health difficulties (medical diagnosis of schizophrenia or bipolar disorder). The EOLAS project was a collaborative venture between service users, family members, practitioners and academics.

Methods:
The research design adopted for the project was informed by a participatory collaborative frameworks. The programme was developed in collaboration with service users, family members and clinicians and delivered using a co-facilitation model involving both clinicians and peer facilitators. An exploratory mixed method approach using pre and post questionnaires and interviews were used for the evaluation.

Results & Conclusions:
Findings indicated that participants were positive about the dual nature of the facilitation. In their view peers (users and family members) had credibility and provided hope and inspiration. In contrast the clinicians had a ‘clinical expertise’ that they also valued. Findings also demonstrated a number of positive outcomes including enhanced knowledge, self advocacy, empowerment, and support. Both groups of participants (users and family) spoke of leaving the programme with a ‘better understanding’ of either their own or another’s mental health problem. In addition, users of services, in particular, spoke of feeling more empowered to question practitioners about their care and treatment. While acknowledging a need for further capacity building to ensure equality of participation among all, feedback from stakeholders indicates that the EOLAS Project was a positive initiative as it commenced a dialogue on the importance of user and family involvement within the service. The project design, governance, delivery and evaluation offers a blueprint for future developments that are collaborative in nature and provides a framework by which other services can work towards achieving a number of the quality standards on information giving as laid down by the Mental Health Commission.
Collaborative Recovery Care Planning in St John of God Hospital (Adult)
National Mental Health Services Collaborative Team

Presenting Author: Ms Janice Huet, Clinical Nurse Specialist, Psychosis

Co-Authors & Participants: Dr Mary Clarke, Consultant Psychiatrist, Ms Karen O’Connor, Special Lecturer/Senior Registrar, Elizabeth Lawlor, Psychologist, Pauline Hogan, CNM II, Carol Meere, Occupational Therapist, the patients’ families and carers who contributed to this pilot study and the entire staff of St Joseph’s Suite

Purpose:
- To achieve patient centric, recovery focused, individualised multidisciplinary care planning in an inpatient setting, to comply with the MHA 2001, specifically the Approved Centre Regulations 2006, to adopt best practice and improve team work and systematic care planning. To move from current practice which is the medical model where professionals complete the multidisciplinary care plan and ask for a patient signature, to a more collaborative approach; i.e. from “do for” to “doing with.” To engage and empower patients’ and their families / carers in understanding and participating in planning care, maintaining an updated plan and evaluating target / goal achievements as the plan alters through treatment.

Our Objectives:
- To position the patient at the centre of the care planning process.
- To improve how we plan care and work as a team.
- To collaborate and engage patients the patient’s family / carer / other (with patient consent) in care planning.
- To develop and pilot an Individual Recovery Care & Treatment Plan Template with patients and stakeholders to document care planning and evaluation.
- To meet statutory requirements.

Methods
- The St John of God Hospital Psychosis Team accepted the nomination to undertake this project and we obtained approval from the Hospital Clinical Governance Committee.
- We utilised the Plan, Do, Study, Act cycle to iteratively develop the Recovery Care plan in collaboration with stakeholders (patients / families / carers / multidisciplinary team members).
- We reviewed our current multidisciplinary operational methods and the extent of patient input and devised a strategy to centralise the patient at the heart of care planning. This included meeting and drafting an initial plan with the patient before the team meeting and reviewing and finalising it after the MDT meeting on a weekly basis.
- The pilot was undertaken in collaboration with one designated suite in the hospital: St Joseph’s.
- Patients and staff were instrumental in designing each draft of the Individual Recovery MDT Care plan which progressed through 4 distinct drafts as the pilot proceeded.
- Patients / service users were central to the evaluation process.
- Evaluation methods included weekly auditing of standards achieved, using the NMHSC audit tool, discussions with patients, carers and the team, consultation with the Irish Advocacy Network.
• The wider hospital community were provided regular updates on progress.
• We set measurable targets which were audited weekly, the Irish Advocacy Network engaged with patients independently but as part of the project to objectively observe progress.
• We collaboratively evaluated the outcome and contributed to the National Mental Health Services Collaborative.

