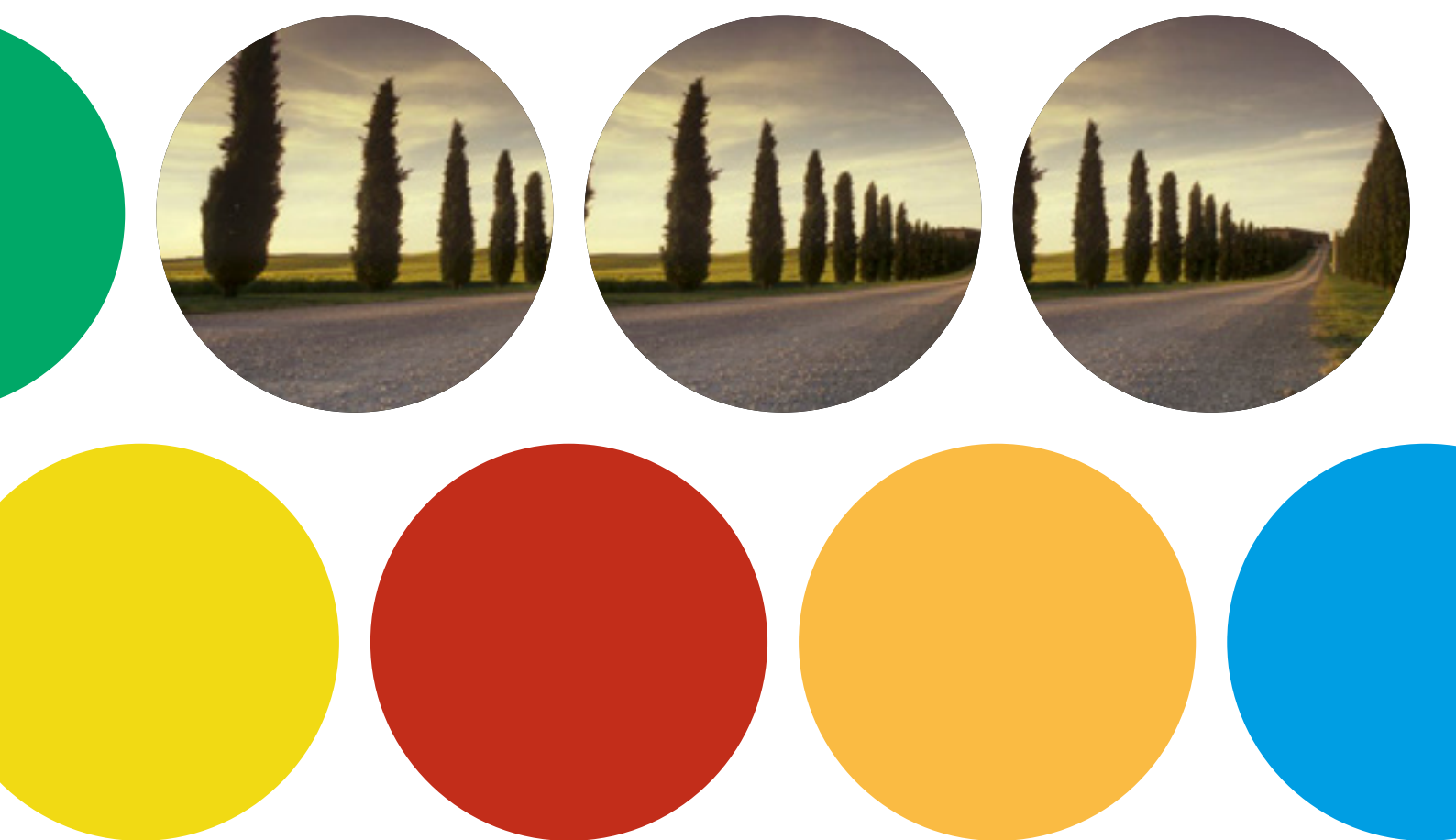# Model of Care for People with Severe and Enduring Mental Illness and Complex Needs

HSE Mental Health Services

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Contents

Foreword

This 'Model of Care for People with Severe and Enduring Mental Illness and Complex Needs' has been developed as a result of an initiative from the Health Service Executive (HSE) Mental Health Service. It arose from the recognition that those with arguably the most severe and enduring mental illnesses need specialist services to assist the individual service user in their recovery.

The most effective services are those that take a holistic view of the individual service user's needs, strengths and interests, and use the skills of the multidisciplinary team to develop an individual care plan that supports the individual service user on their recovery journey.

The Project Working Group concentrated on the features these services have in common to identify the themes, processes and cultural factors that contribute to successful rehabilitation. We have also incorporated these features in our recommendations for the development of a range of rehabilitation and recovery services that should be available for service users across all Community Healthcare Organisations.

We have described the function and operation of inpatient Specialist Rehabilitation Units in detail. These will cater for a small group of service users with the greatest needs. We recognised early in our discussions that the majority of service users with rehabilitation needs will benefit from services that provide rehabilitation focused community residences and support to those in independent living through Community Rehabilitation teams and interventions such as assertive outreach and tenancy support.

In conclusion, I would like to thank each member of the Working Group who I believe worked hard to enrich the final document with their own perspective and experience.

Dr. Donal O'Hanlon, Clinical Director,
Consultant Psychiatrist,
Chair of the Project Working Group.

Message from the National Director, Community Operations

It gives me great pleasure to present this "Model of Care for People with Severe and Enduring Mental Illness and Complex Needs". This Model of Care specifically addresses the requirements for people with severe and enduring mental illness and complex needs through the development of a range of rehabilitation and recovery services.

Through its support of Rehabilitation and Recovery Services and the recognition of the need to enhance services for people with severe and enduring mental illness and complex needs, the HSE Mental Health Services has prioritised the provision of high quality rehabilitation and recovery services. This Model of Care document has been developed in order to guide the delivery of those services.

It is important for mental health services to ensure people with severe and enduring mental illness and complex needs are supported throughout their journey of rehabilitation and recovery. A key recommendation in this Model of Care includes the implementation of a rehabilitation care pathway for people with severe and enduring mental illness and complex needs. Although ambitious, developing this care pathway within our mental health services is required to ensure the delivery of a high quality and safe rehabilitation and recovery service in Ireland.

I would like to thank all members of the project working group, for their commitment, insight and collaboration in the development of this Model of Care. I would also like to express gratitude to Family Carers Ireland who reviewed the document and provided advice and support to the project working group.

Mr. David Walsh,
Interim National Director,
Community Operations.

Executive Summary

This Model of Care (MOC) has been developed as an initiative of the Health Service Executive (HSE) Mental Health Services. It outlines a care pathway designed to meet the needs of people with severe and enduring mental illness and complex needs. This includes diagnoses such as schizophrenia and affective disorders. It describes a rehabilitation care pathway that helps individuals who have had prolonged episodes of severe and enduring mental illness to experience recovery and regain the skills and confidence required to live an independent life. The programme aims to meet the needs of a small, but significant, number of service users who attend mental health services. It also aims to support family members. It is estimated that as many as 10% of people entering mental health services will have complex needs that require rehabilitation and support over many years.

Currently, many of these service users have been residing in acute inpatient units for prolonged periods. Consequently, to address this difficulty, a Project Working Group was established. It is the view of the working group that prolonged acute inpatient care, when the acute phase of illness has stabilised, could be counter-productive for individuals who are deemed to require rehabilitation. Significantly, it is possible that these individuals may lose essential living skills unless a programme of rehabilitation is made available to retain and further develop these skills. Therefore, it is envisaged that alternative care structures, such as rehabilitation focused inpatient units will provide the therapeutic input service users need. Conversely, this increases the number of beds available for acute inpatient admissions. Components of a specialised rehabilitation care pathway will include:

- Community Rehabilitation and Recovery Services

- Specialised Rehabilitation Units (SRUs)

- Community Rehabilitation Residences

- Individualised Accommodation Options

- Occupation and Employment Supports

- Peer Support and Advocacy

Summary of Recommendations

National

1. National mental health services will develop a rehabilitation care pathway for service users with severe and enduring mental illness and complex needs.

2. This specialised care pathway will include the development of inpatient specialist rehabilitation units to provide an intensive inpatient rehabilitation programme for those service users with the greatest needs.

3. Community rehabilitation and recovery services will be developed to provide high quality, recovery oriented, safe services that are responsive to service user's needs and preferences across all Community Healthcare Organisations.

4. All services in the rehabilitation care pathway should be recovery oriented and adhere to the National Framework for Recovery in Mental Health.

5. All services in the rehabilitation care pathway will ensure that family members are supported and included in the process of care and along the care pathway.

6. High quality training will be provided for qualified staff working within specialist rehabilitation services.

7. The HSE Best Practice Guidance for Mental Health Services (HSE, 2017) will be implemented throughout all services in the rehabilitation pathway.

8. A clear governance structure will be adhered to.

Community Healthcare Organisation (CHO) / Community Rehabilitation and Recovery Services

9. Each Community Healthcare Organisation will develop a rehabilitation care pathway for service users with severe and enduring mental illness and complex needs.

10. They will develop capacity and have access to an inpatient specialist rehabilitation unit with an intensive rehabilitation and recovery programme for service users whose rehabilitation needs cannot be met in a community rehabilitation residence.

11. Historically, many mental health community rehabilitation residences were organised around a high support hostel model of care. However, it is now recognised that there is a danger that these residences could become mini-institutions. Consequently, to improve current practice, services will develop complementary forms of community rehabilitation residences. While continuing to provide intensive staff support, they may be more suitable for a rehabilitation

and recovery oriented programme.

12. To successfully live in their chosen community, it is recognised that a small cohort of service users will need the on-going support and structure of a community residence which is geared towards continuing care. Consequently, services should reconfigure residences where necessary in order to provide for the differing care needs of these distinct groups of service users.

13. Each CHO will ensure they have an adequate number of community rehabilitation residences focused on active rehabilitation and recovery to enable residents to progress to independent community accommodation.

14. As outlined in "A Vision for Change" (2006) each CHO will develop multidisciplinary community rehabilitation teams with an assertive outreach component. Community rehabilitation teams will provide a range of interventions based on the changing needs of the individual service user. It is expected that service users will progress across levels of care. This progression will be a key productivity indicator of an effective service.

15. Teams will support service users in obtaining appropriate independent community accommodation. Teams will link with local authorities and voluntary housing associations to advocate for access to appropriate housing for service users.

16. They will develop the capacity to provide support for service users who transition to independent community accommodation and develop links with other tenancy support and visiting services.

Specialised Rehabilitation Unit (SRU)

17. Inpatient SRU will provide an intensive inpatient rehabilitation programme for service users with the greatest need.

18. Referrals to the inpatient SRU will be completed by the community rehabilitation team. Alternatively, this will be provided by the community mental health team responsible for individual service user care.

19. SRUs will provide individual care plans (ICP) for all service users. They will focus on identified needs and goals, reflecting the views of the service user. They will be coordinated by a designated member of the SRU multi-disciplinary team, i.e. a key worker. ICPs will be regularly reviewed. They will include a proposed discharge plan.

20. SRUs will ensure that family members are included and fully supported in the process of care.

21. Each SRU will maintain a clear governance structure and implement the "Best Practice Guidance for Health Services" (HSE, 2017).

22. They will create calm, respectful, inclusive and genuinely hopeful therapeutic environments in which to foster and develop open, supportive and inclusive relationships. To ensure a high-quality service, they will adhere to Royal College of Psychiatrists Enabling Environment Standards (see Appendix E).

23. They will provide regular clinical supervision for all clinical staff as a core requirement of the work, and key to creating enabling environments.

24. They will provide regular debrief opportunities to safeguard individual service users following serious incidents.

25. Length of stay will depend on individual need. This will be based on continued therapeutic benefit to the service user from the programme. In most cases it is expected to be in the range of 1 to 3 years.

26. To ensure an integrated approach to assessment and treatment, SRUs will maintain close communication with catchment area mental health services. To facilitate this communication, a care coordinator from the referring service will be appointed for each service user.

Community Rehabilitation Residence

27. Community Rehabilitation Residences (CRR) will provide an active rehabilitation programme for individuals in need of continued support around their mental health needs. The objective is to move towards less supported community accommodation.

28. They will prioritise the promotion of a recovery-oriented service built on a culture of hope and expectation that the person can recover and build a fulfilling life of their own choosing based on the National Framework for Recovery in Mental Health.

29. CCR will provide an individual care plan (ICP) for all services users. They will focus on identified needs and goals, which reflect the views of the service user. ICP will be coordinated by a designated member of the multi-disciplinary team, i.e. a key worker. ICPs will be regularly reviewed. They will include a proposed discharge plan.

30. CRRs are designed to create calm, respectful, inclusive and genuinely hopeful therapeutic environments in which to foster and develop open, supportive and inclusive relationships. To ensure a high-quality service they will adhere to the Royal College of Psychiatry's Enabling Environment Standards (see Appendix E).

31. They will ensure that family members are included and fully supported in the process of care.

32. Each CRR will maintain a clear governance structure and implement the "Best Practice Guidance for Health Services" (HSE, 2017).

