REHABILITATION AND RECOVERY MENTAL HEALTH SERVICES 2011

As part of the Inspection of mental health services in 2011, the Inspectorate sought information regarding rehabilitation and recovery services throughout Ireland. Each catchment area was asked to submit a self assessment and was then invited to attend a meeting of all rehabilitation and recovery teams with the Inspectorate in order to obtain further information and to take part in a discussion of their rehabilitation and recovery service.

A rehabilitation and recovery service provides specialized mental health care for people with severe and enduring mental illness which cannot be adequately met by general adult services. The needs of people with enduring mental illness are often complex and include treatment of long term illness and prevention of relapse, finding and maintaining accommodation, vocational and educational training, improvement of social skills and prevention of social isolation. Rehabilitation and recovery can enable individuals to lead as independent a life as possible while exercising control over their own lives.

A Vision for Change recommends the development of rehabilitation and recovery services. It recommends one team per 100,000 population, with a minimum of 39 teams nationally. According to *A Vision for Change* the team should consist of the following: one consultant psychiatrist, 10-15 psychiatric nurses for assertive outreach team, mental health support workers, two occupational therapists, two psychologists, two social workers, a cognitive behavioural therapist/psychotherapist, an addiction counsellor as well as a domestic skills trainer, recreational therapists, administrative staff and staff associated with day centres and community residences. It is abundantly clear from the information detailed below that there are an insufficient number of teams and the existing teams are understaffed*. A Vision for Change* also recommended that each team should have a team headquarters, a day centre, access to acute in-patient care, 30 places in 24-hour supervised residences with a maximum of ten places in each residence. It also recommended the development of formal coordination structures between health services and employment agencies in facilitating the service user in re-establishing meaningful employment and the development of mainstream training support services and coordination between the rehabilitation services and training and vocational agencies.

In this report each the rehabilitation and recovery team composition, facilities and functioning is examined in each catchment area.

HSE DUBLIN MID-LEINSTER

Longford Westmeath Mental Health Services

Catchment Population: 128,000

The Longford Westmeath Mental Health Service did not have a consultant–led Rehabilitation and Recovery team as outlined in *Vision for Change.*

Team members	**WTE/Sessions**
Consultant Psychiatrist	0.5
Non Consultant Hospital Doctor	0
Assistant Director of Nursing	0
Community nurses	2 sessions per week from CNM3
Clinical psychologist	1 day per month
Occupational therapist	0 (access from general adult service if required)
Social worker	0 (access from general adult service if required)
Other	Multi-task Attendants provide support in low support residences

Assertive outreach team: There was no dedicated assertive outreach team but staff in the community residences provided a limited assertive outreach support to those living in low support and independent accommodation.

Facilities under care of Rehabilitation and Recovery team	**Number**
Team Base	0
Acute beds	Access to acute beds
Continuing care beds	17 beds in St. Loman's Hospital, Mullingar
Rehabilitation bed	0
Day Centre	0
24 Hour supervised residences	5 residences with 56 places

There were a number of low support and medium support residences in the catchment area.

Vocational Training: There was a workshop in Mullingar and there were close links with the VEC, FAS, assertive outreach and other agencies.

Accommodation Links: There were good links with the local authority and some voluntary agencies including the Simon Community.

Developments: Plans for a new 24 hour supervised residence had been submitted for planning permission. There was one point of access to the community residences and regular input from the consultant psychiatrist to the residences. There was relocation of low support residents to

more independent living with closure of a low support residence. Prescription kardex were being improved and risk assessments introduced.

Quality Outcomes: An audit of the 24 hour supervised residences had been completed. Key Performance Indicators currently measured residence numbers, bed occupancy, admissions and discharges.

Service user input: Patient feedback questionnaire had been developed and a resident carer survey carried out with 17 residents in the continuing care unit. All residents had access to advocacy and other voluntary groups. Residents had received feedback on their needs assessment.

Assessments: A needs assessment had been completed on all residents in community residences. The results of this showed that 77% of residents had been in community residences for more than 5 years.

Care Planning: Multidisciplinary care plans were being introduced to the community residences. Risk assessment was carried out as part of care planning. One or two-weekly review meetings took place in the community residences and in the continuing care unit.

Training and education: There was no training available in Rehabilitation and Recovery.

Challenges and unmet needs: The service required a full multidisciplinary Rehabilitation and Recovery team. A further twelve 24 hour supervised places were also required to cater for people who were long stay in the admission unit and those who could move from the continuing care unit. There was the challenge of stigma when sourcing local authority housing.

Laois Offaly Mental Health Services

Catchment Population: 137,616

While there was a dedicated rehabilitation and recovery team, established in 2006, it was very limited and provided mainly nursing and medical input.

Team members	**WTE/Sessions**
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	0.5
Assistant Director of Nursing	0.5
Team Coordinator	0.5
Community nurses	2
Clinical psychologist	0
Occupational therapist	0
Social worker	0.03
Other- Art Therapist	1 session;

Assertive outreach team: The assertive outreach team comprised of two community mental health nurses.

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	1
Acute beds	Access in Dept. of Psychiatry, Portlaoise
Continuing care beds	23 beds in St. Fintan's Hospital in Portlaoise
Rehabilitation unit	1
Day Centre	1 (Link Centre : Day Programme for Rehabilitation Service)
24 Hour supervised residences	2 with 31 places

Vocational Training: Vocational training needs are met through the National Learning Network, Local VEC, Laois Community College and institutes of Technology, social skills training and literacy skills were provided by a staff teacher.

Accommodation Links: Options for closing St. Fintan's Hospital and the provision of more suitable accommodation were being explored with Respond Housing as a replacement for the rehabilitation unit (17 residents). Links were developed with housing associations such as Cluaid and Steer. There was also liaison with the local authority with regard to housing.

Developments: There was a collaborative art project with local schools and clients of the day centre addressing the issues of stigma and funding was obtained from the local authority to facilitate art projects. There was fund raising for social inclusion and funding was obtained from Genio Project for a community Living Project.

Quality Outcomes: Statistical information on admissions, discharges length of stay, home visits, attendance to day facilities and contact times were collected. Audits of service, care plans, art therapy and community living had been completed. Comments and feedback from outside agencies were obtained.

Service user input: A Client Survey was conducted in 2008 for the development of the Rehabilitation Recovery Programme. Service users assisted in developing the current programme at the Day Programme (Link Centre). Satisfaction surveys have been completed in relation to accommodation needs and preferences. There has also been participation in art projects.

Assessments: A number of assessments were conducted. These included Social Functioning Scale, Life Skills Profile, Mini Mental State Examination, Rosenberg Self Esteem, HCR 20, and a Dedicated Rehabilitation Service Assessment.

Care Planning: There is limited multidisciplinary care planning due to the lack of multidisciplinary team members. Risk assessment is part of care planning. There are weekly team meetings.

Training and education: There are continuing education programme schedules available to staff through the Regional Centre of Nursing and Midwifery. There is no specific training in rehabilitation and recovery.

Challenges and unmet needs: There had been difficulty in replacing staff due to the embargo on recruitment. The team was lacking psychology, social work and occupational therapy. Accommodation was not suitable as the community residences had stairs. Due to the limited income that service users received many fell within the poverty bracket.

Kildare West Wicklow Mental Health Services

Catchment Population: 210,000

The rehabilitation and recovery team was minimal with only 0.5 whole time equivalent (WTE) consultant psychiatrist and 1.9 WTE community nursing staff. There was no occupational therapist, social worker or clinical psychologist.

Team members	**WTE/Sessions**
Consultant Psychiatrist	0.5
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	0.2
Community nurses	1.9
Clinical psychologist	0
Occupational therapist	0
Social worker	0
Other	0

Assertive outreach team: There was no assertive outreach team.

