Stock-take of progress on A Vision for Change (AVFC)

Reports prepared for AVFC Refresh Oversight Group

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WRC

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Working Document

Preamble

The material presented in this document comprises two working reports prepared for the AVFC Refresh Oversight Group as part of a relatively small-scale exercise in budget and timeframe. These reports were independent pieces of work prepared by the author as discussion documents to provide input to the Oversight Group at a particular stage of its work. Any analysis and assessments provided in the documents reflect the author's own perspective and judgement. The reports were originally made available as working documents and not for general circulation. This document makes the reports more generally available for interested parties, but they remain working documents prepared for the Oversight Group and not a fully-worked policy assessment by the author.

Document 1: Working paper on policy orientation and vulnerable groups

This paper was prepared at the request of the Oversight Group to supplement the detailed stock-take and assessment of progress against the AVFC set of recommendations presented in Document 2. It aimed to provide a broader contextualisation and stock-take of mental health policy evolution in Ireland, building on the work in the External Evidence Review report (Cullen and McDaid, 2017).[1]

Document 2: Assessment of progress against the AVFC recommendations

This document presents the output from an assessment of progress against the 208 AVFC recommendations. The primary source material came from a detailed report prepared by HSE and circulated to the Oversight Group in 2017.[2] Additional information came from a review report prepared by Mental Health Reform in 2015.[3] Document 2 presents results of the work, and its introduction section outlines the methodology and discusses its strengths and limitations.

The primary purpose of the rating exercise was to provide a tool that could help the Group to bridge from the existing policy framework (as outlined in the AVFC recommendations) to a framework that would optimally support a refreshed policy formulation and implementation going forward. The structure in Document 2 directly follows the AVFC structure and the specific recommendations contained for each theme, and provides an indicative picture of relative progress under each theme and for each recommendation. This is useful as a general orientation and guide on the patterning of progress (or lack of it) across the entire AVFC policy framework, but any individual scores for themes and recommendations may be misleading if taken individually and/or out of context.

Importantly, the recommendation-by-recommendation assessment process highlighted the heterogeneity contained within the AVFC recommendation set. This includes wide variability across recommendations both in their relative systemic importance and in their implications for action. Background work under the assignment examined ways of re-grouping and/or stripping-down the AVFC recommendation set within a more operationally useful framework for the policy refresh. It also considered the relative merits for the policy refresh of carrying forward the detailed structure and recommendation set from ACFC or developing a new framework that would best support the next policy cycle. Either way, the approach taken in the stock-take assessment could help ensure fidelity with AVFC and its recommendations, and facilitate transparency and cross-linkage to AVFC from the policy refresh.

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[1] Cullen K and McDaid D (2017) Evidence review to inform the parameters for a refresh of A Vision for Change. Dublin: Dept Health.

[2] HSE (2017) A Vision for Change: Review of Implementation at November 2017. National Mental Health Division HSE – a working document under review as part of the assessment of extent of implementation of Vision for Change and informing future development of any revised policy.

[3] Mental Health Reform (2015) A VISION FOR CHANGE NINE YEARS ON: A coalition analysis of progress.

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Stock-take of progress on AVFC

Document 1:

Working paper on policy orientation and vulnerable groups

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1 Introduction

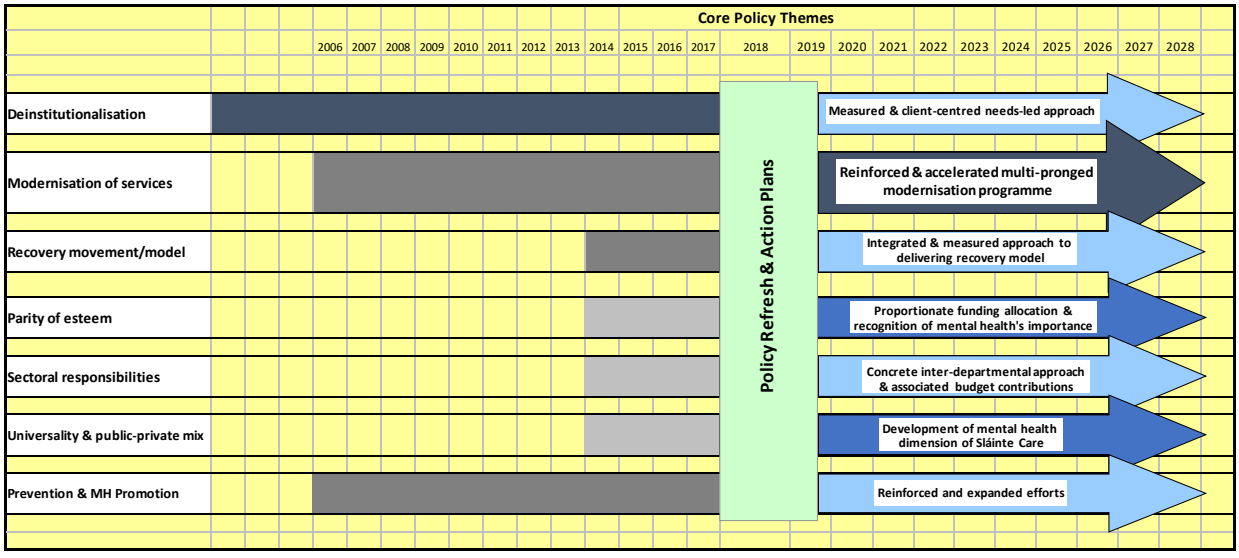
This working paper builds on the work in the External Evidence Review report[6] and the AVFC stock-take report presented in Document 2. It addresses the request of the Group to:

- identify specific policy changes that may be required since the old policy was drafted (i.e. policy themes that may require attention in the refresh)
- identify vulnerable groups and associated actions, such as not mentioned in previous AVFC policy, that need to be included in the policy refresh.

Given the limited resources available for this piece of work, the analysis does not attempt to be comprehensive. The aim is to highlight some ways of looking at mental health policy as it has evolved over time in Ireland, and to suggest some policy themes/perspectives that might help orient the next phase of policy and action.

In developing the paper, it proved useful to adopt a mix of thematic and evolutionary perspectives on mental health policy development in Ireland. This helps organise the policy space in an overarching manner whilst also facilitating operationalisation in the next policy phase. Figure 1 presents the framework developed for this purpose. [Please note that the indicated historical timings in the Figure are for indicative/heuristic purposes, and are not intended as a precise and accurate historical mapping.]

Figure 1. Core policy themes and evolutionary perspective



This is a new conceptualisation, prepared quite quickly for this report, and can be built-upon and improved with more time and deeper consideration. Nevertheless, it may provide a helpful framework to bridge from the existing AVFC structure and recommendations to an articulation of policy directions suitable for the coming years. The framework in Figure 1 can support continuity with AVFC, where appropriate, as well as a refreshed and re-focused policy perspective for the next policy cycle.

[6] Cullen K and McDaid D (2017) Evidence review to inform the parameters for a refresh of A Vision for Change. Dublin: Dept Health.

Figure 1 identifies seven core policy themes:

- de-institutionalisation
- modernisation of services
- recovery movement/model
- parity of esteem
- sectoral responsibilities
- universality & public private mix
- prevention & mental health promotion.

These themes overlap and inter-link in various ways, but each merit focused attention in the policy refresh. The following sections briefly discuss these to give an indicative flavour of the rationale for, and substance of each theme. The framework and themes could be further elaborated for application within the policy fresh.

2 De-institutionalisation

As utilised here, 'de-institutionalisation' is an umbrella term referring to all aspects of policy concerning mental health service users in residential settings or who regularly attend more traditional day support settings. These include: in-patients; people living in longer-stay residential settings (e.g. HSE hostels); and people using training centres or more old-fashioned day centres. The External Evidence Review report gave some attention to these areas, although not in any great depth.

In 2006, the closure of dedicated psychiatric hospitals was already well underway and AVFC recommended further consolidation and progress on this. Reduction in the provision of long-term community-based residential accommodation (hostels), and closure of many of these, has also been a policy focus over recent years, alongside efforts to help current residents to move to more independent living in the community. The policy refresh could give attention to the need for a stock-take in these areas, to be followed by an action plan to deliver a measured and client-centred approach over the coming years.

Inpatient beds

One current issue is the adequacy or otherwise of the stock of psychiatric inpatient beds currently available, now that the de-institutionalisation agenda has been extensively progressed. OECD data positions Ireland at a little below the OECD average in number of beds provided per capita whereas Eurostat data suggests that Ireland has the third lowest number of beds per capita in the EU.[7] Either way, whilst having a relatively high or low number of beds is not necessarily a good or a bad thing, a review of the adequacy of current supply in amount and mix of bed types relative to need is necessary. It may be that more beds or more of certain types of beds (e.g. for children) are required to cater for needs. Anecdotally, there have also been questions about the quality and fitness-for-purpose of some of the psychiatric units in general hospitals, and there has been extensive criticism around the unsuitability of having to present at A&E for acute mental health crises.

[7] It is not always clear what beds are counted in such international comparisons (e.g. only short-stay and longer-stay beds in psychiatric hospitals or psychiatric units in general hospitals, or also some beds in community residential facilities).

The Mental Health Commission monitors and reports on various aspects of inpatient mental healthcare, including use of restraint and seclusion. Its annual reports have raised a number of issues around quality of care, involuntary admission, and use of seclusion. The external evidence review of other countries found examples of well-developed approaches to improving practice in the use of restraint and seclusion (England and the Netherlands), as well as extensive investment to upgrade inpatient infrastructures and patient facilities (England) and provision of advocacy for inpatients (Netherlands).

Hostels

The AVFC report envisaged a major reduction in provision of HSE community residential facilities (hostels), a re-focusing towards supporting independent living in the community, and transfer of the housing/accommodation responsibilities to the housing sector. Progress appears to have been slow in this area although activity is now intensifying. However, alongside efforts to help clients (for whom it is appropriate) to move from hostels to more independent living, it is also necessary to ensure a needs-led and client-centred approach. Anecdotal evidence suggests that some people are moved from hostels to inappropriate, albeit more independent, living arrangements without adequate preparation or support and/or against their wishes.

It will be important to ensure that a cohort of 'legacy' clients can remain living in quality hostel-type accommodation with an appropriate array of supports to meet their needs. In this regard, the Mental Health Commission has pointed to a number of issues of concern in the current provision of community residential facilities, including poor physical infrastructure, institutional nature, and lack of individualised care plans. It may also be useful to look more broadly at the role that (upgraded and refurbished) community facilities might continue to play in the Irish situation. This could include a potential role in provision of short-term crisis care facilities, as well as in step-down and other interim or transitional arrangements for people discharged from psychiatric inpatient beds or other situations.

Training and day centres

There are also a considerable number of clients using other traditional service settings, including training centres and more old-fashioned day centres. Some of these centres are winding-down but anecdotal evidence suggests that many clients wish to continue to attend and are ending up with little or nothing to do. Again, it may be important to ensure that a cohort of 'legacy' clients can remain using these services with an appropriate array of activities and supports to meet their needs.

3 Modernisation of services

Modernisation of Irish mental health services was the central plank of AVFC, especially around the development of community-based services. This is also likely to be a central focus of the current policy refresh. The AVFC vision and recommendations address mental health in primary care, adult mental health services, CAMHS, and mental health services for older persons, as well as rehabilitation/recovery services and liaison structures. It also addresses user involvement at different levels of service design and provision, and social inclusion as an important issue for service users.

The resource allocation approach in AVFC focused mainly on the numbers of multidisciplinary community mental health teams required on a geographical/per capita basis, and on the profile of psychiatric/medical, nursing and allied professionals per team. Available quantitative data suggests a certain level of progress against the targets set in AVFC, both in the numbers of teams in situ and the

numbers of whole-time-equivalent staff. However, levels of provision and coverage across the country still fall short of the AVFC targets.

The Mental Health Commission annual report 2015 noted that, despite progress, *'much needs to be done to ensure the delivery of consistent, timely and high quality services in all geographic regions and across the full range of clinical programmes and age groups*'. The report also noted a serious deficiency in the development and provision of recovery oriented mental health services, and that there needs to be a cultural shift away from a linear model towards a more holistic bio-psychosocial one.

The external evidence review report also highlighted that available information on community services in Ireland has focused on quantitative profiling of staffing numbers and on numbers of teams. It is less clear how the relatively large number of teams actually operate and the range and levels of services they provide. The evidence review report suggested that the AVFC refresh may wish to give attention to this topic, including the need for a qualitative mapping of existing community-based services/teams in their structural and operating characteristics and in the service portfolios that they offer. In regard to the latter, the issue of choice was also highlighted. A recurrent theme in the wider discourse in Ireland has been variation across the country in the therapeutic options available, such as in orientations towards medication or talking therapies and in choice of talking therapy. This is an issue for consideration in quality assurance of mental healthcare in Ireland.

A non-exhaustive listing of other relevant modernisation themes covered in the external review report includes:

- Balance of care: ensuring balanced coverage across the spectrum of mental health needs, including services for common conditions such as anxiety and depression and services for more severe and/or enduring conditions.

- Primary and secondary care roles and inter-working: the external evidence review report provides information on approaches in other countries and on a range of issues requiring attention in this area; this is a central theme for further development in Ireland, both for provision of psychological therapies at scale for common conditions (see below) and for ongoing care management for people with severe/enduring conditions.

- Needs-based resource allocation: the external evidence review also identifies approaches in other jurisdictions to develop resource allocation frameworks based on the level of support needs of clients (e.g. the NHS Mental Health Care Clusters in England); this issue needs further attention in Ireland to support development of approaches to complement the geographical/per capita approach in AVFC.

- Early intervention in psychosis (EIP): a growing evidence base indicates the importance and value of this; models of good practice are available from other jurisdictions as well as service performance indicators (e.g. the Duration of Untreated Psychosis (DUP) which combines both help-seeking delay after first appearance of symptoms and treatment delay following help-seeking); development of nation-wide capacity to provide EIP in Ireland is important.

- Delivery of psychological therapies at scale: this is an important theme in other jurisdictions, and has begun to receive attention a certain extent in Ireland through the CIPC programme; experiences in other jurisdictions, such as England (IAPT programme) and the Netherlands (mental health professionals in primary care settings) can provide useful insights and guidance for Ireland.

- eMental health: the opportunities presented by eMental health also need exploration; this may provide ways of supporting delivery of psychological therapies at scale for common mental health conditions as well as a range of innovative forms of support for people with severe and/or enduring conditions; an Irish report funded by Mental Health Reform and HSE may be useful for the Group in this area.[8]

- Data, monitoring, and outcomes measurement: improved monitoring information, including outcomes data, is essential for development and operation of a modernised mental health service in Ireland; better data on prevalence across the spectrum of mental health conditions is also needed; the external evidence review report provides examples of useful approaches in other countries, for example, the outcomes monitoring under the IAPT programme in England and recent plans there to introduce an outcomes-based performance payment as an addition to the core case-mix based payment system.

- Research: the AVFC report highlighted the lack of priority given to mental health research in Ireland and recommended much more focus on and funding for this; this situation remains the case today and is an important theme for the policy refresh. In particular, more health economics work in the mental health field would be useful to support funding and resource allocation decision-making.

4 Recovery movement/model

In recent years, one important development in the mental health sector in Ireland has been the emergence of the recovery movement/model, and its espousal by HSE and others as a core model for mental health service modernisation and transformation. This is evident in the publication of the National Recovery Framework, and initiatives like ARI, recovery colleges, peer support workers, the Service Reform Fund, and so on. Whilst these are positive developments, it may be useful at this point to take stock and reflect a little on how they fit with and complement other efforts towards mental health service improvement.

Internationally, Ireland seems to be at the forefront in adoption of the recovery movement/model principles and language, both as an overarching vision and as an intended core operational framework for mental health services. The 'IMROC' approach has been to the fore in efforts so far, although this is a fairly 'soft' approach without much concrete mapping to structural requirements for mental health services or to the practical skills and practices for application in day-to-day services for clients. At the same time, mental health rehabilitation teams remain under-developed and under-resourced in many parts of the country. It may be useful to reflect on the current approach and seek to also develop (in parallel) a more concrete and practical line of activity for promotion of recovery-orientation in mental health services. Some of the reasons for this are discussed briefly below.

Over the last few decades there have been at least two parallel forces in efforts to promote recovery-orientation in mental health - the recovery social movement as an equality/rights driven movement with a strong ideological dimension, and the emergence of psychosocial rehabilitation perspectives and approaches within mental health services and professional groupings.[9] Both are

[8] Cullen K (2018) eMental Health State-of-the-art & Opportunities for Ireland. https://www.mentalhealthreform.ie/wp-content/uploads/2018/10/eMental-Health-State-of-the-art-Opportunities-for-Ireland-Full-Report.pdf

[9] for a useful discussion of these developments in the US see: Jacobson N and Curtis L (2000) Recovery as Policy in Mental Health Services: Strategies Emerging from the States. Psychosocial Rehabilitation Journal, Spring, 2000

important but the latter is sometimes lost sight of in the enthusiasm for the principles/ideology emanating from the recovery social movement. These two lines of activity and development share considerable common ground but each also separately emphasises and addresses particular components of what is necessary to achieve a recovery-driven mental health system. The social movement is especially strong on rights, equality, and stigma reduction; the psychosocial rehabilitation perspective and approach is especially strong on modernisation of therapeutic approaches and in the embedding of a broader range of skills and supports within mental health services. Important shared themes include the centrality of user wishes/preferences and their active involvement in decision-making about approaches to treatment (including medication, shared risk-taking, etc).

One of the barriers to promotion of more recovery-oriented mental health services has been the limited recognition given to existing and emerging good practice approaches within mental health services and professional groupings, but not cast in recovery language. Research and more anecdotal evidence suggest that lack of recognition of this is demotivating for mental health professionals and can lead to a more generalised scepticism towards the ideological rhetoric of the recovery movement. More generally, such good practice developments are often occurring in isolated pockets and require much wider dissemination.