33. They will ensure the delivery of regular Clinical Supervision for all clinical staff as a core requirement of the work, and key to creating enabling environments.

Evaluation

34. Evaluation of all aspects of this Model of Care is essential to ensure an effective service and a positive experience of the care described. Consequently, to enable service evaluation and on-going re-evaluation, standard data will be returned by each inpatient specialised rehabilitation unit and community rehabilitation residence.

35. Service user input will be vital in evaluating the service. This will ensure resources are allocated to meet the needs and preferences of service users travelling along the Model of Care pathway (see Appendix F).

Membership of Project Working Group

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1. Introduction

Rehabilitation in mental health can be defined as:

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

<div align="right">(Killaspy et al. 2005)</div>

A national study of inpatient mental health rehabilitation services across England found that 80% of people using rehabilitation services have a diagnosis of psychotic illness. This is usually schizophrenia or schizo-affective disorder. On average, these service users experienced mental health difficulties for 13 years (Killaspy et al. 2013). Prior to referral for rehabilitation, they had been recurrently admitted to hospital and spent ten months in the acute unit prior to transfer to a rehabilitation unit. Unfortunately, these individuals often experience on-going symptoms which may not respond to standard therapeutic interventions. They may also have co-existing problems such as anxiety, depression, substance abuse, long-term physical health conditions and pre-existing disorders that make their presentation complex and often difficult to manage (Holloway, 2005). Notably, this indicates that some service users present with challenging behaviours, including aggression towards others and difficulties engaging with treatment and support. They may have considerable disability and impaired mental capacity to make everyday decisions. Consequently, they can be vulnerable to exploitation and abuse by others and thus require a safe therapeutic environment.

Regrettably, the availability of inpatient rehabilitation services varies across healthcare locations. Inner city areas tend to have a greater need for inpatient rehabilitation units. From here, service users generally move to a community-based rehabilitation unit in preparation for independent, supported community living. Encouragingly, 57% of people who require inpatient rehabilitation care successfully move to supported accommodation within 18 months. Significantly, without readmission of placement breakdown, two-thirds of service users identified successfully sustained their community placement five years on (Holloway et al. 2015).

Clearly, there is a need to further develop inpatient rehabilitation services for service users with long term and complex mental health needs with a view to supported community rehabilitation residential programmes and independent community living.

With this in mind, the following document outlines the background, aims, objectives, core values, principles of Rehabilitation and Recovery Services, Specialist Rehabilitation Units (SRUs), Community Rehabilitation Residences and individualised accommodation options along a clearly identified rehabilitation care pathway.

2. Background

Traditionally, psychiatric hospitals catered for service users with cross-sectional presentations that varied in type. They included service users with 'complex needs' who often require specialist treatment and care. Recent changes in mental health policy meant that almost all psychiatric institutions in Ireland closed down. Subsequently, they were replaced with acute inpatient units within general hospitals and the development of community mental health services. However, following these closures, a focus was placed on acute care. This was perhaps an unrealistic expectation - that some people do not require more intensive, specialist rehabilitative inpatient care. This has led to several problems, including:

- Difficulty in understanding and managing the often challenging behaviour of service users with severe mental illness within current acute units based in general hospitals.

- Service users remaining on acute inpatient units for prolonged periods where their needs remain unaddressed and their condition may deteriorate. While attempting to support service users with complex needs, the therapeutic environment for the wider inpatient group in the acute unit is often adversely affected.

- Reduced availability of admission beds for the sectors served by the acute inpatient units, due to reduced inpatient turnover and delayed discharges.

- In many cases, lack of specialist placements within the mental health services resulting in funding and financial approvals being sought from local mental health budgets for placements of this service user group with private providers.

- In the absence of specialist beds, there are increasing demands on the available staffing resource, as acute inpatient units attempt to manage day-to-day, using prescribed special observations and one-to-one assignment of staff. As neither the acute inpatient unit nor the model of care is designed to meet the medium or longer-term needs of this service user group, this can consequently escalate to containment.

3. Rationale

Through the establishment of the Project Management Office (PMO), the Health Service Executive (HSE) Mental Health Service initiated a national project to review rehabilitation and recovery services in Ireland for service users with severe and enduring mental illness and complex needs.

Firstly, a Project Steering Committee was established as a project level decision forum to:

- Approve movement of projects through different stages

- Approve project changes if required

- Provide guidance for the Project Manager

- Inform the Project Manager of strategic or organisational changes that may have an impact on the project

- Manage project Stakeholders at management level

- Monitor and control project progress via regular meetings and reports

- Promote value of project outcomes to the wider organisation.

(See Appendix A for membership)

Secondly, an assessment of the number and needs of service users with severe & enduring mental illness and complex needs placed in either approved centres or external placements was carried out. To identify a MOC for these service users, and provide a comparative context, members of the Project Steering Committee visited a rehabilitation service in Islington and Camden NHS Trust to observe how their renowned rehabilitation care pathway operates.

Thirdly, based on the model observed during their visit, the Project Steering Committee established a project working group to develop a Model of Care for people with severe and enduring mental Illness and complex needs.

4. Aim & Objectives

The aims and objectives of this Model of Care are to:

- Create a recovery focused MOC for people with severe and enduring mental illness and complex needs,

- Ensure the identified group are provided with a continuum of care along a whole system rehabilitative pathway,

- Support the development of a robust governance structure, establishing areas of responsibility, authority, accountability and reporting relationships,

- Support training, education and competence development for all members of the multidisciplinary team, and

- Assist performance measurements and evaluation systems, including service user's and family member's experiences of service provision.

5. Core Values and Principles of the Model of Care

Vision

The vision is to direct the future delivery of rehabilitation mental health services by providing high quality, progressive and recovery based healthcare on a national scale.

Mission

The mission is to enable people with severe and enduring mental illness and complex needs to live their lives to their fullest potential.

Purpose

The purpose is to design a specialised rehabilitation care pathway for people with complex mental health illness, ensuring they have access to high quality mental health services and evidence-based interventions centred on clearly identified needs and service user preferences.

Values

Caring

Provision of the highest quality care with evidence-based best practice and where the views and opinions of service users are considered in how services are planned and delivered.

Compassionate

Dedicated professional staff who show kindness, consideration and empathy in all communications and interactions with service users. Service users to be treated with dignity and respect with adequate time devoted to building therapeutic, trusting, supportive and enabling relationships.

Safe

Provision of safe environments for service users and their families that balances safeguarding and positive risk taking while maximising service user's autonomy and personal responsibility. Open and transparent services incorporating integrity, consistency and accountability in all decisions and actions.

Creative

Maximising the skills and talents of staff and service users to co-produce forward thinking approaches to mental health recovery while fostering an environment of learning, innovation and creativity.

Inspirational

Foster hope-inspiring relationships between staff, service users and families/carers and provide enabling environments based on a culture of mutual respect and genuine hopefulness.

Principles

Recovery Orientated

A service focused on the key recovery principles of hope, connectedness, empowerment, the creation of meaningful roles and identity in which service users are assisted to define what recovery means to them. Promotion of choice and provision of opportunities for service users to build social roles and positive self-identity.

Comprehensive

A high-quality rehabilitation mental health service that provides a range of comprehensive and multi-dimensional treatment/therapeutic options for service users, rooted in evidence-based best practice.

Multi-Disciplinary

Interventions based on an approach that acknowledges the biological, psychological, cultural and environmental factors that contribute to positive health outcomes for service users. The benefits of multi-disciplinary team working are central to the provision of a high-quality service and excellent outcomes for service users. Such an approach values the input of clinical and non-clinical staff and peer support workers.

Collaborative

Services are delivered through a combination of the unique lived experience of the service user and family members and the professional expertise of healthcare staff. In this way, services will actively seek out service user and family members' feedback that allows meaningful participation and representation of service users and family members at all stages of service planning, delivery and evaluation.

Enabling Environment

It is important to create a calm, respectful and hopeful therapeutic environment. This is based on the establishment and maintenance of safe and supportive relationships between staff and service users. In this way services place a key emphasis on staff availability to service users and thereby promote respectful day-to-day interactions by building understanding and collaborative relationships.

Positive Risk Management

Services recognise the skills, talents and resilience of service users. This is balanced with identification of risk and vulnerabilities. In collaboration with service providers, service users, family members and key stakeholders, risk assessment and safeguarding become a negotiated process that maximises service user autonomy and personal responsibility.

(Adapted from A National Framework for Recovery in Mental Health: HSE 2018-2020 & Building a High-Quality Health Service for a Healthier Ireland: HSE Corporate Plan 2015-2017)

"Well I was diagnosed with paranoid schizophrenia which is quite a frightening diagnosis for a young fellow to have on his shoulder … And I felt I was a reject, I was rejected from family, friends, the whole world and somehow, you know, distanced from the whole … And with this diagnosis they don't offer, they didn't offer me any hope, they didn't say you can do this, and you'll be alright. Nothing really, they said 'medication'".

(Cited in Kartalova-O'Doherty and Tedstone Doherty, 2010)

6. Proposed National Model of Care: Rehabilitation Mental Health Services

Current Service Pathway, Delivery and Challenges

In most acute inpatient units in Ireland, there are a small, but significant, number of service users with severe mental illness and complex needs who have had lengthy inpatient admissions. This is far from ideal. The acute environment is primarily focused on short-term admissions designed to treat and manage acute mental illness. For service users who have more significant mental health difficulties with severe functional impairment, they often require lengthy admissions and on-going intensive support in a specialist inpatient rehabilitation unit. This is designed to stabilise their health and social needs and manage risk behaviours in the context of mental illness with co-morbid diagnoses (Holloway, 2005).

According to the Joint Commissioning Panel for Mental Health (2012), therapeutic interventions focus on recovery oriented clinical practice which supports the individual to progress towards discharge to community living. Individuals using rehabilitation mental health services are a 'low volume, high needs' group. 80% have a diagnosis of major psychotic disorder, such as schizophrenia or schizo-affective disorder. Prior to referral to rehabilitation services, many may have had repeat readmissions to acute inpatient units. Consequently, they may require extended admission to inpatient rehabilitation services and on-going specialist community rehabilitation over several years (Holloway, 2005).

In Irish mental health services, a service gap has been identified in the care pathway of service users with severe and enduring mental illness and complex needs who require further inpatient treatment in an inpatient specialist rehabilitation unit. As previously mentioned, following the closure of traditional large psychiatric hospitals, the number of inpatient rehabilitation units has declined. While some service users with complex needs can be successfully discharged into their chosen community, there are a small number who are sometimes repeatedly readmitted to acute inpatient units. Consequently, to ensure that the needs of this group are met, a rehabilitation care pathway is essential (Holloway et al. 2015).

Service User Group

According to Craig et al. (2004a), roughly 10% of mental health service users have complex needs that necessitate rehabilitation and intensive support, often over many years. The majority have a diagnosis of psychosis complicated by negative symptoms. This often impairs motivation and organisational skills. It can also adversely affect everyday activities and put them at risk of self-neglect (Wykes & Dunn, 1992; Green, 1996). Additionally, some service users may exhibit positive symptoms (delusions and hallucinations) that may not fully respond to medication. This can lead to communication

and engagement difficulties (Holloway, 2005). Regrettably, this small group has evolved as the new long-stay service users who remain inappropriately placed in acute inpatient units where their rehabilitation needs are neglected (see case study below).

Alice

Alice has a history of schizophrenia. She has required multiple readmissions to acute units to treat her relapsing psychosis. When she was younger, Alice experienced significant psychological trauma. She was a victim of emotional and physical abuse. This had led Alice to develop many risk related problems including cognitive deficits, lack of insight, and poor concordance with medication. Alice has very limited family and social supports. A couple of years ago, Alice moved out of her family home and into supported, independent accommodation. However, due to her high level of functional disability, she found it difficult to cope with a domestic environment. Regrettably, she was forced to return to her family home. Unfortunately, there was a significant level of social stressors in the family home. This included emotional abuse and a significant threat of domestic violence from certain family members.

Needless to say, in the last year, Alice's mental and physical health needs have increased. She has had several prolonged inpatient admissions. During her last admission she was referred to the local specialist rehabilitation service. Following this, she was discharged to a community 24-hour supported residence. However, she unfortunately experienced further relapses which required readmission to the acute unit. Her progress was complicated by her physically aggressive behaviours towards others. To stabilise her mental health, under the Mental Health Act (2001), Alice required transfer to a Psychiatric Intensive Care Unit (PICU). Despite this, Alice has been slow to respond to standard therapeutic interventions. In addition, she has developed significant physical health problems, including obesity, gallstones, chronic pleural effusion and poor mobility. Consequently, she requires intensive support to engage in her personal care and the therapeutic activities on the acute unit. Alice has now been 'living' on this unit for the last three years.

Ultimately, Alice may need further intensive MDT rehabilitation care in an inpatient specialist rehabilitation unit. Once there, she can be supported to address her mental and social needs, reduce the level of risk related behaviours and enable stabilisation of her mental health. This should identify the supports she requires to move back into the community where she can begin to live the life she deserves – the life she always dreamed of.