Implementation:
All suites in St John of God Hospital are designated for acute psychiatric care. The Individual multidisciplinary care plan was piloted on St Joseph’s Suite with patients treated by the Adult Psychosis Team. Rather than use the existing hospital multidisciplinary care plan we used each successive draft of the care plan as devised with patients and team. We went through four iterations devising standards and moving more towards use of Recovery language / patients own words. It became clear that acutely unwell patients may not be able to engage in planning care whilst in the most severe phase of illness. Sensitivity and timing are key considerations when engaging patients in care planning. Approaching patients too early may be overwhelming for some. Patients expressed a preference for completing the care plan with the key worker initially within a week of admission but not on the first day necessarily. This was then reviewed by the team each Thursday and following the MDT review the plan was re-discussed with the patient, signed and copies maintained by the patient and team. Some patients declined to accept copies of the care plan. We set standards which included that all patients in the study would have an MDT Recovery Care Plan devised collaboratively with them and ensured we met this standard.

Outcomes:
We audited the extent of use of the MDT care plan, and the extent to which all fields on the care plan were completed correctly, the identification of, approachability and role of the key worker.
We monitored patient inclusiveness and collaboration in care planning: their sense of involvement / influence on care planning, the relevance of the C.P. plan to the patient condition, family / carer involvement (with patient consent), knowledge of the care plan and whether they had signed and held onto a copy of the care plan.
We also audited the extent to which information was imparted, contact with the team and team functioning metrics.
We audited the extent of Recovery Model use in care planning (Hope, Person-centredness, Leadership, Education etc).
The results were that 100% of patients in the study had individual MDT care plans, reported feeling that their key worker was approachable, had received adequate information on procedures and their rights; for example they knew how to make a complaint. Patients also reported that they were involved and their families included in planning care and almost all had signed their care plan although some refused to have a copy.
Authors: Antoinette Hughes, CMHS/CNS, Michael McCormick, CMHN/CNS

Co-Authors: Elizabeth Collins and Laura Buchanan.
North Strand Community Mental Health Team, North Strand Rd, Dublin 1.

Objectives:
To provide those who experience psychosis with a choice of evidenced-based therapeutic interventions which are empowering and collaborative in nature.

To develop a range of psycho-social interventions in practice which would reflect the philosophy and process of recovery. The interventions included Early Warning Signs training; Medication Concordance; Hearing Voices Work and a Social Skills group.

The development of a referral form which reflected a recovery orientation and the use of therapeutic interventions.

Methodology:
The method used was an Action Research approach; its cyclical and evaluative nature was seen as appropriate when the aim was to bring about change in practice.
Critical reflection as part of data analysis, learning and action was utilised through the use of weekly educational sessions; clinical peer supervision and continuous evaluation. Challenges to implementation were worked through these sessions. Evaluation as part of the Action Research process using group workshops/meetings was ongoing throughout the process.

Results:
An evaluation using a questionnaire was undertaken of both staff and clients responses to the use of the interventions and indicated positive results.
Further project development has been ongoing through the team and sector following this project.

Conclusions:
- It is possible to implement EWS and Medication Concordance into routine community clinical practice.
- A high level of team commitment is required to ensure the interventions become embedded into practice.
- The project and the interventions had an empowering effect upon clients in the development of skills and in gaining a sense of control but also amongst the team where the interventions facilitated the articulation of therapeutic work being done.
- Flexibility is important in delivery of interventions. In the area where this project occurred there is a high level of illiteracy therefore paper–based activities must be tailored to respond to individual clients.
24. The Use of the Recovery Star as a Tool for Planning With Service Users in a Mental Health Rehabilitation Service

Presenting authors: Susan Kehoe and Bridget Harney

Aims/Objectives:
To promote and encourage more active participation by the service user in their occupational therapy intervention and to begin to highlight the use of the Recovery Approach within the wider service on a practical level. The Recovery Star enabled us to begin to translate theory into practice.