An issue for consideration by the Group, therefore, might be how to complement the general recovery-oriented principles and perspectives in the National Recovery Framework (and associated activities such as ARI, recovery colleges, service user engagement, peer support workers) with operationally useful guidance for the day-to-day work of the range of practitioners in the mental health services (psychiatrists, nurses, psychologists, social workers, OTs etc). One approach might be to prepare practice guidance/examples based on vignettes showing the practical application of recovery-principles by the relevant professionals in care planning and care pathways, covering a range of client groupings with different presenting conditions and needs. More generally, a useful research literature is emerging on aspects of these issues and this could be brought to bear to support policy and practice development in Ireland.

5 Parity of esteem & more attention to physical/mental health co-morbidity

The External Evidence Review Report addresses these themes in some detail, giving attention to two dimensions; for convenience, the following sections present a reiteration of the main points from that report.

Parity of esteem for mental health within the healthcare sector

Along with many other countries, Ireland allocates a smaller proportion of the overall health budget to mental healthcare than its relative importance warrants given the enormous disability burden, economic impact, and potential for efficient use of scarce resources. Countries with better developed mental healthcare systems allocate proportionally greater amounts to this sector.

Some countries, such as England, frame the issue as one of 'parity of esteem'. This refers both to resourcing mental healthcare commensurate with its importance in the wider healthcare system and to broader issues around professional recognition for mental healthcare. There may be merit in developing this perspective in Ireland as well, and the external evidence review presents various sources of evidence that bolster the case for increasing resource allocation to mental healthcare.

Physical health co-morbidities

Another development since AVFC has been the increasing recognition and evidence of the interplay between mental health conditions and physical health conditions. Relevant issues include gluco-metabolic effects of medication treatment for psychoses and impacts of mental health conditions on management/outcomes of long-term physical health conditions. More generally, international studies consistently find mental health disorders are associated with much higher risks of all-cause mortality compared to the general population, as well as increased risk of many health conditions and poorer outcomes.

6 Sectoral responsibilities - mental health as a cross-sectoral issue

The External Evidence Review Report addresses this aspect in some detail, emphasising the importance of prioritisation of mental health as a major societal issue. The review found extensive evidence indicating the economic and social importance of mental health issues, as well as efforts in various countries to give more priority to mental health both within the healthcare system and by other relevant sectors.

Recognition and strategic action on the economic and social importance

There is strong evidence showing the economic and social importance of mental health disorders in Ireland and internationally. This includes the enormous human costs but also the very large economic costs. A large portion of these costs accrue to the social protection system, employers and the wider economy. Studies have shown the substantial returns on investment that a broad range of prevention and treatment mental healthcare interventions can yield. This may include better outcomes for the mental health care sector and for the physical healthcare sector, cost-savings arising from prevention, and substantial cost-savings and other contributions across other areas of the public sector, economy and society.

Public spend on mental health - especially strategic 'upstream' investment in preventative, early intervention and community-based services - is therefore best viewed as an investment rather than a cost. Australia has clearly articulated this perspective to underpin government policy. Such investment can yield substantial 'downstream' savings from less utilisation of more expensive services/facilities and from gains in other areas of public expenditure and the wider economy and society. For optimal economic and societal gains, this requires a visionary cross-sectoral perspective by government. Investments in one area of the public sector (such as mental healthcare treatment and prevention) may yield cost-saving and economic benefits in other areas of the public sector, sometimes in the short-term but also in the medium and longer term.

Establishment of concrete cross-sectoral actions

The review indicated the cross-sectoral nature of many of the issues in the mental health domain. The mental healthcare sector has important shared and overlapping responsibilities with other sectors, including the legal and judicial systems; the employment, education and housing sectors; and the social protection system.

There is increasing recognition of this cross-sectoral dimension in Ireland, with some structures and activity emerging between mental health and sectors such as housing, employment and the judicial system. However, this area requires much more attention and development. Other countries provide potentially useful examples of concrete inter-sectoral actions at governmental/ministerial levels and amongst key players at sectoral levels. Just some examples are the covenants and

concordats with the police in England and the Netherlands, and the arrangements between mental healthcare services and employment services in the Netherlands.

7 Universality & public-private mix

The External Evidence Review Report also addresses this theme in some detail. There is ongoing policy consideration of how best to achieve universality in Irish healthcare against the background of the public-private mix that currently prevails, most recently following the publication of the Sláintecare report. One feature of the mix is the differential access to healthcare services for those with medical cards and those with private health insurance. Another feature is the range of public, private (for-profit) and non-profit organisations involved in the provision of services. The report develops a mapping of some of the many elements of this complex ecosystem as it applies in the mental healthcare field in Ireland today.

Public-private mix

The public system provides much of the public mental healthcare services directly but also outsources (and/or funds in various ways) a considerable volume of service provision in the mental health domain. The HSE Mental Health division accounts for the largest share of public spending; other divisions also make important contributions, including Primary Care, Social Care, and Health and Wellbeing. HSE also provides or funds a substantial part of inpatient care, as well as a range of community-based residential settings.

Third sector service providers play a formal role in some parts of the public mental healthcare services. For example, a number of area-based services receive funding under Section 38 arrangements and a range of mental health activities are funded through Section 39 arrangements. HSE also commissions from or outsources to the private sector in various ways, for example through the Counselling in Primary Care (CIPC) scheme (funding counselling services for medical card holders), and funds some high cost services for small numbers of clients in secure units in Ireland or abroad.

The private mental healthcare sector provides both institutional and community/ambulatory services, and includes the large private practitioner sector (psychiatrists, psychologists, psychotherapists, counsellors, etc). Clients of these services may be covered by private health insurance and/or have to pay out-of-pocket (in addition to private health insurance premiums they may already be paying).

The refresh of AVFC may wish to consider how best to encompass this mixed economy in the articulation of an overarching policy framework and in practical governance arrangements. An overall ecosystem perspective may also be helpful in seeking ways to effectively and equitably cover the full population, and to optimally leverage the available capacity and activity across the different elements and sectors. For example, there may be possibilities to further develop mental health service commissioning, and experiences under programmes such as CIPC may be useful in guiding further activity in this area.

Differential access for public system users and private system users

The current de facto arrangements result in differential access for public system users and private system users of mental healthcare services. The data from the 2015 QNHS shows an inverse socio-economic gradient in utilisation of mental healthcare services in Ireland relative to need. This underscores the importance of improving access to mental healthcare services for users following the public route. Initiatives such as CIPC are relevant in this context.

Public oversight of the private route is also important. This is currently fairly minimalist, applying mainly in the public regulatory role of the private health insurance sector under the Minimum Benefit legislation. These issues of public-private mix and differentials also have relevance in the wider review of the Irish healthcare system as part of the ongoing efforts to design a more universal system (in line with the Sláintecare report, as well as previous efforts examining how best to reform the health insurance market). Studies conducted in this context have included mental health in their modelling of costings for various benefit 'Baskets'. The refresh of AVFC may also wish to give attention to this wider aspect of universality in mental healthcare in Ireland, including parity issues in the coverage of mental health care and physical health care.

Governance - stakeholder roles and user organisation involvement

Given the mix of players in the current mental healthcare ecosystem in Ireland, the issue of stakeholder roles and involvement in the overall governance of the domain is important. This is a theme that the refresh of AVFC may wish to address.

As an illustration, the arrangements in the Netherlands may provide insights useful for Ireland. The transition in 2006 to compulsory universal health insurance through a (regulated) competitive private insurance provider market required the development of appropriate governance and regulatory arrangements to reflect the various stakeholders in the system. The result is a system regarded as very transparent and underpinned by strong information systems that facilitate negotiation and agreement amongst the competing interests. Those with formalised structural roles include the government, insurers, healthcare providers (including mental healthcare providers), professional organisations (including mental health professionals) and user/family organisations.

In the Irish context, national policy and the HSE strongly espouse the user role. This encompasses various levels of involvement, including a mandated involvement in the composition of the Mental Health Commission and the significant efforts and investments by the HSE in certain aspects of user involvement. However, the strong involvement of user (and family) organisations at a structural level in the Netherlands is noteworthy and may provide useful insights for a refresh of AVFC.

8 Prevention and mental health promotion

Finally, policy attention to the important themes of prevention and mental health promotion is likely to continue. The External Evidence Review report addressed a number of settings and target groups for prevention and mental health promotion, including perinatal and early years, educational settings, and the workforce. The review also identified a range of programmes across other countries targeting particular at-risk groups, for example, unemployed people and older people. The refresh of AVFC may wish to give more detailed attention to mental healthcare issues and supports for these groupings. Given the timeframe, the review gave just brief attention to suicide prevention and initiatives addressing self-harm. These are clearly important areas for the refresh of AVFC.

9 Vulnerable groups

The following is a listing of some important vulnerable groups identified in the analysis in previous sections and/or in the wider External Evidence Review report. Unfortunately, time does not allow elaboration on these in this paper but there may be possibilities for this at some other point.

- Legacy service users - hostels, training centres, day centres, long-term inpatients...
- Prisoners
- Addictions

- Family members of people with MH difficulties
- Children of people with MH difficulties
- Travellers
- Non-nationals
- Older persons (with common mental health conditions such as depression)
- Unemployed
- People with debt problems
- Homeless
- People in inappropriate living circumstances.

Stock-take of Progress on A Vision for Change (AVFC)

Document 2:

Assessment of progress against each of the AVFC Recommendations

Kevin Cullen

Contents

1. Introduction

This report presents a stock-take on progress against A Vision for Change (AVFC), prepared as a working input for the Oversight Group. Chapter 1 (this Chapter) outlines the context and objectives of the exercise, and explains the methods used in the work. Chapter 2 presents the detailed results of the stock-take, organised according to the 22 themes and 208 recommendations in AVFC.

1.1 Context and objectives

The assignment was conducted at the request of the Group to provide a stock-take of progress against the AVFC recommendations. This would help the Group in focusing its work going forward, and might also help the Group in deciding whether or not, and/or how closely to organise its work with reference to the original set of recommendations in AVFC.

1.2 Methods

The agreed approach was to conduct a synthesis and analysis of a number of information sources available to the Group. Two main sources providing information on progress against the AVFC thematic structure and set of recommendations were utilised. One source was the HSE document providing a detailed compilation of activities and achievements mapped to the AVFC recommendations.

The other source was a document produced by Mental Health Reform (MHR) in 2015, providing a stock-taking and indicative rating of progress against a number of the core themes addressed in AVFC.

The analysis mainly focused on these two sources, and explored a variety of ways of synthesising the material in a manner likely to be most helpful for the group. The challenge was to come up with a way of complexity reduction whilst maintaining transparency and cross-linkage to the detailed set of AVFC recommendations. Chapter 2 presents the results of the approach adopted. This comprises a rating system for assessing progress against each AVFC recommendation, with cross-linkage to the specific information/data from the HSE and MHR documents upon which the ratings are based.

<u>Rating system</u>

The rating system employed is designed as a heuristic tool. It provides a way of reducing complexity and gaining a high-level perspective on the overall shape of progress against AVFC. The rating approach utilises a 5-point scale:

++ = very good progress
+ = reasonably good progress
+/- = moderate and/or patchy progress
- = a little progress, but clearly not enough
-- = very little or no progress.

The report presents our own first-cut at rating achievement/ progress against each AVFC recommendation. For a minority of the AVFC recommendations, the available documents did not provide any information. These are indicated by a '?' in the relevant tables in the report and were not included when calculating mean scores for the themes in question.

In this type of exercise, ratings are susceptible to the perspective of the person doing the rating and there is potential for substantial inter-rater variation. The Group might like to consider conducting a similar rating exercise using the same approach and compare the results with those in this report. This would support a final consensus assessment by the Group to support the policy refresh.

More generally, it is important to bear in mind that the scores for a given theme (e.g. social inclusion, user involvement, primary care…) are based on the particular set of recommendations in the AVFC report. There may well be topics not included in the AVFC set of recommendations for a particular theme that the Group might feel are important. In addition, the nature and importance of the individual AVFC recommendations varies a lot (both within and across themes), but the rating system does not attempt to apply any weighting to address this. We have provided an initial quick commentary/discussion on the ratings for each theme, but the Group may wish to reflect on this aspect also.

Linkage to other policy

The Department of Health also provided two documents containing compilations of potentially relevant recommendations and actions in other current policy documents. These covered youth mental health, maternity and perinatal supports, suicide prevention, and a number of other areas. Separate to this report we have done some mapping of relevant items from these documents to the AVFC themes and associated recommendations. The Group may wish to consider how to further incorporate this perspective in its work. For example, 'being addressed in other/ongoing policy and associated implementation actions' might be a criterion the Group could employ in decisions on what to (or not to) focus on in its work.

Structure of the report

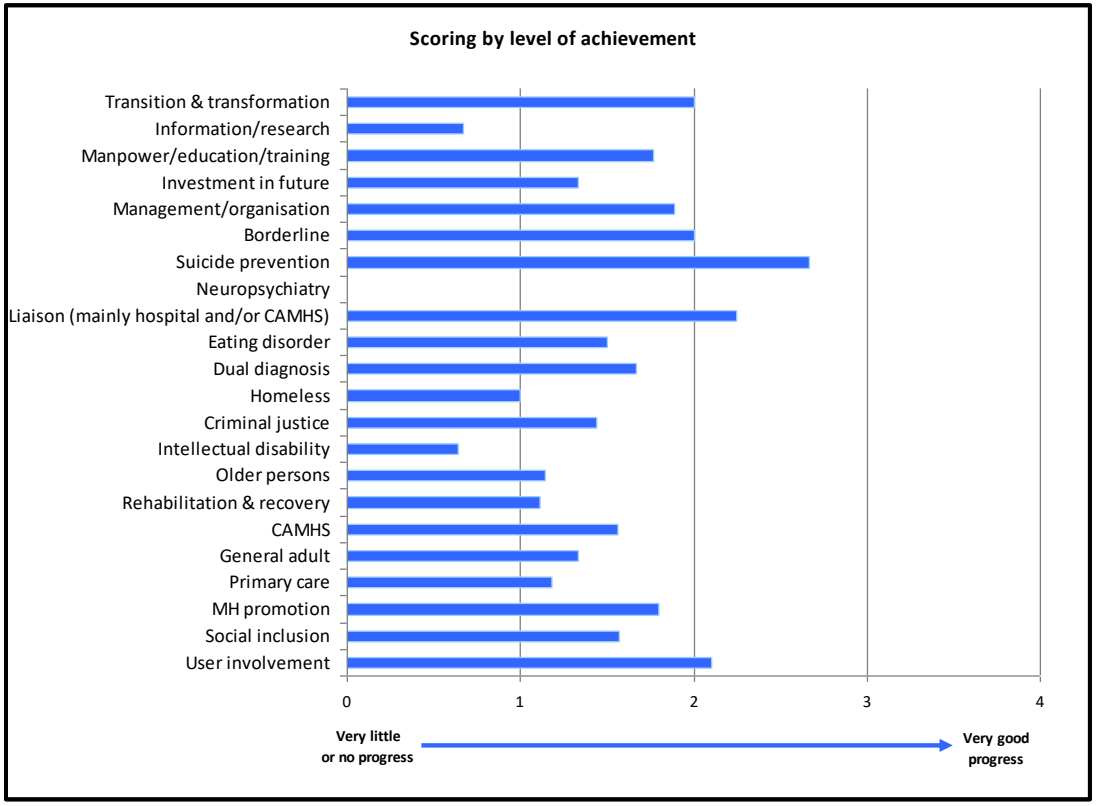
Chapter 2 constitutes the core result and output of the assignment. The Chapter takes each of the 22 themes covered in the AVFC recommendations. These are:

1. User involvement
2. Social inclusion
3. MH promotion
4. Primary care
5. General adult
6. CAMHS
7. Rehab & Recovery
8. Older persons
9. Intellectual disability
10. Criminal justice
11. Homeless
12. Dual diagnosis
13. Eating disorders
14. Liaison
15. Neuropsychiatry
16. Suicide prevention
17. Borderline personality dis.
18. Mgmt. & Organisation
19. Investment in future
20. Manpower/skills
21. Info. & research
22. Transition & Transformation

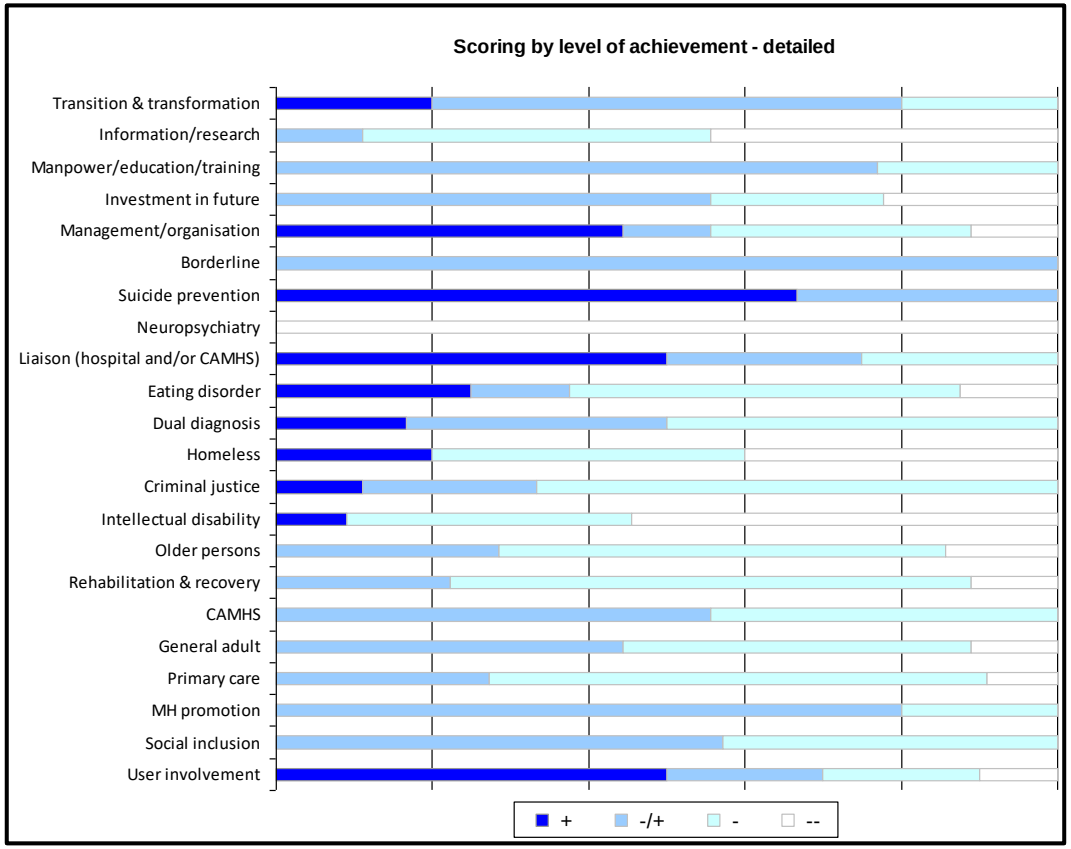
Each theme is addressed in a separate section containing three components: a table with ratings for each AVFC recommendation; source data for the ratings; and some initial commentary on the ratings and issues the Group might wish to consider.

