

Schizophrenia Ireland

Lucia Foundation



Recovery in Practice

**Submission to the Expert Group on Mental Health Policy
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“The level of help shown to the mentally ill by their family, friends and workmates has a great influence on their recovery.”

(Planning for the Future, 1984)

Introduction

The purpose of this document is to outline the main issues confronting people with schizophrenia and their families in Ireland today, and to make recommendations for the reform and development of Ireland’s mental health policy framework.

It is estimated that 1 in 100 people worldwide has schizophrenia. This means that in Ireland alone, there are approximately 39,000 people with schizophrenia. Mental illness is not a marginal issue but is central to the lives of a significant number of people in Ireland today.

At present, there is a groundswell of determination around the country to abandon outdated and inadequate mental healthcare services and increase funding for mental healthcare. Schizophrenia Ireland (SI) welcomes the Department of Health and Children’s establishment of the Expert Group, along with this opportunity to engage in promoting a reformed and enhanced national mental health policy framework that meets the real needs of the people it serves.

Background

Service delivery in Ireland has seen a fundamental shift from institutional care towards care in the community. Many key elements of treatment, however, are still provided in centralised treatment facilities while the provision of coordinated and extensive community services still remains incomplete. There also continues to be a reliance on the maintenance model of care for people with a psychiatric illness, consistent with an absence of belief in the ability of people to participate actively in the management of their own care, or to recover from this experience. In setting out a mental health strategy for future service delivery, **it is vital that services and research are re-oriented towards partnership and recovery, and that recovery is viewed as the overarching objective for mental health policy.**

To achieve quality of services, increased funding for mental healthcare is necessary. According to the World Health Organisation (WHO), “People with mental health problems have to cope with stigma, exclusion, taboo, and refusal by their society to recognize the real cost of mental disorders and mental health. This is reflected in an inappropriate allocation of financial and human resources.”¹ In Ireland, mental healthcare as a proportion of the overall healthcare budget has dropped from 10.6% in 1990, to just 6.8% in 2003.²

Recovery

Throughout this submission, recovery is the overriding theme and focus. It is SI’s view that recovery must be at the foundation of the mental health policy framework. If we are to adopt the principle of recovery into our thinking, however, it will require

¹ World Health Organization (WHO) Regional Office for Europe, (2003): <http://www.euro.who.int/eprise/main/WHO/Progs/MNH/Home>.

² Mental Health Commission Annual Report, (2002), p. 22.

a shift away from ideas like “cure” and “treatment” and a greater emphasis on ideas such as self-management and facilitation.

Dr. William Anthony, Executive Director of the Centre for Psychiatric Rehabilitation at Boston University defines recovery as, "the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability".³ Recovery does not imply a cure, but rather that the individual lives a productive and meaningful life despite symptoms which occur less frequently and are more effectively controlled.

The supports required by people who are experiencing or recovering from an acute or active state of psychosis are necessarily complex, intense and fluid. The structures need to support a person centred response involving a wide range of expertise and a rapid response communication system. As Anthony notes, “recovery is a deeply personal unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness”.⁴

Language and Terminology

The language of Psychiatry needs to be changed. Terms such as “acute”, “treatment”, “mental illness” and so on need to be reviewed and re-formulated to encourage more holistic and inclusive views of people with self-experience of mental illness. Appropriate terms need to be discussed and agreed upon by people with self-experience and their relatives. For clarity sake, however, this document uses *status quo* terms.

Research

The Mental Health Commission acknowledges that there is need for evaluation of models and dissemination of best practice.⁵ Better information about the prevalence of illness, assessment of needs for treatment and rehabilitation, and processes and outcomes of treatment/rehabilitation are essential. Without urgent action to address information gaps, the development of responses will continue to be piecemeal, inconsistent and inadequate to need. This is relevant not only in the area of mental health services, but also in developing broader social policy for people with self experience, of whom there are currently no accurate statistics.

Mental Health Promotion

A new mental health policy framework must prioritise changing public attitudes towards people living with a diagnosis of mental illness. This must occur not only through broad anti-stigma campaigns and targeted educational programmes, such as for young people, the gardaí, public servants, etc., but also must occur through incorporating mental health into a wide range of community development programmes. This need is particularly indicated by the higher incidence of mental illness amongst unskilled workers⁶ and the fear articulated about accessing mental health services for the first time.⁷

³ Anthony, W. 1993.