Methods/Implementation:
We introduced the Recovery Star as part of our rehabilitation programmes. The star was used with service users before and after OT intervention

- The process enabled the service user to identify their strengths
- The perspective of the service user was brought to the forefront of intervention
- The use of the star challenged the way we worked to move from being client centred to service user led
- Intervention was tailored according to the areas the service user identified as being their priority

Results/Outcomes:
- The Recovery Star was one of the outcome measures used to identify changes for the service user after intervention. The Star provided a visual representation of service user progress which was valued by the service user and the goal setting mapped the process of recovery for the individual.
- The results for every individual were different and as such difficult to quantify. Case studies best show the outcomes. For the service users, some of their ratings increased and some decreased. Please see below an example of a Recovery Star used with a service user before and after an OT programme. The reasons for some of the decreases were explained by the service user as being as a result of gaining insight into his skills in a particular area. His ‘living skills’ rating for example, decreased from 9 to 6. He had just taken part in an OT programme which focused on living skills and gained this insight from taking part. Objectively we would have scored him pre-programme at a 3 and post-programme at a 5. However, the Recovery Star enabled him and us to gain his perspective pre- and post programme and was a powerful tool in this way. He was much more motivated to continue to work on these skills after the programme as he had identified it as a need himself and not through us. He had not got this insight before using the Recovery Star.
- We were able to start discussing the recovery approach and begin to introduce ‘Recovery’ language with service users and with the wider service.
- The Recovery Star prompted us to develop programmes and interventions that the service users were identifying as being important to them. Many service users had identified ‘Work’ and ‘Social Networks’ as being priority areas for them. As the ‘professionals’ we would have started working on things like living skills and self-care as we would have seen these as priorities. However, as a result of gathering the data from the Recovery Star we instead formed a ‘Community Information’ group where the members went to visit community facilities that could help them access courses/jobs and we got speakers in from the local community e.g. Volunteer Ireland. We may have done this group at some point but it would not have been our priority in starting to work with this service user group as many had difficulties in basic living skills and self-care. However, by starting the ‘Community Information’ Group the needs were service user led, and we were able to have an impact on such areas as self-care and living skills indirectly e.g. having to look presentable in order to visit an
external resource. Again, by taking the lead from service user identified priorities, motivation to participate was at a much better level.

- Using the star within our OT intervention provided evidence that it is a valuable tool to use with our service users and that it could be used in a wider context, as part of multi-disciplinary care planning. However, using the Recovery Star on a continued basis as one discipline in isolation will not enable the service user to gain the most from the experience in the long term. To promote the concepts of recovery such as empowerment and responsibility requires full MDT and service user involvement. By using it in OT intervention, we have been able to provide the evidence to move the process forward within the service.
PROTECT (Personalised Recovery Orientated Treatment, Education and Cognitive Therapy) – Ensuring Engagement with the Recovery Model in Early Interventions for Psychosis

Presenting Author: Bridget Harney, Senior Occupational Therapist, PROTECT, Lincara Centre

Co-Authors: Dr Jannat Adil, Specialist Registrar PROTECT, Lincara Centre, Boghall Road, Lecturer, Department of Psychiatry, Trinity College, Dr Brian Fitzmaurice, Consultant Psychiatrist, HSE Wicklow Mental Health Service Clinical Senior Lecturer, Department of Psychiatry, Trinity College

Background:
Detect assesses the majority first episodes of psychosis in South-East Dublin & Wicklow. Though Detect offer all cases phase specific interventions the majority in Wicklow were unable to engage with treatments offered. Assertive case management and recovery principles were not prioritised or systematically provided by the individual's CMHT. Most individuals were not receiving optimal treatment in the early “critical phase” of psychotic illness. Many were disabled by illness, reliant on a medical model of illness only.