Facilities under care of Rehabilitation and Recovery team	**Number**
Team Base	1
Acute beds	2-4
Continuing care beds	0
Rehabilitation unit	0
Day Centre	0
24 Hour supervised residences	2 with 28 places

Vocational Training: Vocational training needs were addressed through EVE holdings, the Harvest training centre and the Clubhouse.

Accommodation Links: There was liaison with the local authority regarding housing. Apart from this accommodation links were limited.

Developments: A group home (Allenview) opened in 2010 with four places. The Wellness Recovery Action Plan (WRAP) was in operation.

Quality Outcomes: Reviews were carried out as part of multidisciplinary reviews.

Service user input: Family and Carers meetings were held as often as possible. There was a residents group in each residence.

Assessments: Assessments used included Life Skills Profile, Social Functioning Scale, Positive and Negative Symptoms of Schizophrenia (PANSS), Functional Analysis of Care Environment (FACE), FACE risk profile, Liverpool University Neuroleptic Side Effect Rating Scale (Lunsers) and the Beck Depression Inventory (BDI-11).

Care Planning: Multidisciplinary care plans were in operation and were reviewed every six months. There was a weekly team meeting. Risk assessment was completed on each service user.

Training and education: There was access to training and education in anxiety management, reminiscence therapy, experiential arts, Wellness and Recovery Action Plan, cognitive behavioural therapy, dramatherapy and recovery.

Challenges and unmet needs: Apart from the two 24 hour supervised residences and the group home there was a lack of residential places and respite for service users. There was no day centre. There was an absence of any occupational therapy, social work or psychology on the team.

National Forensic Mental Health Services

Catchment Population: National population.

The forensic rehabilitation and recovery team is a dedicated specialist multidisciplinary team which operates as part of the national forensic mental health service and was established in 2007. It constitutes the third step on the pathway through the national forensic service preceded by the Acute Cluster and Medium Cluster teams.

Team members	**WTE/Sessions**
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	0.2
Community nurses	2
Clinical psychologist	0
Occupational therapist	1
Social worker	0
Other	Vocational training Officer 1

Assertive outreach team: There was an assertive outreach team with 0.5 -1 nursing staff

Facilities under care of Rehabilitation and Recovery team	**Number**
Team Base	1
Acute beds	0
Continuing care beds	Access through Central Mental Hospital or local services
Rehabilitation unit	1
Day Centre	1
24 Hour supervised residences	1 with 6 places

Vocational Training: Vocational needs were addressed through referrals to the VEC, FAS, third level education, EVE Holdings. FETAC training was undertaken at Usher's Island Day Centre.

Accommodation Links: Accommodation links are with the homeless mental health services and with local authority with regard to housing.

Developments: There were increased contacts with local mental health and vocational services. An increased number of service users were followed up by the rehabilitation and recovery team and the number making the transition from the Central Mental Hospital to the community was likely to be between 12 and 20.

Quality Outcomes: There were continuous audits of outcome measures using the DUNDRUM toolkit, HCR-20 dynamic measures and the Suicide Risk Assessment and Management Manual

(S-RAMM) dynamic measures, the PANSS and Gobal Assessment of Functioning (GAF) and Camberwell Assessment of Need Forensic Version (CANFOR).

Service user input: There was a service users' forum, service user involvement in policy governance group and individual service user involvement in care planning. The senior management team and the chair of the user forum visited each unit monthly to meet with residents and obtain feedback. Service users were involved with the Quality Network Peer review. There were monthly meetings between the rehabilitation and recovery team and the service users living in the community residences. There was regular contact between members of the rehabilitation and recovery team and carers.

Assessments: The HCR-20, S-Ramm, DUNDRUM 3&4 and also discipline specific assessments.

Care Planning: Multidisciplinary care planning was in operation. There were six monthly case conferences and weekly team meetings. There was a comprehensive risk assessment.

Training and education: There was multidisciplinary teaching at the Central Mental Hospital each week. There were six monthly inductions for all new team members that included training in the use of assessment tools and policies. There was access to the resources of the training department and weekly in-house training programmes. There was also an annual team away day involving multidisciplinary identification of service's needs.

Challenges and unmet needs: There was a lack of psychology and occupational therapy on the Rehabilitation and Recovery Team. More community residential places were required.

Dublin South East Mental Health Services

Catchment Population: 110,000

Team members	**WTE/Sessions**
Consultant Psychiatrist	0.5
Non Consultant Hospital Doctor	0.5
Assistant Director of Nursing	0.5
Community nurses	Shared
Clinical psychologist	Shared
Occupational therapist	Shared
Social worker	Shared
Other	Access to Cognitive behavioural therapy, bereavement counseling.

Assertive outreach team: There is an assertive outreach team with six nursing staff and non-consultant hospital doctor sessions.

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	0
Acute beds	As required
Continuing care beds	As required
Rehabilitation unit	0
Day Centre	1
24 Hour supervised residences	2 (one closed for refurbishment)

There was also a medium support residence and a group home catering for 5 residents.

Vocational Training: Service users are referred to vocational officers, Reach programmes, Roslynn Park Rehabilitation and Thomas Court.

Accommodation Links: Psychiatric social workers assist service users to apply to Dublin City Council and to work with Community Welfare Officers to access rent allowance and other benefits.

Developments: Medication audits were carried out. In the medium support residence there was a self administration medication programme. Admission, discharge and transfer reviews had been carried out.

Quality Outcomes: Medication audits had been completed. Reviews of admission, discharge and transfers had been carried out. Individual care plans had been evaluated.

Service user input: Advocacy services were available for service users. There was a relative and family support service and education was provided to relatives.

Assessments: There was a nursing assessment and Plan and Evaluation of Independent Living Skills (Community, Residential and Day Care programme)

Care Planning: Each service user had an individual multidisciplinary care plan and recovery plan. The service was involved in the National Collaborative Project on individual care planning with the Mental Health Commission. There was a weekly multidisciplinary meeting.

Training and education: The service stated that education was for professional competence standard.

Challenges and unmet needs: There were no challenges or unmet needs outlined at the presentation by the service. However it was clear that the lack of a full rehabilitation team was a deficit in the service.

East Wicklow Mental Health Services

There was no rehabilitation team in East Wicklow. Service users in this clinical group had integrated care with acute services. There were two 24-hour supervised residences, one medium support residence and six group homes in Wicklow.

Vocational Training: East Wicklow service users had full access to EVE Limited New Dawn which delivered the HSE's vocational and rehabilitation services.

Developments: Recovery initiatives had started in each service, for example the Recovery STAR instrument was used and the Wellness and Recovery Action Plan had been initiated.

Quality Outcomes: There were no rehabilitation specific quality outcomes in East Wicklow

South Dublin

In the Cluain Mhuire service there was no dedicated team but there were four day programmes in relation to rehabilitation. There was one 24-hour supervised residence in Stillorgan.

Vocational Training: In the Cluain Mhuire service there were two active recovery orientated training programmes in place. The Refresh rehabilitation programme was located in Elvira Gate on the Sandyford Industrial Estate and featured trainees weekly attendance in UCD during term time. The REACH programme was funded through a partnership with FAS and offered FETAC accreditation to trainees. The service also offered a back to education course through Dun Laoghaire Vocational Education College which lead to FETAC qualification.

Accommodation Links: Accommodation links were through community residences and local authorities. There were also formal links with Dun Laoghaire/Rathdown County Council, HAIL housing, CLUID, St. John of God, RESPOND and Vergemount Housing Associations.

Developments: Supported community residences reconfiguration was in progress. In the Cluain Mhuire service the former Corres Centre workshop in Burton Hall rehabilitation service had changed to a members-led club model called Club Los Pisa.

Quality Outcomes: There were no rehabilitation specific quality outcomes in East Wicklow. In Cluain Mhuire services satisfaction audits were carried out in all programmes. Service-wide satisfaction audits were held every two years and undertaken by the service users in the SOURCE research group. Multidisciplinary audits of all services were planned and undertaken by the services Clinical Audit Committee and presented on a bi-monthly basis.