2. Stock-take & mapping

Overall ratings



Commentary: This chart presents the average scores for each of the 22 AVFC themes. The scoring system is based on a 0 – 4 scale (with 0 equating to a '- -' rating; 1 to a '-' rating; 2 to a '-/+' rating; 3 to a '+' rating; and 4 to a '++' rating). Note: as mentioned in the Introduction, these ratings are applied to the AVFC recommendations for the theme and may not necessarily indicate the extent of progress on the theme from other perspectives not covered by the AVFC's set of recommendations.



Commentary: This chart presents a more detailed picture based on the patterns of scoring across the various recommendations within each of the topic areas. It provides an indication of patchiness in terms of the spread of progress (or lack of progress) across the various recommendations for each topic.

Detailed ratings

2.1 User involvement

Rating based on 5-point scale

AVFC Rec.	--	-	-/+	+	++	Score
3.1						3
3.2						2
3.3						3
3.4						3
3.5						3
3.6						1
3.7						0
3.8						1
3.9						2
3.10						3

Simplified 3-point scale

3.1		+
3.2		-/+
3.3		+
3.4		+
3.5		+
3.6		-
3.7		-
3.8		-
3.9		-/+
3.10		+

Data

	HSE	MHR
3.1: Service users and carers should participate at all levels of the mental health system	•The innovative work of the Reference Group – co-produced recommendations on how to embed engagement structures and mechanisms in all HSE mental health services •The appointment of the Head of Mental Health Engagement (MHE) to the National MHD Management Team and to lead the Office of MHE •The launch of A Partnership for Change: Report of the Mental Health Reference Group •The publication of the Listening Meetings Report •Appointment of 9 Area Leads to Area Management Teams •Appointment of 24 Peer Support workers in February 2017 Ongoing extensive contact and partnering, where appropriate, with relevant Government Departments and bodies, Non-Governmental Organisations (NGOs) and academic institutions.	- local structural arrangements (nature and extent) vary across the country
3.2: Advocacy should be available as a right to all service users in all mental health services in all parts of the country	•Funding of Advocacy organisations •Start of CAMHs Advocacy initiative	- family involvement protocols under-developed
3.3: Innovative methods of involving service users and carers should be developed by local services, including the mainstream funding and integration of services organised and run by service users and carers of service users.	•the delivery of PrSW training in DCU, commissioned by the HSE • the peer-run community projects for people who experience mental health difficulties- Aras Follain and Gateway •the establishment of a five service user-led Recovery Colleges throughout the country •Eolas family and service user education programmes •the involvement of a service user in the Advancing Recovery Ireland (ARI)project at project management level •the developments as set out in Partnership for Change for the establishment of engagement structures at Area and local level throughout MHS the establishment of a project to formalize service user, family member and carer engagement recognition and reward procedures	- care plans (and user involvement in same) under-developed
3.4: The adult education system should offer appropriate and supported access to information, courses, and qualifications to service users, carers and their representatives that would help to enhance and empower people to represent themselves and others.	This largely is the responsibility of the Department of Education The ARI Colleges also act as a source of education for service users regarding Recovery principles, and supporting people to achieve recovery, often through education and adult education.	•
3.5: A National Service User Executive should be established to inform the National Mental Health Service Directorate and the Mental Health Commission on issues relating to user involvement and participation in planning, delivering, evaluating and monitoring services including models of best practice; and to develop and implement best practice guidelines between the user and provider interface including capacity development issues.	The appointment of the Head of Mental Health Engagement (MHE) and to lead the Office of MHE	•
3.6: Carers should be provided with practical support/measures such as; inclusion in the care planning process with the agreement of the service user, inclusion in the discharge planning process, timely and appropriate information and education, planned respite care and should have a member of the multidisciplinary team to act as a keyworker/ designated point of contact with the team and to ensure these services are provided.	The National Recovery Framework indicates that mental health services should work with carers and family members. Family members and carers are to be involved in co-production, that is, working together with others to improve services for all stakeholders. The EOLAS project delivers two mental health information and learning programmes, one for service users with a diagnosis of schizophrenia or bipolar disorder and another for their families and friends. The delivery of the EOLAS Programmes is unique as they are co-facilitated or co-produce by a peer facilitator and a clinical facilitator. Clinicians bring their professional expertise and family members and service users are experts by experience.	•
3.7: The experiences and needs of children of service users should be addressed through integrated action at national, regional and local level in order that such children can benefit from the same life chances as other children.	The National Mental Health Division have commissioned NUI Maynooth to identify and evaluate projects that support family-focussed interventions for parents with mental illness (PMI). To date, 12 have been identified that specifically address PMI and its impact on children; including Behavioural Family Therapy.	•
3.8: Mental health services should provide on-going, timely and appropriate information to service users and carers as an integral part of the overall service they provide.	•Mental Health LGBT Booklet •Not Alone Booklet •Concerned about Suicide Leaflet • Mental Health Tough Economic Times •Self-Harm Parents Leaflet / Self-Harm for Young people •Your Mental Health Booklet Your Mental I Health	•
3.9: Information on the processes involved in making complaints or comments on mental health services should be widely available.	In December 2014, the HSE appointed a confidential recipient to whom anyone can make a complaint or raise concerns about the care and treatment of any vulnerable person receiving residential care in a HSE or HSE funded facility, including individuals receiving mental health treatment in inpatient, outpatient and day centre clinics.	•
3.10: Service user involvement should be characterised by a partnership approach which works according to the principles outlined in this chapter and which engages with a wide variety of individuals and organisations in the local community.	The National Recovery Framework was launched in November 2017 to support CHO's in developing the recovery orientation of their service through a consistent, good quality and evidenced based approach. The Framework was developed in collaboration with a wide range of stakeholders and coproduced with Service Users, Family Carer reps.	- very limited development

National approach implemented but variability across the country
Also applies to case level
Advocacy needs further development (none for children under 18)
Complaints systems not sufficient – issue of involuntary detainment etc.

Possible conclusions/commentary

User Involvement

Recommendation	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	3.9	3.10
Rating	+	-/+	+	+	+	-	-	-	-/+	+

- **has received a lot of attention; reasonably good progress on a number of fronts**
- **possible future policy focus:**
  - **more attention to user/family involvement at case-level (cf. ratings for recommendations 3.6, 3.7, 3.8)**
  - **anecdotally, family involvement appears to be a problematic issue for many people**
  - **consider developing more high-level structural mechanisms for stakeholder involvement (e.g. in NL – approach involves ministry, providers, professionals, insurers, user/family umbrella orgs.)**
  - **conduct a more general stock-take and reflection on the current centre of gravity of activity in Ireland (peer support, local user engagement mechanisms, etc.); is this getting the best results?**

2.2 Social Inclusion

Rating based on 5-point scale

AVFC Rec.	--	-	-/+	+	++	Score
4.1						2
4.2						2
4.3						?
4.4						1
4.5						2
4.6						1
4.7						1
4.8						2
4.9						?
4.10						?

Simplified 3-point scale

4.1		-/+
4.2		-/+
4.3		?
4.4		-
4.5		-/+
4.6		-
4.7		-
4.8		-/+
4.9		?
4.10		?

Data

Many problems remain in employment and housing supports

		HSE	MHR
4.1	4.1: All citizens should be treated equally. Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.	416 Services Users supported to move from congregated settings in to Local Authority housing	- Lack of access to employment etc.
4.2	4.2: Evidence-based programmes to tackle stigma should be put in place, based around contact, education and challenge.	• See Change, the national mental health stigma reduction partnership, was launched in 2010 and facilitated the second annual Green Ribbon campaign in May 2014. • The national mental health and wellbeing #Little Things Campaign was developed by the HSE's National Office for Suicide Prevention (NOSP) and more than 30 partner organizations. Its focus is to share evidence based day to day little things people can do to protect their own mental health • NOSP are currently undertaking a project called the Future of Mental Health Stigma Reduction. This project aims to examine how Irish stigma reduction campaign could be strengthened and better integrated, including where the	- Progress, but more needed
4.3	4.3: The flexible provision of educational programmes should be used to encourage young people to remain engaged with the education system and to address the educational needs of adults with mental health problems.	This is the responsibility of the Department of Education With the role out of the Early Intervention in Psychosis Clinical Programme, a key component of this is the IPS support to service users to initiate/return to education.	
4.4	4.4: Measures to protect the income of individuals with mental health problems should be put in place. Health care access schemes should also be reviewed for this group.	The HSE Mental Health Division are currently developing formal processes for the recognition and rewarding (reimbursement and/or remuneration) of Service User, Family Member & Carer engagement by the HSE Mental Health Division	
4.5	4.5: Mental health services should take account of local deprivation patterns in planning and delivering mental health care.	The National Mental Health Division has moved towards a focus on deprivation adjusted population based funding in its operational plans.	- general HSE model for this
4.6	4.6: Evidence-based approaches to training and employment for people with mental health problems should be adopted and such programmes should be put in place by the agencies with responsibility in this area.	There have been a number of projects throughout the country undertaken, with the focus of the work being on developing opportunities to support people with mental health difficulties to remain in, or have access to work and work-enhancing education/training in mainstream settings	- underdeveloped area
4.7	4.7: The provision of social housing is the responsibility of the Local Authority. Mental health services should work in liaison with Local Authorities to ensure housing is provided for people with mental health problems who require it.	18 million has been provided by Atlantic Philanthropies and the HSE through the Service Reform Fund (SRF) to transform existing mental health services towards more recovery orientated services and maintain employment and housing	-many problems remain in this area (discharge into homelessness, people with mental health issues needing social housing etc.)
4.8	4.8: Mental health services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard, and mental health services should be resourced to provide services to other ethnic groups, including provision for interpreters.	Mental health services are provided from community mental health teams to ethnic groups within their catchment areas and funding has been provided for provision of interpreters to services for asylum seekers	- various gaps remain in this area - also gaps in services for people who are deaf
4.9	4.9: Community and personal development initiatives which impact positively on mental health status should be supported e.g. housing improvement schemes, local environment planning and the provision of local facilities. This helps build social capital in the community.	This is the responsibility of HSE Primary Care - Social Inclusion.	
4.10	4.10: The National Mental Health Service Directorate should be specifically represented in the institutional arrangements which implement the National Action Plan against Poverty and Social Exclusion, with specific targets to monitor action in achieving greater social inclusion for those with mental health problems.	This is largely the responsibility of social protection with the National Action plan subsumed under social protection. The service developments as envisaged under the SRF (Service Reform Fund) will assist people with mental health problems to return to work (among other ambitions).	

Possible conclusions/commentary

Social inclusion

Recommendation	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.8	4.9	4.10
Rating	-/+	-/+	?	-	-/+	-	-	-/+	?	?

- the recommendations cover quite a mix of aspects of 'social inclusion'
- two important concrete elements score poorly – employment (4.6) and housing (4.7); these also come up again under the 'rehabilitation & recovery' heading
- recommendation 4.4 also scores poorly; this includes two rather separate themes – income protection and income-related issues in access to mental health services; both of these are not developed much further in AVFC recommendations and are topics the Oversight Group might wish to address
- the WRC external evidence review's discussion of the public-private mix dimension of mental healthcare in Ireland may be useful in this context.

2.3 Mental health promotion

Rating based on 5-point scale

	--	-	-/+	+	++	Score
5.1						2
5.2						2
5.3						1
5.4						2
5.5						2

Simplified 3-point scale

5.1		-/+
5.2		-/+
5.3		-
5.4		-/+
5.5		-/+

Data

Relatively well-developed area; more evaluation needed; more implementation (support) in schools; etc

		HSE	MHR
5.1	**5.1: Sufficient benefit has been shown from mental health promotion programmes for them to be incorporated into all levels of mental health and health services as appropriate. Programmes should particularly focus on those interventions known to enhance protective factors and decrease risk factors for developing mental health problems.**	#Littlethings is a mental health and wellbeing campaign, launched at the end of 2014 by the National Office for Suicide Prevention (NOSP)	
5.2	**5.2: All mental health promotion programmes and initiatives should be evaluated against locally agreed targets and standards.**	Many of the health promotion initiatives are being tracked and audited through connecting for life and the reporting mechanisms in place for CFL.	- not enough on this
5.3	**5.3: A framework for interdepartmental cooperation in the development of crosscutting health and social policy should be put in place.**	There are a number of ongoing interdepartmental cooperation; • Youth Mental Health and Pathfinders • National Office for Suicide Prevention- Connecting for Life • Employment of Scan Nurses as a joint initiative between Primary Care and Mental Health • PHEMI Project - Physical Health of those with enduring mental illness project is a collaboration between ICGP and mental health division	
5.4	**5.4: 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.**	• 6 Mental Health Promotion Officers assigned to the HSE Health Promotion and Improvement • One Mental Health Promotion Officer who is funded through an external agency. • Mental health funded Dietician posts and other supports to improve the physical health of mental health users • Approximately 100 other health promotion and improvement staff that engage in mental health promotion work through a variety of contexts, including training programmes	
5.5	**5.5: Training and education programmes should be put in place to develop capacity and expertise at national and local levels for evidence-based prevention of mental disorders and promotion of mental health.**	• Recovery Principles (ARI) • Eolas • Clinical Supervision • Assist • Safe talk • Mental Health First AID	

Possible conclusions/commentary

Mental health promotion

Recommendation	5.1	5.2	5.3	5.4	5.5
Rating					
	-/+	-/+	-	-/+	-/+

- **this theme scores moderately well**
- **recommendation 5.3 scores less well; this concerns the important issue of inter-departmental and inter-sectoral cooperation in the development of cross-cutting health and social policy**
- **this is a theme that the Group may wish to given attention to; the WRC external evidence review report provides a lot of potentially useful material on this.**

2.4 Primary care

Rating based on 5-point scale

	--	-	-/+	+	++	Score
7.1						2
7.2						0
7.3						1
7.4						2
7.5						1
7.6						2
7.7						1
7.8						1
7.9						1
7.1						1
7.11						1

Simplified 3-point scale

7.1		-/+
7.2		-
7.3		-
7.4		-/+
7.5		-
7.6		-/+
7.7		-
7.8		-
7.9		-
7.10		-
7.11		-

Data

Very under-developed

		HSE	MHR
7.1	7.1: All individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services.	• Over 90% of mental health needs can be successfully treated within a Primary Care setting, with less than 10% being referred to specialist community based mental health teams. • Delivery of Counselling in Primary Care and National Counselling Service funded by HSE Mental health Division • In excess of 100 assistant psychology posts to meet needs of under 18's in Primary Care funded by mental health	- lack of data on provision (# psychologists etc.; types of intervention provided) - CIPC – some data on waiting times can be long...)
7.2	7.2: Further research and information on the prevalence of mental health problems in primary care and the range of interventions provided in primary care is needed to effectively plan primary care services and the interface between primary care and specialist mental health services.	With the appointment of the HSE Director of Research (Nov. 2017), this research objective will form part of the HSE Mental Health Division's research strategy.	- little data available
7.3	7.3: All mental health service users, including those in long-stay wards, should be registered with a GP.	It is normal practice for patients attending services to be registered with a GP.	- data for inpatients, but not for users of community-based services
7.4	7.4: Appropriately, trained staff should be available at the primary care level to provide programmes to prevent mental health problems and promote wellbeing.	• 72 GPs completed eLearning module on Suicide Prevention module in 2016 • 300 practice nurses /IPNA members. Practice Nurses registered users Suicide Prevention eLearning module • 78 GPs completed eLearning module on Depression - 2016 • The HSE Mental Health Division has ongoing engagement with the Mental Health Lead of the Irish College of General Practitioners	- not much information on this
7.5	7.5: It is recommended that the consultation/liaison model should be adopted to ensure formal links between CMHTs and primary care.	The consultation/liaison model is the way of working for our Community teams and there are a number of excellent examples of the shared care approach around the country such as the Roscommon Primary Care and Adult Mental Health Service and Primary Care Teams and the Tallaght Adult Mental Health Service, Team Based Approaches to Mental Health in Primary Care: Training for Primary Care Health Professionals (DCU).	?
7.6	7.6: Mental health professionals should be available in the primary care setting, either within community care, the primary care team or the primary care network.	• In 2017, €5million was allocated to Primary Care to recruit 120 Assistant Psychologists and 10 supervising Psychologists, to develop early intervention services for those under 18. • The HSE also has service level agreements with a number of partner organisations in the community who provide psychological supports to the population e.g. Jigsaw	- lack of data on provision (# psychologists etc.; types of intervention provided)

Data (continued)

		HSE	MHR
7.7	7.7: Local multidisciplinary CMHTs should provide a single point of access for primary care for advice, routine and crisis referral to all mental health services (community and hospital based).	This is currently the model of care in Community Mental Health Teams and the further development of the Team Coordinator role in Community mental health teams will also support this aim	
7.8	7.8: Protocols and policies should be agreed locally by primary care teams and community mental health teams - particularly around discharge planning. There should be continuous communication and feedback between primary care and the CMHT.	The HSE has published a guidance paper 'Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services' in 2012. The Mental Health Division has recently completed a Protocol with TUSLA, Primary Care and Social Care regarding improved referral practices between the relevant agencies for children and young people.	
7.9	7.9: A wide range of incentive schemes should be introduced to ensure mental health treatment and care can be provided in primary care.	The Mental Health Division is funding a number of services provided at a primary care level through general practice or community based services	
7.10	7.10: Physical infrastructure that meets modern quality standards should provide sufficient space to enable primary care and CMHTs to provide high quality care.	Ongoing capital funding has been provided to move community mental health teams into primary care settings and an additional 14 million has been spent on minor capital investment to improve safety and experience of service users and staff	
7.11	7.11: The education and training of GPs in mental health should be reviewed. GPs should receive mental health training that is appropriate to the provision of mental health services described in this policy (i.e. community-based mental health services). Service users should be involved in the provision of education on mental health	The HSE in partnership with ICGP has funded a Mental Health Project role which has developed a range of materials and training programmes to support GPs and General Practice in particular. Approximately 100 primary care professionals have participated in mental health training provided through Dublin City University	- not a national programme to ensure all GPs are trained

Possible conclusions/commentary

Primary care

Recommendation	7.1	7.2	7.3	7.4	7.5	7.6	7.7	7.8	7.9	7.10	7.11
Rating	-/+	-	-	-/+	-	-/+	-	-	-	-	-

- this theme scores poorly on many of the recommendations; where the ratings are moderately positive, this is mainly to recognise the roll-out of some new initiatives (e.g. CIPC, Assistant Psychologists) and SLAs with providers like Jigsaw
- in practice, the impact to date has been modest and a lot more needs to be done; this includes better articulation of the respective roles of primary care and secondary care in this field, and how they interwork
- other key issues include the need for a major ramping-up of access to psychological therapies at scale for common mental health conditions, and the role of primary care (especially GPs) in longer-term management/ support for people with enduring and serious mental health conditions
- these are themes that the Group may wish to given attention to; the WRC external evidence review report provides a range of potentially useful material on this.

