Executive Summary

Despite the many developments in mental health treatments and investment in community-based services over the past few decades, some people continue to present with particularly complex problems that require longer-term care.

The majority of people with severe and enduring mental illness are unemployed, have poor education levels, impaired social skills and limited contacts. Many people with serious mental illness also experience poor physical health. The high and continuing levels of burden associated with serious mental illness have prompted mental health professionals, service users and carers to call for widespread systemic change to the way mental health services are delivered, promoting an increased emphasis on shared decision-making, financial, residential and personal independence, and social connectedness.

While psychopharmacological treatments for people with mental illness have improved and are considered fundamental to managing illness, their role in the restoration of skills which are considered essential for a satisfying and fulfilling life, is at best limited.

Disorders such as schizophrenia were historically viewed as chronic, degenerative illnesses, with little prospect of improvement or recovery. The service user movement challenged these negative and pessimistic notions of serious mental illness, with recovery perspectives bringing a new sense of meaning and purpose to individuals’ lives, even though symptoms might remain. It is now generally accepted that improved mental health outcomes can be achieved through access to a range of psychosocial, evidence-based interventions.

Early access to rehabilitation interventions has been associated with better functional outcomes. Making rehabilitation available across the continuum of care may reduce health costs by shortening hospital admissions, reducing activity limitations and improving quality of life.

It is disappointing, therefore, to observe the continued lack of development of mental health rehabilitation services in Ireland. While national mental health policy, A Vision for Change (2006) recommended a total of 48 rehabilitation teams (based on current population), we have only 23 very poorly staffed teams. Our only specialist rehabilitation inpatient units are privately provided, with the HSE funding beds providing an out-of-area service, a practice which has been strongly criticised internationally. We have over 1,000 people in highly supervised residences with little or no prospect of moving to more independent living due to lack of both adequately resourced rehabilitation teams and suitable accommodation. We have a large cohort of people in continuing care inpatient units who could live in more independent accommodation but do not have access to rehabilitation and recovery focused care to enable them to do so. We have people trapped in the acute system of inpatient mental health care because the services are not in place for them to be discharged.

Finally, we have an unknown number of people with enduring mental illness living with families or on their own who require rehabilitation services to maximise their potential to live satisfying lives in their own communities.

The frustration of rehabilitation staff and people with enduring mental illness at the lack of progress was evident across the country. Rehabilitation staff, without exception, were dedicated, creative and hard-working, using interagency collaboration and accessing community resources to provide a recovery orientated service for people who used the service. However, to provide a rehabilitation service there must be adequate supported housing with varying levels of support, an adequate number of rehabilitation teams to provide the service, adequate number of suitably trained staff, and funded evidenced-based therapeutic programmes. To date, these have not been provided to an acceptable level.

There have been some developments, jointly funded by philanthropic organisations and the HSE, which are recovery orientated. These include housing and employment support staff and peer workers. Advancing Recovery Ireland (ARI) provides training, education, and information for staff, family and carers in Recovery.

A Model of Care for the provision of rehabilitation services was launched in September 2019. This is a development in a service that has been grossly under-resourced, and where provision of care-pathways has been mostly absent. It will be imperative that funding is made available to implement this, and that there is prioritisation of providing care pathways for people with severe and enduring mental illness, rather than simply providing highly supported residential care.
What are mental health rehabilitation services?

NHS England has defined rehabilitation as a personalised, interactive and collaborative process which aims to enable a person to maximise their potential to live a full and active life within their family, community, and education or workplace as appropriate. It has also been defined by the UK’s National Institute for Health and Care Excellence (NICE) as an active process to restore or optimise physical, mental and social capability and full autonomy and prevent avoidable functional regression. The rehabilitation process has short, medium and long-term goals. In mental health rehabilitation, there is also an emphasis on the ‘whole system approach’. This includes inpatient and community components, and supports individuals to progress in their recovery by encouraging their skills, functioning and autonomy, providing them hope for the future, and leading to successful community living and social inclusion.

