Change for the future – *A Vision for Change* ‘refresh’

Final Version

11 December 2019
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Section A  Introduction

A.1  Foreword – chair of oversight group

The publication of *A Vision for Change* (2006) was an important milestone in the development of mental health policy in Ireland. Many significant changes and improvements have taken place since 2006, but it has been central in providing multi-annual funding for mental health service development. The policy was generally well received and accepted and had some success in implementation.

An oversight group was appointed by the Department of Health to conduct a ‘refresh’ of *A Vision for Change* (2006), which on finalisation will become the government’s national policy. Rather than beginning again, the focus of this ‘refresh’ is to build on the existing policy and to future proof government policy for the next ten years.

Although *Vision for Change* (2006) has supported significant development over the past thirteen years, the government has much more to do to develop stronger, more appropriate mental health supports at community and primary care levels and to develop robust and reliable supports to ensure effective use of appropriate inpatient care. This refreshed policy focuses very strongly on developing a broad based, *whole system* mental health policy for all of the population, and concentrates on developing policy for effective specialist mental health services. Many other partners have an important role to play in improving the mental health of our population. This includes multiple government departments, state agencies, the voluntary and community sector as well as employers and educators. This ‘refresh’ policy also aligns closely with the main provisions of *Sláintecare*.

The oversight group consulted widely, by arranging *town hall* type meetings across the country. It spoke directly to over 1,000 people, including people with personal experience, family members, community and voluntary sector groups and staff. It also used many other consultation and information sources that were recently produced by separate but relevant mental health policy projects. For example, it used input to the Joint Oireachtas Committee on the Future of Mental Health, as well as submissions made in the development of *Connecting for Life* strategy.

Following an extensive consultation process, the final document will become a successor document to *A Vision for Change* (AVFC), as it carries forward those elements of the original which is still felt to have relevance and these elements have been combined with new recommendations to create this successor document which, when finalised, will become the government’s national policy.

The main concern was to develop a policy which would be action-oriented and focused on bringing about tangible changes in the lives of people experiencing mental health difficulties – representing a change in the services and supports they receive. This will be best achieved through a policy focusing on delivering better outcomes for people. By concentrating on outcomes this ‘refresh’ supports significant changes in the delivery of mental health services, ensuring individuals can achieve better results. The policy is informed by an *ecological approach*, placing the individual in the wider and layered context of family, community and state. A lifecycle approach will also enable the government to consider the needs of people of all ages at all stages of life.
Within this outcome-based framework, some high-level outcomes have been set. All those with implementation responsibility must develop actions to deliver on these outcomes. Resources must follow outcomes and deployment of resources, both existing and new, must demonstrate how these resources will deliver the policy outcomes.

Supporting the mental health of the population must encompass actions that range from building resilience, through prevention, early intervention and treatment of mental health issues, to treatment and on-going support for those with complex conditions. By developing resilience amongst our population, we learn the skills and competencies to manage the difficulties we all encounter daily. We begin to develop these skills within our families, our communities, our schools and in our work. Recommendations have been made to support the valuable role of community and voluntary sector organisations and to build capacity for mental health treatment and support in primary care. This is designed to improve access to support for people with mental health difficulties and will help avoid an inappropriate over-reliance on specialist mental health services. Recommendations have also been made about improving the resources and working practices of community mental health teams and other parts of the specialist mental health services, to maximise the outcomes from the most effective use of these resources.

Effective delivery across the whole of the mental health ‘system’ requires clear care pathways, extensive use of shared care models and ownership of care and supports. Care cannot be denied due to siloed working, where individuals fall between services. Adequate resources, staffing and settings are required, which are properly and effectively deployed and governed. Staff must be adequately trained, supported and valued and settings must be appropriately located and of high quality.

The recruitment and retention of appropriate staff is a regular challenge to all service industries, including healthcare. Wider systemic issues affecting recruitment and retention in many sectors such as rates of pay, availability of accommodation, training, development opportunities, career progression and valuing staff require a range of actions at state level. Recommendations have therefore been made to consider alternative options, rather than developing responses based solely on existing professions that are in short supply. The potential of other staffing arrangements must be examined to deliver the required outcomes, through a comprehensive skills-mix analysis. What will best deliver good outcomes is a workforce that is more future-oriented and flexible and that responds to needs in different ways.

We are aware that in many mental health services use of acute inpatient beds is operating in excess of 100 per cent bed occupancy. Yet there are still more beds than was envisioned in AVFC. In our view we need to focus on the effective use of inpatient services, supported by better developed prevention and community intervention services, before additional inpatient beds are developed. Otherwise little will change fundamentally in the structure and provision of mental health services. This is vital, considering the expected doubling of capacity within the National Forensic Service over coming months.

The lack of a 24/7 access to services is of serious concern. This policy recommends alternative options to emergency departments for people in crisis where medical assessment is not required. The advantages of technological developments must be exploited, while developing new ways of working which are more responsive to the needs of people using services. The use of appropriate digital health solutions (in particular a comprehensive and connected electronic health record) must be supported as a way of providing easier access to treatment and support, to triage care needs and to provide alternative models of treatment. The use of technology, coupled with new types of staff and staff working in different places and in different ways will enhance the offering and deliver on better outcomes for those individuals who require supports.
Our good health is very precious to us all. Mental health particularly requires a range of commitments and responses to ensure good outcomes. When society coalesces behind an effective policy change, it can deliver improved benefits for everyone. Wide support should therefore be provided to implement the range of recommendations and improvements included in this refreshed policy.

On behalf of the Department of Health I want to thank the members of the oversight group for their huge input as volunteers to this revised policy. I would also like to thank colleagues from the department for their support to this work which will form future government policy in this vital area of healthcare. Finally, I wish to thank all those who came to meet us and share their experiences and views for a better mental health service for all.

______________________________
Hugh Kane
Chairperson – Oversight Group, Department of Health
A.3 List of acronyms

ACEs – Adverse Childhood Experiences
AHPS – Allied Health Professionals
AVFC – A Vision for Change
CAMHS – Child and Adolescent Mental Health Services
CES – Centre for Effective Services
CFL – Connecting for life
CHN – Community Health Network
CHNs – Community Health Networks
CHO – Community Healthcare Organisations
CIPC – Counselling in Primary Care
CMH – Central Mental Hospital
CMHTs – Community Mental Health Teams
CNS – Clinical Nurse Specialist
COG – CAMHS Operational Guidance
CPD – Continuing Professional Development
CRRs – Community Rehabilitation Residences
CRTs – Crisis Resolution Teams
DA – Disability Allowance
DEASP – Department of Employment and Social Protection
DES – Department of Education and Skills
DHPLG – Department of Housing, Planning and Local Government
DoH – Department of Health
ED – Emergency Department
EMAP – European Mental Health Action Plan
FCAMHS – Forensic Child and Adult Mental Health Service
FFSs – Family Friends Supporters
FMHS – Forensic Mental Health Service
GAMHS – General Adult Mental Health Service
IAN – Irish Advocacy Network
ICRU – Intensive Care Rehabilitation Unit
ID – Intellectual Disability
Intensive Recovery Support teams
IPS – Individual Placement and Support
IRSS – Intensive Recovery Support Services
LMHS – Liaison Mental Health Service
MHC – Mental Health Commission
MHIAP – Mental Health in all Policies
MHIDT – Mental Health Intellectual Disability Teams
MHR – Mental Health Reform
MHSOP – Mental Health Services for Older People
MOC – Models of Care
MOCEIP – Early Intervention Psychosis Model of Care
MHEHR – Mental Health Electronic Health Record
NCHD – Non-Consultant Hospital Doctors
NCH–ED – National Clinical Programme for Eating Disorders
NEPS – National Educational Psychological Service
NGO – Non-Governmental Sector
NFMHS – National Forensic Mental Health Service
NGBRI – Not Guilty By Reason Of Insanity
NOSP – National Office for Suicide Prevention
NWIHP – National Women and Infants Health Programme
OTs – Occupational Therapists
PBP – Population Based Planning
PH&HS – Research – Population Health and Health Services Research
PICLS – Prison In-reach and Court Liaison Service
PICU – Psychiatric Intensive Care Unit
RICO – Regional Integrated Care Organisations
SLTs – Speech and Language Therapists
SOG – Standard Operating Guideline
SOP – Standard Operating Procedure / Scope of Practice
SPPMO – Strategic Portfolio and Programme Management Office
SRF – Social Reform Fund
SRUs – Specialised Rehabilitation Units
TILDA – The Irish Longitudinal Study on Ageing
UNCRPD – UN Convention of the Rights of Persons with Disabilities
VCS – Voluntary Community Sector
WHO – World Health Organisation
YMHTF – Youth Mental Health Task Force
WRC – Work Research Centre
A.4 A note on terminology

Mental health difficulty
The term mental health difficulty has been used throughout to describe all mental health difficulties that might be encountered, from the psychological distress experienced by many people, to severe mental disorders that affect a smaller population.

Trauma-informed care
Trauma-informed care acknowledges that many people who experience mental health difficulties have had some form of trauma in their lives, although this is not the case for everyone. A trauma-informed approach seeks to resist traumatising or re-traumatising service users and staff. Trauma-informed service delivery means that everyone at all levels of the mental health services and wider mental health provision has a basic understanding of trauma and how it can affect families, groups, organisations and communities as well as individuals.

Scope of practice
The scope of practice sets out the procedures, actions and processes that the registered or licensed professional is allowed to perform. The individual practitioner’s scope of practice is determined by a range of factors that gives them the authority to perform a particular role or task.

Social prescribing
Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Social prescribing is an opportunity to implement a sustained structural change to how a person moves between professional sectors and into their community. To fully address the social determinants of health, social prescribing schemes view a person not as a ‘condition’ or disability, but quite simply as a person.

Referral pathway
A service user referral pathway is the process by which a service user is referred from one doctor to another. Normally specialists cannot be seen without a referral from a generalist, such as a family doctor.

Dual diagnosis
‘Dual diagnosis’ is the term used when a person experiences both a substance abuse problem and a mental health issue such as depression or an anxiety disorder. Treatment options must address both.

Recovery colleges
Recovery colleges often focus on equipping students with new skills that can foster their recovery, while enhancing their overall capacities and capabilities. Common offerings include classes focused on self-care, life-skills, physical health, and employment and information technology. Recovery colleges are open to everyone in the community (thus reducing stigma) and involve co-production, whereby people with self-knowledge of a mental health experience co-design and deliver training alongside mental health professionals and family members or carers.

Crisis resolution
Crisis Resolution (CR) offers after-hours and urgent mental health assistance. This is an integral part of each community mental health team, providing twenty-four-hour advice and assessment for people presenting in crisis in association with a known or suspected mental health problem.
**Assertive outreach**
Assertive outreach teams provide intensive support for people with complex needs. The teams support such people to get help from other services. This helps the person to manage his other condition better and reduces the chances of going back to hospital.

**Talking therapies**
Talking therapy is a general term to describe any psychological therapy involving talking, such as counselling or psychotherapy. Talking therapies are psychological treatments. They involve talking to a trained therapist to support service users to deal with negative thoughts and feelings. They help people to make positive changes and they take place in: groups, one-to-one, online or over the phone.

**Peer support**
Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful. It is not based on psychiatric models and diagnostic criteria, but is about understanding another’s situation empathically through the shared experience of emotional and psychological pain.

**Digital health**
Digital health refers to using online or other digital technology to provide prevention and care. Some digital health programmes focus on promoting health and well-being and preventing ill health, while others may deliver early intervention and mental health treatment. There are numerous digital health programmes available, covering a range of mental and physical health concerns, and thus increasing individual healthcare management choices and improving access to support.
A.5  Acknowledgments

**Chairperson**
Mr Hugh Kane  Independent Chair

**Oversight Group**
Mr Stephen Brophy  DoH (November 2018–March 2019)
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Members of the Joint Oireachtas on the Future of Mental Healthcare in Ireland
HSE CHO Mental Health Leads
Peer Network
NGO sector representatives

The oversight group was very fortunate to have had various forms of input from service users, their families and carers who provided meaningful and insightful feedback during the stakeholder consultation process. It is hoped that this policy accurately represents your views as well.
Section B  Background and context

B.1  Introduction

The refresh of *A Vision for Change* (AVFC) is closely aligned with the ten-year vision for reform and transformation of Ireland’s health and social care services encapsulated in the *Sláintecare* report. Built on cross-party political consensus, *Sláintecare* supports a system where the majority of services are delivered in the community, where care is safe, timely and accessible, and where access is based on need, not ability to pay. It further emphasises the importance of a preventative approach (and the related promotion of that approach) and the creation of an integrated system of care, with healthcare professionals working closely together.

Importantly, the *Sláintecare* report highlighted the need for significant improvement and investment in mental health services, as part of the planned, integrated approach to health and social care. While acknowledging the significant shift in services from institutions to the community, it recognised that teams remain under-resourced and overly reliant on the use of medication in the absence of sufficient allied health professionals (AHPs) and other health professionals with the correct skills to provide a range of talk therapies and other interventions. This absence of talk therapies can result in an over-dependence on medication and an over-reliance on acute services. It further noted significant inconsistencies in how services are provided across the country. The *Sláintecare* implementation strategy lays out the direction for the ten-year vision and sets out actions for the next three years that will lay the foundations for reform. It is structured around the four goals and associated strategic actions shown in Figure B.1 below – many of which agree with identified issues and needs in relation to the refresh of AVFC.

![Figure B.1 Sláintecare goals and strategic actions](https://www.gov.ie/en/campaigns/slaintecare-implementation-strategy/)

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The *Sláintecare* report acknowledges the work of the Department of Health and the oversight group in the policy review process of AVFC and the importance of it in providing information to help in making decisions about further investment in this area. The common ground between this policy ‘refresh’ of AVFC – co-ordinated through the Department of Health and the oversight group – and the work of the Joint Committee on the Future of Mental Health should be noted. This committee was established by an order of Dáil Éireann on 13 July 2017 and by order of the Seanad on 18 July 2017, to achieve cross-party agreement on the implementation of a single, long-term vision for mental healthcare in Ireland. Its work progressed through two interim reporting stages, with the final report published in October 2018. Many of the issues and actions emerging from the work of that committee agree with those experienced by the oversight group during the countrywide engagements and research for the ‘refresh’ process put in place for AVFC.

Despite the fact that there can be ‘no health without mental health’, typically, mental health does not enjoy parity with physical health in national policies and budgets or in medical education and practice. This limited integration between physical and mental health care can mean that needs go unmet and that there are shortcomings in delivering a ‘whole person’ approach towards the highest attainable standards of physical and mental health – even though some of the key risk factors for poor physical health and reduced life expectancy can be more prevalent amongst people living with mental health difficulty than among the general population.

Building on the priority in the report about ‘creating an integrated system of care, with healthcare professionals working closely together’, a key focus of the oversight group in the refresh of AVFC has been to create equality between physical and mental health and exploring opportunities for improved integration between the two. Often, efforts to promote integrated care models have centred on linking health and social care or primary and secondary care. It is now increasingly recognised that there should be a new effort to integrate, bringing together physical and mental health. This will simultaneously improve the physical health of people with mental health problems and the mental health of people with physical health problems. Better integration between the two will also support prevention and will allow early intervention work, ensuring non-discrimination in the achievement of a human rights-based approach.

**B.2 Why a refresh?**

The term of AVFC concluded over two years ago in 2016. There are several aspects of the original policy that remain core to the effective delivery of mental health services and support in Ireland. For instance, the policy put forward a holistic view of mental health, recognising that a complex interplay of factors contributes to mental health difficulties. It proposed a person-centred approach, recognising a need for the voice of the service user to be heard and it also highlighted the importance of community and social inclusion in facilitating recovery. Interventions and supports included within the policy were focused on enabling recovery through an emphasis on personal decision-making supported by clinical best practice and lived mental health experience.

However, it is important to highlight that, despite some of the focus in AVFC remaining relevant, not all of the ambitions and policy goals in that policy have been fully realised. During the life of the policy, various reviews and related evidence pointed to a partial but improving picture of implementation over the decade 2006–2016. An overview of the performance of the policy was completed by the oversight group to help organise their work in terms of ‘bridging the gap’ between the original policy and of giving consideration to the formulation of the new policy which will form national policy for the next ten years.
Despite general agreement that there should have been more progress in some areas, there is also evidence of a range of issues where there has been progress, illustrating innovation and good practice over the period 2006–16. Examples include the publication of the National Recovery Framework and related support for recovery work; publication of Connecting for Life (the new national strategy to reduce suicide 2015–2020); the development of a number of standard operating procedures (SOP), models of care and other quality frameworks for a range of HSE mental health services; the establishment of the Counselling in Primary Care (CIPC) programme; the HSE’s progression of the service user involvement agenda with the setting up of the Office of Mental Health Engagement; and the closure of some of the old psychiatric hospitals and their replacement with bespoke new facilities, better suited to modern mental health care. The number of community mental health teams and the staffing profile has also changed, with a positive shift in the proportion of allied health professionals (AHPs) working on community mental health teams. These examples show the need to embed and extend on some of the progress, innovation and good practice that has been achieved in the first version of AVCF.

But in looking ahead and in using the term ‘refresh’, it is agreed that there are considerable challenges and issues in the current delivery of mental health services and supports, and the development and delivery of prevention programmes, in Ireland. For example, as noted in the Sláintecare report and repeated during the course of engagements to inform this ‘refresh’, while there has been a significant shift in services from institutions to the community, teams operating in the community remain under resourced. As noted in the Sláintecare report, these teams can be overly reliant on the use of medication in the absence of sufficient numbers of AHPs and other health professionals with the right skills to provide a range of talk therapies and other professional expertise. The absence of talk therapies can result in an over-reliance on acute services. While recognising the well-developed national suicide prevention strategy connecting for Life, stakeholders have commented on the underdevelopment of prevention initiatives and the absence of a systematic approach to promoting positive mental health and building resilience. There is therefore considerable scope for activating sectors across government towards building a society that fosters good mental health.

AVFC envisaged that a significant proportion of mental health services and supports could and should be provided as part of primary care, a view repeated in the Sláintecare report. Over the decade of the policy (2006–16), this increased role for primary care has not been sufficiently resourced and there have been shortfalls in creating the necessary integration between primary care and specialist mental health services. The proportion of the overall health budget spent on mental health has also lagged below what was expected within the AVFC.

Taking all this into account, the term ‘refresh’ is grounded in the realities of the challenges and issues that presently exist. The ‘refresh’ acknowledges that while considerable change, on-going reform and investment is needed, much of the AVFC policy still stands. Some recommendations remain valid (with minor refinements); others have been more substantially changed or updated. Others are no longer valid or, having been delivered, are no longer needed. Finally, there are many recommendations in this ‘refresh’ of the policy that are entirely new, reflecting issues that have arisen during the course of the ‘refresh’ work. The diagram below (Fig B.2) shows how Vision for Change recommendations are now part of this refresh.
Figure B.2: Original Vision for Change recommendations covered in this refresh

![Correlation of Original and Refreshed AVFC Recommendations]

Figure B.3 Correlation of original and refreshed recommendation

A final point with respect to the 'refresh' of AVFC is the identified need for a degree of streamlining in the structure of the policy. The original policy had twenty-two themes and 208 separate recommendations. The oversight group engaged with the authors of the Work Research Centre (WRC) report and sought their views on the overall performance of the Vision for Change policy. The WRC advised the oversight group about the diverse nature of the recommendations, which varied widely in their relative systemic importance and in their implications for action. To achieve this streamlining, the oversight group combined related policy/service delivery areas into four ‘domains’ requiring action and oversight in the ‘refreshed’ policy. These are reflected in the organising framework detailed in Figure B.4 which follows through to the report structure. The Oversight Group engaged in a literature review of mental health outcomes from other jurisdictions to gain a sense of...
the various interventions and descriptions of outcomes and outcome measures being delivered internationally. Five countries were identified as having well-developed and well-resourced mental health outcome infrastructures that moved from a focus on the volume of services delivered to the value created for service users. In the body of the report the Oversight Group also identified a number of specific high-level outcomes within each of the four domains and these are described at the beginning of each of the domain chapters.

![The Organising Framework](image)

**Figure B.4 organising framework**

**B.3 The refresh process**

The ambition, intended outcomes and recommendations set out in this refreshed AVFC are the product of intensive work co-ordinated through the Department of Health and the oversight group. They have been backed by extensive research, benchmarking activity and evidence-based reviews, together with a wide-ranging and comprehensive consultation process.

This process was central to the ‘refresh’ and was shaped to be inclusive, placing service users and family, carers and supporters (FCSs) as well as healthcare staff and representatives from the voluntary and community sector (VCS). The process was implemented through collaborative meetings and workshops to
develop ideas and comment on evolving policy frameworks. Over 1,200 people across Ireland came together to make their contributions.

The work of the oversight group was also shaped by the commissioning in 2016 of an internationally focused evidence-based expert review of mental health policy and practice – designed to bring ideas and inspiration to the ‘refresh’ process. It was also informed, as noted previously, by the advice received for providing an overview of the overall performance in implementing the proposals and recommendations in AVFC in the 2006–16 period. The WRC report provided important ‘building blocks’ to determine some of the parameters and considerations for the ‘refresh’ of AVFC that could then be consulted upon. Throughout this ‘refresh’, all the original AVFC recommendations were reviewed for on-going relevance based on the consultation and engagement process, with amendments, enhancements, deletions and new recommendations made, as appropriate.
The policy development process was informed by the following activities and sources of evidence.

- ‘My Voice Matters’ – a national survey of service users and family, carers and supporters (FCSs) which was funded by the HSE’s National Mental Health Services. The research conducted by Mental Health Reform (MHR), captured the views of around 2,000 individuals from these two constituencies on their experiences with mental health services in Ireland. As such, it is an important national data-set which acts as a baseline for the forward implementation of the revised AVFC.

- Irish Advocacy Network (IAN) – report on IAN’s Peer Advocacy Services (2018). These advocacy services are predominantly provided in acute units, step down units and, where possible, long stay units. In 2017, IAN had 12,399 one-to-one engagements with service users in this context.

- Report on the stakeholder feedback to CHOs (2018) which captured views of service users, FFSs, staff working in service delivery and community organisations.

- Findings from consultation sessions set up by the HSE MHID Service Improvement Programme with Inclusion Ireland, where the focus of the engagements was on MHID services in Ireland with the attendance of service users, families and clinicians.

- Reports from the CHO area leads for mental health engagement on the experiences and views of service users and FFSs in thirty-five dedicated local peer groups from across the country.

- Some forty individual written submissions.

- Unsolicited inputs from interested member organisations of MHR as a follow on from the reference group.

The chair of the oversight group also met with various agencies as invited, including Mental Health Commission, Psychiatric Nurses Association and Addiction Service representatives.

- BeLonG To
- Cairde
- Hugh Kane (VfC Refresh)
- Irish Association for Counselling and Psychotherapy
- Irish College of General Practitioners
- Irish College of Psychiatrists of Ireland
- Irish Hospital Consultants Association
- Jigsaw
The work of the oversight group was guided throughout by a reference group established to connect with a wider group of experts as the policy proposals were evolving. This included representatives from clinical bodies, NGOs and service user representative organisations who met to discuss the framework and feedback from the stakeholder process.

Consequently the refreshed policy is a powerful representation of the views of service users, FFSs, service providers, representative organisations and NGOs for mental health services and supports in Ireland. The ambition, outcomes and recommendations that it sets out have strong collective support. The consultation and engagement process itself has also been very valuable in establishing a network(s) to advocate and support the required change and reform.

B.4 Key underpinning concepts

The determinants of mental health (Fig B.5) include individual, family, community and societal factors, and their interactions. Essentially, mental health for individuals is neither separate nor isolated from the other dimensions of their overall personal well-being nor insulated and shielded from political, economic, material and social conditions around them. Multiple factors across these dimensions, as well as an individual’s more personal biological and psychological well-being, have an influence on mental health. Some people may be particularly vulnerable to mental health difficulties because of demographic characteristics – for example, their cultural background, or their experiences through exposure to trauma or abuse. Targeting the various determinants of mental health in this way, in this ‘refresh’ of AVFC has helped with planning on ‘where and how’ to intervene to prevent mental health difficulties and to support recovery.

The Department of Health recognises the need for a whole-of-population, whole-of-government approach to the delivery of mental health services. In doing so this policy is underpinned by an ecological model which uses a stepped-down approach which would fit well within such a framework.
B.4.1 Lifecourse approach

Individuals continue to develop and change throughout life. In keeping with this, the spectrum of mental health is dynamic and changes in response to the life experiences of individuals and how they function within the environment of their family, friends, community and society, at different stages in their life. Moreover, at different stages of life, people have different capacities for sustaining mental health and these stages may be associated with increased vulnerability to particular mental health difficulties. Even with the same mental health difficulty, the needs of an individual can be very different depending on their stage in life.

Thus, in adopting an ecological approach in this ‘refresh’ of AVFC, the concept of the life course is important. Essentially, ensuring a focus on services and supports that begin with pre/peri-natal mental health, through infancy, childhood and adolescence, to adulthood and onto old age. In formulating the policy ‘refresh’, a focus on the life course has helped to map relevant risk factors in a chronological order. It also provides the basis for mental health professionals to work together across all age groups, sharing knowledge and expertise.

B.4.2 Population based planning

It is insufficient for a comprehensive mental health policy to make recommendations relating solely to specialist mental health services. It must also deliver interventions and supports that support the well-being of the whole population, preventing mental health difficulties and enhancing the possibilities for the recovery and inclusion of people experiencing mental health difficulties.

This ‘refresh’ of AVFC has been underpinned by a population-based planning approach, which has helped to guide the distribution and development of mental health services and supports in Ireland in response to need.
In Figure B.6, the inverse pyramid represents the total population. At one end of the pyramid, the needs relate to promoting mental health, resilience and well-being. Interventions in this area are relevant to a very wide population – in effect, society at large in Ireland. This work can be supported through access to range of resources and tools, including e-mental health tools, which enable individuals to help themselves, that is, self-agency. The work can also address social determinants such as creating healthy living and working environments and reducing social and economic inequalities. Beyond this in the pyramid, individuals move through different levels of support and services, from informal care and support in their own community to primary care, to specialist mental health services, all based on their mental health needs. This can also include accessing support for crisis / emergency response needs that are more episodic in nature. At the other end of the pyramid, there is a small proportion of the population who have complex mental health difficulties. These individuals typically require intensive multi-disciplinary support over extended periods. There is inverse relationship between the frequency (and intensity) of the support need and the cost required to deliver the services in moving from the top to the bottom of the pyramid. In keeping with the aims of Sláintecare, investment at the wider levels of the pyramid can help to prevent people needing to use more intensive, costly services later on.

It should be noted that the various layers in the pyramid in Figure B.6 are not mutually exclusive but are closely integrated and rely on each other. For example, an individual who is accessing specialist mental health services still requires the support of his/her family, community and GP. A further example relates to individuals in an acute in-patient setting, where the emphasis is on implementation of specific interventions, with the aim, where appropriate; of achieving the earliest possible discharge of the individual back to his/her family and the on-going care of the Community Mental Health Team (CMHT).

The organisation of the delivery of mental health services and supports in this manner will increase effectiveness by facilitating ‘stepped care’, that is, each person can access a range of options of
varying intensity to match his/her needs. In other words, there can be a ‘stepping up’ or a ‘stepping down’ in accordance with the stage of recovery.

This approach to organising and accessing care is referred to throughout this refreshed policy. The aim of this approach is to enable the individual to access the range of support and services needed to achieve personal recovery. As regards the service user experience, this means an individual can access the support needed as close to home as possible and at the level of complexity that best corresponds to the individual’s needs and circumstances. The dotted lines between the tiers indicate that the supports and services at the lower tiers are available to those accessing services at all other tiers. For example, peer support is described in tier 1 but applies to all steps. Access to tier 1 support is not closed off if an individual is at tier 3 or 4. Where mental health team members work in partnership with the service user and FCSs, supports can be ‘stepped up’ to more intensive supports, ‘stepped down’ where a less intensive support becomes needed and ‘stepped out’ when an alternative support or no support becomes appropriate.

**B.4.3 Stepped care approach**

A stepped approach to care should also help to increase efficiency by ‘shifting’ constituencies of need towards more of the ‘upstream’ services, that is, promotion, prevention, early intervention, recovery and participation. Over time, this should reduce the need for more expensive ‘downstream’ acute and crisis response services. In this context, strategic investment in ‘upstream’ services should be viewed as an investment rather than a cost. This applies not just to the healthcare system, but also to the potential to yield ‘downstream’ gains in other areas of public expenditure and the wider economy and society in Ireland, for example: legal and judicial systems; the employment, education and housing sectors; and social protection systems.

