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

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Multiple pathways on the route to recovery

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

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

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

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

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

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

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The economic cost of schizophrenia in Ireland

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

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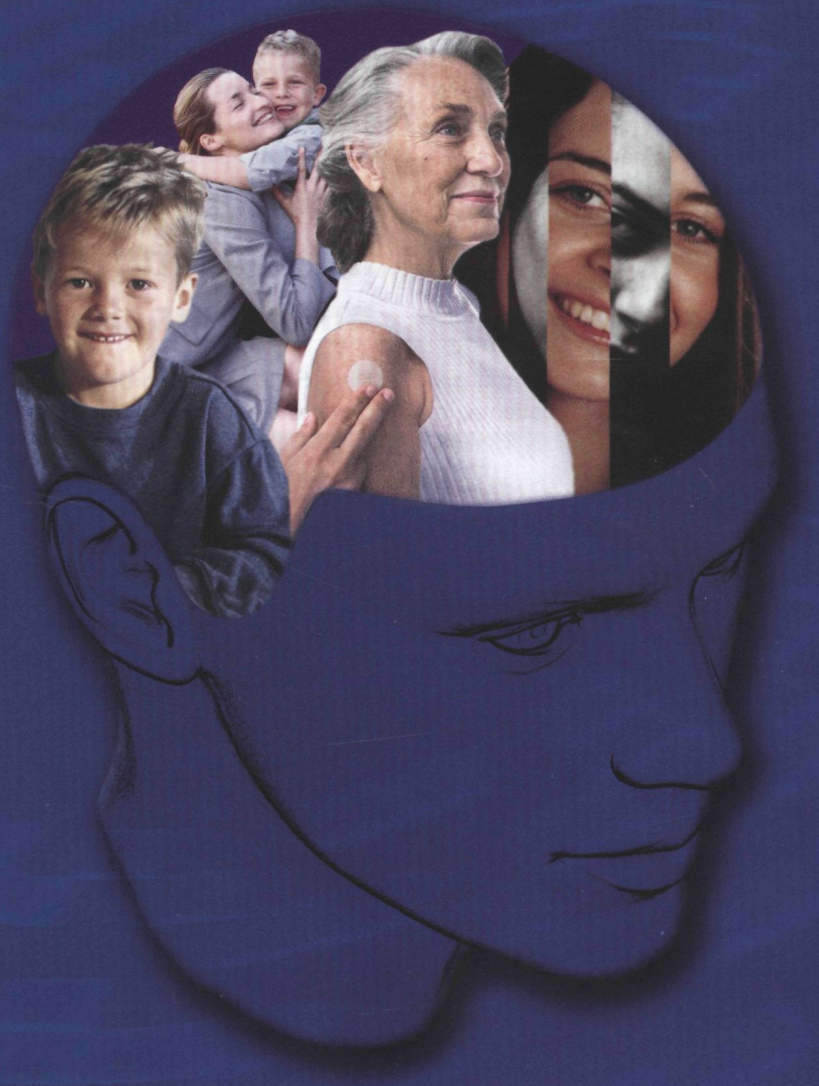

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impact of schizophrenia on various resources in Ireland.

Schizophrenia is a chronic disease associated with a significant and long-lasting health, social, and financial burden, not only for patients but also for families, other caregivers, and the wider society. Knapp *et al*, in their widely cited systematic review and English study, have pointed out that the inpatient admission is the single largest contributor to the direct costs of treating schizophrenia.[2,3] Hence I wish to point out a better way of estimating this direct cost of schizophrenia – by using the annual reports published by the Health Research Board (HRB), Dublin, Ireland.[4]

Behan *et al* have used the data about inpatients with schizophrenia, estimated on the recording of inpatient data using the hospital inpatient enquiry system (HIPE), which records the discharge diagnoses using the ICD-10, coding system. The authors' estimation is based on certain assumptions; and hence it is an approximation.

Behan *et al* found that psychosis was the primary diagnosis in 0.1% of the total discharges from Irish hospitals in the year 2006. They used the methodology of Mangalore and Knapp's cost-of-illness in schizophrenia in England, which assumes that on an average 40% of all those who have psychoses will have schizophrenia.[3] In the cost studies the results are based upon the quality and the accuracy of the patients' databases used.