⁴ Anthony, W. 1993.

⁵ MHC Annual Report 2002

⁶ Irish Psychiatric Hospitals and Units Census 2001

⁷ Schizophrenia Ireland/WHB 2002

A. Mental Health Policy Framework

I. Policy Framework Overview

According to the World Health Organisation (WHO), “mental health policy is an organised set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population. It defines a vision for the future and helps to establish a model for action.”⁸

Key Mental Healthcare Policy Areas

In SI’s view, there are five key areas of mental health policy that need to be highlighted and examined if consistency throughout the country is to be achieved, while also meeting the needs of service users and their relatives. These are:

1. Mental Health Promotion & Early Intervention
2. Acute Service Provisions
3. Crisis Intervention
4. Rehabilitation Services
5. Legislation

Aims of Mental Healthcare Policy

The overall aims of the mental healthcare policy framework should be:

- To promote the recovery of people with self experience and reduce the impact of mental health problems on individuals, families and society at large;
- To promote the mental health of society and prevent the development of mental health problems and disorders, where possible; and
- To ensure the human rights of people with self experience.

Policy Drivers for Mental Health Services

In conjunction with the above, it is imperative that the following policy drivers be embedded within the overall mental health policy framework to underpin an effective and holistic model:

Recovery	Recovery recognized as the goal for mental healthcare.
Holistic Participation	Mental healthcare conceptualised beyond a medical model. Service users and family members to be partners in service treatment, planning and policy development at all organizational levels.
Integration	Mental health should not be ghettoised. Recovery services to be integrated across all government departments and to foster social integration.
Access	Access to services, information, education and support to be actively fostered for both service users and their relatives.
Partnership	Development of effective partnerships with other providers including Non-Governmental Organizations (NGOs)/Voluntary Agencies.
Choice	Choice is given to people with self-experience and their relatives.
Advocacy	Access to a full range of advocacy services and training in self-advocacy should be available at all points of service delivery.

⁸ World Health Organisation (WHO): http://www.who.int/mental_health/policy/en/.

II. Implementation

Extent

To ensure that effective implementation of a reformed mental healthcare service be delivered, it is necessary that enhanced services are offered locally to all people with self experience, irrespective of what part of the country they live in. Therefore, it will be necessary for the services to address whether:

- The services are meeting the needs of people with self-experience; and
- All those with a diagnosis are receiving adequate services.

Process

It is essential that all stakeholders are committed to the implementation of a reformed mental healthcare service, and that there is a clear interpretation and consensus of the overall policy framework at all working levels. The policy process must support people with self-experience to engage and contribute at all policy making levels. Crucially, all of the relevant governmental departments (i.e. Department of Health and Children, Department of Finance, Department of Justice, Equality and Law Reform, Department of Social and Family Affairs, Department of the Environment and Local Government and Department of Enterprise, Trade and Employment) must communicate and co-operate on inter-agency aspects that impact the mental health policy framework.

III. Evaluation

Outcomes

The outcomes that are expected to be achieved when the mental healthcare services are reformed include, *inter alia*:

- i. Comprehensive, holistic treatment and service provision.
- ii. Sufficient and appropriate accommodation provisions with greater flexibility to meet the needs of people with self experience.
- iii. Enhanced focus on recovery.
- iv. Improved quality of life for people with self experience and their families.
- v. Improved responsiveness of services.
- vi. Consistency and accessibility of services nationwide.
- vii. Increased appropriateness, accountability, accessibility and equitability of services.
- viii. Reflection of the true cost of mental illness in the level of social welfare payments.
- ix. Involvement of people with self-experience and family members in service planning and policy development at all levels.
- x. Effective protection of the human rights of people with self-experience and rights based legislation underpinning the mental health policy framework.
- xi. Decreased stigma of mental health disorders.
- xii. Improved communication throughout the services.
- xiii. Greater cost effectiveness and accountability of utilised resources.
- xiv. Enhanced integration and coordination between medical and social/vocational rehabilitation services.
- xv. Increased funding for mental health and rehabilitation services.
- xvi. Increased recognition that early intervention and identification programmes must be the norm in mental health services nationally.
- xvii. Increased employment of people with self-experience.
- xviii. Increased social inclusion of people with self-experience.