There is evidence for this cost/benefit in a 2018 OECD Health Policy Study. That study estimated the total costs of mental ill-health in the EU at over €600 bn – or more than 4% of GDP – across the 28 EU countries. It argues that a large part of these costs are a result of lower employment rates and productivity among people with mental health difficulties (1.6% of GDP or €260 bn) and greater spending on social security programmes (1.2% of GDP or €170 bn), with the rest being direct spending on health care (1.3% of GDP or €190 bn). In these circumstances, the benefits to be realised from strategic ‘upstream’ investment to prevent and/or reduce the impacts of mental health difficulties greatly exceed the direct spending on healthcare.

**B.4.4 Whole-of-government approach**

This ‘refresh’ of AVFC brings the population-based planning framework, as set out in Figure B.6, into operation through a ‘whole of government’ approach. Good mental health underpins a productive and inclusive society and, as such, is a priority across all areas of government. It contributes to well-being and economic success and is also intertwined with efforts to tackle persistent problems that impact upon society such as homelessness, violence and abuse, substance misuse and crime.

Thus, the context for this ‘refresh’ of AVFC is that mental health is not a matter for the health sector alone. It sits in a much broader context of how society views mental health and how decisions can be made right across the spectrum of relevant public services to invest in the wellbeing of the
population and support individuals living with a mental health difficulty on their recovery path. As
detailed in Domain 1, such a cross-sectoral focus is consistent with international policy, for example,
as enshrined in World Health Organisation (WHO) definitions and in the European Mental Health
Action Plan (EMAP).

Indeed, international practice indicates a focus on a *Mental Health in All Policies* (MHiAP) approach.
This approach emphasises the impacts of public policies on mental health determinants, strives to
reduce mental health inequalities, aims to highlight the opportunities offered by mental health to
different policy areas, and reinforces the accountability of policy-makers for mental health impact.
Of fundamental importance is that the MHiAP approach promotes: positive mental health and well-
being; the prevention of mental health difficulties and early intervention and support for the
recovery of individuals with existing mental health difficulties - all consistent with this ‘refresh’ of
AVFC.

Accordingly, this ‘refresh’ of AVFC emphasises that good mental health for the population of Ireland
cannot be achieved without measures being also taken by other government Departments as well as
the Department of Health.

Departments / agencies with responsibility for policy and service delivery in all of the areas
illustrated in Figure B.8 have been involved in the ‘refresh’ process and are committed to various
actions that collectively are consistent with the MHiAP approach. In many cases, these commitments
involve building on and extending upon existing initiatives and cross-sectoral working. In other cases,
it means developing new actions and models of service delivery with enhanced integration and
collaboration.

The governance and accountability arrangements for the ‘refreshed’ policy set out in Domain 4 are
consistent with this. In essence, they recognise that, while responsibility for establishing an
accountable mental health service lies primarily with the health sector, they provide for the
involvement of relevant Government departments/ agencies to oversee and account for their
respective areas of responsibility and action.

**B 4.5 Partnership in care**

AVFC recommended that service users, family, carers and supporters (FCSs) should participate at all
levels of the mental health system and be active partners in designing, planning, monitoring and
evaluating the services. As such it seeded the concept of *Partnership in Care* which remains integral to the ‘refresh’ of the policy.

Through the auspices of a Reference Group established by the then HSE Mental Health Division in 2014, a range of structures and mechanisms for service user and FCS engagement are now embedded in the HSE. As a result, a Head of Mental Health Engagement was appointed who is a member of the HSE Mental Health Community Operations team and who leads the Office of Mental Health Engagement & Recovery. Nine Area Leads for mental health engagement have also been appointed as members of the mental health services area management teams in CHOs.

As set out in the original policy, service users and FCSs can be involved in the development and delivery of mental health services and supports in a range of ways, all characterised by a partnership approach. At an individual level, the most immediate way that a service user can be involved is through the development of their own care plan and by being able to advocate for the services and supports they require, as active partners in their own recovery, both of which are considered later in Domain 2.

FCSs can play a key role in providing recovery support and should be involved in care planning except where the service user does not want to have them involved. The issue of confidentiality and the sharing of information with FCSs is one which requires continuous and careful attention. Stakeholders commented on difficulties that can be experienced when there is a blanket refusal to engage with FCSs on the basis of confidentiality. The *Family, Carer and Supporter (FCS) Guide*, produced by the Office of Mental Health Engagement and recovery at the HSE National Mental Health Services describes the on-going process of obtaining consent for sharing information, the kinds of information that can be shared and the specific circumstances where information can be shared without the permission of the service user. Importantly, mental health staff can listen to FCS and provide them with advice and support without breaching the confidentiality of their relationship with the service user.

Having service users and FCS as trained peer advocates is another mechanism for involvement. This entails supporting those who, after a period of severe emotional distress, may not be able to advocate for themselves. Peer advocates provide a listening ear, information and support. Ideally, the advocate empowers the service user to do things for themselves and to reclaim control over their own lives. Access to advocacy as a right for all service users and FCS across the country is an area to focus on in the lifetime of the ‘refresh’. It is considered later in Domain 2.

The recovery ethos promotes the idea of bringing people with lived experience of mental health difficulties into contact with those who are in recovery to foster hope. Access to peer-provided services in the community and the employment of peer support workers in statutory mental health services remain important priorities for the future. In February 2017, the first cohort of peer support workers were recruited and there are 28 posts now in CMHTs across the country. Indications from a review of the work and experience of this initial cohort provide insights into the positive impacts for service users. The roles aim to inspire hope and empowerment, boost self-esteem and confidence with individuals accessing services. Most importantly, they show that recovery is possible, where peer workers themselves are the proof that an individual can have a good quality of life after a diagnosis or other mental health challenge. There are also benefits for staff from all disciplines in the CMHTs. Such staff have a better awareness of the language and approach used by teams, making them more recovery-oriented and person-centred.

Finally, the involvement of service users and FCSs in decision-making and oversight structures in relation to the development of mental health services is a key mechanism to facilitate ‘Partnership in Care’. Two cases in point are the establishment of the Office of Mental Health Engagement and
Recovery at the HSE National Mental Health Services and its associated structures in accordance with the recommendations of the Partnership for Change Report and the development of the National Framework for Recovery in Mental Health (2018-2020). Partnership for Change, which was produced by service users and FCS and was launched in 2016, outlined the structures to be rolled out across the country to put service users and FCS at the centre of the design delivery, monitoring and evaluation of mental health services as recommended in AVFC. There are now 35 local fora of service users and FCS in all CHOs doing just that. The National Framework, which was launched in 2017 to provide guidance to service providers on ways of working to deliver a quality person-centred service aligned to the recovery model. It was developed in collaboration with a wide range of stakeholders and co-produced with service users and FCS. The governance and accountability arrangements to oversee the implementation of this ‘refreshed’ policy, as outlined in Domain 4, include service users and peers/experts by experience as a further example of the on-going priority that is Partnership in Care.

In summary, there will be a strengthened focus on ensuring that service users and FCSs are involved at all levels of design, development and delivery of services – building on the Partnership in Care ethos embedded in AVFC.

**B.5 Core values and principles**
Consistent with the original policy, core values are central to this policy ‘refresh’ and they underpin its service philosophy. Human interaction is at the heart of the delivery of mental health supports and care, where this is an expression of individual and organisational values. This was emphasised strongly in the consultations for this policy ‘refresh’ where participants described their ambition, and those of the oversight group, for a service based on the core values of respect and compassion and where service users are given hope and treated equitably. These core values are set out graphically in Figure B.9. They are the foundation for the four principles of service delivery expressed in Table B.1 (page 13). Both the core values and service delivery principles honour the findings of the consultation process for this ‘refresh’ of AVFC. They should be reflected in all future service planning and delivery by the Department of Health.
The core values of respect, compassion, equity and hope prescribe at a very fundamental level the way in which a person using mental health services and supports should expect to be treated:

<table>
<thead>
<tr>
<th>Core Values</th>
<th>Description</th>
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<tbody>
<tr>
<td>Respect</td>
<td>Respecting each person as an individual and treating everybody with dignity at every level of service provision</td>
</tr>
<tr>
<td>Compassion</td>
<td>Treating everybody in a friendly, generous and considerate manner and developing a rapport with each person – demonstrating understanding and sensitivity</td>
</tr>
<tr>
<td>Equity</td>
<td>Access to services characterised by inclusiveness, fairness and non-discrimination</td>
</tr>
<tr>
<td>Hope</td>
<td>Interactions during the course of service delivery full of positivity, and empowerment, with a strengths-based focus</td>
</tr>
</tbody>
</table>

These service delivery principles are a working ‘reference framework’ for the implementation of all service delivery models and approaches recommended in this ‘refresh’ of AVFC. They explain what someone can expect each principle to mean for them in their day-to-day experience of using services and supports. They also explain to those delivering services – in the statutory, VCS and independent sectors – and those supporting and scrutinising service delivery, what each principle should mean to individuals using services and supports.
AVFC contained mixed principles underpinning service delivery, characteristics of “good” services and approaches to service delivery – all of which have been reviewed based on the consultation to develop the core values and service delivery principles already outlined here.

The values from AVFC are preserved throughout this refreshed policy. For example, a population-based planning approach – mentioned in Section B.4 – provides the over-arching framework for the ‘refresh’. A community-based approach to care is central. It is wider than providing mental health services and includes a core role for VCS and for other non-mental health public agencies and organisations. Integrated and coordinated care according to service users’ total individual needs should include these interests and is described and incorporated in various recommendations in Domain 2. Mental health services should be accessible for all, not just geographically accessible but provided at a time, in a setting, in a culturally competent manner, that makes access as easy and as straightforward as possible. What such services should look like are described and incorporated in various recommendations in Domain 2. Mental health supports and services should focus on prevention and early intervention – an approach central to Domain 1 of this ‘refresh’. Services must be effective and high quality with appropriate governance arrangements to ensure accountability.

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These priorities are described in detail in Domain 4 and now include a focus on continuous improvement and innovation.
Section C Domain 1 – Promotion, prevention and early Intervention

C.1 Introduction

The original AVFC policy highlighted the importance of mental health promotion and recognised that everyone has mental health needs, whether or not they have a diagnosis of mental ill health. It therefore had a series of population-based actions focusing on the protective factors for enhancing well-being and quality of life, together with early intervention and prevention of mental health difficulties. It recognised that mental health promotion works at three levels – to strengthen individuals and improve their emotional resilience; to strengthen communities, improving social capital through increased participation; and to reduce structural barriers to mental health through initiatives to reduce discrimination and inequalities.

These actions all remain highly relevant to the ‘refresh’ of the policy. This domain now reiterates the importance of supporting positive mental health as part of a spectrum of population-based responses, recognising a range of policy developments that have occurred in the period since the publication of AVFC.

Positive mental health builds resilience, so that people can adapt to challenges and adversity, get the most out of life and maintain a positive sense of well-being and self-worth, combined with a sense of control and self-efficacy. The concept of positive mental health also means that ‘mental health’ is not just an absence of ‘mental illness’ but is a separable, albeit often linked, characteristic, concentrating on positive well-being. This could mean having good mental well-being while living with significant and enduring mental health difficulties. In other words, ‘living well with a mental health difficulty’, as defined by the WHO.

The WHO definitions recognise the need for a ‘whole person’ approach towards the highest possible standards of physical and mental health and well-being. The interdependencies between physical and mental health are well recognised. For example, some of the key risk factors for poor physical health and reduced life expectancy can be more prevalent among people living with a mental health difficulty than among the general population. Equally, there can be higher rates of mental health difficulties among people with long-term physical health difficulties and a need for support to address the wider psychological aspects of such physical health challenges.

This Domain is consistent with the overarching national framework for health and wellbeing, Healthy Ireland, which aims to improve both physical and mental health and recognises the interdependencies between the two. A key part of this ‘refresh’ of AVFC is to explore opportunities for improved integration between physical and mental health, with such integration being reflected as a national policy priority in the Sláintecare report. The Healthy Ireland framework also recognises that well-being includes the concept of positive mental health – in line with the World Health Organisation (WHO) definitions already set out – whereby ‘a person can realise his or her own abilities, cope with the normal stresses of life, work productively and fruitfully, and be able to make contributions to his or her community’.

It is estimated that one in every four adult’s experiences at least one diagnosable mental health difficulty in any given year, with the corresponding figure for children aged 5-16 being one in ten. It is also estimated that half of all mental health difficulties have been established by the age of 14.

With such difficulties starting early in life, they can be prevented or reduced in their severity of impact through actions across a range of sectors. This is the focus of Outcome 1d. Cross-sectoral

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actions can impact on the factors that contribute to mental health by creating healthy environments in schools, communities and workplaces that foster mental well-being.

As set out in Section B, the context for this ‘refresh’ of AVFC is that positive mental health is not a matter for the health sector alone. It is part of a much broader context of how society views mental health and how decisions can be made across the spectrum of relevant public services to invest in the well-being of the population and to support individuals living with a mental health difficulty in their recovery. This cross-sectoral approach is consistent with international policy. For example, the WHO supports an environmental and community approach to supporting health. Similarly, the European Mental Health Action Plan 2013–2020 (EMAP) highlights that ‘levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological well-being.’

C.2 Outcomes for promotion, prevention and early intervention

This ‘refresh’ of AVFC, as noted in Section B, adopts a lifecycle approach, acknowledging that the foundations for mental well-being are established before birth and that much can be achieved through interventions and supports to build resilience and improve well-being throughout childhood, teenage years and on into adulthood and later life. So this domain includes recommendations relating to different age groups across the lifecycle. It also has more generally focused recommendations, centred on tackling stigma and discrimination as per Outcome 1c and building resilience at a broader societal level. It also recognises that greater emphasis is needed on promoting positive mental health and building resilience amongst specific priority groups, deemed to be ‘at risk’. In these cases, more tailored approaches are needed and this is the intent of Outcome
1b. All recommendations in Domain 1 are intended to achieve the four outcomes 1(a)–1(d) set out in (Fig. C.1).

C.3 Understanding mental health

Mental health describes how we think and feel about ourselves and our relationship to others and how we interpret events in everyday life. It also relates to our ability to cope with change, transition, significant life events and understanding how to deal with stresses that often come our way.

Good mental well-being, on the one hand, and mental health difficulties, on the other, arise as a result of a complex mix of social, economic, psychological, biological and genetic factors. These factors come together in a way that is unique to each individual. Mental health can be thought of as existing in a continuum from mental well-being through experience of emotional distress to living with an on-going mental health difficulty and, sometimes, experiencing a crisis.

C.4 Building community resilience and well-being

A continued commitment to fostering community resilience and well-being is consistent with emphasis in the Sláintecare report on the importance of a preventative approach. It is also consistent with the 2030 Agenda for Sustainable Development, adopted by all UN member states in 2015, which under the Sustainable Development Goal (SDG) of ‘Good Health and Well-Being’ acknowledges the need to promote ‘well-being for all and for all-ages’.

This work moves control more towards the community through educating the wider public about mental health and well-being and mental health difficulties and providing structural supports that encourage resilience. Promoting well-being for everyone in the community also involves targeting the social factors outside the direct control of the health services that foster positive mental health and the development of resilience. These social factors are described in more detail in Domain 3 (Social Inclusion) and include other policy areas such as access to housing, employment and pathways to employment.

Central to all of this is empowerment, both at personal and community levels. At a personal level, actions to build community resilience and well-being aim to empower individuals to take charge of their health and well-being. Implicit in this is having the information, choices and confidence to make informed decisions and having access to self-help options, when necessary. All of these can build the capacity of people who experience mental health difficulties to influence their health outcomes positively. At a community level, empowerment is about having opportunities to participate and influence decisions about access to local services and supports.

The first recommendation is the resourcing of a National Mental Health Promotion Plan. This should be located within the Healthy Ireland framework. That framework has the ambition that ‘everyone can enjoy physical and mental health and well-being to their full potential’. The plan should strengthen communities’ capacity to foster mental health, addressing the environmental factors that contribute to mental health and well-being, and building individuals’ resilience. The plan should focus strongly on triggering local action across Ireland. It should incorporate evidence-based interventions known to enhance protective factors and decrease risk factors for developing mental health difficulties. The effectiveness of the plan should be regularly monitored and assessed by objective, measurable targets or performance indicators (PIs).

The plan should be underpinned by the following principles:

7 https://health.gov.ie/healthy-ireland/
▪ Strengthening the individual by improving emotional resilience through interventions which equip people with positive coping skills and self-esteem;
▪ Strengthening the community by increasing social inclusion and participation and by improving neighbourhood and workplace environments, facilities and services;
▪ Reducing structural barriers to health by challenging discrimination and inequity and by promoting access to education, meaningful employment, housing, and social services; and
▪ A Mental Health in All Policies approach to promote population mental health and well-being by initiating and facilitating action in different non-health public policy areas as part of the overall Healthy Ireland implementation plan.

There is general agreement – at both national and international level – that mental health promotion can be improved by building on current infrastructure and embedding principles of mental health promotion into the existing fabric of communities. The benefits of such an approach can be seen in global programmes such as Thrive and policies such as Together for Mental Health – A Strategy for Mental Health and Well-being in Wales 8. These work to build sustainable, nurturing communities, by drawing on resources from all sectors of society, including health, education, employment and transport to promote mental health. This approach is also clearly reflected in this ‘refresh’.

Recommendation 1
Healthy Ireland already has a remit for improved mental health and wellbeing. To further strengthen this, a dedicated National Mental Health Promotion Plan should be developed and overseen within Healthy Ireland implementation frameworks, with appropriate resourcing. The plan should be based on the principles and scope described in this Section.

<table>
<thead>
<tr>
<th>Recommendation 1</th>
<th>Contributing to Outcome 1(a)</th>
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<tr>
<td>Healthy Ireland already has a remit for improved mental health and wellbeing. To further strengthen this, a dedicated National Mental Health Promotion Plan should be developed and overseen within Healthy Ireland implementation frameworks, with appropriate resourcing. The plan should be based on the principles and scope described in this Section.</td>
<td>New Recommendation</td>
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The National Mental Health Promotion Plan will be the framework of reference and the overarching context for all mental health promotion and campaign activity in Ireland. A relevant example already in place is the #littlethings mental health and well-being campaign delivered by the HSE National Office for Suicide Prevention (NOSP) and about thirty-five partner organisations. The campaign shares evidence-based, simple and powerful day-to-day steps – ‘little things’ – that anyone can take to protect their own mental health and well-being. The campaign directs people to the mental health one stop shop, ‘yourmentalhealth.ie’, for more information as well as the Samaritans’ 116123 national free-to -call number for extra support. It is designed to change the shape and tone of the suicide prevention sector by encouraging everyone to work together, as well as solving a major issue about awareness of relevant supports for the public.

There is also interest in a public information campaign to raise awareness of the importance of promoting social-emotional development, positive mental health and reducing the impact of early childhood trauma in babies and young children. Such a campaign should also be a part of the recommended National Mental Health Promotion Plan and an integral component of the life cycle approach. (The needs of babies and young children are discussed further in the context of the ‘First 5’ policy described later in this domain).

C.5 Harnessing digital technologies and promoting mental health

Enhanced digital health supports will ensure opportunities are maximised to support additional quality-focused services into the future. There are several emerging mobile apps and online supports focusing on helping people achieve positive mental health and well-being. Engagement with digital technology is increasing in popularity. There is some evidence that well-designed products can have beneficial impacts, but it is acknowledged that this is a very dynamic and largely unregulated field

and studies have found that design and psycho-educational content is very variable. In developing supports, the experience of organisations and countries that are further down this digital path must be drawn upon. Research is required to determine the effectiveness and safety of some digital offerings as there is little benchmarking about the effectiveness of many solutions on the market.

Various Irish initiatives have used digital channels to support public mental health promotion. The development of a crisis text line, online counselling and tele-psychiatry are currently being tested to see how online interventions can deliver mental health outcomes for service users seeking treatment. This is a field that should be further evaluated, resourced and enhanced, subject to the qualification about design, psycho-educational content and other concerns, such as quality assurance. Digital developments will form part of the proposed National Mental Health Promotion Plan.

Opportunities for mental health promotion, prevention and early intervention using social media also need to be considered. This should be a priority of the National Mental Health Promotion Plan, given the prominence of social media in all our lives. The plan should promote activities for prevention and early intervention on social media and identify opportunities for promotion of positive messages and supports to users. It should also provide education and guidance for social media users on supporting the mental health of others and education and guidance for influencers, moderators and other key parties. There are excellent examples of this provided by the Blurt Foundation and the Black Dog Institute.

New and emerging technologies may bring enormous benefits to society and it is important that everybody can avail of these benefits responsibly without compromise to their safety and privacy online. The Irish Government’s Action Plan for Online Safety 2018–2019, was launched by the Taoiseach, Leo Varadkar TD in July 2018 and is currently being implemented. The report was a starting point for the government’s commitment to address issues about online safety involving a wide range of stakeholders and several government departments, including the Department of Education and Skills, the Department of Justice, the Department of Communications, Climate Action and Environment and the Department of Health. This recognises that responsibility for the issues relating to online safety needs collaboration between many parties, including government, parents, children, the EU and online platforms. This ‘refresh’ supports the actions contained in the Action Plan for Online Safety 2018–2019 and recognises that research is needed to understand better the negative impacts of engaging in online activities.

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<tr>
<th>Recommendation 2</th>
<th>Contributing to Outcome 1(a)</th>
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<tr>
<td>Digital and social media channels should be exploited to maximise promotion of mental health and appropriate awareness of available supports. The use of these media should be based on best practice and available evidence. Resources should be provided to address gaps in the evidence base related to this outcome and to examine any negative impacts of social media activity on mental health.</td>
<td>New Recommendation</td>
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AVFC 2006–16, at Recommendation 5.4, recommended that ‘designated health promotion officers should have special responsibility for mental health promotion, working in cooperation with local voluntary and community groups and with formal links to mental health services.’ There is now a number of national health promotion and improvement officers operating across HSE areas. The HSE must ensure a consistent focus on mental health promotion and physical health promotion by these officers. So there needs to be a parity of effort between mental and physical health officials as they carry out their promotional roles. The job specification for these tasks should be reviewed accordingly, with a need for on-going monitoring of the extended work in mental health promotion. They must deliver specific, evidence-informed mental health promotion programmes relatable to the National Mental Health Promotion Plan. Staff in mental health and other services also have a critical role to play in mental health promotion.
Recommendation 3
Ensure the work programme for health promotion and improvement officers is reviewed to ensure parity of effort and emphasis on mental health promotion as well as physical health promotion.

A mental health focus is also needed in other health promotion initiatives such as on obesity, smoking, and alcohol misuse. The mental health component should be evidence informed to ensure that all activity meets with best practice in mental health promotion. Performance indicators (PIs) should also be developed to measure outcomes from mental health promotion programmes, which is an element of a wider recommendation included in Domain 4.

Generic health promotion programmes should also target people with existing mental health difficulties, to promote their well-being and recovery. In recent years there has been an uptake in health promotion messages among people who have mental health difficulties related to smoking cessation, diet and nutrition and physical exercise. Such efforts should continue and be supported with measureable results, such as the numbers of people with mental health difficulties who engage in health checks like Cervical Check and Breast Check. Historically, participation of people with mental health difficulties in such health services has been lower than in the general population.

AVFC 2006–16 recognised the valuable role of Voluntary and Community Sector (VCS) organisations in supporting the mental health of individuals and communities. The VCS engages in extensive mental health promotion work to both prevent mental health difficulties in local communities and to support the mental well-being of people with existing difficulties. The range of services provided by the VCS sector include the provision of information and direction to relevant supports, awareness-raising events, resource centres and peer support groups, and access to counselling and other talk therapies (These are described in Domain 2 – Service Access, Co-ordination and Continuity of Care). Local VCS organisations can play an important role in tailoring national mental health programmes to their community’s needs, preferences and circumstances. It remains important that local community projects connect with a national mental health promotion agenda so that their joint efforts can be effective.

Recommendation 4
New and existing community development programmes which promote social inclusion, engagement and community connectedness should be appropriately resourced and developed in line with the proposed National Mental Health Promotion Plan.

C.6 Building resilience amongst priority groups

The research and engagement for this ‘refresh’ of AVFC indicates that greater emphasis is needed on promoting positive mental health and building resilience amongst specific priority groups, deemed to be ‘at risk’. This should complement the universal actions targeted at the general population.

Connecting for Life (CFL) (2015–2020) is the whole-of-society strategy to co-ordinate and focus national efforts in Ireland to reduce the loss of life by suicide and limit cases of self-harm. It covers preventive and awareness-raising work with the population as a whole, supportive work with local communities and targeted approaches to priority groups.

The research and consultation for this ‘refresh’ of AVFC 2006–16 indicates that the identification of priority groups, displaying evidence of vulnerability to, and increased risk of, suicidal behaviour in
CFL is a useful reference point for this domain. These groups include members of the LGBTQ+ community, members of the Traveller community, people who are homeless, drug users, people who come in contact with the criminal justice system, people who have experienced domestic, clerical, institutional, sexual or physical abuse, asylum seekers, refugees, migrants and sex workers. In line with Sláinte Care implementation strategy recommendations, responsive and integrated approaches with the inclusion health agenda are required to ensure services are accessible to all citizens, including those from identified priority groups who often have multiple and complex health needs. Inclusion health is a service, research, and policy agenda that aims to prevent and redress health and social discrimination among the most vulnerable and excluded populations. This approach should complement the overall services accessed by the general population.

The work for this ‘refresh’ would indicate that this list is a useful starting point, with some additional groups such as children in care, care leavers, people with disabilities, people who have severe to profound deafness and people with substance – that is drug and alcohol – misuse problems. This should not be viewed as an exhaustive list and, as is the case with CFL, the list of priority groups should be regularly kept under review and updated, if necessary.

Interventions to build strengths amongst these groups must take into account the stigma, discrimination and marginalisation that individuals can experience, often leading to higher risks of mental health difficulties. An analysis of the most common vulnerabilities and issues for each priority group is needed to develop tailored mental health promotion and prevention measures. Such tailored interventions will help to promote inclusion and respond to evidence about unmet needs and barriers to building strengths. Targeted campaigns and preventative outreach work should be done in partnership with organisations working with the priority groups to achieve increased effectiveness and impact.

These proposals, in Domain 1, match the delivery of ‘culturally competent’ mental health services, as set out in Domain 2 (Service Access, Coordination and Continuity of Care). Delivery of culturally competent mental health services is based on integrating cultural, linguistic and other diversity into the delivery of all mental health services.

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<tr>
<th>Recommendation 5</th>
<th>Contributing to Outcome 1(b)</th>
<th>Contributing to Outcome 1(d)</th>
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<tr>
<td>The proposed National Mental Health Promotion Plan and the existing work of Connecting for Life should incorporate targeted mental health promotion and prevention actions that recognise the distinct needs of priority groups.</td>
<td>New Recommendation</td>
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### C.7 Reducing stigma and discrimination

Reducing the stigma and discrimination associated with mental health difficulties is central to improved well-being at a societal level. It presupposes a culture of understanding and consideration of how a person with lived experience of a mental health difficulty is viewed by those they interact with, for example, at school, at work and in the wider community. Mental health stigma, self-stigma, prejudice and discrimination are some of the main reasons why people experiencing mental health difficulties do not seek help and, as a consequence, it may hinder their recovery.

To build a ‘whole community’ approach to reducing stigma and discrimination, it is recommended that a National Stigma Reduction Programme with a coherent theory of change be developed. This should build on existing programmes and evidence and should have shared ownership and reach across government. In other words, it should not be solely the responsibility of the health services. This ‘refresh’ of AVFC emphasises how decisions can be made across all relevant public services to invest in the well-being of the population and support individuals living with a mental health difficulty as they recover from that difficulty.
The research and outcomes for this ‘refresh’ indicates that anti-stigma efforts to date have concentrated on depression and anxiety and that, in the future, consideration should also be given to stigma associated with other conditions such as schizophrenia and psychosis. A *National Stigma Reduction Programme* must tackle prejudice and discrimination in respect of all mental health conditions, prioritised according to the evidence of need. It should rationalise such programmes and develop stigma-reduction initiatives for the general population, workplaces, health and social care settings and for other specific groups. The programme would therefore not be a single intervention, but a portfolio of coherent and parallel stigma-reduction initiatives developed collaboratively and with shared responsibilities across government and health services.