What is Rehabilitation in Mental Health Services?

Due to the complex nature of individuals with severe and enduring mental illness, mental health rehabilitation services often work with this specialist group over many years. This enables them to gain or regain their confidence and skills in everyday activities and in the management of symptoms (Lavelle et al. 2011). However, sustaining the hope of recovery over prolonged periods can be difficult for staff, service users and carers. Therefore, a key feature of rehabilitation services is the relentless encouragement of hope and optimism (Killaspy et al. 2012).

Requirements

Rehabilitation within mental health services centres on a whole-system care pathway (Appendix B): An effective rehabilitation service requires a well-managed collaborative system of services across a wide spectrum of care. Exact components of the care pathway will be determined by local need (Killaspy et al. 2012). The rehabilitation care pathway will provide a recovery focused continuum of treatment and support that facilitates recovery. Although this is not a linear process and, acknowledging that individual service users will progress at a different pace, these supports will include:

- Community Rehabilitation and Recovery Services

- Specialised Rehabilitation Units (SRUs)

- Community Rehabilitation Residence

- Individualised Accommodation Options

- Occupation and Employment Supports

- Peer Support and Advocacy Services (see Section 9)

(Adapted from the Joint Commissioning Panel for Mental Health, 2012)

Please note: specific components of the rehabilitation care pathway may be provided by third party and non-governmental organisations. Ideally, service users should move seamlessly through each pathway component. However, this will depend on positive partnerships between services.

Community Rehabilitation and Recovery Services

Central to any successful rehabilitation and recovery service is the community rehabilitation team (CRT). As stated by Holloway et al. (2015), an effective CRT will have an appropriate understanding of, and maintain strong connections across, a wide range of mental health services and external agencies. The CRT is a vital component of the rehabilitation care pathway. While working closely with both local acute inpatient

units and SRUs, it provides a useful overview of the service user's journey. Furthermore, when CRTs work collaboratively with local acute inpatient units, SRUs and community residences, service users can move readily through the rehabilitation care pathway (Holloway et al. 2015).

Another important feature of the rehabilitation process is the fostering of community re-integration. This is achieved through engaging in community networks and social activities. This requires an on-going commitment by the CRT to work alongside each service user. Accordingly, community rehabilitation teams must ensure that service users with complex needs are supported to live in their local community. This is accomplished through working closely with service users and their family members to ensure that, while considering their individual wishes and choices, they are placed in an appropriate setting (Joint Commissioning Panel for Mental Health, 2012).

A cornerstone of a successful rehabilitation and recovery service is a successful care planning process. Care planning is a developing record of an individual's care process. It is developed as a collaborative document, between services users and members of their treating team. In line with their expressed needs and preferences, an effective CRT ensures that all service users are provided with a care plan that describes the levels of support and treatment required. Individual care plans will be co-ordinated and regularly reviewed by a member of the multi-disciplinary team, i.e. a designated key worker. It should also include a discharge plan (Mental Health Commission, 2012).

To summarise, essential functions of the community rehabilitation mental health team include:

- Individual care planning and direct care coordination,

- Working alongside service users and family members when transitioning from higher to lower levels of support,

- Working collaboratively with local accommodation providers, and

- Education and vocational rehabilitation.

(Adapted from Joint Commissioning Panel for Mental Health, 2012)

Evidence shows that service users with severe mental illness do not do well in a demand-led health service. Hence, the concept of 'assertive outreach' care was developed. As a subgroup within the CRT, they provide assertive outreach care to service users with complex needs (Department of Health (DOH), 2006). A key principle of assertive outreach care is to provide individualised, recovery-focused, proactive care that, while maximising direct involvement in the recovery process with the community, minimises the risk of disengagement (DOH, 2006). Significantly, the assertive outreach model is utilised worldwide. Critical features of successful assertive outreach teams include:

- A service delivered by a multi-disciplinary team providing a full range of interventions,

- Services directly provided by the team, rather than through an agency,

- Low staff to service user ratio, that is, 1:10 to 1:12,

- Most interventions to be provided in the community,

- An emphasis on engagement and maintaining contact with service users,

- A highly coordinated intensive service with daily handover meetings and weekly clinical reviews, and

- Extended hours, 7 days a week service with a capacity to manage crises and increase daily contact, according to need.

(Macpherson & Gregory, 2009)

Successful assertive outreach teams will work directly with service users to:

- Enable them to gain confidence with everyday living skills which emphasises access to mainstream activities;

- Support service users to self–manage their illness - this is achieved by progressing through working on basic needs (food, accommodation, finance) to higher level needs (relationships, work);

- Encourage them to improve their social network - focusing on developing social functioning and family involvement;

- Focus on service user's individual strengths;

- Support engagement with specialised rehabilitation and relevant agencies;

- Ensure they have access to a range of adequate treatments and supports (see Section 8);

- Support service users to engage with education and meaningful occupations.

(Adapted from Macpherson & Gregory, 2009)

Specialised Rehabilitation Units (SRUs)

An SRU is designed as an inpatient approved centre. It provides 24-hour nursing care. Its primary focus is active medium-term rehabilitation. Service user progressing across levels of care is its primary goal with the expected length of stay being 1 to 3 years (Killaspy et al. 2012). With a consultant psychiatrist or other professionals acting as responsible clinician, such units can cater for those detained under the Mental Health Act (2001). However, not all service users will be detained involuntarily (Killaspy et al. 2012). It is crucial to successful rehabilitation and recovery that SRUs are not viewed as standalone units, but rather as part of a whole-system rehabilitation care pathway. Furthermore, SRUs are not

Low Secure Units or Psychiatric Intensive Care Units (PICUs) nor are they suitable for long-term continuing care.

Significantly, some service users deemed suitable for SRUs and rehabilitative care may have a history of challenging behaviour. Emerson (1995) defines challenging behaviour as "culturally inappropriate behaviour of such an intensity, occurrence or length that the physical safety of the person or others is likely to place them in danger". Nevertheless, it is important that SRU staff understand that challenging behaviour is not a diagnosis in itself. Therefore, challenging behaviour must be understood as part of the overall picture of complex needs and should be assessed and treated as such (Holloway et al. 2015).

Fundamentally, bespoke multidisciplinary assessments must include Clinical Psychology assessment and formulation. This will aid the understanding of challenging behaviour as part of the overall picture of complex needs. These assessments will identify needs and abilities as the primary drivers of interventions and enable staff to engage therapeutically with service users, without fear and with an acute awareness of boundaries and safety issues for all. Hence, clinical supervision for staff is key to enabling supportive, respectful relationships with service users with complex needs. However, should a service user continue to exhibit significant challenging behaviour, referring community mental health teams will support the SRU by facilitating re-admission to an acute inpatient unit or a suitable alternative healthcare setting.

Operating an SRU

Principles underlying the operation of an SRU are:

1. SRUs are operated as a tertiary centre of excellence.

2. SRUs are staffed by nurses and support workers on a 24-hour basis with input from the SRU multi-disciplinary team (MDT) and the referring Community Rehabilitation Team.

3. Each service user will have an individual care and treatment plan. It will describe the levels of support and treatment required in line with their needs. It is co-ordinated by a designated member of the SRU MDT, referred to as a keyworker.

4. All units will have access to a full range of treatments and supports provided by the SRU MDT (see Section 8).

5. The unit will provide a range of relevant activities which build service user confidence and skills on site and in the community (Killaspy et al. 2012).

6. Approved Centre (Mental Health Act, 2001) classification with single en-suite rooms applying and designed to the highest standard with ligature points minimised throughout.

7. Where necessary, gender segregation should be made available.

8. Accommodation will include therapy/group rooms, nurses' station and office, visitors' area, dining room with adjacent kitchenette, sitting room with TV and enclosed external sensory garden.

9. Significantly, as most service users will require prolonged, extensive inpatient treatment, and whilst providing a positive, safe and nurturing environment for service users and for staff, SRUs will provide a safe and homely living space that fosters stability and security, thus avoiding potential institutionalisation.

10. SRUs will be part of range of complementary facilities that work as part of a whole rehabilitation care pathway, rather than stand-alone units (Killaspy et al. 2012).

Staffing of an SRU

To address the complex and diverse needs of service users, an expert multidisciplinary team (MDT) is required. Risk management will consider the need for higher staffed SRUs (often locked/lockable) with staff who can understand and thereby manage challenging behaviour. The SRU MDT should include:

- Consultant Adult Psychiatrist with recovery focused rehabilitation expertise;
- Non-Consultant Hospital Doctor (NCHD) on Postgraduate Training Programme;
- Clinical Nurse Manager (CNM 2) - SRU Manager and Coordinator;
- Registered Mental Health Nurses;
- Mental Health Care Support Staff;
- Senior Clinical Psychologist;
- Senior Occupational Therapist;
- Senior Social Worker;
- Art / Drama / Music Therapist;
- Peer Support Worker;
- Administrative Support;
- Catering and Housekeeping Assistant.

Community Rehabilitation Residences

In many mental health services, community residences are organised around a 'High Support Hostel' model of care. Potentially, these residences can become mini-institutions. To prevent this, services will develop alternative Community Rehabilitation Residences which, although continuing to provide intensive MDT support, are primarily geared towards active rehabilitation and recovery.

Accordingly, Community Rehabilitation Residences will provide active rehabilitation and recovery programmes. Provision of this type of care will be made available to those who require continued input around their mental health needs. Its focus shall be movement towards independent community living accommodation. Crucially, each CHO will provide an adequate number of Community Rehabilitation Residences (with a focus on rehabilitation and recovery programmes). This will enable service users to progress towards independent living.

Despite this, a small cohort of service users may need the on-going support and structure of a community residence geared towards continuing care. Therefore, to provide for the varying care needs of these distinct service user groups, where necessary, local mental health services in each CHO will reconfigure their existing community residences.

Operating Community Rehabilitation Residences (CRR)

Principles underlying the operation of CRRs are:

1. To support people with complex mental health needs who, due to their on-going mental health needs, cannot be directly discharged from an acute inpatient unit and/or an SRU to an independent or supported community placement.

2. Service users will have access to the full complement community rehabilitation team and an allocated key worker.

3. They will be provided with an individual care and treatment plan that describes the levels of support and treatment required in line with their needs. It will be co-ordinated by a designated member of the multi-disciplinary team, i.e. a key worker.

4. CRRs will focus on assisting service users in their further recovery, optimising medication regimes, engaging in psychosocial interventions and attaining increased independent living skills (see Section 8).

5. They will be part of the service user's accommodation pathway with an active focus on assisting service users transition to independent community living.

6. They will be defined by the nature of the rehabilitation and recovery programme on offer rather than by staffing levels.

7. Local, community-based units will provide a domestic environment that facilitates service users to achieve optimum autonomy and independence.

8. All community rehabilitation residences will prioritise the promotion of a recovery-oriented service built on a culture of hope and expectation that the person can recover and build a fulfilling life of their own choosing. Accordingly, all staff must continually practice established recovery principles.

(Adapted from a VfC 2006: Chapter 12, Rehabilitation and Recovery Services for People with Severe and Enduring Mental Illness)

Individualised Accommodation Options

Thankfully, only a minority of service users with severe mental illness and complex needs will require SRUs or community rehabilitation residential facilities. Provided they have access to good quality, secure accommodation with appropriate mental health support, most service users can live independently within their community. This is achieved through supports that enable recovery, improve service user ability to manage independent community accommodation and promote social and community networks.

The Government's National Housing Strategy for People with a Disability (NHSPWD) (2011), and Rebuilding Ireland, the Government's Action Plan for Housing and Homelessness (2016), recognises that mental health requires specific emphasis (Strategic Aim 5) regarding the housing needs of people with mental health difficulties. In relation to meeting this need within communities, this aim gives effect to the housing commitments contained in the Government's mental health policy, A Vision for Change (2006). It is within these policy contexts that the Model of Care recognises that the provision of appropriate, high-quality accommodation options is an essential component for the social inclusion of people with severe and enduring mental health difficulties.

Independent Community Accommodation

Independent community accommodation includes services users living in or returning to live in the family home, through tenancies in the private rented sector or social housing tenancies provided by the Local Authorities and Voluntary Housing Bodies. While, the statutory responsibility for social housing lies with the relevant Local Authority, mental health services must work in close cooperation with relevant housing bodies to ensure that people with complex needs can access independent accommodation. Significantly, Community Rehabilitation and Recovery services play a vital role in understanding the accommodation needs of each service user. Accordingly, they advocate for service user access to safe and secure housing. Of vital consideration is the sustainability of such accommodation and the need for continuing mental health supports for tenants. To deliver appropriate and sustained settlement support, community rehabilitation teams will develop links with relevant

tenancy support and visiting services.

Long-term Supported Housing

Long-term supported housing options may be available through the Local Authorities and various housing associations which provide varying degrees of on-site staff support in a non-mental health setting. In these circumstances, to support their mental health needs, service users would continue to receive visiting mental health support from the rehabilitation and recovery services.