- xix. Comprehensive knowledge base on the prevalence of mental health problems, needs for recovery, treatment actions and recovery of people with self-experience.
- xx. Adequate advocacy resources available for all people with self-experience in all service settings.
- xxi. Increased partnership between mental health services and Non-Governmental Organisations/voluntary sector.
- xxii. Mental health services must be provided on a twenty-four hour, seven days a week basis.
- xxiii. Yearly, open-source analysis of mental healthcare services.
- xxiv. Mental health prioritised as an essential component of public health.
- xxv. Reorganisation of the mental health structure for service provision and funding allocation, based on the following model:

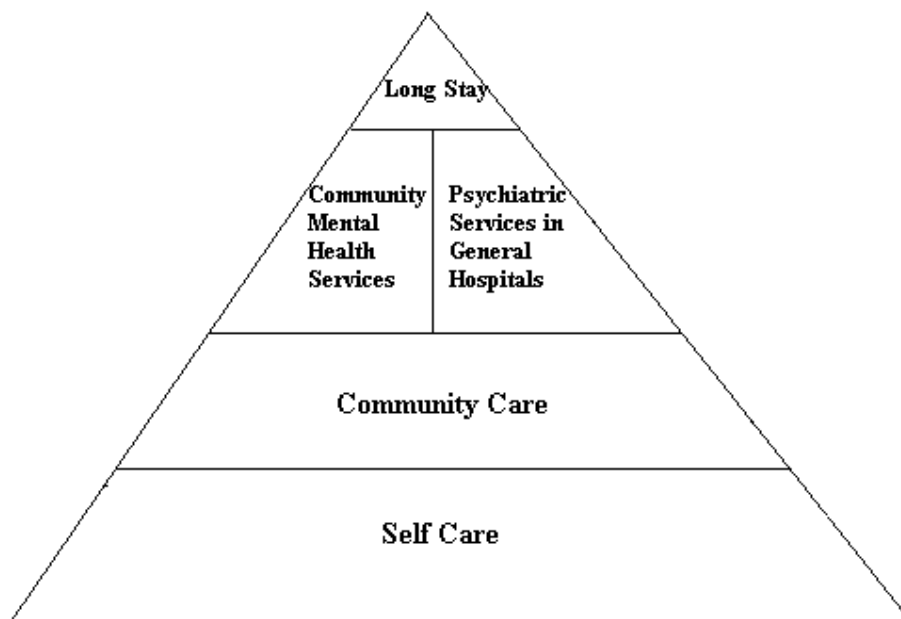


Figure 1 David McDaid, "An international perspective on the development of mental health policy and services", diagram sourced from the WHO, presented at the Mental Health: The Right to Best Practice Conference, 19th December 2003, Marino Institute of Education, Dublin.

B. Recommendations for the Organisation and Delivery of Services

An Example of Failure on behalf of the Services

An anecdotal but true experience:

A young man is encouraged by his Local Employment Scheme (LES) to take up a place on a Jobs Initiative (JI) scheme in a new Community Centre, as the Community Employment Scheme he is currently on is due to close. The LES staff knows that the young man has “some issues” but nothing more specific. In order to participate in the JI scheme the young man must relinquish his disability allowance.

Within a month of taking up his post at the Community Centre, the young man is experiencing difficulties with simple and routine tasks. He discloses to the Centre Manager over a cup of coffee that he is a person with schizophrenia.

The Centre Manager works with the young man over the next few weeks to try to support him but this becomes increasingly difficult, as very minor things seem to send him into a state of anxiety or distress. No one in the LES has experience of dealing with these issues. Contact is made with SI and some contacts are shared with the LES and suggestions made for trying to resolve the situation.

Very shortly after this, the young man fails to turn up for work. When the LES liaison person calls to his home, she is sometimes unable to rouse him. When she does make contact, he appears dishevelled, tired and uncommunicative. Negotiations to have his disability allowance restored are undertaken but prove protracted and uncertain.

This young man is subsequently readmitted to hospital.

Introduction

It is necessary to recognise that the absence of services leads to crisis care. The organisation and delivery of mental health services must be modelled on a partnership approach at every stage, with emphasis on communication, information, education and support. Recovery must be at the foundation of all services.

Role of People with Self-Experience and Relatives

In order to ensure genuine inclusiveness and a commitment to change, it is essential that people with self experience and family members are part of the central decision-making process and are directly involved on an on-going basis in service planning, policy development and other appropriate areas. It must be recognised that people with self-experience and family members are experts through experience and can enrich and inform service development. Without this specific involvement, any new service will be lacking the authority of authentic personal experience. In order to implement this, resources must be invested in capacity-building and on-going support for service user and family member representatives within decision-making bodies.