### Recommendation 6

A *National Stigma Reduction Programme* should be implemented to build a ‘whole community’ approach to reducing stigma and discrimination for those with mental health difficulties. This should build on work to date and determine a clear strategic plan, with associated outcomes and targets across related strands of work.

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<tr>
<th>Contributing to Outcome 1(c)</th>
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<tr>
<td>Building on Recommendation 4.2 in AVFC 2006-16</td>
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### C.8 Suicide prevention and initiatives addressing self-harm

As noted earlier, *Connecting for Life* (2015–2020) is a ‘whole-of-society’ strategy to coordinate and focus national efforts in Ireland to reduce the loss of life by suicide and to limit cases of self-harm. It involves preventive and awareness-raising work throughout the entire population, supportive work with local communities and targeted approaches to priority groups.

The strategy is now being implemented fully, through the HSE National Office for Suicide Prevention (NOSP). There are also seventeen multi-agency local *Connecting for Life* Suicide Prevention Action Plans in place and being implemented across the country. The local action plans play an important role in enhancing community capacity to reduce suicide and more widely to building the capacity of communities to support well-being and mental health.

An independent Interim Reviewa of CFL was completed in February 2019 which clearly shows that progress has been made in implementing the strategy. It concludes that the strategic vision and core components of the evidence-informed suicide prevention approaches – which are fundamental to the national strategic response to reduce deaths by suicide – remain appropriate for the future. It highlights that consistent implementation of the strategy beyond 2020 is required, recognising that there is still work to be done before the seven strategic goals of the strategy and their associated actions are fully achieved and the vision of an Ireland where fewer lives are lost through suicide is realised and sustained. Specifically, the review recommends that the Department of Health should extend the timeframe and funding of *Connecting for Life* to 2024 and develop an implementation plan with key partners for this. The extension of *Connecting for Life* to 2024 will support the ambition of, and desired outcomes in, this and other domains of this ‘refresh’ of AVFC. As such, it is endorsed by the oversight group as appropriate to become part of future policy by the Department of Health.

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Recommendation 7
The Department of Health should extend the timeframe and funding for the strategy for Connecting for Life (CFL) to 2024.

Contributing to all four outcomes.

New Recommendation

C.9 Promotion, prevention and early intervention across the lifespan

C.9.1 Early years

It is widely acknowledged that the first five years of a child’s life ‘last a lifetime’ and shape the person they are going to be. It is at this stage that children learn appropriate behaviour, boundaries, empathy and many other important social skills which will remain with them for life. ‘First 5’, A Whole-of-Government Strategy for Babies, Young Children and their Families 2019–2028 ref 12 here was launched in November 2018 by the Department of Children and Youth Affairs. One of its key objectives – Objective 6 – is that ‘babies, young children and their parents enjoy positive mental health’.

This ‘refresh’ of AVFC endorses and supports the various recommendations and actions set out in ‘First 5’ under Objective 6 to improve (a) the early identification of mental health difficulties among babies, young children and families and (b) access to mental health supports and services for babies, young children and families, with a particular emphasis on initiatives that integrate mental health supports and services into child-serving settings and the wider community.

Recommendation 8
The relevant recommendations of the First 5 strategy under Objective 6 - relating to primary prevention, early intervention and positive mental health, should be implemented.

Contributing to Outcome 1(a)

Contributing to Outcome 1(d)

New Recommendation

For children, there is also an opportunity in this ‘refresh’ of AVFC to recognise and incorporate work being piloted on the impact of Adverse Childhood Experiences (ACEs) on the well-being of children in their later life. Children who have been exposed to ACEs such as domestic violence, alcohol or drug abuse, mental health difficulties and bereavement can experience negative impacts which last well into adulthood. Prevention and early intervention are critical to the reduction of trauma associated with these ACEs by vulnerable children. The provision of trauma-informed services, as described in Section B.6, recognises this. There are pilot cross-border projects, supported through INTERREG VA funding, which are supporting vulnerable families who are at risk from multiple adversities in their lives, through identification, early intervention and the provision of support in their communities. The learning from such projects as well as from others working in this field should be part of mainstream services to support vulnerable families.

Recommendation 9
It is recommended that the learning from pilot programmes centred on addressing the impact of Adverse Childhood Experiences (ACEs) through prevention and early intervention work, is incorporated into mainstream services for the support of vulnerable families.

Contributing to Outcome 1(d)

New Recommendation

C.9.2 Promotion and well-being in schools

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10 [https://www.dcy.gov.ie/documents/earlyyears/19112018_4966_DCYA_EarlyYears_Booklet_A4_v22_WEB.pdf](https://www.dcy.gov.ie/documents/earlyyears/19112018_4966_DCYA_EarlyYears_Booklet_A4_v22_WEB.pdf)
Having looked at the needs of infancy and early childhood, the promotion of well-being and mental health for school-aged children is the next important springboard to lifelong social and emotional well-being. Schools and educational settings provide a powerful context for the promotion of well-being. In 2018, the Department for Education and Skills (DES) launched its *Well-being Policy Statement and Framework for Practice (2018–2023)* which recognised that the mental health and well-being of young people is critical to success in school and life. It provides an overarching structure that encompasses existing and developing work in the area of well-being and mental health promotion in education, including the Junior Cycle well-being programme. It was informed by consultation with stakeholders and international research and practice.

The policy statement and framework sets out the DES’s ambition and vision for well-being promotion, to ensure that the experience of children and young people in our schools is one that enhances, promotes, values and nurtures their well-being. Within its policy statement and framework, the DES proposes a whole-school, multi-component, preventative approach to well-being and mental health promotion in education that includes interventions at both universal and targeted levels.

The framework includes an *Implementation Plan (2018–2023)* and highlights that implementing the policy will require allocation of resources to ensure the framework’s actions are carried out. This plan includes the provision of a national programme of continuing professional development for teachers by DES support services, a review of existing supports and resources to include consideration of the developing role of the National Educational Psychological Service in this area and the development of a web portal to facilitate access to supports, practical tools and resources. The DES highlights within this plan the need for strong cross-sectoral collaboration to ensure a whole-of-system, aligned approach to well-being and mental health promotion and the development of clear pathways to a continuous range of services for children and young people.

Through the implementation of this framework, mental health promotion, prevention and early intervention will become part of the ‘whole school approach’ to well-being. The role of National Educational Psychological Service (NEPS) psychologists in the area of well-being promotion and early intervention will also be developed. As such, it will contribute strongly to the targeted outcomes in, and ambition of, this domain of the refreshed AVFC policy by the Department of Health.

To reinforce the effectiveness of the framework, an effective structure for cross-sectoral collaboration in the area of well-being and mental health promotion should be established as part of the *National Mental Health Promotion Plan*. There should be an agreed protocol in place between primary and post-primary schools and HSE services about referral pathways to local services and signposting, including digital signposting, to such services, as necessary. All of this should be informed by the work and role of NEPS in primary and post-primary schools in Ireland.

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<thead>
<tr>
<th>Recommendation 10</th>
<th>Contributing to Outcome 1(a) Contributing to Outcome 1(d)</th>
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<td>It is recommended that the Department of Education and Skills <em>Wellbeing Policy Statement and Framework for Practice (2018-2023)</em> is implemented in all schools and centres for education across Ireland, and that the support services involved in its implementation, including NEPS, are adequately resourced.</td>
<td><em>New Recommendation</em></td>
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<th>Recommendation 11</th>
<th>Contributing to Outcome 1(d)</th>
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<td>A protocol should be developed between the Department of Education and Skills and the HSE on the liaison process that should be in place between primary/post-primary schools, mental health services and supports such as NEPS, GPs, primary care services and specialist mental health services. This is needed to facilitate referral pathways to local services and signposting to such services, as necessary.</td>
<td><em>New Recommendation</em></td>
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C.9.3 Additional youth supports

The National Youth Mental Health Task Force (YMHTF) was established in response to an undertaking in the Programme for Partnership Government to provide national leadership in the field of youth mental health and to ensure that the public, private, voluntary and community sectors work together to improve the mental health and well-being of young people. In December 2017, the task force produced a set of ten recommendation areas that were distilled from twelve months of discussion and consultation. These form a template to transform Ireland’s approach to youth mental health over the coming years with a ‘whole community’ approach.

In its domain of education and prevention, the YMHTF report contains several key recommendations that are consistent with themes raised during the engagements and work done to ‘refresh’ AVFC.

The task force suggested that the recommendations in its report be implemented within three years. While it is acknowledged that there has been progress with many of the actions outlined in the report, this ‘refresh’ of AVFC supports maintaining momentum and implementing the report’s remaining recommendations by 2020.

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<tr>
<th>Recommendation 12</th>
<th>Contributing to Outcome 1(a)</th>
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<td>In order to build on progress and maintain momentum, the remaining recommendations contained in the Youth Mental Health Task Force Report by 2020 should be implemented.</td>
<td>Contributing to Outcome 1(d)</td>
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<td>New Recommendation</td>
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C.9.4 Mental health in the workplace

The Healthy Ireland framework estimates that mental health difficulties cost the Irish economy €11 bn each year, much of it related to lost productivity in the labour market from both absenteeism and presenteeism, that is, functioning at less than optimum capacity while at work.
Studies show that improved well-being reduces sickness absence and increases performance and productivity. See Change, the national stigma reduction partnership, has identified that workplaces which allow for open discussion about mental health, including people’s own personal experiences, can promote overall organisational and individual well-being. There is an opportunity to promote positive mental health and well-being among the working age population by building on existing initiatives in the workplace.

**Recommendation 13**
The National Mental Health Promotion Plan integrated with the Healthy Workplace Framework should incorporate actions to enhance the mental health outcomes of the working age population through interventions aimed at mental health promotion in the workplace. This should consider environmental aspects of the working environment conducive to supporting positive mental health and well-being.

**Contributing to Outcome 1(a)**
**Contributing to Outcome 1(d)**

**New Recommendation**

### C.9.5 Mental health and older people

Having looked at the needs of all other age cohorts, it is appropriate now to turn to later life. An important element of healthy ageing is the promotion of good mental health and well-being. According to the WHO, between 2015 and 2050, the proportion of the world’s population over 60 years will nearly double, from 12 per cent to 22 per cent. Mental health and well-being are as important in older age as at any other time of life. Older adults make valuable contributions to society and, while most maintain good mental health, many are at risk of developing poor mental health. Older people are exposed to multiple risk factors that contribute to poor mental health such as reduced mobility, chronic pain, frequent illness, loneliness and on-going loss of sight and hearing. Older people also experience loss and bereavement that are significant contributors to poor mental health.

The *Healthy Ireland* framework makes a clear commitment to improving ‘partnerships, strategies and initiatives that aim to support older people to maintain, improve or manage their physical and mental well-being’. This involves addressing risk factors and promoting protective factors at every stage of life, including old age, to support lifelong health and well-being.

There are a number of actions that should be taken to promote the mental health and well-being of the older population. These include enhancing the capacity at primary care level to support the identification of mental health need among the older population. As such, many of the recommendations in Domain 2 (Service Access, Coordination and Continuity of Care), and centred on an enhanced capacity for primary care, will help with this, not least in recognising the interrelationship between physical and mental health and the mental health impact of chronic physical health conditions on older people.

The first results from TILDA reported that quality of life increases with greater social integration and that there is a strong positive association between social engagement and physical and mental health outcomes. In addition, it is noted that common and predictable life events such as bereavement can be provided for not only through identification of need and service access, but also through strengthened, enhanced communities.

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17 [https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0121101&type=printable](https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0121101&type=printable)
A wide range of actions targeted at achieving the goals of the *National Positive Ageing Strategy* should be developed and implemented. These include mental health training and supports for health professionals and home help teams and carers who provide services for older people; creating mental health supports for those in long-term palliative care; and developing age-friendly services and settings, for example, in the community and in primary care. These could include the provision of peer and professional supports; as well as support for community-based projects which develop social networks for older people through involvement in meaningful activity in their local community. A final action that could inform planning in this area is to ensure that mental health identifiers are part of the *Healthy and Positive Ageing Initiative’s* research programme.

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<tr>
<th>Recommendation 14</th>
<th>Contributing to Outcome 1(d)</th>
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<td>A range of actions designed to achieve the goals of the <em>National Positive Ageing Strategy</em> for the mental health of older people should be developed and implemented, supported by the inclusion of mental health indicators in the <em>Healthy and Positive Ageing Initiative’s</em> research programme.</td>
<td><em>New Recommendation</em></td>
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Section D  
Domain 2 – service access, co-ordination and continuity of care

D.1 Introduction

As a natural development from the wider, population health focus of Domain 1 (Promotion, Prevention and Early Intervention) and taking into account the population-based planning approach set out in the inverse pyramid at Figure B 2, the focus of this domain is on the mental health services themselves. These include the full range of mental health services and supports, as well as how those services are coordinated and the need for continuity of care. Domain 2 relates to the two levels at the lower end of the inverse pyramid.

In line with the core values and principles, set out previously in Section B.6, mental health services will be evidence-informed, recovery-orientated and will adopt trauma-informed approaches to care, based on lived experience and individual need. They will be clinically effective, delivered in adherence to statutory requirements and based on an integrated multidisciplinary approach.

There will be a strengthened focus on ensuring that service users are involved at all levels of design, development and delivery of services – building on the Partnership in Care ethos described in Section B. This extends to the needs and interests of family, friends and carers (FCSs), as appropriate. This ‘refresh’ of AVFC particularly affirms the need to ensure a partnership approach at the individual level in the care and recovery planning process to ensure that people with mental health difficulties are leaders of their own care and recovery plans, and that FCSs with the permission of the individual concerned are involved in care and recovery planning as full partners.

D.2 Outcomes – service access, co-ordination and continuity of care

Figure D.1 summarises the four high level outcomes for Domain 2. The outcomes suggest what a service user or FCS might expect from the mental health services in the future. The recommendations set out for this domain are designed to contribute to the achievement of one or more of these outcomes.

![Figure D.1 Outcomes service access, co-ordination and continuity of care](image-url)

**Outcome 2(a)**  
All service users have access to timely, evidence-informed interventions.

**Outcome 2(b)**  
Service delivery is organised to enable increased numbers of people to achieve personal recovery.

**Outcome 2(c)**  
Services are coordinated through a ‘stepped care’ approach to provide continuity of care that will deliver the best possible outcomes for each service user.

**Outcome 2(d)**  
Health outcomes for people with dual/multi diagnosis are improved by ensuring greater collaboration between mental health and other relevant services.
In adopting an outcomes-based focus in this ‘refresh’ of AVFC 2006–2016, the main concern is the experience of people who use mental health services. This perspective has informed the recommendations about service design and related practices. In putting people before processes, the overriding intention in this domain is to ensure that service users and their FCSs have timely access to evidence-informed supports as indicated by Outcome 2a. This means that individuals, in need of services and support, get to the ‘right door’ faster because of the manner in which their mental health difficulty is assessed and the way in which referrals between different components of mental health system are managed.

Effective partnership and interworking between different services and professionals along the care pathway will also help service users and their FCSs to be better informed about the range of resources available. This will remove some of the barriers being experienced at present in ‘navigating’ the mental health system. In this way, service delivery will be better organised so that more people can achieve personal recovery as proposed in Outcome 2b. Information will be shared along the care pathway, from the first point of access right through to aftercare arrangements and the process of discharge. This will avoid the frustration repeatedly expressed in the engagements for this ‘refresh’ of AVFC of service users having to repeat the details of their circumstances ‘from scratch’ with each professional encountered along the care pathway.

This domain sets out proposals for a continuous range of integrated service elements needed in a modern recovery-orientated mental health system. Inherent in this process all services will be co-ordinated through a ‘stepped care’ approach to provide continuity of care in accordance with figure B3. Such a ‘stepped care’ and ‘continuity of care’ approach will deliver the best possible outcomes for each service user.

Finally, in shaping the recommendations in this domain, a key imperative was to ensure that greater collaboration and joint working should be in place between mental health and other relevant services to deliver improved health outcomes for people with dual or multi diagnosis. This will prevent service users from ‘falling through the cracks’ because sectors or services are guided by different policies, resulting in a disconnect between available resources and service user versus professional preferences for support and care.

D.3 Overview of the mental health care ‘system’ and proposed continuum of service elements

The recognition that no single service can cater for the diverse needs of the person with a mental health difficulty is central to improving his or her health and social care outcomes. Unsurprisingly therefore, this ‘refresh’ of AVFC reiterates the multi-sectoral, multi-stakeholder nature of mental health supports and services. The ‘refresh’ also incorporates the ‘stepped care approach’ – the aim of which is to enable the individual to have the needed range of support and services as close to home as possible and at the level of complexity that corresponds best to their needs and circumstances.

The mental health system blends effort, commitment and innovation across a range of sectors to support service users in their recovery. However, the system can be insufficiently integrated; can be difficult for service users and FCS to navigate; and can be inefficient where services are not co-ordinated – either across sectors or across the lifespan. Accordingly, in this ‘refresh’ of AVFC, a key focus has been on working to shape a system in which local VCS groups have a recognised role, where primary care supports are closely linked to specialist mental health services and where mental health services across the lifespan are integrated and coordinated.

Figure D.2 provides an overview of the ‘continuum’ of service elements proposed in this ‘refresh’ of AVFC.
Figure D.2 Continuum of mental health services and supports from CVS, through primary care to specialist mental health services.
The overview builds on the progress with service reform in recent years. The service elements, however, need to integrate with one another and with the different contexts, in which a service user may live, to ensure that needs are met in keeping with their stage of recovery and individuals’ wishes and preferences.

In interpreting the continuum of care, it is important to recognise that an individual may need services and supports from one or more of the service elements at the same time, depending on his or her prevailing needs and preferences.

For example, a person with a mild or moderate mental health difficulty would access support through the GP and, possibly, also avail of counselling in primary care or provided in the community by partners who have a service contract with the HSE. For an individual with a more acute mental health difficulty, care would be co-ordinated and delivered by the CMHT appropriate to the individual’s age—that is, child and adolescent, adult, or later life. This might also entail high-intensity support in an acute unit or day hospital or by a home-care team or through some combination of these. For example, there could be a short acute admission followed by day hospital or home care. For an individual presenting in a crisis, where the crisis has a medical component, such as a suicide attempt or self-harming, the expertise of an ED is typically required with a suicide liaison nurse and follow up by the relevant mental health team. A non-medical crisis may require a combination of the services of a crisis café and access to a bed in a crisis house, if a short-term residential response is needed. Finally, for individuals with complex mental health difficulties requiring long-term support, access to various service elements simultaneously may be needed. For example, those living independently in the community may require assertive outreach support, peer support, recovery education courses provided by a recovery college as well as wider links to support taking up employment under such schemes as the Individual Placement and Support (IPS) approach. The continuum aims to reduce the confusion between primary care and community-based care by providing clarity in terms of location, settings and levels of specialism.

For example, three types of mental health services and supports are located in the community setting (a) VCS groups; (b) primary care services consisting of GPs and primary care health professionals such as public health nurses, occupational therapists (OTs), psychologists; and (c) specialist community mental health teams (CMHTs) consisting of psychiatrists, community mental health nurses, OTs, psychologists, social workers and others, as part of statutory or public mental health services. A service such as counselling, for example, can be provided in all three settings. The difference is in the level of intensity and specialism of the support and the seriousness of the service user’s problem.

In order to describe the different service elements in some detail and to propose recommendations, the continuum will be separated into Mental health services and supports accessed through primary care, VCS and self-referral, as shown in Figure D.3, and Referral pathways and specialist mental health services, shown in Figure D.4 which illustrates many of the supports and services that are accessed on a self-referral basis or through primary care.
Figure D.3 Mental health supports and services accessed through CVS, primary care and self-referral

Supports Accessed Through Primary Care, Community Voluntary Sector or SelfReferral

ACCESS → GP’s → Primary Care Teams → ACCESS

- Digital Health Interventions
  - Access to Talking Therapies and related supports in the Voluntary or Community Sector
  - Community-Based Supports provided by CMHT
  - Peer Networks and Recovery Education
  - One to One Support
  - Access to a range of Talking Therapies in Primary Care Settings

- Other State Agencies as required
  - Community Based Supports provided by CMHT
  - Peer Networks and Recovery Education
  - One to One Support
  - Access to a range of Talking Therapies in Primary Care Settings

Some digital health programmes focus on promoting health and wellbeing and preventing ill health, while others may deliver early intervention and mental health treatment. There are numerous digital health programs available, covering a range of mental and physical health concerns, and thus increasing individual healthcare management choices.

Talking therapies are psychological treatments. They involve talking to a trained therapist to support you to deal with negative thoughts and feelings. They help you to make positive changes, and they take place in groups, one-to-one, using a computer or over the phone.

Social prescribing or community referral, enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. An individual's health is determined primarily by a range of social, economic, and environmental factors, social prescribing aims to support people to take greater control of their own health. Referrals can be made to a variety of activities which are typically provided by voluntary and community sector organizations, such as arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.

Peer Support: A system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathetically through the shared experience of emotional and psychological pain.
D.4 Access to supports in the VCS sector

The voluntary and community sector (VCS), with its strong local focus and ability to be responsive to the needs and preferences of service users (and FCSs) has the potential to become an increasing provider of the community-based recovery responses. These can form an integral part of the supports that individuals need when they experience a mental health difficulty. The contribution of the VCS is an important feature in every domain in this ‘refreshed’ policy. Services such as peer support, education and training, assistance with daily living activities, counselling, housing and employment supports, as well as connections to local social activities in the community are all important inputs to the recovery process. Supports are also available to people privately, such as talking and other therapies to which people can self-refer.

It is important to acknowledge and recognise that the some of the supports provided by the VCS sector are funded and or provided through a service agreement with the public mental health system. This investment by the public health system typically leverages considerable assets, investment and resources from the VCS sector, including access to volunteer or peer expertise and time. To get the best value from the VCS sector and to draw upon the sector’s strong position within communities, it is vital that public primary care and mental health services work in partnership with VCS groups, involving them in the design and delivery of integrated area support services. At a very basic level, this means mental health professionals engaging regularly with the VCS sector and linking individuals with VCS community supports.

A key aspect of promoting recovery among people with mental health difficulties is supporting individuals to link in with local community services and supports, including access to talk therapies and related supports provided by VCS organisations. One of the strengths of the VCS sector is that people can access many of these services themselves locally. Those working in primary care and CMHTs can consciously connect service users with supports provided by VCS organisations. This can link the person with services and supports not provided in the health sector and can facilitate the integration of service users into their local community. However, to do this, mental health professionals and GPs need to be aware of the VCS supports available locally.

**Recommendation 15**

Staff working in primary care and CMHTs should ensure that they are aware of and inform service users and FCSs about supports available from Voluntary Community Sector organisations in the local area.  

*Contributing to Outcome 2(a)*

*Building on Recommendations 3.8 and 9.3 in AVFC 2006-16*

The role of VCS organisations can be on a self-funded or resourced basis. For example, some peer support networks; funded or part-funded through a service contract with the public mental health system; or working in partnership with the public mental health system and other local stakeholders to deliver particular services and supports. Given the VCS’s accessibility and responsiveness to local users’ needs and preferences, VCS organisations should be key partners in the design and development of the HSE’s mental health services at national and local level, as well as referral partners for primary mental healthcare. Their services extend to therapeutic and other recovery supports for individuals and support for FCS which are particularly relevant to this. They can therefore help to reduce the use of specialist mental health services to those who need this level of specialist care. While there are positives to such VCS services maintaining a level of independence from the HSE’s mental health services, they also require assured governance and operational effectiveness, supported by secure and sustainable funding to provide contracted services and supports over the long term.

**Recommendation 16**

Directories of information on VCS supports should be made available to staff working in primary care and CMHTs and to individuals accessing mental health care and their Families, Carers and Supporters.  

*Contributing to Outcome 2(a)*

*Building on Recommendations 3.8 and 9.3 in AVFC 2006-16*
**Recommendation 17**
Where Voluntary and Community Sector organisations are providing services aligned to the outcomes in this policy, operational governance and funding models should be secure and sustainable.

**Contributing to Outcome 2(a)**
**Contributing to Outcome 2(b)**

**New Recommendation**

**D.5 Primary care services and supports**

AVFC recognised the essential role played by the primary care sector in providing mental healthcare in Ireland. Over 90 per cent of mental health needs can be successfully treated in a primary care setting, with less than 10 per cent being referred to specialist secondary care mental health services. Secondary care services are designed to respond to the varied and complex clinical requirements of those individuals with greater need. Accordingly, this ‘refresh’ of AVFC envisages an increasing role for the primary care sector which, if appropriately resourced and with agreed governance arrangements in place, can provide a comprehensive range of interventions, including better access to counsellors and psychologists providing a range of talk therapies. Such a role would be appropriate to most of the mental health presentations encountered in primary care. General practitioners in the primary care sector will continue to play a pivotal role as the first and continuing point of contact to service users. CMHTs will provide specialist mental health services for individuals whose needs cannot be met in primary care. This ‘refresh’ makes recommendations to scale up access to supports for common mental health difficulties in primary care settings, including for those individuals who have co-occurring substance use difficulties.

By linking primary care services with the VCS, social prescribing – sometimes referred to as community referral – is a way for GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports. There are many different models for social prescribing but most involve a link worker or navigator who works with people to access local sources of support. Social prescribing is operating in several places in Ireland and has potential to be rolled out more widely.

**Recommendation 18**
Social prescribing should be promoted nationally as an effective means of linking those with mental health difficulties to community based supports and interventions, including those available through local Voluntary and Community Sector supports and services.

**Contributing to Outcome 2(a)**
**Outcome 2(c)**

**Building on Recommendation 7.1 of AVFC 2006-16.**

AVFC, in Recommendation 7.1, recommended that all individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services. There are a range of interventions, some begun more recently that make a contribution in this context, such as the establishment of the HSE Counselling in Primary Care (CIPC) service in 2013. CIPC provides eight counselling sessions for medical card holders, who are 18 years of age or over, and who need help with mild to moderate psychological difficulties that are appropriate for time limited counselling in non-specialist settings. There has also been a programme of investment through mental health funding to create Psychologist and Assistant Psychologist posts in primary care to deliver rapid access, low intensity psychological interventions for those under 18 years of age. Despite this progress, the demand for this ‘refresh’ of AVFC indicates that there is still insufficient access to these types of supports in primary care. This, in turn, has contributed to an

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over-reliance on specialist secondary care systems, resulting in long waiting lists for such care, not least in Child and Adolescent Mental Health Services (CAMHS).

Accordingly, there needs to be a sufficient resource in place to ensure rapid access to these types of supports in primary care, so that they are available universally, with minimum waiting lists and without the requirement for a medical card. The supports should be delivered by appropriately qualified therapists such as counsellors and psychotherapists. The supports should provide care to individuals with co-existing mental health and addiction needs, given the substantial overlap between the conditions. While therapists may work in a variety of settings, the co-location of therapists with GPs and or primary care teams should be considered to facilitate access for the individual and greater integration with primary care services.

In this wider context, there is scope to use digital health as an enabler to facilitate increased availability of these supports. There is increasing recognition of the growing relevance of video and other online delivery media – text, private instant chat, email and so forth – for counselling and talk therapies, but these have limited application in terms of scale in Ireland. Evidence from elsewhere suggests the efficacy of such media – in combination with a face-to-face approach – to improve access to mental health services for common conditions like mild or moderate depression and anxiety. A case in point is the NHS-funded Improving Access to Psychological Therapies (IAPT) programme in England, where the guidance indicates that up to 75 per cent of the sessions could be delivered by phone, video and instant chat media.

**Recommendation 19**  
Access to a range of counselling supports and talk therapies in the community/primary care should be available on the basis of identified need so that all individuals, across the lifespan, with a mild to moderate mental health difficulty can receive prompt access to accessible care through their GP/ Primary Care Centre.  
Contributing to Outcome 2(a)  
Outcome 2(c)  
Building on Recommendation 7.1 of AVFC 2006—16.

**Recommendation 20**  
Counselling and talk therapies in primary care and in all other settings, must be delivered by appropriately qualified and accredited professionals.  
Contributing to Outcome 2(a)  
Building on Recommendation 7.6 of AVFC 2006—16.

**Recommendation 21**  
Digital health solutions should be used where appropriate for counselling supports and talk therapies in primary care/community.  
Contributing to Outcome 2(a)  
New Recommendation

There was progress during the course of AVFC on improving collaboration between primary care and specialist or secondary mental health services to facilitate integration of care for service users. Such progress includes the co-location of CMHTs and primary care teams in some areas and the creation of the Team Co-ordinator role in some CMHTs.