A definition of rehabilitation, based on the findings of a national survey of rehabilitation services in England undertaken in 2004, is as follows:

A whole systems approach to recovery from mental illness that maximizes 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 leads to successful community living through appropriate support.

Despite its continuing relevance, ‘rehabilitation’ is an unfashionable term within mental health services, where the dominant paradigm is the throughput of individuals along a time-limited care pathway. This stems partly from the mistaken belief that the task of rehabilitation services was completed when the large mental hospitals closed, and partly from the phenomenon of ‘out of sight, out of mind’ in which people with continuing needs are placed out of area or in residential care, or simply ignored.

Unlike physical medicine, where recovery goals are generally well understood, the role and significance of rehabilitation for people with serious mental illness has been less well understood. The term recovery is clearly multi-layered but it carries an unequivocal message of a better outcome, conveying a sense of hope and expectations in regard to interventions, timeframes and supports. It is based on the view that recovery is possible even though residual limitations may remain. The aim is to promote personal recovery ‘whilst accepting and accounting for continuing difficulty and disability’ and promoting “therapeutic optimism”. These principles are integral to the recovery orientation of services that aim to provide person centred, collaborative care with service users as partners.

---

7 NICE guideline: Rehabilitation in adults with severe and enduring mental illness draft scope for consultation 2018
The Integrated Recovery Model (below) outlines one way of considering how rehabilitation services assist a person with enduring serious mental illness on their individual journey to recovery.10

Who requires rehabilitation mental health services?

People who require mental health rehabilitation represent a relatively small proportion of people in receipt of mental healthcare; it is estimated that around 14% of people newly diagnosed with psychosis will develop the kinds of complex problems that will require rehabilitation services.\(^\text{11}\) As they usually require lengthy inpatient admissions and more intensively supported accommodation on discharge, they absorb 25-50% of the mental health budget.\(^\text{12}\)

Despite the many developments in mental health treatments and investment in community-based services over the past few decades, some people continue to present with particularly complex problems. These difficulties can have a severe impact on the person’s day-to-day function and often make it impossible for them to be discharged from acute mental health inpatient care back to the community. Complex problems can include:

- Treatment-resistant ‘positive’ symptoms (delusions and hallucinations) and ‘negative’ symptoms (loss of motivation and apathy).
- Specific cognitive impairments that negatively affect the person’s organisational, executive and social skills.
- Additional conditions co-occurring with primary mental illness, including other mental health problems, such as anxiety and depression.
- Co-existing problems such as substance misuse.
- Pre-existing conditions such as mild learning disability, Asperger’s syndrome.
- Physical health problems, such as diabetes, and cardiovascular and pulmonary conditions as a result of a combination of lack of exercise and inactivity, poor diet, smoking, and the side-effects of psychotropic medication.
- Lack of family and social support.
- Homelessness or lack of appropriate accommodation.
- Interruption of education and training.
- Inability to continue occupation/career due to mental illness.

---

How should mental health rehabilitation be delivered?

Rehabilitation for people with severe and enduring mental illness should be provided in an integrated care pathway that includes inpatient and community rehabilitation services. Ongoing support to enable further recovery after discharge should be provided by specialist mental health supported accommodation services, with clinical input from community rehabilitation teams and an emphasis on social inclusion.

**Figure 1 Components of a "whole system" rehabilitation care pathway**

From: The Joint Commissioning Panel for Mental Health. Guidance for Commissioners for Rehabilitation Services for people with complex mental health needs. Updated 2016
The Joint Commissioning Panel for Mental Health (JCPMH), co-chaired by the Royal College of Psychiatrists and the Royal College of General Practitioners, provides specific guidance for commissioners of rehabilitation services for people with complex mental health needs. It outlines key issues in planning mental health rehabilitation services:

1. Identifying people with complex psychosis who are likely to benefit most from referral to rehabilitation services.
2. Identifying barriers for people with complex psychosis in accessing rehabilitation services, including co-existing medical, social (including family, cultural and ethnicity), communication, neurodevelopmental, cognitive or mental health problems.
3. Organisation, function and structure of services, including inpatient and community-based rehabilitation units and teams.
4. The required components of an effective rehabilitation pathway.
5. The barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent, and voluntary services).
6. Delivering optimised treatments for people with complex psychosis to help recovery and prevent relapse.
7. Types of supported accommodation and housing required.
8. The best way of facilitating collaborative care planning between people with complex psychosis, practitioners and providers, ensuring interventions are valued by people with complex psychosis and valued by their families.
9. Transition from rehabilitation services to other parts of the mental health system or discharge to primary care.