Service user input: Service users were on local and integrated service area management teams. Advocacy was available in all inpatient settings. Elected committees of members were in place at Venegas House and Club Los Pisa (previously Burton Hall). Regular meetings took place between the clinical director of Cluain Mhuire services and the local branch of SHINE. A service user research group named SOURCE completed patient satisfaction audits with the

services and programmes on offer. Trainee evaluations were embedded within the feedback structure of all programmes.

Assessments: The Cluain Mhuire service uses the CASIG system of assessing needs with input from the service user and community mental health teams.

Care planning: Multidisciplinary care plans were used. Plans were agreed by the service user.

Training and education: Recovery orientated training was available. There were scheduled multidisciplinary events and ongoing individual career developments and training. The partnership between Cluain Mhuire services and UCD had continued to promote the recovery model amongst both trainees and student nurses. Three nurse managers in the Cluain Mhuire service had obtained a MSc. in psychiatric rehabilitation. Two nurses had undertaken the HSE supported Nurse Prescribers Course.

Challenges and unmet needs: The East Wicklow service required a rehabilitation team.

HSE SOUTH

Kerry Mental Health Services

Catchment Population: 139,835

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	1
Community nurses	0
Clinical psychologist	0.3
Occupational therapist	0
Social worker	0.5
Other	0

Assertive outreach team: There was no assertive outreach team in this area.

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	0
Acute beds	Access (care transfers to sector teams on admission)
Continuing care beds	Access to St. Finan's Hospital (44 beds) and nursing homes
Rehabilitation unit	0
Day Centre	4
24 Hour supervised residences	3

Vocational Training: Vocational training was met through Coolgrane Training Centre, supported employment service and Rehab Care referral.

Accommodation Links: Accommodation and housing needs were met within HSE resources, Local Authority and Social Housing Schemes including Kerry Mental Health Association and Cluid.

Developments: The building of a new 24-hour supervised residence had been completed. A new individual care plan had been developed and integrated case file proposed. A dedicated assistant director of nursing had been assigned to the team during 2011. There were ongoing discussions with Kerry Mental Health Association on developing a club house in Killarney and a peer-led Drop-In Centre in Tralee.

Quality Outcomes: Stage 1 of an audit of service users understanding of care planning process had been completed. Stage 2 was to follow.

Service user input: There were individual care planning reviews. The key worker reviewed pre-care plan forms with the service user. Advocates could attend care plan meetings.

Assessments: A needs assessment using psychiatric history and treatment summary was carried out. The service also used the Social Functioning Questionnaire, Special Problem Questionnaire, Mental State Assessment and Physical Illness assessment.

Care Planning: Individual multidisciplinary care plans were used. Care plans were reviewed every six months. Service users completed a pre-care plan review with their key worker. The care plan summary was typed and distributed.

Training and education: There was training in Recovery by the Sainsbury Centre. Training also took place at monthly management meetings.

Challenges and unmet needs: There was an institutionalised population in St. Finan's Hospital who required placement in the community. At the time of the inspection residents with challenging behaviour were admitted to St. Finan's Hospital from the community or from the Department of Psychiatry in Tralee, which caused difficulty for the rehabilitation programme. There was no occupational therapist. The recruitment embargo and retirements in nursing staff could be challenging in ensuring continuity of care. The geographical area was difficult to provide a service to due to its spread and topography.

West Cork Mental Health Services

Catchment Population: 53,445

There was no dedicated rehabilitation team in West Cork. Recovery and rehabilitation was part of the service offered by the three sector teams and it was planned to develop this further using the Sainsbury Framework. There were three24-hour supervised residences, and one low support residence with seven places. Respite beds were available in two of the residences.

Vocational Training: Vocational training was accessed though the National Learning Network and the VEC.

Accommodation Links: Accommodation was accessed through Residential Services in the HSE, Cork Mental Health Foundation, Rehab Care and Cluid.

Developments: There was an emphasis on multidisciplinary working. Wellness and Recovery Action Plan(WRAP) was in use. A telephone listening service was provided by staff on a 24 hour basis. Group therapy, music therapy and a garden project were being provided.

Quality Outcomes: The service used health statistics, Statutory Regulation policies, good practice policies and Common National Data Set audit to measure quality outcomes.

Service user input: The senior management team met with service users on a regular basis. A peer group offered a weekly drop-in facility. The RENEW group was set up to provide a facility where service users can explore the nature and meaning of psychosis. There were facilitated group meetings between service users, carers and professionals in which various aspects of mental health were discussed. There was active involvement with the Irish Advocacy Network.

Assessments: There was ongoing needs analysis by the multidisciplinary team.

Care Planning: Recovery care plans were in use by the service and signed by the service user.

Training and education: The service stated that there was ongoing supportive training.

Challenges and unmet needs: Some of the challenges outlined by the team included the fact that there was no rehabilitation team, there was a large geographical area to cover, there was a lack of housing and few links with the intellectual disability service.

North Cork Mental Health Services

Catchment Population: 80,795

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	0.5
Community nurses	3
Clinical psychologist	0.5
Occupational therapist	1
Social worker	0
Other	0

Assertive outreach team: There was 2.5 nursing staff on an assertive outreach team.

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	0
Acute beds	access
Continuing care beds	0
Rehabilitation unit	0
Day Centre	0 (can access 6 generic day centres)
24 Hour supervised residences	3

Vocational Training: The service stated that multidisciplinary assessments including occupational therapy assessments informed decisions in this area. Referrals were made to the most appropriate agency based on these assessments.

Accommodation Links: Accommodation needs were assessed by the multidisciplinary team. Decisions were made involving service users and their carers regarding the most appropriate and least restrictive setting to meet identified needs.

Developments: There was an ongoing active audit programme. There was also constant improvement to care planning and care pathway process to enhance service user experience.

Quality Outcomes: There was an active multidisciplinary audit programme with the rehabilitation service. The service stated that care was delivered in keeping with evidence based protocols and guidelines.

Service user input: All service users were given the option of completing a self-report questionnaire regarding their experience of the service. This form was drafted by the Irish Advocacy Network. The advocate met with nurse management on a monthly basis and visited units and community residences on a regular basis.

Assessments: The service used the Camberwell Assessment of Need, Sainsbury Risk Assessment, Service User Self Report and the Social Functional Questionnaire.

Care Planning: Multidisciplinary care planning was in place in all residential settings. The multidisciplinary team meeting took place weekly.

Training and education: An active teaching programme was incorporated into the clinical governance structures.

Challenges and unmet needs: The range of mental illness that service users in the service suffered from was complex and severe. There was no funding to enhance the rehabilitation team which was missing a social worker and it was stated that there was poor morale within the team. The area was felt to have a wide geographical spread which caused some difficulty in providing a service.

Carlow Kilkenny Mental Health Services

Catchment Population: 120,631

Team members	**WTE/Sessions**
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	1
Community nurses	2
Clinical psychologist	0
Occupational therapist	0
Social worker	0
Other	0.5 Clinical Nurse Manger 3

Assertive outreach team: There were 2.5 whole time equivalent nursing staff on the assertive outreach team.

Facilities under care of Rehabilitation and Recovery team	**Number**
Team Base	0
Acute beds	Access
Continuing care beds	9 beds
Rehabilitation unit	0
Day Centre	2 (shared with sectors)
24 Hour supervised residences	7

Vocational Training: Assessment, training and employment are provided through the vocational educational Committee, KASES (supported employment), the National Learning Network, TASK and Rehab care. Applications may be passed through the vocational training officer if necessary.

Accommodation Links: High, medium and low supported accommodation was provided through the Carlow Kilkenny Mental Health Services. Supported housing accommodation was facilitated through partnership with the Brothers of the Good Shepherd. The service was in discussion with Focus Ireland about up-coming availability of supported accommodation in Kilkenny city. There was also a good relationship with the Local Housing Authority and private landlords.