Aims:
PROTECT aimed to engage and enable individuals who had failed to engage with Detect with the opportunity to set and achieve their own recovery goals in a CMHT context.

Methods: Engagement with a case manager able to use a recovery model was identified as the first and most important step. The collaborative development of Recovery Support Plans was a protracted process involving close liaison with their existing supports. The PROTECT team included occupational therapists, social care workers, an employed service user & a CBT therapist.

Recovery Support Plans were based on Mental Health Commission guidance on care planning and the Mental Health Recovery Star. Each Recovery Support Plan included clear goals, time frame, intervention and process strategies, people responsible and outcome of each individual goal. The Recovery Star was regularly rated at Recovery Support Plan reviews. This measured change and also visually mapped the process of intervention provision and achievement of recovery goals.

Results:
PROTECT team were able to engage in Recovery planning nearly all of those who had previously failed to engage with interventions offered by Detect, raising engagement with early interventions to 80% of first episodes of psychosis.

Conclusion:
PROTECT provides a model of how CMHT staff might provide recovery orientated treatment within emerging Early intervention services nationally. The CMHT working in conjunction with PROTECT has made transformational changes in developing skills in using recovery and CBT.
26. Developing an Effective Multidisciplinary Individualized Care Plan Programme.
National Mental Health Services Collaborative Team

Presenting Author: Ian Lihou, (CNM2, Éist Linn.)

Project Participants: Ian Lihou, CNM2, Michael O’Sullivan, DON, Dr Maura Delaney, Consultant Psychiatrist, Catherine White, Social Worker, Dr Aileen Whyte, Psychologist, Vivienne Foley, SLT, Bernadette Spellman, SN, Joanne Corbett Dietitian

Objectives:
1. Formulate and implement a multidisciplinary care plan document to suit a child and adolescent inpatient group.
2. Ensure the creation and use of this document reflects a collaborative and client-centred ethos.
3. Ensure that changes implemented have a measurable, sustainable positive impact on engagement with young people and their families.

Methods:
1. Consultation with multidisciplinary team, and formulation of the initial document. Through drafting, redrafting and discussing the document, agreement was reached by team members on what would be suitable.
2. Piloting the new documentation and reviewing feedback. This was a cyclical process which involved utilizing the document, discussing it with young people and their families, and auditing how effectively the care plans were being used. Changes to document and protocols were made throughout this period.
3. Sustainability testing. At this stage the document and protocols were established. A “hands off” period of six months was then observed, before a final audit of effectiveness. The purpose of the “hands off” period was to gauge how well the care planning process holds without intense scrutiny and intervention from senior staff.

Results:
The introduction of new documentation and protocols was broadly successful. Young people and their families were engaged in the care planning process, as evidenced by audit data (the majority of care plans were seen and signed by young people and their families.) The sustainability test indicated that following a six month “hands off” period, there was only a slight drop in effectiveness.

Conclusions:
An effective multi-disciplinary individualized care planning programme can be implemented in an inpatient child and adolescent mental health facility. In this case the majority of care plans were seen and signed by young people and their families. Once documentation and protocols are established they did not require constant intense scrutiny and intervention from senior staff.
Development and Implementation of Individual Service Plans on a Child and Adolescent Mental Health Community Team-Lucan/Adamstown CAMHS
National Mental Health Services Collaborative Team

Presenter: Dr Catherine McElearney

Co Authors: Sadie Tierney, Niamh Quinlivan, Lilly Clarke
Linndara Lucan /Adamstown Child and Adolescent Mental Health Community Service

Objectives/Aims:
- Development of a written care plan for service users as per standard 1.1 of the Quality Framework.
- To implement in daily clinical practise by developing a user friendly plan to assist compliance in a busy clinical setting.
- To develop a document that did not interfere with process in therapeutic relationships and embraced the principals of effective care planning.