2.5 General adult

Rating based on 5-point scale

	--	-	-/+	+	++	Score
9.1						2
9.2						2
9.3						2
9.4						?
9.5						1
9.6						1
11.1						2
11.2						2
11.3						1
11.4						2
11.5						0
11.6						1
11.7						1
11.8						1
11.9						?
11.1						1
11.11						0
11.12						1
11.13						2
11.14						2
11.15						?

Simplified 3-point scale

9.1		-/+
9.2		-/+
9.3		-/+
9.4		?
9.5		-
9.6		-
11.1		-/+
11.2		-/+
11.3		-
11.4		-/+
11.5		-
11.6		-
11.7		-
11.8		-
11.9		?
11.10		-
11.11		-
11.12		-
11.13		-/+
11.14		-/+
11.15		?

Data

Some progress but still many limitations

	VFC Recommendations	HSE	MHR
9.1	9.1: To provide an effective community-based service, CMHTs should offer multidisciplinary home-based treatment and assertive outreach, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families. Each multidisciplinary team should include the core skills of psychiatry, nursing, social work, clinical psychology, occupational therapy. The composition and skill mix of each CMHT should be appropriate to the needs and social circumstances of its sector population.	• During the early years of implementation of AVFC little development of CMHTs took place because when the economic crisis hit, resources were hit hard with the loss of more than 1,000 staff • Since 2012 additional investment has resulted in real change in the composition of mental health services to become more multidisciplinary. (See tables in appendix 5 for data and trends on development of Community teams) • HSE initiatives to improve team-working and coordination of supports for individuals have also been undertaken e.g. Enhancing teamwork and Team coordinators • Investment in further development of Homebase Treatment teams and Assertive Outreach has gradually increased over the years with a number of teams now	
9.2	9.2: The cornerstone of mental health service delivery should be an enhanced multidisciplinary Community Mental Health Team (CMHT), which incorporates a shared governance model, and delivers best-practice community-based care to serve the needs of children, adults and older people.	There are: • 114 General Adult Mental Health teams • 69 CAMHS teams • 30 Psychiatry of Later Life (See tables in appendix 5)	
9.3	9.3: Links between CMHTs, primary care services, voluntary groups and local community resources relevant to the service user's recovery should be established and formalised.	The HSE mental health services has developed a number of joint working links with other HSE services and NGOs	
9.4	9.4. All CMHTs should have direct access to medical and radiological services as part of the comprehensive assessment of specific presentations.		
9.5	9.5: Evaluation of the activities of the CMHT in terms of meaningful performance indicators should take place on an annual basis and incorporate service user feedback.	To comply with the monthly performance framework the Mental Health Service developed a suite of metrics and number of Key Performance Indicators (KPI's) a list of these are available on (see indicator and performance tables and trends in appendix 5) http://www.hse.ie/eng/services/publications/KPIs/	
9.6	9.6 Research should be undertaken to establish how many services currently have effective CMHTs and to identify the factors that facilitate and impede effective team functioning and the resources required to support the effective functioning of CMHTs.	• The HSE published a series of Guidance Papers in 2012 to support teamwork and instituted an Enhancing Teamwork programme. (see appendix 2) • The Mental Health Division has instigated a Service Improvement project to develop the Implementation of the Team Coordinator role	
11.1	11.1 Education and promotion of positive mental health should be encouraged within the general community. These initiatives should have clearly specified goals and objectives and should be evaluated regularly.	See achievements outline under VFC Chapter 3 section	
11.2	11.2: A Health Promoting College Network should be developed and implemented.	Recovery Colleges as set up by ARI have significant mental health promotion consequences for it's students.	

Data (continued)

	VFC Recommendations	HSE	MHR
11.3	11.3: CMHTs should provide support and consultation to primary care providers in the management and referral of individuals with mental health problems.	Local multidisciplinary Community Mental Health Teams provide a single point of access for primary care for advice, routine and crisis referral to all mental health services.	
11.4	11.4: The proposed general adult mental health service should be delivered through the core entity of one Community Mental Health Team (CMHT) for sector populations of approximately 50,000. Each team should have two consultant psychiatrists.	• There are 114 CMHTS throughout the country • Current staffing of General Adult teams is at 76% of Vision for Change recommendation • The HSE is committed to ensuring all CMHTS have a consultant psychiatrist, however there continues to be significant difficulties in recruitment of posts in some areas	
11.5	11.5: It is recommended that a shared governance model, incorporating clinical team leader, team coordinator and practice manage be established to ensure the provision of best-practice integrated care, and evaluation of services provided.	Currently the HSE have a service improvement project implementing Team Coordinators in Community Mental Health Teams (CMHTs).	
11.6	11.6 CMHTs should be located in Community Mental Health Centres with consideration for easy access for service users. High quality day hospitals and acute in-patient care facilities should also be provided.	• The HSE endeavour to ensure CMHTs are located where there is easy access for service users • There are 70 day hospitals throughout the country • There are 1018 acute adult beds throughout the country	
11.7	11.7: CMHTs should evolve a clear care plan with each service user and, where appropriate, this should be discussed with carers.	• *Best Guidance for Mental Health Services* (2017) clearly states that each service user should have an individual care and treatment plan • The National Framework for Recovery in Mental Health 2018-2020 also recommends that individual care plans should contain the goals of the service user articulated in his or her own words. • Education programmes and evaluation processes are carried out through Best Guidance for Mental Health Services for ensuring compliances.	
11.8	11.8: Each team should include a range of psychological therapy expertise to offer individual and group psychotherapies in line with best practice.	• The development of the Counselling in Primary Care (CIPC) service represents an important advance in the availability of counselling for people attending primary care and specialist mental health services. • In addition important initiatives have taken place to develop specialist psychological therapies within specialist mental health services including Dialectical Behavioural Therapy • Within the Mental Health Clinical Programme looking to provide Early Intervention in Psychosis (EIP) significant training has taken place with relevant CMHT clinical staff to provide specialist family therapy as part of a evidence based model of family therapy. • Cognitive Behavioural Therapy (CBT) is also being provided in the context of the Clinical Programme for the management of Eating Disorders • In many CMHTs, Consultant Psychiatrists and Clinical Psychologists, in particular, provide psychotherapy as part of the care plan.	

	VFC Recommendations	HSE	MHR
11.9	11.9: Service users and providers should collaborate to draw up clear guidelines on the psychological needs of users and the range of community resources and supports available to them locally.	• The HSE are committed to ensuring the "expert "by experience is utilised throughout its specialist mental health service as evidenced in the Recovery Framework and Office of Mental Health Engagement • Currently there are a number of peers support workers employed through the country who work collaboratively with CMHTs	
11.10	11.10 Home-based treatment teams should be identified within each CMHT and provide prompt services to known and new service users as appropriate. This subteam should have a gate-keeping role in respect of all hospital admissions.	The home-based treatment is provided as part of the service offering from some of our community mental health teams and specific funding has been provided in programme for Government funding 2015/16	
11.11	11.11: Arrangements should be evolved and agreed within each CMHT for the provision of 24/7 multidisciplinary crisis intervention. Each catchment area should have the facility of a crisis house to offer temporary low support accommodation if appropriate.	• Improving the accessibility of out-of-hours and providing 7 day services response for known mental health service users in crisis has been made a priority by the Mental Health Division in 2017. • Following investment from the Programme for Government Funding 2017, additional funding was obtained for the development of a model within all CHO areas for the provision of enhanced 7 day services in all sectors for known service users in crisis. • This model aims to expand existing community mental health services such that there will be a commitment to the provision of a seven day community service to all sector areas by the end of 2017, with recruitment to posts expected by first quarter of 2018.	
11.12	11.12: In addition to the existing Early Intervention Services (EIS) pilot project currently underway in the HSE, a second EIS pilot project should be undertaken with a population characterized by a different socio-demographic profile, with a view to establishing the efficacy of EIS for the Irish mental health service.	• The National Clinical Programme for Early Intervention in Psychosis is a joint collaboration between the HSE Mental Health Division and the HSE Clinical Strategies and Programmes Division (CSPD). • A National Working Group has recently completed a draft Model of Care (November 2017), and this is due to be formally launched within the first quarter of 2018. • As part of this Clinical Programme, in early 2018 the Demonstration Sites will be developed across the Country, resourced with all of the required elements of an EIP service, with a view to carrying out a process evaluation of this treatment approach. • Training per the agreed EIP programme is already underway for CBT and FBT	
11.13	11.13: Each 50 bed acute psychiatric unit should include a close observation unit of six beds	• There are approximately 12 high observations units through the country with at least one in every CHO area (except CHO 3 and 4.) • CHO 3 are currently in negotiation on the opening of their funded high observations unit. • CHO 4 utilise their Psychiatric Intensive Care unit (PICU) in Cork for people who require a higher level of care.	
11.14	11.14: Each of the four HSE regions should provide a 30-bed ICRU unit – with two sub-units of 15 beds each – to a total of 120 places nationally, staffed with multidisciplinary teams with appropriate training.	• Currently there are two Psychiatric Intensive Care units (PICU) in the country The Phoenix Centre in Dublin and the Carraig Mór Centre in Cork. • Phase 2 of the development of Forensic Mental Health Services will include additional ICRU Beds as included in the Capital Plan. • The Mental Health Division are currently in negotiation with two external providers in the Dublin area in relation to the provision of specialised rehabilitation Units (SRUs) for people with severe and enduring mental illness and complex needs. • A series of placements are also provided for those with specialist rehabilitation needs	
11.15	Each of the four HSE regions should provide two high support intensive care residences of 10 places each.	• ???	

Possible conclusions/commentary

General adult MH services

Rec	9.1	9.2	9.3	9.4	9.5	9.6	11.1	11.2	11.3	11.4	11.5	11.6	11.7	11.8	11.9	11.10	11.11	11.12	11.13	11.14	11.15
Rating																					
	-/+	-/+	-/+	?	-	-	-/+	-/+	-	-/+	-	-	-	-	?	-	-	-	-/+	-/+	?

- this theme scores poorly on many of the recommendations; where the ratings are moderately positive, this is mainly to recognise the apparent progress in relation to implementation and staffing of community mental health teams to a certain degree
- however, it is not clear how the more than one hundred teams actually operate in practice, what range of services they are providing, how well they are meeting demand, etc; Mental Health Commission and others have pointed to the need for much more progress in this area
- this is a theme that the Group may wish to given attention to; one possible focus might be to work with HSE to get a better picture of the actual nature and modus operandi of the teams that are in place; without this, it is difficult to assess progress and identify policy and practice priorities going forward.

2.6 CAMHS

Rating based on 5-point scale

	--	-	-/+	+	++	Score
10.1						1
10.2						2
10.3						2
10.4						2
10.5						2
10.6						?
10.7						1
10.8						1
10.9						1
10.10						2

Simplified 3-point scale

10.1		-
10.2		-/+
10.3		-/+
10.4		-/+
10.5		-/+
10.6		?
10.7		-
10.8		-
10.9		-
10.10		-/+

Data

No CAMHS-specific quality standards and guidelines; no quality and outcome monitoring system

		HSE	MHR
10.1	10.1 The need to prioritise the full range of mental health care, from primary care to specialist mental health services for children and adolescents is endorsed in this policy.	CAMHS is applied very specifically to services that provide specialist mental health treatment and care to young people up to 18 years of age through a multidisciplinary team approach, treating moderate to severe mental health disorders. • There are 69 Community Child and Adolescent Mental Health Teams as compared to 49 in 2008. • This represents 87% of the total Vision for Change recommended 79 teams these teams represent 56% of Vision for Change staffing levels recommendation (see table 6.1 below)	- waiting times can be long for many
10.2	10.2 Child and adolescent mental health services should provide mental health services to all aged 0- 18 Transitional arrangements to facilitate the expansion of current service provision should be planned by the proposed National Mental Health Service Directorate and the local CMHTs.	The Standard Operating Procedure for CAMHS clearly states that CAMHS services should be available to young people up to the age of 18. Management at CHO level are engaging with staff to standardise the acceptance of 16 and 17 year olds across all teams. • An audit of the number of existing teams that accept 16 and 17 year olds was completed in May 2017 by the HSE Mental Health Division.93.8% of CAMHS teams are seeing 16 year olds and 78.1% are seeing 17 year olds.	- Some teams not accepting 16/17 year olds?
10.3	10.3 It is recommended that service users and their families and carers be offered opportunities to give feedback on their experience and to influence developments within these services.	• The Office for Mental Health Engagement has developed feedback mechanisms for Service Users their families and carers. • HSE Your Service Your Say Process provides the mechanism for service users and their families to give feedback on services • Since September 2017 the HSE Mental Health Division has begun monthly engagements with parents of children who have attended CAMHS. These meetings allow us to provide them with progress reports on CAMHS service improvement and also to listen to any concerns or suggestions they have about services. • Youth and family representatives have been invited to be active members of project groups in CAMHS so that they can influence developments within the service. • A pilot CAMHS advocacy project is underway in CHO 2	- Not well developed
10.4	10.4 Programmes addressing mental health promotion and primary prevention early in life should be targeted at child populations at risk	• HSE Health Promotion and Improvement (HP&I) engage with schools and encourage all school to become Healthy Ireland Health Promoting Schools • Zippy's Friends and Mind Out programme is currently being rolled out by HSE HP&I Schools Health Promotion Officers in primary schools to promote mental wellbeing in conjunction with the Department of Education. • HSE HP& I fund the Smart Start programme for preschools which has mental wellbeing as a component of the programme	- AP funded PEII programmes
10.5	10.5 For those children in school settings it is recommended that the SPHE be extended to include the senior cycle and that evidence-based mental health promotion programmes be implemented in primary and secondary schools.	• This is the responsibility of the Department of the Department of Education • HSE HP & I also collaborate and fund Jigsaw with whom they deliver training on youth mental health in schools and in the community to support those working with young people in either a paid or voluntary capacity.	- SPHE rec. implemented

Data (continued)

		HSE	MHR
10.6	10.6 Provision of programmes for adolescents who leave school prematurely should be the responsibility of the Department of Education and Science.	• Recommendation suggests that this is the responsibility of the Department of Education. • HSE HP & I also collaborate and fund the National Youth Council of Ireland to support the mental wellbeing of young people in the out of school sector	
10.7	10.7 Two child and adolescent CMHTs should be appointed to each sector (population: 100,000). One child and adolescent CMHT should also be provided in each catchment area (300,000 population) to provide liaison cover	• There are currently 87.3% (69) of the 79 recommended Community CAMHS teams in place. There are an additional 4 Adolescent Day Service teams & 3 Hospital Liaison Mental Health Teams, however this is less than the 16 teams each recommended in a Vision for Change (see appendix 6).	- Still considerably under target (esp. Wtes)
10.8	10.8 These child and adolescent CMHTs should develop clear links with primary and community care services and identify and prioritise the mental health needs of children in each catchment area.	• Local multidisciplinary Community Child and Adolescent Mental Health Teams provide a single point of access for primary care for advice, routine and crisis referral to all mental health services. • The further development of the Team Coordinator role in CAMHS Community mental health teams will also support this aim	- Still very under-developed
10.9	10.9 Urgent attention should be given to the completion of the planned four 20-bed units in Cork, Limerick, Galway and Dublin, and multidisciplinary teams should be provided for these units.	• There are four CAMHS Acute Admission Units in Ireland, with a maximum capacity of 74 beds available (94 including Private Healthcare providers). • At November 2017 there are 68 beds operational. • Construction has commenced on an additional 10 Forensic CAMHS beds as part of the new National Forensic Mental Health Service • There will also be 20 additional beds in the new National Paediatric Hospital to include 12 specialist Eating Disorder beds by 2019 and 2021 respectively.	- Still have admissions to adult units
10.10	10.10 Early intervention and assessment services for children with autism should include comprehensive multidisciplinary and paediatric assessment and mental health consultation with the local community mental health team, where necessary	• The diagnosis of autism and intellectual disability remains the remit of primary care and disability services. Children with autism are seen by CAMHS when there is a co-morbid moderate to severe mental health disorder. Where the child/young person has a moderate or severe degree of intellectual disability and co-morbid mental health disorder, they are managed within Mental Health Intellectual Disability Services for Children and Adolescents (CAMHS-MHID). • The HSE MHD has contributed significantly to the ongoing HSE Review of Autism Services, commissioned by the Department of Health.	- ? see comments on AD/HD also

Possible conclusions/commentary

CAMHS

Recommendation	10.1	10.2	10.3	10.4	10.5	10.6	10.7	10.8	10.9	10.10
Rating										
	-/+	-/+	-/+	-/+	-/+	?	-	-	-	-/+

- this theme scores poorly on a number of the recommendations; where the ratings are moderately positive, this is mainly to recognise the apparent progress in relation to implementation and staffing of community mental health teams to a certain degree

- given the focus on CAMHS in the Task Force report and other contexts, the Group may decide to address this in a lighter touch manner than some of the other core services (general adult, older persons, rehab & recovery, ….).