Helping and enabling people with persistent and serious mental illness to live a normal life in the community shifts focus from an illness model towards a model of functional disability. Therefore, other outcome measures become relevant, in addition to clinical outcomes. In particular, social role functioning – including social relationships, work and leisure, as well as quality of life and family burden – is of major importance for individuals with enduring mental illness living in the community. There are therapeutic programmes that specifically address both functional and clinical challenges for people with severe mental illness.

**Therapeutic programmes specific to rehabilitation include:**

- Self-care.
- Life skills, for example cooking, cleaning, shopping, budgeting, maintaining accommodation tenancy.
- Cognitive Remediation.
- Creative Arts Therapy.
- Cognitive Behavioural Therapy for Psychosis.
- Relapse prevention.
- Social skills.
- Vocational rehabilitation (including leisure, education and work).
- Healthy living (including diet, exercise, oral health, health monitoring and accessing health services, and cessation programmes for smoking and alcohol/drugs).
The main short-, medium- and long-term outcomes that may be considered when assessing outcomes are:

- Social functioning.
- Activities of daily living.
- Successful discharge from inpatient rehabilitation unit to community.
- Independent or successful community living.
- Gaining or maintaining employment.
- Participation in education and training.
- Service user experience.
- Carer experience.
Consequences of lack of investment in mental health rehabilitation services

The long-term neglect of people with severe and enduring mental illness has negative outcomes for the service user and their families. It also has a financial cost to the health services and society as a whole. Funding is diverted to providing long-term care in highly staffed, costly residential care instead of in therapy, training and support for people living in their own homes.

Some other consequences of not investing in mental health rehabilitation include:

- People with complex needs become stuck on acute admission wards (delayed discharges).
- Increased use of local low secure units.
- Increased use of out of area placements – the “virtual asylum”:  
  - Forensic beds.
  - Private hospital beds ("locked rehabilitation"/low secure).
  - Nursing/residential care beds.
  - More expensive, poor rehabilitative culture, social dislocation.
- Increased use of private beds for acute patients and people with complex mental health needs.
- Supported housing pathway becomes blocked with no progression to more independent living.
- Clinical iceberg in community of people with negative symptoms and treatment resistant symptoms.\(^\text{13}\)

---

Mental Health Rehabilitation services in Ireland

The Irish government’s mental health policy, *A Vision for Change*, included the development of specialist rehabilitation and recovery mental health services. Historically, rehabilitation mental health services in Ireland had been associated with ‘resettlement programmes’ for long-stay patients with enduring mental illness who resided in psychiatric institutions. These programmes sought to resettle individuals in supported community residential homes but lacked an emphasis on active rehabilitation. This has resulted in a large cohort of people with enduring mental illness who did not receive appropriate rehabilitation and who are destined to remain in highly supported institutional type care, either in inpatient units or in supervised residences in the community; in the community but not part of it. In addition, around 14% of people newly diagnosed with psychosis will develop the kinds of complex problems that will require rehabilitation services.

A national survey of mental health rehabilitation services in Ireland was carried out in 2008 and found the number of consultant led rehabilitation and recovery mental health teams had increased from five to sixteen since 2006. This fell far short of what was recommended in the *A Vision for Change* policy. The survey also found that all mental health rehabilitation services were under-resourced in terms of multi-disciplinary input. Community rehabilitation teams were not found to be operating with the recommended “assertive outreach” model, either because of lack of local consensus about the role and function of the community rehabilitation component of the service, or because of lack of resources.