Methods:
- Nominated team members participated in training modules and received training in guidelines for care planning and in PDSA Cycles.
- Brain-storming with team members re proposed format of care plan encompassing criteria for effective care plans. Individual Service care plan devised.
- 2 Audit phases to test the use of the Individual Care plan in clinical activity. Phase 1 over a 6 week time frame. Phase 2 over an 8 weeks week time frame.

Results:
- Pilot of format 1, using the Individual care plan over a 6 week period for 15 new service users.
- A short qualitative questionnaire was completed to evaluate staff and family views of the format and process. Discussion and changes following the feedback from service users and staff.
- Audit of format 2 over an 8 week time-frame.

Conclusions:
- All team members in agreement that individual planning fits with good clinical practise and positive feedback elicited from families supportive of care planning.
- Regular review of individual care plans required as clinical goals change over time.
- Booklet with duplicate copies to be developed by Linndara Service following a service wide audit of all Community teams.
Author: Ms Catherine O Grady

Setting the context:
The Creative Well is an exciting new integrated arts and health programme which draws on a number of well established arts on prescription and ‘social prescribing’ projects for inspiration and evidence based practise.

What makes this programme so unique is that it is open to all in the community to participate but a no numbers of places are reserved for mental health service users. All applicants are interviewed prior to commencement to allow for the best possible mix of abilities and outcomes. This programme provides a unique opportunity for mental health service users to mix with others in their local community outside of the mental health system.

Aim:
The aim of the Creative Well is to develop a social model for supporting mental health and wellbeing through the use of the arts and within the context of local communities.

Objectives:
- To provide a regular programme of weekly arts workshops in County Kildare to support and promote mental health and well being.
- Using the arts as a social development tool, to create opportunities for participants
- Build self-esteem and confidence
- Enhance personal development
- Develop skills
- Connect with others and form links in their local communities
- Explore creative ways of overcoming emotional difficulties

How does it work?
The Creative Well is a twelve week creative programme open to all over the age of 18. Workshops are facilitated for two hours, once a week by professional and experienced artists and content may vary on programmes but could include visual arts, drama, dance, creative writing, film, music and storytelling. On completion of the programme participants are signposted to other activities or opportunities in their local community. The programme will be run in a number of locations throughout the county to allow opportunity for all.

Evaluation:
The first programme began in September and has just been concluded. The Warwick-Edinburgh Mental Wellbeing Scale has been used pre and post programme to assess this programme on mental health and wellbeing. A completion questionnaire was used to gain insight into the benefits for participants of being involved in the Creative well. The final results are being analysed.

This unique initiative has been developed through interagency partnership within the voluntary and statutory sectors. The Creative Well partnership includes HSE Kildare West Wicklow Adult Mental Health
Testimonials from participants include:
- “I have to say this has been the most wonderful experience, something very special comes from classes like this”
- “This course has added interest to my life and has inspired me to be more creative”
- “Every week I just lived for the workshop and looked forward to meeting the other participants”
- “We also learned from each other and learned to appreciate each other’s abilities”
- “I rediscovered a hobby I loved and the happiness it brings to create something.”
29. Recovery Focused Care; Impact of Assertive Outreach Treatment on hospital stay of Patients with Severe and Enduring Mental Illness in the Sligo Leitrim Mental Health Service

Presenting Author: Dr. Munir Qadir, Research Fellow

Authors & department(s): Dr. Munir Qadir Research Fellow, Dr. Absar Ahmad, Registrar, Ms. Billie Anne Johnston, Social Worker, Ms Anne Ward, OT, Mr. Dermot Davitt, CNMII, Ms Una McGinley, Co-Ordinator, Dr. Michael Reilly, Consultant.

Introduction: A Vision for Change (2006) strongly supports the Recovery Focused Care to improve outcomes for patients with severe and enduring mental illness. It promotes the development of Assertive Outreach Treatment for the delivery of services in the community to institutionalised and ‘new long-stay’ patients in inpatients services. Such patients mostly have persistent psychopathology, marked clinical and social instability associated with frequent relapse and complex psychosocial need. Assertive community treatment (ACT) is one of the most widely tested models of community care.

