parental consent. It is probable that children from more chaotic backgrounds where drug misuse may be an issue were under-represented in this study.

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Multiple pathways on the route to recovery

Dear Editor – In *Facilitating journey to recovery – Ir J Psych Med 2008; 25(3)* Khan and Murray[1] recently outlined the requirement for a multidisciplinary assessment by a rehabilitation and recovery team and the use of a comprehensive assessment tool to help guide mental health service users toward recovery. The authors restate the Expert Group on Mental Health Policy[2] *A Vision for Change* recommendation that a recovery orientation inform every aspect of service delivery.

Unlike the authors, we do not believe that a specialist comprehensive initial assessment is always 'crucial in order to identify needs and the rehabilitation goals for [or even of] the service user'. The US SAMHSA (Substance Abuse and Mental Health Services Administration) 2006 Consensus Statement on Mental Health Recovery[3] sets out 10 fundamental components of recovery, including that journeys be individualised and person-centred. Recognition is given to the fact that 'there are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences, and cultural background'. Many people who come into contact with mental health services are capable of assessing their own needs and determining their own path to recovery with minimal or even no professional support.

It is interesting to note that the CASIG (Client Assessment of Strengths, Interests and Goals) validation studies[4,5] were based on data collected by 18 peer-interviewers with serious and persistent mental illness. The research team reported 90% accuracy for task performance based on examination of CASIG documentation and audio records of the interviews.[5] On the other hand, there are service users with severely functionally disabling mental illness or more complex needs who require significant specialist rehabilitation assistance.

We are currently testing the utility of the CASIG as part a larger rehabilitation and recovery process pilot within our residential rehabilitation service. This experience allows us to usefully add to the author comments on its use in this context. In this population administration often exceeds the suggested range of 60-90 minutes and requires significant staff skill to assist both in the formulation of realistic and attainable goals and in incremental plans to achieve them. Also, while the framework is recovery based, it is possible (and sometime easy) to deviate from recovery principles within the structure.

Significant effort has to be given to staff training in recovery principles and practice and to the maintenance of a recovery ethos. While the CASIG is wide ranging it is by no means all encompassing. We use a small number of core additional assessments to inform care planning. These include a Rehabilitation Readiness Assessment (to determine whether an individual desires and is sufficiently skilled to engage in a comprehensive formal rehabilitative process at this time), a risk assessment, and an independent physical health assessment. Not infrequently more specific testing or assessments are required to delineate strengths and barriers to recovery.

While assessment tools such as the CASIG may aid our efforts, implementing *A Vision for Change* recommendations in a truly meaningful way will involve sustained organisational commitment to the core principles of recovery.

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The economic cost of schizophrenia in Ireland

Dear Editor – This is in reference to the interesting article *The economic cost of schizophrenia in Ireland: a cost of illness study'. Behan et al; Ir J Psychological Medicine 2008; 25(3).*[1] This study provides a very useful evidence for the

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