Original

Mental health rehabilitation services in Ireland: vision and reality

Atif Ijaz, Helen Killaspy, Frank Holloway, Fiona Keogh, Ena Lavelle

Ir J Psych Med 2011; 28(2): 69-75

Abstract

Objectives: The Irish national mental health policy document, *A Vision for Change*,[1] included recommendations to develop specialist rehabilitation mental health services. This survey was conducted as part of a multicentre study to investigate current provision of mental health rehabilitation services in Ireland and factors associated with better clinical outcomes for users of these services. The aim was to carry out a detailed national survey of specialist rehabilitation services in order to describe current service provision.

Method: A structured questionnaire was sent to consultant rehabilitation psychiatrists in all mental health catchment areas of Ireland that had any rehabilitation services to gather data on various aspects of service provision.

Results: Twenty-six of the 31 mental health areas of Ireland had some form of rehabilitation service. Sixteen teams working in 15 of these areas fulfilled *A Vision for Change*[1] criteria to be defined as specialist rehabilitation services and all 16 responded to the survey. The overall response rate was 73% (19/26). Most services lacked a full multidisciplinary team. Only one service had an assertive outreach team with acceptable fidelity to the assertive outreach model. Urban services were less well resourced than rural services.

Conclusion: This is the first national survey to describe the provision of mental health rehabilitation services in Ireland. Although there has been an increase in the provision of consultant-led specialist rehabilitation services nationally, these services lack multidisciplinary input. There also appears to be a lack of planned provision of the facilities required to provide comprehensive rehabilitation services with unequal distribution of resources between urban and rural areas. This has potential cost implications for local mental health services in relation to 'out of area treatment' placements and perhaps more importantly to the overall quality of patient care.

Key words: Rehabilitation; Recovery; Specialist services; Enduring mental illness.

***Atif Ijaz**, Clinical Research, Fellow Royal College of Surgeons in Ireland, 123 St Stephen's Green, Dublin 2 and St Ita's Hospital, Portrane, Co Dublin, Ireland.
Helen Killaspy, Senior Lecturer and Honorary Consultant in Rehabilitation Psychiatry, Royal Free and University College London Medical School and Camden and Islington NHS Foundation Trust.
Frank Holloway, Clinical Director, Croydon Integrated Adult Mental Health Services, South London and Maudsley NHS Foundation Trust.
Fiona Keogh, Research Consultant, Mental Health Commission, St Martin's House, Waterloo Road, Dublin 4, Ireland.
Ena Lavelle, Consultant in Rehabilitation Psychiatry, St Ita's Hospital, Portrane, Co Dublin, Ireland.
**Correspondence*

SUBMITTED: JUNE 29, 2009. ACCEPTED: MAY 6, 2010.

Background

Successive mental health strategies and policy documents in Ireland have recommended the development of specialist rehabilitation mental health services to meet the needs of individuals with enduring mental illness.[1-3] In Ireland rehabilitation services for this group of patients have evolved from the resettlement programmes of long-stay patients into supported community residential programmes following the closure of large psychiatric institutions. The number of inpatients in psychiatric hospitals has decreased from a total of 19,801 in 1963 to 3,314 in 2007.[4]

In parallel with this decrease in hospital beds there has been a significant rise in community based facilities. There were 942 places in community residences in1983 increasing to 3065 in 2004.[5] In Ireland community residential provision for people with enduring mental illness is provided by mental health services and staffed by nurses and care staff. Successive mental health reports also highlighted the presence of new long-stay patients (patients in hospital for more than one year and less than five years) in acute admissions units across the Ireland.[4]

The resettlement programmes associated with the downsizing and closure of large institutions had a limited vision of rehabilitation, lacked multidisciplinary input and active rehabilitation interventions[5] which would enable those individuals with enduring mental illness to progress further towards independent living. The new mental health strategy *A Vision for Change*[1] highlighted gaps within existing services including under-provision of specialist rehabilitation teams and recovery oriented clinical services, inadequate access to vocational training programmes and employment opportunities, inadequate housing and accommodation options, lack of advocacy and peer support for individuals with enduring mental illness and the significant burden of care being provided by family and other informal carers.