AVFC, in Recommendation 7.5, recommended the implementation of a consultation or liaison model to develop close links between the primary care team and the CMHTs, together with the presence or accessibility of a mental health professional as part of the primary care team or network. The objective of this recommendation was to reduce referrals of milder mental health difficulties to secondary services, to encourage the referral of persons with severe mental health difficulties on a more selective basis and to enhance GPs’ skills in the diagnosis and management of mental health difficulties. The objective remains relevant to this ‘refresh’ of AVFC and will be supported by some of the additional recommendations relating to a ‘shared care’ approach to mental health in primary care.
Recommendation 22
It is recommended that the mental health consultation/liaison model continues to be adopted to ensure formal links between CMHTs and primary care with the presence of, or in-reach by, a mental health professional as part of the primary care team or network.

Contributing to Outcome 2(b)
Contributing to Outcome 2(c)
Building on Recommendation 7.5 in AVFC 2006–16

A guidance paper was jointly developed in 2012 to act as a roadmap for collaboration between the two sectors and the development of a ‘shared care’ approach to mental health in primary care. While it has not been widely used, the guidance and its recommendations may still be relevant and should be examined and updated, as appropriate.

Recommendation 23
An implementation plan should be developed for remaining relevant recommendations in ‘Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services’ (2012) in order to improve integration of care for individuals between primary care and mental health services in line with emerging models and plans for Community Health Networks and Teams.

Contributing to Outcome 2(b)
Contributing to Outcome 2(c)
Building on and expanding Recommendations 7.8 and 7.11 in AVFC 2006-16.

As set out in AVFC, it should remain the case that all users of specialist mental health services, including those in long-stay facilities, must be registered with their GP. The recommendation needs to be extended, however, to emphasise that mere registration is insufficient and that people in long-stay care should be able to access primary care supports. The physical healthcare of people with a mental health difficulty should be led by their GP. The only exception to this would be for individuals who have recently been diagnosed and treated by a psychiatrist for a severe mental health difficulty for the first time. In these cases, the shared care approach should ensure that GPs work with the individual’s psychiatrist to provide coordinated physical healthcare. This recommendation is consistent with the priority in the Sláintecare report attributed to ‘creating an integrated system of care, with healthcare professionals working closely together’ bringing together physical and mental health services to improve the physical health of people with mental health difficulties and vice versa simultaneously.

Recommendation 24
The physical health needs of all users of specialist mental health services need particular attention by their GP. A shared care approach is essential to achieve the best outcomes.

Contributing to Outcome 2(b)
Contributing to Outcome 2(c)
Building on and expanding Recommendation 7.3 in AVFC 2006-16

In the course of the countrywide consultations for this ‘refresh’, there was evidence that people across the life course who are using specialist mental health services can be excluded from some primary care services as a matter of routine because they are in the care of specialist mental health services. This should not be the case and this practice should cease.

Recommendation 25
Any person using a specialist mental health service should have enabled access to GP and primary care services on the same basis as other citizens.

Contributing to Outcome 2(b)
Contributing to Outcome 2(c)
Building on and expanding

18 Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services’ in 2012.
Access to CAMHS was another issue which was raised in the consultation process and there are several recommendations in later subsections to address this. However, some referrals to CAMHS may be supported more appropriately in a primary care setting. The scaling up of access to supports in primary care should help to reduce the over-reliance on specialist mental health care such as CAMHS. In this particular context, developing further capacity for Attention Deficit Hyperactivity Disorder (ADHD) and autism-specific services will play a role in reducing the numbers of referrals into CAMHS.

**Recommendation 26**

There should be further development of early intervention and assessment services in the primary care sector for children with ADHD and autism to include comprehensive multi-disciplinary and paediatric assessment and mental health consultation with the relevant CMHT, where necessary.

Contributing to Outcome 2(a)

*Building on Recommendation 10.10 in AVFC 2006-16.*

A key issue that has arisen during the course of consultations and engagements for this ‘refresh’ of AVFC is access to addiction services in primary care and access to existing mental health supports in primary care when there is a co-existing addiction problem. One concern raised is that first line treatments for common mental health difficulties encountered in primary care such as counselling, talk therapies, CBT, first line antidepressants and so forth cannot work well unless substance misuse difficulties involving drug and or alcohol consumption are recognised and addressed. However, there must be recognition of the significant overlap between these conditions and this cannot be used as a barrier for an individual to access relevant mental health supports within primary care. The HSE has lead responsibility for the national policy on substance misuse¹⁹ – ‘Reducing Harm/Supporting Recovery’, which describes how tiered levels of alcohol addiction supports are needed in order to develop effective mental health services for people with co-existing mental health difficulties and addiction or dual diagnosis. This tiered approach should extend to mental health supports within primary care. The HSE Dual Diagnosis Improvement Programme also emphasises the need for integrated services across primary care and specialist mental health services. In the primary care sector, the consultations for this ‘refresh’ of AVFC indicate issues about universal access to primary care addiction services with a strong need for further development of these services, including associated models of leadership and governance.

**Recommendation 27**

Dedicated Community based Addiction Service Teams should be developed/enhanced with psychiatry input, as required, as well as improving access to mental health supports in the community for individuals with co-existing low-level mental health and addiction problems.

Contributing to Outcome 2(a) Contributing to Outcome 2(b)

*New Recommendation*

Reflecting on all the recommendations made in this subsection, it is obvious that there is a need to resource GPs and primary care practitioners, more generally, to play the extended and enhanced role envisaged for them in the overall balance of care in mental health services in Ireland. This echoes the evidence provided in the review²⁰ undertaken to inform this ‘refresh’ of AVF.

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¹⁹ Reducing Harm, Supporting Recovery – a health-led response to drug and alcohol use in Ireland 2017–2025
²⁰ Evidence Review to Inform the Parameters for a Refresh of A Vision for Change (AVFC), WRC February 2017
D.6 Specialist mental health services – overview and pathways to care

The range of supports available through community mental health teams (CMHTs) are set out in Figure D.4. Access to CMHTs is generally through a GP referral or it can occur following attendance at an emergency department (ED).

As recommended in AVFC, when an individual presents with a mental health crisis at an ED, a mental health assessment is offered and is available at all times. The investment in acute medical emergency services under the HSE’s Acute Medicine Clinical Programme needs to be prioritised to include the streamlining of the triage process so that access to the correct mental health assessment can be had as soon as possible. In this context as well, the investment needs to prioritise the provision of appropriate physical environments for individuals requiring an emergency mental health assessment in an ED. The provision of such appropriate environments needs to be a priority for some EDs.

There is now a standardised process in place for the assessment and management of individuals who present with self-harm to ED through progressive mental health investment and service development. In particular, Clinical Nurse Specialists (CNS) have been recruited as part of the HSE’s National Clinical Care Programme for the Assessment and Management of Patients Presenting to Emergency Departments following self-harm. From the time of presentation by a service user to discharge from the ED, this integrated programme centres on the provision of a mental health/psychosocial assessment and the direction of the service user to continuing care. A core element of the clinical programme is the consolidation and further development of and, in some areas, the formation of, close working relationships between the ED, the clinical programme mental health liaison staff, that is, CNSs and non-consultant hospital doctors (NCHDs), and CMHTs and GP services.

**Recommendation 28**
Prioritise the provision of appropriate environments for those presenting at Accident and Emergency departments who additionally require an emergency mental health assessment.

**Recommendation 29**
There should be continued investment in, and implementation of, the National Clinical Care Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm.

Notwithstanding these recommendations, EDs can be a challenging environment for some people with mental health difficulties and so a new referral option is proposed in this ‘refresh’ of AVFC – Out-of-Hours Crisis Cafés. These will provide an accessible and normal café environment, open in the evenings and at weekends, where individuals who feel they are in or at risk of a mental health crisis can attend as an alternative to going to an Emergency Department (ED). They can provide a safe space and welcoming environment, where support is on hand from both professionals and their peers. Crisis Cafés are described in more detail in Section D.6.

In proposing the continuum of services set out at Figure D.4 as the vision for a modern recovery-orientated mental health system, it is recognised that the balance of emphasis across each service element may vary in each CHO area across the country, in line with prevailing needs and geographies. However, it is proposed that every service element must be present in each CHO area, but that geography and the dynamics of prevailing need may influence the emphasis on each service element and, in some cases, how services are delivered for each element. For example, in rural areas with dispersed populations, alternative approaches to delivering some services may be necessary. This could include greater use of digital health interventions.
Figure D.4 sets out proposals for the required service elements for a modern recovery-orientated mental health system. In this context, each CHO area would consider the best balance for, and models of delivery of, the service elements to meet their area needs, taking into account their staffing levels.

These proposals include the proviso that all service elements in Figure D.4 should include access to talk therapies. Talk therapies should be a first-line treatment option for the most people who experience mental health difficulties. In consequence, all relevant recommendations made in this domain relating to each service element provide for access to talk therapies.
**Referral Pathways and Specialist Mental Health Services**

Recovery Colleges often focus on equipping students with new skills that can foster their recovery, as well as enhancing their overall capacities and capabilities. Common offerings include classes focused on self-care, life-skills, physical health, employment and information technology.

Crisis Resolution (CR) offers after hours and urgent psychiatric assistance. CR is an integral part of each Community Mental Health Team providing 24 hour advice and assessment for people presenting in crisis which is associated with a known or suspected mental health problem.

The Assertive Outreach Teams provide intensive support if you have complex needs. The team aim to support you to get help from other services. This support can help you to manage your condition better and reduce your chances of going back to hospital.

Talking therapy is a general term to describe any psychological therapy that involves talking. You may also hear the terms, counselling or psychotherapy.
D.7 Out-of-hours crisis cafés

Figure D.4 proposes a new element in the continuum of service elements in the form of out-of-hours ‘Crisis Cafés’. As noted already, these will provide an accessible and normal café environment, open in the evenings and at weekends, where individuals who feel they are in or at risk of a mental health crisis can come as an alternative to presenting at an ED. They can provide a safe space and welcoming environment, where support is on hand from both professionals and their peers.

Based on models in place in England, these are typically publicly or NHS funded and operated through partnerships between an NHS Trust and a VCS organisation(s). They support individuals to deal with an immediate crisis and to plan safely, drawing on their strengths, resilience and coping mechanisms to manage their mental health and well-being. Attendees can access talk therapies, coping strategies and one-to-one peer support. Paid core staff should be helped by a team of appropriately trained volunteers, working on a rota basis. The cafés need to be supported by CMHT crisis resolution teams where clinical interventions are required.

Some early, if limited, evidence indicates the effectiveness of such cafés in reducing avoidable psychiatric hospital admissions. They may also reduce demands on EDs as they provide an environment that can be more suited to the needs of some individuals who present. Crisis Cafés are sometimes located close to major hospitals and work collaboratively with them to limit demands on EDs. It is recommended that support be provided to pilot a number of such out-of-hours cafés. Each CHO should consider what their particular needs may be in this regard as part of their wider assessment of the balance required across the full range of service elements in Figure D.4.

Recommendation 30
Out-of-hours Crisis Cafes should be piloted and operated based on identified good practice. Such cafés should function as a partnership between the HSE and other providers/organisations.

Contributing to Outcome 2(a)
New Recommendation

D.8 Operation of community mental health teams (CMHTs)

The cornerstone of service delivery in secondary care will continue to be the multi-disciplinary CMHTs. The teams are the first line of acute secondary mental health care, designed to serve the needs of particular care groups throughout the lifespan, from childhood to later life. The multidisciplinary nature of the CMHT team enables a variety of professional perspectives to be combined in case formulation, care planning and service delivery and provides integrated care to service users, with the emphasis on supporting individuals to recover in their own community. Looking ahead, the CMHTs will co-ordinate access to, and delivery of, many of the supports detailed in Figure D.4, where service delivery is informed by international evidence for clinical best practice.

Recommendation 31
While the broad core functions and staffing of the CMHTs remain fit for purpose, it is recognised that each team needs to agree flexible protocols for its clinical and operational practice, adapted to the needs and social context of its sector population.

Contributing to Outcome 2(a)
Contributing to Outcome 2(b)
As in Recommendation 9.1 in AVFC 2006-2016

Recommendation 32
The multi-disciplinary CMHT as cornerstone of service delivery in secondary care, will be strengthened through the development and agreed

Contributing to Outcome 2(a)
Contributing to Outcome 2(b)
As in Recommendation 9.2 in AVFC 2006-2016

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21 https://www.england.nhs.uk/mental-health/case-studies/aldershot/
22 https://www.england.nhs.uk/mental-health/case-studies/aldershot/
implementation of a shared governance model. 2016

However, the engagement for this ‘refresh’ of AVFC has highlighted some issues for consideration about the operation of the CMHTs and has informed the development of the recommendations set out below. The recommendations apply to all CMHTs in each CHO area.

A core function of CMHTs that should be emphasised is the need for them to link in with local VCS supports in order to build a sustaining network around the service user concerned and their FCS. CMHTs which engage positively with the VCS supports in their local area can create a wider range of supports for service users. This, in turn, can lead to more sustained recovery and lesser use of the specialist mental health services.

**Recommendation 33**
CMHTs outreach and liaison activities with the VCS partners in the local community should be enhanced to help create a connected network of appropriate supports for each service user and their FCS.

**Contributing to Outcome 2(b)**
Adapted from relevant aspects of Recommendation 9.3 in AVFC 2006–16

AVFC highlighted the need for an integrated recovery care plan, developed and agreed with service users and FCS. Some evidence, for example, from the *My Voice Matters* surveys and from the various reports of the Inspector of Mental Health Services, suggests that this is not always or, even, often the case. This ‘refresh’ of AVFC re-emphasises the critical importance of care planning with service users as leaders in the decision-making about their own care or recovery plan and with FCS as partners to the plan where, of course, the service user concerned agrees. Care plans should reflect the service user’s particular needs, preferences, goals and potential, including community factors that may impede or support recovery. The plans should be rights-based.

**Recommendation 34**
An individualised recovery care plan, co-produced with service users and/or Families Carers and Supporters, where appropriate, should be in place for, and accessible to, all users of specialist mental health services.

**Contributing to Outcome 2(b)**
Adapted from relevant aspects of Recommendations 3.6 and 11.7 in AVFC 2006–16

As more than one team member may be involved in the care of an individual, AVFC recognised the need for a key worker, that is, a team member who would be known and accessible to the service user and FCS and through whom services could be personalised and coordinated. It was recognised that the key worker role could be assigned to any discipline in the team, subject to discussion and agreement. There is some evidence, for example, in the *My Voice Matters* surveys and the Inspector of Mental Health Services reports that this is not always the case, but that, where the service user has the contact details of a key worker, their satisfaction with services is higher. This ‘refresh’ re-emphasises the need for, and importance of, the keyworker role.

**Recommendation 35**
All service users should have a mutually agreed key worker from the CMHT to facilitate coordination and personalisation of services in line with their co produced recovery care plan.

**Contributing to Outcome 2(b)**
Adapted from relevant aspects of Recommendation 3.6 in AVFC 2006–16

Apart from the progress that has been made in ensuring a recovery ethos in service delivery during the course of implementation of AVFC, the engagement for this ‘refresh’ suggests that the application of a recovery ethos across the mental health system can be patchy and inconsistent. To further embed the change towards a recovery ethos, it is suggested that resources are made available to build capacity in this area among mental health professionals in the CMHTs as well as all other professionals delivering services elsewhere in the totality of care set out in Figure D.4. Team
members must be trained adequately and supported by management to talk to service users about recovery and about their strengths and to discuss with them how their mental health difficulty affects other areas of their life. Such training should have a strong human rights base. Team members should be supported to link service users with other VCS supports, as proposed in Recommendation 2.18. Finally, team members must also be trained in active listening and mentored to ensure that they are engaging in such listening with service users.

**Recommendation 36**
Further training and support should be put in place to embed a recovery ethos among mental health professionals working in the CMHT as well as those delivering services elsewhere in the continuum of services.

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<td>Adapted from relevant aspects of Recommendation 12.1 in AVFC 2006—16</td>
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The proposed model of mental health supports re-conceptualises the role of the outpatient clinic to a broader concept of community-based sessional support. These sessions will be appointment-based for either assessment, follow-up or continuing management of a mental health difficulty. They will be provided by consultant psychiatrists, community mental health nurses, psychologists, therapists and peer support workers. Sessional supports may include individual therapy, group therapy, psychiatric consultation, coordination with care partners in the VCS and medication management.

The physical environment where these services are delivered and the locations of the CMHTs needs to change and move with the times. Specifically, it is proposed that CMHTs either have their own modern, fit-for-purpose premises or be accommodated in primary care centres, family resource centres, community centres or local authority owned buildings to integrate with other services and supports at a local level. Ideally, welcoming, homely, non-clinical spaces should be provided.

There has already been a programme of capital investment to move some CMHTs into primary care settings and there are some excellent examples of this. There should be an on-going programme of investment to move CMHTs into primary care centres and other community settings, as already described. Such centres should also facilitate VCS provision to integrate CMHT and VCS supports, where appropriate. Even when CMHTs are relocated as proposed, this should not inhibit them from providing sessional supports in other community settings.

The location of CMHTs in physical environments of this kind will reinforce the access that individuals have to short-term assistance in their own community, drawing on a wide range of therapies and supports in the wider mental health system. For example, therapeutic interventions, such as social prescribing, can be best delivered in a community setting, where linkages with VCS groups which can facilitate volunteering and social connections in the local community would be possible. Underpinning all interactions with services – whether provided by the public health services and or the VCS sector – should be courtesy, compassion and respect and a service setting which is warm, friendly, generous and kind.

While the physical environment for CMHTs and sessional support should be of high quality, there is also considerable potential for e-mental health/telepsychiatry/telepsychology/telecounselling to deliver services, particularly, where there is an established relationship with the individual using mental health services. Thus some sessional support can operate from a community facility, connecting with service users through technology so that they do not have to attend physically at every session.

**Recommendation 37**

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CMHTs and sessional contacts should be located, where possible and appropriate, in a variety of suitable settings in the community, including non-health settings.

**Recommendation 38**
The potential for digital health solutions to enhance service delivery and empower service users should be developed.

While AVFC prescribed the exact composition of CMHTs, this may have restricted the development of appropriate responses in some teams and for some service user groups. The CMHT should continue to include, but not necessarily be limited to, the core skills of psychiatry, nursing, social work, clinical psychology and occupational therapy. Given developments over the last decade and the emphasis on achieving recovery-oriented outcomes, there should be additional competencies to teams, such as peer support workers, outreach workers and others. In this ‘refresh’, rather than specify absolute numbers of specific professionals that should be on the different teams, the approach is to emphasise the importance of determining the specific skills that are required by a team. Thus, the composition and skill mix of each CMHT should take into consideration the needs and social circumstances of its population, with flexibility as to how these are to be met. As well as the core skills this could include, for example, bringing in sessional workers with specific therapeutic skills and other professionals as needed. These might include speech and language therapists (SLTs), family therapists, addiction counsellors, family peer support workers, health care assistants and others. This resourcing should be supported through strong population-based needs assessment data.

**Recommendation 39**
The composition and skill mix of each CMHT, along with clinical and operational protocols, should take into consideration the needs and social circumstances of its sector population and the availability of staff with relevant skills. As long as the core skills of CMHTs are met, there should be flexibility in how the teams are resourced to meet the full range of needs, where there is strong population-based needs assessment data.

The engagement for this policy ‘refresh’ indicates that models of leadership for the CMHTs should be reviewed in line with international practice. The clinical leadership, as described in AVFC 2006–16, vested this role in the consultant psychiatrist, in keeping with the requirements of current legislation. Team co-ordinators have been appointed in some CMHTs. These roles should, in fact, be in place and be effective in all CMHTs. On referral, the CMHT team co-ordinators facilitate intra-team discussion of how to manage best the referrals across the team. The wider range of linkages to the local community will also need to be co-ordinated so that all the service elements in Figure D.4 can be accessed, as appropriate. The recommendation about directories of services in Recommendation D.2 and the facilitation of a model of stepped care, as described in Section B.5, are relevant in this context too.

Consideration should be given to amend legislation to facilitate the delivery of a shared governance model as recommended in AVFC. A shared governance model requires change on the part of all team members and it is widely recognised that change can be difficult sometimes. It is essential that all team members work to the maximum of their scope of practice. This means that each member of...
the team takes responsibility for the effectiveness of the team so that there is appropriate service delivery and the outcomes set out in this refreshed policy are achieved.

Recommendation 40
The shared governance arrangements for CMHTs as outlined in AVFC 2006-16 should be progressed, including further rollout of Team Co-ordinators. This bit has been deleted and was considered very important: Each member of the CMHT should work to the maximum of their scope of practice and each member of the team should take responsibility for effective team working.

Finally, the CMHTs will continue to be a single point of access for primary care for advice as well as for routine and crisis referral to all secondary services. In facilitating such access, the team co-ordinator will have a key role.

Recommendation 41
Referral pathways to all CMHTs should be reviewed and extended by enabling referrals from a range of other services, (as appropriate) including Senior Primary Care Professionals in collaboration with GPs.

D.9 Child and adolescent mental health services (CAMHS)
CAMHS CMHTs are the first line of specialist mental health services for children and young people who are directly referred to the CAMHS team from a number of sources. The CAMHS teams accept referrals for moderate to severe mental health difficulties of children and adolescents which cannot be managed within primary care.

In the course of the consultations for this ‘refresh’, a number of issues were raised about CAMHS and the recommendations in this section are made to address these.

Out-of-hours access to CAMHS can be difficult in some parts of the country. While some cases are most appropriately seen in an ED, an alternative to the ED is also needed for individuals for whom ED may not be appropriate. In these circumstances, this ‘refresh’ proposes a national out-of-hours service response. This should comprise a 24-hour psychiatrist on call with maximum use made of digital health solutions to facilitate access. Appropriately and safely staffed Crisis Cafés, as described in Section D.6, can also be an appropriate response for children and adolescents.

Recommendation 42
A comprehensive specialist mental health out of hours response should be provided for children and adolescents in all geographical areas. This should be developed in addition to current ED services.

The transition from CAMHS to adult services was also raised as a difficulty. At present, the arrangements provide for young people to make the transition to adult services at the age of 18. This can be an age in life when change, uncertainty and vulnerabilities prevail. Failure to secure a safe transition can lead to disengagement, to unwillingness by young service users to take responsibility for their mental health difficulty and, ultimately, to poorer health outcomes. Much of the debate for this ‘refresh’ has focused on changing eligibility for CAMHS up to an age limit of 25,
with potentially two age bands of 0-16 and 17-25, as recommended in the Youth Mental Health Task Force Report.

Wilson et al suggests that moving to a ‘0-25 years’ service may improve the continuity of care and lead to better outcomes for service users. However, there are considerable implications in this for the re-configuring of services. As such, it is proposed that, in year one of implementation a reconfiguration of this kind be examined. CAMHS and General Adult Mental Health Services (GAMHS) will need to work together to achieve this integration. A reconfiguration of existing resources in the current complement of CAMHS and GAMHS is envisaged so that appropriate expertise can be applied to the care of the 16-25-year age group. Over time, this will result in a reconfiguration of services to cover the two age groups of 0–15 and 16–25. As the prevalence of mental health needs in these two age groups is quite different, the numbers of CAMHS and GAMHS teams and their staffing will need to be considered as part of the reconfiguration exercise. While this reconfiguration has produced positive outcomes in other jurisdictions it is proposed that this change be piloted at first in an Irish context. It is recognised that it will take a number of years to provide the necessary training for a new cohort of mental health professionals. The change will also require the relevant professionals to be flexible and open to new approaches. However, in the medium term, it should be possible to provide a seamless, age appropriate specialist mental health service for those aged up to 25 years.

| Recommendation 43 | An Expert Group should be convened to develop a reconfiguration plan which will facilitate the provision of age-appropriate specialist mental health services up to age 25. | Contributing to Outcome 2(b) | New Recommendation |

In the interim, an immediate priority is to ensure that short-term additional supports are available for individuals who are making the transition from CAHMS to GAMHS at age 18, given the issues and vulnerabilities that can prevail. A nominated key worker to support the transition in line with an agreed transition plan in accordance with the CAMHS SOG is the minimum needed. This is supported by the oversight group as the basis for future Department of Health policy.

| Recommendation 44 | Appropriate supports should be provided for individuals transitioning from CAHMS to GAMHS at 18 years. | Contributing to Outcome 2(b) | Adapted from Recommendation 10.2 in AVFC 2006-16. |

| Recommendation 45 | Nationally agreed criteria should be developed to govern and resource individualised support packages for the specific needs of a small cohort of children and young people who have complex needs | Contributing to Outcome 2(a) | Contributing to Outcome 2(b) | New Recommendation |

A further issue raised is the number of acute inpatient beds for children and adolescents in dedicated, age-appropriate units. There has been progress over the AVFC 2006–16 period on the number of CAMHS inpatient beds, with an increase from 16 in 2008 to 74 in 2017. However, set against a backdrop of a growing population of under 18s and increasing prevalence of mental health difficulties amongst children and adolescents, there have been some challenges in accessing sufficient age-appropriate inpatient beds, exacerbated by maintaining beds opens due to staff availability and complexity of cases. In 2017, some 27 per cent of the 308 children and adolescents

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24 Ibid.
admitted had to be accommodated in adult approved centres, although almost all 94 per cent – were 16 or 17 years old and were short-stay, with 74 per cent being discharged within a week. Despite this, it has to be reiterated that adult inpatient units are generally speaking not appropriate environments for children and adolescents.

However, in the event that there is no CAMHS inpatient bed available and short-term admission to an adult unit is the only option, for example, to meet crisis or emergency mental health needs, then, a range of actions is necessary. These actions need to be consistent with the CAMHS inpatient standard operating guidelines to provide appropriate, effective and safe care.

**Recommendation 46**

In exceptional cases where child and adolescent inpatient beds are not available, adult units providing care to children and adolescents must adhere to the CAMHS inpatient Code of Governance.

An additional twelve CAMHS inpatient beds are planned for the new National Children’s Hospital being developed at the campus of St. James’s Hospital in Dublin. This hospital will also accommodate the national specialist eating disorder service with a further eight inpatient beds. The new National Forensic Hospital being built in Portrane, County Dublin will include a ten-bed secure adolescent inpatient unit. Both of these capital projects when complete will contribute to a total of 104 acute inpatient beds for children and adolescents across the country by 2021, as against the current total of 74 beds.

One of the main challenges about access to inpatient or residential care concerns the small number of children and adolescents who often have multiple needs, including intellectual disability, and require high-intensity support. A specialist unit for such children and adolescents would not necessarily address the unique needs of each and would be geographically inaccessible for many. A preferred approach is to develop a bespoke set of supports that address the needs of each individual case in the most appropriate setting. A national picture is needed on the needs of this small group so that an appropriate national response can be developed.

**D.10 General adult mental health services (GAMHS)**

There are 114 General Adult CMHTs operating across the country with a staff in 2017 of 1,522 clinical whole-time-equivalents (WTEs) – about 76 per cent of that envisaged in AVFC 2006–2016. It is worth noting that the adult population of 18 to 65 years has only been growing modestly in recent times, averaging 0.8 per cent each year between the 2011 and the 2016 census.

A service improvement project in the HSE has been examining the service user’s journey through General Adult CMHTs to ensure consistency in user experiences and service offerings across the country. Key themes and priority areas have been identified which agree with many of the recommendations already made in Domain 2, and apply to and beyond General Adult CMHTs. These themes include information, education and signposting for service users, real multidisciplinary working, greater links with external community services, FCS involvement and support and many more. An implementation plan will be developed to this end. The Oversight Group is encouraged to see the complementarity of this work with many of the recommendations proposed in this ‘refresh’.

**Recommendation 47**

The HSE should consult with service users, FFCs, staff, and those supporting priority groups to develop a standardised access pathway to timely mental health and related care in line with the individuals’ needs and preferences.

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<tr>
<th>Recommendation 46</th>
<th>Contributing to Outcome 2 (a)</th>
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<tr>
<td>In exceptional cases where child and adolescent inpatient beds are not available, adult units providing care to children and adolescents must adhere to the CAMHS inpatient Code of Governance.</td>
<td>New Recommendation</td>
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<th>Recommendation 47</th>
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<td>New Recommendation</td>
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In order to buttress the continuum of care, priority should be given to the development of day hospitals, operating according to agreed standard operating procedures, and home care teams, involving assertive outreach teams and crisis resolution teams, so that an integrated range of alternatives to inpatient care is available. Home-based crisis resolution teams and day hospitals are described below and assertive outreach teams are described in Fig D.19.