1. Mental Health Promotion and Early Intervention Strategies

Mental Health promotion is concerned with increasing people's resilience and ability by developing their general life skills and identifying and using positive ways of coping. It aims to work at reducing environmental pressures that are causing stress and to further identify and maximise people's social support network.⁹ It can also play an important role in improving the well being of people living with a diagnosis.¹⁰

While schizophrenia as an illness cannot be prevented in ways similar to other illnesses, mental health promotion as a component of early intervention strategies can significantly reduce the disability felt by those experiencing a psychosis related illness.

The essential components of early intervention strategies are:

1. Community based educational/anti stigma programmes
2. Easily accessible and highly responsive community and outreach based services.

Health promotion research has identified that misconceptions, with regard to mental health and to stigma within the general public and the health services, contribute to the lengthening of the duration of untreated psychosis (DUP). Thus, mental health promotion must have effective awareness raising and stigma reducing / anti stigma elements in order to be successful. Broad based educational campaigns need to target individuals, families, communities, health care professionals, schools and colleges, the workplace and the media and disseminate information on mental health and illness issues generally, in conjunction with information outlining the early signs of serious mental illness. The focus of such campaigns is on the positive outcomes of accessing help and support early as well as stressing the importance of accessing such support promptly, just as it is for medical conditions.

With improved knowledge about psychosis from such educational measures, individuals and families are more likely to seek help sooner with respect to the risk and presence of psychosis. Services then need to be ready to respond and intervene promptly to such enquiries.

Early intervention strategies aim to detect symptoms during the onset of schizophrenia or related disorders at the earliest possible point and begin treatment. Early intervention strategies should follow along the lines of the bio psychosocial model of intervention. Therefore, early detection strategies should include low dosage atypical medication in combination with a range of supports including information, education and family work with psychosocial supports and rehabilitation.

How to Deliver Such Services/What is Needed

A steering group in the East Coast Area of ERHA identified the following needs:

- Integrating early detection strategies into existing services. The development of a detection team multidisciplinary in approach, that would attach itself to outpatient services and possibly work on an outreach model of service provision, with identifiable avenues of support available after hours.

⁹ Presentation by SHB HPU, 2003.

¹⁰NeLH 2002.

Core elements of the service should include:

- Early assessment of psychotic symptoms
- Assessment plan that includes assessment of all needs, taking into consideration the needs of the individual, and those of the family.
- Prompt clinical intervention and treatment
- Relapse prevention input
- Everyday living needs to be addressed, including, financial, housing and employment needs.
- General health promoting strategies / behaviours.

Rationale/Why Intervene Early

The benefits to the individual (in terms of health, well being and quality of life gains), to the family, and to the state (in terms of economics) are well documented and in need of urgent investment. Early intervention and identification programmes must be the norm in mental healthcare services nationally. The shorter the period of time between initial presentation and diagnosis, the greater the long-term prognosis for a sustained recovery.

Information, Education and Support

Through SI's contact with people with self-experience and relatives, many have indicated that the early stages of diagnosis and treatment are particularly difficult due to a lack of information and education about schizophrenia and treatment. SI recognises how varied and complex the information needs of people with self-experience and family members are. Nevertheless, experiences and much research demonstrate that the provision of accurate, person specific, and timely information provided in an appropriate form that can be personalised and utilised is central to supporting the development of insight and recovery. **Information, education and support should be offered throughout the use of services in a form that is understood, and should be offered to both people with self-experience and relatives.** This should be seen as the beginning of an ongoing dialogue. Opportunities should be afforded to return and discuss matters as people with self-experience and relatives see fit.

2. Acute Service Provisions

Introduction

Many Health Boards have recently completed (or are about to complete) reviews of their mental health services. These are significant pieces of work and those that have been published or drafted demonstrate a growing awareness of the holistic and personal needs of people who need to utilise the psychiatric services. The reviews include developments in the following areas:

- Development and strengthening of Primary Care role
- Development of Community Mental Health Teams
- Development of Home Treatment/Crisis Intervention teams
- Provision of an Advocacy Service
- Redefinition of Day Hospital and Day Centre roles
- Provision of Community Rehabilitation Teams
- Redefined role for Acute Units (attached to General Hospitals)
- Development Psychiatric Intensive Care Units
- Development of Family Work and supports for family members

In other words, the overall approach consists of many of the same elements described in *Planning for the Future*, together with some new developments such as the provision of Advocacy and Psychiatric Intensive Care Units. The “patient” much quoted in *Planning for the Future* has been redefined in the context of the Department of Health & Children’s Health Strategy to a “Person Centred” approach and promotes the principle of recovery.