2.7 Rehabilitation & Recovery

Rating based on 5-point scale

	--	-	-/+	+	++	Score
12.1						2
12.2						1
12.3						1
12.4						1
12.5						1
12.6						2
12.7						1
12.8						1
12.9						0

Simplified 3-point scale

12.1		-/+
12.2		-
12.3		-
12.4		-
12.5		-
12.6		-/+
12.7		-
12.8		-
12.9		-

		HSE	MHR
12.1	12.1: A strong commitment to the principle of "Recovery" should underpin the work of the rehabilitation CMHT - the belief that it is possible for all service users to achieve control over their lives, to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation.	See 12.2 below The HSE Mental Health Divisions have appointed a national expert group who are currently developing a recovery focused model of care for people with serve and enduring mental illness and complex needs, including commissioning of additional services for 2018	
12.2	12.2: Some 39 rehabilitation and recovery CMHTs should be established nationally, with assigned sector populations of 100,000. Assertive outreach teams providing community-based interventions should be the principal modality through which these teams work.	• There are up to 19 rehabilitation and recovery CMHTs across the country providing various levels of rehabilitation service for people with severe and enduring mental illness. • Home-based treatment and Assertive outreach is provided by a number of specialist teams and also as part of the services offered by the General adult mental health teams • The HSE Mental Health Division is committed to the further development and extension of Rehabilitation and Recovery CMHTS and Homecare Teams throughout all of the CHO's.	
12.3	12.3: The physical infrastructure required to deliver a comprehensive service should be provided in each sector. Rehabilitation and recovery CMHTs should have responsibility for those physical resources appropriate to the needs of their service users, such as community residences.	• The Mental Health Division recognises that housing is an essential element of care for individuals with a mental illness, particularly for those with long-term mental illness. • There are high, medium and low support residences provided or funded by the mental health services throughout the country.	
12.4	12.4: Opportunities for independent housing should be provided by appropriate authorities with flexible tenancy agreements being drawn up in accordance with each service user's needs. Arrangements that best enable service users to move from high support to low support and independent accommodation need to be considered.	Please reference Recommendations 4.1 and 4.7 • The provision of independent housing is the responsibility of the Local Authority however; HSE Mental Health Services liaises with Local Authorities and other agencies to ensure housing is provided for people with mental health problems who require it. • The Service Reform Fund (SRF) has been established by the Department of Health (DOH), the HSE and Atlantic Philanthropies in collaboration with Genio to implement mental health and disability service reform in Ireland. • The SRF will provide resources to transform existing services towards more person-centred and recovery-oriented services, in line with government policy. • One of the priorities for mental health service reform is the development of non institutional housing models and supports for people transitioning to independent living in the community. • The HSE MHD is currently working with Hail Housing in CHO8 on a pilot project to develop independent accommodation for long term mental health service users.	
12.5	12.5: Rehabilitation and recovery mental health services should develop local connections through linking with local statutory and voluntary service providers and support networks for people with a mental illness is required to support community integration.	Rehabilitation and recovery services continue to link with local services to support community integration for people with mental illness.	

Data (continued)

		HSE	MHR
12.6	12.6: All current staff within the mental health system who are appointed to rehabilitation and recovery services should receive training in recovery-oriented competencies and principles.	Staff within the mental health service receive training on recovery principles and the recently launched Recovery framework includes the requirement for standardised training	
12.7	12.7: The development of formal coordination structures between health services and employment agencies should be a priority if the delivery of seamless services is to be facilitated.	• The SRF is also providing an opportunity to roll out Individual Placements and Support (IPS) in a partnership arrangement with all CHO Mental Health Services. • The objective is to ensure that in the next 3-5 years all service users can have a realistic expectation of getting support in finding, accessing and maintaining employment for service users with mental illness	
12.8	12.8: To facilitate the service user in re-establishing meaningful employment, development of accessible mainstream training support services and coordination between rehabilitation services and training and vocational agencies is required.	• The setting up of recovery colleges throughout the country • Links with local vocational training agencies continue throughout the country • As part of the MOC for people with severe and enduring mental illness, training and education is seen as a significant component of people's recovery (Reference Recommendation 4.6	
12.9	12.9: Evaluation of services to the severe and enduring service user group should incorporate quality-of-life measures and assess the benefit and value of these services directly to service users and their families	• Evaluation of services incorporating quality of life measurements will be describe within the MOC for people with severe and enduring mental illness.	

Possible conclusions/commentary

Rehabilitation & recovery

Recommendation	12.1	12.2	12.3	12.4	12.5	12.6	12.7	12.8	12.9
Rating	-/+	-	-	-	-	-/+	-	-	-

- this theme scores poorly on most recommendations
- problematic aspects include the limited availability of rehab & recovery teams, home-based treatment teams, and assertive outreach teams across the country; full implementation and staffing of these services across the country is a key need; initiatives like ARI are making a contribution, but the core HSE services must be in place to provide the bedrock infrastructure and professional services
- important themes, such as housing and employment, require a lot more attention; this arises both within HSE services and in development of effective inter-sectoral working arrangements with local authorities, approved housing bodies, employment services, etc.
- this is a topic that the Group may wish to give attention to; the external evidence review presents a lot of material on approaches in other countries and in some parts of Ireland
- another important theme not given much attention in AVFC is the legacy situation where people may reside in or attend facilities that are inappropriate to their needs (e.g. hostels, training centres, day centres); this is an important issue that needs attention in a focused and sensitive manner, and it seems that this is not always the case in practice (e.g. people moved out of hostels when not ready or without adequate support; training centres winding down so users have little to do); the Group might consider this topic for attention.

2.8 Older people

Rating based on 5-point scale

	--	-	-/+	+	++	Score
13.1						1
13.2						2
13.3						2
13.4						0
13.5						1
13.6						1
13.7						1
13.8						?
13.9						?
13.10						?
13.11						?
13.12						?
13.13						?
13.14						?

Simplified 3-point scale

13.1		-
13.2		-/+
13.3		-/+
13.4		-
13.5		-
13.6		-
13.7		-
13.8		?
13.9		?
13.10		?
13.11		?
13.12		?
13.13		?
13.14		?

Data

Still not available in all areas;
under-resourced relative to growing older population;
large unmet need for primary mental health supports

		HSE	MHR
13.1	13.1: Any person aged 65 years or over with primary mental health disorders or with secondary behavioural and affective problems arising from experience of dementia, has the right to be cared for by mental health services for older people.	Mental health services provide care and treatment specifically for older people who develop functional mental health difficulties, such as depression after the age of 65 with dementia whose diagnosis is associated with significant behavioural and/or psychological symptoms. Mental Health services for older people aim to provide mental health supports within or as near to the individual's home as possible. The demands on the Psychiatry of Later Life teams have increased year on year as the at risk population has increased in size. • 97% of the over 65 year old population has a dedicated Psychiatry of Later Life team serving their community, with the remaining 3% covered by their General Adult service. The current level of staffing of these teams is at 60.5% of VFC recommendations (See table 8.1 below)	Much fewer teams than recommended (pro-rated for increase in older person pop)
13.2	13.2 Mental health promotion among older adults should preserve a respect for the potential in older people to grow and flourish in later life and to counter negative myths of ageing that can become self-fulfilling prophesies		
13.3	13.3: Health promotion programmes and initiatives found to be beneficial to older adults should be implemented.	• There are seven social prescribing projects throughout the country. Three of which are funded through the National Office for Suicide Prevention. The terms 'social prescribing', 'community referral' and 'non-traditional providers' have all been used to describe a way of expanding the range of non-medical options that could be available to healthcare professionals when a person has needs that are related to socioeconomic and psychosocial issues. Social Prescribing is also a component of the Physical Health of those with Enduring Mental Illness (PHEMI) programme. (See Appendix 3) This is a service for everyone but has been very beneficial to connect older persons who are isolated into local communities. • HSE Health Promotion and Improvement supports the Men's Sheds Programme which tackles isolation among older men. With over 400 men's sheds in Ireland – at least three in each county, north and south – the country enjoys the greatest concentration of men's sheds anywhere in the world. Men's sheds help men of all backgrounds lead happier, healthier and more productive lives. • Dementia Understand Together, a campaign to increase awareness of dementia, is supported by the HSE	
13.4	13.4: Primary health care teams should play a major role in assessment and screening for mental illness in older people and should work in a coordinated and integrated manner with the specialist teams to provide high quality care, particularly care that is home-based.	Community Mental Health teams Model of Care is to work closely with their referrers including primary care	No data on extent of services or number of presentations; TILDA data suggests 80%+ remain undiagnosed/ untreated (2009-2011)

Data (continued)

		HSE	MHR
13.5	13.5: One MHSOP multidisciplinary team should be established per 100,000 populations (46 teams).	Currently there are 30 Psychiatry of Later Life community teams with a number of teams in development which have been resourced from the Programme for Government investments in recent years.	Much fewer teams than recommended (pro-rated for increase in older person population) Some areas have none...
13.6	13.6: Priority should be given to establishing comprehensive specialist MHSOP where none currently exist.	Currently, 30 of the 48 recommended Psychiatry of Later Life teams are in operation. In some CHO areas, teams serving larger populations are operating as double or triple teams	
13.7	13.7: Physical resources essential to service delivery, acute beds and continuing care, service headquarters, community-based and day facilities should be provided for MHSOP in each sector.		Very few dedicated beds; otherwise must be requested from gen psychiatric beds Fewer day hospitals and continuing care units than recommended Also issues of access to specialist MHOP for older people admitted to acute hospitals
13.8	13.8: There should be eight acute assessment and treatment beds in each regional acute psychiatric unit for MHSOP.		
13.9	13.9: There should be one central day hospital per mental health catchment area (300,000 population) providing 25 places, and a number of travelling day hospitals in each mental health catchment area.	Day hospitals have been developed which enhance the level of community care available to older people. They can also reduce the requirement for acute inpatient care and facilitate earlier discharge	
13.10	13.10: There should be an appropriate provision of day centres in each mental health catchment area, but their provision should not be the responsibility of the MHSOP.		
13.11	13.11: There should be appropriate recognition and linkage with voluntary agencies in the field.		
13.12	13.12 Carers and families should receive appropriate recognition and support including education, respite, and crisis response when required.		
13.13	13.13 Older people with mental health problems should have access to nursing homes on the same basis as the rest of the population		
13.14	13.14 There should be 30 continuing care places for older people with mental disorders in each area		

Possible conclusions/commentary

Older people

Recommendation	13.1	13.2	13.3	13.4	13.5	13.6	13.7	13.8	13.9	13.10	13.11	13.12	13.13	13.14
Rating														
	-	-/+	-/+	-	-	-	-	?	?	?	?	?	?	?

- this theme scores poorly on most recommendations, although the data sources available appear not to have covered some of the recommendations (?)
- problematic aspects include the limited availability of Psychiatry of Later Life teams across the country
- primary care services targeting common mental health conditions (such as depression) amongst older people are underdeveloped; this might be a theme for attention by the Group, and could be addressed alongside this issue for general adult services
- dementia services need development; evidence from the Genio programme suggest that joint initiatives by mental health, social care, and health promotion/wellbeing have considerable potential; one topic the Group might consider is enhancement of mental health services for those with behavioural and/or psychiatric symptoms.

2.9 Intellectual disability

Rating based on 5-point scale

	--	-	-/+	+	++	Score
14.1						1
14.2						1
14.3						0
14.4						0
14.5						0
14.6						1
14.7						1
14.8						0
14.9						0
14.10						0
14.11						3

Simplified 3-point scale

14.1		-
14.2		-
14.3		-
14.4		-
14.5		-
14.6		-
14.7		-
14.8		-
14.9		-
14.10		-
14.11		+

Data

		HSE	MHR
14.1	14.1: The process of service delivery of mental health services to people with intellectual disability should be similar to that for every other citizen.	• The HSE Mental Health Division recognizes that there are significant gaps in MHID service across the country. They and are fully committed to implementing a programme of works to improve MHID services for children and adults with moderate to profound Intellectual Disability who experience mental health problems. • A National MHID clinical lead was appointed in 2016, and a national MHID Service Improvement (SI) programme was initiated at the start of 2017	
14.2	14.2: Detailed information on the mental health of people with intellectual disability should be collected by the NIDD. This should be based on a standardised measure. Data should also be gathered by mental health services for those with intellectual disability as part of national mental health information gathering.	• The collection of detailed information by the NIDD is not within the remit of the MHD • As part of the national MHID SI programme, 3 pilot sites have been set up to start to pilot MHID specific clinical data. The sites are a mix of rural, urban community services and both HSE and Voluntary Services • An MHID Clinical Data Working group will shortly be started to learn from the experience of the pilot sites and develop recommendations for national collection, analysis, feedback and monitoring of MHID specific data. The aim is to better understand the specific needs of an MHID service and to better enable the quality of MHID services to be a focus at all performance reviews	
14.3	14.3: A national prevalence study of mental health problems including challenging behaviour in the Irish population with intellectual disability should be carried out to assist in service planning.	• Currently, there has been no specific study undertaken within Ireland. However it is hoped that the recommendations of the MHID Clinical Data working group (see 14.2) would start the basis of collecting this information in a consistent manner across all MHID teams. This information would then be directly used in Phase 2 of MHID's strategic resource planning, to objectively direct Multi Disciplinary resources to where there is the greatest need.	
14.4			
14.5	14.5: All people with an intellectual disability should be registered with a GP and both intellectual disability services and MHID teams should liaise with GPs regarding mental health care.	• Currently a MHID national working group is developing a Model of Service for MHID teams across the country. The aim of the Model is to provide clear best practice guidance for teams on how best to run a MHID service. • GP liaison, communication, education and the development of proactive working relations will be part of the group's recommendations. GP input and feedback will be sought into developing and finalising the Model of Service. Once agreed, local teams will then communicate how liaison can best be achieved with local GPs.	

Data (continued)

		HSE	MHR
14.6	14.6: Mental health services for people with intellectual disability should be provided by a specialist MHID team that is catchment area based (2 per 300,000)	• As mentioned earlier (14.1), A National MHID Service Improvement Project has been established to improve services for children and adults with moderate to profound Intellectual Disability who experience mental health problems. This programme is working in close co-operation with the HSE's Social Care Division and relevant Voluntary agencies • The programme aims to build on the 2013, 2014 & 2015 Programme for Government (PfG) funding of posts and further expand and develop MHID services across the country based on operationalising AVFC. • Specifically the programme aims to provide a strategic framework and support that will enable MHID services to be provided equitably across each CHO, and build the foundations of a quality, multi-disciplinary community based, specialist MHID services. It is envisaged that this will achieved through the alignment of existing Mental Health, Social Care and Voluntary services, within a two year timeframe. • To date progress that has been made includes: ○ Appointment of a National MHID Clinical lead ○ Mapping has been completed for all existing MHID resources, including pre 2013 posts in both the HSE and Voluntary Agencies. ○ MHID Service Plans for <u>both</u> Adult and CAMHS have been drafted by each CHO ○ A Phased Resource plan has been agreed by Senior Management to initially develop Baseline teams i.e. Consultant Psychiatrist, Clinical Nurse Specialist, Psychology and Admin support, in areas where there are service gaps and augment existing teams as needed. Further Multi disciplinary resources can then be allocated based on overall level of CHO need (see 14. 3) ○ Model of Service Working Group and Clinical data pilot sites established	Very under-developed
14.7	14.7: The multidisciplinary MHID teams should be provided on the basis of two per 300,000 populations for adults with intellectual disability.	• Please see 14.6 regarding the establishment of MHID Adult Baseline teams, to start to close the service gaps across the country and enable Service Users and their families to access MHID services no matter where they live. • Resource planning and gap identification is based on VFC recommended ratios. • Currently there are 18 MHID Adult teams across the country and 96 WTE, and 34.5 unfilled posts. • The HSE Mental Health Division's plan is to initially achieve 40% VFC coverage with Baseline Teams within each CHO, and then when there is an initial team in place with clinical governance, further build up these teams based on MD input and clinical need. • Recruitment of MHID specialist staff is and will be a challenge due to the limited pool of available specialists	As above
14.8	14.8: One MHID team per 300,000 populations should be provided for children and adolescents with intellectual disability.	• Please see 14.6 regarding the establishment of MHID CAMHS Baseline teams, to start to close the service gaps across the country and enable Service Users and their families to access MHID services no matter where they live. • Resource planning and gap identification is based on VFC recommended ratios. • Currently there are 2 MHID CAMHS teams, 13 WTE and 19 unfilled posts. The majority of services are provided by single Consultant Psychiatrists operating within CHOs. • Our plan is to initially achieve 40% VFC coverage with Baseline Teams within each CHO, who will work in close tandem with existing CAMHS services. When there is an initial team in place with clinical governance, these teams will be further developed based on MD input and clinical need. • Recruitment of MHID specialist CAMHS staff is and will be a challenge due to the limited pool of available specialists	As above

Data (continued)

		HSE	MHR
14.9	14.9: A spectrum of facilities should be in place to provide a flexible continuum of care based on need. This should include day hospital places, respite places, and acute, assessment and rehabilitation beds/places. A range of interventions and therapies should be available within these settings.	The MHID Model of Service (see 14. 5) will address this issue and detail the best practice guidance for MHID services	
14.10	14.10: In order to ensure close integration, referral policies should reflect the needs of individuals with intellectual disability living at home with their family, GPs, the generic intellectual disability service providers, the MHID team and other mental health teams such as adult and child and adolescent mental health teams.	The MHID Model of Service (see 14. 5) will address this issue and detail the best practice guidance for MHID services	
14.11	14.11: A national forensic unit should be provided for specialist residential care for low mild and moderate range of intellectual disability. This unit should have ten beds and be staffed by a multidisciplinary MHID team	The National Forensic Mental Health Service has developed a 10 bedded Forensic MHID unit. • It has recruited a multidisciplinary MHID team	

Possible conclusions/commentary

Intellectual disability

Recommendation	14.1	14.2	14.3	14.4	14.5	14.6	14.7	14.8	14.9	14.10	14.11
Rating											
	-	-	-	-	-	-	-	-	-	-	+

- most recommendations score poorly, apart from the provision of a national forensic MHID unit (14.11)
- the National MHID Service Improvement Project is currently underway and may address many of the AVFC recommendations
- one theme not given much attention in AVFC is the legacy situation where people with ID, and not necessarily having serious MH difficulties, may be inappropriately residing in or attending MH facilities; this is an example of some of the legacy issues that need to be properly and compassionately addressed by MH (see also people in hostels, attending training centres and attending day centres, as already mentioned under the rehabilitation & recovery theme); the Group might wish to consider this theme for attention in its work.