---

16 Lavelle E. et al Mental Health Rehabilitation and Recovery Services in Ireland: A multicentre study of current service provision, characteristics of service users and outcomes for those with and without access to these services. Mental Health Commission 2007.
How have rehabilitation services for people with enduring mental illness progressed in the past 10 years?

There has been minimum improvement in the number of rehabilitation teams between 2008 and 2018/19. Bearing in mind the population increase since 2006, when A Vision for Change made its recommendation for rehabilitation and recovery mental health services, we now require 47 rehabilitation teams across Ireland, with a minimum staffing of 21 WTEs per team.

There are 23 rehabilitation teams nationally; 48% of what is required under current mental health policy. Within CHOs, there are areas, and therefore service users, with no access to rehabilitation services. For example, there is no rehabilitation team in Donegal; only four nursing staff are providing a recovery service as best they can and with few resources. In CHO 6, there is only one recently recruited consultant psychiatrist in rehabilitation.

Table 1 Current number of Rehabilitation Teams per CHO

| Community Healthcare Organisation (CHO) | Population of each CHO | Number of specialist rehabilitation teams in each CHO | Number of teams recommended by A Vision for Change for each CHO per 100,000 population | Percentage of recommended number of teams in A Vision for Change for each CHO |
|-----------------------------------------|------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------
| CHO 1                                   | 404,321                | 2                                                    | 4                                                                                         | 50%                                                                            |
| CHO 2                                   | 453,413                | 3                                                    | 5                                                                                         | 60%                                                                            |
| CHO 3                                   | 385,172                | 2                                                    | 4                                                                                         | 50%                                                                            |
| CHO 4                                   | 689,750                | 2                                                    | 7                                                                                         | 29%                                                                            |
| CHO 5                                   | 511,070                | 4                                                    | 5                                                                                         | 80%                                                                            |
| CHO 6                                   | 424,772                | 0*                                                   | 4                                                                                         | 0%                                                                             |
| CHO 7                                   | 674,071                | 3                                                    | 7                                                                                         | 43%                                                                            |
| CHO 8                                   | 618,000                | 3                                                    | 6                                                                                         | 50%                                                                            |
| CHO 9                                   | 621,405                | 4                                                    | 6                                                                                         | 67%                                                                            |
| Total                                   | 23                     | 48                                                  | 48                                                                                         | 48%                                                                            |

*Recruitment for a consultant psychiatrist has been completed.
Percentage of recommended number of teams in A Vision for Change for each CHO

- CHO Area 1: 50%
- CHO Area 2: 60%
- CHO Area 3: 29%
- CHO Area 4: 50%
- CHO Area 5: 43%
- CHO Area 6: 0%
- CHO Area 7: 80%
- CHO Area 8: 67%
- CHO Area 9: 60%
A Vision for Change outlines in its recommendations the core staffing of a rehabilitation adult mental health service to serve a population of 100,000:

- One consultant psychiatrist.
- 10 to 15 psychiatric nurses for assertive outreach nursing teams (with a maximum case load of 12 service users to one nurse).
- Mental health support workers, sufficient for the numbers of service users who require such support, who can provide peer support and advocacy.
- Two occupational therapists.
- Two social workers.
- Two clinical psychologists.
- One cognitive-behavioural therapist/psychotherapist.
- One addiction counsellor.

**Additional staff**

- Domestic skills trainer.
- Creative/recreational therapists.
- Administrative supporting staff associated with day centres and community residences.

Overall, rehabilitation teams are operating with only 35% of staffing recommended by A Vision for Change in 2006.