Primary Care

The role of Primary Care is central to the development of community mental health services. The recent ‘Primary Care Strategy’ does not go far enough to address the issues of early identification and specific responses to people who may be presently unwell, but not in crisis.

Service Structures

The new service structures outlined in many of the reviews still reflect the traditional power and leadership balance. While the focus is altered (i.e. acute service being viewed as a support to the community), the domination of the “medical model” remains intact, which needs to be altered. All other elements such as psycho/social therapies, personal development, etc. remain *desirable* rather than *essential*. The dominant role of medical psychiatry in all elements of the “treatment” cycle must be redressed. Equal status should be allocated to psychological, rehabilitative and social skills expertise. Additionally, services must be made available on a twenty-four hour, seven days a week basis.

Advocacy

The inclusion of an advocate as part of these teams is a central issue that must be addressed. Capacity building for peer advocates and service user representatives must be adequately resourced.

Acute Units & Intensive Care Hostels

Treatment in an acute hospital unit may be the most appropriate setting for the management of the acute episode of schizophrenia. The environment of such units should aim to promote recovery, should be safe and should be able to provide a full range of therapeutic activities. The continued location of acute units in the General Hospital setting needs to be reviewed in the context of current negative experience. The provision of small intensive care hostels or homes within communities should be examined. Rehabilitation programmes need to be in place at this stage.

Relatives

The role and needs of *all* family members (parents, spouses, siblings, children) should be integrated into the service. Specific and varied information, education, coping and conflict resolution programmes need to be available. Where applicable, the role and needs of other significant individuals should also be identified and met. Mental health services should develop a specific protocol to deal with conflicts between patients’ confidentiality and relatives’ need for/right to information.

Treatment Settings—Primary Care

It is important that there are clearly agreed and understood methods of referring individuals for prompt, specialist psychiatric assessment by their local GP service. Most people who develop schizophrenia for the first time will seek help from their

general practitioner. In some situations, an immediate emergency referral may need to be made but, in general, it is preferable that a member of the community mental health sector team carries out the initial assessment. In some circumstances the general practitioner may initiate treatment with appropriate medication before the individual is seen by the specialist psychiatric service, which should be in the shortest possible time.

Comprehensive Assessment

A comprehensive assessment of the person's physical health, psychological health and social needs should be carried out. Such assessment should involve the individuals themselves. An individual will need access to other members of the multidisciplinary team in addition to a psychiatric assessment. With the consent of the individual, a relative or advocate may be included in the assessment process.

Establishment of a Therapeutic Alliance

In all situations, it is essential that a therapeutic alliance be established between the person receiving treatment, the mental healthcare team and family members. Such an alliance will ensure that everyone is working towards the same goals in a supportive partnership.

Community Mental Health Team (CMHT)

Each team should be adequately staffed so that physical, psychological and social interventions are available. Every person experiencing psychiatric distress should have access to a CMHT. The CMHT should have a range of expertise, which allows them to support the individual and their caring relatives.

Home Treatment

Home treatment should be available and adequate resourcing of home treatment teams in all parts of the country should be a priority. Home treatment teams, either on their own or as part of a CMHT, can provide a responsive, high quality method of delivering acute care for those with schizophrenia.

Day Hospital/Day Facilities/Day Centres

Such services should be available to facilitate the delivery of a full range of treatment options including acute care. There is good evidence available indicating that acute day hospitals can provide efficacious and cost effective treatment of the acute episode of schizophrenia as an alternative to inpatient treatment. Such day hospitals need to be adequately staffed and resourced.

Pharmacological Interventions

Atypical antipsychotic drugs should be considered the first-line treatment of schizophrenia. The prescribing of medication should be based on best evidence and with attention to possible side effects, the individual's life circumstances and attitudes to medication. No medication should be restricted on the grounds of cost alone. In general, the use of more than one antipsychotic drug should be avoided. If side effects occur, the nature and dosage of the antipsychotic should be reviewed and modified to eliminate the need for additional medication. Where agreed, caring relatives or advocate should be included in the review process. Reviews must occur regularly.

Physical Environment

All mental health facilities should offer a high standard of privacy, safety, comfort, hygiene, décor and maintenance. The dignity of the person in residential or hospital settings should always be respected. Such facilities should not be seen as permanent, as individuals' long-term abodes should be in a domestic type unit.

Discharge Planning

Everyone should have a comprehensive discharge plan that has been agreed on in consultation with the person themselves, and all other relevant individuals. Community services and the GP should receive a copy of the discharge plan. Appropriate accommodation must be part of the discharge plan. It is unacceptable to place people in temporary, short-term emergency accommodation (emergency shelters, homeless shelters, bed and breakfasts).

3. Crisis Intervention

Introduction

Ireland's current high rate of involuntary admission, relative to other European countries, stands as a reflection not only of poor legislation, but also of inadequate alternative services. The future statistics on involuntary admission will therefore be viewed as a key indicator of improved mental health policy.

Involuntary Admissions

Involuntary admission to a psychiatric hospital must always be used as a last resort. Where there may be a significant risk of harm to self or others or where the individual refuses to seek treatment and their health is being seriously harmed, it may be necessary for someone to be committed to hospital against their will. The process of involuntary admission is a traumatic and devastating occurrence for the individual and their family. It should be a primary aim of all professionals involved to acknowledge and respect the sensitivities of the whole family and respond appropriately.

Advocacy

A legal advocate should be made available to every person admitted involuntarily. Full information about the person's rights under the current Mental Health legislation should be conveyed in a manner understood by the person admitted, and at a number of points in the treatment process.

GPs

It is important that GPs are sufficiently skilled in crisis intervention to facilitate their being an access point for services.

Home Based Teams

The nature of crisis intervention/ home based teams is that they are flexible and responsive to the individual's needs. The best-known practice of crisis intervention/home-based treatment should be available to all people regardless of geography.

4. Rehabilitation Services

Introduction

Rehabilitation is an essential component in fostering recovery. Appropriate interventions must be provided continuously from early intervention to special long term needs.

What is rehabilitation?

The Irish Association of Rehabilitation Professionals has defined rehabilitation as: "A facilitative process involving individuals who are disadvantaged in terms of accessing life in the main stream. The rehabilitative process aims to enable individuals to access as independent a life as possible in social, cultural and economic terms which is congruent with their aspirations."¹¹

Fundamental Principles of Rehabilitation

Rehabilitation services should be based on the following fundamental principles:

1. The role of the rehabilitation services is to provide education, training, resources and supports that foster the recovery process. As a general principal, rehabilitation services should be based on a model, which serves to meet the needs of the individual in a holistic manner. This holistic approach must recognize the biological, psychological and social needs of service users.
2. Rehabilitation should serve to provide a meaningful range of occupations and lifestyles so that the person can have an acceptable quality of life.
3. Rehabilitation services should be re-integrative in the sense that they should aim to reintroduce the person back into the mainstream of society and prevent and minimise the effects of stigma arising out of illness.
4. Rehabilitation services should be consultative and user friendly in their approach, i.e. the person receiving service should have an input into the type and style of service that the person uses.
5. There is a need to avoid fragmentation of services whereby pieces of services are delivered in a sporadic and uneven manner. The desired plan would be a comprehensive and coordinated national framework for delivery of rehabilitation services.

Pillars of Rehabilitation

The four pillars of rehabilitation services arising out of the bio psychosocial model should be:

1. Adequate income and maintenance.
2. Reasonable levels of accommodation, which should be community based and supported at an appropriate level for the individual.
3. The provision of a range of meaningful training and occupational services to allow the person to enhance their occupational skills and provide a meaningful role in society.
4. The development of social integration services to ensure that issues such as social isolation, stigma and low self-esteem are addressed.

Recommendations

Re-integration

The end goal of, and therefore, the model arena for re-integration is the mainstream of society and local community. Mainstream structures and systems must be inclusive of

¹¹ Irish Association of Rehabilitation Professionals, Articles of Association (1998).

marginalized groups in terms of their design, planning, structures and processes. This should include supports directly aimed at group and individual needs.

Specialist Services

A significant number of people who have severe mental illness will continue to have ongoing difficulties throughout their life. People with enduring mental illnesses require specialised multi-disciplinary rehabilitation and habilitation interventions in order to maintain an acceptable quality of life. Social and vocational rehabilitation plays an important part in this recovery process through training and development, as well as having the potential to be a normalizing experience. SI recommends the following:

1. Service users should be recognized as key stakeholders and must be involved in the design, planning and running of services.
2. Specialist services should reflect the mainstream. The practice of providing for a range of life needs in one setting encourages institutionalisation and needs to be questioned. Interventions such as vocational training, education, work and social outlets should be separate from each other, as found in mainstream society.
3. Because the funding model currently utilized within Irish rehabilitation is based on a training model, services tend to be clustered around pre-vocational and vocational services. Furthermore, service provision is often fragmented with service providers competing for both funding and clients.
 - a. Local Health Boards should have a strategic responsibility to co-ordinate a rehabilitative response.
 - b. Funding must be made available to support the development of new and more responsive models.
 - c. For some, recovery is life long; services need to reflect the ongoing support needs of people.
 - d. Attention needs to be given to improving the interface between strands of services and to improving the interface between individual services.
 - e. A framework needs to be established to allow individuals to effectively move between services according to their needs. This is particularly relevant *vis a vis* needs identification and individual planning.

Recovery

For many, recovery is life long and may involve relapse. Issues such as stigma, social isolation and low self-esteem must be considered. This may occur in the context of treatment, support and educational courses. An improved level of public awareness is essential to long term stability and recovery—and is the responsibility of statutory, professional and voluntary organisations. SI recommends that:

1. The role and importance of peer groups and supports needs to be recognised by medical and other professionals and included as equal partners in the process of recovery.
2. Health education and management should be an integral part of all programmes and services.
3. Health education and management should be available at all stages of recovery from initial diagnosis and throughout the process.
4. Interventions should include a wide range of complementary and alternative therapies and supports, for example: peer support, drop-in and outreach services, information and advocacy services, educational programmes, family interventions,

social skills training, psycho social and vocational rehabilitation, day centre programmes and cognitive behaviour and other talking therapy.¹²

Meaningful Occupation

The occupational needs of people with self-experience vary greatly from individual to individual and will change for any one individual through the duration of his/her recovery. There is need for a range of meaningful occupational options both work based¹³ and non-work based.

Living and Accommodation

Housing is a major cause of stress amongst people with self-experience of mental illness. Of particular concern are levels of homelessness and the high cost, uncertain tenure and poor conditions found in the private rented sector. Additionally, many people with severe mental illness find themselves having to remain in the family home beyond a time that is of their choosing. Through SI's contact with service users and relatives, housing is often cited as their most serious concern. Increased provisions for accommodation is paramount along with greater flexibility to meet the current needs. SI recommends that:

1. Adequate levels of accommodation are needed which should be community based and supported at an appropriate level for the individual.
2. Supports need to include community based life skills training and development (as apposed to centre based training).
3. It should be acknowledged that some people might always require some degree of supported accommodation.
4. There is a need for a range of social housing to facilitate people who no longer require supported housing.

Advocacy

Access to a full range of advocacy services and training in self-advocacy should be available. Services may be in the form of self-advocacy, peer advocacy, professional advocacy, group advocacy and legal advocacy. Such services should be available at all stages of the treatment and recovery process. Access to advice/assistance on topics such as income support, support services, employment, new skills development and accommodation is a necessary part of the recovery process.

Specialised Rehabilitation

A small number of individuals will have ongoing difficulties in reaching independence. These individuals require more intensive specialised multidisciplinary rehabilitation interventions. Such interventions might include Cognitive Behaviour Therapy, anxiety management, confidence and self-esteem enhancement, assertiveness and personal development, vocational training, as well as general supportive psychotherapy and counselling. A range of residential rehabilitation settings should be available to supplement high quality therapeutic day rehabilitation programmes.

¹² Schizophrenia Ireland, "A Question of Choice Survey", 2002.

¹³ In general, SI supports the recommendations of the NCATE report (1997).

Support Groups and Voluntary Groups

The importance of user support groups and the voluntary agencies, which support these groups, should not be underestimated. Their roles include support, advocacy and information, education and awareness raising. Voluntary agencies and support groups are often the first point of contact for people with self experience and their relatives at critical times during the recovery process. In light of this, SI recommends that:

1. Local mental health support groups should be recognised as key stakeholders in the planning and provision of services.
2. Provision of information about the range of services offered by the voluntary sector and their potential benefits to all those effected by the onset of mental illness should be made available at the earliest possible time.
3. Reversal to local support groups should be standard practice by mental health teams.
4. Access to potential beneficiaries by support groups and agencies should be facilitated by mental health and rehabilitation teams.

5. Legislation

The government's White Paper of 1995 stated that "new legislation offered an opportunity to provide a statutory framework for the development of psychiatric services as recommended in *Planning for the Future*." The resulting Mental Health Act 2001 was, instead, a limited exercise in the most basic fulfilment of Ireland's international obligations, without specific provision for voluntary patients, rights to treatment, quality and standards of care, mental health of prisoners, homelessness and mental health or requirements for further development of services. A new mental health policy should be enshrined in comprehensive, rights-based legislation.

Recommendations relating to Mental Health Legislation

Schizophrenia Ireland recommends that:

1. Definitions of mental illness and disorder should be consistent in Irish legislation in order to ensure harmonisation of practice and implementation between governmental agencies, i.e. there should be a detailed definition of mental disorder as defined in the Mental Health Act 2001 with a provision that a person will not be considered to suffer from mental disorder merely due to evidence of eccentric or anti-social behaviour or unconventional opinions.
2. A full reform of legislation pertaining to mental illness needs to be carried out. Any new mental health policy must be enshrined in comprehensive, rights-based legislation.
3. The Criminal Law (Insanity) Bill 2002 should clearly stipulate that provisions only apply to non-violent offenders, and that provisions for violent offenders should await the creation of regional secure facilities in the health services.
4. Irish legislation should provide for the opportunity to treat a non-violent offender as an outpatient accessing services in the community.
5. The Law Reform Commission and the Mental Health Review Board, to be established under the Criminal Law (Insanity) Bill, communicate with mental health NGOs to discuss areas of serious concern.
6. Rights-based mental health legislation should be enacted to fully comply with Ireland's international human rights obligations.
7. Mental health treatments and interventions must be a legally protected right enshrined in Irish legislation.

8. With regards to Forensic Psychiatry, legislation must ensure that prisoners are entitled to the same mental health services and standards as applicable to the rest of society and that compulsory treatment must adhere to international human rights standards, of which Ireland is bound by.
9. It is SI's view that mental healthcare services for the prison population should be incorporated into the Department of Health and Children, thus ensuring compatibility with the national mental health service framework.

C. Potential Cost Implications for Recommendations

In order to help fund the preceding recommendations, it is SI's view that there are sufficient existing resources that could be utilised to help fund the enhancements necessary for mental health services. Government must make more efficient use of the lands currently tied up in some of the older mental health buildings. Any new mental health policy framework must address this issue and resolve to improve the allocation of resources. In this regard, below is an outline of a capital funding policy that SI suggests Government consider.

Funding Policy Recommendation

Financial pressures are currently putting mental health services at risk. Funding, as a proportion of the overall healthcare budget, has dropped from 10.6% in 1990 to 6.8% in 2003.¹⁴ As the funding for mental healthcare dwindles year-by-year, mental health services fall further behind in their ability to meet the needs of service users. Mental health often loses out in the competition for resources, and it is up to Government to ensure that mental health gets sufficient resources. It is imperative to acknowledge that mental illness costs society much more, if adequate services are not delivered. These social costs include lost output in the economy caused by people unable to work; human costs of reduced quality of life amongst those with a mental illness; costs of State support for those unable to work due to mental illness; and the costs for care provided by the State and relatives of those with a mental illness.¹⁵

Against this background, it is essential Government increases its investment in mental healthcare in order to provide services of a high standard, which are adequately resourced and meet the actual needs of people using the services.

It is recommended that Government implement a policy approach that a) sells off property held by some of the larger, older mental health establishments to private developers on the basis that money secured from such sales would be ring-fenced for capital funding of new community based mental healthcare services; and b) utilises government owned land banks and/or buildings for new community based housing and day facilities for people, including those with a mental illness.

This two-pronged policy approach would allow for maximum capital development in these stringent times, and addresses both the current economic constraints while providing an enhanced economic platform for much needed services.

¹⁴ Mental Health Commission Annual Report, (2002), p. 22.

¹⁵ The Sainsbury Centre for Mental Health, *Economic and Social Costs of Mental Illness*, (2003).