The use of home-based care and crisis resolution teams was recommended in AVFC. This model has evolved into home-based crisis resolution teams, the aim of which is to provide intensive support to individuals with severe mental health difficulties or those with first incidence presentation who are in crisis and to provide an alternative to inpatient treatment. Support from these teams is time-limited, providing intensive intervention and support with sufficient flexibility to respond to different service user or carer needs. Typically, this entails a range of therapeutic approaches, including medication management, cognitive and behavioural interventions and evidence-informed family interventions. The teams provide a rapid response and twenty-four hour service, with support provided in the service user’s own environment and with the active involvement of service users and family, carers and supporters (FCSs) and liaison with local partners – GP and VCS services. Home-based crisis resolution teams could also play a role in supporting out-of-hours Crisis Cafés.

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<th>Recommendation 48</th>
<th>Contributing to Outcome 2(a)</th>
<th>Contributing to Outcome 2(b)</th>
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<tr>
<td>Sufficient resourcing of home-based crisis resolution teams should be provided to offer an alternative response to inpatient admission, when appropriate.</td>
<td>Contributions to Outcome 2(a)</td>
<td>Contributions to Outcome 2(b)</td>
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| Building on recommendation 11.10 in AVFC 2006–16 |

The function of a day hospital is to provide intensive treatment equivalent to that available in a hospital inpatient setting for acutely ill individuals, where they typically attend from their home or care setting for assessment, care and support.

AVFC recognised the role of day hospitals as an alternative to inpatient admission for some service users, thereby diverting admissions to acute units. Day hospitals can also play a wider role to facilitate a faster and graded discharge from inpatient care. The length of stay depends on needs but is generally for a period of one to six weeks.

In day hospitals a mix of staff, such as clinical psychologists, consultant psychiatrists, nurses, occupational therapists and social workers provides a range of therapeutic services, including occupational, psychological and social therapy programmes, and medication management. Service users have integrated recovery care plans and can access group and individual support as established in their integrated care plan. To support the development and functioning of day hospitals a core staff team should be available to operate the day hospital. Such core staff would be in addition to the relevant CMHTs. Standard operating guidance should also be developed to ensure day hospitals operate as effectively as possible. To meet different geographic needs within and across community Healthcare organisations (CHOs), flexibility of infrastructure should be considered, with day hospitals operating as a fixed facility with mobile staff, or mobile staff providing day hospital care in a number of facilities.

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<th>Recommendation 49</th>
<th>Contributing to Outcome 2(a)</th>
<th>Contributing to Outcome 2(b)</th>
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<tr>
<td>A Standard Operating Guideline needs to be developed to ensure sufficiently staffed day hospitals operate as effectively as possible as an element of the continuum of care and an alternative to inpatient admission.</td>
<td>Contributions to Outcome 2(a)</td>
<td>Contributions to Outcome 2(b)</td>
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| Building on recommendation 11.6 in AVFC. |
The Recovery College is another service element which has been developed more recently and which offers an opportunity for service users and those who support them to create and facilitate recovery education courses along with mental health professionals. The goal of a recovery college is to create a culture of recovery, and to empower people with mental health problems, families, friends and the broader community to improve quality of life and to promote community involvement through the provision of co-produced and co-facilitated learning and conversation.

**D.11 Mental health services for older people (MHSOP)**

In keeping with the terminology used in AVFC and to reflect the range of expertise in the teams providing this service, the term mental health services for older people (MHSOP) should be used in relation to this group. There has been a growth in the number of MHSOP teams operating across the country from twenty-two teams in 2013 to thirty–teams in 2017. There has been a parallel growth in staffing to some 305 clinical WTEs in 2017. Staffing levels – at 58 per cent in 2017 – are still short of that envisaged in AVFC. Just as is the case with CAMHS, the MHSOP teams are operating at a time of increasing demand. Between 2014 and 2017, there was an increase of 3.7 per cent nationally in the number of referrals accepted by MHSOP teams.

As in other European countries, the population over 65 years is rising in Ireland, representing 13.4 per cent of the total population. From 2011 to 2016, there was a 19 per cent increase in the population aged over 65. Mental health difficulties in later life are both common and treatable but left unrecognised and or untreated are associated with increased morbidity and mortality.

The expertise for the assessment and treatment of mental health difficulties in older people is found in MHSOP teams. Access to these teams can be difficult for people who have had mental health difficulties in the past and who are directed back to the general adult mental health service, even though they may not have had contact with that service for many years. While it may be appropriate for some people who have had a long-standing relationship with a general adult community mental health team to remain in the care of that team, most older people who have mental health difficulties should have access to specialist expertise. Joint care arrangements should be put in place where expertise to meet the needs of an individual is located in both the general adult and mental services for older people teams. To offset a possible increase in numbers, the age range for mental health services for older people could be increased to 70 years, with a corresponding increase in the age range of the general adult teams up to 70 years. This increased age also reflects the higher life expectancy and changing expectations of ageing in Ireland. For example, the age at which pensions can be accessed has been increased.

Dementia affects 5 per cent of people over 65. The prevalence, however, is age-related, increasing to 20 per cent of those over 80 years. People with dementia are typically referred to mental health services for older people teams when their diagnosis is associated with significant behavioural and psychological symptoms. There is, nevertheless, an issue relating to access to such services for people with early onset dementia, as there is inconsistent practice across the country.

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<th>Recommendation 50</th>
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<tr>
<td>Individuals who require specialist Mental Health Services for Older People (MHSOP) should receive that service regardless of their past or current mental health history. People with early onset dementia should also have access to MHSOP.</td>
<td>Contributing to Outcome 2(b)</td>
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<td><strong>New Recommendation</strong></td>
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<th>Recommendation 51</th>
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<td>The age limit for MHSOP should be increased from 65 years to 70 years supported by joint care arrangements between, GAMHS and MHSOP teams for individuals who require the expertise of both.</td>
<td>Contributing to Outcome 2(b)</td>
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<td><strong>New Recommendation</strong></td>
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Home-based assessment and supports are particularly important for older people. So too are voluntary community sector (VCS) organisations which have an important role in connecting older people to activities in their local community.

Polypharmacy is also an issue for older people. The Irish Longitudinal Study on Ageing (TILDA) indicates that one in three people over 65 regularly take five or more medications. Thus, as well as the focus on improving access to talk therapies for older people, there should be a focus on more effective medication management.

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<th>Recommendation 52</th>
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<tr>
<td>GPs, mental health service prescribers and relevant stakeholders should collaborate to actively manage polypharmacy.</td>
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D.12 Adult inpatient capacity and alternatives to inpatient admission

The engagement for this ‘refresh’ of AVFC highlighted a need to consider the adequacy of acute inpatient beds provided for the general adult and older adult population. At present, there are twenty-nine adult acute inpatient units nationally. Seven of these have separate older adult provision and a further two units for older people are planned as part of the commissioning of a new adult unit – reflecting policy that all new adult units will include a dedicated older adult unit.

There are 1,039 acute adult inpatient beds at present in the mental health system, a rate of 21.8 per 100,000 population. This compares to the recommended level of 16.6 per 100,000 recommended in AVFC while being somewhat less than average when compared with international provision. Occupancy levels in acute beds are between 84 per cent and 111 per cent, with all except one community healthcare organisation operating at over 90 per cent occupancy, indicating that the acute inpatient system is under considerable stress. These numbers relate to acute adult inpatient beds and any consideration of capacity needs to take into account the availability or lack of other beds, such as forensic, mental health and intellectual disability, child adolescent mental health services and other specialist provision. Additional capacity is planned in some of these specialty areas. Consideration of capacity also needs to look at the alternatives to acute inpatient care, such as home care teams, assertive outreach teams, day hospitals and so forth, as described in Figure 2.2.

In this ‘refresh’, the ambitious focus is on prioritising the development of a full suite of services operating alongside appropriate and effective acute inpatient care and to consider then the need for further acute inpatient beds. Moving to alternative provision, any need for additional inpatient beds should be considered against available local services.

Bed capacity also needs to examine the use of beds to ensure that acute beds are used as intended and that delayed discharges receive a better response. A delayed discharge is defined as a ‘patient who remains in hospital after a senior doctor, that is, a consultant or registrar, has documented in the medical chart that the patient can be discharged’. In contrast to the general medical acute sector, with its national focus on delayed discharges, and funded initiatives to address this issue, there is no national data on delayed discharges in mental health acute units. Anecdotal reports indicate this is a significant problem, with at least three main groups identified; people who have no accommodation or precarious accommodation; people who have complex needs and require intensive support that is not available elsewhere; and people who are awaiting a nursing home placement. A study in an acute unit in Dublin indicated that almost all delayed discharges had

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25 Polypharmacy in adults over 50 in Ireland: Opportunities for cost saving and improved healthcare, TILDA 2012.
26 HSE Mental Health Division Delivering Specialist Mental Health Services 2017.
accommodation needs which were not being met. Recommendations about housing are made in Domain 3 at Section E of this report.

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| **Recommendation 53**  
HSE should collate data on the number and profile of delayed discharges in acute mental health inpatient units and develop appropriately funded responses. | Contributing to Outcome 2(c)  
New Recommendation |
| **Recommendation 54**  
An Expert Group should be set up to examine Acute Inpatient (Approved Centre) bed provision (including PICUs) and make recommendations on capacity reflective of emerging models of care, existing bed resources, future demographic changes and aligned with Sláintecare. | Contributing to Outcome 2(c)  
New Recommendation |

As described in the child and adolescent mental health section, for people who have multiple needs and require high-intensity support, a specialist unit will not necessarily address the unique needs of each person, and will be geographically inaccessible for many. It is better to design a bespoke set of supports that address the needs of each person in the most appropriate setting. This should also deliver care for many of those who are on placements outside their area.

One of the recommendations in AVFC which was only partly implemented was about the need for intensive care rehabilitation units (ICRUs) for a small number of people with difficult to manage behaviour. These units were to include both psychiatric intensive care (PICU) and rehabilitation units for people requiring longer rehabilitation. A change in terminology and definition of such units has taken place since AVFC, with ICRUs now referring to units which provide secure care for a small number of people on a longer-term basis. Further detail on ICRUs is provided in the section on forensic mental health services.

The continued need for this short-term PICU service for a small number of people who cannot be accommodated in acute units due to the nature of their behaviour was identified during the consultation process. Two psychiatric intensive care units to meet this need (PICUs) have already been developed in response to AVFC and it is proposed that two more units are developed and future capacity considered as part of the acute inpatient group.

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<th>Recommendation</th>
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| **Recommendation 55**  
Sufficient Psychiatric Intensive Care Units (PICUs) should be developed with appropriate referral and discharge protocols to serve the regions of the country with limited access to this type of service. | Contributing to Outcome 2(a)  
Building on Recommendation 10.9 in AVFC 2006-16. |
| **Recommendation 56**  
Future investment in service capacity should prioritise the development of alternatives to acute inpatient beds. This is in line with the outcomes focus of this ‘refresh’ and the community-based direction of Sláintecare. | Contributing to Outcome 2(b) / 2 (c)  
New Recommendation |

An alternative form of care to PICUs and ICRUs is the development of individualised packages of care for people whose behaviour and complexity of need requires a high level of care. Individuals may have other diagnoses as well as mental health difficulties. As described in the child and adolescent mental health section, for people who have multiple needs and require high-intensity support, a specialist unit will not necessarily meet the unique needs of each person and will be geographically inaccessible for many. A preferred approach is to have a special set of supports that address the

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29 Cowman and Whitty (2016)
needs of each case in the best setting. This should also facilitate the care for many of those who are currently on placements outside their area.

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<th>Recommendation 57</th>
<th>Contributing to Outcome 2(a)</th>
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<tr>
<td>A cross-disability and mental health group should be convened to develop national competence in the commissioning, design and provision of intensive supports for people with complex mental health and intellectual disabilities and to develop a set of criteria to govern the provision of this service.</td>
<td>Building on Recommendation 10.9 in AVFC 2006-16.</td>
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D.13

**Intensive recovery support services (for individuals with complex mental health difficulties)**

To reflect the recovery ethos and the nature of the work in rehabilitation teams, the Oversight Group proposes that rehabilitation and recovery services for people with complex and complex mental health difficulties are re-named intensive recovery support services (IRSS). These teams can be accessed by people who have complex and multiple needs and who require intensive support, often, but not always, on a long-term basis. The strong focus on facilitating social inclusion is described in more detail in Domain 3 at Section E of this ‘refresh’, particularly in relation to housing, using a Housing First approach, and employment, using an individual placement and support (IPS) approach.

Emerging models of care (MOC) recommend a range of alternative care structures and associated intensive recovery support services for service users across all community health organisations. These include specialised rehabilitation units (SRUs) providing an intensive inpatient rehabilitation programme for service users with the greatest need. Active medium-term recovery support will be provided based on an integrated recovery care plan. Specialised rehabilitation units are included in the proposed ‘continuum of care’ in Figure D.2, together with community rehabilitation residences (CRRs). Typically community residences have been organised around a high support hostel model of care, which can run the risk of becoming what the Inspector of Mental Health Services has described as ‘mini-institutions’. The vision for the community rehabilitation residences is a move away from high support hostels towards the provision of intensive MDT support primarily geared towards active rehabilitation and recovery. The purpose of such support is to enable the person concerned to move towards independent community living accommodation.

The full range of supports and services described in Figure D.2 should be available to this group. The only element that has not been described so far is assertive outreach teams. These teams have a specific focus on rehabilitation and recovery and operate specialised mobile treatment. They reduce hospital admissions and readmissions, prevent relapse, and improve a person’s chances of returning to employment, education or training, and, more generally, to enhance their quality of life. Such intervention involves a multi-disciplinary team that could include a range of professionals. These are clinical psychologists, nurses, occupational therapists, peer and mental health or social care support workers, psychiatrists and social workers. The emphasis must be on an assertive approach to maintaining contact with service users and on encouraging them to return to normal vocational and other life pursuits.

The work of the assertive outreach team and the intensive recovery support service should focus on providing and linking service users with appropriate supports for housing, employment and education. There is a clear need to work in collaboration with social inclusion strategies to ensure enhancement and sustainability of integrated approaches and approaches that improve access to services for vulnerable groups. This work is described in more detail in Domain 3. Finally, for this group, it is important to repeat Recommendation 2.10, highlighting the need for all users of

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30 Model of Care for People with Complex Mental Illness and Complex Needs, 2019
specialist mental health services, to receive assessment and treatment for their physical health through their GP.

**Recommendation 58**

Intensive Recovery Support (IRS) teams should be provided on a national basis to support people with complex mental health needs in order to avoid inappropriate, restrictive and non-recovery orientated settings.

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*Building on/Replacing Recommendations 12.1-12.9 in AVFC 2006-16.*

### D.14 People with an Intellectual Disability (MHID)

Approximately 3.8 per cent of the population have an intellectual disability (ID) of which 3 per cent have mild and 0.8 per cent have moderate or greater degrees of intellectual disability (HRB NIDD report). As described in AVFC, mental health and intellectual disability (MHID) teams should be developed to provide population-wide coverage by this service and ensure fair and equal access to mental healthcare for people of all ages with an intellectual disability.

Historically, specialist intellectual disability mental health services have been, and continue to be, provided directly by the HSE and by many national Section 38–39 voluntary agencies as part of their disability services. Since 2013, the HSE has invested additional funding and resources in developing mental health and intellectual disability teams in accordance with AVFC recommendations. The National Forensic Mental Health Service has also developed a ten-bed Forensic mental health intellectual disability unit and recruited a multidisciplinary MHID team.

Significant mental health and intellectual disability service gaps remain across the country, based on lack of funding as well as a shortage of experience and expertise specialising in the mental health needs of people with an intellectual disability, not least in relation the levels anticipated in AVFC.

The key objective for the next ten years should remain as the delivery of a national network of MHID teams – for adults and children – with clear catchment areas defined and published in accordance with the original AVFC recommendations. Realising this objective can be informed by more recent actions to speed up progress, with the appointment of a National MHID clinical lead in 2016 and the start of a national MHID service improvement programme in 2017. A person-centred MHID team model of care is being formalised to ensure consistent service delivery. This model should be adopted and replicated nationally. A phased resource plan is in place to develop ‘baseline teams’ involving a consultant psychiatrist, a clinical nurse specialist, a psychologist and administrative support) in areas where there no existing team and to augment the existing teams as needed.

There is another recommendation, given the communication challenges that can exist for these service users, to include speech and language therapists (SLT) as core members of the Adult-ID and CAMHS-ID teams. There is also a need for advocacy services for service users where SLT expertise is provided.

AVFC recommended the development of acute beds and day hospital services for mental health intellectual disability treatment. Limited progress has been made in this regard. Investment in acute MHID services needs to be prioritised, as envisaged in AVFC, and developed as part of the HSE MHID service improvement programme and in conjunction with HSE social care and Section 38/39 social care voluntary agencies.

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AVFC ‘refresh’ supports the case for the same bed numbers and day hospital places as AVFC originally recommended. Reflecting best international practice, acute MHID hospital bed development should occur in new or re-configured acute units, based on separate but integrated specialist bed provision in a way similar to that for MHSOP. Innovative acute treatment services need to be explored. These might, include therapeutic respite for children with intellectual disabilities and significant mental health and behavioural support needs.32

Recommendation 59
Prioritise the development of a national network of MHID teams and acute treatment beds to people of all ages with an intellectual disability.

Recommendation 60
Speech and Language Therapists (SLT) should be core members of the Adult-ID and CAMHS-ID teams.

**D.15 Mental health services for early intervention in psychosis**

The HSE *National Clinical Programme for Early Intervention in Psychosis* has the potential to transform the lives of people with emerging or first episode psychosis. Where access to a specialist integrated service is not available, the risk and experience of long-term disability in this population is well known. The clinical programme published a model of care for early intervention in psychosis (MOCEIP) in June 2019. For this model there has been extensive training of clinicians in behavioural family therapy (BFT) as well as on-going work to provide specialist cognitive behavioural therapy (CBT) for service users with psychosis. All this is enhanced by the development of an individual placement and support (IPS) service to facilitate progression or return to competitive employment. Funding for three demonstration sites for implementation of the MOCEIP has been agreed so that the effectiveness of its ‘hub and spoke’ model in an Irish service delivery context can be evaluated.

Recommendation 61
Continue the investment in the implementation of the Model of Care for Early Intervention Psychosis (EIP), informed by an evaluation of the EIP demonstration sites.

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Adult Attention Deficit Hyperactivity Disorder
While attention deficit hyperactivity disorder (ADHD) in children is a clearly recognised condition requiring a stepped care approach, as is evident in a growing body of clinical research, ADHD in adults is an impairing lifelong condition which is under-recognised and under-diagnosed, leading to impaired quality of life, resulting in on-going distress and impairment, and often associated with inappropriate treatment interventions. Once diagnosed, adults with ADHD can benefit from mental health treatment, including psychosocial interventions. Responding to this emerging service need, the HSE has already developed a national clinical programme for adults with ADHD to develop a consensus-based model of care. This clinical programme emphasises the development of appropriate specialist assessment, psycho-social interventions, and with specific service elements to support affected people moving from children’s to adult’s mental health service.

**Recommendation 62**
The phased implementation and evaluation of appropriate service responses to support adults with ADHD needs to be developed and resourced in line with the National Clinical Programme for Adults with ADHD.

**D.16 Forensic mental health services**
The forensic mental health services (FMHS) are concerned with the treatment of people with mental health difficulties who have come in contact with law enforcement agencies – that is, An Garda Síochána, the Courts and the Prison Service. The FMHS also provide expertise to other specialist mental health services on the assessment and management of people with mental health difficulties who have a propensity for violence and challenging behaviour.

Broadly speaking, the recommendations in AVFC on the FMHS are a useful starting point from which to build. Some, such as the commitment to replace the Central Mental Hospital (CMH) in Dundrum, have been fully implemented. This service is moving to a new state-of-the-art facility in Portrane, North County Dublin in 2020 where the new hospital being built at present. It will provide care for up to 170 individuals and will continue to provide services both in the community and in prisons. The facility will also have a forensic child and adolescent mental health service (FCAMHS) unit and an intensive care rehabilitation unit (ICRU).

In this ‘refresh’ it is important to repeat the commitment made in AVFC that services to this group should be based on the same values and principles applied throughout the policy. Thus, the first of the AVFC recommendations for this population remains unchanged.

**Recommendation 63**
Every person with mental health difficulties coming into contact with the forensic system should have access to a comprehensive stepped (or tiered) mental health support, that is recovery orientated and based on integrated co-produced recovery care plans supported by advocacy services as required

**Recommendation 64**
The stepped care approach applies to the forensic population as to any other groups. Access to mental health prevention, primary care mental health support, early
intervention and specialist mental health services should be available to this group without discrimination. Connections to clearly identified care pathways should be made, where appropriate, to ensure that mental health difficulties do not escalate.

The 2015 *New Connections* report set out a series of recommendations to adequately meet the psychological needs of the prisoner population. These are promoted and endorsed in this ‘refresh’ of AVFC. It is important to ensure access to a range of talking therapies and to develop and deliver mental health peer supports in the prisons.

**Recommendation 65**
The recommendations of the *New Connections* report are promoted and endorsed in this ‘refresh’ of AVFC

**Recommendation 66**
Where mental health services are delivered in prison, they should be person-centred, recovery orientated and based on integrated recovery care plans. Involvement of service users and their family, carer, supporters (FCSs) and the provision of advocacy services are all essential to facilitate co-produced care plans.

AVFC highlighted the importance of court diversion schemes. These seek to promote diversion to ensure that offenders with a mental health difficulty do not get involved needlessly in the criminal justice system. When offending behaviour is clearly related to a mental health difficulty, a diversion scheme can allow offenders to be diverted to the care of the mental health services. In those circumstances, offenders do no go into the prison service where, otherwise, there may be a delay in identifying and responding to their mental health needs.

The national forensic mental health service (NFMHS) began its prison in-reach and court liaison service (PICLS) in 2007. The service aims to identify prisoners with a mental health difficulty as rapidly as possible and put in place practical solutions for appropriate mental healthcare. The service operates a ‘liaison’ model, with assertive efforts to link individuals to their local mental health services, when this is feasible and safe. This service was designed to be appropriate for the demographics, legal and service structures of Ireland. It is recognised as a model than can identify major mental health difficulties and provide for diversion to healthcare in a risk-appropriate manner. Other countries have introduced specific and comprehensive mental health policy changes to provide for court diversion. While Ireland does not yet have a specific policy to provide for court diversion to community settings or in-voluntary community treatment, the process can take place within the existing structures. The effectiveness of the service depends on on-going resourcing and access to facilities and services in the community to which individuals can be diverted. The other recommendations in this ‘refresh’ of AVFC may, if implemented, help in this context.

**Recommendation 67**
There should be on-going resourcing and support for diversion schemes where individuals with mental health difficulties are diverted from the criminal justice system at the earliest possible stage and have their needs met within community and/or non-forensic mental health

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33 “*New Connections*” Embedding Psychology Services and Practice in the Irish Prison Service.

There is a small group of individuals each year who are found not guilty by reason of insanity (NGBRI) and who must be detained under the Criminal Law Insanity Act in a designated centre under the Act. Currently, the only designated centre is the Central Mental Hospital. As a result, capacity in the CMH in Dundrum to cater for the needs of the forensic population who need specialist mental health care is significantly reduced. An intensive care rehabilitation unit (ICRU) will shortly be available as an adjunct to the new CMH on the Portrane campus. This unit will have dual registration as an approved centre under the Mental Health Act and a designated Centre under the Criminal Law Insanity Act. It will therefore be available to accept those who have an NGBRI status but who do not require the level of care provided in the CMH. The ICRU will also be available as a secure unit for other individuals who require this level of care, for example those on remand who have severe mental health difficulties. The operation of the new ICRU centre should be reviewed after a reasonable period of time (two years) to determine the need and effectiveness of this model of care, and possible location of further ICRUs (Recommendation D.53). Alternatives should also be explored to minimise the risk of institutionalisation of this group of individuals with complex needs and to facilitate their opportunity to live in the community, with high support if needed. The need for an ICRU may also be informed by work carried out on foot of Recommendation D.53.

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<tr>
<th>Recommendation 68</th>
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<td>Prioritise the development of further Intensive Care Rehabilitation Units (ICRUs) following successful evaluation of operation of the new ICRU on the Portrane Campus.</td>
<td>Building on Recommendation 15.1.2 in AVFC 2006-16</td>
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Further understanding of the profile of the mental health needs of the prison population is needed. Indications are that there is a greater prevalence of autism, intellectual disability and needs relating to addiction and dual diagnosis, often not specifically catered for by an associated model of care (MOC) in prisons. A more joined-up approach by all professionals delivering care in a prison setting is needed. This must draw appropriately on all the various MOCs and services designed for specific needs, outlined in this ‘refresh’ of AVFC. Mental health advocacy groups should be encouraged and supported to reach into prisons setting to ensure that individuals are aware of and can access the services they need to support them in their recovery.

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<th>Recommendation 69</th>
<th>Contributing to Outcome 2(a)</th>
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<td>There is a need for further research to understand the prevalence of mental health difficulties among the prison population and the specific profile of need for which services should be delivered. This will allow for a more joined-up approach by all professionals delivering care in prisons.</td>
<td>New Recommendation</td>
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<th>Recommendation 70</th>
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<td>Mental health advocacy groups should be encouraged and supported to reach ‘in-reach’ into prisons so that individuals are aware of and can access the services they need to support them in their recovery.</td>
<td>New Recommendation</td>
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**D.17 Dual diagnosis**

Dual diagnosis is defined as the co-existence of both mental health and significant substance – drug and alcohol – misuse problems in an individual. Drug and alcohol misuse frequently co-exist with mental health difficulties. As recognised in AVFC, mental health issues are almost three times as common among those with alcohol dependence, compared to the general population and 40 per
cent of service users managed by CMHTs reported drug or alcohol misuse. Once mental health and drug and alcohol problems become established, they can negatively impact each other. The presence of both complicates treatment and support and means that services should be organised to treat individuals holistically.

AVFC recommended that general CMHTs include addiction counsellors, where warranted by the local population, as well as the development of specialist adult and adolescent dual diagnosis mental health teams to manage complex, severe substance abuse and mental health difficulties. These specialist teams would operate through clear linkages to CMHTs and would clarify pathways in and out of their service. AVFC further recommended that the dual diagnosis mental health teams be multidisciplinary, similar to other mental health services and that those working with such teams should have a special interest and expertise in supporting people with a dual diagnosis involving moderate to severe mental health difficulties. These recommendations remain in place.

AVFC recommended that specialist mental health services should only support individuals ‘whose primary difficulty is mental health’. But this ‘refresh’ of AVFC revises that recommendation, recognising that both challenges co-exist and that having an addiction either to alcohol or drugs or both should not be a barrier to accessing mental health services. Consequently it will not be necessary to establish whether a mental health difficulty is ‘primary’ for an individual to access the support of a mental health team. To make services more effective clear models and methods of care need to be developed. So a tiered level of mental health services between primary care level services and specialist mental health services is required and should include direction to appropriate addiction or mental health services. A shared case management approach may be required for particularly complex service users.

Collaborative working between mental health services and social inclusion addiction services has commenced with the development of shared areas such as alcohol liaison posts with acute hospitals and an emerging model of tele-psychiatry support for services dealing with adolescents with both mental health and addiction problems.

This approach agrees with the recommendations of the national policy on substance misuse – Reducing Harm/Supporting Recovery – and it is planned to implement the National Drug Rehabilitation Framework with the associated tiers of addiction supports. In order to provide care with clear pathways, a model of care describing the tiered levels of support needs to be developed and, in fact, work is continuing in the HSE to prepare such a model. The model should provide for psychiatry support at primary care level, if required, but developed as an ‘outreach’ service from dual diagnosis specialist mental health teams.

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<th>Contributing to Outcome 2(d)</th>
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<td>A tiered model of integrated service provision for individuals with a dual diagnosis (substance misuse with mental illness) needs to be developed to ensure that pathways to care are clear.</td>
<td>Building on / Replacing Recommendations 15.3.1 -15.3.6 in AVFC 2006-16</td>
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D 18  Specialist perinatal supports
The perinatal period, that is, pregnancy to one year brings risks of mental health difficulties for some women. Perinatal mental health disorders include both new onset and a relapse or reoccurrence of pre-existing disorders. Mental health difficulties at this sensitive time may affect the relationship between mother, child and family unit. This carries the risk of the later development of significant emotional and behavioural difficulties in the child.