Specialised Accommodation (Continuing Care)

Options for service users who require on-going, long-term care outside the provision and resources of the rehabilitation and recovery services, may include Nursing Home Care, Continuing Care Placements and specialised out-of-area placements.

Occupation and Employment Supports

According to Killapsy et al. (2012), maintaining a focus on rehabilitation services facilitates meaningful occupation for service users. These include hobbies, leisure activities, social engagements, educational and vocational courses and voluntary supported and paid employment.

The SRU MDT plays a vital role in encouraging service users to engage with local community resources, such as the cinema, health and fitness centres or adult education. To facilitate a smooth transition from an SRU into the community, local CRTs will forge strong links with the local community, i.e. social, educational and employment resources. Moreover, the team will play a vital role in linking service users with the following community resources:

1. Individual Placement and Support (IPS)

IPS aims to place service users in competitive employment through 'on the job' training and support. Some IPS services help clients develop their CVs, conduct mock interviews (including 'how to' disclose a mental health problem), and provide long-term support such as mentoring and coaching.

2. Educational Opportunity

This includes information and support in accessing courses in adult education, post leaving certificate (PLC), university and university study.

3. Pre-vocational Training Programmes

This relates to preparatory work training in a protected environment to familiarise

service users with working environments and develop the skills necessary for competitive employment. Specialist services will offer transitional employment schemes which provide work experience in a mainstream employment setting.

4. Welfare Benefits Advice Services

These provide independent and benefits advice to address service user concerns around the potential impact on their benefits when entering full-time employment. They will also advise service users on all benefits and services they are entitled to.

5. Volunteering Services

Assist individuals in returning to employment through part-time, flexible posts that help them learn new skills, gain confidence and reduce social isolation.

> "I always have the impression that they treat you as an illness rather than a person. Like, you are schizophrenic, we are going to give you this, this and that, you take them all and see if it works. You are a manic depressive, take this, this, just like I gave the last manic depressive, and see if it works for you. I know they are not psychologists and not counsellors, not there to listen as such, but at the same time I'd like to be treated like a person and not just like a guinea pig, like a guinea pig that you just throw pills into".

> (Cited in Kartalova-O'Doherty and Tedstone Doherty, 2010)

7. Referral, Admission, and Discharge Process for Inpatient Specialised Rehabilitation Units (SRUs)

Referral

Each participating Community Healthcare Organisation (CHO) must have access to several rehabilitation beds in the SRU that serves their area. This will be proportionate to the population served by the CHO. All referrals must be agreed with the Clinical Director of the referring service. SRU admission eligibility will be established prior to referral (see Appendix C). An SRU referral will be made in conjunction with the local CRT. Alternatively, in the absence of a CRT, a referral can be made by the General Adult (GA) community mental health team caring for the service user in their CHO.

Required Information for Referral

From the outset, each CHO Senior Management Mental Health Team must provide a suitable community placement under the care of the CRT. This is either in community rehabilitation residences with an active rehabilitation and recovery programme or in suitable living arrangements (as clinically indicated) following SRU discharge. Crucially, a care coordinator must also be identified. To successfully monitor service user's progress they will link with the SRU team, the designated Key Worker and the referring community mental health team.

Usually, service users referred to an SRU will have had numerous interactions with mental health services. Consequently, there will be comprehensive service user information previously gathered by local mental health services. This will aid the development and implementation of individualised rehabilitation and recovery plans (see Appendix D for Standardised Referral Form).

The Role of the Care Coordinator

Background

As part of the SRU referral process Care Coordinators must be nominated from the referring community rehabilitation team. As a senior clinician on the CRT their role is not discipline dependent.

Responsibilities

The care coordinator will:

- Act as the principal point of contact between all relevant stakeholders, including the SRU MDT, their Key Worker, the referring CRT, the service user and their family members;

- Determine on-going service user needs in conjunction with SRU MDT, and CRT;

- Arrange and oversee pre-admission visit to SRU on request;

- Manage admission process, prior to and following discharge;

- Coordinate transfer of service users to SRUs and community rehabilitation residences;

- Maintain regular contact and communicate relevant data, including unsuccessful placements and referral outcomes, to referring community mental health team and the SRU MDT;

- Manage a timely review process (minimum three monthly) for service users in SRUs;

- Establish and maintain clinical review input and contribute to relevant meetings;

- Verify that the ICP reflects service user wishes and goals;

- Ensure comprehensive, structured and phased discharge plans are in place;

- Coordinate and support out-of-area placement issues, such as contact with family/friends, travel and subsistence arrangements, change of address notifications and transfer of appointments and social welfare payments;

- Remain involved in the service user's care and provide appropriate support following discharge from the SRU to community rehabilitation residences.

The Role of the Key Worker

In addition, each service user will be assigned a Key Worker from the SRU MDT. They will work collaboratively with service users throughout their stay and:

- Work in partnership with service users and their family members to inform them of the SRU process at each stage of the rehabilitation pathway,

- Coordinate all stages of service user's stay whilst in the SRU,

- Be the main point of contact for the service user and their family members or chosen advocate, and

- Address service user's treatment goals and needs.

The Role of the SRU / Multidisciplinary Team

Each SRU is responsible for the day-to-day care of every service user they admit. Consequently, they must maintain full service user progress records and reports. Also, as Approved Centres, SRUs must comply with Mental Health Commission Codes of Practice and the Judgement Support Framework (2016). Moreover, service users must be provided with an ICP in which they can be actively involved. ICPs will focus on individual goals and recovery plans. They will include risk management and discharge plans. Service users must be given adequate notice of care planning meetings if they wish to attend. Furthermore, the SRU MDT must ensure that service users have access to Independent Advocacy Services, based on a clearly documented advocacy referral and support pathway defined by the SRU.

Admission to the SRU

Upon admission to the SRU, the Care Coordinator, the SRU MDT and the Key worker will work in tandem with service users and their family members as they transition through the service. They shall support all aspects of the service user's SRU placement, such as support in achieving their set goals, and help them maintain their progress.

Discharge from the SRU

Discharge planning must commence prior to the allocation of an SRU placement. With this in mind, it is essential that each CHO Senior Management Mental Health Team provides an appropriate step-down community rehabilitation residential placement. Furthermore, each placement will incorporate an active rehabilitation and recovery programme available to each service user upon SRU discharge. Ideally, this should be close to the service user's original catchment area.

Following admission to the SRU, as part of the ICP, a comprehensive and structured discharge plan must be drawn up. This will focus on each service user's recovery journey. It must include:

- An estimated discharge date;
- Documentary evidence of regular communication between service user, key worker, care coordinator and CRT;
- Timely implementation of actions with specified time periods to complete each discharge action.

Furthermore, to ensure they are fully aware of the transitioning process, it is essential that each service user, care coordinator, key worker, other relevant members of the SRU MDT, and the service user's family member and/or chosen advocate are directly involved in all stages of the care pathway.

In addition, a planned discharge meeting must convene at least 3 months prior to

discharge. The service user, care coordinator, key worker and other relevant members of the SRU MDT and family member/ chosen advocate must be present. This is to ensure that all issues concerning the discharge process are dealt with effectively and that an appropriate step-down community placement is available to each service user upon discharge from the SRU.

8. Treatments and Supports Delivered in SRUs and Rehabilitation Services

Rehabilitation care is focused on addressing and thereby minimising symptoms and functional impairment. This is designed to improve cognitive, emotional, social, intellectual, and physical skills required to function as independently as possible within the community (Liberman, 2008; Lavelle et al. 2012). To ensure success, a graduated approach is advised. This is delivered through a care pathway that provides a range of treatments and recovery supports. These include:

- Pharmacological Management
- Psychosocial Interventions
- Creative Therapies
- Self-Care and Everyday Living Skills
- Physical Health
- Promoting Healthy Living

(Adapted from Joint Commissioning Panel for Mental Health, 2012)

Pharmacological Management

Prescribed medications play a key role in the treatment of psychiatric disorders. They help reduce symptoms and prevent relapse. Most service users who are referred to rehabilitation services have a diagnosis of major psychosis such as schizophrenia and schizo-affective disorders. They often display prominent 'negative' symptoms that impair organisational skills and motivation to manage everyday activities. In addition, many individuals display on-going 'positive' symptoms such as delusions and hallucinations. These may not have fully responded to medication. This can often make engagement difficult. Finding the appropriate medication regime designed to minimise symptoms without causing harmful side-effects is a key skill of rehabilitation psychiatrists.

Self-medication

> "Self-administration of medications involves the independent use of medication by a patient in a way that supports the management and administration of his/her own medication."

(An Bord Altranais,2007, p.19)

Through open discussion about medication, its management and administration, the

involvement of the service users is an important part of any rehabilitation and recovery programme. Such programmes increase opportunities for service users to learn about their medication. This empowers them to become active partners in the planning and organisation of their own care. In addition, it:

- Informs and educates service users about their medication;

- Encourages and promotes service users' independence to take responsibility for their own medication;

- Assesses and determines the ability of residents/service users to safely self-administer their medication;

- Provides a series of steps that supports concordance with their agreed prescribed medication regime.

Psychosocial Interventions

All MDT members have a key role to play in the provision of therapeutic interventions. Their aim is to encourage communication that increases understanding of individual mental health difficulties. They use their skills and experience to recognise and promote methods that may help reduce distress and unhelpful interaction patterns. To this end, skilled MDT members will undertake identified interventions in a creative and supportive manner with an attitude of therapeutic optimism. Ultimately, staff will work alongside service users to gain a deeper understanding of their experiences. This may help them understand and thus identify relapse triggers and self-management strategies. Useful interventions include:

- Wellness Recovery Action Plans and Recovery Stars

- Mental health management information groups and workshops

- Individual and group work designed to promote interpersonal and social skills and reduce social isolation

- Individual work on identified psychosocial needs, such as:

    o   anxiety management

    o   physical health issues

    o   environmental challenges

    o   family and relationship issues

    o   future accommodation needs

Specific approaches for severe and enduring mental health needs include:

- Cognitive Rehabilitation (including Cognitive Remediation)

- Cognitive Analytic Therapy

- Cognitive Behavioural Therapy (CBT)

- Management of Emotional Dysregulation

- Support for Relationship Dysfunction

- Specific Mood and Anxiety Disorder interventions

- Personality Disorders Interventions

- Trauma Processing

Psychological assessment

Comprehensive psychological assessment includes assessment of:

- current cognitive functioning

- current adaptive functioning

- premorbid cognitive and adaptive functioning

- emotional and/or behavioural difficulties

- personality

Creative Therapies

Where verbal engagement may be difficult, art, music, drama, and dance allow for emotional processing and expression. Through physical and sensory expression, Creative Art Therapies can also aid the reduction of stress (NICE Guidelines, 2009).

Self-Care and Living Skills

All MDT members have a key role to play in ensuring service users gain/regain the confidence and routine required to successfully manage their mental health. This includes medication and activities of daily living. MDT members must assess service user functional levels, identify strengths and pinpoint any functional difficulties. These must be included in individual care plans. This will help nurture necessary recovery skills, such as developing a daily routine, using community resources, cultivating leisure interests and considering vocational options.

Comprehensive occupational therapy assessments are carried out as part of the core MDT assessments. These include the Allen Cognitive Level (ACL-5) (Allen et al. 2007), Occupational Self-Assessment (OSA,) (Barron et al. 2006), and Vocational Assessments, (Braveman et al. 2005). Assessment outcomes allow occupational therapists to set individual functional goals. They then analyse and grade therapeutic activities. This allows service users to progress from exploring an activity to acquiring the necessary skills to attain their goals. As an essential component of therapy for groups specified in the Model

of Care, it offers positive experiences that promote hope, the opportunity to participate in previously stimulating activity or to explore new occupations.

As active MDT members, Occupational Therapists facilitate group work. This intervention method provides service users with opportunities to share their experiences, support and learn from one another and problem solve. It provides a useful platform for developing skills such as cookery, gardening, crafts and promoting physical activity.

Physical Health

To counteract unhealthy lifestyles, guidance, support and monitoring of physical health are vital elements of high-quality rehabilitation services. All MDT members have a responsibility to promote healthy living. A coaching approach or motivational interviewing style can enable the self-management of physical health.

Significantly, medical team members perform regular physical health assessments. This leads to the appropriate referral and treatment of co-morbid physical health problems. This is especially relevant to regular side-effects screening. As individuals progress towards community living, to ensure early identification and treatment of physical health issues, liaison with general practitioners is crucial. Agreement as to who shall undertake routine physical health monitoring, and how results are shared between services is also important. Therefore, robust arrangements between specialised rehabilitation services and local primary care services to assess, manage and monitor physical health must be maintained.

> [How would you know you're completely recovered?] "Well I mean, a proper health, like be able to go to work, to be able to go out, to be able to deal with myself, you know, and just keep going, the way I'm going … When I get older, you know, to be able to cope, and hope I don't get any sickness that will stop me doing what I'm doing now, like, does that make sense? Like I mean, life in general, just to be happy in myself, and content with what I've got."
>
> (Cited in Kartalova-O'Doherty and Tedstone Doherty 2010)

9. The Service User Perspective and Family Involvement

The Service User Perspective

Common responses from people given a psychiatric diagnosis or detained on an acute psychiatric facility include:

- Disbelief: "It must be a mistake."