Aims & objectives: To determine the impact assertive outreach treatment (AOT) on Hospital stay in the first cohort of patients with severe and enduring mental illness referred AOT Service (Est. 2007) of the Sligo Leitrim Mental Health Service.

Methodology: Data was collected on the number and status at each admission as well as length of stay in the hospital in the two years before and after referral to the AOT Service.

Results: The total number of patients included was 31 {18 (58.1%) males and 13 (41.9 %) females}. The age range for males was 32 to 57 (median 36 years); for females it was 20 to 58 (median 29). Diagnoses included Schizophrenia (58.0%) and Bipolar Affective Disorder (19.3%). The total number of voluntary admission was reduced to 37 in two years after referral to the AOT service, from 48 in two years prior to the transfer of care. Similarly number of involuntary admissions was reduced to 7 from 14. A reduction in number of days spent in the hospital for this patient group from 3297 days to 1404 days was also seen after the introduction of focused care by AOT.

Conclusion: Results show reduction in admissions (vol. & Invol.) and decrease in length of hospital stay after the introduction of Recovery Focussed Care by AOT services. This treatment model can help in reducing the burden on inpatient services as well as promoting independence among patients with severe and enduring illness.
Supporting Recovery: Using a Collaborative Learning Approach – Student Nurses and Service Users Working and Learning together in University College Dublin

Authors: Ann J Sheridan, Elaine Collins
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Abstract:
The purposes of this module are supporting student psychiatric nurses to develop recovery based nursing interventions, and supporting service users to increase their personal knowledge of mental health issues, set and achieve recovery goals. These outcomes are achieved using collaborative learning approach with nursing students and service user students undertaking a rehabilitation and recovery programme (Re-Fresh Programme). A primary purpose of adopting this collaborative approach is to provide both opportunity for students to meet in a natural environment and move beyond their usual roles of professional and service user towards genuine collaboration.

The nature of relationships between service users and professionals, how power impacts these relationships and how relationships need to change to reflect a recovery orientation is a key focus. Collaborative relationships are forged with service user students supporting nursing students to develop a deeper understanding of how mental illness and its treatment affect their lives, and how they initiate and engage with their personal recovery journey. Nursing students bring their knowledge/skills in intervention approaches and knowledge of the health system to assist service users identify, refine and support achievement of personal recovery goals.

Evaluation of this module has been undertaken with service users by the Resource service user research group and with nursing students by the module coordinator. Reflective assignments, anonymous structured feedback sheets, interviews and facilitated group feedback sessions have been utilised. Feedback has been utilised to revise structure, content and delivery of the module. Benefits of the module identified include recognising capabilities of service user; recognising personal and professional development requirements of nurses to be recovery focused and improved knowledge, confidence and a sense of empowerment among service users.
Developing a Service User-Centred Quality of Care Instrument

Presenting Author: Niamh Skelly

Authors: Rebecca Schnittger*, Niamh Skelly*, Lisa Butterly*, Charlotte Frorath*, Craig Morgan*, Declan McLoughlin*, Paul Fearon*

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Background:
The shift towards recovery-focused care in mental health services, which emphasises individual pathways to recovery, necessitates the incorporation of service-user perspectives. If a mental health service is to promote recovery, it must understand how the users of that service define recovery and which aspects of care they believe will move them towards that goal. The current study aims to examine service-user perspectives on quality of care. From this, a service user-centred quality of care instrument will be developed and its relationship to outcomes investigated.

Methodology and Expected Results:
Current inpatients in an independent psychiatric service in Ireland with diagnoses of bipolar or psychotic disorders are being invited to take part in focus groups to explore their views on quality of care. Data arising from these focus groups will be subjected to thematic analysis and core themes identified. These themes, along with issues identified from a systematic review of the existing literature on quality of care, will be used to generate items for an initial questionnaire. This questionnaire will be field tested and validated within the same psychiatric service.