In its 2016 Service Plan, the HSE mental health division, in recognition of the importance of perinatal mental health, included the development of a model of care (MOC) for specialist perinatal mental

health services. This was prepared by a national working group and launched in November 2017 and is intended to support the actions on mental health outlined in the national maternity strategy through the National Women and Infants Health Programme (NWIHP). The circumstances of pregnancy, birth and early mother–infant bonding requires staff who are knowledgeable, skilled, sensitive and experienced. So the philosophy underpinning this model of care is to focus on the mother, the baby and their relationship in the context of the family.

The model is a ‘hub and spoke’ delivery model with a specialist perinatal mental health service in six designated ‘hub’ hospitals and liaison psychiatry teams in the remaining thirteen maternity units, that is, the ‘spokes’, which are linked to the hub specialist perinatal mental health teams for advice, regular meetings, training and education. The Department of Health and the NWIHP are considering the development of further mental health midwife posts and other clinical areas to support this integrated care model for women.

**Recommendation 72**
The Model of Care for Specialist Perinatal Mental Health should continue to be resourced and rolled out nationally.

**Contributing to Outcome 2(a)**

**Building on Recommendation 15.5.4 in AVFC 2006-16**

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**D.19 Mental health services for homeless people**

Regarding other people who need mental health support, there should be a stepped approach to providing mental health care and access to specialist mental health services for people who are homeless. Where possible, these individuals should receive support at the primary care level through a GP, as described in Section D.4, and, if necessary, be referred to the relevant CMHT in their area.

**Recommendation 73**
In order to address service gaps and access issues, a stepped model of integrated support should be available for people experiencing homelessness to provide mental health promotion, prevention and primary intervention supports.

**Contributing to Outcome 2(a)**

**New Recommendation.**

For people living in emergency accommodation long term and who cannot access the mental health support they need, homeless services should provide their mental health needs. This would include low level interventions and appropriate referrals to specialist services. But duplication of services should be avoided and, where possible, homeless people should access their local community mental health team. This should not create a barrier to accessing mental health services. For the rough sleeping population, a dedicated mental health service operating on an outreach model is required in large urban areas.

**Recommendation 74**
Assertive outreach teams should be expanded so that specialist mental health care is accessible to people experiencing homelessness.

**Contributing to Outcome 2(a)**

**Building on Recommendation 15.2.5 in AVFC 2006-2016.**

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**D.20 Mental health services for people with eating disorders**

Eating disorders are associated with high mortality and morbidity. Such disorders affect somewhere between 1–4 per cent of the population at some point in their lives. The HSE *National Clinical Programme for Eating Disorders* (NCP-ED) is a collaborative initiative between the HSE, the College of Psychiatrists of Ireland and BodyWhys – the national support group for people with eating disorders. This programme applies across the age range, that is, child and adult, and has developed a model of care to introduce new and improve existing services for people with eating disorders. The eight recommendations on eating disorders of AVFC are covered in the actions in the model. Three
child and adolescent mental health eating disorders specialist teams and one adult eating disorders specialist team have been funded and are being recruited. The new National Children’s Hospital will have dedicated beds for children with complex cases that cannot be managed by local CAMHS services.

**Recommendation 75**  
The Model of Care for Eating Disorders should continue to be resourced and rolled out nationally.  
Contributing to Outcome 2(a)  
Contributing to Outcome 2(b)  
Building on Recommendations 15.4.1 to 15.4.7 in AVFC 2006-2016

### D.21 Liaison mental health services

Liaison mental health services (LMHS) provide a critical specialist mental health service for everybody, young and old, attending emergency departments, as well as service users with co-occurring physical and mental health support needs who are inpatients in acute hospitals. Liaison mental health deals with the area where physical and mental health meet and ensures that individuals in acute hospitals can access mental health services. An important task of hospital-based liaison mental health services is to ensure that there are strong links with other mental health services particularly, those based in the community. Liaison mental health service teams are multidisciplinary and clinically led by a consultant liaison psychiatrist, with team members, including specialist mental health nurses, clinical psychologists, occupational therapists and social workers, along with administrative support. AVFC recommended an increase from nine LMHS teams to thirteen.

Service pressures in acute hospitals about providing liaison mental health services are emerging, specifically in the areas of psycho-oncology, perinatal mental health and the mental health of older people – not least in the context of the ageing population. Investment in the expansion of LMHS services is needed to address emerging liaison demands, while responding to newer LMHS service developments. A clear mental health service facility must be identified for these service developments so that they are integrated with primary care services, community mental health services and acute hospital services.

**Recommendation 76**  
Continued expansion of Liaison Mental Health Services for all age groups needs to take place in the context of an integrated Liaison Mental Health Model of Care.  
Contributing to Outcome 2(a)  
Contributing to Outcome 2(b)  
Building on Recommendation 15.5.3 in AVFC 2006-2016

### D.22 Suicide prevention, responding to self-harm

Suicide prevention and initiatives addressing self-harm must be considered. *Connecting for Life* (CFL) (2015–2020) is a whole-of-society strategy to co-ordinate and focus national efforts in Ireland to reduce the loss of life by suicide and to reduce cases of self-harm. The strategy applies to the whole population and to specified priority groups. It involves preventive and awareness-raising work with the population as a whole, supportive of work with local communities and targeted approaches to priority groups.

*Connecting for Life* highlights that in Ireland, one in four people will use a mental health service at some stage in their lives. It
further highlights that research shows a strong link between mental health difficulties and death by suicide. In high-income countries, it notes that mental health difficulties are present for up to 90 per cent of people who die by suicide. It recognises that linking with AVFC is central to the success of the work outlined in Connecting for Life.

CFL sets out a vision of an Ireland where fewer lives are lost through suicide and where communities and individuals are empowered to improve their mental health and well-being. To achieve this vision, it sets out seven overarching goals illustrated in the adjacent schematic where goals 4 and 5 are particularly relevant to this ‘refresh’ of AVFC. The strategy is now being fully implemented, with the HSE National Office for Suicide Prevention (NOSP) monitoring implementation of the strategy – reporting quarterly to the National Cross Sectoral Steering and Implementation Group.

At present, there are seventeen multi-agency, local CFL suicide prevention action plans in place and being implemented across the country. The local action plans play an important role in building community capacity to reduce suicide. Immediate priorities in the implementation of the strategy, which are relevant to this domain include development of the network of suicide and self-harm prevention training programmes.

### Recommendation 77

Continued investment should be provided for the implementation of the priorities in the national and local Connecting for Life plans.

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### D.23 Providing mental Health Services that recognise and respond to diversity

The AVFC policy recognised that there are groups of people in the population who have additional needs when they develop a mental health difficulty. Specifically, it recognised that service users from other countries and cultures, Travellers and the LGBTQ+ community may have specific vulnerabilities or difficulties that should be considered in the way mental health services are delivered. This ‘refresh’ of AVFC proposes that a more developed framework for the implementation of cultural diversity and gender competency is required to respond to the needs of these groups. This would involve dissemination of guidance, training in cultural and diversity competency for mental health professionals, skills training for mental health service staff in providing LGBT+ sensitive services, training for interpreters working with individuals from ethnic minority groups and the inclusion of cultural competency as part of the core curriculum for mental health trainees of whatever discipline and in continuing professional development (CPD) activities.

### Recommendation 78

The HSE should maximise the delivery of diverse and culturally competent mental health supports throughout all services.

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People from the deaf community also need to be considered. Around seven per 10,000 people in the general population have severe to profound deafness at any one time, with the onset of their deafness having emerged before language had been established.\(^{36}\) The prevalence of mental health difficulties amongst this group is much higher than in the population generally and yet there is a lack of appropriate and accessible mental health services for them. Part of the actions needed to address this is ensuring that mental health services are culturally appropriate and accessible to members of the deaf community, through training, supervision and support for staff. Allied to this there is a need to ensure that interpreters are appropriately qualified to work in a mental health service context. It

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\(^{36}\) Based on information provided to MHR by DeafHear.
is proposed to go beyond this to provide outreach initiatives from mental health services to people who are deaf, living in the community and at risk or already living with a mental health difficulty.

**Recommendation 79**
Staff working in mental health services should have the appropriate skills and knowledge to work with the deaf community.  
*Contributing to Outcome 2(a)*

**Recommendation 80**
Building on service improvements already in place, individuals who are deaf should have access to the full suite of mental health services available to the wider population.  
*Contributing to Outcome 2(a)*

People living in direct provision can have a higher prevalence of mental health difficulties than the general population. This group should have access to mental health services and supports, as described in the stepped care approach, on the same basis as the rest of the population. Provision of specialist dedicated mental health services should be considered, when appropriate. The mental health needs of this group should be taken into account when direct provision services are being planned.

**Recommendation 81**
Persons in Direct Provision services should have access appropriate tiered mental health services through primary care and specialist mental Health services.  
*Contributing to Outcome 2(a)*

**Recommendation 82**
Appropriately qualified interpreters must be made available within the mental health service and operate at no cost to the service user.  
*Contributing to Outcome 2(a)*

**D.24 Access to advocacy**

For a variety of reasons, people may not be able to advocate for themselves. So people may require support to advocate for themselves (‘self-advocacy’), support from a peer (‘peer advocacy’) or someone to speak on their behalf (‘representative advocacy’).

AVFC, in Recommendation 3.2, recommended that ‘advocacy should be available as a right to all service users in all mental health services in all parts of the country. There is some funding available at present to advocacy organisations and a national advocacy service for people with disabilities is now run by the National Advocacy Service Board which can be used by people with complex mental health needs.

Nevertheless, the research and engagement for this ‘refresh’ of AVFC showed that there are gaps in access to advocacy supports and that some needs are unmet. Challenges include a lack of awareness of existing advocacy supports. This is particularly relevant for people with mental health difficulties living in the community, relative to those being supported in acute units and longer stay facilities. Specific groups, such as individuals from ethnic minority communities, have more specialised advocacy needs, while family involvement in this area is underdeveloped and requires attention. Family members themselves may need advocacy support, as suggested in the *My Voice Matters* survey and by existing advocacy organisations such as the Irish Advocacy Network (IAN) and Cairde.

So the right to advocacy needs to be re-emphasised and the development of additional advocacy services pursued. There is also a need for research to determine the advocacy needs of people with

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37 Nwachukwu I, Browne D, Tobin J. (August 2009), The Mental Health Service Requirements for Asylum Seekers and Refugees in Ireland, College of Psychiatrists of Ireland.
a mental health difficulty living in the community, as knowledge of the scale and nature of need in this area is limited. Similarly, research with stakeholders and voluntary community sector organisations representing the needs of groups with particular advocacy needs, for example, those from ethnic minority communities, should be carried out to see what is needed for such groups. This work should be done in consultation with the National Advocacy Service Board. All this research should inform the development of a plan and associated resourcing for advocacy services in Ireland. This plan should include the development of protocols for family engagement and its implementation should be supported through a renewed and expanded focus on advocacy training.

Recommendation 83
The HSE should ensure access to appropriate advocacy supports can be provided in all mental health services.

Contributing to Outcome 2(a)
Expansion of Recommendation 3.2 in AVFC 2006-16.

D.25 Neuro-rehabilitation (including acquired brain injury)
Neuro-rehabilitation is the process of supporting individuals with brain or spinal injuries, who often experience significant mental health difficulties requiring specialist care. People with these types of injuries often experience significant difficulties in accessing appropriate services that require an integrated response from the health service. People needing specialist neuro-rehabilitation have complex disabilities and present with a diverse mixture of medical, physical, sensory, cognitive, communicative, behavioural and social problems requiring specialist services from a wide range of rehabilitation disciplines, such as rehabilitation-trained nurses, physiotherapy, occupational therapy, speech and language therapy, psychology, dietetics, orthotics, social work and specialist mental health supports such as neuro-psychiatry.

In 2019 the HSE published the National Strategy for and Policy for the Provision of Neuro-rehabilitation Service in Ireland-Implementation Framework (2019–2021), which includes specific specialist mental health service provision, including neuro-psychiatry, which is an essential part of an effective neurorehabilitation service. These mental health supports could be provided as part of the development of liaison mental health services (See recommendation 2.61), and in the context of the proposed integrated liaison mental health model of care.

Recommendation 84
Implementation of the HSE National Strategy and Policy for the Provision of Neuro-rehabilitation Service in Ireland-Implementation Framework should remain a priority and should include the essential mental health support components of this service development, in the context of the proposed Liaison Mental Health Model of Care.

Contributing to Outcomes 2 (a) / 2 (b)
New recommendation

38 https://www.hse.ie/eng/services/list/4/disability/neurorehabilitation/
Section E  Domain 3 - Social inclusion

E.1  Introduction

Implicit in the recovery ethos is that individuals can reclaim their lives to their best extent and be involved in society – that is, be ‘socially included’. But they need supportive mental health services and supportive communities that support actions to address basic needs such as access to housing, employment and training or education.

This domain focuses mainly on people living with complex mental health difficulties who are most vulnerable to social exclusion. Domain 1 (promotion, prevention and early intervention) contains actions and recommendations to allow a broader population of people living with more mild and moderate mental health difficulties to be included in wider society. It targeted some of the social factors outside the direct control of the health services – which favour positive mental health, develop resilience and tackle stigma and discrimination.

People living with complex mental health difficulties are particularly vulnerable to social exclusion, because of stigma and discrimination, inadequate accommodation of their needs in workplaces and insufficient access to income, housing, employment and training or education. The episodic nature of these mental health problems can lead to employment difficulties and challenges with social support systems that, historically, have been designed for visible, persistent disabilities.

Previous studies of disability and the labour market in Ireland have indicated that people with an emotional or psychological disability are nine times more likely to be out of work than those of working age without a disability\(^{39}\) – the highest rate for any disability group in Ireland. Similarly, the Department of Employment Affairs and Social Protection’s (DEASP) 2015 survey of disability allowance (DA) recipients found that 50 per cent of participants reported mental health difficulties as the primary reason for being on DA. It further identified significant levels of interest among individuals on disability allowance in taking up both part-time and full-time work.

Among those who were not currently working, 35 per cent expressed an interest in working part-time, while a further 8 per cent expressed an interest in full-time employment, given the right supports. The survey also identified that people with disabilities, including mental health difficulties, experience numerous barriers to employment and that a range of supports are required to help achieve employment ambitions and goals. These included factors such as being able to retain social welfare payments, supportive work environments, access to transport, mental health supports, adaptation of job tasks, flexible hours and flexible work arrangements.

Regarding housing, a recent social housing assessment needs report\(^{40}\) indicated that 1,522 households needed access to social housing because of a prevailing mental health difficulty.

E.2  Outcomes – social inclusion

The various recommendations and interventions proposed in this domain are all geared to enable service users living with complex mental health difficulties and their family, carers and supporters to feel connected and valued in their community as described in Outcome 3a. Living a better life and being connected, respected and valued in society is a meaningful goal that many in society would aspire to, no matter what their prevailing circumstances and experiences might be. But for an individual living with complex mental health difficulty, this may seem out of reach. Being empowered to live in one’s own home and community, with additional supports where appropriate,


is a key factor in facilitating and sustaining recovery. The possibility of securing employment or returning to work – with supports in place as necessary – can also be essential to recovery. As well as employment, other options for participation and social inclusion are needed, such as access to various community-based programmes that build personal capacity and competencies and support community involvement.

Taking all of this into account, the recommendations proposed for this domain have as their objective to allow people with mental health difficulties to have improved outcomes in housing, employment, income and training or education, as indicated in Outcome 3c.

Stronger social relationships, brought about through access to housing, employment, income and education or training, will nurture social inclusion and respect for diversity. They are particularly important in empowering service users and in supporting them to achieve full and effective participation in society as set out in Outcome 3b.

Figure E.1 summarises the three outcomes for this domain. These draw on the experiences which might be desirable for people living with a complex mental health difficulty. The recommendations in this domain are geared to the achievement one or more of these outcomes.

- **Outcome 3(a)**
  Service users are respected, connected and valued in their community

- **Outcome 3(c)**
  Improved outcomes in relation to education, housing, employment and income for service users relative to the population as a whole (i.e. reduced disparity).

- **Outcome 3(b)**
  Increased ability of service users to manage their own lives [self-determination] via stronger social relationships and sense of purpose

*Figure E.1 Outcomes Social Inclusion*
Apart from structural supports in areas such as housing and employment, there may also be barriers to more general social inclusion of people with mental health difficulties. Tackling stigma and discrimination, as outlined in Domain 1 (promotion, prevention and early intervention) can help to build social inclusion. Similarly, peer-led and peer-run community development projects for people with mental health difficulties play an important role in enabling social inclusion and contributing to recovery.

E.3  Equality of access

AVFC, in Recommendation 4.1, recognised that individuals with mental health difficulties should have access to housing, employment and education or training on the same basis as every other citizen. International human rights law, to which Ireland is signed up, provides that everyone has an equal right to live in and fully participate in the community. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which was adopted in December 2006, recognises that people with disabilities should have equal rights to live in the community and that governments should put in place measures to facilitate this right as well as measures to facilitate their full inclusion and participation in the community – including access to education, health, employment and social protection.

The WHO recognised that the coming into force of the UNCRPD ‘marks a major milestone in efforts to promote, protect and ensure the full and equal enjoyment of all human rights of persons with disabilities’. The ‘refresh’ of AVFC incorporates the same fundamental principle of equality of access to housing, employment, and training or education for people living with a mental health difficulty. But sometimes people who experience mental health difficulties may need extra measures or supports to achieve suitable housing, employment, education and training and income.

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<th>Recommendation 85</th>
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<td>Tailored measures should be in place in relevant Government Departments to ensure that individuals with mental health difficulties can avail, without discrimination, of employment, housing and education opportunities and have an adequate income.</td>
<td>Contributing to Outcome 3(c) Building on Recommendation 4.1 of AVFC 2006-16</td>
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E.4  Housing supports

There is a strong link between poor mental health and people having housing problems and being homeless. Access to good quality, secure and appropriate housing is vital to facilitating and sustaining recovery. A lack of suitable housing as an alternative to institutional care can lead to an inefficient and expensive mental health system, with service users receiving unsuitable care. Housing supports for these people needs effective collaboration between the Department of Health (DoH), Department of Housing, Planning and Local Government (DHPCLG), local authorities and social housing organisations.

According to AVFC, there is a need for liaison between mental health services and local authorities in the provision of social housing for service users who require it. Social housing organisations not only provide housing directly which may meet the needs of people with complex mental health difficulties, they are provide specialist supports to improve the quality of life and housing sustainability of people with such difficulties. Access is key for service users with social housing needs, along with assistance to help service users sustain these tenancies and to live independently.

Central to this is ensuring that people with complex mental health difficulties have equal access to housing allocations and that any particular needs about their living environment are properly planned. This means estimating and planning ahead to ensure an adequate stock of social housing
units matched to the profile of need. For example, Cowan and Whitty\(^{41}\) found that 38 per cent of inpatients, many of whom were single men with a mental health difficulty, had accommodation-related needs. Single men are typically not a priority group in the allocation of social housing.

Effective discharge planning for many inpatients in mental health units is also important in this context, requiring close liaison between the mental health service and the relevant local authority.

*Rebuilding Ireland – the Action Plan for Housing and Homelessness (2016)*\(^{42}\) committed to increase social housing and speed up its delivery over the period 2016–2021, building up to delivery of 10,000 units on an annual basis. Local authorities and approved housing bodies are delivering these units through a variety of new-build and acquisition mechanisms, as well as through leasing arrangements and tackling vacant stock. This commitment reiterates the need for liaison between mental health services and local authorities.

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<th>Recommendation 86</th>
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<td>Local authorities must liaise with statutory mental health services in order to include the housing needs of people with complex mental health difficulties as part of their local housing plans.</td>
<td>Building on Recommendation 4.7 of AVFC 2006-16</td>
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AVFC highlighted that many people in HSE hostel accommodation would be better living more independently in the community. It recommended that the housing and mental health sectors work together to achieve this and clarified the roles of the two sectors. Progress, at least in the early period of AVFC, was slow, partly because of the economic crisis at that time and partly because of shortfalls in housing units that were suitable for this purpose.

There has been important progress made and good practice developed through recent pilot projects that provide access to appropriate housing, as well as practical supports to sustain independent living, along with mental health rehabilitation supports.

The Doras and Slán Abhaile projects in North Dublin funded by the Genio Programme between 2012–16, involved a partnership between HAIL (a specialist housing agency) and the HSE. The projects provided accommodation and offered support to those who were living in HSE residential services to move to independent living. The support is best described as a tenancy-related, independent living support service with a range of clinical interventions from a HSE intensive recovery support team. The success of the approach depended on the high degree of collaboration between HAIL and HSE to support service users and to contribute to their recovery in their new accommodation. The evaluation of the pilot project concluded that there was a ‘strong value case and value for money argument for continuation and expansion of the floating support service.’\(^{43}\)

A second example was a pilot project in Laois-Offaly that began in 2015, supporting fifteen people with low and medium-support needs to move from HSE mental health facilities to more appropriate community-based arrangements. The project, which was part-funded by DHPLG and the HSE on an equal basis, including a new model of support with the introduction of mental health tenancy sustainment officers.

To speed up plans to move people living in HSE mental health service congregated settings to mainstream community-based living, a joint protocol should be developed between the DoH and the DHPLG in consultation with key stakeholders. The protocol should be informed by the learning from

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\(^{41}\) Cowan, J. and Whitty, P. (2016) Prevalence of housing needs among inpatients: a 1 year audit of housing needs in the acute mental health unit in Tallaght Hospital. Irish Journal of Psychological Medicine, 33, 159-164.


the various pilot projects around the country. This would help to ensure that there is an understanding of what is needed to ensure effective transitions from HSE facilities.

**Recommendation 87**

Housing Planning and Local Government, in consultation with relevant stakeholders, should develop a joint protocol to guide the effective transition of individuals from HSE supported accommodation to community living.

Building on the positive evaluations of the pilot projects, there should be sustainable resourcing in place for tenancy-related/independent living supports for service users with complex mental health difficulties. This should apply to service users moving from HSE-supported accommodation to independent living and for individuals in hospital or homeless services identified as having a housing need. It should be based on identified need and apply to service users with complex mental health difficulties, living independently in the community to enable them to continue to do so. This would help to prevent homelessness or entry to residential facilities, while promoting recovery.

Many specialist housing agencies provide tenancy-related and independent living supports to service users living in the community. These services require sustainable funding. They should be delivered in collaboration with supports from HSE intensive recovery support teams, in accordance with the recently developed model of care for service users with complex needs and described in Domain 2 (Service Access, Coordination and Continuity of Care).

**Recommendation 88**

In conjunction with supports provided by HSE including Intensive Recovery Support teams, sustainable resourcing should be in place for tenancy-related/independent living supports for service users with complex mental health difficulties.

*Rebuilding Ireland – the Action Plan for Housing and Homelessness* commits to delivering supports to homeless people with mental health and addiction issues. The plan recognises that homelessness is a complex phenomenon. It is usually the result of a number of inter-related issues, including mental health issues, addictions, relationship breakdown, family issues, domestic violence, financial loss, economic insecurity, rent arrears, tenancy issues, anti-social behaviour, crime, prisoner release and the vulnerability of migrants, amongst other factors. It therefore recognises that a successful ‘whole-of-Government’ response is needed to such issues, if the current homelessness crisis is to be tackled effectively.

Evidence from elsewhere suggests that a ‘housing-led’ model is particularly effective with long-term homeless individuals who have a history of mental health difficulties and drug and or alcohol misuse. This model is known as *Housing First*, developed initially in the United States and Canada, which focuses on offering permanent, affordable independent housing as quickly as possible to individuals and families experiencing poor mental health. *Rebuilding Ireland – the Action Plan for Housing and Homelessness* commits to strengthening efforts and improving resources to provide homeless people with a home, by following the *Housing First* approach.

In 2018, a homelessness programme was begun under the ambit of the Service Reform Fund (SRF). This involved an integrated approach by DHPLG, local authorities, DoH and the HSE, in keeping with the policy commitment in *Rebuilding Ireland*. The SRF Homelessness Programme focuses on three areas (1) supporting 100 additional housing-led tenancies in Cork, Limerick and Galway; (2) exploring whether the existing *Housing First* initiative in Dublin needs additional integration and health supports; and (3) improving integrated pathways and joint working through a pilot implementation of a Dublin-wide homeless hospital discharge policy which would include enhanced screening and referral processes for *Housing First* tenancies.
The Housing First model is endorsed in this ‘refresh’ of AVFC. The learning from pilot projects in Ireland and international good practice in this field should be applied. Rebuilding Ireland – the Action Plan for Housing and Homelessness (2016) has already committed to strengthening efforts and resources to provide homeless people with a home using the Housing First approach. The Oversight Group supports these developments.

Providing accommodation on its own will not address all the underlying problems of the vulnerable group of homeless people who have addiction and or mental health difficulties. As such, Recommendation E.5 needs to be implemented, together with various actions covered in Domain 2 (service access, co-ordination and continuity of care), including access to primary care services; supports for individuals with a dual diagnosis; and access to outreach mental health services for homeless people in emergency accommodation.

In 2016 new housing design guidelines were launched by the HSE and the Housing Agency to promote independent living and mental health recovery for people living with mental health difficulties. The guidelines offer a perspective on housing type and design for people considering alternatives to congregated settings. They should be a factor for all of the housing-related recommendations in this ‘refresh’ of AVFC.

Recommendation 90
The housing design guidelines, published by the HSE and the Housing Agency in 2016, to promote independent living and mental health recovery should be a reference point for all housing related actions in this ‘refresh’ of AVFC.

E.5 Employment supports

People with mental health difficulties are less likely to be in employment compared to those who have such difficulties. This is the case both internationally and in Ireland. Not having a job is the single biggest inequality that people with experience of a mental health difficulty can face. For individuals with enduring mental health difficulties, or those recovering from a once-off but significant mental health difficulty, the possibility of securing employment or returning to work can be key factors in recovery. This depends on certain circumstances. For example, a person who is of working age and does not have full-time caring responsibilities.

Employment is important to social status and identity as it provides social connection 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 a greater disposable income for those with mental health difficulties. Employment can reduce negative mental health symptoms and hospital admissions or readmissions.

AVFC recommended that evidence-based approaches to training and employment for people with mental health difficulties should be adopted.

An important intervention piloted in four sites across Ireland from 2015 has been the individual placement and support (IPS) employment model, an evidence-informed approach to supported employment for people who have a severe mental health difficulty. It supports those individuals to remain in, or have access to work in mainstream settings while also supporting employers to address related recruitment and retention issues. As such, it differs from other vocational rehabilitation approaches that employ people in sheltered workshops and other non-mainstream jobs.

There is strong international evidence that an IPS model is the most effective method of supporting people with severe mental health difficulties to achieve sustainable, competitive employment. The IPS model has also been shown to be both cost effective and less expensive than traditional vocational approaches.

The approach includes seven essential principles, including integrated mental health and employment supports, intensive individual support and rapid job search, based on the person’s employment interests and preferences, followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer. Evaluation evidence\(^45\) from the four pilot sites in Ireland is encouraging about the effectiveness of the model in providing a more integrated supported employment service and better cost benefits.

The operation of the Service Reform Fund provides an opportunity to scale up the innovation in the IPS model through a partnership arrangement with all CHO mental health services. The objective is to ensure that in the next three to five years, all service users can have a realistic expectation of having support to find and maintain employment, where it is their choice to do so. The IPS is a model of employment activation consistent with the work of the Department of Employment and Social Protection.

**Recommendation 91**

A sustainable funding stream should be developed to ensure agencies can work effectively together to get the best outcomes for the individual using The Individualised Placement Support model which is an evidence-based, effective method of supporting people with complex mental health difficulties to achieve sustainable, competitive employment where they choose to do so.

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**E.6 Training and vocational education supports**

Other rehabilitative and vocational supports are also important to ensure the social inclusion of people with mental health difficulties. The HSE’s *New Directions – Personal Support Services for Adults with Disabilities Report (2012)*\(^46\) included people with mental health difficulties and the principles and models described in it are highly relevant for people with these difficulties. *New Directions* includes a commitment to developing services that are person-centred, that support the social inclusion of individuals in their community and that build personal capacity and competencies. Where desired, services can provide bridging programmes to vocational training; access to vocational training and other formal education and learning opportunities. The research for *New Directions* indicated the variable quality on offer – from clearly planned programmes of activity to services where people spend time with nothing to do or engage in repetitive activities, which they see as of little use or value.

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46 https://www.hse.ie/eng/services/publications/disability/newdirections.html
Existing resources should be used by the HSE to reconfigure adult day supports for people with complex mental health difficulties, in line with the *New Directions* policy. Peer-provided and Peer-led supports could have an important role to play in the range of services offered. These services should sit alongside the continuum of community-based mental health services outlined in Domain 2 (service access, co-ordination and continuity of care). In the community-based mental health services offered, the recovery education courses provided by recovery colleges have a particular role to play.