2.10 Criminal justice system

Rating based on 5-point scale

	--	-	-/+	+	++	Score
15.1.1						2
15.1.2						1
15.1.3						2
15.1.4						1
15.1.5						1
15.1.6						1
15.1.7						3
15.1.8						1
15.1.9						1

Simplified 3-point scale

15.1.1		-/+
15.1.2		-
15.1.3		-/+
15.1.4		-
15.1.5		-
15.1.6		-
15.1.7		+
15.1.8		-
15.1.9		-

Data

Various gaps and need for further development; some promising progress as well

		HSE	MHR
15.1.1	15.1.1: Every person with serious mental health problems coming into contact with the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done. Where mental health services are delivered in the context of prison, they should be person-centred, recovery oriented and based on evolved and integrated care plans.	• There has been significant investment by the HSE in forensic mental health prison in reach and court liaison services (PICLS) • A Psychiatric Prison in- reach and Court Liaison Service has been developed by the Central Mental Hospital at Ireland's main remand prison, Cloverhill • Forensic nursing and medical staff screen all new remands (over 4000 annually) for severe mental illness and accept referrals from courts, prison staff and other stakeholders. • There is also a housing and support officer who supports people on their release from prison to secure emergency accommodation and housing.	
15.1.2	15.1.2: FMHS should be expanded and reconfigured so as to provide court diversion services and legislation should be devised to allow this to take place.	Legislation on court diversion has not yet been passed in Ireland	No legislation, but positive examples of existing arrangements (Cloverhill in-reach team for remand prisoners) Central Mental Hospital only option in serious matters – no local facilities
15.1.3	15.1.3: Four additional multidisciplinary teams for forensic mental health services should be provided; one per HSE region	• The National forensic service provides a service across the country and includes multi-disciplinary teams serving both acute mental health inpatient units and prisons • There is also a specialised forensic intellectual disability team with access to 10 beds within the Central Mental Hospital • The NFMHS also provides in-reach clinics in the Dublin and Leinster region • Funding has been allocated from PFG towards increased prison in-reach clinics in Castlerea, Limerick and Cork prisons	In-reach teams for a number of prisons Separately, there is the prison service Psychology Service (17 wtes) – can be long waiting times; not followed-up by the service after release (the service was to be reviewed in 2015)
15.1.4	15.1.4: The CMH should be replaced or remodelled to allow it to provide care and treatment in a modern, up-to-date humane setting, and the capacity of the CMH should be maximised.	Construction has commenced on the new hospital which will be completed by early 2020	? status of Portrane

Data (continued)

		HSE	MHR
15.1.5	15.1.5: Prison health services should be integrated and coordinated with social work, psychology and addiction services to ensure provision of integrated and effective care. Efforts should be made to improve relationships and liaison between FMHS and other specialist community mental health services.	The NFMHS works in collaboration with prison health services and maintains a shared care approach to the management of prisoners with mental illness	
15.1.6	15.1.6: A dedicated residential 10-bed [forensic] facility for child and adolescents should be provided.	• Dedicated residential 10-bed forensic facility for child and adolescents will be provided within the new forensic hospital. • CAMHS Forensic team developed in advance of opening from PFG funding	Not in place yet
15.1.7	15.1.7: A 10-bed residential unit with multidisciplinary team for mental health & intellectual disability in context of criminal justice system.	Dedicated MHID unit in place within the existing national forensic hospital	
15.1.8	15.1.8: Education and training in the principles and practices of FMH should be established and extended to appropriate staff, including An Garda Siochana.	The NFMHS provides Training to Gardai on an on-going basis and also provide Siege support in line with Barr Report Recommendations	Some training for Gardai in student programme
15.1.9	15.1.9: A senior garda should be identified and trained in each Garda division to act as resource and liaison mental health officer.	• Inspector nominated in each Gardaí division to act as liaison person to the approved centres in their division. • Training programme developed and delivered by the Garda College for the appointed liaison Inspectors.	[As in HSE doc]

Possible conclusions/commentary

Criminal justice system

Recommendation	15.1.1	15.1.2	15.1.3	15.1.4	15.1.5	15.1.6	15.1.7	15.1.8	15.1.9
Rating									
	-/+	-	-/+	-	-	-	+	-	-

- **whilst there are some positive developments, this is an area that warrants substantial further improvement; the overall model and various components of the system could be reviewed and improved in line with good practice in other countries**

- **this is a theme that the Group might consider for attention; the external evidence review report provides a lot of material on approaches in other countries, including delivery of prison MH services via the main MH services, interworking concordats between police and MH services, and other aspects.**

2.11 Homeless

Rating based on 5-point scale

	--	-	-/+	+	++	Score
15.2.1						0
15.2.2						0
15.2.3						?
15.2.4						?
15.2.5						3
15.2.6						1
15.2.7						1

Simplified 3-point scale

15.2.1		-
15.2.2		-
15.2.3		?
15.2.4		?
15.2.5		+
15.2.6		-
15.2.7		-

Data

		HSE	MHR
15.2.1	15.2.1: A data base should be established to refine the dimension and characteristics of homelessness and analyse how services are currently dealing with it.	Data Base not established	
15.2.2	15.2.2: In the light of this information, scientifically acquired and analysed, make recommendations as to requirements and implement them.	Data Base not established	
15.2.3	15.2.3: The Action Plan on Homelessness should be fully implemented and the statutory responsibility of housing authorities in this area should be reinforced.	The provision of independent housing is the responsibility of the Local Authority however; HSE Mental Health Services liaises with Local Authorities and other agencies to ensure housing is provided for people with mental health problems who require it.	
15.2.4	15.2.4: A range of suitable, affordable housing options should be available to prevent the mentally ill becoming homeless.	• As per (15.2.3) the provision of independent housing is the responsibility of the Local Authority however; HSE Mental Health Services liaises with Local Authorities and other agencies to ensure housing is provided for people with mental health problems who require it. • The HSE Mental health Division are committed to creating a stepped model of care in which the homeless population receives timely access and appropriate mental health care, addiction interventions and other secondary specialist services appropriate to their mental health needs supported through PFG funding for this purpose	
15.2.5	15.2.5 Two MDTs should be provided, one each in North and South Dublin, to provide a mental health service to the homeless population.	Four community mental health teams for people who are homeless and have a mental health difficulty; two in Dublin, one in Cork and one in Waterford. All in place.	Are teams, but various gaps in service (tenancy sustainment supports, ring-fenced housing, time limits on support, inappropriate placements) Also: lack of crisis support, follow-up support at discharge from hospital/prison, access to MH services for those who also have addictions
15.2.6	15.2.6: CMHTs should adopt practices to help prevent service users becoming homeless, such as guidelines on discharge of people from psychiatric in-patient care and an assessment of housing need/living circumstances for all people referred to mental health services.	As per (15.2. 4)a national Project underway to create a stepped model of care in which the homeless population receives timely access and appropriate mental health care, addiction interventions and other secondary specialist services appropriate to their mental health needs	Still under-developed
15.2.7	15.2.7: Integration and coordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged.	The proposed stepped model will work towards an overall integrated health services response for those with mental health needs who are homeless involving primary care services, addiction services and mental health services (see appendix 1 regarding SRF developments)	

Possible conclusions/commentary

Homeless

Recommendation	15.2.1	15.2.2	15.2.3	15.2.4	15.2.5	15.2.6	15.2.7
Rating							
	-	-	?	?	+	-	-

- **some positive developments, such as CMHTs in Dublin, Cork and Waterford (15.2.5); a lot more development needed in this area, including enhanced inter-working with housing sector (e.g. tenancy sustainment, ongoing supports, etc.)**

- **this is a theme that the Group might consider for attention in its work; the scope includes those currently homeless, but also people with MH difficulties who are living in inappropriate housing situations; it also links with the broader rehabilitation & recovery theme; the external evidence review presents some examples of good practice from Ireland (e.g. HAIL-HSE projects in North Dublin) and other countries.**

2.12 Dual diagnosis

Rating based on 5-point scale

	--	-	-/+	+	++	Score
15.3.1						2
15.3.2						1
15.3.3						3
15.3.4						1
15.3.5						1
15.3.6						2

Simplified 3-point scale

15.3.1		-/+
15.3.2		-
15.3.3		+
15.3.4		-
15.3.5		-
15.3.6		-/+

Data

		HSE	MHR
15.3.1	15.3.1: Mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems.	A Service Improvement project has been established to implement this recommendation	
15.3.2	15.3.2: General adult CMHTs should generally cater for adults who meet these criteria, particularly when the primary problem is a mental health problem.	General adult CMHS follow this recommendation. Available data indicates that there are seven community mental health teams providing an enhanced addiction services.	
15.3.3	15.3.3: The post of National Policy Coordinator should be established to deliver national objectives and standards pertaining to primary care and community interventions for drug and alcohol abuse and their linkage to mental health services.	A National Policy coordinator has not been put in place; however a National Clinical Lead, a Programme Manager and a National Working Group have been put in place with mental health service engagement, primary care and other stakeholder involvement. to develop a Dual Diagnosis Clinical Programme	
15.3.4	15.3.4: Specialist adult teams should be developed in each catchment area of 300,000 to manage complex, severe substance abuse and mental disorder.	Specialist community teams designated to address complex, severe substance abuse and mental disorder have not been developed. HSE Mental Health Division in collaboration with the HSE Clinical Strategies and Programme Division had developed a National Clinical Programme in Dual Diagnosis (Mental Illness and Substance Misuse). In 2017 a National Clinical Lead, a Programme Manager and a National Working Group were developed, with mental health service engagement, primary care and other stakeholder involvement. It is envisaged that the Model of Care for this Clinical Programme will be completed within the second quarter of 2018, with a view to service development based on an agreed model of care. As part of the 2018 estimate process 20 posts have been sought	? status
15.3.5	15.3.5: These specialist teams should establish clear linkages with local community mental health services and clarify pathways in and out of their services to service users and referring adult CMHTs.	The model f care as described above will take this recommendation into account. (see 15.3.6)	
15.3.6	15.3.6: Two additional adolescent multidisciplinary teams should be established outside Dublin to provide expertise to care for adolescents with co-morbid addiction and mental health problems. This provision should be reviewed after five years.	Designated multidisciplinary teams set up for adolescents with co morbid addiction and mental health problems.	? status

Possible conclusions/commentary

Dual diagnosis

Recommendation	15.3.1	15.3.2	15.3.3	15.3.4	15.3.5	15.3.6
Rating						
	-/+	-	+	-	-	-/+

- **there has been progress on a number of aspects of the AVFC recommendations in this area, including establishment of a Dual Diagnosis Clinical Programme (links to 15.3.3)**
- **the external evidence review found examples of well-developed addiction services as part of MH services in countries such as NL (also SAMSHA in US); this aspect could be further developed in Ireland.**

2.13 Eating disorders

Rating based on 5-point scale

	--	-	-/+	+	++	Score
15.4.1						3
15.4.2						3
15.4.3						2
15.4.4						1
15.4.5						1
15.4.6						1
15.4.7						0
15.4.8						1

Simplified 3-point scale

15.4.1		+
15.4.2		+
15.4.3		-/+
15.4.4		-
15.4.5		-
15.4.6		-
15.4.7		-
15.4.8		-

Data

		HSE	MHR
15.4.1	15.4.1: Health promotion initiatives that support greater community and family awareness of eating disorders should be supported and encouraged.	Bodywhys, the national eating disorders association, who receives funding from the HSE co-ordinates an annual Eating Disorders Awareness Week to raise awareness and challenge stigma on eating disorders.	[as HSE doc]
15.4.2	15.4.2: The activities of voluntary agencies in promoting awareness and responses to eating disorders should be supported.	Bodywhys provides a range of support services, including a national helpline; face-to-face support groups; online support groups and an outreach programme.	[as HSE doc]
15.4.3	15.4.3: Special emphasis should be placed on including training modules on eating disorders in the undergraduate and postgraduate training of health professionals.	A National Clinical Programme has provided specialist training in Family Based Therapy and Specialist Cognitive Based Therapy for staff currently providing specialist eating disorder interventions.	
15.4.4	15.4.4: Eating disorders in children and adolescents should be managed by the child and adolescent should be managed by the child and adolescent CMHTs on a community basis, using beds in one of the five in-patient child and adolescent units if required.	Currently there are Specialist Eating Disorder services for children at Linn Dara Services in Dublin. Other CAMHS teams across the country provide support to children with eating disorders but not in a programmatic fashion	
15.4.5	15.4.5: There should also be a full multidisciplinary team in a National Centre for Eating Disorders, to be located in one of the national children's hospitals, for complex cases that cannot be managed by local child and adolescent CMHTs.	2016 a National Clinical Programme was developed by the HSE Mental Health Division in partnership with the HSE Clinical Strategies and Programmes Division, and Bodywhys, tasked with the development of high quality services for children and adults. It is envisaged that the Model of Care will be formally launched in January 2018.	Not yet established
15.4.6	15.4.6: There should be four specialist multidisciplinary teams providing specialist inpatient, outpatient and outreach services for eating disorders; one team per HSE region. These teams should link closely with local adult CMHTs to ensure continuity of care.	• Currently there are Specialist Eating Disorder services for adults (including inpatient bed provision) at St Vincent's University Hospital in Dublin, and for children at Linn Dara Services also in Dublin. • Under the model of care when implemented there will be a national n network of specialist eating disorder networks community team and special treatment beds	Needs further development
15.4.7	15.4.7: Each team should manage an eating disorder sub-unit in a regional general hospital mental health unit. These subunits should have six beds each, thereby contributing 24 public ED beds nationally.	• Eating disorder sub units in regional general hospitals mental health units have not been established • See 16.4.6 above	Not yet established
15.4.8	15.4.8: The four specialised multidisciplinary adult teams, and the national team for children and adolescents, should provide community based consultation, advice and support to all agencies in their area.	Based on the model of care a national provision has been designed and is in implementation at a level beyond what was envisaged in Vision for Change.	