Discussion:
It is hoped that high quality research on service-user perspectives on mental health care will influence service development and facilitate the move towards more patient-centred, recovery-oriented care.
32. Recovery from Psychosis: The Outcomes of Recipients of an Early Intervention for Psychosis Model

Author/Presenter: Niall Turner

Co-Authors: Laoise Renwick, Aine Kelly, Mary Clarke, Eadbhard O’Callaghan

Background:
Historically only a minority of people with psychotic conditions recovered fully. Efforts to improve outcome led to the development of new models of care. One such model is the early intervention approach. Early intervention has been shown to lead to better outcomes and to be cost effective. The DETECT early intervention service began in South Dublin and North Wicklow in 2006. DETECT provides a rapid assessment service for the mental health services in the region, educates professionals and the public about psychosis to minimize delays to effective treatment, and offers specialised treatments.

Aim:
To evaluate the 1-year outcomes of recipients of the DETECT service and to investigate the influence of delays to effective treatment on outcomes.

Method:
DETECT received ethical approval to approach all recipients of the service after 1-year to establish their outcomes. Reliable measures of health, wellbeing, and the recovery process were included.

Results:
Over 500 people were referred between 2006 and 2009; 240 were diagnosed with a first episode of a psychotic illness. 133 (55%) people consented to the assessment of their 1-year outcome. Consenters do not significantly differ to non-consenters on any baseline characteristic. Analyses found significant changes in a positive direction between baseline and follow up scores in functioning, positive, negative, and depressive symptom severity; these changes were most pronounced amongst those with short delays. On the Strauss Carpenter Levels of Functioning Scale; 82% had no/minor symptoms in the past month; 64% needed no help to meet their needs; 60% had been working for > 50% of the last year, and over 60% were meeting friends weekly.

Conclusions:
At 1-year the majority of people who attended an early intervention for psychosis service had attained a significant level of recovery; this was most pronounced amongst those with shorter delays to effective treatment.
33. Designing, Measuring and Evaluating Individualised Recovery Focused Care Packages within an Anxiety Disorders Program

Presenting Author: Debbie van Tonder
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Cognitive Behaviour Psychotherapist.
Clinical Nurse Specialist: Anxiety Disorders Program,

Co-Authors: Martha Ryan, Patrick Hill, Dr Michael McDonough
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Aim:
Strengthen the Anxiety Program compliance to the Mental Health Commission (MHC) Quality framework (QF) Standards 1.1 and 3.5 and Statutory Instrument (SI) 551 of 2006, Section 15 and 16.

Objectives:
- To design and introduce a structured assessment system enhancing adaptable and flexible care-planning according to individual service user’s needs within the complexities of the program.
- To measure the impact of the recovery-focused individualized care package and effectiveness of the Anxiety program interventions.
- To provide the service user and consultant with a comprehensive therapeutic report at the end of treatment.

Methods:
- Introducing a structured, systematic three tier assessment process after initial referral.
- Capturing routine outcomes measures and disorder specific measures at three stages (initial, middle and end).
- Collaborative weekly review of care plan with service user linking with recovery process.
- Evaluating and auditing the routine outcomes measures.

Results:
- Initial verbal feedback from MHC inspectorate suggests compliance to QF standards 1.1 and 3.5.
- Person-focused care package within complex program ensuring individual needs are addressed in group context.
- Comprehensive end treatment report of therapeutic process issued to service user and consultant indicating stage of recovery and recommendations for future recovery pathways.
- Qualitative feedback and Routine outcomes measures available for auditing and analysis of efficacy of the program and needs for development.

Conclusion:
The Anxiety program’s project to incorporate individualized care packages goes a long way towards more person-centered, recovery-focused care. Although the project is in its infancy the initial results and feedback from the service users and MDT’s prove that the individualized care package approach is a valuable part of the treatment and recovery process for Anxiety disorders.
Introduction:
Care planning forms an essential component of everyday practice for all mental health teams. The care planning process is viewed as an integral mechanism for promoting recovery and when facilitated by an identified key worker ensures the needs of individuals attending the service are met. The ‘Care Planning in Mental Health: promoting recovery’ poster outlines essential concepts of care planning and explores how mental health professionals utilising current research and service users’ expertise can deliver collaborative holistic recovery focused care.