Developments: Multidisciplinary care plans had been introduced to community residences and continuing care wards. Detailed multidisciplinary needs assessment of residents were conducted with case conferencing of each resident. St. Luke's continuing care ward was closed and there was successful resettling of the majority of residents. Intensive Activities of Daily Living (ADL) training of residents was commenced, with several moving to independent living. A Day Services review group was established for the purpose of optimizing training opportunities.

Quality Outcomes: There were regular reviews and audits of care planning. A facility questionnaire was completed for each residence. Client satisfaction questionnaires and needs assessments were completed for each resident. Medication audits were carried out on a regular basis.

Service user input: There was service user input through the Consumer Panel and Link-up. There were regular family meetings and case conferences facilitated where required.

Assessments: The following assessments were used: Camberwell Assessment of Needs, medical, nursing and psychiatric assessments, Lawton Instrumental Scale of ADL Assessment, Level 1 Risk Assessments and Standard HSE Financial Assessments.

Care Planning: Multidisciplinary individual care planning was fully implemented. A weekly multidisciplinary team meeting took place.

Training and education: On-going staff education needs were identified in the area of rehabilitation and recovery.

Challenges and unmet needs: New referrals had been suspended due to the demands of resettled service users but had resumed in December 2011. The future of the service was unclear with the amalgamation of the Carlow Kilkenny service with the South Tipperary service.

Tipperary South Mental Health Services

Catchment Population: 89,628

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	0.5
Community nurses	0
Clinical psychologist	0.6
Occupational therapist	1
Social worker	0
Other: Recreation therapist	1

Assertive outreach team: There were two WTE nursing staff on the assertive outreach team.

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	0 (plans in progress)
Acute beds	Access
Continuing care beds	19
Rehabilitation unit	15 beds
Day Centre	0
24 Hour supervised residences	1

Vocational Training: An occupational therapist had been recruited to the team. There was a recreational therapy department. A number of service users were employed in the Cluin Training Centre. There were strong links with FAS, National Training and Development Institute and the VEC.

Accommodation Links: Most service users were on the Local Authority housing list. There was access to a 24- hour community residence and a low support residence.

Developments: An occupational therapist was recruited. An operational policy was drawn up for assertive outreach services that was in line with *A Vision for Change*. All service users in supported accommodation were reviewed as were all attending day services. A rehabilitation and community nursing unit were under construction. There was ongoing development of a respite facility. The number of long-stay beds had been reduced. A service user forum had been developed.

Quality Outcomes: Standardised tools were used to inform clinical decisions. Ongoing audits included medication audit, prescription kardex audit, care planning audit and audit of the use of respite services.

Service user input: Service users had input into their individual care plans. A local service user forum had been developed with the assistance of the local peer advocate. Service users and carers representatives were on the sub-group for the development of rehabilitation and recovery services across the catchment area. The advocate was on the local senior management team.

Assessments: Assessment tools included Sainsbury Risk Assessment, Camberwell Assessment of Need and Community Placement Questionnaire.

Care Planning: All service users had a multidisciplinary individual care plan. Care plans were developed in association with service users and carers using a standardised approach and key workers were assigned. The team met weekly, and each clinical area had weekly or fortnightly multidisciplinary team meetings.

Training and education: Team members had been offered the opportunity to participate in regionally run cognitive behavioral therapy course. A number of staff attended an intensive three day course on Recovery. There was ongoing training in mental health assessment, needs assessment, risk assessment and care planning. The rehabilitation and recovery team is involved in developing some training modules within the extended catchment area particularly in relation to Recovery ethos.

Challenges and unmet needs: There was some uncertainty around the future of the rehabilitation and recovery team in the planned amalgamation of South Tipperary services with Carlow Kilkenny services. There was no representation from rehabilitation in the governance framework and it was felt that it was difficult to keep rehabilitation and recovery on the current agenda. There had been difficulty in fully staffing the rehabilitation and recovery team.

Wexford Mental Health Services

Catchment Population: 132,000

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	1
Community nurses	3
Clinical psychologist	0.6
Occupational therapist	0.8
Social worker	0.8
Other	0

Assertive outreach team: There were two clinical nurse managers 2 on the assertive outreach team

Facilities under care of Rehabilitation and Recovery team	**Number**
Team Base	1
Acute beds	Access
Continuing care beds	yes
Rehabilitation unit	0
Day Centre	1
24 Hour supervised residences	3 (27 places)

Vocational Training: Vocational training needs are addressed through Link and SWAN Vocational Training and through guidance officers assessments.

Accommodation Links: All residents are on the Local Authority Housing List. Some service users are in private rented accommodation and in high, medium and low support residences.

Developments: The Killagoley Training and Activation Centre (KTAC) was renovated with the help of Wexford Mental Health Association and the HSE. The rehabilitation and recovery team were moved to KTAC. The horticultural programme was opened. A Sports Group was established.

Quality Outcomes: A number of Audits had commenced in the use of benzodiazepine and Z drugs, the use of antipsychotic medication and in the rehabilitation service. All service users completed an annual self report. Medication prescribing was based on the Maudsley Prescribing Guidelines.

Service user input: All service users completed an annual self report. An audit of patient satisfaction was due to start soon. There was access to advocacy services.

Assessments: The following assessments were carried out: The Sainsbury Risk Assessment and a modified Camberwell Assessment of Need.

Care Planning: Multidisciplinary care plan were in operation for the past three years with service user involvement. Weekly team meetings were held.

Training and education: There was a monthly multidisciplinary educational meeting and well as continuing professional development.

Challenges and unmet needs: There had been a reduction in Mental Health Association funding for accommodation.

Waterford Mental Health Services

Catchment Population: 250,000

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	1
Community nurses	2
Clinical psychologist	0
Occupational therapist	0.5
Social worker	1
Other	0

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	1
Acute beds	16
Continuing Care beds	30 beds
Rehabilitation unit	0
Day Centre	1
24 Hour supervised residences	2 (27 places)

Vocational Training: The service stated that the service user was assessed by the multidisciplinary team and referred to the appropriate agencies. No further details were given.

Accommodation Links: The service stated that the service user was assessed by the multidisciplinary team and referred to the appropriate agencies. No further details were given.

Developments: Two new booklets were designed and printed incorporating history, annual assessments and annual collaborative multidisciplinary care plans. Three staff had been trained in cognitive behavioural therapy (CBT). There were a number of projects ongoing such as gardening, art, music, creative writing, gym and swimming. There had been a housekeeping training programme and personal and social skills training programme. Easy to read information on psychotropic medication had been extended to include information on other medication.

Quality Outcomes: A number of audits and research had been completed. These included quality of life after psychiatric rehabilitation, an audit of prolactin monitoring, benzodiazepine prescribing, the use of psychotropic medication, ECG abnormalities in patients on clozapine and a liaison consultation model in nursing homes.

Service user input: There was regular verbal and written feedback through the care plan and focus groups. There were also feedback meetings between the advocate and senior clinical staff.

Assessments: The Camberwell Assessment of Need and the Sainsbury Risk Assessment were used.

Care Planning: There was multidisciplinary care planning in operation. The service user filled out a care plan preparation form. There was a weekly team meeting.

Training and education: There were presentations by the rehabilitation team at case conferences. The training of medical and nursing students is facilitated. Staff were trained in CBT.

Challenges and unmet needs: The embargo on staff recruitment was having an effect on the staffing of the rehabilitation and recovery team, especially in the area of nursing. Finding accommodation for single young males was difficult as was the finding of appropriate employment.

HSE DUBLIN NORTH EAST

North Dublin Mental Health Services

Catchment Population: 240,000

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	2
Assistant Director of Nursing	2
Community nurses	0
Clinical psychologist	0
Occupational therapist	1
Social worker	1
Other	0

Assertive outreach team: There was one assertive outreach team with 4.5 whole time equivalent nursing staff.