Possible conclusions/commentary

Eating disorders

Recommendation	15.4.1	15.4.2	15.4.3	15.4.4	15.4.5	15.4.6	15.4.7	15.4.8
Rating								
	+	+	-/+	-	-	-	-	-

- **some recommendation areas have progressed, for example through HSE funding of Bodywhys (15.4.1, 15.4.2)**
- **there is a National Clinical Programme underway and this will produce a Model of Care to be followed nationwide; follow-through and continued attention to this area is important**

2.14 Liaison

Rating based on 5-point scale

	--	-	-/+	+	++	Score
15.5.1						3
15.5.2						3
15.5.3						1
15.5.4						2

Simplified 3-point scale

15.5.1		+
15.5.2		+
15.5.3		-
15.5.4		-/+

Data

		HSE	MHR
15.5.1	15.5.1: The existing provision of nine LMHS teams nationally should be increased to thirteen.	There are in excess of 13 liaison mental health teams in existence	
15.5.2	15.5.2: Complete multidisciplinary LMHS should be established in the three national children's hospitals.	3 Paediatric liaison mental health team have been developed in each of the Paediatric Hospitals in Dublin (Temple Street University Hospital, Our Lady's Crumlin and the Children's Hospital in Tallaght).	
15.5.3	15.5.3: Liaison child and adolescent mental health services should be provided by a designated child and adolescent CMHT, one per 300,000 population (see Chapter Ten).	• Child and adolescent mental health services are provided by CAMHS CMHTs • Referring to 15.5.2 the 3 Paediatric liaison teams have been developed as multidisciplinary teams	
15.5.4	15.5.4: One additional adult psychiatrist and senior nurse with perinatal expertise should be appointed to act as a resource nationally in the provision of care to women with severe perinatal mental health problems.	• Responding to service demands, the Mental Health Division is prioritising the development of specialist perinatal mental health services. • Model of Care for Specialist Perinatal Mental Health services launched in November 2017. • This Model of Care envisages specialist perinatal mental health teams based in the larger maternity units, with embedded specialist perinatal mental health resources in liaison mental health services in the other smaller maternity units across the country (19 in total). • In early 2018, 9 new specialist clinical posts will be developed in the specialist perinatal mental health teams of the larger maternity units	

Possible conclusions/commentary

Liaison

Recommendation	15.5.1	15.5.2	15.5.3	15.5.4
Rating	+	+	-	-/+

- **the HSE review document indicates that there has been progress in relation to hospital liaison services for adults and for children, hence the positive ratings for some recommendations (15.5.1, 15.5.2)**
- **however, a Mental Health Commission national overview from 2010 provides a profile of services at that time, and indicates various areas requiring improvement; this includes coverage of gaps in service in some parts of the country and a need for more consistency of approaches and funding arrangements; more generally, there is a lot of anecdotal evidence that presentation with acute MH problems at hospital ED continues to be a very problematic area**
- **this theme might be one for the Group to consider giving attention, perhaps linked to the broader issues around crisis support and aspects of recovery/rehabilitation, home-based treatment and assertive outreach teams' work in this area; the external evidence review report presents information on approaches in a number of other countries.**

2.15 Neuropsychiatry

Rating based on 5-point scale

	--	-	-/+	+	++	Score
15.6.1						0
15.6.2						0
15.6.3						0

Simplified 3-point scale

15.6.1		-
15.6.2		-
15.6.3		-

Data

		HSE	MHR
15.6.1	15.6.1 Two specialist neuropsychiatry multidisciplinary teams should be established in the major neuroscience centres in Dublin and Cork.	As part of the plan for the implementation of the National Neuro rehabilitation Strategy being developed by HSE Social Care Division, the HSE Mental Health Division has submitted a plan to develop Neuropsychiatric services	
15.6.2	15.6.2 As a national resource, a special neuropsychiatric in-patient unit with six to ten beds should be established	This Implementation Plan is currently being developed, and a presentation to the Minister for Health is planned for early December 2017	
15.6.3	15.6.3 Facilities for video-conferencing and telemedicine should be considered to extend the expertise located in these units nationally, and to enable them to become a consultation and training resource	This is being considered as part of the above Implementation plan	

Possible conclusions/commentary

Neuropsychiatry

Recommendation	15.6.1	15.6.2	15.6.3
Rating			
	-	-	-

- this has remained under-developed to date, although an Implementation Plan is expected to be launched in 2018

- one recommendation addressed video-conferencing and telemedicine in this area; this might be relevant for the Group in the context of its planned examination of the broader eMental Health field; the external evidence review report provides information on this; also, Mental Health Reform have funded a review of the eMental health field that is expected to be available in April of this year.

2.16 Suicide prevention

Rating based on 5-point scale

	--	-	-/+	+	++	Score
15.7.1						3
15.7.2						2
15.7.3						3
15.7.4						?

Simplified 3-point scale

15.7.1		+
15.7.2		-/+
15.7.3		+
15.7.4		?

Data

		HSE	MHR
15.7.1	15.7.1: There should be agreed protocols and guidelines for engaging with those assessed to be at high risk of suicidal behaviour, and for engaging with those who are particularly vulnerable in the wake of a suicide, within mental health care settings.	• The National Clinical Programme (NCP) for the Assessment and Management of Patients Presenting to Emergency Departments (ED) following Self-Harm was published in March 2016 • A Standard Operating Procedure has been published in order to aid services to establish the service locally and a review of the operation of the programme was published October 2017 • Funding for 35 clinical nurse specialists (CNSs) posts was made available. By 2017, 24 of the 26 adult EDs had a CNS delivering the NCP	
15.7.2	15.7.2: Particular care should be given to service users of mental health services who have been identified as being at high risk of suicidal behaviour e.g. those with severe psychosis, affective disorders, and individuals in the immediate aftermath of discharge from in-patient settings.	• Alongside the NCP and as part of the National Training Plan developed by the National Office for Suicide Prevention (NOSP), Safe Talk and ASIST training is available to caregivers, while STORM training is available to Clinical Staff in Mental Health Services • The Suicide Crisis Assessment Nursing (SCAN) service is fully or partly available in 6 CHOs, which offers support to GPs regarding access to assessment of patients who present to them in difficult circumstances with thoughts of suicide	
15.7.3	15.7.3 Integration and coordination of statutory, research, voluntary, and community activities is essential to ensure effective implementation of suicide prevention initiatives in the wider community. In this regard the National Office for Suicide Prevention should be supported and developed.	• Connecting for Life 2015–2020 (CFL) is the national strategy to reduce suicide. CfL has at its core a cross-cutting, whole-of-society approach, with a focus on integration and coordination of statutory and non-statutory services/activities • NOSP co-ordinates the implementation of CfL, which includes supporting a National Cross-Sectoral Steering and Implementation Group with representation from the health sector, government departments, agencies and NGOs • As part of CfL, local multi-agency suicide prevention action plans are being developed to enhance communities' capacity to respond to suicidal behaviour. it is expected that a total of 17 Local CfL Action Plans will be in place by end of Quarter 1 2018. To date, 10 Local CfL Action Plans have been launched.	
15.7.4	The strategies recommended in Reach Out to prevent suicide and to improve mental health provision for people engaging in suicidal behaviour should be adopted and implemented nationally.		

Possible conclusions/commentary

Suicide prevention

Recommendation	15.7.1	15.7.2	15.7.3	15.7.4
Rating				
	+	-/+	+	?

- there has been quite good progress on a number of the recommendation areas, and this should continue with the implementation of the Connecting for Life strategy; the National Office for Suicide Prevention has developed a number of programmes and initiatives; a National Clinical Programme on self-harm presentation in ED has been implemented; Clinical Nurse Specialists are available in most adult EDs; other initiatives include ASSIST and STORM, SCAN service for GPs in 6 CHOs, etc

- in the eMental health field there have been various developments of relevance for this domain; this might be interest for the Group's work on eMental health more generally.

2.17 Borderline personality disorder

Rating based on 5-point scale

	--	-	-/+	+	++
15.8.1					
15.8.2					

Simplified 3-point scale

15.8.1		-/+
15.8.2		-/+

Data

		HSE	MHR
15.8.1	15.8.1 The needs of people with mental health problems arising from or comorbid with borderline personality disorder should be recognised as a legitimate responsibility of the mental health service, and evidence-based interventions provided on a catchment area basis.	• The MHD has invested in Dialectical Behavioural Therapy (DBT) to support people who have been identified as a high risk of suicidal behaviour, including those with borderline personality disorder • The DBT model facilitates enhanced co-ordination of care, with a targeted evidence based intervention leading to better outcomes for clients, reduction in resource utilisation and reduction in demands on wider CMHTs staff time	
15.8.2	15.8.2: Specialised therapeutic expertise should be developed in each catchment area to deal with severe and complex clinical problems that exceed the available resources of generic CMHTs	• Through the National DBT Programme, additional teams and therapists have been trained in this model across CAMHS and Adult Mental Health Services, including advanced training for existing DBT team leaders to build capacity and grow local expertise • A gap analysis was completed in 2017 to identify need for further DBT teams in Adult and CAMHS Mental Health Services with a view to consider sustainable models for enhanced access to and sustainability of DBT in Mental Health Services • 50% of our general adult services provide access to DBT	

Possible conclusions/commentary

Borderline personality disorder

Recommendation	15.8.1	15.8.2
Rating		
	-/+	-/+

- the HSE review document points to the MH service investment in Dialectical Behavioural Therapy (DBT), and its relevance for people with borderline personality disorder amongst others
- however, the AVFC recommendations refer to an explicit recognition/focus on borderline personality disorder; this seems not to have been followed-up, as such (although it is taken up in relation to self-harm and suicide risk)?

2.18 Management & organisation

Rating based on 5-point scale

	--	-	-/+	+	++	Score
16.1						3
16.2						1
16.3						3
16.4						3
16.5						1
16.6						1
16.7						3
16.8						2
16.9						0

Simplified 3-point scale

16.1		+
16.2		-
16.3		+
16.4		+
16.5		-
16.6		-
16.7		+
16.8		-/+
16.9		-

		HSE	MHR
16.1	16.1 Mental Health Catchment Areas should be established with populations of between 250,000 and 400,000 with realigned catchment boundaries to take into account current social and demographic realities. These catchment areas should be coterminous with local health office areas and the new regional health areas. They should take into account the location of acute psychiatric in-patient units in general hospitals	The Community Mental Health services align currently to the Community Health Organisation (CHO) boundaries except for a variance CHO 6 & CHO 7 reflects the current coterminous anomaly between specialities. This anomaly will be resolved with alignment to the primary care network population catchments.	
16.2	16.2 Substantial upgrading of information technology systems should occur to enable the planning, implementation and evaluation of service activity	Provision of basic desktop technology is underway as part of the IT improvement plan for mental health services. An e-rostering solution will be in place in 2018 however implementation of an integrated mental health information system has not been possible as the HSE is required to prioritise the e-mental health record implementation through the new Paediatric hospital implementation. Because of this Plans are being developed to implement the existing national patient Integrated Patient Management Systems in acute hospitals across mental health services.	
16.3	16.3 A National Mental Health Service Directorate should be established, which includes senior professional managers, senior clinicians and a service user. The new National Mental Health Service Directorate should act as an advisory group and be closely linked with the management of the Primary and Continuing Community Care Division of the Health Service Executive	The Mental Health Division was established in 2013. It has operational and financial authority and accountability for all mental health services delivered by the HSE.	
16.4	16.4 Multidisciplinary Mental Health Catchment Area Management Teams should be established. These teams should include both professional managers and clinical professionals along with a trained service user and should be accountable to the National Care Group Manager and the National Mental Health Service Directorate.	Area Mental Health Management Teams have been established in each CHO Area. The role of Area Mental Health Management Teams is to provide leadership, direction and support to services locally in the achievement of the targets.	
16.5	16.5 Community Mental Health Teams should self-manage through the provision of a team coordinator, team leader and team practice manager	The Team Coordinators have been appointed in a number of both General adult and CAMHS teams and there is an improvement plan in place to ensure enhanced and standardised implementation across the teams	

		HSE	MHR
16.6	16.6 Community Mental Health Teams should be responsible for developing costed service plans and should be accountable for their implementation.	• As part of the national planning process community mental health teams submit their prioritised development requirements to their area mental health team for submission as part of the consolidated national mental health costed service plans • As part of the national accountability framework and associated performance management processes community and area teams report nationally on implementation of approved developments • The National Mental Health Division has put in place since 2015 a programmatic approach to the development and improvement of services, appointed dedicated service improvement leads and agreed a single directory of services	
16.7	16.7 A management and organisation structure of National Mental Health Service Directorate, a multidisciplinary Mental Health Catchment Area Management Team and local, self-managing CMHTs, should be put in place.	These governance structure are all in place and report to the local Heads of Service for Mental Health and the HSE Mental Health Division on progress on a regular basis. They are comprised of multidisciplinary members and generally include a Business Manager, Principal Psychologist, Director of Nursing, Executive Clinical Director, an Occupational Therapy Manager, and a Principal Social Worker	
16.8	16.8 Mental Health Catchment Area Management Teams should facilitate the full integration of mental health services with other community care area programmes. This should include the maximum involvement with self-help and voluntary groups together with relevant local authority services.	Mental health services in Ireland are integrated with primary care, acute hospitals, services for older people, services for people with disabilities and with a wide range of community partners. Services are provided in a number of different settings including health centres, day hospitals, inpatient units and in the service user's own home. Services are provided by a range of statutory and non-statutory providers	
16.9	16.9 Community Mental Health Teams and Primary Care Teams should put in place standing committees to facilitate better integration of the services and guide models of shared care.	This recommendation will be progressed through the proposed primary care network and team implementation	

Possible conclusions/commentary

Management & organisation

Recommendation	16.1	16.2	16.3	16.4	16.5	16.6	16.7	16.8	16.9
Rating	+	-	+	+	-	-	+	-/+	-

- at an overall structural level, there has been quite good progress against some AVFC recommendations (at the time of preparation of this report, when the HSE Mental Health Division was operational)
- however, there has been less progress at Community Mental Health Team (CMHT) level, including limited implementation of team coordinators, as well as various issues already flagged in relation to primary care, general adult and other core service components
- the Group might consider giving attention to these key issues at CMHT level, as well as the need for integration of all levels of service; IT systems also need much further development.

2.19 Investment in future

Rating based on 5-point scale

	--	-	-/+	+	++	Score
17.1						0
17.2						2
17.3						2
17.4						0
17.5						2
17.6						2
17.7						2
17.8						1
17.9						1

Simplified 3-point scale

17.1		-
17.2		-/+
17.3		-/+
17.4		-
17.5		-/+
17.6		-/+
17.7		-/+
17.8		-
17.9		-

		HSE	MHR
17.1	17.1 Substantial extra funding is required to finance this policy. A programme of capital and noncapital investment in mental health services as recommended, adjusted in line with inflation, should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services	• Based on 2005 figures Vision for Change stated that the non-capital investment needed would result in mental health receiving approximately 8.24% of the health budget. The current percentage is 6.3%, excluding mental health community drug costs. • The total revenue budget for Mental Health in 2017 is €867.8m including the development funding. This represents 6.3% of overall health spend. The budget for mental health in other countries internationally is comparably higher, with Britain and Canada allocating 12% of their health budget to mental health and New Zealand allocating 11%. The recent SlainteCare report recommends 10% for Ireland. • Programme for Government funding 2012-2017 has provided an additional €175 million to invest in modern mental health services (See appendix 12 for further breakdown)	
17.2	17.2 Capital and human resources should be remodelled within re-organised catchment-based services to ensure equity and priority in service developments.	• Vision for Change recommendations regarding alignment of teams to populations- see section 5 above • The Mental Health Division have developed a deprivation adjusted population based resource allocation model to inform decision making on the use of funds • Mental health has benefited from the 'sell to reinvest' policy which involved the capital funds arising from the sale of former mental health facilities being reinvested in new mental health facilities across the country	
17.3	17.3. Other agencies must take up their responsibilities in full so mental health services can use their funding for mental health responsibilities. Mental health services should not provide the broad range of services which are more appropriately provided elsewhere.	Since the inception of the Division mental health funding has been ring-fenced for appropriate mental health service development including capacity building for mental health promotion and early intervention	
17.4	17.4. Approximately 1,800 additional posts are required to implement this policy. This significant non-capital investment will result in mental health receiving approximately 8.24% of current, non-capital health funding, based on 2005 figures.	• Adjusted for 2016 population the Vision for Change recommended staffing levels are 12,354.Currently staffing levels are at 80% of this recommendation (9,767 WTE) • Funding currently represents 6.3% of the overall health budget	Decrease in wtes since 2008?
17.5	17.5. Recognition must be given to the need for extra funding for areas that exhibit social and economic disadvantage with associated high prevalence of mental ill health.	• See 17.2 above regarding deprivation adjusted resource allocation • As part of the PFG funding since 2012 there has been targeted initiatives towards improving the mental health of priority groups such as travellers, homeless etc.	

		HSE	MHR
17.6	17.6. Resources, both capital and revenue, in the current mental health service must be retained within mental health.	See 17.3 above which references ring fencing of budget since establishment of Mental Health Division	
17.7	17.7. The full economic value of psychiatric hospital buildings and lands should be professionally assessed and realised.	See 17.2 above and in fact the investment in mental health facilities arising from the HSE capital plans has exceeded that generated through the resale of psychiatric hospital buildings	
17.8	17.8. Provision of community mental health centres as service bases for multidisciplinary community mental health teams should be given priority.	This has been implemented through the development of community teams located in a range of community and primary care settings nationally	
17.9	17.9. The comprehensive and extensive nature of the reorganisation and financing of mental health services recommended in this policy can only be implemented in a complete and phased way over a period of seven to ten years.	The development of services has taken place at a slower pace than envisaged by Vision for Change due in part to the post publication recessionary years and the challenge of recruitment	

Possible conclusions/commentary

Investment in the future

Recommendation	17.1	17.2	17.3	17.4	17.5	17.6	17.7	17.8	17.9
Rating	-	-/+	-/+	-	-/+	-/+	-/+	-	-

- it is difficult to rate some of the recommendations under this theme, and it is not clear how many of them are helpful to revisit at this point in time
- overall, a core issue is the continued under-funding of mental health, both against the targets set in AVFC and in comparison to funding in countries with more developed mental health systems
- this is a theme that the Group may wish to give attention to; however, the resource allocation perspective could be more sophisticated than in AVFC, for example looking at issues around the 'balance of care', where money is currently and/or should be spent (in some countries the data suggests that a relatively small number of clients consume a large share of resources); also relevant are issues around the responsibilities of other sectors (housing, employment, education, social protection etc.) to contribute their share – MH spending is an investment that benefits these sectors; the external evidence review reports addressed a number of these aspects.

2.20 Manpower, education & training

Rating based on 5-point scale

	--	-	-/+	+	++	Score
18.1						2
18.2						2
18.3						1
18.4						2
18.5						2
18.6						2
18.7						2
18.8						2
18.9						2
18.10						1
18.11						2
18.12						?
18.13						?
18.14						?
18.15						?
18.16						?
18.17						?
18.18						?
18.19						?
18.20						?
18.21						?
18.22						?
18.23						?
18.24						2
18.25						1
18.26						?
18.27						?
18.28						?

Simplified 3-point scale

18.1		-/+
18.2		-/+
18.3		-
18.4		-/+
18.5		-/+
18.6		-/+
18.7		-/+
18.8		-/+
18.9		-/+
18.10		-
18.11		-/+
18.12		?
18.13		?
18.14		?
18.15		?
18.16		?
18.17		?
18.18		?
18.19		?
18.20		?
18.21		?
18.22		?
18.23		?
18.24		-/+
18.25		-
18.26		?
18.27		?
18.28		?