**Recommendation 92**
The current HSE funding provided for day centres should be reconfigured to provide individualised supports for people with mental health difficulties and be consistent with the *New Directions* policy.

**Contributing to Outcome 3(a)**
**Contributing to Outcome 3(b)**
**Contributing to Outcome 3(c)**

**New Recommendation**

### E.7 Income protection and social welfare

In Recommendation 4.4 of AVFC, measures were put forward to protect the income of individuals with mental health difficulties. This centred on the need to inform people with mental health difficulties about the benefits to which they are entitled. It also recognised that help and advice needed to be given to ensure such individuals are supported by the social welfare system, including the flexible provision of social welfare payments.

These issues are still relevant. For example, individuals with episodic mental health difficulties may have fluctuating work capacity and move in and out of work numerous times while of working age. A crucial requirement is that income supports are flexible to allow people enter or leave the workforce in times of illness, automatically reverting to previous relevant benefits if the person has to leave the labour force for a time. It is also important to recognise the benefits trap and to let the people with mental health difficulties keep secondary benefits such as the medical card.

**Recommendation 93**
In line with the strategic priorities of the Comprehensive Employment Strategy for People with Disabilities the way people come on/off income supports should be streamlined to maximise entry or re-entry to the workforce with confidence and security. This should happen without threat of loss of benefit and with immediate restoration of benefits where they have an episodic condition or must leave a job because of their mental health difficulty.

**Contributing to Outcome 3(c)**
**Building on Recommendation 4.4 of AVFC 2006-16.**

### E.8 Peer-led, Peer-run and community development projects

Domain 2 (service access, coordination and continuity of care) highlighted the importance of training and support for peer workers and of their integration as respected colleagues at all levels of specialist mental health services, where they can innovate and be part of a joint leadership structure. Staff with a lived experience of mental health difficulties offer hope and understanding as well as knowledge and support – factors highly effective for recovery.

Peer-led and peer-run projects in the community are important ways to promote the social inclusion of people with a mental health difficulty. Specifically, there are key social and community activities that can enhance positive mental health by generating social capital and promoting an individual’s social inclusion and mental health recovery. Strengthening and broadening social networks foster social inclusion. Such networks are a buffer against stress, while creating opportunities for meaningful social engagement and personal development.
The Gateway project in Rathmines in Dublin is a good example. This is a community-based, member-led social support group for people with experience of mental health difficulties. It provides a safe, friendly and inclusive space locally where people can come together, make friends and get support while learning about positive mental health, well-being and recovery. The project supports the personal, social, health, educational and employment needs of people with mental health difficulties. Members work together to meet these needs and interests through a wide range of activities and training and through informal peer and social support. The ethos is based upon community development principles of equality, participation, inclusion and social justice. The project workers are mostly former members themselves and best placed to empower members and promote the values and ethos of recovery.

There can be challenges for these projects, not least in relation to continuity of financial resources. Then the core work of the projects has to be limited and associated volunteers diverted by the necessity to raise funds. While the HSE should continue to fund existing and new similar services, this must be informed by project evaluation and have standard guidance (an SOG) in relation to applications for such funding. It is still important that these services should be viewed as an important part of quality mental health services in local communities.

**Recommendation 94**
The HSE should continue to develop, fund and periodically evaluate existing and new peer-led / peer-run services provided to people with mental health difficulties across the country.

**Contributing to Outcome 3(a)**
**Contributing to Outcome 3(b)**
*New Recommendation*
Section F  Domain 4 - Accountability and continuous Improvement

F.1 Introduction

This domain focuses on the organisational processes needed to implement and track delivery of the reforms proposed in this ‘refresh’ of AVFC, with an emphasis on innovation and continuous improvement.

As highlighted previously, positive mental health is not a matter for the health sector alone but sits in a much broader context of decisions made across the relevant public services. These can impact positively or negatively on the well-being of the population generally, as well as on the mental health of individuals living with a mental health difficulty. Mental health policy must therefore be an integral national cross-cutting priority. As such it needs to be integrated into all key and relevant policies and settings in society.

All recommendations in this ‘refresh’ of AVFC and associated actions as part of the implementation planning will have assigned lead responsibilities across relevant government departments and agencies, as set out in the Implementation Framework (section G). Such governance will be reinforced by the setting up of a national ‘whole-of-government’ implementation committee, representative of cross-sectoral interests as well as service users, FCS and peer organisations.

F.2 Accountability and continuous improvement

The need to build a more accountable and transparent health service is a focus of Sláintecare and is also a key objective for this ‘refresh’ of AVFC. Service users, FCSs, and the public must be able to
make informed judgements about the extent of reform of the mental health system. This is especially the case where that system encompasses the breadth of supports and services available at a primary care level through to the various components of specialist mental health services as described in Domain 2 (service access, co-ordination and continuity of care). Service users, FCSs and the wider public need to have confidence in the information available so that they can judge the pace and impact of this refreshed policy and the difference it makes to the health and well-being of service users. Dynamic performance reporting, as expressed in Outcome 4b, will facilitate this.

Along with the system perspectives described in Outcomes 4a and 4b, at an individual level services must deliver high-quality people-centred supports consistently which meet the needs and have the confidence of service users and FCSs. This is the intent of Outcome 4c.

Policy implementation and reform in the future must maintain the effort and build on the evidence of ‘what works’ in the present. Continuous improvement and the capacity to address new challenges depend on innovation and new ways of working across systems and sectors.

There are a number of established national initiatives to support innovation in replicating ‘what works’. The emphasis now must be on future-focused, continuous improvement, driven by adequately-resourced innovation while activating the processes and skills to support change. The focus on continuous improvement must extend to other sectors contributing to the well-being of the population, supporting people living with a mental health difficulty while they recover. These are all captured in Outcome 4d. The fostering of research and the dissemination of findings to support the implementation of evidence-informed and innovative models of care is essential.

All recommendations within Domain 4 are geared towards the achievement of these four outcomes.

F.2 Governance leadership and organisation

AVFC recommended that a National Mental Health Directorate should be established under the leadership of a national director to prioritise the mental health agenda and to drive it centrally by the HSE (Recommendation 16.3). This was achieved with the appointment of the first HSE national director in 2013. The focus provided by a national director and the associated national mental health division management team provided sustained and consistent leadership to drive the implementation of AVFC. It enabled a national overview of key issues such as workforce planning and resource allocation, while permitting local flexibility. National initiatives under this office include those for improving the experience of service users (such as the National Framework for Recovery in Mental Health) and others which improved the capability of the mental health services to bring about sustained change, such as the Office of Mental Health Engagement and the Strategic Programme and Project Management Office for service improvement.

As part of structural changes announced in 2016, a new national director of community health service operations subsumed the operational roles of the existing national directors for primary care, social care, health and well-being and mental health. These changes enabled the existing national directors to work closely with the chief strategy and planning officer to plan the integration of acute care, primary care, social care, mental health and health and well-being through a ‘commissioning’ type approach. The changes introduced by the HSE were designed to enhance performance and management across the health service and to integrate HSE services to deliver the health priorities outlined in the Programme for Government.

A consequence of this change is that the role of national director for mental health no longer exists. As a result, there is no single leadership for mental health at present under the proposed new structures. The oversight group recognises the need to have dedicated attention to strategy while also giving the required attention to operational issues, and maximising integration across care groups. This can be achieved while maintaining a single, dedicated, national individual accountable for mental health. This dedicated, visible and single line of authority should ensure that the mental
health budget is ring-fenced and is not used to fund shortfalls in other parts of the health service while at the same time supporting appropriate co-ordinated and integrated models of care in line with the principles and values outlined earlier in Section B.

### Recommendation 95
There should be a dedicated, visible and accountable single line of authority for strategy, planning and operations relating to mental health in the HSE, with integration across care groups for mental health actions. A supporting governance /accountability structure and ‘ring-fenced’ resources are required for this.

**Contributing to Outcome 4(a)**  
**Contributing to Outcome 4(c)**  
**Building on Recommendations 16.4, 16.7 and 20.20 of AVFC 2006-16**

### F.3 Service organisation
The single line of authority and integration across care groups at the departmental and national HSE levels should be carried through to the regional level – that is the nine CHO structures and the ‘soon to be’ five to six regional integrated care organisations (RICOs) under plans drawn up by the Sláintecare Health Reform Office.

The model for delivery of care, mental health services should align to the community health networks (CHNs) structure being introduced at present. The CHNs each serve an average population of 50,000 and are a critical element of the move towards a more community-led model of care. This model aims to enable community health and social care services across primary care, social care, mental health and health and well-being to be provided in a more coordinated and integrated way. The move to collaborative and cross-boundary working in CHNs will encourage primary and secondary care to be aligned and delivered closer to the community. So the CHN manages the delivery of primary care services and ensures the effective co-ordination and integration of other community services, including social care and mental health, as well as access to acute hospitals. This is entirely consistent with the focus in this ‘refresh’ of AVFC on the co-ordination and integration of mental health services and supports provided at a primary care level and specialist secondary mental health services.

AVFC stipulated in Recommendation 11.4 that for general adult mental health services there should be one community mental health team (CMHT) for sector populations of approximately 50,000. This remains valid and provides a good basis for synergy with the CHN model which also operates to a catchment population of 50,000, thereby providing scope for ‘co-terminosity’ of service delivery. More specialist CMHTs, such CAMHS and MHID teams servicing larger catchment populations should operate across one or more CHN areas. As the CHN model is implemented in 2019 and 2020, there must be formalisation of these alignments and associated arrangements.

### Recommendation 96
The single line of authority and integration across care groups should be visible in the structures at regional level where the delivery model for mental health services is aligned to the Community Health Networks (CHNs) model.

**Contributing to Outcome 4(a)**  
**Contributing to Outcome 4(c)**  
**New Recommendation**

It is important to ‘future proof’ the recommendations on governance, leadership and organisation, so that whatever structures are put in place, it should be possible to demonstrate a dedicated single line of authority for mental health from the national level through to the regional levels. The rationale for this is underpinned by the history of underfunding of mental health, the scale and speed of implementation of AVFC and the need for collaboration and action across multiple stakeholders and government departments. The relative success of the National Mental Health
Division since its establishment in 2013 in speeding up the more recent implementation of AVFC, with an emphasis on fair and equal national action essential.

Finally, it is important to take an interim position about the change that is taking place presently in HSE structures. These included the move to RICOs and the progressive implementation of CHNs. Effective organisational structures are essential to deliver integrated mental health services and to bring about the reform and implementation of the associated recommendations proposed in this ‘refresh’ of AVFC. But there is a need to prioritise the implementation of recommendations and actions that will directly impact on the lives of people with mental health difficulties as soon as possible and not to wait until all structural changes are finalised.

**Recommendation 97**

In the context of on-going structural changes in health services, it is important that the implementation of the relevant recommendations and actions that will directly impact on the lives of people with mental health difficulties is prioritised. In the case of delays in organising and implementing structural changes in the HSE, the CEO of the HSE will be responsible for reporting on the implementation of the relevant recommendations and actions, proposed in this ‘refresh’ of AVFC.

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**F.4 Disadvantage and service planning**

AVFC recognised the central importance of socio-economic factors in mental health and of poverty in particular. Experiencing poverty is not just about lack of income but also about barriers of access to services and opportunities which prevent people from participating in society. Poverty increases the risk of mental health difficulties and can be both a cause and a consequence of mental health difficulties.

Regional differences in poverty and deprivation continue, with a higher incidence in the border, midland and west regions of Ireland, relative to the southern and eastern regions. Deprivation can also manifest itself in different ways. For example, urban disadvantage may be manifest as localised communities of households with high concentrations of poverty. In rural areas specific factors can prevail to disadvantage a community, such a lack of services and employment opportunities and a high incidence of isolation and loneliness. These elements can be the cause of poverty and deprivation.

AVFC highlighted the need to take account of local deprivation patterns in planning and delivering mental health services. This is now done through the national mental health resource allocation model. This calculates the budget by CHO on a per capita basis using census data and is adjusted for the deprivation indices from the HSE Health Atlas. This model helps the national mental health office make decisions about the allocation of funding to ensure it is given to CHOs on an equitable basis.

There is a need for a continued emphasis not just to promote greater accountability and transparency in resource allocation, but also to support the achievement of some of the outcomes about access to services and social inclusion. Areas that have poor levels of provision for specific services, taking deprivation into account, relative to other areas, will be prioritised. So when new resources become available, they will not be allocated on a ‘something for everyone’ basis but will be targeted based on need. This allocation model should include the skill mix in mental health human resources. Skill mix analysis should be carried out to determine the optimum number and type of health and social care professionals in any given service. The emphasis will be on meeting the needs of service users rather than filling quotas for any single professional group.
Recommendation 98
Implementation of this policy over the next ten years should achieve a re-balancing of resources and take account of population deprivation patterns in planning, resourcing and delivering mental health services.

Contributing to Outcome 4(b)
Contributing to Outcome 2(a)
Contributing to Outcome 3(c)
Building on Recommendation 4.5 of AVFC 2006–16

F.5 Measuring performance

To establish targets, allocate resources and set mental health priorities, standardised performance indicators (PIs) and targeted service outcome data are required. These must be set at a national level, led and co-ordinated by the Department of Health. The format of progress reporting should also facilitate the capture of unique issues in CHO/RICO areas. Service users and their FCSs should be involved in this process and in data capture mechanisms. There should be public access to this performance data, at a minimum in the form of an annual performance report on the mental health system, for transparency purposes.

Recommendation 99
A standardised set of performance indicators (PIs) directly aligned with the desired outcomes in this ‘refresh’ of AVFC and agreed standards of care and quality frameworks must be developed by the Department of Health and the National Implementation Monitoring Committee accounting for quantitative and qualitative delivery of intended outcomes.

Contributing to Outcome 4(b)
New Recommendation

An important component of measuring and monitoring performance is regular tracking of the views of service users about their experiences with the mental health system and the impact of these experiences on their health and well-being outcomes. It is important to capture the experiences of FCSs as well to ensure that they understand the support being accessed by their relative or friend and their expected outcomes.

Recommendation 100
Regular surveys of service users and FCSs should be independently conducted to inform assessments of performance against PIs and target outcomes in this refreshed policy.

Contributing to Outcome 4(b)
New Recommendation

Complaints represent a valuable source of information on the performance of a system and can offer useful guidance for service improvement. Mechanisms to hear and act on complaints are a potentially powerful way to provide a visible response to issues that are raised in the context of continuous improvement. However, there is evidence that people with mental health difficulties can find it difficult to make a complaint and there can be specific vulnerabilities in this regard. Models for improving the complaints process in other sectors of service delivery, such as disability services, include improvements in the availability of information and providing training in making complaints. Each CHO has an independent complaints system and awareness of these needs to be raised47.

Recommendation 101
Information on the process of making a complaint, including necessary contact details, should be visible,

Contributing to Outcome 4(b)

47 https://www2.hse.ie/services/your-service-your-say/make-a-comment-compliment-or-complainhtml
accessible, and widely available in a variety of media, languages and formats for maximum accessibility in all mental health service settings and in other fora.

**New Recommendation**

**Recommendation 102**
Training should be provided for services users and staff on making and dealing respectively with complaints.

**Contributing to Outcome 4(b)**

**New Recommendation**

### F.6 Delivering against standards in quality frameworks and best practice guidelines

In 2008 the Department of Health and the HSE committed to the development of a health service charter. The National Healthcare Charter, *You and Your Health Service*, was developed by service user advocacy groups and other interest groups to describe what service users can expect when using health services in Ireland. The charter focuses on eight principles that underpin high quality, people-centred care to inform and empower individuals, families and communities to look after their own health and influence quality healthcare in Ireland.\(^{48}\)

The charter is important because it sets out what people using the service can expect and provides a shared vision of the values, principles and behaviours that should be evident in all those providing mental health services. A charter should emphasise the need for a partnership approach to delivering care and supports a culture providing health and social care services in a predictable, preventative, personal and participatory way. The focus on service user-centred care and service development should involve advocacy and self-determination, where possible.

The National Healthcare Charter broadly outlines the terms expected from the delivery system. Mental health principles must be part of the charter so that people using mental health services know what to expect from those services and so that these principles can be included in staff contracts and in induction continuing training to encourage quality in mental health service delivery. This approach is more appropriate than the development of a separate charter for mental health services and is consistent with the need to integrate physical and mental healthcare advocated in *Sláintecare*.

**Recommendation 103**

Mental health services should ensure that the principles set out in the National Healthcare Charter, *‘You and Your Health Service’*, are embedded in all service delivery.

**Contributing to Outcome 4(c)**

**New recommendation**

The *Quality Framework for Mental Health Services in Ireland* (Mental Health Commission, 2007\(^{49}\)) presents the national standards for all specialist mental health services. The themes, standards and criteria contained in the *Quality Framework* provide clear guidance for service users, their families and chosen advocates, service providers and the public about what to expect from a mental health service. The *Judgement Support Framework* was developed by the Mental Health Commission in 2015 as a guidance document to help approved centres comply with the Mental Health Act 2001 (Approved Centre) Regulations 2006. The *Judgement Support Framework*, now in its fifth version, also promotes the continuous improvement of the quality of services provided to service users in approved centres.

The HSE launched *Best Practice Guidance for Mental Health Services*\(^{50}\) in 2017. The guidance is a practical tool, based on legislation and best available evidence. It was developed in consultation with staff, service users, families and carers. The *Quality Framework*, the *Judgement Support Framework* and the *Best Practice Guidance for Mental Health Services* serve to complement each other.

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\(^{50}\) https://www.hse.ie/eng/services/list/4/mental-health-services/mental-health-guidance/best-practice-guidance/
and the Best Practice Guidance are generally consistent with the ethos of this ‘refresh’ of AVFC and its many themes developed across the four domains. Future updates of the Quality Framework, The Judgement Support Framework and the Best Practice Guidance should be consistent with the ambition for the specific outcomes for the mental health system set out in this ‘refresh’ of AVFC.

The guidance and standards in these three documents all play an important role in continuous improvement and in the measurement and monitoring of desired standards and practices. The effort and paperwork needed to comply with these different frameworks and guidance – which overlap in many ways – places a considerable burden on mental health services. The PIs and performance measurement system for the monitoring of this refresh of AVFC may create another measurement and compliance system, so two recommendations are made: that all future updates of quality or continuous improvement systems should be consistent with the outcomes in this refreshed policy and that work be undertaken to streamline these different systems.

This should be informed by any PIs and service outcome targets developed through Recommendation F.6. To reinforce national standards in the streamlined systems, all funded contracts for service delivery in mental health in future must refer to these standards.

<table>
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<tr>
<th>Recommendation 104</th>
<th>Contributing to Outcome 4(c)</th>
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<tr>
<td>Future updates of the Quality Framework, the Judgement Support Framework and the Best Practice Guidance should be consistent with the ambition and the specific outcomes for the mental health system set out in this ‘refresh’ of AVFC.</td>
<td>New Recommendation</td>
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<th>Recommendation 105</th>
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<tr>
<td>The relevant bodies should come together to ensure that the measures for the Quality Framework, the Judgement Support Framework, the Best Practice Guidance, the refreshed AVFC PIs and performance system and any future measurement systems are aligned and that the required data is derived, where possible, from a single common data set.</td>
<td>New Recommendation</td>
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F.8 Enablers

New policy recommendations are implementable and achievable, with overarching ‘enablers’ to support and encourage change. There are important areas of work that will enable the achievement of target outcomes across the domains. These are detailed under respective sub-headings below.

For the next ten years of the policy, further areas of work may emerge as ‘enablers’. Flexibility and an openness to change will enable the successful implementation of the ‘refreshed’ policy. This is illustrated by the change that has occurred in mental health services because of successive policies and the system level changes arising from HSE restructuring.

F.8.1 Commissioning model

Wider health system changes referred to in Section B above will significantly affect approaches to funding the mental health service over the next ten years in line with recommendations. Recent health system thinking has emphasised the need to move away from traditional incremental budgeting arrangements, often in block sums, and towards a more strategic approach to investing in health promotion, early prevention and care services.

The HSE has reorganised to emphasise the need to highlight the commissioning role and the operational and resource management responsibilities. Sláintecare sets out a very extensive agenda of
strategic planning and commissioning reform to support the goal of a single-tier integrated universal healthcare system. Major elements of the Sláintecare financial reform agenda include:

- develop a way to determine resources and integrated services on a regional basis
- develop an integrated regional resource allocation formula
- design proposals for multi-annual budgeting
- design a system of population-based funding
- benchmark quantum of health and social care budget in a comparative international context
- advance community-based costing and work with key health stakeholders and academic researchers to develop an activity and cost database for health and social care in Ireland

For many sectors of the health and social care system these approaches will mark a significant departure from the traditional resource allocation methodologies at national, regional and service provider level. As noted earlier (section F.4), the mental health service has been developing the application of deprivation-adjusted population based resource allocation in the Irish health context. Building on a recommendation in AVFC, a national mental health resource allocation system is now in place which informs decisions on the prioritised allocation of resources where available. It represents a valuable platform on which to build the comparative cases for the investment required in the service and, ultimately, to demonstrate the outcomes achieved.

There are many features of this funding model which need refinement or expansion. For example, core change for the future values such as a community-based approach and integrated services present real challenges when looked at in the resource allocation context due to the multiplicity of funding routes, variation in strategic priorities and differentials in existing funding levels. The link between how physical health services and mental health services are resourced is significant. For the mental health services, given the distinctive importance of other sectors such as housing and employment in mental health protection, in particular, it is essential that effective mechanisms are developed early for integrated approaches to resource allocation, in line with the Sláintecare ambition.

Equally, the way in which service providers and partners are paid hugely shapes the nature of service provision. It can incentivise less desirable interventions or prioritise activity without regard to targeted outcomes. Resource allocation mechanisms for mental health need to target inequalities incentivise quality service delivery and are linked to demonstrable outcomes. Attaining this aim will not be easy but a clear vision will help guide the long-haul work involved.

We can learn from experience in countries such as the UK and Australia, what is involved in this journey to a strategic approach to resource allocation in the mental health domain. In NHS England the Mental Health Taskforce Strategy – Five Year Forward View for Mental Health (2016)51 recommended that

‘In future, payments should incentivise swift access, high quality care and good outcomes, while deterring cherry picking of people who seem ‘easiest-to-treat’. Payment models should include a range of capitated or population-based approaches ... Payments should incentivise provision of integrated mental and physical healthcare and be adjusted to account for inequalities. Funding decisions should be transparent and public.’

In Australia, at a national level there has been a focus in recent years on the issue of mental healthcare services and costs in the acute setting. This was driven initially by the implementation of the activity based funding (ABF) resource allocation system to acute general hospitals, many of the features of which have also been adopted in Ireland’s acute hospital funding system.

It was recognised in Australia that integrating service planning, resourcing and evaluation for mental health service users across the hospital and community divide required a special focus and much better data than were traditionally available from either the general hospital system or the community based services. This led to a programme of work, starting in 2012, to develop agreed activity classification and costing systems supporting effective resource allocation for specific categories of mental health service users across care settings.

It is clear that the shift towards resource allocation approaches in line with *Change for the Future* will require very significant ground work about the basic data which will support more evidence-based and strategic funding. New ways of funding mental health will require basic building blocks such as standardised service descriptors, quantification of interventions and activities, reliable expenditure analysis and agreed outcome measures.

The acute hospital system has already had three decades of development work behind it, but in the wider health service there is considerably less groundwork done. Recently HSE mental health services and HSE cost accounting and funding function together conducted a ‘discovery’ project to scope out the current status of these building blocks across a number of CHOs. This confirmed the need for significant improvements in several areas, including standardised approaches and systems for coding of financial data aligned to service and sub-service descriptions. After this work a follow-on exercise to standardise approaches to expenditure analysis and service descriptors is nearing completion. The wider HSE plan to introduce an integrated financial management system will also be a key element for advancing more developed resource allocation methods.

The *Sláintecare* Action Plan 2019 identifies a number of specific tasks to be completed in the current year which would directly support the further development of the desired resource allocation approach for mental health services. Under the *Financing Reform Programme* (workstream 2.5) are included commitments to:

- Invest in a multi-annual programme of work with key health stakeholders and academic researchers to develop an activity and cost database for health and social care in Ireland
- Develop proposals for multi-annual budgeting in the healthcare and social care system to facilitate accountability and planning and strengthen financial management for revenue and capital funding
- Develop a plan for the design of a system of population-based funding
- Advance community-based costing, focusing initially on residential placements and home help services
- Benchmark quantum of health and social care budget in a comparative international context

### Recommendation 106

The work underway at national level to develop a cost and activity database for health and social care in Ireland should prioritise Mental Health services to leverage developmental work already underway and support the evolution of outcome-based resource allocation.

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<th>Contributing to</th>
<th>Outcome 4 (d)</th>
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<td>New Recommendation</td>
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F.8.2 Mental health information systems

Domain 2 emphasises the importance of information-sharing, from the initial point of access right through to aftercare arrangements and the process of discharge (as appropriate). Effective information sharing will avoid the frustration of service users often having to repeat the details of their circumstances ‘from scratch’ with each professional encountered. It will also facilitate partnership and interworking between different services and professionals – contributing to better organisation of the mental health ‘system’ that may help increased numbers of people to achieve recovery.

National mental health services within HSE have long recognised the need for a single national information system for all of the above. Considerable work has been undertaken within mental health services to develop and deliver on the vision for a mental health electronic health record (MHEHR). In seeking to develop the MHEHR, HSE national mental health services efforts were and continue to be informed by both Ireland’s e-health strategy (2013) and the HSE’s knowledge and information strategy (2015).

F.8.3 ICT enabled supports for mental health services

The establishment of the mental health division in 2013 led to the inclusion in the 2014 service plan of an interim data gathering solution project with the aim of supporting the CMHTs to manage the performance information required of them for reporting on the service plan. As part of this project, a proof of concept initiative was conducted with three community mental health teams across CAMHs, general adult and POLL services. This initiative led to an agreement with the Office of the Chief Information Officer, of a framework for ICT-enabled supports for the mental health services which included the three projects:
- The National Mental Health ICT Infrastructure Improvement Project
- The National Mental Health e-rostering Project
- The National Electronic Mental Health Record Project

Progress in these areas will contribute strongly to the ambition outlined within this ‘refresh’ of AVFC for reform and continuous improvement as indicated in section C5.

<table>
<thead>
<tr>
<th>Recommendation 107</th>
<th>Contributing to Outcome 4 (a) / 4 (d)</th>
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<tr>
<td>A National mental health information system should be implemented within three years to report on the performance of health and social care services in line with this policy.</td>
<td>New Recommendation</td>
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F.8.4 Legislative reform

There is a programme of continuous legislative reform that underpins the modern mental system articulated within this ‘refresh’ of AVFC. Various areas are being updated at present. The current review of the Mental Health Act 2001; updating the Assisted Decision-Making (Capacity) Act 2015; and the establishment of a new decision support service.

In the forensic mental health area an interdepartmental working group has been established, and chaired by the Department of Justice and Equality, to examine issues about people with a mental health difficulty coming into contact with the criminal justice system, with a view to facilitating the delivering on the relevant aspects of AVFC. This includes circumstances where it might be appropriate to divert people suffering from a mental health difficulty away from the criminal justice system to more appropriate services, how best to achieve this and whether guidelines, principles or statutory provisions should be introduced to facilitate or inform such diversion. It is understood that this work is more centred on policy rather than legislative change, but it will be an important enabler to some of the forensic mental health recommendations in Domain 2 of this ‘refreshed’ policy. The group published a first interim report in September 2016 and a further report is due shortly.

F.9 Safety, risk and human rights

The fundamental aim of mental health services is to protect, promote and improve the lives and mental well-being of all service users. People with complex mental health needs are, or can be, particularly vulnerable to abuse and violation of their rights. While legislation is created to protect the most vulnerable in society, it is acknowledged that further work is required to ensure that all individuals accessing services, voluntarily or involuntarily, are guaranteed respect and protection of their human rights.