### Percentage Rehabilitation Staffing recommended by A Vision for Change in each CHO (minimum of 21 WTEs per team serving 100,000 population)

<table>
<thead>
<tr>
<th>Community Healthcare Organisation (CHO)</th>
<th>Number of specialist rehabilitation teams in each CHO</th>
<th>Percentage Rehabilitation Staffing recommended by A Vision for Change in each CHO (minimum of 21 WTEs per team serving 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHO 1</td>
<td>2</td>
<td>65%</td>
</tr>
<tr>
<td>CHO 2</td>
<td>3</td>
<td>45%</td>
</tr>
<tr>
<td>CHO 3</td>
<td>2</td>
<td>30%</td>
</tr>
<tr>
<td>CHO 4</td>
<td>2</td>
<td>12%</td>
</tr>
<tr>
<td>CHO 5</td>
<td>4</td>
<td>34%</td>
</tr>
<tr>
<td>CHO 6</td>
<td>0</td>
<td>4%</td>
</tr>
<tr>
<td>CHO 7</td>
<td>3</td>
<td>33%</td>
</tr>
<tr>
<td>CHO 8</td>
<td>3</td>
<td>16%</td>
</tr>
<tr>
<td>CHO 9</td>
<td>4</td>
<td>77%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>35%</strong></td>
</tr>
</tbody>
</table>
It is important to note that *A Vision for Change* was written 13 years ago and does not reflect the development of rehabilitation services internationally and in line with current best practice. Within our rehabilitation services, we have seen the development of the peer support worker’s role, the appointment of housing coordinators and the Individual Placement and Support officers. The role of healthcare assistants and multi-task attendants have added to rehabilitation processes. The importance of interagency working and using local community resources has become evident. There is a realisation that delivery of rehabilitation and recovery involves more than the traditional multi-disciplinary approach and the HSE and has recognised this.

Training of staff in rehabilitation and associated therapies varied significantly nationally. Most staff had Recovery Principle training, and Wellness Recovery Action Plan training. Some members of teams had training in Dialectic Behavioural Therapy, Family Therapy and Cognitive Behavioural Therapy for Psychosis. Difficulty in releasing staff for training was a problem in some areas, resulting in staff working in a specialist area with no training or expertise in rehabilitation.
Specialist Rehabilitation Inpatient Units

The lack of investment in rehabilitation mental health services has resulted in approximately 10% of people with enduring mental illness remaining in acute mental health inpatient units, often for months or years after the acute phase of their illness has been treated. The difficulties experienced by these people are compounded by institutionalised care with its consequences of erosion of self-care skills and social skills. Many need intensive rehabilitation initially, followed by progression through a rehabilitation care pathway to independent living.

Until recently, there were no specialised inpatient rehabilitation units, resulting in people with enduring mental illness remaining for extended periods of time in acute units. In the absence of such units, three independent Specialist Rehabilitation Inpatient Units (SRUs) were opened in the private sector, providing beds for public patients, paid for by the HSE. Two Specialist Rehabilitation Units in Bloomfield Hospital and Highfield Hospital are in Dublin and the other, Cois Dalua, operated by Nua Healthcare, is in a rural area in Co Cork. These beds are made available to all HSE areas in Ireland.

This had the immediate result of out of area placement of people with enduring mental illness, a practice, started a number of years ago by the NHS and that has been severely criticised by regulatory bodies, Royal College of Psychiatrists, Mind and other mental health organisations.

Out of area placement means that people are placed many kilometres from their home location, away from family and friends, their treating team, and their local community support for periods up to two years, with a detrimental impact on continuity of care and effective discharge planning.

### Out of Area Rehabilitation Beds

- Unclear remit.
- Social dislocation.
- Disruption of care pathway.
- Longer admissions than necessary.
- Financial disincentives to repatriate to local services.
- More expensive than local inpatient rehabilitation services (cost twice as much).

---

### CARE QUALITY COMMISSION

*’We do not consider that this model of care has a place in today’s mental health care system.’*