- Humiliation: "I hope no one finds out."

- Sorrow: "My life is over."

- Anger: "Why me? It's not fair."

- Fear of isolation: "No one will want to know me now."

- Panic: "What's going to happen to me?"

(Open University, 2010)

Such uncertain times can have a negative impact on a person's wellbeing. The longer a person stays on an acute unit, for example, the more used to their environment and their new 'sick role' they become (Parsons, 1951). Being treated in a mental health facility can be a terrifying and confusing time. Under constant observation, service users often feel disconcerted, uncomfortable and alone. Once involved with mental health services and hence labelled in some way, the mental health system tends to preserve these categories. So, people become labelled by having a mental health problem, regardless of any other aspects of their lives, and any subsequent difficulties are viewed through the lens of mental illness (Open University, 2008). People get stuck and without sufficient involvement and support may find it hard to move on.

Studies have shown that those who are involved in decisions about their care experience better health (Loring, 2002). Consequently, a feature of modern mental health service policy is the frequent declaration that service users should be involved in the processes of planning, developing and delivering services (DOH, Vision for Change, 2006, p. 24). Therefore, reflecting service user perspectives that include unique and valuable insights will actively contribute to a fully rounded picture of requirements by combining diverse perspectives on care that truly reflect a person-centred, needs-based approach. To that end it is imperative that the service user voice is included at all stages of the design, delivery and evaluation of the recovery and rehabilitation care pathway described in this Model of Care (see Appendix B).

Naturally, the way in which service users encounter services and staff will influence the degree to which they engage and sustain their engagement in the future. Clearly,

mutually respectful, trusting and reciprocal relationships between service users and providers are key to a quality service. Actively listening to service users' needs and designing SRUs and CRRs to meet those needs will result in an environment where individual service users feel genuinely supported and cared for.

> "People will not care how much you know until they know how much you care."

<div align="right">(T. Roosevelt, 1906)</div>

Research suggests that service users appear to value professionals' interpersonal and 'human' qualities rather than specific therapeutic approaches (McIntyre et al. 1989; Ballard & McDowall 1990). A good nurse, for instance, was frequently described by service users as someone with the lay qualities of "common sense", "warmth and sensitivity", "being nice", and "someone who can be a friend". Consequently, effective working relationships based on these principles are vital to the success of any transition from an acute setting to an SRU or a community rehabilitation residence - from there and back to their community and on to independent living.

Done well, SRUs, community rehabilitation residences and associated community rehabilitation and recovery mental health services can become beneficiaries of service user experiences. By listening to and acting on service users' expert knowledge and understanding of mental health difficulties and services, the benefits of user involvement draws attention to the way in which mental health services can be improved through the recovery and rehabilitation practices outlined in this Model of Care. Becoming involved in a genuine and meaningful way can have a positive effect on the experiences, opportunities and relationships of service users, family, friends and health care management and staff. In a broader sense, the acknowledgement and recognition of service users' experiences, skills and understanding also impact on popular perceptions of mental health service users in society. A more respected and influential role for service users in mental health services may also contribute to the process of achieving less stigmatised, more accepted and valued roles for mental health service users in wider society, which ultimately may be understood as the chief undertaking and legacy of this ground-breaking Model of Care.

Advocacy

When you are distressed, or your views may be discounted as part of your 'illness', exercising your right to be informed and involved in your own treatment and care can be difficult. The experience of a prolonged inpatient admission or transition to rehabilitative services can be hugely unsettling and disempowering. In these circumstances an advocacy service can provide support. As advocates do not work in their client's best interests but to their individual direction they can complement and enhance clinical care practices.

An advocate's primary role is to listen to their client, build trust and rapport, identify service user needs and support them in having their voice heard. This simple act of providing a non-judgmental, active listening ear can often give a huge boost to self-esteem, build confidence and alleviate feelings of isolation. By encouraging service users to speak up, speak out and take control of their lives and by enabling the voices of people who experience mental distress to be heard, advocacy has the potential to make a real difference and perhaps help change people's lives.

Peer Support

Like advocacy, Peer Support Workers help service users build and rebuild their wellbeing, confidence and self-esteem by allowing them to take back control of their own lives (Hurley, 2015). Significantly, as there is no power imbalance between the PrSW and the service user, peer support is founded on empathy and equality.

Trained Peer Support Workers (PrSWs) provide emotional, social and practical support to fellow service users. Through mutual trust and positive, reciprocal relationships they provide guidance, feedback and reassurance. Utilising their own experiential knowledge, they navigate mental health services, solve problems and, ultimately seek to improve service users' quality of life. By offering companionship and empowerment, feelings of isolation and rejection can be replaced with hope, a belief in personal control (Repper, 2013) and a successful path along which others can follow.

Significantly, they can enhance the multi-disciplinary rehabilitation team skill mix and inspire team members to be more transparent and open about their own mental health experiences (Crawford et al. 2002). Most importantly, by complementing and enhancing clinical practice, they impact on the quality of mental health services, making them more sensitive and responsive to service users' needs.

Family Involvement

The term 'family member' extends to relatives, friends and other supporters who are involved in the care and support of the service user and are recognised and identified by the service user as important to them. From the outset, staff working in rehabilitation mental health services must recognise the importance of involving family members in as open and inclusive a way as possible. Accordingly, they will provide support and guidance on how to be effectively involved in their loved ones' care. Consequently, staff will actively engage family members in meaningful and creative ways to ensure:

- Family members are assisted in understanding how each component of the specialised rehabilitation care pathway operates and are supported in successfully navigating the healthcare system;
- Family members are supported in recognising how the MDT and community rehabilitation teams work, including how each discipline supports the service

user on their recovery journey;

- Clarity is given as to how they can contribute to decision making;

- They are assisted in preparing for and attending care planning and discharge meetings;

- Staff help aid their understanding of confidentiality parameters in particular settings;

- Staff address family members' concerns around transitioning through the care pathway and accommodation options;

- Family members are supported in their own wellbeing and recovery by directly offering or signposting support services such as Behavioural Family Therapy, the EOLAS Psycho-education programme, Carer Support Group, Family WRAP or through supportive work with family members;

- Teams provide a family friendly environment within each SRU and community rehabilitation residence, whereby family members and friends have appropriate facilities to visit service users. Furthermore, it should be borne in mind that some service users may be parents and that services should facilitate appropriate contact with children where indicated.

> "Well I'm back to what I was, but better than I was. [Better, how better?] Well to be having a life of my own is better, getting the house on my own is better, everything is better, everything that most people take for granted I now have, so it's like winning the lotto, going into [town] or [city], it's given me a sense, it's great happiness".
>
> (Cited in Kartalova-O'Doherty and Tedstone Doherty 2010)

As illustrated previously, SRUs, Community Rehabilitation Residences and accommodation services are designed to provide rehabilitation service to individuals with severe illness and complex needs. Their ethos is to nurture recovery and promote independence. However, they cannot operate in a vacuum. Therefore, referring community rehabilitation teams must ensure all SRU referrals are appropriate. Accordingly, each CHO mental health senior management team must facilitate the post-SRU discharge recovery process. This is achieved through community rehabilitation residential placements and/or individual accommodation options. For rehabilitation services to maintain active rehabilitation geared toward independent living, each CHO must provide long-term continuing care for those who require it.

As outlined in A Vision for Change (2006), rehabilitation services should support individuals with severe mental illness to live in the community. Therefore, the availability of sufficient community housing is critical to the success of an effective mental health rehabilitation and recovery service. The following are critical success factors and potential pitfalls affecting the delivery of SRUs, Community Rehabilitation Residences and associated community rehabilitation and recovery services.

Effective Governance Structures

To avoid confusion and misinterpretation, it is important that clear governance structures are established. Confusion can lead each area to either wish to relinquish, or to assume, full control. Consequently, all care providers need to understand what aspect of care they are responsible for and develop agreed protocols on how care is delivered. There must be clear purposes and desired outcomes, such as:

- appropriate capacity and capability to govern effectively
- effective engagement with, and accountability to stakeholders
- effective performance in relation to defined functions and roles
- promotion of shared values across each agency involved
- Informed and transparent decision making, and appropriate management of risks.

Senior Management Support

Undoubtedly, without support from senior management nothing will happen. Thus, management teams must prioritise the staffing of CRT in their annual development plans as multidisciplinary teams need to be adequately staffed and resourced as per A Vision for Change (2006) recommendations. Crucially, adequate finances and resources must be aligned with all stages of this Model of Care. This will ensure equitable funding

distribution for different services or levels of services to sustain change.

Community Health Organisation (CHO) Participation

It is vital that each CHO is actively involved in the care of individuals placed in an SRU. This comprises the provision of adequate step-down community rehabilitation residences, individualised accommodation supports or continuing care for service users upon discharge from an SRU. However, there is a danger that both SRUs and community rehabilitation residences could become long-term care facilities. Hence, the ethos of active service user engagement and rehabilitation would be lost. For this reason, it is essential that the primary focus of SRUs and community rehabilitation residences remains on active rehabilitation, after which service users can move to suitable living arrangements within their own community.

Successful Transitions

Whether you live in an acute in-patient unit, a congregated setting or otherwise, leaving the place you may have considered home can bring unwanted change. Therefore, service providers must remember that someone's 'home', however acute, is not just a physical space. It is a social environment where people relate to and interact with others, a place where relationships matter. It is a psychological space where people develop feelings and emotional attachments to their experience of living there. Consequently, any proposed move to an SRU, community rehabilitation residence and associated rehabilitation settings must be handled with respect and the full input of service users and their families.

Appropriate Accommodation Options

If rehabilitation and recovery services are to offer comprehensive and recovery oriented interventions to service users, the CRT must access appropriate accommodation options at key transitioning times. This includes appropriate options for service users moving on from the SRU within the mental health services. Examples include an active rehabilitation programme in a suitable community rehabilitation residence or outside the mental health services, such as long-term supported accommodation. Thus, each CHO must ensure they have an adequate number of community rehabilitation residences with an active rehabilitation focus.

Of critical importance for service users moving on from a rehabilitation programme (such as social housing with tenancy support) is access to independent community accommodation. As this is a multi-faceted issue situated within the wider housing policy context, to ensure that people with complex needs can access independent accommodation options, mental health services must maintain links with relevant Local Authorities and housing bodies. Furthermore, to successfully advocate for suitable accommodation when service users are moving into the community, mental health

services and CRTs must develop local links with relevant housing bodies and tenancy support services.

Enabling Environment

The importance of creating a calm, respectful, inclusive and genuinely hopeful therapeutic environment cannot be underestimated. How people react to care environments, their design and the feelings they evoke are crucial factors in the experiences of those who deliver and receive services. Enabling environments are defined as places where positive relationships promote well-being for all participants; people experience a sense of belonging; people can learn new ways of relating; contributions of all parties are welcomed and respected; engagement and purposeful activity is actively encouraged; and where it is recognised that carers also need to be cared for (National Offender Management Service & Department of Health, 2012). Whilst physical elements of an environment are very important, only effective relationships built on genuine understanding and collaborative working where service users are supported to be actively involved in their own rehabilitation can maintain this kind of a culture.

In the UK, an Enabling Environment Award is granted to environments that meet a defined set of standards set out by the Royal College of Psychiatrists Centre for Quality Improvement (Royal College of Psychiatry, 2013). These are fundamental factors of a successful care pathway - factors which can otherwise be difficult to define, measure and reward. Although there is no equivalent award in Ireland, having extensively reviewed international best practice, we believe the Royal College of Psychiatrists model and Enabling Environment Award provides a framework to create and sustain a therapeutic environment with open, supportive and inclusive relationships (see Appendix E).

Effective Risk Management

Greater tolerance of risk is a key feature of personalised approaches to care. However, service users and service providers often have different views of 'challenging behaviour'. Alaszewski and Alaszewski (2005) contend that risk taking is an important part of developing a sense of identity. Therefore, people who use mental health services should be permitted to take reasonable risks in everyday life. Significantly, many individuals are prepared to live with a measure of 'acceptable risk' because the alternative of overprotection or undue restriction is not palatable. It may even be considered to infringe their human rights. In this light, the HSE's Integrated Risk Management Policy (2017) states that:

> "It is . . . important to note that positive risk taking (as opposed to risk avoidance) within a framework of safety can and should be encouraged to support Service Users attain their potential."

(HSE, 2017)

In this light, it is essential that risks are appropriately assessed by balancing the risks associated with challenging behaviour against the risks of a reduced quality of life for individuals in specialised rehabilitative mental health services.

Leadership

An effective leader creates urgency (when required), shows initiative, acts positively, is determined and perseveres until the job is done. They can remove obstacles, create short-term wins and implement change within organisations and services. Thus, to successfully implement all aspects of this Model of Care, it is imperative to identify, appoint and support self-confident leaders with strong personal, team, goal and contextual awareness.