A Vision for Change[1] recommended the development of 39 specialist rehabilitation and recovery community mental health teams nationally, with one multidisciplinary team per 100,000 population (ie. around three per mental health catchment area). Each team was expected to have a consultant psychiatrist, team co-ordinator and practice manager. Teams were encouraged to adopt the assertive outreach approach in providing intensive community based support and interventions.[6] The recommendations also included the

https://doi.org/10.1017/S0790966700011460 Published online by Cambridge University Press

provision of adequate community resources appropriate to the needs of the client group such as community residences and vocational rehabilitation. It was recommended that 30 24-hour-staffed residences be provided in large urban areas (with a maximum of 10 beds per unit) and fewer in areas with lower deprivation levels. In addition, it was recommended that opportunities for independent housing should be provided by local authorities in order to ensure move through from these higher supported placements.

Rehabilitation and recovery services were also advised to develop local connections with statutory and voluntary service providers including employment and training agencies. One or two day centres per catchment area were also recommended, to provide individualised programmes for service users[7] who are unable to use community based employment or recreational activities.

A Vision for Change[1] also emphasised a strong commitment to the principle of recovery and the need for training in recovery oriented clinical practice for all staff working in rehabilitation and recovery services. It also recommended the development of specialist services such as psychiatry of old age and learning disability services. Finally, *A Vision for Change*[1] recommended that evaluation of rehabilitation and recovery services should incorporate quality of life measures and assess the benefit of these services to service users and their families.

This survey was carried out as the first phase of a multi-centre study to investigate specialist mental health rehabilitation service provision in Ireland, characteristics of service users and outcomes for those with and without access to these services.

Method

The survey was conducted between January and March 2008. AI and EL identified 26 of the 31 mental health catchment areas of the Health Service Executive (the national body for health service provision in Ireland) where mental health rehabilitation services existed in some form.[4] A 23 item questionnaire was developed by the authors (available on request) and sent to the consultant psychiatrist responsible for each mental health rehabilitation service. The questionnaire collected information about service structures, staffing, case load, referral process, remit of the service and access to other services. Definitions were provided to categorise hospital and community based facilities as described in *Table 1*. The questionnaire was mailed or emailed and non-responders received a telephone reminder to complete the questionnaire.

Statistical analysis

Data were entered into the statistical software package SPSS v. 12.[8] Descriptive statistics were used to describe service characteristics.

Results

Response

Of the 26 mental health areas that had a rehabilitation service, 15 fulfilled the *A Vision for Change*[1] criteria for specialist mental health rehabilitation services. All 15 had dedicated rehabilitation teams and a consultant psychiatrist who was the clinical leader. One area had two specialist rehabilitation teams (Dublin North West). All 16 specialist teams responded to the survey. Of the remaining 11 mental health areas, completed questionnaires were received from four, giving an overall response rate of 73% (19/26). Three of these four areas regarded their service as providing rehabilitation, despite the fact that they were not led by a full time consultant psychiatrist. These are referred to as 'non-specialist' services. The remaining service was a general adult service that provided some rehabilitation interventions and due to its major deviation from the usual configuration of rehabilitation services, it was excluded from the results.

Table 1: Definitions of hospital and community based facilities

Hospital based facilities

- Intensive rehabilitation units: Dedicated inpatient units with mental health rehabilitation service input
- Long stay units: Dedicated inpatient units for 'old long stay' patients (inpatients for over five years) with mental health rehabilitation service input
- Low secure units: Dedicated inpatient units that deliver intensive, multidisciplinary treatment and rehabilitation for patients who present with a serious behavioural disturbance in the context of mental disorder

Community based facilities

- High Support Hostel: Community based unit with 24 hour nursing care on site with mental health rehabilitation service input
- Medium support Hostel: Community based unit with 12 hour nursing care on site and 24 hour care staff availability/on call with mental health rehabilitation service input
- Low Support Hostel: Community based unit with 12 hour care staff availability and visiting nursing staff with mental health rehabilitation service input
- Group home: Community based unit with visiting nursing staff support only and mental health rehabilitation service input