I found that the rehabilitation services provided by the three independent Specialist Rehabilitation Inpatient Units were needs based and were evidence based. Staffing included disciplines with experience and training in rehabilitation as well as peer support workers and mental health workers. Creative arts was an important element of the programmes. The environments of all three units was appropriate and each person had their own en suite bedroom. Initial staffing recruitment difficulties in Bloomfield were overcome and at the time of writing, Bloomfield had a full complement of staff and programme implementation. [Reports about the Specialist Rehabilitation In-patient Units in Bloomfield Hospital, Highfield Hospital and Cois Dalua are published on the Mental Health Commission’s website (https://www.mhcirl.ie).]
Discharge planning for people receiving specialist inpatient rehabilitation services is particularly challenging. I found an attitude of “out of sight, out of mind” among some of the referring teams and senior management in the HSE. There appeared to be no planning to provide a comprehensive rehabilitation pathway. It was evident that transferring people from acute units to Specialist Rehabilitation Inpatient Units was a quick solution to “delayed discharges” in acute units. Despite the allocation of a care coordinator from the referring mental health service, it was difficult to ascertain exactly what arrangements were in place for discharge from the Specialist Rehabilitation Inpatient Units back to the person’s local service. Rehabilitation teams in the CHOs were either not in place or were poorly staffed.

Suitable accommodation was either not available or unsuitable, and there was no sense of any rehabilitation care pathway. There is a very significant risk, with the current poor rehabilitation availability in the HSE, that people discharged from these units back to their local area, will be placed in restrictive environments, or readmitted to inpatient care with little, if any, rehabilitation follow-up. Specialist Rehabilitation Inpatient Units must be provided locally as part of a care pathway, not a solution to pressures in other parts of the services or because nothing else is available.
Employment

The right to work and the right to "just and favourable conditions of work" are basic human rights recognised in Articles 6 and 7 of the International Covenant on Economic, Social and Cultural Rights, Article 23 of the Universal Declaration of Human Rights (UDHR) and Article 27 of the Convention on the Rights of Persons with Disabilities. Work is also a major determinant for good mental health and for recovery from mental health problems. Thus, the right to work and its associated benefits is indivisible from the right to the highest attainable standard of mental health. Employment is also important to our social status and identity as it provides social connectivity and promotes self-esteem, self-worth, increased confidence, responsibility and independence. Meaningful employment fosters hope, participation and a sense of a better and brighter future. Employment can reduce and/or stabilise symptoms, increase self-worth and provide an increased disposable income for those with a lived experience of mental health difficulties. Employment can reduce negative mental health symptoms and hospital admissions.

Discrimination of people with experience of mental health difficulties is a real obstacle to finding and keeping meaningful employment. Misconceptions and low expectations towards those with a mental health difficulty can impact on recruitment and hiring opportunities.

The low rate of competitive employment among people diagnosed with a serious mental health condition constitutes a major barrier to social inclusion. People with mental health difficulties experience both individual and structural barriers to employment due to low motivation and confidence, side-effects of medication, fear of losing welfare benefits, employers’ attitudes, perceived stigma and discrimination, and healthcare professionals’ low expectations of them. Mental health professionals may underestimate the skills, experience and capabilities of people with severe and enduring mental illness and overestimate the risk to employers.

The HSE, in conjunction with Genio through the Social Reform Fund, is putting in place a number of Individual Placement and Support (IPS) officers in each CHO. Currently, some are in post while others are in the process of recruitment.

IPS is an evidence-based approach to supported employment for people who have a severe mental health difficulty. IPS supports people in their efforts to achieve steady employment in mainstream competitive jobs, either part-time or full-time. A Cochrane review of vocational rehabilitation for people with severe mental health difficulties found that individual placement and support (IPS) was more effective than other approaches in helping individuals to gain and retain competitive open employment. Subsequent randomised clinical trials by Mueser et al (2004), Burns et al and Cook et al published similar results in favour of the approach. The longitudinal effectiveness of the approach has been shown in follow-up studies after 8-12 years.

---

Accommodation

The National Housing Strategy for People with Disabilities (2011-2016) states clearly that housing for people with disabilities falls within the remit of housing authorities. Protocols have been developed to link the provision of housing for individuals with disabilities with the provision of required social supports from the health service.

The strategy sets out as one of its nine aims:

To address the specific housing needs of people with a mental health disability, including through the development of frameworks to facilitate housing in the community, for people with low and medium support needs moving from mental health facilities, in line with good practice.

The UN Convention on the Rights of Persons with Disabilities (CRPD) has a number of provisions that relate to housing. It is worth quoting Article 19 in full:

ARTICLE 19 – LIVING INDEPENDENTLY AND BEING INCLUDED IN THE COMMUNITY
States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

ARTICLE 28 – ADEQUATE STANDARD OF LIVING AND SOCIAL PROTECTION STATES:

State Parties...shall take appropriate steps to safeguard and promote the realization of this right, including measures:

d) To ensure access by persons with disabilities to public housing programmes;

The majority of those who use mental health services will live independently with little or no special housing support needs. However, there is a cohort of people with enduring severe mental illness who require supports across a range of accommodation needs. For some this requirement will be short term. For others the requirement may be longer term, though not necessarily continuous, and will require flexibility in respect of the nature and levels of support required at any particular time. Yet, for others, there is a lifetime need for continued support by mental health services in order to help them maintain their tenancy and, in addition, a requirement for flexible provision of housing and other benefits which takes account of their changing needs over the lifespan.26

At present, there is a serious lack of adequate housing and accommodation options for enabling service users to move through the different stages of recovery and progress towards the goal of independent community-based living. The majority of new service users with severe mental illness will not require community residential facilities, but will need varying degrees of support to live in individualised, independent accommodation.

There are 113, 24-hour supervised residences, with approximately 1,200 people with severe enduring illness nationally. The number of residents and the number of residences have not decreased significantly since 2005. Needs assessments indicate that if the appropriate resources were in place, many could move to smaller, more independent accommodation; however, this is not happening due to a lack of appropriate housing, including medium and low support accommodation, as well as there not being enough adequately staffed rehabilitation teams.
Conclusion

Recovery is about people experiencing and living with mental health challenges in their lives and the personal goals they want to achieve regardless of the presence of those mental health issues. This recognises their right to create a good life, make a home, engage in meaningful work or learning and build good relationships with family, friends and people in their community.

In 2018/2019, I met many people who provide rehabilitation services on the ground for those marginalised and disabled by their enduring mental illness. In all instances, I was impressed by the dedication, creativity, inter-agency collaboration and the hard work that these staff members demonstrated in under-resourced and difficult circumstances. I also spoke with people with enduring mental illness who were frustrated and angry with their lack of progression to more independent living and who were stuck in a system that was not meeting their needs.

There are 23 rehabilitation teams across Ireland, 48% of that recommended by A Vision for Change. Of those teams, none are staffed to recommended levels. Over the last 10 years, the number of teams increased by 7 rather than the 25 required. Many areas have no access to rehabilitation services, leaving people with enduring mental illness no prospect of reaching their full potential, attaining employment or education, a satisfying social and community life, or living in suitable housing with appropriate levels of support. The provision of out of area specialist rehabilitation placements as a quick fix solution to delayed discharges contravenes best practice, has been proved to be detrimental for people in other jurisdictions and is unacceptable.

The new Model of Care for People with Severe and Enduring Mental Illness and Complex Needs is an opportunity to provide a service which is based on best practice, and to provide a care pathway for each person with severe and enduring mental illness.

The prospect for these people is to remain in continuing care or overly supported accommodation, with the consequent de-skilling and increased institutionalisation that this brings. Others are left with families, often with ageing parents, who cannot provide the support and care needed. A small but significant number remain in inappropriate acute inpatient care, unable to move to community living due to the lack of provision of rehabilitation services. Because of the unmet need for rehabilitation, many people with enduring mental illness have repeated admissions to inpatient psychiatric units, are then discharged, to be readmitted when things breakdown again – the so-called revolving door of admissions. In the long-term, this is counterproductive for both the person with enduring mental illness and the already severely under-resourced acute services, pushing costs to the mental health service increasingly higher. The short-sightedness of not providing adequate mental health rehabilitation services, from both a human rights and a financial viewpoint, is quite astounding.

In the end, the lack of provision of mental health rehabilitation is a human rights issue. The right to access appropriate mental healthcare, the right to choose where to live, the right to education/training and access to employment, the right to privacy and the right to live to the full of one’s potential, have not been adequately provided for many people with an enduring mental illness and who cannot access mental health rehabilitation services.