Aims/Objectives:
The aims of developing a recovery care plan within the service, was to improve the quality of care and outcomes, ensure multidisciplinary team input for all. Key workers would work collaboratively with the Service user to develop the plan focusing on strengths and needs and not illness and ensuring delivery of the care plan goals.

Method:
Recovery care planning was developed and introduced to the service in 2005 by a working group comprising of all multidisciplinary team disciplines. International literature was examined and professionals drew on their clinical experience. A care plan document and standard was developed. All staff were educated on the use of the new document and standards of care in house. The document was piloted and introduced.

Results:
Audits showed that all service users had a care plan with multidisciplinary input. It was found to be strengths based addressing carers and families’ needs. It streamlined service delivery, promoted engagement levels and enhanced the role of key workers with increased accountability, autonomy and empowerment.

Conclusion:
Collaborative Recovery care planning is now firmly embedded within the service. It was health promoting in nature as it facilitated Service users to be actively involved in the process and increased their autonomy to recovery with support and guidance while drawing on community supports. It is identified as one of the practice initiatives that contributed to the service receiving the “best community mental team award 2010”.

Presenting Authors: Mr Francis Walsh, Ms Anne Cleary
**The Introduction of Advance Directives in Irish Mental Health Care**

**Author:** Fiona Morrissey, B.A., LL.B, LL.M., DLIS

**Aims/Objectives:**
The aim of the study is to explore the introduction of a legal framework for advance directives in Irish mental health care. Advance directives allow capable individuals to outline their treatment preferences and other life choices in advance of a mental health crisis. The explicit wishes of the individual are therefore considered during periods when decision-making autonomy may be impacted. Advance directives are proposed as an innovative way to reduce the need for coercive treatment, decrease readmission rates and strengthen autonomy for persons with mental health difficulties. The potential therapeutic and human rights implications warrant their consideration in the Irish mental health context. While there is no law prohibiting an individual from expressing their treatment wishes in Ireland, the absence of a legal framework means these may or may not be respected. The objective of the research is to examine the legal, ethical and implementation issues associated with their use. Due consideration will be given to practice in other comparable jurisdictions and the impact of international agreements such as the UN Convention on the Rights of Persons with Disabilities. In order for advance directives to be effectively implemented, it is important to understand whether such documents will be supported. The empirical research seeks to determine the views of Irish service users and consultant psychiatrists towards the proposed use of advance directives in mental health care.

**Methods:**
The empirical research relies on a mixed methods approach using quantitative and qualitative data to understand the research problem more fully. Surveys and interviews are being used as an appropriate methodology for the research with service users and consultant psychiatrists.

**Proposed Outcomes:**
The study will assist in gaining an understanding of the legal, ethical and implementation issues surrounding the introduction of advance directives in Irish mental health care.
West Cork Mental Health Service (WCHMS) in collaboration with Service Users, Service Providers and Carers have made concrete changes towards a Recovery Model of care. This has been helped by participating in the DCU Leadership programme in Dublin University, by multi-disciplinary team support of Recovery ethics, and with the support of Genio funding for recovery orientated care for service users.

With the support of Genio funding, WCMHS has been able to move the service in a ‘recovery direction.’ In 2011, Dr Pat Bracken, on collaboration with the team and community, produced a document ‘Moving West Cork Mental Health Service in a Recovery Direction.’ This document attempts to make sense of what ‘recovery’ means and outlines how this culture is being developed by the service. It incorporates the new initiatives by the team within the service as well as in collaboration with the community. For example, one of the most successful initiatives by the West Cork Co-operative Leadership Group has been the establishment of the Trialogue, a process whereby service users, providers and carers others in the community come together to discuss mental health issues and service planning.