Recommendation 109
The full legislation to reform the Mental Health Act 2001 should be published by the end of 2020

F.9.1 Self-Determination

Self-determination is a vital part of successful treatment and recovery. The principles of recovery emphasise the importance of choice and self-determination. But these principles exist in a medico-legal and duty of care requirements. In Ireland, the Assisted Decision Making (Capacity) Act 2015 (ADM Capacity Act) is a central part of the relevant medico-legal framework. Recognising the will and preference of the person is a guiding principle of the Act and replaces the concept of ‘best interests’. The ADM Capacity Act creates the right for a person whose capacity may be in question to be supported to make their own decisions and there is an obligation to fulfil this right. The Act states that a person ‘shall not be considered as unable to make a decision in respect of the matter concerned unless all practicable steps have been taken, without success, to help him or her to do so.’ The guiding principles of the ADM Capacity Act include the presumption of capacity and the requirement that a person ‘should be given all possible support to make their own decision. This means that all relevant information about the decision is given to the person in a way that is appropriate to their own circumstances, considering the person’s means of communication, the time and place that best suits the person, and using appropriate communication aids to assist the person’.

So a person has the right to make their own decisions and, even if these decisions are perceived to pose some risk, the person has to be supported appropriately to live a full life. This requires a recognition that that the goal of reducing all harmful risks is not achievable and may even be discriminatory. In practice, services are required to manage various tensions including: maximising

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choice and autonomy; supporting positive risk-taking; the dignity of risk; medico-legal requirements; duty of care and promoting safety.

Excessive concern for physical safety can unwittingly take away of some of the purpose in people’s lives, ‘diminishing their quality of life’. These are referred to as ‘silent harms’. Titterton (2005) argues very strongly against managing risk by attending to physical safety only and further suggests that it can lead to the ignoring of other needs; the denying of the right to choose and self-determination; the loss of a sense of self-esteem and respect; a form of institutionalisation with loss of individuality, volition and increase in dependence; and, at its worst, can lead to abuse of people at a vulnerable time of their life.

For children, managing positive risk taking requires a collaborative approach where the family, the child and the mental health professionals work out a positive risk-taking strategy as part of the care planning process.

**F.9.2 Safeguarding vulnerable people**

An important issue to highlight is the national safeguarding policy – *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures*, put in place in 2014 applies to all HSE and HSE-funded services. It recognises that all vulnerable people have a right to be protected against abuse and to have any concerns about abusive experiences addressed. It highlights that it is the responsibility of all service providers, statutory and non-statutory, to ensure that service users are treated with respect and dignity, have their welfare promoted and receive support in an environment in which every effort is made to promote welfare and to prevent abuse.

The implementation of the policy is underpinned by the work of the HSE National Safeguarding Office. This office oversees the implementation, monitoring, review and on-going evaluation of the policy as well as co-ordinating the development and implementation of safeguarding training. Anecdotal evidence suggests that mental health services can have difficulties in accessing the support of safeguarding teams and relevant training. The implementation of the safeguarding policy should therefore be supported and provision made for access to safeguarding teams and related resources to up-skill staff working in statutory and non-statutory mental health services.

An adult safeguarding health sector policy is being developed by the Department of Health. This policy will cover all health services and it should inform the delivery of care in mental health services when it is complete.

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<th>Recommendation 110</th>
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<td>Training and guidance should be provided to staff on the practice of positive risk-taking, based on the principles of the Assisted Decision Making (Capacity) Act 2015 where the value of promoting positive risk taking is recognised by the regulator.</td>
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**F.9.3 Service users, self-harm and suicide**

For health and support services to effectively respond to suicide and self-harm in the community, access to timely and high quality data on suicide and self-harm must improve, reflecting practice in other jurisdictions. The collection and reporting of incidences of suicide needs to be reviewed and revised, to provide timely data for enhanced and focussed suicide prevention actions in the

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59 [https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/](https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/)

60 [https://fingertips.phe.org.uk/profile/suicide](https://fingertips.phe.org.uk/profile/suicide)
community. These issues have been clearly described in Connection for Life Strategic Goal 7, with limited progress to date.

**Recommendation 111**
The Justice and Health sectors should engage with the Coroner, the Garda Síochána, NOSP, CSO and research bodies in relation to deaths in custody, recording of deaths by suicide and open-verdicts, to further refine the basis of suicide statistics.

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Other countries have recognised the potential of strategically focusing on levels and patterns of self-harm and suicidality among people attending mental health services as an effective means of potentially reducing levels of morbidity and mortality, through strategic service enhancements and responses, based on the availability of good data. The most comprehensive model is the national confidential inquiry into suicide and homicide by people with mental illness (NCISH) which is based in the UK. 61 This has significantly improved service initiatives at national level. 62

*Connecting for Life* (CfL) recognises the importance of high-quality surveillance data on suicide and self-harm within HSE mental health services. More specifically, CfL action 7.2.2 requires HSE mental health services to ‘collate and report on incidences of suicide through current and expanding health surveillance system over the life time of Connecting for Life’.

While the Mental Health Commission (MHC) does collect data on unexpected deaths in mental health services, a comprehensive ‘whole system’ monitoring and response to these deaths does not exist, but is required.

**Recommendation 112**
Significant improvements are required in the monitoring and reporting of levels and patterns of self-harm and suicidality among people attending mental health services, to inform a comprehensive and timely service response to effectively reduce levels of harm and death.

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**F.9.4 Involuntary detention**
Most admissions to approved centres occur on a voluntary basis, but situations still arise where a person can be admitted to an approved centre involuntarily.

People with a diagnosis of mental illness have the same human rights as everyone, including a civil right to liberty and autonomy. According to the National Disability Authority, the purpose of the Convention on the Rights of Persons with Disabilities is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. It applies established human rights principles from the UN Declaration on Human Rights to the situation of people with disabilities. It covers civil and political rights to equal treatment and freedom from discrimination, and social and economic rights in areas like education, healthcare, employment and transport. These rights continue to apply for people who are involuntary detained.

**Recommendation 113**
In keeping with the evolving understanding of human rights, particularly the UN Convention on the Rights of Persons with Disabilities, it is recommended that involuntary detention should be used on a minimal

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61 [see http://documents.manchester.ac.uk/display.aspx?DocID=38469].
A range of advocacy supports including both peer and representative advocacy should be available as a right for all individuals involved with the mental health services.

Restrictive interventions are still in use in Ireland in various approved centres regulated by the Mental Health Commission (MHC). The MHC recognises that any intervention employed that may compromise a person’s liberty should in all instances be the safest and least restrictive option of last resort necessary to manage the immediate situation. Such intervention ought to be proportionate to the assessed risk, and employed for the shortest possible duration. Four main areas of seclusion and restraint are currently in use in approved centres:

<table>
<thead>
<tr>
<th>Seclusion</th>
<th>Leaving a person alone in a room at any time where the exit door is locked, preventing a person from leaving.</th>
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<tbody>
<tr>
<td>Mechanical Restraint</td>
<td>A bodily restraint uses devices or special clothing to limit an individual’s free movement.</td>
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<tr>
<td>Physical restraint</td>
<td>When a person is prevented from free movement due to physical force applied by one or more persons.</td>
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<tr>
<td>Involuntary Medication</td>
<td>When a person receives intramuscular or intravenous medication against his or her will.</td>
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While a zero restraint and seclusion service may not always be achievable due to safety requirements of service users and staff, there are some examples where major reductions in the use of restraint are working effectively. Therefore, a high-level aim of this ‘refresh’ is to reduce the use of restraint and seclusion where possible.

**Recommendation 114**

It is recommended that Ireland should progress a ‘zero restraint, zero seclusion’ action plan that should be developed in partnership with mental health services.

**Contributing to Outcome 3(c) /3(b)**

**New Recommendation**

Finally, throughout this ‘refresh’ of AVFC the potential for application of digital technologies has been recognised as an aid to core service delivery. The use of digital technologies can support individualised care, provide on-line professional development and enhance on-line therapeutic support interventions. Remote consultations with clinical teams offer the potential to reduce travel times for mental health professionals. Moreover, capacity can be increased by offering online sessional support to service users from mental health professionals who can work more flexibly at different stages of their career. In promoting this potential there are safety and risk issues to be highlighted.

**Recommendation 115**

The use of digital health solutions in the mental health ‘system’ must adhere to quality, evidence-informed guidance that align with best practice guidelines in areas such as data protection, confidentiality and maintenance of patient records.

**Contributing to Outcome 4(c)**

**New Recommendation**

Mental health research is potentially a very big field, ranging from research on genetics and pharmacological treatments to the outcomes produced by mental health services. The oversight...
group reiterates the emphasis in AVFC on two areas of mental health research in Ireland. These are population health research and health services research. The first is a field which analyses health outcomes and patterns of health determinants as well as the policy interventions linking them. The second examines how people get access to healthcare, how much that care costs and what happens as a result of the care. These two areas of research are referred to collectively as PH&HS research.

**Recommendation 116**
A National Population Mental Health and Mental Health Services Research and Evaluation Strategy should be developed and resourced to support a portfolio of research and evaluation activity in accordance with priorities identified in the research strategy.

**Contributing to Outcome 4(d)**

**Building on Recommendations 19.7 to 19.13 in AVFC 2006-16.**

AVFC identified intelligence and structural gaps, including the lack of a national mental health research strategy, poorly developed mental health research infrastructure, paucity of personnel with the training, experience and interest in mental health service research, lack of funding to support this research and a low level of service user involvement in such research. There have been some positive developments since that time. These include greater involvement of service users in research, largely because of research initiatives at Trinity College Dublin, University College Dublin and Dublin City University. A more recent initiative is the Dublin City University *Ignite* project—a three-year project begun in 2018—which aims to involve members of the public and service users in research projects in an active and collaborative manner.

Opportunities for service user and family involvement in research are still limited and overall numbers are low. The appointment of a head of research and development in the HSE is a welcome step in developing a supportive infrastructure for research in the HSE.

Making research funding available, particularly for mental health services research, continues to be a major barrier. In 2017, €39m was awarded for health research in Ireland through a combination of HRB funding (€15.9m) and funding from partners (€23.2m). An examination of this funding shows that there were five major grant awards for projects in mental health areas; two in mental health services research (€516,000) and three in bio-medical mental health research (€1,097,000). An additional €82,000 was awarded in a grant stream related to dissemination of mental health research grants from earlier years. These grants taken together represent a total of 4 per cent of the health research funding awarded in 2017.

It is obvious from these figures that there is a need for a national mental health PH&HS research strategy and adequate funding for mental health PH&HS research. As part of the process of developing such a strategy, research priorities for mental health PH&HS research should be identified. All those working in the mental health services should be encouraged to get involved in mental health PH&HS research and there should be a continuing focus to ensuring that people with lived experience of mental health difficulties are involved at every stage of the research process. This would include the development of research agendas, commissioning, overseeing, conducting and evaluating research as well as supporting the use of the emerging evidence base in policy and practice. The allocation of research funding in this area should reflect parity of esteem for mental health compared to other health conditions.

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66 HRB Annual Report 2017
Capturing and embedding innovation

The mental health division of the HSE has been working in partnership with the centre for effective services (CES) since 2015 to implement change and wider reform in line with AVFC. This partnership has resulted in the co-establishment of a strategic portfolio and programme management office (SPPMO).

A core function of this partnership is fostering innovation and the application and adaptation of evidence-informed methods to secure sustainable implementation and improvement in delivering mental health services. The partnership is underpinned by the application of established change management standards and project management methodologies. The latter is key to ensuring that consistent change processes are applied to identify, capture and embed innovation and service improvement. Change teams typically include a mix of technical, operational, clinical and management resources. Service user and FCS engagement is integral to all service improvement projects, with a consistent focus on the development of recovery-focused services through co-production.

A further initiative to foster innovation and continuous improvement is the social reform fund (SRF). This was established by the Department of Health, the Atlantic Philanthropies, the HSE and Genio to support the re-configuration of services towards more person-centred supports which are also transparent, accountable and cost-effective. The mental health component of the SRF has focused on three areas; advancing and embedding recovery practices; implementing employment supports for people living with a mental health difficulty through delivery of the IPS model outlined in Domain 3 (social inclusion); and community-based living, which supports people with mental health difficulties to identify and address their housing needs and to make the best of their opportunities to live independently in the community. The SRF has been central to achieving innovation and to providing the evidence of ‘what works’ as a basis for accelerating reform.

There are other areas of innovation in the mental health services and the wider mental health system. It is important that information is gathered on all innovations so that learning can be shared and replicated, and duplication avoided. All innovation in mental health services should be under the

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67 [https://www.hse.ie/eng/staff/resources/mentalhealthdivisionsspmo/](https://www.hse.ie/eng/staff/resources/mentalhealthdivisionsspmo/)
auspices of the strategic portfolio and programme management office, so that proven innovations can be introduced more widely and the practices or services which they supersede can be ceased or modified appropriately.

**Recommendation 117**

In order to bring about change, a strategic approach is required involving the necessary skills in change management. This approach has been developed in the former HSE Mental Health Division Strategic Portfolio and Programme Management Office and should be mainstreamed and embedded in the wider HSE.

**New Recommendation**

**Recommendation 118**

The initiatives under the former Mental Health Division Strategic Portfolio and Programme Management Office (SPPMO) and the ongoing Social Reform Fund (SRF) should be gathered together and made available to both encourage further innovation and avoid duplication in both the public service and NGO sectors.

**New Recommendation**

**Recommendation 119**

Innovations which have good evidence for clinical and/or social and cost effectiveness should be rolled out nationally. This will require the changing of practices and modification or cessation of services which are superseded by the new form of delivery.

**New Recommendation**

**F.11 Physical infrastructure for mental health services**

As noted in Domain 2 (service access, co-ordination and continuity of care), this ‘refresh’ of AVFC envisages greater use of appropriate mainstream premises, such as family resource centres, schools and community centres in the delivery of a more individualised and recovery-oriented mental health service.

Modern primary care centres and other new-build facilities should be used where possible to provide a good quality, built environment for people accessing and for staff working in mental health services.

Approved centres or acute units are a particular part of the mental health infrastructure needing special attention. Many psychiatric units in acute hospitals were not purpose-built and were designed as standard hospital wards and simply designated as psychiatric units. This environment did not take into account the needs of people with mental health difficulties, particularly for access to outside space, and, indeed, more space generally. For example, need for ligature-free environments is a specific requirement. Nevertheless, research has shown that hospital service users can benefit from better physical amenities such as wider spaces, decorations, greater light and access to outdoors. People generally feel better when they have control of their environments and, when this ability is taken from them, a sense of helplessness can occur.68

A key element of continuous improvement is therefore the provision of physical environments which are conducive to recovery and which create a good working environment for professionals delivering

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services. As a general principle, multi-stakeholder, service design methodologies\textsuperscript{69} should be employed when mental health premises and inpatient units are being designed or refurbished.

<table>
<thead>
<tr>
<th>Recommendation 120</th>
<th>Contributing to Outcome 4(c)</th>
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<tbody>
<tr>
<td>Mental health services should make use of other non-mental health- community based physical facilities, which are fit for purpose, to facilitate community involvement and support the implementation of the outcomes in this refreshed policy.</td>
<td>New Recommendation</td>
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<table>
<thead>
<tr>
<th>Recommendation 121</th>
<th>Contributing to Outcome 4(c)</th>
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<tbody>
<tr>
<td>Capital investment should be made available to redesign or build psychiatric units in acute hospitals which create a therapeutic and recovery supportive environment. It is essential that all stakeholders are involved in a structured service design process for all redesigns or new builds.</td>
<td>New Recommendation</td>
</tr>
</tbody>
</table>

Section G  Implementation framework 2019–2029

G.1 Introduction

The implementation of government policy is a challenging process. The literature on what determines a successful transition from policy thinking into reality emphasises that implementation is complex, contextual and as much a bottom-up as a top-down imperative. This is particularly so where the strategic ambition of this refresh is characterised by being:

- **Long-run** – a ten-year framework with some returns only measurable over several years
- **Whole-system** – covers all aspects of the mental health domain and beyond
- **Dispersed governance** – multiple actors with distinct mandates and accountability
- **High requirement for collaboration** – working through partnership a core value

A repeated theme in the extensive process of consultation, review and validation which underpinned our ‘refresh’ process was the need to do everything possible to ensure effective implementation of the next phase of the national plan. In considering the implementation approach against this backdrop we have borne in mind a number of critical success factors which experience has shown to be decisive. These key factors include

- Leadership
- Implementation structures
- Planning
- Resourcing
- Communication
- Data and Research
- Evaluation

G.1.2 Leadership

The synergy between the work on the policy ‘refresh’ co-ordinated by the Department of Health and the oversight group and the work of the Joint Committee on the Future of Mental Health and the extent to which many of the issues and actions emerging from the work of the Joint Committee resonate and align with those encountered by the oversight group during the countrywide engagements and research undertaken has been noted. The cross-party agreement on *Sláintecare*, with its core emphasis on integration, represents a new development in whole-system leadership in Irish healthcare and a real opportunity to deliver our specific vision for mental health.

G.1.3 Implementation structures

An overarching monitoring structure is required to drive reconfiguration, monitor progress against outcomes and deliver on the commitments made in this ‘refreshed’ policy. This structure needs to take account of actions and outcomes relating to ‘all-of-Government’ – not just those within the remit of the health service.

We believe that the oversight group structure currently in place can evolve. A national ‘whole of Government’ group should be established with service user and peer representation to roll out the recommendations within the ‘refresh’ of AVFC. This new group should be independently chaired and have wide representation from the statutory, voluntary and community sectors.

Currently there are several strategies driven by the Department of Health which contain strong mental health actions that are being implemented and will assist the implementation of the *Connecting for the Future* recommendations. These include

- **Connecting for Life (CfL)** – the current national government strategy to reduce suicide in Ireland, from 2015–2020.
- **Healthy Ireland** – a national framework to improve the physical and mental health and well-being of the population of Ireland over the coming generation.
- **Reducing Harm, Supporting Recovery** sets out the government’s strategy to address the harm caused by substance misuse in our society up to 2025.

In addition there are also a range of other national strategies that relate to similar priority groups, including:

- **Better Outcomes Brighter Futures** – the national policy framework for children and young people. It makes a commitment to positive physical and mental well-being, specifically noting that ‘the recent rise in demand for mental health services and the incidence of self-harm and suicide among children and young people is of significant concern’.
- **National Taskforce on Youth Mental Health** – established by the Minster of State Helen McEntee (2016) with responsibility for mental health to progress the youth mental health agenda.
- **The LGBTI+ National Youth Strategy 2018 - 2020** – provides an opportunity to build a more inclusive Ireland for LGBTI+ young people and is the first of its kind in the world.

The key stakeholders involved in delivering these policy and strategy actions will also be involved in the Implementation Monitoring Committee of the *Change for the Future*. Working together to deliver shared goals and common actions will ensure momentum is maintained in delivering the recommendations contained in this policy refresh. We have set out the proposed implementation structure in the graphic below.
**Recommendation 122**
A national ‘whole of government’ Implementation Committee should be established with strong service user and VCS representation to oversee the implementation of the recommendations in this policy and to monitor progress.

*Contributing to Outcome 4(a)*
*Contributing to Outcome 4(b)*

**New Recommendation**

**G.1.4 Planning**
Work remains to be done in the immediate future to develop a high-level Implementation plan which the new National Implementation Monitoring Committee can use to begin their work without delay. This work will be completed over coming months by the Department of Health with a view to completion in third quarter of 2019.

The implementation plan will be built around the four outcome domains to which all of our recommendations relate. As described earlier in section B.6, the implementation plan needs to be clear about how the action will contribute to the desired outcomes, the manner in which each recommendation will be delivered, where responsibility for action lies, including information on appropriate timelines and sequencing. This implementation plan needs to be developed within a three-month period after submission of this ‘refreshed’ policy.

**Recommendation 123**
Following on the submission of this policy, a high-level Implementation Plan should be prepared as a matter of urgency (i.e. within 3 months) for adoption in full by the Implementation Monitoring Committee, together with completion of a costing exercise to identify the immediate funding requirements and priorities for delivery of the policy objectives set out.

*Contributing to Outcome 4(b)*

**New Recommendation**

**G.1.5 Resourcing**
While the funding for mental health services is substantial, it has fallen short of the target level of 8.24 per cent share of overall health spending ten years on from AVFC, a point which was repeatedly underscored in our consultation process. We have noted earlier in section B.4 the very significant benefits to be realised from strategic ‘upstream’ investment to prevent and/or reduce the impacts of mental health difficulties, which greatly exceed the direct spending on healthcare. Many of the Recommendations in Change for the Future will require additional resources. It is therefore essential that sufficient, sustainable funding be provided to facilitate policy implementation.

These resources need to be deployed in a prioritised manner within an agreed multi-annual protected budget. The Oversight Group understands that a development funding level of €35m per annum will be sought over the lifetime of Change for the Future.

In tandem with the work on the high-level implementation plan it is considered that a costing exercise should be carried out to specifically to identify the funding requirements for at least the short-term initiatives which form part of the overall recommendations.

One consistent barrier to implementation is the lack of skilled knowledgeable staff available nationally. Issues with staff recruitment, dealing with anticipated turnover and the loss of valuable experience are real challenges that need to be addressed. Staff retention stabilises service provision and there are recommendations in this ‘refresh’ that support staff to complete their day-to-day work, while also managing to implement new policy recommendations. It is acknowledged that this commitment will require investment in newly created roles, additional training, expansion of community mental health teams and additional supports for out-of-hours services. This approach
will assist staff to respond to crises directly in health and social care sectors and beyond and seek to support teams by advocating for multi-disciplinary flexibility. The availability of skilled, knowledgeable staff who are offered continuing training is therefore an extremely important resourcing implication if implementation of this ‘refreshed’ policy is to be realised.

### Recommendation 124
Sustainable, continuous investment and financial resourcing should be prioritised over the 10-year life of this policy to ensure that the wider mental health system can deliver optimum outcomes for people with mental health difficulties.

<table>
<thead>
<tr>
<th>Contributing to Outcome 4(a) / 4(d)</th>
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<tbody>
<tr>
<td>New Recommendation</td>
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### Recommendation 125
A joint review of the two specialist training programmes by the Irish College of Psychiatrists and the Irish College of General Practitioners is proposed to develop an exemplar model of mental health medical training and integrated care.

<table>
<thead>
<tr>
<th>Contributing to Outcome 1(a)/4(d)</th>
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<tbody>
<tr>
<td>Linked to section 18 in VfC</td>
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</table>

### G.1.6 Communication
This report was approached in a different way to previous policy proposals. One feature was the extent of engagement and communication sought. Town-hall type consultations took place across the country. Through this process over 1,000 people were spoken to, including people with personal experience, family members, community and voluntary sector groups and staff. Importantly, however, there was also a need to look beyond mental health services to build resilience in the wider population and specifically to address the needs of many vulnerable groups in our society. This requires real effort at cross-departmental and cross-agency working to support well-being and help stem the flow of people into specialist mental health services. Experience shows that effective policy implementation is built on effective early engagement with those who are at the heart of the policy in question. It will be essential in the implementation of *Connecting for the Future* that these high levels of continuing communication through all possible channels be maintained over the delivery programme.

### Recommendation 126
Throughout the lifetime of this policy, it is important that on-going communication and engagement takes place to ensure that implementation plans are consistent with the priorities identified by multiple stakeholders.

| Contributing to Outcome 4(d) |

### G.1.7 Evaluation
Implementation structures, processes and planning must be complemented by rigorous and repeated evaluation, particularly in a long-run policy such as *Change for the Future*. Sections F.5 and F.6 above set out a series of recommendations for regular review of the policy implementation with publicly accessible performance measures and broad-based participation in the evaluation process.

To enhance the independent perspective and to ensure performance of the implementation of the ‘refreshed’ policy, the overview group recommend an independent review be conducted every three years over the ten-year lifetime of the policy. This would fulfil a similar purpose to the independent interim review recently completed of the *Connecting for Life* policy, which commenced three years into the implementation period, so a model of how this would work is already available.

### Recommendation 127
An independent review of the implementation of the refreshed AVFC should be conducted and publicly reported every three years over the lifetime of this policy.

| Contributing to Outcome 4(b) |
G.1.8 Data and research

The ability to make investment cases for new resourcing, to redeploy existing resources in line with needs-based allocation principles, to target special groups such as the prison population, to carry out effective research and, ultimately, to evaluate progress and effectiveness in implementing this policy will depend on significant improvements in data. Domains to be covered include interventions, inputs (by resource type), cost, output and outcome measures.

A specific recommendation (F.19) has been made in relation to the development of a national mental health population health and health services research and evaluation strategy, with resources made available to support a portfolio of research and evaluation activity. It is essential that people with lived experience of mental health difficulties should be involved at every stage of the research process.

G.1.9 Staff retention and training

Healthcare employee retention is a significant challenge, and employee turnover is not a good outcome for anyone involved. It is expensive for organisations, worrying for employees who want a stable work environment, and does not create a positive environment for service users. It has already been noted in G.1.5 that resources are essential to ensure sustainable recruitment is prioritised in parallel with the reconfiguration and flexibility proposed in the outcomes model for Change for the Future. However, it is also important to ensure that training for all existing mental health professionals in the course of their professional development is provided.

Continuing education and professional development can assist healthcare professionals improve both their technical and people skills, both of which are essential for providing an exceptional service user experience, improving productivity, and increasing employee satisfaction.

The opportunity to learn and develop new skills and the ability to engage in a training course ensures that employees are being given the tools to help them achieve their career goals, improve the service user experience, and support the organisation as a whole.

An example of how training existing staff can assist with staffing levels is provided by the Irish College of Psychiatrists. Undergraduate psychiatry training and intern posts are currently delivered by the universities, as recommended by the Fottrell Report (2006). Postgraduate training in psychiatry has been developed by the College of Psychiatrists of Ireland since its establishment in 2006. Training aims to provide the best possible training for qualified doctors at both basic and higher ‘specialist’ level in psychiatry. Recruitment into psychiatry has presented a challenge for some time and recruitment to psychiatry remains at around 4–5 per cent of medical graduates, and it has remained so for some time (Goldacre et al, 2013). The need for increased uptake in recruitment of psychiatrists is on-going, but there is a number of suggested ways forward to increase numbers through the utilisation of existing staff working in the healthcare system. For example, the College of Psychiatrists in Ireland have identified the need for more flexible training approaches to assist resourcing vacant posts. There is a group of registrars who are currently on the general division of the Medical Council’s register. Some of these doctors have completed training in psychiatry and could be encouraged to continue training to reach specialist level.

G.1.10 Performance management

The outcomes-based approach that underpins this policy ‘refresh’ will require a fundamental shift in how mental health services are delivered. If Ireland is serious about delivering a person-centred,
whole-of-government approach, there will need to be a real focus on how mental health services are planned and delivered. This policy ‘refresh’ promotes outcomes that are dependent on government departments, service providers, voluntary and community organisations and service users. These groups work together to promote better mental health, build mental resilience and offer services to those with mental health requirements specific to their needs.

The Northern Ireland Audit Office published a good practice guide in 2018 that names performance management as an essential component underpinning delivery of outcomes.2 Performance management aims to improve the lives of service users by introducing medium and long-term structures to produce achievable plans that are overseen and evaluated by an implementation committee and subject to independent review. The good practice guide indicates that performance management occurs within six key areas:

<table>
<thead>
<tr>
<th>Understanding the environment</th>
<th>With service user input, establish priorities that are relevant to the outcome-focused recommendations contained in this ‘refresh’.</th>
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</thead>
<tbody>
<tr>
<td>Setting priorities</td>
<td>Implement recommendations that matter to the service user not the organisation (outputs as opposed to inputs).</td>
</tr>
<tr>
<td>How allocation of resources levers for action</td>
<td>Move away from high level decisions about funding and moving to a focus on the outcomes being achieved. Spending should be aligned with delivery plans built upon inter-agency consultation.</td>
</tr>
<tr>
<td>Performance managing projects</td>
<td>Key partners work to share the vision with all service providers, encouraging a culture of reporting both positive and poor performance.</td>
</tr>
<tr>
<td>Monitoring of progress</td>
<td>Effective performance</td>
</tr>
<tr>
<td>Making improvements</td>
<td>Mechanisms to evaluate performance or under-performance in place. Resource allocation is fluid and moves to support services that perform well. Poor performance trends are captured to determine required corrective actions.</td>
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</table>

This ‘refresh’ recognises the need for continuing monitoring and performance management. While it will be the responsibility of the implementation and monitoring committee to develop actions arising out of the recommendations, the health system itself will need to understand the importance of collaborative working to meet the needs their specific defined population. Understanding the mental health needs of the population being served, defining local and regional priorities and making decisions about resource allocation will be a catalyst for targeted mental health service delivery. It is hoped that the Implementation monitoring committee will then work with partners to establish standardised key performance indicators to check progress and gather information on examples of both good and bad practice. It is only when these mechanisms are in place, that the system will be in a position to respond effectively to support the mental health needs of the whole population.

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