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	1
Acute beds	Access
Continuing Care beds	26 places
Rehabilitation Unit	1
Day Centre	1
24 Hour supervised residences	3 (31 Places)

Vocational Training: Following assessment by the multidisciplinary team service users were referred to the appropriate services. No further details were available.

Accommodation Links: There was liaison with the Local Authority housing services where appropriate.

Developments: The rehabilitation service had been reconfigured. Funding had been obtained from the Genio Trust to employ an occupational therapist to work individually with twelve service users. A national multicentre study of recovery services had been completed.

Quality Outcomes: An audit of high dose antipsychotic treatment had taken place. Team based performance management had taken place with annual in service training and structural maintenance review of community residences. There was also a review of bed activity which showed that length of stay and admission numbers had reduced with the use of the respite facility.

Service user input: A Recovery Workbook had been developed. The Verona Satisfaction Questionnaire had been completed and findings fed back to senior management and clinical staff. There were family focus groups and family psycho-education.

Assessments: The following assessments were used: Social Functioning Questionnaire, Functional Needs Assessment, Community Placement Questionnaire, Occupational Self Assessment, HCR 20 (risk assessment), Clifton Assessment Procedures for the Elderly (CAPE), Minnesota Multiphasic Personality Inventory (MMPI) and the Mini Mental State Examination.

Care Planning: Multidisciplinary care planning was in operation. There were weekly team meetings.

Training and education: Psychosocial Intervention Skills training had taken place. There had been training in Wellness Recovery Action Plan (WRAP) as well as CBT training.

Challenges and unmet needs: Challenges that faced the service included the resettlement of high risk long stay residents following ward closures, lack of adequate assertive outreach services and the stigma facing people with mental illness living in the community.

Dublin North Central Mental Health Services (Formerly Area 7)

Catchment Population: 146,000

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	0
Community nurses	1
Clinical psychologist	0.5
Occupational therapist	1
Social worker	1
Other	0

Assertive outreach team: There was no assertive outreach team in the service.

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	1
Acute beds	Access
Continuing care beds	15 places
Rehabilitation unit	0
Day Centre	1
24 Hour supervised residences	2

Vocational Training: Following assessment service users were referred to National Learning Network or to EVE Holdings.

Accommodation Links: Close links were forged with voluntary and statutory housing agencies. Fair deal applications were completed for those service users suitable for nursing home assessment.

Developments: A rehabilitation day service was established in 2010 in Clontarf, Dublin 3. A new 24-hour community residence was planned. The vacant social worker post was filled in December 2010 and a clinical nurse manager 2 was appointed to the team in June 2010.

Quality Outcomes: Non consultant hospital doctors (NCHD) carried out audits every six months. A team day was held annually where full service reviews took place. Statistics were recorded on referrals, admissions, discharges, home visits, outpatient attendances and on transitions within the service from higher to lower levels of support.

Service user input: Focus groups had been convened. Service users and their families were informed of complaints procedures. There was regular liaison with the Irish Advocacy Network and advocates were invited to attend outpatient reviews.

Assessments: The assessments used included the following: Social Functioning Questionnaire, Camberwell Assessment of Need KGV, Risk of Violence Assessment, HCR-20 (risk assessment), Functional Assessment of the Care Environment (FACE) Assessment of Motor and Process Skills, Adult Sensory Profile, Rivermede Behavioural Memory Assessment, Occupational Therapy Screening Tool and a range of assessments based on the model of human occupation (MOHO).

Care Planning: A case management system was in operation. The service used multidisciplinary care plans. A copy was given to the service user. A new care plan is completed every six months. There were weekly team meetings. Case conferences were held at least every six months for inpatients.

Training and education: There was regular attendance at hospital academic sessions. There was weekly supervision of the rehabilitation NCHD and there was a six-monthly induction for NCHDs. Mandatory training took place. Rehabilitation academic sessions took place every two weeks. Recovery orientated practice workshops were held. Rehabilitation lectures for medical students took place.

Challenges and unmet needs: There was a shortage of nursing staff and a clinical psychologist. It was found to be difficult to place some residents who were in continuing care wards. There were difficulties in accessing intellectual disability and forensic services.

North West Dublin formerly St. Brendan's Hospital Rehabilitation Team

Catchment Population: 67,183 (plus Programme for the Homeless North Dublin and low secure units in St. Brendan's Hospital).

Team members	**WTE/Sessions**
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1.5
Assistant Director of Nursing	0.5
Community nurses	1
Clinical psychologist	0.25
Occupational therapist	1
Social worker	1
Other	0

Assertive outreach team: There was no assertive outreach team in the service.

Facilities under care of Rehabilitation and Recovery team	**Number**
Team Base	1
Acute beds	4
Continuing Care beds	33 beds

Rehabilitation unit	0
Day Centre	0
24 Hour supervised residences	3 and 1 shared (44 beds)

Vocational Training: There were close links with the National Learning Network, Eve Holdings, Shine and Solas.

Accommodation Links: Service users were supported with applying to and attending the Local Authority. There were close links with Hale Housing, Threshold, the Salvation Army and the Simon Community. There was a placement Committee that met monthly and offered places with a range of community residences.

Developments: Wellness Recovery Action Plan (WRAP) training had taken place. Work was ongoing to develop policies for residences. Medication management programmes had been introduced. There was a six-monthly audit introduced to monitor metabolic syndrome for all service users on antipsychotic medication. The new occupational therapist was developing greater links with community support services. The psychologist was conducting weekly groups for all service users. Funding had been received from the Genio Trust which would fund a care worker for one year to work with the team in supporting 10 service users in finding and maintaining tenancies.

Quality Outcomes: There were yearly audits of referrals to the Placement Committee and feedback to referrers ensuring transparency regarding decisions.

Service user input: Service users contribute to the WRAP programme. They were also involved in developing policies for the community residences and attended subcommittee meetings. Carers were involved with all care plans.

Assessments: The assessments used included the Camberwell Assessment of Need, Life skills Profile, Risk Assessment Tool developed by St. Brendan's Hospital, Special Behaviour Skill and drug and alcohol assessments.

Care Planning: There was multidisciplinary care plans used. There were team meeting every six months or more frequently if necessary.

Training and education: According to the service this had yet to be developed.

Challenges and unmet needs: There was no access to day hospital or day centre and no weekend cover. There were no female-only community residences. The forensic risk of some service users provided a challenge.

Dublin North West (formerly Area 6)

Catchment Population: 165,000

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	0
Community nurses	2 (shared)
Clinical psychologist	0.25 (shared)
Occupational therapist	0.7
Social worker	0.5 (shared)
Other	0

Assertive outreach team: While there was no current assertive outreach team, one was in development.

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	1
Acute beds	Access
Continuing Care beds	26 beds
Rehabilitation unit	1
Day Centre	shared
24 Hour supervised residences	3 (38 places)

Vocational Training: The area was served by Eve Holdings.

Accommodation Links: There was liaison with independent agencies to move services users to more independent living.

Developments: A new assertive outreach team was planned. There was a new Transitional Residential and Rehabilitation Unit (TRRU). All residents in this unit were on A Wellness Recovery Action Plan (WRAP). There was also a personal recovery plan which was multidisciplinary and had a patient contract section. It contained a weekly schedule of care and activity and programmes. This project won a Genio Trust award and funds were earmarked for an assertive outreach worker. Some residents in community residences partook of a project planning their move to nursing homes.

Quality Outcomes: A service-wide assessment of needs of all residents in community residences was undertaken. There had been a reduction in the prescribing of benzodiazepines. All residents had appropriate metabolic syndrome monitoring. There was a recent audit on dental care and knowledge among residents. A general practitioner/update form had been developed to ensure better communication between professionals.

Service user input: Service users were encouraged to invite advocates or family members to attend care plan meetings. Residents participated in meetings in their residences. Service users were offered the WRAP.