Table 2: Role of mental health rehabilitation services

Role of rehabilitation mental health service	N = 13
Service for individuals with severe and enduring mental illness and complex needs	6
Recovery oriented/based service	5
Increase biopsychosocial functioning and fulfil intellectual needs	4
Maximise functioning of clients	4
Co-ordination of vocational rehabilitation inputs	4
Management of complex cases and treatment resistance	2
Resettle long-stay patients/rehabilitation patients/accommodation needs	4
Provide care in least restrictive environment	1
Client centred care plan	1
Share care with clients	1
Advice on out of area treatments	1

Role of the specialist rehabilitation mental health service

Respondents were asked what they felt the main role/s were for rehabilitation services. Responses were received

https://doi.org/10.1017/S0790966700011460 Published online by Cambridge University Press

Table 3: Population and bed provision for rehabilitation mental health services

Service name	Catchment area pop.	Type of pop.	Intensive rehab unit beds	Long stay beds	Low secure beds	High support hostel beds	Medium support hostel beds	Low support hostel beds	Group home beds	Total rehab-	Rehab beds per 10,000 pop
Specialist services (urban)											
Dublin North A7	143,333	Urban	19	0	0	16	0	0	0	35	2.44
Dublin North West A6	185,000	Urban									9.56
Team 1			0	0	0	61	32	10	0	103	
Team 2 (SBH)			0	0	32†	67	0	7	0	74	
Dublin South and South West A4/5	260,000	Urban	22	0	0	43	20	15	31	100	3.84
North Co Dublin A8	240,000	Urban	30	0	0	31	42	8	0	111	4.63
Total	828,333		71	0	32†	218	94	40	31	423	5.1
Specialist services (rural)											
Cavan/Monaghan MHS	107,951	Rural	0	0	0	58	0	0	42	58	5.37
Mayo MHS	129,000	Rural	10	40	10††	6	0	0	15	66	5.12
Kerry MHS	140,000	Rural	0	22	20††	34	0	0	46	76	5.43
North Cork MHS	83,000	Rural	21	30	0	42	4	0	28	97	11.69
Sligo/Leitrim MHS	93,000	Rural	0	0	10†	19	0	0	4	19	2.04
Total	552,951		31	92	10†, 30††	159	4	0	135	316	5.7
Specialist services (mixed)											
Waterford MHS	125,000	Mixed	40	68	0	27	0	0	44	135	10.8
Wexford MHS	131,615	Mixed	15	30	0	0	15	25	0	85	6.46
Limerick MHS	183,863	Mixed	21	0	0	74	29	16	0	140	7.61
Clare MHS	110,800	Mixed	8	10	0	57	0	29	15	104	9.39
Donegal MHS	139,432	Mixed	0	21	0	20	0	0	30	41	2.94
Laois/Offaly MHS	137,927	Mixed	0	29	0	31	8	43	9	111	8.05
Total	828,637		84	158	0	209	52	113	98	616	7.4
Non-specialist services (rural)											
South Tipperary MHS	84,000	Rural	22	60	0	10	0	0	0	92	10.95
East Galway MHS	110,000	Rural	0	16	0	16	0	0	4	32	2.90
Total	194,000		22	76	0	26	0	0	4	124	6.4
Non-specialist services (mixed)											
Kildare West MHS	205,000	Mixed	0	0	0	26	0	0	17	26	1.26

* Total number of rehabilitation beds includes all hospital and community units as described in Table 1 except group homes and low secure units not under clinical responsibility of Rehabilitation team. SBH = St Brendan's hospital. MHS = Mental health service. †† = Low secure beds under clinical responsibility of rehabilitation team. † = Low secure beds with rehabilitation team access.

from 11 specialist and two non-specialist services and grouped into similar themes *(see Table 2)*.

Population size and context

Table 3 shows the population and bed provision in each service. The mean population for the catchment areas of the fifteen specialist rehabilitation mental health services was 147,328 (range 83,000-260,000). Four services (26%) were urban (Dublin South and South West, Dublin North West, Dublin North and North Co Dublin), five (33%) were rural (Kerry, North Cork, Sligo/Leitrim, Cavan/Monaghan and Mayo) and six (40%) covered both urban and rural areas (Clare, Donegal, Laois/Offaly, Limerick, Waterford and Wexford). The urban services had a mean population of 207,000 (range 143,000-260,000), the rural services had a mean population of 110,000 (range 83,000-140,000) and the mixed urban and rural services had a mean population of 138,106 (range 110,800-183,863).

All the specialist mental health rehabilitation services had one team except Dublin North West where there were two (total 16 teams in 15 specialist mental health rehabilitation services). Nine (56%) teams were community and hospital based, five (31%) were solely community based and two (13%) solely hospital based. Six teams had access to acute beds in a psychiatric hospital and the remaining 10 had access to acute beds in a psychiatric unit in a general hospital.

The three non-specialist mental health rehabilitation services were: Kildare West (mixed) rural and urban population of 205,000); South Tipperary (rural population of 84,000) and East Galway (rural population of 110,000). All three non-specialist mental health rehabilitation services had one rehabilitation team each. The East Galway team had access to acute beds in psychiatric hospitals whilst the other two teams accessed acute beds in the psychiatric units of their local general hospitals.

https://doi.org/10.1017/S0790966700011460 Published online by Cambridge University Press

Table 4: Core staffing of mental health rehabilitation services (excluding number of community nurses)

Service name	CON	SR	SHO	CC	CNS	ADN	P	SW	OT	AT	CS	Total staff*
Specialist services (urban)												
Dublin North A7	1 wte	0	1 wte	0	0	0	S	S	1 wte	0	S	4.5 wte
Dublin North West A6												
Team 1	1 wte	0	0	S	0	S	0	0	0	0	0	2 wte
Team 2 (SBH)	1 wte	0	2 wte	0	0	1 wte	0	1 wte	1.5 wte	0	0	6.5 wte
Dublin South and South West A4/5	1 wte	0	1 wte	0	0	1.5 wte	0	1 wte	1 wte	0	0	5.5 wte
North Co Dublin A8	1 wte	1wte	1 wte	0	0	1wte	0	1 wte	1 wte	0	1 wte	7 wte
Specialist services (rural)												
Cavan/Monaghan MHS	1 wte	1wte	1 wte	1 wte	12 wte	NK	0	1 wte	1 wte	1 wte (CBT)	1 wte	20 wte
Mayo MHS	1 wte	0	1 wte	S	0	S	0	S	S	1 wte (Art)	S	5.5 wte
Kerry MHS	1 wte	1wte	0	0	0	0.5 wte	0	1 pt	0	0	1 wte	4 wte
NorthCork MHS	1 wte	0	1 wte	0	0	0	0	0	1 wte	0	1 wte	4 wte
Sligo/Leitrim MHS	1 wte	0	1 wte	1 wte	0	1 wt	0	1 wte	1 wte	0	1 wte	7 wte
Specialist services (mixed)												
Waterford MHS	1 wte	0	1 wte	0	1 wte	S	0	1 wte	0	0	1 wte	5.5 wte
Wexford MHS	1 wte	1wte	1 wte	0	0	0.8 wte	1pt	1 wte	1 pt	0	1 pt	6.3 wte
Limerick MHS	1 wte	0	1 wte	0	0	1 wte	0	0	1 wte	0	1 wte	5 wte
Clare MHS	1 wte	0	1 wte	0	0	1 wte	1 wte	0.8 wte	0	0	1 wte	5.8 wte
Donegal MHS	1 wte	0	1 wte	1 wte	0	0	S	1 wte	1 wte	0	1 wte	6.5 wte
Laois/Offaly MHS	1 wte	0	0.5 wte	1 pt	0	0	0	0	0	1 wte (Art)	1 pt	3.5 wte
Non-specialist services (rural)												
South Tipperary MHS	0.5wte	0	1 wte	0	0	S	S	0	1 wte	0	1 pt	4 wte
East Galway MHS	S	0	1 wte	0	0	0.5 wte	0	1 wte	S	0	1 pt	4 wte
Non-specialist services (mixed)												
Kildare West MHS	S	1wte	1 wte	0	0	0	0	S	0	S	0	3.5 wte

CON = Consultant Psychiatrist; SR = Senior Registrar; SHO = Senior House Officer/Registrar; CC = Clinical Co-ordinator; CNS = Clinical Nurse Specialist; ADN = Assistant Director Of Nursing; P = Clinical Psychologist; SW = Social Worker; OT = Occupational Therapist; AT = Other Allied therapist; Art = Art therapist; CBT = Cognitive behavioural therapist; CS = Clerical Staff
wte = Whole time; pt = Part time; S = Sessional input; NK = Not known. SBH = St Brendan's Hospital; MHS = Mental health service.
* Total staff wte is approximate as community nurses are not shown (data not available) and S and pt staff were estimated at 0.5 wte each

Inpatient and community rehabilitation beds

The total number of rehabilitation beds per service was calculated by adding hospital based rehabilitation, ie. non-acute beds including intensive rehabilitation, long stay, low secure beds and community rehabilitation beds including high, medium and low support hostel beds excluding group homes. The number of hospital and community based beds available in each service is shown in *Table 3*. The mean number of beds per 10,000 total population in the specialist mental health rehabilitation services was 4.1 for urban services, 6.4 for rural services and 7.0 for mixed urban/rural services. For non-specialist rehabilitation services the corresponding numbers were 6.9 for rural services and 1.3 for mixed urban/rural services. There were no statistically significant differences in total bed numbers per 10,000 population between urban, rural or mixed urban/rural services.

Nine of the 16 specialist rehabilitation services (56%) reported the availability of intensive rehabilitation inpatient beds (mean 21, range 8-40) which were available to two of the five specialist rural services and three of the five specialist urban services. Eight (50%) specialist rehabilitation services (three rural and five mixed) reported the availability of long stay beds (mean 31, range 10-68). Two specialist rehabilitation services (both rural) had low secure units under their clinical responsibility and two specialist rehabilitation teams (one rural one urban) had access to beds in a local low secure unit, not under their clinical responsibility (mean beds 18, range 10-32).

Amongst the non-specialist services, intensive inpatient rehabilitation beds were available only in South Tipperary (22 beds). Long stay beds were available in South Tipperary (60 beds) and East Galway (16 beds). None of the three non-specialist rehabilitation services had access to local low secure unit beds.

https://doi.org/10.1017/S0790966700011460 Published online by Cambridge University Press

Community based rehabilitation beds

Fourteen of the 16 specialist rehabilitation services had high support hostel beds (mean 41, range 6-128); seven had medium support hostel beds (mean 21, range 4-42); seven had low support hostel beds (mean 21,range 8-43); and 10 had group home beds (mean 26, range 4-46).

All three non-specialist services had high support hostel beds (mean 17, range 10-26). There were no medium or low support hostel beds under the clinical responsibility of the three non-specialist services.

Staffing

Table 4 shows the full time equivalents of core multidisciplinary team staff in each service. It was not possible to gain accurate numbers of community nurses as many worked across services and these are therefore not included in *Table 4*. Gaps in multidisciplinary provision were common: 73% of specialist services had no specialist registrar or clinical psychologist, 86% lacked a clinical nurse specialist, 35% lacked an assistant director of nursing, 40% lacked a full time occupational therapist, 26% had no social worker, 13% lacked a full time SHO/registrar and 13% lacked a clerical officer.

Non-specialist services had even fewer staff. Though all three services had medical input, only one had a consultant psychiatrist (0.5 WTE), only one had an occupational therapist and only one had a social worker.

Outreach services

Nine specialist teams reported that they had a partially dedicated community rehabilitation team where staff (usually nurses) worked across or rotated between provision of an outreach community service supporting people living in their own homes or group homes, with on site care in the community residential facilities. Seven teams did not provide an outreach function, occasionally seeking help from the local mental health services for outreach work. Only one team reported a functioning assertive outreach team.

Of the nine specialist rehabilitation mental health teams where there was a community element to the service, five responded to the question "What is the role of your community rehabilitation team component?" The responses are shown in *Table 5.*

None of the three non-specialist services reported that they had a community rehabilitation team/service component.

Case load and referrals:

The mean case load for the 16 specialist rehabilitation services was 127 (range 30-220) and the mean referral rate per annum (last 12 months) was 31 (range 5-102). The mean case load for urban specialist services was 103 (range 30-170) and the annual referral rate was 26 (range 5-48). For mixed urban/rural specialist services the mean case load was 150 (range 93-220) and the annual referral rate was 37 (range 10-102). For rural services the mean case load was 106 (range 38-160) and the annual referral rate was 21 (range 12-30) (*see Table 4*). Two of the urban specialist services also commented that due to increasing demand and resource shortages they were providing rehabilitation interventions while patients were still under the clinical responsibility of sector teams. For the non-specialist services the mean case load was 54 and the mean referral rate per annum (last 12 months) was 17. The breakdown of caseloads in terms of inpatients and community patients per team is shown in *Table 6*.

Table 5: Role of the community rehabilitation service

- "Community rehabilitation team component includes AST. It covers medium and long stay patients and people in independent accommodation, day centres and hostels."
- "Provide outreach support for all community dwelling service users. Key workers are assigned for the people living in medium support residences, group homes and people in independent living."
- "To coordinate and provide optimal psychiatric care and support to those clients who can survive outside the hospital."
- "Nursing care for patients in the community residences."
- "Assertive outreach team aims to avoid admissions where possible and to access relevant supports with statutory and voluntary sectors"

New long-stay patients

Fourteen (88%) specialist and all non-specialist services reported the presence of new long-stay patients (length of stay of over one year) in their local acute admission units. A mean of 3.4 new long-stay patients per annum (range 1-10) were reported by the specialist services and 3.1 (range 2-5) by the non-specialist services over the previous five years.

Other specialist mental health services

Eight (50%) of the 16 specialist rehabilitation services reported that the other specialist mental health services recommended by *A Vision for Change*[1] (older people's services and services for those with intellectual disability) were available locally. This was the case for two of the five urban and three of the five rural specialist rehabilitation services. A further six specialist rehabilitation services reported that either older people's or intellectual disability services were available locally. Of the three non-specialist rehabilitation services only one reported an additional specialist service locally (older people's service).

Structured day time activities and employment

Ten (63%) of the 16 specialist rehabilitation services reported that they had at least one day centre within their service. Three (19%) services reported access to day centres run by other mental health services and three (19%) reported no access to day centres. All specialist rehabilitation services reported some access to local vocational training organisations with a mean of two different organisations locally. The most common were the National Learning Network and EVE Ltd.

Of the three non-specialist services, none had a day centre within their service but all reported access to local vocational training organisations.

Discussion

This survey describes current provision of mental health rehabilitation services in Ireland. We achieved a good response rate with full response from all specialist

https://doi.org/10.1017/S0790966700011460 Published online by Cambridge University Press

Table 6: Case loads and referral rates of different rehabilitation services

Service name	Overall Case load	Referral rate per annum	No. of inpatients	No. of patients in supported residences	No of patients living independently
Specialist services (urban)					
Dublin North A7	51	48	19	32	0
Dublin North West A6					
Team 1	30	8	27	3	0
Team 2 (SBH)	109	5	15	74	20
Dublin south and southwest A4/5	153	42	22	78	53
North Co Dublin A8	170	25	30	80	60
Specialist services (rural)					
Cavan/Monaghan MHS	170	24	-	-	-
Mayo MHS	150	50	60	50	40
Kerry MHS	120	-	42	78	0
NorthCork MHS	160	12	54	55	51
Sligo/Leitrim MHS	38	30	1	17	20
Specialist services (mixed)					
Waterford MHS	121	40	32	27	62
Wexford MHS	140	10	45	40	55
Limerick MHS	220	102	19	119	82
Clare MHS	163	25	18	80	65
Donegal MHS	93	35	22	51	20
Laois/Offaly MHS	140	10	5	27	108
Non-specialist services (rural)					
South Tipperary MHS	90	12	80	10	0
East Galway MHS	36	17	16	20	0
Non-specialist service(s) (mixed)					
Kildare west MHS	36	-	1	26	9

- = breakdown not provided SBH = St Brendan's hospital; MHS=Mental health service

rehabilitation services and with around half the non-specialist services responding. Given the self-complete nature of the questionnaire, it is possible that responses could have been subject to inaccuracies in recall or local knowledge and no corroboration was attempted. New services that have been implemented since the survey were obviously not included and existing services may have changed since the data was collected. However the results provide the first overview of mental health rehabilitation service provision in Ireland.

The survey indicates that since 2006[1] there has been an increase in the number of consultant led rehabilitation mental health teams from five to 16. However there are still fewer than the 39 recommended in the *A Vision for Change* strategy.[1] Ten of the 16 specialist services are serving a population greater than the 100,000 recommended, two of these being within urban areas.

All services were understaffed compared with the *A Vision for Change* guidelines, and lacking multidisciplinary input, although it should be borne in mind that it was difficult to accurately determine the number of community nursing staff. Many services lacked a psychologist and few services had a specialist training post for junior doctors wishing to pursue a career in rehabilitation psychiatry.

There was a noticeable lack of consensus about the role and function of the community rehabilitation component of the service and only one appeared to be operating in the assertive outreach style as recommended by *A Vision for Change*.[1]

An ideal assertive outreach team provides individualised focused and proactive care to service users to minimise the risk of disengagement and to maximise involvement in recovery process. Each member of assertive outreach team is key contact for an optimal number of 10-12 service users.[1] If the case load for individual members of community rehabilitation team increases beyond the optimal number, the team can not be expected to function in an assertive outreach style rather they just provide outreach work.

The case loads, referral rates and proportion of inpatient and community based patients give an indication of the demands on rehabilitation services. Although no data on caseload 'weighting' (in terms of morbidity or need) was collected, there appeared to be considerable variability in caseloads and referral rates between services.

Some services, particularly in urban areas, reported that due to resource shortages they were providing rehabilitation interventions to 'wait listed' patients, while they were under

https://doi.org/10.1017/S0790966700011460 Published online by Cambridge University Press

the clinical responsibility of sector teams an arrangement similar to shared care model recommended by *A Vision for Change*. The presence of new long-stay patients in the local acute units was noted by most services and may reflect a shortage of more appropriate alternative community accommodation, specialist community mental health services as well as rehabilitation services. This finding is in keeping with that of the "We have no beds…" report[17] that found 45% of acute beds were occupied by non-acute patients.

The majority of rehabilitation services reported a lack of development of other specialist mental health services such as mental health teams for older people and mental health teams for intellectual disability. This could potentially mean that rehabilitation services have to extend their resources to provide for these groups of clients and lack the necessary expertise to do so. However we note that our survey did not explore whether this was in fact the case.

Almost all rehabilitation services reported the availability of inpatient and community beds, but 40% of specialist and 75% of non-specialist rehabilitation services lacked short term inpatient rehabilitation beds for assessment and initial interventions: this can be compared with the UK where 77% of services had such facilities.[9]

Most services lacked access to low secure beds. It has been suggested that providing adequate local low secure services prevents reliance on medium and high security services by providing early intervention for challenging behaviours.[10] Moreover, most patients needing medium or high security come from urban populations.[11,12] Low secure beds were available in three rural areas but only one urban area. There therefore appears to be a lack of strategic organisation of inpatient and secure inpatient facilities to meet local need.

A Vision for Change[1] recommended a decrease in the number of supported community residences in parallel with increases in well developed multidisciplinary community mental health teams for outreach support. Our results suggest that community mental health and outreach services are underdeveloped and there is excess reliance on supported community residences.

Conclusion

In summary, although successive mental health strategies have recommended a broad range of new mental health rehabilitation service provision, these do not appear to have been adequately implemented. In keeping with previous reports, there continues to be variable provision, unrelated to the needs of the local population.[9,13-18] The need for rehabilitation services is not only based on the geographical area but also on the other factors such as deprivation index[19] and that schizophrenia prevalence is higher in urban areas.[20-22]

The quality and context of care and resources in mental health catchment areas will also impact on referral rates to rehabilitation team. Although information on sector team resources was not collected in this survey, in many services the referring team is still better resourced than the rehabilitation team. This is particularly worrying if the client groups referred are those who manifest the most severe illness and have the greatest needs in a service. All this needs to be taken in to consideration for planning and development of current and new services in future.

Declaration of interest: This study was funded by Mental Health Commission Research Scholarship 2007.

Acknowledgements

We also wish to thank all the services who provided valuable information by responding to the questionnaire.

References
1. A Vision for Change. Dublin: Report of the Expert Group on Mental Health Policy, 2006.
2. Department of Health. Planning for the Future. Report of a Study Group on the Development of the Psychiatric Service. Dublin, Ireland: Department of Health, 1984.
3. OP64. How to set up rehabilitation and recovery services in Ireland. Occasional paper by The Irish College of Psychiatrists, 2007.
4. Mental Health Commission Annual report including the report of the inspector of mental health services. Dublin, Ireland: Mental Health Commission, 2007: 81, 82, 85.
5. Tedstone D, Walsh D, Moran R. Mental Health Commission. Happy Living Here…A Survey and Evaluation of Community Residential Mental Health Services in Ireland. Ireland: Health Research Board, 2007: 129 10.9.
6. Teague GB, Bond GR, Drake RE. Program fidelity in assertive community treatment: development and use of a measure. Am J Orthopsychiatry 1998; 68: 216-232.
7. Walsh D, Moran R. Psychiatric Day Care – An underused option? The purposes and functions of psychiatric day hospitals and day centres: A study in two health boards. 2003.
8. Norusis M. SPSS for Windows version12.0.1 (11 November 2003). Chicago: SPSS Inc. 2004.
9. Killaspy H, Harden C, Holloway F, King M. What do mental health rehabilitation services do and what are they for? A national survey in England. J Mental Health. 2005: 14; 157-166.
10. O'Grady J. The complimentary role of regional and local secure provision for psychiatric patients. Health Trends 1990; 22: 14-16.
11. Bacik I, Kelly A, O'Connell M, Sinclair H. Crime and Poverty in Dublin: an analysis of the association between community deprivation, District Court appearance and sentence severity. Dublin: Round Hall Press, 2000.
12 O'Neill C, Sinclair H, Kelly A, Kennedy HG. Interaction of forensic and general psychiatric services in Ireland: learning the lessons or repeating the mistakes? Ir J Psych Med 2002; 19(2): 48-54.
13. Mental Health Commission. Annual report including the report of the inspector of mental health services. Ireland: Mental Health Commission, 2004: 113-115, 134.
14. Mental Health Commission. Annual report including the report of the inspector of mental health services. Ireland: Mental Health Commission, 2005: 5, 56-60, 62.
15. Mental Health Commission. Annual report including the report of the inspector of mental health services. Ireland: Mental Health Commission, 2006: 82, 84, 86.
16. Mental Health Commission. Annual report including the report of the inspector of mental health services. Ireland: Mental Health Commission, 2007: 81, 82, 85.
17. Keogh F, Roche A, Walsh D. "We have no beds..". An enquiry in to the availability and use of acute psychiatric beds in eastern health board. Ireland: Health Research Board, 1999.
18. O'Keane V, Walsh D, Barry S. The Black Hole. The Irish Psychiatric Association Report on the funding allocation to the adult mental health services: where is it actually going. Ireland: Irish Psychiatric Association, 2003.
19. www.sahru.tcd.ie
20. Kelly BD, O'Callaghan E, Waddington JL, et al. Schizophrenia and the city: A review of literature and prospective study of psychosis and urbanicity in Ireland. Schiz Res 2010; 116: 75-89.
21. Krabbendam L, van Os J. Schizophrenia and urbanicity: a major environmental influence – conditional on genetic risk. Schiz Bull 2005; 31: 795-799.
22. Marcelis M, Takei N, van Os J. Urbanisation and risk for schizophrenia: does the effect operate before or around the time of illness onset? Psychol Med 1999; 29: 1197-1203.