Education, Training and Continued Professional Development

Successful outcomes depend on the training and continuous professional development (CPD) of all staff working in rehabilitation services. It covers assessment through to treatment. Naturally, each discipline will have their own CPD requirements necessary for registration with their professional body. Nonetheless, training and CPD topics should include:

- Understanding of major mental health diagnosis, presentation, assessment, and treatment
- Awareness of capacity, including capacity assessment, assisting with decision making and legislative frameworks
- Mental Health Act Training
- Safeguarding of Vulnerable Adults
- Risk Management in the clinical environment
- Recovery Orientated practice/ Recovery Principles Training
- Enabling Environments
- Management of transitions and clinical pathways for service users
- Assessment of housing/accommodation needs
- Effective Advocacy
- Psychosocial Interventions for the self-management of mental health
- Medication Management
- Effective Multi-Disciplinary Team-working

- De-escalation Techniques

Clinical Supervision

Reflective practice is required in all layers of the organisational culture. Good quality, regular clinical supervision is essential for:

- Supporting staff in delivering evidence-based, quality care that adheres to best-practice guidelines

- Reflective practice that supports a relational model of intervention and therapeutic management of risk

- Debriefing following challenging incidents or engagements

- Staff engagement, support and retention, leading to better outcomes for service users

- Maintaining a recovery focus and preventing therapeutic nihilism.

Furthermore, the possibility of clinical teams obtaining psychologically-informed group supervision as an optimal method of maximising team cohesion and shared learning must be considered (Turley, Payne & Webster, 2013). Crucially, clinical supervision and line management supervision should not be confused. Ideally clinical supervision is not provided by one's line manager. If this is the case, it is essential that supervisors have the necessary skills and qualifications to provide good quality, relationally aware, clinical supervision. Where necessary, supervision may be provided by another discipline or externally funded. Hence, as a core requirement of good working practice, it will require adequate financial support, scheduled within working time and occur for a minimum of one hour per month.

Team-Working

To maintain effective team-working, staff members must be included and supported in the decision-making process. To ensure successful outcomes for service users, appropriate training required to successfully operate a rehabilitative service must be offered to all staff. In particular, MDT training and development can help break down barriers, smooth cultural differences and facilitate a unified approach to rehabilitation services. Moreover, it builds cohesive and effective teams that actively challenge and thereby change previously ineffective methods that often persist in services. These include the disabling features of the physical and social environment for staff and service users. Crucially, to avoid confusion or duplication, regular communication between team members is vital. Undoubtedly, as they are the primary mode through which service users experience care, effective teamwork is essential to the successful implementation of this Model of Care.

Shared Decision-Making

Service users often feel that their strengths, abilities and needs sometimes go unrecognised. This can result in feeling excluded from the decision-making process or feeling that they do not fully contribute to their own treatment and care. What emerges is a struggle to be perceived as a competent and equal individual. Therefore, to actively promote transparency and co-production ideals, conditions that promote participation in decision-making include:

- confidence in one's ability

- access to knowledge

- clarity about responsibilities

- respect and support.

Champions

Within each service, success depends on the continuing commitment of recognised champions. These are capable people who believe in and accordingly transmit the ethos of recovery and rehabilitation. They also inspire others, delegate well and lift team and organisation morale when needed. Hence, they are essential to creating inspiring partnerships.

Partnerships

Service users with severe and enduring mental illness and complex needs often require several agencies to support them with their rehabilitation. Therefore, effective partnership working is required. However, it can take time to work through organisational and professional differences. Consequently, clarity around agendas and purpose of the partnership is important as are establishing and achieving individual and team goals. Importantly, a firm foundation and a history of successful collaboration between mental health services and outside agencies may facilitate further success. Similarly, structural and organisational stability may further facilitate change.

11. Governance

The HSE has responsibility for all Mental Health Services including in-patient approved centres, community residences and community based mental health teams. Each Community Healthcare Organisation (CHO) has a Mental Health Management Team led by a designated Head of Service. Each Head of Service reports to the CHO Chief Officer. They also regularly engage with the HSE National Mental Health Management team. In turn, the CHO Mental Health Management Team is responsible for managing all mental health services in their CHO, both in terms of day-to-day duties and clinical governance arrangements. In this context, it encompasses rehabilitation mental health services, Community Rehabilitation and Recovery Services (including community rehabilitation and assertive outreach teams), SRUs and Community Rehabilitation Residences within each CHO.

In the case of rehabilitation mental health services, whether provided internally by the HSE or by an external provider, it is recommended that clinical leaders within each rehabilitative mental health service collaborate with the HSE National Mental Health Management Team and the CHO Mental Health Management Team. This will ensure regular MOC evaluation and progress review. This is particularly relevant for measuring specified key performance indicators (KPIs). Thus, it is recommended that consultations are scheduled on a quarterly basis. Furthermore, the HSE National Mental Health Management and CHO Mental Health Management Teams must ensure:

- Appropriate structures to facilitate consultation and involvement of service users, carers and family members in the design and delivery of services

- Delivery of a recovery focused clinically excellent service for people with severe and enduring mental illness, based on HSE National Framework for Recovery in Mental Health

- Delivery of safe services

- A framework and commitment to deliver on these services, based on HSE Best Practice Guidance for Mental Health Services (2017) and regulations inspected by the Mental Health Commission

- In line with MOC recommendations, provision of Clinical Supervision and training as required.

12. Evaluation

In a modern healthcare system, services must show that they are providing a high-quality, safe and effective services that ensure service users have a positive experience of care. Incorporating three distinct elements, quality can be defined thus:

1. Effectiveness of treatment and care provided to service users

2. Safety of treatment and care provided to service users

3. The broader experience service users and their carers/families have of the treatment and care they receive.

Regulatory Measures in Ireland

Service quality and performance in Ireland are measured by recognised accreditation programmes. For example, the Mental Health Inspectorate (MHA, 2001) carry out a programme of inspections of approved mental health facilities. They report their findings on the quality of care and treatment services and associated aspects of services to the Mental Health Commission.

To ensure quality standards by promoting improvements in how services conduct reviews of patient safety incidents, the Health and Information and Quality Authority (HIQA) and the Mental Health Commission have produced the 'National Standards for the Conduct of Reviews of Patient Safety Incidents'. In addition, the Mental Health Commission provides 'Decision Support Services' (Capacity Act, 2015). This Decision Support (Capacity) Act 2015 provides a statutory framework to support decision making of adults who have difficulty making decisions without assistance.

In addition, the HSE best practice guidelines, which include 'The Best Practice Guidance' (HSE, 2017) document, provide a basis for improved governance in planning and managing services, measuring improvement, identifying and addressing gaps, and pinpointing areas of concern or deterioration in the quality and safety of the services provided. A self-assessment IT tool called the 'GAIT-Guidance Assessment Improvement Tool' is also available.

Effectiveness of Care and Treatment

It is vital that rehabilitation and recovery services utilise effective tools to measure outcomes of treatment and care provided. This can be achieved through identifying and measuring:

• Service user's identified goals (in line with the recovery model, ICP)

• Reduction of symptoms of mental illness (use of condition specific scales)

• Physical health outcomes, such as metabolic screening

- Achievement of desired social outcomes, such as access to employment, engagement in community activities, fiscal management and housing needs

- Quality of life

Camberwell Assessment of Need (CAN)

The CAN is a popular, easy-to-complete assessment instrument. It illustrates how services can improve service users' proportion of met needs (versus unmet needs) even if the total needs do not change. As it provides evidence as to the degree SRUs are addressing the service user's complex problems, it is especially relevant to rehabilitation services.

Social Functioning Questionnaire (SFQ)

Lavelle et al. (2011) completed a validation of the SFQ that is consistently used in rehabilitation mental health services in Ireland and the UK (Killaspy, 2011). It includes inter-rater reliability, test retest reliability, convergent validity. This measurement tool has recognised advantages over other well-known measures of social functioning and life skills profile, for example, in marking change as service users progress individually, or in groups. Significantly, it provides a graphical representation of the results.

Mental Health Recovery Star

This is a very popular instrument in many rehabilitation services. It is useful for facilitating collaborative care planning. It is quick and easy to use. It has good test-retest reliability. Collaborative ratings are higher than staff only ratings. Convergent validity suggests it assesses social function more effectively than recovery (Mac & Burns, 2011; EuroQoL Group,1990; Killaspy et al. 2011).

Clinical Global Impression (CGI)

The Clinical Global Impression (CGI) is another useful tool for rehabilitation services. CGI is a short scoring tool. It is composed of the CGI-Severity which relates to illness severity, and the CGI-Improvement which rates global improvement or change and therapeutic response. It was developed to provide a brief, standalone assessment of clinicians' views of global functioning prior to and following initiating medication. The CGI Improvement and CGI Severity scales are 7-point scales. Treatment response ratings take account of both therapeutic efficacy and treatment related adverse events. They range from 1 to 4. Importantly, each component of the CGI is rated separately.

Health of the Nation Outcome Scales (HoNOS)

The Health of the Nation Outcome Scales (HoNOS) is a 12-scale clinician-rated measure developed by the Royal College of Psychiatry to guide everyday clinical practice. It measures health and social care outcomes in secondary care mental health services. England, Australia and New Zealand have mandated HoNOS for routine monitoring and outcome measurement across their mental health services at national level. It is intended as an outcome measure for people with severe mental illness.

Quality Indicator for Rehabilitation Care (QuIRC)

The QuIRC is a web-based self-assessment tool for inpatient rehabilitation units/24-hour community units completed by the unit manager. It has sound psychometrics, takes approximately 90 minutes to complete and prints out a report on the unit. Importantly, it illustrates its performance against similar units on a national scale. Results correlate with service user experiences of the unit. The QuIRC is validated against service user experiences and can be used as a proxy measure of their experiences.

Service User and Carer Experience

In the UK, an example of service user and carer experience assessment tools is the CQC's Mental Health Acute Inpatient Service Users Survey (Care Quality Commission [CQC], 2009). Another innovative assessment tool for service users is the Recovery Context Inventory (RCI). This tool has been developed by EVE, who are responsible for creating person-centred, recovery-oriented community services on behalf of the Health Service Executive (HSE). The RCI is an online profiling, recovery planning and outcome tool designed to support personal recovery and recovery-oriented service development (O' Brien, 2015). The RCI tool can help improve people's self-awareness, aid personal reflection and encourage action. It also has the potential to offer effective solutions to address service users' needs through identifying and measuring their priorities (O' Brien, 2015).

Effectiveness of Measures

Examples of Key Performance Indicators (KPIs) for SRUs, Community Rehabilitation Residences and Rehabilitation and Recovery Services include number of:

- New referrals with information on diagnosis, gender, and age

- Admissions length of stay and readmission rates

- Patients detained under the MHA 2001

- Delayed discharges

- Serious incidents (subdivided by violence, self-harm, falls and absconding)

- Service users who have an ICP

- Services users engaging in therapeutic interventions

- Key Worker sessions with service users.

In addition they also measure:

- Bed occupancy

- Use of bank and agency staff

- Clinical supervision for all clinical staff members

- Reflective practice utilised by the MDT with a record of same

- Care Coordinator allocation and reviews

- Service user input and feedback (see Appendix E)

Glossary

Acute Inpatient Unit

An acute in-patient unit provides short-term inpatient assessment and treatment during an acute phase of mental illness. Service users remain on the inpatient unit until they have recovered to a level where they can be treated effectively in the community. Following discharge, follow-up care may be provided in an out-patient clinic, day hospital or by a community mental health nurse. Under Sections 63 and 64 of the 2001 Mental Health Act, every in-patient mental health facility in Ireland must be registered by the Mental Health Commission as an "approved centre" in order to operate (Mental Health Division; yourmentalhealth.ie; HSE.ie).

Approved Centre

An approved centre is registered with the Mental Health Commission. It is defined in the Mental Health Act 2001 as "a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder" (MHA, 2001).

Care Coordinator

A Care Coordinator is a nominated senior clinician on the community rehabilitation team. They act as principal point of contact between all relevant stakeholders. These include the SRU team, their Key Worker, the referring community rehabilitation team, the service user and their family members.

Challenging Behaviour

Emerson (1995) defines challenging behaviour as "culturally inappropriate behaviour of such an intensity, occurrence or length that the physical safety of the person or others is likely to place them in danger."

Community Healthcare Organisation

Nine Community Healthcare Organisations (CHOs) currently deliver Health Services at a local level across Statutory and Voluntary Sectors in the Community setting. They work in partnership with the National Primary Care, Social Care, Mental Health and Health and Wellbeing Divisions. Community Healthcare Services offer a broad range of services outside of the acute hospital system (HSE.ie and Mental Health Division).

Community Mental Health Teams (CMHTs)

A CMHT is a multidisciplinary team is composed of skilled professionals who combine their unique experiences and expertise to provide integrated care to service users in the context of their local community. They are the key component of mental health service delivery and they are the first line of acute secondary mental health care provision. Individuals are also supported through their recovery in their own community. CMHTs are designed to serve the needs of designated groups from childhood to later life, by co-ordinating a range of interventions for individuals in a variety of locations. These include home care, day hospitals and approved centres.