Assessments: Comprehensive needs assessments were used including the Camberwell Assessment of Need and the Life Skills Profile.

Care Planning: There were two types of care planning. The older residents in continuing care had nursing care plans which were not multidisciplinary. Residents in the TRUU had the new Personal Recovery Plans which was multidisciplinary, had a patient contract section; a carer section and an unmet need section. It was rehabilitation focused having sections on crisis management and learning from past illness episodes to anticipate and plan the care of future illness episodes with the service user.

Training and education: Training for the new assertive outreach team was planned and liaison with other assertive outreach teams was also planned. A library/recovery resource centre to embed knowledge and the principles of recovery and assertive outreach was planned for Blanchardstown.

Challenges and unmet needs: There was a necessity to reduce bed days and admissions. The service stated that they would like to develop early intervention for psychosis and a more flexible community care.

Cavan Monaghan Mental Health Services

Catchment Population: 133,369

Team members	**WTE/Sessions**
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	2
Assistant Director of Nursing	0
Community nurses	4
Clinical psychologist	0
Occupational therapist	1
Social worker	0.8
Dedicated Team Coordinator	1

Assertive outreach team: The assertive outreach team had 13.57 whole time equivalents (WTE) nursing staff.

Facilities under care of Rehabilitation and Recovery team	**Number**
Team Base	2
Acute beds	Access

Continuing Care beds	7 beds
Rehabilitation unit	0
Day Centre	2
24 Hour supervised residences	3 (43 places)

Vocational Training: The occupational therapist organized guest speakers to outline local vocational opportunities.

Accommodation Links: The social worker liaises with Local Authorities housing departments and supports service users with finding accommodation.

Developments: There was cognitive remediation assessment and training. There was also an rehabilitation assessment of COPE (early intervention psychosis) service users. Wellness Recovery Action Plan (WRAP) training continued.

Quality Outcomes: A comparison was made between the bed usage over equivalent time periods for service users on the Assertive Outreach Team and while under the care of the community mental health team. This showed a drop in number of admissions, number of bed days and length of stay. A self reporting questionnaire was carried out. There were audits on medical co-morbidity, screening with clozapine use and prolactin levels. There were also annual general practitioner reviews.

Service user input: Service users were involved in their care plan reviews. There was a self report questionnaire called 'How are You'. There were comment boxes in residential settings.

Assessments: The following assessments were used: The functional Assessment of Care Environment (FACE), Camberwell Assessment of Need, Mini Mental State Examination, The Brief Psychiatric Rating Scale and the Lancashire Quality of Life Profile.

Care Planning: Multidisciplinary care plans were in use. These were reviewed annually or when a change in the person's care needs occurred. They were signed by the service user, key worker and multidisciplinary team. There was a weekly multidisciplinary team meeting which rotated between the two principal care sites.

Training and education: There was a multidisciplinary shared learning day with Mayo Mental Health Services. The regional training syllabus was available.

Challenges and unmet needs: There was no psychologist on the team and insufficient social work and occupational therapist. It was difficult to find placements for elderly service users and there was little availability of respite beds. There were difficulties in recruiting staff due to the recruitment embargo and large numbers of retirements from the service. It was difficult to find placements for elderly physically frail service users due to constraints within the Fair Deal application system. There was little availability of respite beds for physical health reasons for people living independently in the community due to bed reductions in HSE nursing homes

Louth Meath Mental Health Services

Catchment Population: 304,507

There was no rehabilitation recovery team in the catchment area. There was an assertive outreach team which was established in 2008 in Louth. It consisted of 3.6 whole time equivalents (WTE) nursing staff. Two staff members in community support teams share the caseload in Louth. There was also an assertive outreach team in Meath which was established in 2008. There were three staff nurses and one CNM2 on this team. Both teams had a dedicated office ad base area.

Assessments: Assessment include the Camberwell Assessments of Needs Scale, the Lancaster Quality of Life Scale and the Lunser Scale for medication.

Challenges and unmet needs: There was a need for rehabilitation and recovery team in the catchment area. It was felt that training should be ongoing. Resources needed included offices and administration staff. As it was a large catchment area current budget cutbacks in travel and recruitment ban on staff were major challenges. A number of retirements had taken place and no replacements were made. There were difficulties with the Fair Deal process. Cutbacks in primary care services including Vocational Education Committee (VEC) FAS, Day Centres, Respite, Local Authority budgets were affecting service users with enduring illness. There were also difficulties in providing placements in appropriate settings and in getting access to acute services. Multidisciplinary care planning is a challenge due to lack of multidisciplinary staff.

HSE WEST

Mayo Mental Health Services

Catchment Population: 130,000

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	0.25
Community nurses	8
Clinical psychologist	0.8
Occupational therapist	0.5
Social worker	0.5
Multi Task assistants	3
Social support workers	3
Team coordinator	1

Assertive outreach team: There was an assertive outreach team with four whole time equivalent (WTE) nursing staff.

Facilities under care of Rehabilitation and	Number

Recovery team	
Team Base	1
Acute beds	2 beds
Continuing Care beds	25 beds
Rehabilitation unit	0
Day Centre	0
24 Hour supervised residences	1 (10 places)

Vocational Training: Vocational training was facilitated through occupational therapy assessment and included the national training and development institute, occupational guidance officers and Employability Mayo.

Accommodation Links: Accommodation links were with HSE houses, Mayo Mental Health Association, the Local Authority and independent accommodation.

Developments: There had been decommissioning of long stay beds with redeployment of nursing and care assistant staff to the new home based treatment team. Implementing Recovery-Organisational Change (ImROC) used methodology developed by the Centre for Mental Health. Mayo Mental Health Services was a participating site.

Quality Outcomes: An audit of care planning took place in May 2011 and a follow-up audit was underway which included service user involvement. A research meeting took place once a month which included members of the team, service users and relative/carer. As part of ImROC a local service evaluation was underway on the level of Recovery practice in the organisation.

Service user input: A service user, carer and Irish Advocacy Network representative met monthly. There was a befriending group set up. Service user- led research was completed. There was research collaboration with Shine in the national evaluation of 'Recovery and the Family'. There was collaboration with the Centre for Recovery in Severe Psychosis (Institute of Psychiatry, U.K.). A relative/carer information evening took place.

Assessments: Functional Assessment of Care Environment and risk assessment were used.

Care Planning: The rehabilitation and recovery service used a strengths-based collaborative individual care and treatment planning process for all service users. The clinical practice and team operation were guided by consultation exercises in the areas of Core Assessment, Care Planning, Care Coordination and Crisis Intervention. There were weekly team meetings and care planning meetings.

Training and education: Higher Education and Training Awards Council (HETAC) 8 Recovery Module was designed and delivered in collaboration between the rehabilitation and recovery team, the Mayo Mental Health Service and Galway Mayo Institute of Technology (GMIT). Further Education and Training Awards Council (FETAC) Level 5 Recovery training was designed and delivered in collaboration between the rehabilitation and recovery team, the Mayo Guidance Service and Galway Mayo Institute of Technology. HETAC Level 8 Multidisciplinary

team working with the GMIT was in development, as was advanced nurse practitioner approval as team coordinator.

Challenges and unmet needs: A complete rehabilitation and recovery team and assertive outreach team was required. Most residential places were full. There had been a loss of nursing staff through retirements with no replacements.

Donegal Mental Health Services

Catchment Population: 151,824

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	1
Community nurses	6
Clinical psychologist	0
Occupational therapist	0
Social worker	0
Healthcare assistants	3

Assertive outreach team: There was no dedicated assertive outreach team. However, assertive outreach was provided for half of the rehabilitation and recovery caseload.

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	1
Acute beds	Access
Continuing Care beds	0
Rehabilitation unit	0
Day Centre	1
24 Hour supervised residences	1 (20 places)

Vocational Training: Vocational training was provided through a referral to Training and occupational Support Services (TOSS). Other agencies included Solas (FAS), Adult Education Programmes by the Vocational Education Committee (VEC) and community allotments programmes.