There is another more reliable and accurate source of data, based on the *Activities of the Irish Psychiatric Units and Hospitals, 2006*, published by the HRB. Since 1965, all the psychiatric units and hospitals in Ireland, send quarterly returns, information about all psychiatric inpatients, in electronic format, to the HRB national psychiatric inpatients reporting system (NPIRS). These are used by the HRB to publish their annual reports.[4]

According to the HRB report 2006; there were 20,288 admissions to Irish psychiatric units and hospitals. Schizophrenia accounted for 20% of all and 13% of first admissions and has consistently remained the second leading cause of psychiatric admissions. Half of all admissions to units and hospitals in 2006 were to general hospital psychiatric units, 32% were to psychiatric hospitals (including the Central Mental Hospital, Dundrum; St Joseph's Intellectual Disability Service, Portrane; and Carraig Mór, Cork) and 19% were to private hospitals. The proportion of non-voluntary admissions remained unchanged from 2005 at 11% of all and 12% of first admissions. Only 3% of admissions to private hospitals were non-voluntary. A total of 847 patients with a diagnosis of schizophrenia (22%) had non-voluntary admissions.

There were 20,098 discharges from, and 161 deaths in, Irish psychiatric units and hospitals in 2006. Schizophrenia, schizo-typal and delusional disorders accounted for 3,861 discharges (19.4% of total discharges) and 150,275 inpatient days (bed-days), which accounted for 27.4% of the total inpatient days, ie. 547,779. In patients with schizophrenia the median length of stay was 21 days, compared to 14 days for all discharges.[4]

Based on this report I have recalculated the bed-days and found that Behan *et al* have possibly underestimated the direct costs of schizophrenia. I found that inpatients with schizophrenia, admitted to various psychiatric units in general hospitals in Ireland, accounted for approximately 75,000 bed days (56,279 Behan et al). While the figures for patients with schizophrenia admitted in psychiatric hospitals were 48,000 (38,227 Behan et al) and for private hospitals were 27,000 (10,167 Behan et al). This would increase the direct cost by €14-15 million, making total direct costs approximately €130 million.

The cost of Mental Health Tribunals should also be included in the estimation. A total 847 patients with schizophrenia had non-voluntary admissions under the Mental Health Act 2001. Even if only 800 had their tribunals, the total cost would be significant.

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Inpatient co-morbidity of mental illness and substance misuse (including alcohol)

Dear Editor – Co-morbidity (simultaneous presence of two or more disorders) of mental illness and substance misuse is well established, but unfortunately, poorly identified by the psychiatric services. A significant number of psychiatric patients with substance dependence/misuse co-morbidity receive no specialist intervention.[1]

Substance misuse co-morbidity has been associated with; increased psychiatric admissions, violence, suicidal behaviour, excess service costs and poor treatment outcome.[1] Ireland has one of the highest per capita alcohol consumptions in Europe. Ireland also tops the country scale for heavy drinking in general population in Europe.[1-3]

The improved management of co-morbid mental illness and substance misuse is currently a National Health Service (NHS) priority in England and indeed the expert group on mental health policy in Ireland also recommend harvesting this relevant information from patients' databases, in order to optimise the management of co morbidity here in Ireland.[1-3]

Recent European studies of psychiatric patients, reported the prevalence of alcohol misuse in up to 50.6% of males and 29.2% of females, and cannabis misuse in 35.2% of males and 11.2% of females.[1,4,5] An Irish study of 50 long-stay psychiatric patients living in high support community residences in Dublin has reported the levels of co-morbid alcohol misuse at 48% and substance misuse as 36%.[6]

An unpublished study, at an inpatient psychiatric unit at the Mercy University Hospital, Cork, found co-morbidity of substance misuse (including alcohol) in over 30% acute psychiatric admissions.[7]

All psychiatric units in Ireland, since the year 1965, send information about their inpatients on the national psychiatric inpatients reporting system (NPIRS). This includes information not only on patients' demographics but also both

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