		HSE	MHR
18.1	18.1. Education and &Training should be directed towards improving services as a primary goal and must have the welfare of service users as its ultimate objective.	The Mental Health Division recognises and acknowledges the workforce as key to service delivery. The Division continues to cultivate, develop and sustain its workforce to be committed to service user recovery orientated services	
18.2	18.2. Training programmes should emphasise the acquisition of skills that are clinically meaningful, should train personnel for leadership and innovative roles, and should foster an attitude of critical enquiry and self-scrutiny in relation to service delivery.	• The HSE has developed a range of training and education programmes for staff supported through the HR Division • An example of these ranges from local clinical skills training, to HSE Leadership Academy to the sponsorship of staff to attend Leadership and Management courses in Universities	
18.3	18.3. There should be centralisation of the planning and funding of education and training for mental health professionals in new structures to be established by the HSE in close association with the National Directorate of Mental Health Services. This centralised E&T authority should be constituted to represent stakeholder and service user interest and E&T bodies representing all disciplines.	The People Strategy 2015-2018 has been developed in recognition of the vital role the workforce plays in delivering safer and better healthcare. The Division will continue to support the implementation of the priorities as set out in the strategy, which is underpinned by the commitment to engage, develop, value and support the workforce. The Division will engage with developments in Workforce planning, Learning & Development and Coaching and Mentoring with National HR	
18.4	18.4. The HSE should commit itself to adequate, rational and consistent funding of E&T. However the accreditation of courses should remain the responsibility of the respective professional bodies.	• The HSE recognises the central role education, training and development plays in supporting good practice, and delivering safe and effective care whilst considering the development needs of all individuals. • The HSE Mental Health Division supports the delivery of specific training and development initiatives through the Mental Health Hub on HSE Land and has recently launched online and face to face training on the Best Practice Guidance. • Mental Health Division has worked with professional bodies in the development of further training for specific groups e.g. postgraduate nursing in mental health	
18.5	18.5. Funding of HSE sponsored training courses should be established on a secure basis to allow for expansion and development of these courses and to ensure manpower requirements in mental health services can be met in coming years.	• Reference 18.4 and 18.6 • In addition mental health division has invested in additional undergraduate nurse training places, additional advance nurse practitioner places and trainee clinical psychology to ensure enhance supply of staff to meet increased demand for mental health services	

		HSE	MHR
18.6	18.6. A multi-profession manpower plan should be put in place, linked to projected service plans. This plan should look at the skill mix of teams and the way staff are deployed between teams and geographically, taking into account the service models recommended in this report, and should be prepared by the National Mental Health Service Directorate working closely with the Health Service Executive, the Department of Health and Children and service providers. This should include consideration of a re-allocation of resources working group to ensure equitable distribution of manpower resources across the four regions.	• The Mental Health Division has established a Workforce Action Plan and a Workforce Planning Steering Group. The Workforce action Plan is aimed at the development of existing staff and recruitment of new staff in meeting our critical staffing needs to deliver a safe and quality mental health service aligned to the agreed model of care. • At the end of December 2016 there were 9,594 WTE positions in place delivering Mental Health Services. The funded workforce also includes agency and overtime expenditure. The funded workforce for Mental Health Services 2017 provides for as many as 11,077 WTEs, including conversion of all overtime and agency. The aim is to provide for a stable workforce which will support the continuity of care required for safe, integrated service delivery. This requires an integrated approach, with service management being supported by HR and Finance.	
18.7	18.7. Family friendly staff policies and flexible rostering with provision of suitable child care facilities is an important issue for the recruitment and retention of staff, as is help with housing, particularly for foreign nationals.	In addition to generous annual leave entitlements, the HSE also has a variety of other leave arrangements available to employees such as family friendly working arrangements, paid sick leave etc. This section sets out the leave arrangements and payments for such leave which apply in the HSE. Some leave types may not apply to all employee categories. Annual Leave; Public Holidays; Sick leave; Serious Physical Assault Scheme; Compassionate Leave; Shorter Working Year Scheme; Elected Representatives of Local Authorities. Details of other leave entitlements listed below can be found in the HSE Terms and Conditions of Employment on the HSE website. Maternity Leave including Health & Safety Leave; Adoptive Leave; Paternity leave; Paternal Leave; Force Majeure Leave; Carer's leave; Special Leave with Pay on Marriage; Career Breaks; Special Leave with Nominal Pay; Leave for Deployment with the Rapid Response Corps; Leave for Trade Union Representatives; Study Leave; Reserve Defence Forces; Other Types of Leave	
18.8	18. 8. A flexible retirement package should be considered to make the best use of valuable experienced staff. This would enable staff nearing retirement to move into part-time work without reducing pension benefit or to retire while carrying on with full or part-time work. Staff earlier on in their career should be able to take a career break and still contribute to their pension benefits.	• See 18.7 above as all HSE leave and arrangements apply equally to mental health staff • Flexible working arrangements are in place pre-retirement in addition to retired staff being allowed to be rehired up to a limited number of hours without affecting their pension arrangements.	
18.9	18.9. Future manpower requirements must be driven by service requirements rather than historical factors and should not be wedded to the perceived needs of any single discipline.	• Workforce plans are developed in line with existing and new models of care and include the development of newer staff types such as peer support workers which significantly enhance the service response • Based on the current staffing levels in October 2017, another 1,137 staff are required to fill the current gap in staffing levels to get to 100% of the Vision for change recommendations for the Community Services. The cost to fill this gap based on an approximate average salary along with associated cost (PRSI, allowances etc) is almost €98 million before conversion of agency and overtime costs currently at an equivalent of in excess of 1,000 WTEs (see table 13.1 below).	

		HSE	MHR
18.10	18.10. Within the context of overall service changes, many currently employed staff will need to redefine their role in the light of the development of new community-based teams focusing on early intervention, assertive outreach, crisis resolution and home treatment. Appropriate training should be available for affected staff.	• The Lansdowne Road Agreement, concluded in May 2015, represents an extension of the Haddington Road Agreement (HRA) until 2018. The enablers under these agreements will continue to be used to effect the transformation of the workforce and organisational change. This will involve skill mix initiatives; systematic review of rosters; de-layering management structures; restructuring and redeployment of existing workforce; new organisation structures and service delivery models. The Division will support service delivery to shape a workforce that is more adaptable, flexible and responsive to needs of the services, while operating with lower pay expenditure costs and within allocated pay envelopes	
18.11	18.11. A personal training and development plan or equivalent should be introduced for all grades of staff in the mental health services. This should help managers set priorities for the use of resources in order to meet common needs more efficiently, organise staff release and target and schedule in house education and training. In this regard it is also important to make available clear information about routes to employment training and career progression within the mental health service	• The HSE has made available Online Personal Development Planning (PDP) to staff to advance both the performance of the organisation and that of its individual staff. They have also recently launched a new online e-learning programme to help managers prepare their own PDP. • The HSE has published a Performance Achievement Framework • Clinical supervision also provides for professional development	
18.12	18.12. The quality and scope of undergraduate medical education programmes should be reviewed and the recommendations of the Fottrell report to increase intake should be adopted		
18.13	18.13. Current steps to revise post graduate training in psychiatry should be undertaken with a view to increasing the number of graduates in this speciality and equipping them with the range of skills required within the proposed restructured mental health service		
18.14	18.14. The GP training body and the psychiatry training body should jointly review all issues in relation to mental health training for GPs		
18.15	18.15. A common foundation core programme for all student nurses, followed by specialist training up to the point of registration as a psychiatric, intellectual disability or general nurse should be given serious consideration. In the interim, shortened training should be available for all qualified nurses wishing to register in any of the other nursing disciplines		

		HSE	MHR
18.16	18.16. The recommendations of the Nursing and Midwifery Resource, July 2002, Final report of the Steering group *Towards Workforce Planning* should be implemented in full and further developed on a multidisciplinary basis		
18.17	18.17. The number of psychiatric nurses in training should be kept constantly under review to allow scope for future development of general adult, child and adolescent and other specialist mental health services and primary care teams		
18.18	18.18. The sponsorship scheme for experienced care assistants to train as nurses should be maintained and extended to ensure appropriate, mature applicants are attracted into the psychiatric nursing profession		
18.19	18.19. There is no official requirement to involve users and carers in the education and training of psychiatric nurses. It is recommended that service users and carers should be consulted and involved in the development of educational programmes		Some developments (e.g. TCD, DCU, Irish College of Psychiatrists, but still limited
18.20	18.20. Specialist and advanced nurse practitioner roles for nurses in intellectual disability should be developed in response to identified needs of people using the service		
18.21	18.21. A mental health training module should be mandatory and standardised in social work training to ensure all staff especially those without practice experience have a basic understanding of mental health issues and mental health services		
18.22	18.22. A significant increase in the number of funded postgraduate training places for clinical psychology is needed urgently to fill the current shortfall and meet projected manpower requirements. Additional appointments at senior grade should be established to facilitate supervised clinical placements for those in training. the use of the Assistant Psychologist grade as a career step should also be considered		
18.23	18.23. In order to increase the attractiveness of mental health social work and occupational therapy posts, existing deficiencies in terms of professional and geographical isolation, lack of supervision and poor facilities should be addressed		
18.24	18.24. It is recommended that the position of mental health support worker be established in the mental health system to support service users in achieving independent living and integration in their local community		Peer support workers – is this mental health support worker role??
18.25	18.25. Advocacy training programmes should be encouraged and appropriately financed		Some training programmes available
18.26	18.26. A National Manpower Planning group should be established to make recommendations regarding the education, training and workforce issues arising from this report, with reference to clinical psychology, counselling psychology and psychotherapy		
18.27	18.27. A variety of programmes should be in place for the workplace such as induction programmes, health and safety programmes (for example, cardio-pulmonary resuscitation) and training in conducting staff appraisals.		
18.28	18.28. The establishment of structured, accredited training courses and other measures to support and encourage volunteering in the mental health service should be considered within the broad context of education and training.		

Possible conclusions/commentary

18.1		-/+
18.2		-/+
18.3		-
18.4		-/+
18.5		-/+
18.6		-/+
18.7		-/+
18.8		-/+
18.9		-/+
18.10		-
18.11		-/+
18.12		?
18.13		?
18.14		?
18.15		?
18.16		?
18.17		?
18.18		?
18.19		?
18.20		?
18.21		?
18.22		?
18.23		?
18.24		-/+
18.25		-
18.26		?
18.27		?
18.28		?

Manpower, education and training

- the documents available for this exercise appear to omit a considerable number of the AVFC recommendations on this theme
- overall, it seems that many of the recommendations on this theme in AVFC may not be especially relevant today, at least not in the way they were stated at that time
- there are clearly important manpower issues at present, as evidenced in the problems to recruit various categories of professional
- there are also issues around education/training in recovery approaches; so far, the focus appears to be on principles and 'softer' skills; it might be useful to develop a more operational focus as well, spelling out in concrete terms what recovery supports (therapeutic and other) should be applied across the spectrum of client presentations and needs, and what this means for clinical practice for the professionals concerned
- another important area is the manpower and skills base for delivering at scale (a range of) psychological therapies for common mental health conditions; experiences under programmes such as the IAPT in England may provide insights, as well as initiatives in the Netherlands to encourage availability of mental health staff (e.g. mental health nurses) in primary care practices.

2.21 Information and research

Rating based on 5-point scale

	--	-	-/+	+	++	Score
19.1						1
19.2						0
19.3						1
19.4						?
19.5						1
19.6						2
19.7						0
19.8						1
19.9						0
19.10						0
19.11						?
19.12						?
19.13						?

Simplified 3-point scale

19.1		-
19.2		-
19.3		-
19.4		?
19.5		-
19.6		-/+
19.7		-
19.8		-
19.9		-
19.10		-
19.11		?
19.12		?
19.13		?

		HSE	MHR
19.1	19.1. Service users and carers should have ready access to a wide variety of information. This information should be general (e.g. on mental health services in their area) and individualised (e.g. information on their medication).	See recommendations 3.1-3.10 above	
19.2	19.2. The HIQA should put mechanisms in place to carry out systematic evaluations on all forms of interventions in mental health and this information should be widely disseminated.	Mental Health Commission remain the regulatory body for mental health services and carry out annual inspections of mental health facilities with published reports and recommendations	
19.3	19.3. Measures should be put in place to collect data on community-based mental health services.	• See recommendation 16.6 and appendix 5 • The Mental Health Division currently collects data monthly on community-based mental health services and this data is reported against the National Service Plan • The National Service Plan 2017 (NSP 2017) sets out the type and volume of health and personal social services to be provided by the Health Service Executive (HSE) in 2017, within the funding available to the HSE.	
19.4	19.4. In accordance with the recommendation in the National Health Information Strategy, an electronic patient record (EPR) should be introduced with a unique identifier for every individual in the state.	See recommendation 16.	
19.5	19.5. A national mental health minimum data set should be prepared, in consultation with relevant stakeholders.	To comply with the monthly performance accountability framework the Mental Health Service developed a suite of metrics and number of Key Performance Indicators (KPI's) a list of these are available on http://www.hse.ie/eng/services/publications/KPIs/	
19.6	19.6. Mental health services should implement mental health information systems locally that can provide the national minimum data set to a central mental health information system	• Development of new models of care e.g. clinical care programmes, service improvement initiatives and best practice guidance are informed by evidence based research • The Mental Health Division provide funding of research based activities as part of their overall funding to organisations such as, NSRF – suicide research foundation, mental health reform, ICGP, Jigsaw etc	
19.7	19.7. A national morbidity survey should be carried out to determine the prevalence of mental health [problems in the population		

		HSE	MHR
19.8	19.8. Research should focus on mental health services – outcomes, policy and service, and economics – creating an evidence base for mental health care.	Not progressed however see 19. 6 above	
19.9	19.9. The recommendations of the Health Research Strategy should be fully implemented as the first step in creating a health research infrastructure in the health services.	Not progressed	
19.10	19.10. A national mental health services research strategy should be prepared.	With reference to recommendations under Chapter 3 service users families and carers will coproduce any emerging research commissioned by the mental health division	
19.11	19.11. Dedicated funding should be provided by the Government for mental health service research.		
19.12	19.12. People with experience of mental health difficulties should be involved at every stage of the research process including 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.		
19.13	19.13. Mental health research should be part of the training of all mental health professionals and mental health services should be structured to support the ongoing development of these skills		

Possible conclusions/commentary

Information and research

Recommendation	19.1	19.2	19.3	19.4	19.5	19.6	19.7	19.8	19.9	19.10	19.11	19.12	19.13
Rating													
	-	-	-	?	-	-/+	-	-	-	-	?	?	?

- **it is well-recognised that this is a very under-developed area in Ireland**
- **this is a theme that the Group may wish to consider addressing; the external evidence review report provides material on information and data approaches in other countries (e.g. to collect prevalence, service usage, and outcomes data) as well as analyses of the return on investment (and in which sector it accrues) from expenditure on different interventions.**

2.22 Transition and transformation

Rating based on 5-point scale

	--	-	-/+	+	++	Score
20.1						1
20.2						3
20.3						2
20.4						2
20.5						2

Simplified 3-point scale

20.1		-
20.2		+
20.3		-/+
20.4		-/+
20.5		-/+

		HSE	MHR
20.1	20.1. It will be the responsibility of the HSE to ensure the implementation of this mental health policy. The key recommendations of the policy must be seen as inter-related and interdependent and should be implemented as a complete plan.	Although significant progress has been made towards meeting many of the 209 recommendations of the group, this has been done whilst services were affected by recession and more recently recruitment challenges	
20.2	20.2. The National Mental Health Service Directorate, in conjunction with the HSE, should put in place advisory, facilitatory and support capacity to assist the change process.	The HSE Mental Health Division was established in 2013	
20.3	20.3. The first steps that should be taken to implement this policy include the management and organisational changes recommended in Chapter Sixteen and the provision of training and resources for change.	• See Section 11 • Mental Health has also moved to a recovery oriented framework which heralds a significant move away from an era of paternalism to recovery and self-determination. Recovery is one of the Mental Health Divisions main strategic priorities and a National Recovery Framework 2018 – 2020 was published in November 2017.	
20.4	20.4. Mental hospitals must be closed in order to free up resources to provide community-based, multidisciplinary team-delivered mental health care for all. A plan to achieve this should be put in place for each mental hospital.	The process of deinstitutionalisation and move to community care in mental health services has been well progressed in the 11 years since the publication of AVFC and there has been a significant decrease in the amount of psychiatric beds. The number of beds in inpatient facilities has dropped from 1,300 in 2006 to 1,018 in 2016 (Population also increased during this period by a half a million people 12%)	
20.5	20.5. An independent monitoring group should be appointed by the Minister for Health and Children to oversee the implementation of this mental health policy.	• In January 2006, the Government adopted the Report of the Expert Group on Mental Health Policy A Vision for Change as the basis for the future development of mental health services in Ireland. In March 2006, the then Minister of State at the Department of Health and Children, Mr. Tim O'Malley, T.D., with special responsibility for mental health services, in line with the recommendation in AVFC, established the First Independent Monitoring Group for a three year period to monitor progress on the implementation of the report recommendations • Responsibility for its continuation or other fora remains with Department of Health	

Possible conclusions/commentary

Transition and transformation

Recommendation	20.1	20.2	20.3	20.4	20.5
Rating					
	-	+	-/+	-/+	-/+

- to a certain extent there has been progress on this theme since AVFC, with the establishment of the MH Directorate and other new structures, de-institutionalisation, and so on
- it is not clear how relevant the specific recommendations in AVFC are today
- it is likely that the Group will give attention to the required next stage of improvement and transformation of the mental health services and supports system in Ireland; this may involve consolidation of and building on progress against AVFC to date where appropriate, but also revamping perspectives and priorities to better reflect the situation today, good practice in other countries, etc.
- one issue for consideration might be how to complement the general recovery-oriented principles and perspectives in the National Recovery Framework (and associated activities such as ARI, recovery colleges, service user engagement, peer support workers) with operationally useful guidance for the day-to-day work of the range of practitioners in the MH services (psychiatrists, nurses, psychologists, social workers, OTs etc); a useful approach might be to prepare practice guidance/examples based on vignettes showing the practical application of recovery-principles by the relevant professionals in care planning and care pathways, covering a range of client groupings with different presenting conditions and needs.