Community Rehabilitation and Recovery Services

The core philosophy of the Adult Community Rehabilitation Service is to provide individualised care programmes for service users and carers, based on identified need. Ideally, it will be implemented in a non-institutional setting. Individuals can only be referred to this service through the mental health service and cannot be referred through your G.P.(HSE.ie/ Mental Health Division).

Community Rehabilitation Residences

Community Rehabilitation Residences are designed to provide active rehabilitation and recovery programmes to service users in a non-institutional environment.

Individual Care Plan (ICP)

The HSE defines an individual care plan as:

> "… a documented set of goals developed, regularly reviewed and updated by the patients' multi-disciplinary team, so far as practicable in consultation with each patient. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the patient. … The individual care plan shall be recorded in the one composite set of documentation."

> (HSE, Best Practice Guidance for Mental Health Services, 2017)

Family Member/Carer

Family member/carer includes relatives, friends, supporters, carers, parents, siblings and children who are involved in the care and support of service users in their recovery journey.

Key worker

A key worker is a designated point of contact on the SRU mental health team. However, key workers do not deliver all treatments. They are responsible for ensuring that all concerned are adhering to agreed care plans (HSE, Best Practice Guidance for Mental Health Services, 2017).

Model of Care (MOC)

A Model of Care outlines best practice of care for a person or population group as they progress through the stages of a condition, injury or event. Accordingly, its primary aim is to ensure people get the right care, at the right time, by the right team in the right place (HSE, National Framework for developing Policies, Procedures 2016).

Multi-Disciplinary Team (MDT)

A multidisciplinary team consists of health care workers from complementary healthcare disciplines, who provide specific services to individual service users. They focus on the issues relevant to their speciality. The activities of the team are brought together during a care plan development. This helps co-ordinate individual services and encourages team working towards a specific set of service user goals (HSE, Best Practice Guidance for Mental Health Services, 2017).

On-going Complex Needs

Individuals who engage in mental health rehabilitation services are a 'low-volume, high-need' group. As well as symptoms relating to psychosis that have only partially responded to medication, they have recognised co-existing difficulties. These include comorbid mental illness, such as depression and anxiety, long-term physical health conditions, such as chronic obstructive pulmonary disease and cardiovascular disease, substance misuse, risk related behaviours, including aggression to others and difficulties engaging with treatment and support. In addition, many individuals may have considerable impairment which requires on-going support with decision-making. They may also be vulnerable to exploitation and abuse by others.

Psychiatric Intensive Care Units (PICUs)

PICU wards specialise in the assessment and comprehensive treatment of people with a broad spectrum of acute and enduring mental health needs. They provide care and treatment to inpatients who are experiencing the most acute phase of a mental illness. Service users who display challenging behaviour that is treatment resistant may require admission to a secure unit for intensive treatment and care. Ideally, this will be on a short-term basis. Whilst respecting privacy and dignity, these specialist units create a safe and

controlled environment to care for acutely disturbed psychiatric patients.

Low-secure Setting

These are settings designed for individuals with diverse needs who have historical offending behaviour or have exhibited challenging behaviour. These individuals will have varying levels of functional skills. Thus, in addition to their mental health difficulties, they are likely to require therapeutic programmes tailored to their offending behaviour. In relation to risk management, they may require higher staffed units that can manage behavioural disturbance with a full range of physical, procedural and relational security and specialist risk assessment and management skills.

Rehabilitation Programme

This is a Multidisciplinary team effort to deliver specialist therapeutic interventions within the collaborative framework of the recovery approach. It emphasises service user autonomy and independence. Components of a rehabilitation programme must include optimal pharmacological and symptom management, the promotion of self-care, living skills, healthy living and meaningful occupation, psychosocial interventions and creative therapies to maximise wellbeing. Such programmes must have access to Peer Support services and provide interventions to support carers. A rehabilitation programme can take place across a range of settings such as inpatient and community services. It should maintain close links with local accommodation providers and services that support occupation and employment. It is essential that Rehabilitation programmes maintain an active and dynamic focus that promotes therapeutic optimism and plans for transitions to independent living (Killaspy et al. 2006).

Recovery Oriented Service

A recovery oriented service is built on a culture of hope and expectation that a person can recover from their mental health challenges and build a fulfilling life of their own. Such a service is outward-looking to engage with all aspects and supports that will constitute and sustain recovery in an individual's life (HSE, 2017).

Service Provider

This is a healthcare professional or other role that provides treatment, care and support to people using services.

Service User

This is a person who is either a current or past user of mental health services (A Vision for Change, 2006).

Specialised Rehabilitation Unit (SRU)

An SRU is an in-patient facility which emphasises re-skilling service-user's socialisation and living skills. This type of care seeks to improve their quality of life and help individual service users regain a level of sustainable independence. This can enable them to return to their own homes or supported community residences.

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Appendices

Appendix A: Project Steering Committee Membership

Dr. Philip Dodd   National Clinical Advisor and Clinical Programmes Group Lead-Mental Health

Mr. Jim Ryan   Assistant National Director, Head of Operations, Mental Health

Ms. Antoinette Barry   Head of Service, Mental Health Services, HSE CHO 6

Mr. Colum Bracken   Programme Manager, Project Management Office, Mental Health

Dr. Amanda Burke   Executive Clinical Director, Mental Health Services, HSE CHO2

Mr. Barry Hurley   Service User Representative

Ms. Anne Callanan Cahill   Service Improvement Lead, Mental Health

Appendix B: Process Map of Specialised Rehabilitation Mental Health Services

Service Rehabilitation Units (Severe & Enduring Mental Health Illness)

Primary Care | Secondary Services | Territory Services

SU attends General Adult CMHT

General Adult CMHT

Referral submitted *

Specialised Rehabilitation Units

Referral submitted

Treatment Received

Community Rehab Team

Acute Inpatient Admission

Discharge from SRU

Discharge from SRU

Discharge from SRU

Scenario Three – Supported / Independent Community Living

Scenario Two – Community Rehabilitation Residences

Scenario One – Other Specialised Accommodation Settings **

* In some instances where a Rehab team is not available the referral to be admitted to the SRU can be completed by the General Adult Community Mental Health Team (GA CMHT)
** Other may include Nursing Homes and Continuing Care Placements

Appendix C: Specialised Rehabilitation Services Criteria for Referral

Inclusion

People defined as having severe and enduring mental health illness whose needs

are not adequately met by the sector or services and who fulfil the following criteria:

- On-going symptoms, such as, hallucinations, delusions, high-levels of anxiety or depression, negative symptoms of psychosis

- On-going complex needs

- Reduced social functioning, such as, breakdown of social relationships, reductions in the capacity for economic support.

Exclusion

- Under the age of 18 years or over the age of 65 years

- Acutely unwell because of their mental illness.

- An Acquired Brain Injury diagnosis

- A primary diagnosis of:

    o   Autism

    o   Personality Disorder

    o   Alzheimer's Disease

    o   Intellectual Disability

- Those who require

    o   a low secure unit setting only

    o   a PICU placement

Appendix D: Rehabilitation Mental Health Services Referral Form

Referral Form for Specialised Rehabilitation Unit (SRU)

General Details		
Last Name:	**First Name:**	**D.O.B:**
Gender:	**Marital Status:**	**No. of Dependent Children:**

Home/Permanent Address:

Contact Number:

Is the service user currently residing in an acute psychiatric unit: Yes ☐   No ☐
If yes, please give address

Length of stay in acute psychiatric unit:

GP Details:	**Name:** **Address:** **Contact No.**

Community Mental Health Team details:	**Name:** **Address:** **Contact No.**
Consultant Details:	**Name:** **Address:** **Contact Mobile No:** **Email:**
*Care Coordinator:	**Name:** **Address:** **Contact Mobile No:** **Email:**
	****NB** (Must be a nominated healthcare professional from the community rehabilitation team/ community mental health team (CMHT). Their role involves managing the SRU referral and discharge. They are the main point of contact between SRU MDT and referring Community Rehabilitation Team/ CMHT. They must attend service user's SRU care planning/review meetings (minimum every 3 months)*

Next of Kin Details:	Name:
	Relationship:
	Address:
	Contact No:
	Last contact/frequency of contact between service user and next of kin:
	Is the next of kin aware of referral to SRU? Yes ☐ No ☐
Legal Status:	Is the service user detained under the Mental Health Act? Yes ☐ No ☐ *If yes for how long?* Is the service user a Ward of Court? Yes ☐ No ☐ Does the service user have any recent court judgements or court orders in place? Yes ☐ No ☐ *If yes, please give details*

Medical Card No: Expiry Date:	PPS No:
Finance: Type of Income: Amount per week:	Public Services Card: Yes ☐ No ☐ Free Travel: Yes ☐ No ☐

Reason for Referral to National Specialised Rehabilitation Unit

N.B. Please refer to Inclusion and Exclusion Criteria for referral to SRU as outlined below. Only complete the referral form if service user's clinical presentation fits the inclusion criteria.

Inclusion Criteria:	Exclusion Criteria:
• People defined as having severe and enduring mental illness whose needs are not adequately met by the sector of services and who fulfil the following criteria: • Ongoing symptoms (e.g. hallucinations, delusions, high levels of anxiety or depressions, negative symptoms of psychosis) • Ongoing complex needs • Reduced social functions (e.g. breakdown of social relationships, reduction in the capacity for economic support)	• Under the age of 18 and over the age of 65 • Acutely unwell because of their mental illness • A primary diagnosis of an Intellectual Disability • A primary diagnosis of Autism • A primary diagnosis of Personality Disorder • A primary diagnosis of Alzheimers Disease • Those who require a low secure setting • Those who require a PICU placement

Brief Account of Reasons for Referral

Professionals Assessment Report Guidelines Section

Guidelines for Psychiatric Case Report

A full case report should be forwarded with each referral. Given the specialised nature of the service it is important to include the information outlined in the table in the case report.

Current Admission:	Please include background to /circumstances of current admission.
Progress in Hospital:	
Past psychiatric History:	Please note previous admissions, diagnoses , treatments used and response to treatment.
Medications:	Please include side effects and adherence
Legal Status:	
Risk Assessment:	Please include up to date risk assessment
Medical History:	
Personal History:	Please Include Early Life/Education and work record: Psychosexual History/Current Relationships
Family History:	Please include: profile of family; degree of contact with each family member, relationship with each family member, History of Mental Illness in the family
Social Circumstances:	e.g. accommodation /Financial
Premorbid Personality:	
Strengths and areas of potential:	
Substance Use History:	
Forensic History:	Violence, threats, protection or barring orders. treatment in a secure setting or forensic hospital (Ireland or Overseas), sexually motivated criminal act, criminal charges or convictions. Pease include forensic report if available
Mental State Examination:	
Diagnosis:	
Assessment of care needs:	

Guidelines for Occupational Therapy Report

Name:

DOB:

Occupational therapist:

Date of assessment:

Reason for assessment:

Techniques for assessment:

Outcome:

Daily Routine (occupational balance)	
Sleep Routine	
Personal Activities of Daily Living (PADLs)	
Basic Activities of Daily Living (BADLs)	
Instrumental Activities of Daily Living (IADLs) e.g. planning, organizational skills, initiating & completing tasks.	
Leisure Interests	
Work/Education	
Transport	
Social Interaction	
What occupations does the person identify as helping them to manage their mental health difficulties?	
What is the persons hope for their future?	
Why do you think this service user is ready for intensive rehabilitation at this time?	
What are the potential challenges to a successful SRU placement for this service user at this time.	

*It is expected that a standardised assessment of occupational function will be used in completing this assessment.

**This is not intended to be an exhaustive list and as always the occupational therapist will use his/her clinical reasoning to determine the assessment required.

Guidelines for Clinical Psychology Report

The Clinical Psychology report should provide a comprehensive psychological assessment and formulation of the service users presenting problems, hich includes history, family background, relationships, strengths and coping skills, previous psychological interventions, if any, current needs and reason for referral to the SRU. Where possible, and clinically indicated, it would also include the results of a recent neuropsychological assessment (see Appendix) Please also include any previously completed psychology reports and/ or results of previous neuropsychological assessments which may guide intervention with this person.

Name:

DOB:

Dates of Assessment/Report:

Presentation:

Presenting Problem:

History of Presenting Problem:

Background History: (to include attachment and relationship history)

Educational & Occupational History:

Risk issues: (present and past, including forensic history, if any)

Strengths:

Assessment techniques/tools and rationale:

Assessment results:

Psychological formulation: (to include, if possible, understanding of complex needs)

Previous psychological interventions, if any:

Current needs:

Service user's view of needs:

Recommendations:

Why do you think this person is suitable for placement in a Specialist Rehabilitation Unit at this point in time?

It is a given that these units are designed for people with complex needs. However, it would be helpful to flag potential challenges to a successful placement at this point, in order to plan for these possibilities. Can you identify any potential challenges to a successful placement on an SRU? Any recommendation to mitigate these challenges?