Accommodation Links: All service users under the rehabilitation and recovery service were encouraged to put their names on the Local Authority housing list. Other housing agencies engaged with include Simon Housing Group, STEER Advocacy Group who was beginning to roll out a housing programme for service users in Donegal, St. Vincent de Paul Housing, and private rental accommodation. Within their own services they had 10 low support residences.

Developments: St. Conal's Hospital was successfully closed. During 2010 operational policies were revised. There was a roll out of WRAP training for staff. There were meetings with the Community Mental Health Teams (CMHT) to elicit feedback on rehabilitation and recovery services referral process having re-opened for referrals. A weekend recreational and therapeutic programme was developed and implemented for service users. There was a preliminary meeting with staff to develop and deliver a county-wide psycho-education programme.

Quality Outcomes: There were six monthly care plan reviews for all service users. There was feedback from the CMHT regarding the rehabilitation and recovery service. There was an audit of service user interventions and on bed days occupied before and after the rehabilitation and recovery service input.

Service user input: Regular meetings took place with residents of the supervised residence and with day centre attendees which were minuted with associated actions to resolve issues. A satisfaction survey was completed in conjunction with STEER Advocacy Service. Service user groups such as a walking group and a cinema group were developed. All care plans were developed with the service users. A weekend recreational and therapeutic programme was developed and implemented for service users. The service user decided who would attend their care plan meeting. They outlined their care plan and gave feedback on the service received. They also got feedback on the progress of their recovery journey.

Assessments: There was an initial screening assessment. This was followed by the Client Assessment of Strengths, Interests and Goals (CASIG), Wellness Recovery Action Plan (WRAP) Assessment, risk assessment, Recovery Star Assessment, Beck Depression Inventory (BDI-11), (if required) and Young's Mania Rating Scale (if required).

Care Planning: All service users had multidisciplinary care plans and case notes. Team meetings are held twice a week. Care planning meetings take place once a week.

Training and education: There had been a one-day course in Recovery Model Training. Two staff were trained as trainers in WRAP. WRAP training was now being delivered to other CMHTs. There was fortnightly in-service training within the team with recovery perspective.

Challenges and unmet needs: There was no psychologist, social worker or occupational therapist on the team. Training had been requested in Recovery Star for the team to audit and reflect service user involvement in their care plans and improvements achieved. Vocational places were funded for only four years; longer than that was required.

Sligo Leitrim West Cavan Mental Health Services

Catchment Population: 105,875

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing/ Dedicated Team Coordinator	1
Community nurses	5 Assertive Outreach nurses
Clinical psychologist	sessional
Occupational therapist	1
Social worker	1

Assertive outreach team: The service had an assertive outreach team that was staffed by five whole time equivalent (WTE) nursing staff.

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	1
Acute beds	access
Continuing Care beds	0
Rehabilitation unit	0
Day Centre	0
24 Hour supervised residences	2 (26 places [including 5 respite beds])

Vocational Training: Following assessment help was given in developing job applications. Contact and liaison with agencies such as FAS, National Learning Network, Vocational Educational Committee (VEC), Institutes of Technology and universities are made on behalf of the service user.

Accommodation Links: Individual housing assessments were completed. Referrals were made to the Local Authority Housing Department, Focus Ireland and Mental Health Ireland. Assistance was given with finding and maintaining privately owned accommodation. There were yearly reviews with the Community Welfare Office and Social Welfare.

Developments: A clinical nurse manager in the assertive outreach team completed registration in nurse prescribing. Two team members were trained as Wellness Recovery Action Plan (WRAP) facilitators. Access to psychology was made possible by the appointment of one WTE psychologist to the mental health service. A Research Fellow/registrar post was developed in rehabilitation and recovery. Research was conducted on the impact of the assertive outreach team on voluntary and involuntary admissions of service users under its care.

Quality Outcomes: A number of research projects had been initiated. These included a survey of assessment tools used by rehabilitation and recovery teams across Ireland, assessment of

needs in service users referred to rehabilitation and recovery, and placement needs of long stay patients in the Sligo Leitrim Mental Health Service. An assessment and review of the residential programme and long stay residents in the Special Care Unit had taken place. There was a policy procedure guideline manual audit completed in 2010 and an audit of medication management and administration practices in Mental Health Services completed. A number of policies were developed including rehabilitation and recovery service operational policy, medication management and administration policy, risk assessment policy and recovery care planning policy.

Service user input: 'Caring for Carers' eleven week psycho-educational programme ran in autumn 2010 and was attended by 12 carers. A carers' weekend was organized jointly by Carers Ireland and the health services and included carers of people with severe and enduring mental illness. Service users met regularly to discuss and plan social activities. Recovery care plans were collaboratively agreed with service users and signed by them. There were weekly residential meetings with service users to discuss issues and plan their week and menus. The Verona service satisfaction scale was used.

Assessments: The following assessments were used: Camberwell Assessment of Need-Research Version, Lancashire Quality of Life Profile, Verona Satisfaction Scale (European version), Community Placement Questionnaire, Involvement Evaluation Questionnaire (European version), Occupational Circumstances Assessment Interview Rating Scale (OCAIRS), clinical symtomatology questionnaires, mental state assessment and risk assessment

Care Planning: The service used a recovery person-centred multidisciplinary care planning approach in collaboration with the service user. There were weekly team meetings. Monthly meetings take place in both supervised residences.

Training and education: A clinical nurse manager in the assertive outreach team had completed registration in nurse prescribing. Two team members were trained as Wellness Recovery Action Plan (WRAP) facilitators. A Research Fellow/registrar post was developed in rehabilitation and recovery. There were monthly rotating journal/case/theory presentations. There was facilitation to attend appropriate course such as STORM and ASSIST (suicide prevention).

Challenges and unmet needs: Further training in Recovery was required by the rehabilitation and recovery team. There was no psychologist on the team. There were difficulties in addressing social and intimate relationship needs of service users. There was also difficulty in accessing appropriate services for young service users.

Limerick Mental Health Services

Catchment Population: 191,303

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	0.5
Community nurses	4
Clinical psychologist	0
Occupational therapist	1
Social worker	1
Other	0

Assertive outreach team: There was no dedicated assertive outreach team

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	1
Acute beds	Access
Continuing Care beds	0
Rehabilitation unit	1
Day Centre	5
24 Hour supervised residences	3 (51 place)

Vocational Training: Vocational goals were identified from the care plan. Training was sourced from community agencies especially Focus Training of the National Learning Network and Vocational Training Services.

Accommodation Links: The relevant domain of the care plan identifies service user requirements. There were links with the Local Authority, Focus Ireland, Cluid and Sophia Housing.

Developments: Three wards closed in St. Joseph's Hospital, reducing the number of residents from 84 to 28. An Bord Altranais approved the Advanced Nurse Practitioner Position in Recovery and Rehabilitation. A simplified management structure was developed by appointing a single assistant director of nursing to manage the nursing component of the service. A social worker was appointed to the team. There was transition to independent accommodation for people living in congregated settings including medium and low support accommodation in liaison with Focus Ireland and Genio Trust funding. The service had engaged external music therapists and art therapist. Anxiety management workshops were provided for service users. A modular recovery based group and individual psychosocial programmes were developed.

Quality Outcomes: The following indicators were used in 2010/2011: Waiting time for initial appointment, number of individuals seen, number of discharges from the rehabilitation service,

the number of people who report progress in the CASIG domains and the number of people moving to lower supported accommodation. Audits included audits of main areas of need identified through the CASIG assessment tool.

Service user input: There were expanded opportunities for consumer participation and engagement through peer-led service advisory groups. A service user newsletter was commenced for and about recovery. It was published and edited by service users.

Assessments: The main assessment was the Client Assessment of Strengths Interests and Goals. (CASIG)

Care Planning: The multidisciplinary care plan was based on assessment using the Client Assessment of Strengths, Interests and Goals (CASIG). The care plan was agreed with the service user. A multidisciplinary review took place as frequently as was necessary but at a minimum of six monthly intervals.

Training and education: Nurses had obtained diplomas and MAs in psychosocial interventions. The Advanced Nurse Practitioner met the criteria for advanced Nurse Practitioner in Recovery and holds an MA in Cognitive Behavioural Therapy. All staff had attended clinical supervision training.

Challenges and unmet needs: There was no psychologist on the team. Referrals often happened late in a person's illness which made rehabilitation more difficult. Education in rehabilitation and recovery was needed. There was a loss of nursing staff due to retirement with no replacement. There was limited communication from the sector teams. Elderly people, people with intellectual disability and those who were physically ill were hard to place in more independent accommodation.

Clare Mental Health Services

Catchment Population: 116,885

Team members	WTE/Sessions
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	0.5
Community nurses	5
Clinical psychologist	0
Occupational therapist	0.8
Social worker	0.8
Other	0

Assertive outreach team: There is no assertive outreach team

Facilities under care of Rehabilitation and Recovery team	Number
Team Base	1
Acute beds	3-5
Continuing care beds	5
Rehabilitation Unit	0
Day Centre	2
24 Hour supervised residences	4 (47 places)

Vocational Training: There was vocational work within the two day centres. There was also access to an HSE run Training Centre that ran a varied curriculum of training programmes. The local adult education and sheltered and supported employment services of the Local Authority were also used.

Accommodation Links: There were supervised residential places available. Each service user was encouraged and assisted to join the town and county council housing lists. Respond Housing association was also used.

Developments: A streamlined referral system was introduced for the community mental health teams to facilitate a more efficient transfer of care and shared care for service users. Funding from Genio Trust had enabled the planning for community support workers to focus on social care and supports.

Quality Outcomes: Clinical audit of referral procedures identified unwieldy practices which lead to clinical meetings to facilitate referrals. Reviews of Recovery Planning sessions led to improvements in service user experiences. Clinical audit of physical health monitoring had streamlined physical review protocol and ensured evidence based practice. Therapeutic programmes were evidence based.

Service user input: Service users experience was measured using part of the FACE package of assessments. Advocacy worker could attend recovery planning meetings at the service user's request. Friends and family were invited to recovery plan meetings at the service user's request. There were focus groups on recovery planning and therapeutic day programmes. Service users had actively contributed to submissions for funding for service development funds.

Assessments: The following assessments were used: The Functional Assessment of Care Environment (FACE), the Client Assessment of Strengths, Interests and Goals (CASIG) and the Manchester Quality of Life.

Care Planning: The service used recovery based care plans which were multidisciplinary. The service user attended the care plan meetings. There were weekly multidisciplinary team meetings.

Training and education: The assertive outreach team completed postgraduate training in psychosocial interventions (higher diplomas and masters degrees). The local academic

programme included recovery practice. There was an annual training day on recovery orientated practices as part of service development. There were also regular case conferences and critical appraisal sessions.

Challenges and unmet needs: The lack of access to forensic assessments was highlighted by the service. The service would welcome the development of regional intensive care rehabilitation units. The lack of staff replacement remained an issue. The reconfiguration of services whereby service users residing in North Tipperary were admitted to acute admission beds in Clare had highlighted the need for rehabilitation and recovery services in North Tipperary which were not in place.

East Galway Mental Health Services

Catchment Population: 110,100

Team members	**WTE/Sessions**
Consultant Psychiatrist	1
Non Consultant Hospital Doctor	1
Assistant Director of Nursing	0.5
Community nurses	0
Clinical psychologist	0
Occupational therapist	0.3
Social worker	0.5
Other	0

Assertive outreach team: There was no dedicated assertive outreach team. Residential staff provided an assertive outreach service.

Facilities under care of Rehabilitation and Recovery team	**Number**
Team Base	0
Acute beds	4
Continuing care beds	0
Rehabilitation unit	1
Day Centre	0
24 Hour supervised residences	2

Vocational Training: The training Centre was strongly linked to the rehabilitation and recovery team. The Training Centre manager attended the rehabilitation business meetings. Training Centre staff attended care plan meetings.

Accommodation Links: Accommodation and housing needs were addressed on a needs basis by the social worker and the occupational therapist.

Developments: An advanced nurse practitioner in psychosis was appointed. The rehabilitation unit was closed in March 2011 with successful placements in the community. The occupational therapist set up a local branch of Shine for service users. The rehabilitation and recovery team were involved in an overview of training programmes in the local Training Centre. Several staff were trained in the Stress Vulnerability Model. There was ongoing training using the Recovery Star Tool.

Quality Outcomes: There were regular audits of documentation, care plans, policies, medication sheets, Codes of Practice and student nurse placements. The service used standardised assessment tools.

Service user input: The advocate attended monthly business meetings. There were regular residents meetings in the community residences. Service users attended Trialogue (facilitated conversations about mental health) in Galway.

Assessments: The following assessments were used: Recovery Star Model, the Client Assessment of Strengths, Interests and Goals (CASIG), Camberwell Assessment of Need, Life Skills Profile Questionnaire.

Care Planning: The service used multidisciplinary care planning. This was reviewed every six months by the team including residential staff, training centre staff and key worker and reviewed on an ongoing basis by the key worker and team. Families and service users attended the care planning meeting. There are weekly team meetings.

Training and education: The service stated that there was ongoing training and development of staff but no further details were available.

Challenges and unmet needs: The main challenge facing the rehabilitation and recovery team was that the temporary consultant psychiatrist post had been terminated with no plans to fill the post. The position of the rehabilitation and recovery service was uncertain. The team itself was inadequate in terms of staffing and there was no replacement for retired nursing staff. It was also pointed out that there was a lack of forensic rehabilitation services.

The following had no rehabilitation and recovery services: Roscommon, West Galway, South Lee, North Lee, Dublin South West. These services did not submit a self assessment and did not attend the national overview meeting.

CONCLUSION

Despite the fact that rehabilitation and recovery services are recommended by *A Vision for Change a* number of catchment areas have little or no such services. Services appeared to have developed in relation to the need to place patients from long stay institutions. Where there were no large psychiatric institution rehabilitation and recovery services were, in the main, extremely under-developed.

Those areas that have rehabilitation and recovery services have poorly staffed teams in all disciplines. No area had a fully staffed rehabilitation team as outlined by *A Vision for Change*. In some areas there were no occupational therapists. Social work and psychology were also lacking in many areas. Very few rehabilitation and recovery services had an assertive outreach team. In the area of rehabilitation and recovery services there has been a lack of implementation of *A Vision for Change*.

All services reported having access to acute in-patient beds. Most had access to community residential beds. However there was a marked lack of community places especially for patients who required low support and independent accommodation. A number of services outlined their difficulties in accessing forensic services.

There appeared to be good links with vocational services and most services had access to day centres.

All teams used multidisciplinary care planning which appeared to be well developed. A wide range of assessments were used and formed the basis for care planning.

In summary there were insufficient rehabilitation and recovery teams to provide a comprehensive service nationally. In existing teams there was a lack of adequate staffing. Where teams existed it was evident that there was strong team working, good service user input, excellent care planning and good service provision within the constraints of poor resourcing.

RECOMMENDATIONS

1. There should be a rehabilitation and recovery team for each catchment population of 100,000 as outlined in *A Vision for Change.*
2. Each rehabilitation and recovery team should be fully staffed as recommended by *A Vision for Change.*
3. Each rehabilitation and recovery team should have an assertive outreach team.
4. Liaison with other agencies should be further developed in order to provide low support and independent accommodation.

Disclaimer: This report was prepared on the basis of information provided prior to and at the 2011 Inspectorate National Overview Meeting.