Appendix

Potential Psychometric Assessment Tools

An assessment battery may include:

- Test of Pre-morbid Functioning (TOPF)

- Wechsler Abbreviated Scale of Intelligence-II (WASI-II)

- Wechsler Adult Intelligence Scale-IV (WAIS-IV)

- Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)

- Behavioural Assessment of Dysexecutive Syndrome (BADS)

- The Dysexecutive Function Questionnaire (DEX)

- Addenbrooke – III (ACE-III)

- Wechsler Memory Scale (WMS)

- Test of Non-Verbal Intelligence (TONI)

- Beck Depression Inventory (BDI)

- Delis-Kaplan Executive Function System (or subtests from it)

This list is not intended to be either a) directive or b) exhaustive. The Clinical Psychologist will use her/ his clinical reasoning to determine the assessment required. Please include any other appropriate assessment tools, assessment findings and recommendations.

Guidelines for Social Work Report

The Social Work Report should provide a comprehensive psychosocial assessment of the service user needs as per standard social work practice. It should highlight the current needs of the service user in all the key areas of their life, the social workers level of contact and key interventions to date and the reason for referral to the SRU. This guideline is intended as guidance only and should not be considered exhaustive. The social worker should use their professional judgement to determine the content of the report as appropriate to the referral.

It would be helpful that the report pay particular attention to the following key areas;

- Accommodation: include an accommodation history, current living situation, previous residential placements, potential for independent living/ independent living skills, supports needed to maintain accommodation, reason for referral to the SRU placement.

- Mental Health: include a mental health history and a description of current mental health difficulties, significant lift events, history of abuse/trauma, and a summary of any complex needs.

- Service User's views: include the service user's views in their care plan and their mental health needs, their plans and hopes for the future, their views on a potential move to an SRU, their strengths and resilience and support network.

- Family/Carers/ Supporters Views: include their views on the care plan, views on a move to SRU placement, the proposed post discharge plan and their own support needs.

- Risk/ Safeguarding Issues: identify current risk factors, vulnerabilities and protective factors, safeguarding issues and safeguards in place.

- Placement Goals for the SRU: identify the proposed goals of an SRU placement, to include a social work opinion on the service user's level of insight and readiness to engage in a specialised rehabilitation programme and any particular issues or challenges that may arise to a successful SRU placement, identify the provisional post SRU discharge plan for the service user.

Guidelines for Nursing Assessment Report

The Nursing Report should include:

1.   A copy of the current Nursing Care Plan

2.   A Nursing summary of the patient's in-patient nursing care / history

3.   A Community Mental Health Nurse Summary
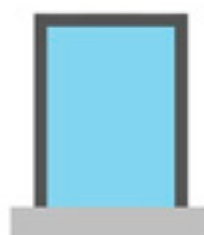
Service User & Family Members

Is the service user aware of the referral?	Yes ☐	No ☐

If not please give reason

Service User information

What is a Specialised Rehabilitation Unit (SRU)?

An SRU is a recovery-focused, inpatient facility which focuses on rehabilitation for people with severe and enduring mental illness and complex needs.

There are two in Ireland. Highfield SRU is in North Dublin and Bloomfield SRU is in South Dublin.

Aim: The staff aim is to listen and support you and your family in a caring and compassionate environment to help you to recover as well as you can.

Assessment

If you go to the SRU, a mental health team will work with you to look closely at your needs, strengths and life goals. The team will include people with nursing, medical and therapy training. They will consider your unique needs, the relationships you have, the things you do every day and what you might like to do. They will use this to help you to work towards your goals.

Support

You and your team will develop a treatment plan together that will support you towards reaching your goals. The team will offer you support in a place that is designed to assist your recovery.

Family/ Friends/ Carer

Family View:

Please state the views of the family members'/ carer's/ friends' needs and the supports they feel they require.

Checklist and Signatures of Referring Agent and Head of Service

Referring Agent :

Name: _____

Job Title: _____

Signature: _____

Date: _____

Checklists for Referral:

Referral Form: ☐

Psychiatric Case Report: ☐

Risk assessment: ☐

OT Report: ☐

Psychology Report: ☐

Social Work Report: ☐

Nursing Report : ☐

Copy of up to Date Individual Care Plan: ☐

Other Relevant Reports: ☐

Checklist to be completed by Head of Service

(This has to be signed by Heads of Service or nominee prior to referral being sent. Please note if this section is not completed referrals will not be accepted)

Does the CHO agree to provide a suitable living arrangement for the service user when the period of inpatient rehabilitation in the SRU is complete:

<div align="center">Yes ☐   No ☐</div>

Has a suitable Community Rehabilitation Residence placement been identified for the service user, if needed, upon discharge from the SRU:

<div align="center">Yes ☐   No ☐</div>

If Yes: Where is this Community Rehabilitation Residences?

If the event of the SRU placement not being successful, do you agree to provide a placement for service user?　　　　Yes ☐　No ☐

Name: _____

Signature: _____

Please provide stamp from Head of Service Office

NB. Please return completed form with appropriate reports to nationalsrureferrals@hse.ie

Appendix E: Enabling Environment Standards

1. Belonging: The nature and quality of relationships are of primary importance

    •   Recipients and providers support newcomers to get involved with others

    •   There are opportunities for recipients and providers to get to know each other

    •   There are ways to mark people leaving

    •   Recipients and providers are learning about building relationships

2. Boundaries: Expectations of behaviour and processes to maintain and review them

    •   Recipients and providers can describe the expectations and how they are maintained.

    •   There is a consistent approach to implementing these expectations

    •   There is an open process to review expectations which includes recipients and providers.

3. Communication: It is recognised that people communicate in diverse ways

    •   Recipients and providers are supported to communicate effectively

    •   There are opportunities for recipients and providers to discuss the feelings behind the way people act

    •   Recipients and providers are encouraged to use a variety of ways to communicate

    •   Providers recognise how the way people act is a form of communication.

4. Development: Opportunities to be spontaneous and try new things

    •   There is management support for spontaneity

    •   Recipients and providers are able to try new things

    •   Recipients and providers are supported to understand risk and risky behaviour

5. Involvement: Everyone shares responsibility for the environment

    •   Recipients and providers take a variety of roles and responsibilities within the environment

    •   Recipients and providers are involved in planning their own development

    •   Recipients and providers are involved in contributing to the development of others

- Recipients and providers are involved in making decisions about the environment

6. Safety: Support is available for everyone

    - It is acceptable for anyone to feel vulnerable and receive the emotional support they need

    - Recipients and providers feel listened to and understood by others around them

    - Providers have regular reflective supervision with a consistent supervisor

    - Peer-support is recognised, valued and encouraged

7. Structure: Engagement and purposeful activity is actively encouraged

    - There is a consistent structure or daily routine

    - There are regular meetings or groups that include significant numbers of both recipients and providers

    - There are spontaneous activities that involve recipients and providers

8. Empowerment: Power and authority are open to discussion

    - Recipients and providers are able to challenge decisions and ask questions

    - Recipients and providers feel supported by those in authority

    - Recipients and providers are able to have their ideas implemented

9. Leadership: Leadership takes responsibility for the environment being enabled

    - There are clear management structures which include opportunities for involvement from recipients and providers

    - The leadership ensures that the environment is the right place for the people within it

    - People with a leadership role are active participants in the life of the community

    - There is continuity of staff

10. Openness: External relationships are sought and valued

    - The environment is welcoming to visitors

    - Everyone is supported to participate in activities outside the environment

    - Everyone is open and responsive to evaluation and learning

(Royal College of Psychiatrists, 2013)

Appendix F: Service User Input and Feedback

According to Martin and Henderson (2014), quality derives from knowing who uses a service; understanding what they would like from it and being able to respond appropriately to their requirement. Although service user feedback can be regarded as the criterion by which services are evaluated it is often gathered in an ad hoc fashion (HSE, 2014). Therefore, a systematic approach to gathering and using information about service user experiences ensures continued service improvement by being more responsive to service users. Consequently, as previously mentioned "mental health services can become beneficiaries of service user experiences". This can be achieved through the following methods:

Weekly

Gathering of Service User Views on SRU by the provision of a weekly Independent Advocacy service

Monthly

Establishment of monthly Resident's Forum / In-patient Feedback Group, conducted by staff, preferably Peer Support Worker.

Quarterly

Formation of Service Improvement Group meetings between designated Advocate and Senior Management to discuss and implement Service Improvement initiatives based on service user input.

Annually

Use service user input to inform Annual Report and celebrate successful initiatives

Periodically

Include service user input to inform Strategic Planning and Evaluation documents
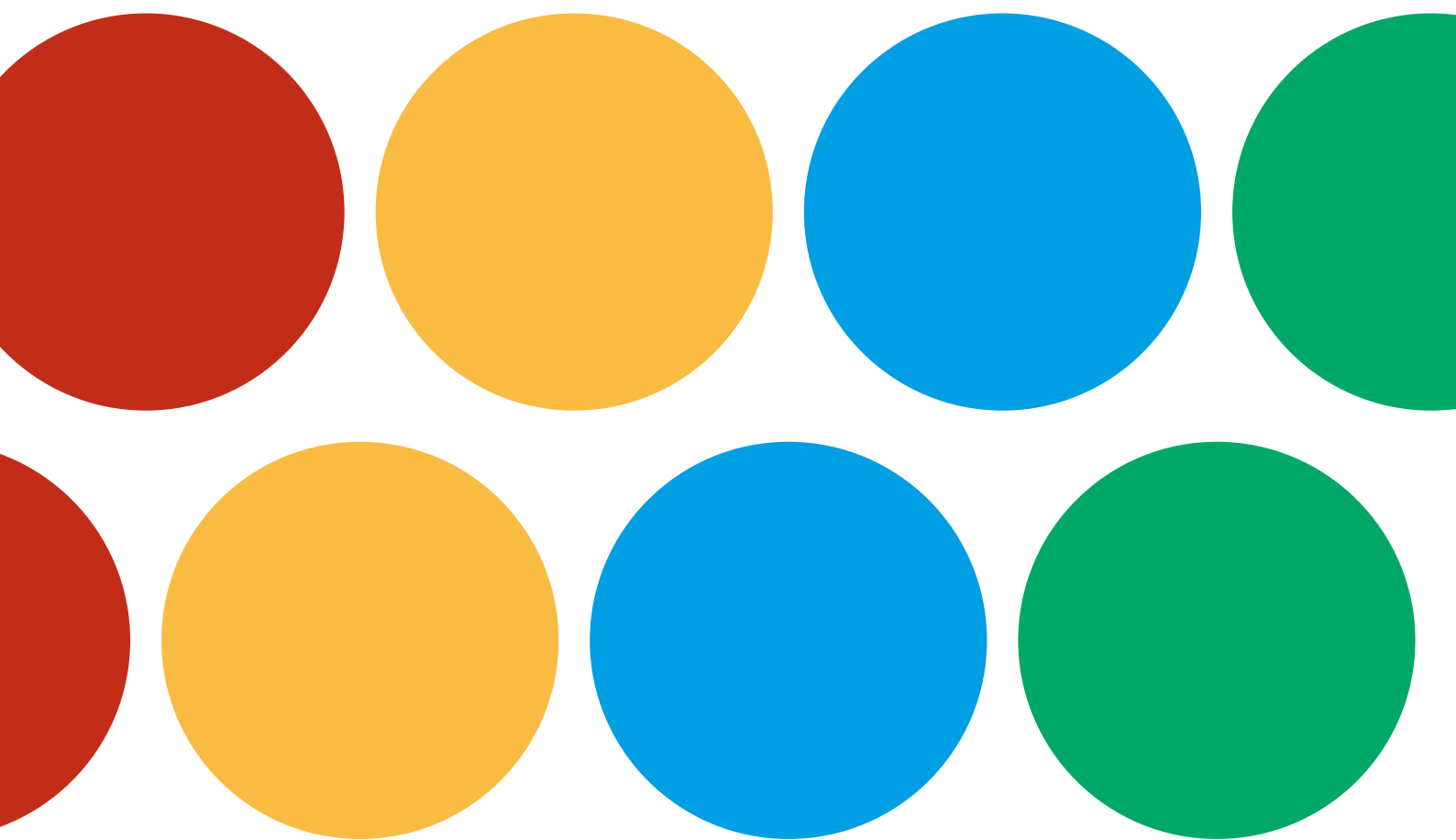
On-going

Including regular contributions to Individual Care Planning, and Medication Reviews a variety of methods should be employed on an ongoing basis to gather service user perspectives on the quality of service in each SRU and related services:

- Interviews
- Focus Groups

- Service User Stories

- Service User Diaries

- Comment Cards

- Suggestion Boxes

- Complaints

- Service User Panels

- Service User Journey Mapping

- Surveys

- Consultation

Any evaluation or quality improvement strategy will help services approach service user feedback by first capturing the service user experience, understanding it, identifying opportunities for improvement and providing feedback to users and other stakeholders about how service user experiences are used to improve mental health rehabilitation services for people with severe and enduring mental illness and complex needs. It is the criterion by which this Model of Care shall be measured.

Notes:

HSE Mental Health Services

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive