



Rialtas na hÉireann
Government of Ireland

Sharing the Vision

A Mental Health Policy for Everyone



Prepared by the Department of Health
health.gov.ie

Sharing the Vision

A Mental Health Policy
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Glossary of Abbreviations

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

A Note on Terminology

Assertive outreach

The assertive outreach teams provide intensive support for a person with complex needs. The teams aim to support the person to get help from other services. This support can help the person to manage their condition better and reduce the person's chances of going back to hospital.

Crisis resolution

Crisis Resolution (CR) offers after-hours and urgent mental health assistance. Crisis Resolution is an integral part of each community mental health team, providing 24-hour advice and assessment for people presenting in crisis associated with a known or suspected mental health problem.

Digital health

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

Dual diagnosis

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

Dual diagnosis may also refer to someone who has a mental health difficulty alongside an intellectual disability, autism or both.

Mental health difficulty

The term 'mental health difficulty' has been used throughout to describe the full range of mental health difficulties

that might be encountered, from the psychological distress experienced by many people, to severe mental disorders that affect a smaller population.

Peer support

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

Recovery colleges

Recognising that people can and do recover from mental health distress, recovery colleges work to create an empowering and inclusive culture of recovery and acceptance in the community through the provision of person-centred, strengths-based holistic learning, underpinned by values of self-determination, choice and human rights. Recovery college courses are designed and delivered by people with experience of overcoming mental health distress in partnership with other key stakeholders including supporters such as family members and friends, and professionals, using a process of co-production. Recovery colleges promote a culture of recovery in Irish society and throughout mental health services, to empower individuals and communities to embrace and overcome mental health challenges collectively; to improve quality of life; and to promote acceptance, community involvement and opportunity for advancement.

Referral pathway

A patient referral pathway is the process by which a patient is referred from one doctor to another. Normally you do not see specialists without a referral from a generalist (i.e. family doctor).

Scope of practice

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

Social prescribing

Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.

Talking therapies

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

Trauma-informed care

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



Message from Minister



The publication of the *Vision for Change* mental health policy in 2006 set a high standard for the development of mental health policy in Ireland. As a result, there have been many important changes in the past decade aimed at improving people's health and wellbeing. In recent times, mental health has received much attention. The outbreak of COVID 19 throughout the world created significant stress, anxiety, worry and fear for many people. The disease itself was further compounded by other impacts such as social isolation, disruption to daily life, uncertainty about employment and financial security. The Government response was rapid and a whole-of-population plan was put in place to support healthcare staff and the general population by providing health and wellbeing advice, resilience based training and providing free online interventions such as counselling and crisis texting for all in need. Indeed, the ability to create additional online interventions to augment existing services with such a wide reach, has in many ways changed how we treat the mild to moderate mental health needs of the population. In many ways the pandemic assisted Ireland to improve public attitudes to mental health because of the statutory, voluntary and community commitment to raising awareness and creating positive changes in how Ireland thinks about and delivers mental health services.

This policy has been developed following a process of research and consultation where international evidence was examined and where those consulted provided the Oversight Group with information about what they would like to see prioritised in the refreshed policy. Based on this approach, the areas that people felt were important to them were identified. This prompted the development of this action-oriented, outcome-focused policy, which adopts a lifecycle approach that places the individual at the centre of service delivery.

Our good health is very precious to us all. Mental health particularly requires a range of commitments and responses to ensure good outcomes. Within this outcome-based framework, high-level outcomes have been set that will deliver improved benefits for everyone.

I would like to thank all of those who generously gave their time and knowledge to engage in this very valuable process. A special thank you to the Oversight Group members, ably chaired by Hugh Kane, and to all those who came to the consultations to provide essential input that helped shape this service user-centred policy.

As Minister with responsibility for mental health, I am encouraged that this policy is wide-ranging and innovative. It promotes early access to support in various locations and seeks to provide individualised care to those who need help as soon as possible. This policy builds on existing services and provides a framework that will seek to measure implementation. There are many challenges ahead, but I am very confident that *Sharing the Vision* will improve the mental health of the nation significantly over the next ten years and beyond as long as we all remain dedicated to working together.

A handwritten signature in blue ink that reads "Jim Daly". The signature is fluid and cursive, with a prominent flourish at the end of the name.

Jim Daly
Minister for Mental Health and Older People



Chapter 1

Background and Context

Introduction

The publication of *A Vision for Change* (2006) represented an important milestone in the development of mental health policy in Ireland. Many significant changes and improvements have taken place over the lifetime of the policy since 2006. Although *A Vision for Change* (AVFC) has supported significant development over the past 13 years, we have much more to do in developing stronger, more appropriate mental health supports at community and primary care levels and in developing robust and reliable services and ensuring effective use of appropriate inpatient care.

The economic decline experienced in Ireland in 2008 influenced the ability of the State to fund the original AVFC policy to anticipated levels; however, between 2012 and 2020, the HSE Mental Health Services base increased by €315m, or around 44%, with €233.6m of this funding new developments. AVFC did not include a framework by which to measure outcomes or assess the impact of the recommendations over the lifetime of the policy; therefore the significant growth within mental health services is demonstrated by increased activity, improved access and other outputs, some of which are highlighted below:

- Between 2012 and 2018, there was an increase of 24% in the number of referrals accepted by Child and Adolescent Mental Health Services (CAMHS). While waiting lists increased by just 4% over the same period, it is noted that the CAMHS waiting list reduced by about 20% between December 2018 and August 2019. Increased access to CAMHS is supported by the additional staffing of CAMHS teams between 2008 and 2017.
- In line with national policy to enhance community services there has been a decrease in admissions to adult acute inpatient units over the lifetime of AVFC. Acute hospital admissions were reduced by 4,138 between 2008 and 2017 and the

re-admission rate was reduced by 8%. This indicates that the shift from institutional care to community care has progressed.

- Overall, mental health staffing has increased with an additional 1,700 new-development posts since 2012, and increased mental health capacity has been built into primary care to help relieve pressures on CAMHS services.
- Four National Clinical Programmes (NCPs) for mental health are in various stages of design and implementation:
 - (i) Assessment and management of service users presenting to emergency departments following self-harm;
 - (ii) The national clinical programme for eating disorders;
 - (iii) An early intervention in psychosis model of care; and
 - (iv) The establishment of a multi-disciplinary national working group to progress an NCP for ADHD in adults.
- Voluntary and community services have also seen improved access and increased activity. Non-governmental organisations (NGOs) have supported individuals by providing workshops and training on healthy living, mental health awareness, resilience and mental health first aid, and by building inclusivity and cohesion. Importantly the development of peer support and service user involvement at national level has ensured that the voice of those using services is heard and incorporated into service provision.

Ireland has changed significantly since AVFC was first published in 2006 and our understanding of mental health has improved greatly in that time. *Sharing the Vision* is a policy that builds upon the good work achieved over the past decade and it will provide a framework for investing in a modern, responsive mental health service fit for the next ten years. Work began in 2016 on this process

¹ Kevin Cullen and David McDaid. Evidence Review to Inform the Parameters for a *Refresh of A Vision for Change* (AVFC) – A wide-angle international review of evidence and developments in mental health policy and practice (Dublin: WRC and LSE, 2017).

The refresh process

AVFC came to the end of its ten-year term in 2016 and preparations for a review and update of the policy commenced with the commissioning in February 2017 of an Expert Evidence Review by the Work Research Centre (WRC) to inform the parameters of the planned refresh of mental health policy in Ireland.¹ The approach encompassed a stock-take of recent success in mental health and a review of international developments, innovation, evidence and good practice. The review had a broad brief covering the various dimensions of the mental health terrain that might have relevance for informing the refresh of mental health policy in Ireland.

The key priorities that emerged out of the review were:

- The prioritisation of mental health in Ireland as a major societal issue
- The importance of primary prevention and positive mental health
- A requirement to focus on social inclusion and recovery
- Expansion of mental health services to address the spectrum of conditions and needs
- Development of governance and financing to include research, evaluation and quality assurance

The WRC completed a supplementary paper to build on the work in the External Evidence Review, which identified specific policy changes for which a requirement may have arisen since AVFC was drafted.² The review identified policy themes that may require attention in the refresh such as the identification of vulnerable groups and associated actions not mentioned in the previous policy. The report also sought to consider new policy areas including a wider focus on education and prevention, and the wider use of accredited digital health interventions. In addition, the report sought to evaluate each recommendation from the previous policy and to rate progress to date on what actions were implemented, what relevant actions remained and what actions were no longer needed. Both WRC reports assisted in identifying priority areas for the newly formed Oversight Group to consider as they drafted their report for the Department of Health.

Oversight Group

As part of the Refresh process, and in line with a commitment given in Dáil Éireann, an Oversight Group (OG) was established in October 2017 to provide a report to the Department of Health setting out current and future service priorities for consideration by government in the development of a successor policy to AVFC. This report was required to take account of existing mental health policy and to have regard to the Expert Evidence Review of international best practice and progress on current service developments in Ireland. The Oversight Group was chaired by Mr Hugh Kane, with a membership reflecting service users, advocacy groups, service providers, operational managers, and primary care and mental health clinicians. The Group's terms of reference and membership can be found at Appendices I and II.

In accordance with the terms of reference, the Oversight Group submitted its report to the Department of Health for consideration.³ The Oversight Group report was reviewed by the Department and a successor policy document to AVFC was produced that carries forward those elements of the original policy which still have relevance, while introducing new recommendations to create a modern mental health government policy suitable for the next ten years.

Sharing the Vision, the successor policy to AVFC, considers the many varied determinants that affect good mental health and seeks to incorporate inter-departmental recommendations into the policy. The ambition, intended outcomes and recommendations set out in *Sharing the Vision* are the product of intensive work coordinated through the Department of Health and the Oversight Group. They are backed by extensive research, benchmarking activity and evidence-based reviews, together with a wide-ranging consultation process. As a result, this policy focuses very strongly on developing a broad-based, *whole-system* mental health policy for all of the population that aligns closely with the main provisions of *Sláintecare*.

² Kevin Cullen. Stock-take of progress on *A Vision for Change (AVFC)* (Dublin: WRC, 2018).

³ A Vision for Change Oversight Group. *Change for the Future - A Vision for Change 'refresh'* (Dublin: 2019).

Methodology

Sharing the Vision was informed by a major stakeholder consultation process undertaken by the Oversight Group and supported by the Department of Health. Over 1,200 individuals representing service users, peer workers, carers, health workers, managers and others attended five stakeholder sessions at various locations throughout Ireland. Participants were provided with an overview of the proposed organising framework (Figure 1.1) and were asked to consider priority areas for each domain within that framework.

The work of the Oversight Group was further guided by a Reference Group established to connect with a wider group of experts as the policy proposals were evolving. This included representatives of clinical bodies, NGOs and service user organisations, who met to discuss the framework and feedback from the stakeholder process.

The consultation process was also informed by a review by the Oversight Group of existing policies and reports with mental health-specific recommendations. To avoid duplication and maintain consistency, the Group made reference to and supported relevant recommendations from the following key documents:

- LGBTQ Strategy (DCYA)
- Children First (DCYA)
- *Connecting for Life* suicide strategy (DoH/HSE)
- HSE Service Plan
- Peer Advocacy Services report (Irish Advocacy Network)
- All submissions to Joint Oireachtas Committee on the Future of Mental Healthcare in Ireland
- Recommendations arising out the *National Youth Mental Health Task Force Report 2017*
- HSE service user Engagement Document
- Report of the Review of the Irish Health Services for Individuals with Autism Spectrum Disorders (HSE)
- Joint Working Protocols with Child and Adolescent Mental Health Services (CAMHS) and Primary Care
- National MHID Service Development Programme
- 'My Voice Matters' service user survey (Mental Health Reform)
- Mental Health Reform report on progress of *A Vision for Change*.

The work of the Oversight Group, supported by the commissioned research by WRC and the input of the Joint Oireachtas Committee on the Future of Mental Health, informs this policy. It is notable that there is a synergy between the recommendations of the Oversight Group and the work of the Joint Committee on the Future of Mental Health. Many of the issues and actions emerging from the work of the Joint Committee resonate and align with those encountered during the countrywide stakeholder engagement by the Oversight Group. The cross-party *Sláintecare* report, with its core emphasis on integration and delivery of services at community level, represents a new development in whole-system leadership in Irish healthcare and a real opportunity to deliver our specific vision for mental health.

In addition to these inputs, the consultation process has been informed by recent work undertaken by the Department of Health's Women's Health Taskforce, 2019. Early research by this group has identified a range of gender differences in mental health which have a significant impact on the needs and service requirements of women, and girls in particular. The Women's Health Taskforce, working with the National Women's Council of Ireland, has prepared a summary document of this research, which is published alongside this report on the Department of Health website.⁴

⁴ Department of Health. Women's Taskforce mental health report (Dublin: 2020). Available at: www.doh.ie/sharingthevision/womenstaskforce

⁵ England, Scotland, Canada, Australia and New Zealand. Taken from Cullen and McDaid, Evidence Review.

Framework

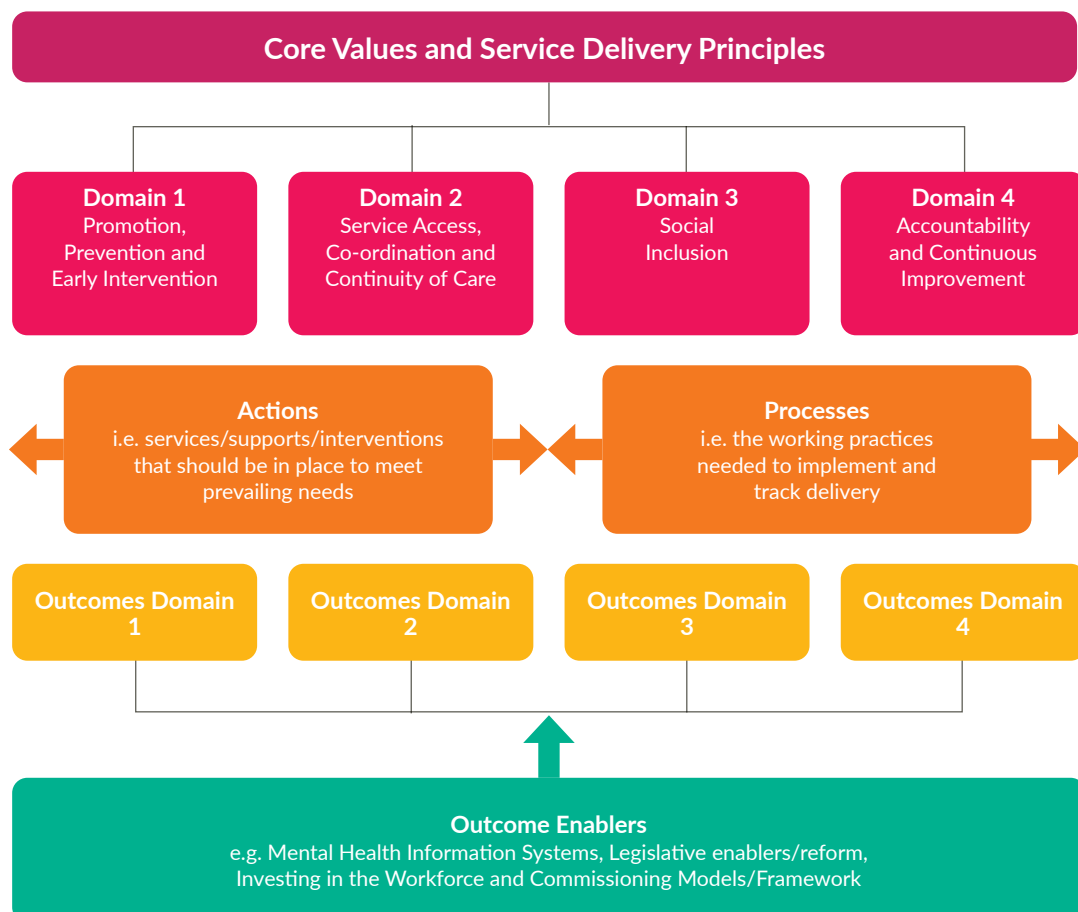
The Oversight Group decided to focus on outcomes in order to emphasise the importance of policy supporting tangible changes in the lives of people using mental health services. The Oversight Group engaged in a literature review of mental health outcomes from other jurisdictions to gain a sense of the various interventions and descriptions of outcomes and outcome measures being delivered internationally. Five countries were identified as having well-developed and well-resourced mental health outcome infrastructures that moved from a focus on the volume of services delivered to the value created for service users.⁵

The Oversight Group proposed developing an overarching framework containing domains, and organised outcomes into groups focused on 'what

matters'. This is an important first step and is separate to choosing outcome measures or indicators. Central to the delivery of a value-based healthcare service is the customer and what they define as value, and what outcomes they expect from their interaction with the service. To achieve this streamlining, the Oversight Group combined related policy/service delivery areas into four 'domains' requiring action and oversight in the refreshed policy. These are reflected in the organising framework detailed in Figure 1.1, which follows through to the report structure. The Oversight Group also identified a number of specific high-level outcomes *within* each of the four domains and these are described at the beginning of each of the domain chapters.

To test the logic of the organising framework, additional inter-departmental meetings were

Figure 1.1: The Organising Framework



conducted across government and with wider public services/agencies to connect related policies and initiatives to the work of the Oversight Group. The consultation process and the associated work completed by the Oversight Group and various committees to incorporate those findings into this policy has resulted in recommendations that truly represent the many voices of those who participated. Consequently, *Sharing the Vision* is a powerful representation of the views of many, who emphasised that the revised policy be underpinned by the core values of respect, compassion, equity and hope.

Core Values

Consistent with the original policy, core values are central to *Sharing the Vision* and underpin its service philosophy. Because human interaction is at the heart of the delivery of mental health supports and care, and is an expression of individual and organisational values, this policy is underpinned by the following core values.

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

AVFC contained mixed principles underpinning service delivery, characteristics of ‘good’ services and approaches to service delivery – all of which have been reviewed based on the consultation to develop these core values as well as the service delivery principles outlined in Appendix III.

The vision

Several aspects of the original policy remain core to the effective delivery of mental health services and support in Ireland. The holistic view of mental health is maintained in this policy while also recognising the complex interplay of other factors that contribute to mental health difficulties. The person-centred approach that focuses on enabling recovery through an emphasis on personal decision-making supported by clinical best practice and the lived mental health experience was a major recurring theme in the stakeholder consultation process.

The policy that follows has captured all of the feedback received to shape the revised vision for mental health in Ireland:

The vision embodied in this policy is to create a mental health system that addresses the needs of the population through a focus on the requirements of the individual. This mental health system should deliver a range of integrated activities to promote positive mental health in the community; it should intervene early when problems develop; and it should enhance the inclusion and recovery of people who have complex mental health difficulties. Service providers should work in partnership with service users and their families to facilitate recovery and reintegration through the provision of accessible, comprehensive and community-based mental health services.

AVFC envisaged that a significant proportion of mental health services and supports could and should be provided as part of primary care, an approach reiterated/supported in the *Sláintecare* report. Over the decade of the policy (2006–16), this increased role for primary care has not been sufficiently resourced, resulting in shortfalls in creating the necessary integration between primary care and specialist mental health services. *Sharing the Vision* is therefore grounded in the realities of the challenges and issues that presently exist. The revised policy acknowledges that while considerable change, ongoing reform and re-investment are needed, much of the AVFC policy remains relevant today. Some recommendations remain valid (with minor refinements); others have led to advances which require updates; and others are no longer valid or, having been delivered, are no longer needed. Finally, there are many recommendations in this policy that are entirely new, reflecting issues that have arisen during the course of the refresh work.

Principles

Mental health for individuals is neither separate nor isolated from the other dimensions of their overall personal wellbeing. People with mental health needs are not insulated or shielded from various political,

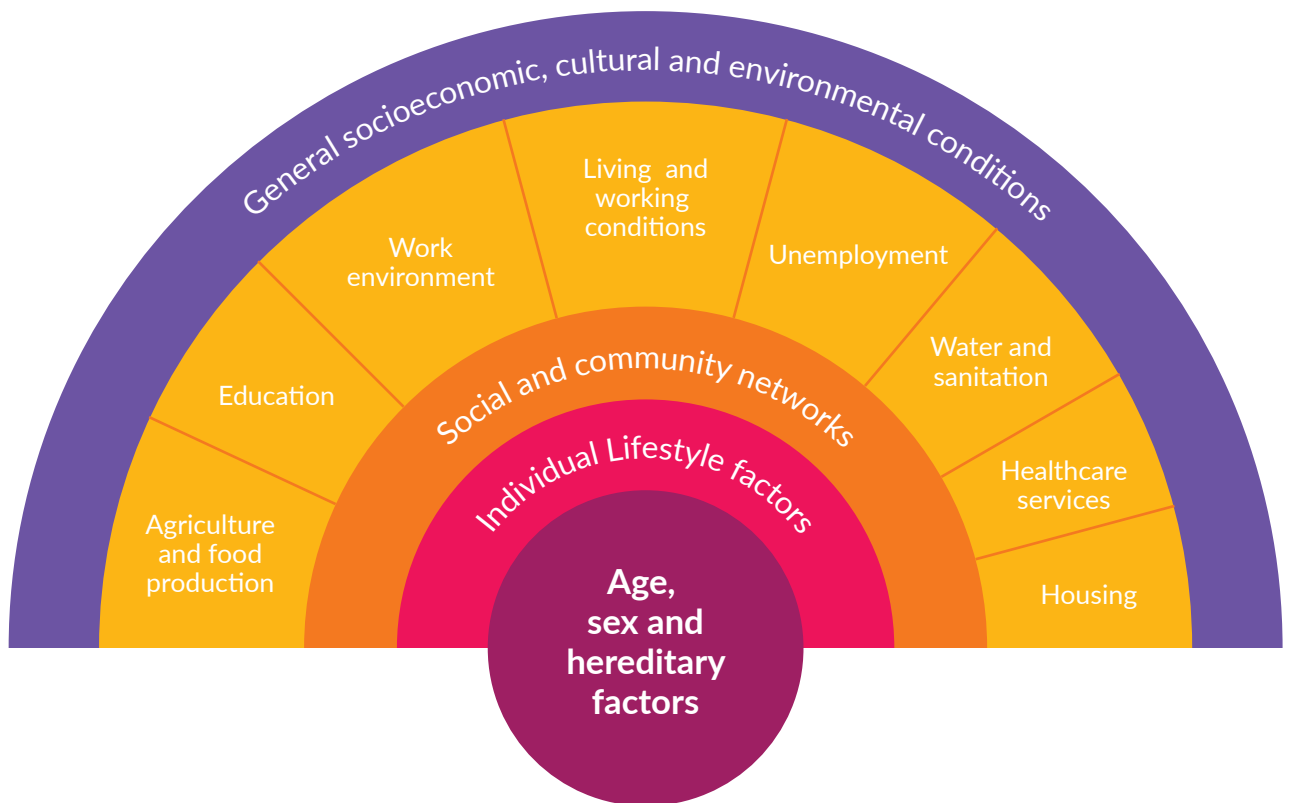
economic, material and social conditions around them. Multiple factors across these dimensions, as well as an individual's more personal biological and psychological wellbeing, have an influence on mental health as shown in Figure 1.2 (overleaf), the 'determinants of health'.

Service Delivery Principles

Recovery	<p>Recovery means people experiencing and living with mental health issues while pursuing the personal goals they want to achieve in life, regardless of the presence or severity of those mental health difficulties. This understanding of recovery is best achieved through the primacy of personal decision-making, supported by informed clinical best practice and lived mental health experience.</p> <p>In line with the National Recovery Framework*, recovery-oriented services empower and facilitate the process of a person's self-determined recovery. Such services offer hope and choice, work in partnership with service users and FCS and are outward-looking. They engage with all the aspects and supports that will constitute and sustain recovery in a person's life.</p>
Trauma-informed	<p>Trauma-informed service delivery means that everyone at all levels of the mental health services and wider mental health provision has a basic understanding of trauma and how it can affect families, groups, organisations, communities and individuals. People delivering services recognise the signs of trauma, which may be gender-, age-, or setting-specific. Services respond by applying the principles of a trauma-informed care. Staff in every part of the organisation change their language, behaviour and policies to take into consideration the experiences of those who have trauma histories, including staff members themselves.</p> <p>A trauma-informed approach resists traumatising or re-traumatising service users and staff. Staff are taught to recognise how organisational practices may trigger painful memories for service users with trauma histories. Applying a trauma-informed approach does not mean that everyone with a mental health difficulty or everyone using mental health services has experienced trauma. It simply means that the service system needs to be aware of and respond to the presence of trauma in people who may be using a wide variety of supports.</p>
Human rights	<p>Human rights treaties recognise the right of everyone to the highest attainable standard of physical and mental health. At the core of Ireland's human rights treaty commitments is a range of principles that underpin the fulfilment of all civil and political, social and economic rights for all people.</p> <p>Service users and their FCS as appropriate should lead in the planning and delivery of their care. Partnership should exist in the planning, development, delivery, evaluation and monitoring of mental health services and supports, and include all stakeholders. Partnership will build trust for all involved.</p>
Valuing and learning	<p>Everyone accessing and delivering mental health services should be valued and respected as human beings in their own right, and for the experience, expertise and skills they bring. Staff and all those involved also need to be valued and respected. Reflective practice and openness to learning are essential qualities for staff, people using mental health services and for the service system itself. All need to be open to continuous learning and development.</p>

* HSE. A National Framework for Recovery in Mental Health 2018–2020 (2017). Available at: <https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/national-framework-for-recovery-in-mental-health/recovery-framework.pdf>

Figure 1.2: Determinants of health



Understanding the various components, personal and societal that influence mental health is important in order to deliver a comprehensive mental health policy that provides interventions and supports that address the wellbeing of the whole population, preventing mental health difficulties and enhancing the possibilities for the recovery and inclusion of people experiencing mental health difficulties. *Sharing the Vision* is underpinned by a population-based planning approach which helps to guide the distribution and development of mental health services and supports in Ireland in response to need (Figure 1.3). Individuals move through different levels of support and services, from informal care and support in their own community to primary care, to specialist mental health services, all based on their mental health needs.

This policy recognises the need for a whole-of-population, whole-of-government approach to the

delivery of mental health services.⁶ In adopting this approach, the policy is underpinned by an ecological model which uses a stepped care approach that ensures that the values from *Sharing the Vision* are preserved throughout. A 'stepped care' approach seeks to ensure that each person can access a range of options of varying intensity to match their needs. In other words, there can be a 'stepping up' or a 'stepping down' in accordance with the stage of recovery. A stepped approach to care should also help to increase efficiency by 'shifting' constituencies of need towards more of the 'upstream' services, that is, promotion, prevention, early intervention, recovery and participation. Over time, this should reduce the need for more expensive 'downstream' acute and crisis response services. In this context, strategic investment in 'upstream' services should be viewed as an investment rather than a cost.

It is understood that throughout life individuals may experience harmful physical, emotional or life-threatening life events that could undermine their mental health. The emerging evidence that trauma-informed systems can result in better outcomes for people affected by trauma is acknowledged. A 'trauma-informed approach' highlights how everyone can have a positive role in preventing mental health difficulties from arising by intervening early to limit further escalation of distress.

In addition, a community-based approach to care is central. It is wider than providing mental health services and includes a core role for the Voluntary and Community Sector (VCS) and for other public agencies and organisations not specifically engaged in mental health. Integrated and coordinated care according to a service user's total individual needs should include these wider community supports. Mental health services should be accessible for all, not just geographically accessible but provided at a time, in a setting, in a culturally competent manner, that makes access as easy and straightforward as possible.

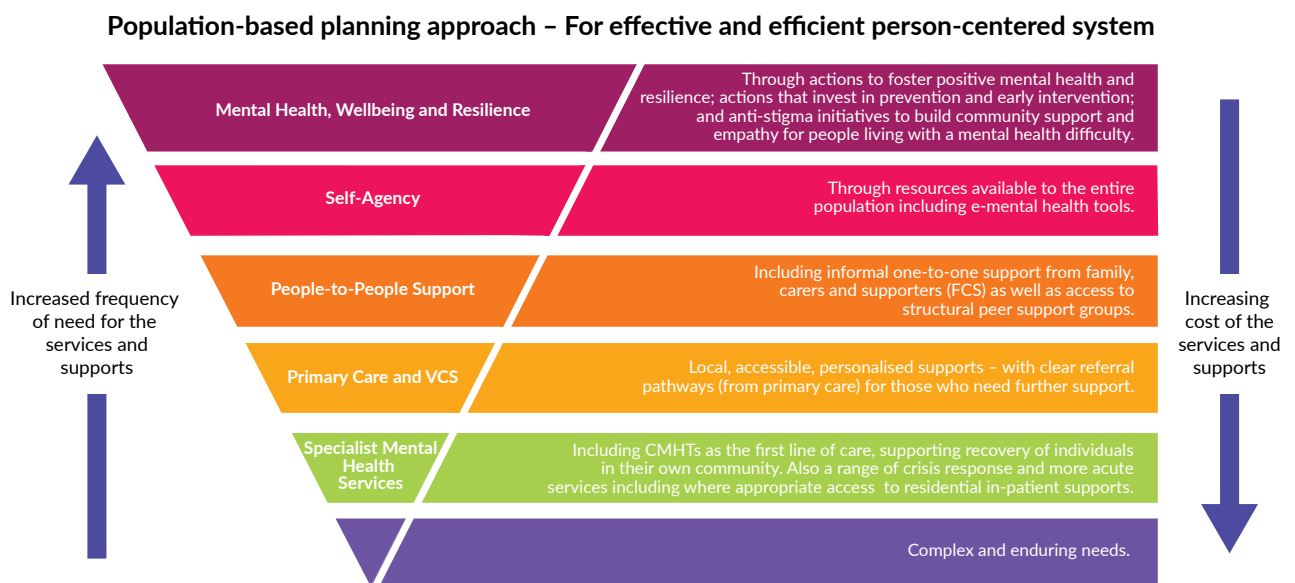
Implementation

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

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

A repeated theme in the extensive process of consultation, review and validation which underpinned the review process was the need to do everything possible to ensure effective implementation of the next phase of the national plan. In considering the

Figure 1.3: Population-Based Planning



⁶ Mental health is not a matter for the health sector alone. It sits in a much broader context of how society views mental health and how decisions can be made right across the spectrum of relevant public services to invest in the wellbeing of the population and support individuals living with a mental health difficulty on their recovery path. Good mental health for the population of Ireland cannot be achieved without measures being taken by other government departments as well by as the Department of Health.



implementation approach against this backdrop we have borne in mind a number of critical success factors which experience has shown to be decisive. These key factors include:

Leadership
Implementation structures
Planning
Resourcing
Communication
Data and research evaluation

In order to ensure delivery on the commitments made in this policy, an overarching National Implementation and Monitoring Committee (NIMC) will drive reconfiguration, monitor progress overall and ensure delivery. The NIMC will have particular regard to tangible outcomes and their measurement so that real impact for service users and their families can be assessed. This structure will take account of actions and outcomes relating to ‘all-of-government’ – not just those within the remit of the health service. The NIMC will be established with service user and peer representation to roll out the recommendations within this successor policy. It will have representation from the statutory, voluntary and community sectors.

The NIMC will work together with the key stakeholders involved in delivering this policy and strategy actions – identified in Figure 1.4/identified by the Policy Roadmap - to deliver shared goals and common actions. Together, they will also ensure momentum is maintained in delivering the recommendations contained in this policy. We have set out the proposed implementation structure in Figure 1.4 opposite.

The outcomes-based approach that underpins this policy will require a fundamental shift in how mental health services are delivered. If a person-centred, whole-of-government approach is to be achieved in practice, there will need to be a real focus on how mental health services are planned and delivered. *Sharing the Vision* promotes outcomes that are dependent on partnerships between government departments, service providers, voluntary and community organisations, and service users. These groups will work together to promote better mental health, build mental resilience and offer services specific to their resources and capabilities to those with mental health requirements.

Further details in regard to the implementation, planning and evaluation of *Sharing the Vision* are set out in Chapter 6.

Figure 1.4: Implementation committee structure





Chapter 2

Promotion, Prevention and Early Intervention Domain

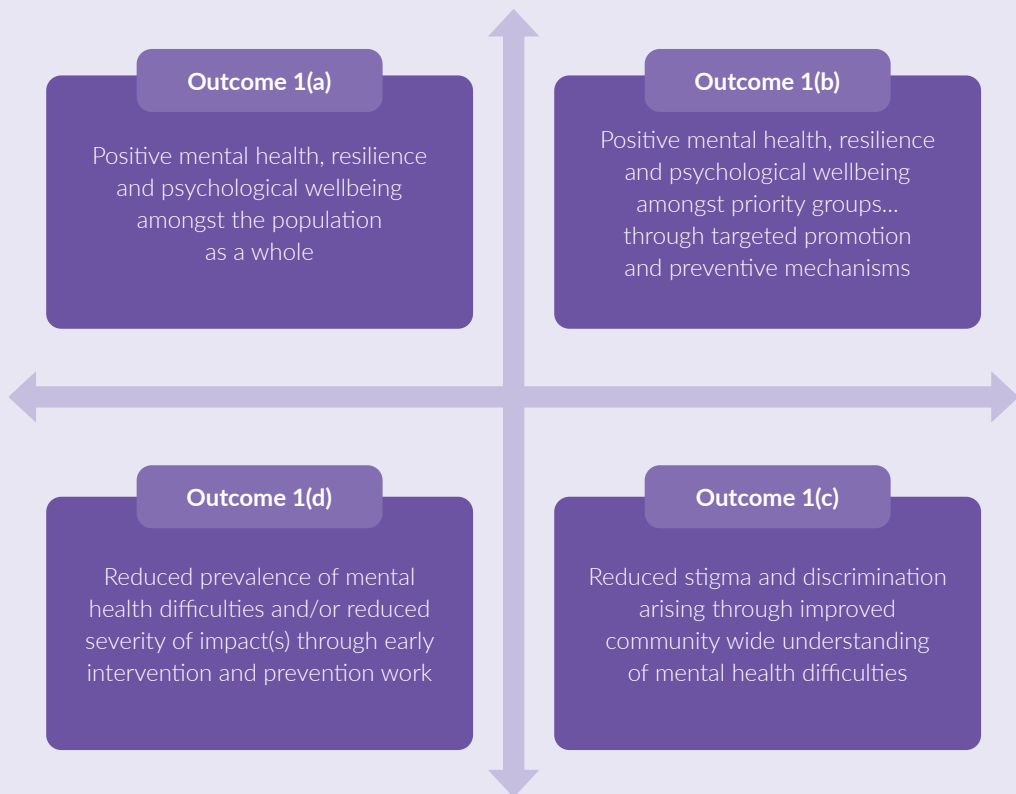


Introduction

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

Everyone has mental health needs, whether or not they have a diagnosis of mental ill health. The population-based actions outlined in AVFC focus on the protective factors for enhancing wellbeing and quality of life, together with prevention and early intervention. Mental health promotion works on three levels: to strengthen individuals and improve their emotional resilience; to strengthen communities and improve social capital through increased participation; and to reduce structural barriers to good mental health through initiatives that reduce discrimination and inequalities. The importance of supporting positive mental health as part of a spectrum of population-based responses recognises a range of policy developments since the publication of AVFC. Figure 2.1 shows the outcomes for the domain promotion, prevention and early intervention.

Figure 2.1: Outcomes: Promotion, prevention, early intervention



Positive mental health and wellbeing

Positive mental health builds resilience so that people can adapt to challenges and adversity, get the most out of life and maintain a positive sense of wellbeing and self-worth, combined with a sense of control and self-efficacy. The concept also means that 'mental health' is not just an absence of 'mental illness' but is a separable characteristic focused on positive wellbeing and having good mental wellbeing while living with a mental health difficulty. It involves moving control towards the community through educating the wider public about mental health and wellbeing and mental health difficulties, and providing structural supports that encourage resilience. Promoting wellbeing for everyone in the community also involves targeting both the social factors outside the direct control of the health services that foster positive mental health, and the development of resilience.

The need for a 'whole person' approach to achieving the highest possible standards of physical and mental health and wellbeing is acknowledged, and the interdependencies between physical and mental health are recognised by the World Health Organization (WHO). WHO research suggests that key risk factors for poor physical health and reduced life expectancy are more prevalent among people living with a mental health difficulty than among the general population.⁷ Equally, there can be higher rates of mental health difficulties among people with long-term physical health problems and a need to support the wider psychological aspects of such physical health challenges.

This domain is consistent with the overarching national framework for health and wellbeing, *Healthy Ireland*, and recognises the need to explore improved integration between physical and mental health as prioritised in the *Sláintecare* report.



⁷ World Health Organization. The World Health Report 2001 – Mental Health: New Understanding, New Hope (Geneva: WHO, 2001). Available at: https://www.who.int/whr/2001/en/whr01_en.pdf?ua=1

Mental health lifecycle

You said...

Mental health affects everyone in some way. The refreshed policy should seek to provide mental health education, supports and services to all people when and where they need it.

We listened.

The Lifecycle Approach

Mental health difficulties can begin early in life, but the severity of impact can be reduced through actions across a range of sectors that promote healthy environments and foster mental wellbeing in schools, communities and workplaces. Positive mental health is not a matter for the health sector alone, and therefore this domain proposes that relevant public services invest in the wellbeing of the population to support individuals living with a mental health difficulty in their recovery. The lifecycle approach acknowledges that the foundations for mental wellbeing are established before birth and that much can be achieved through interventions and supports to build resilience and improve wellbeing throughout childhood, the teenage years and on into adulthood and later life. As a result, greater emphasis on promoting mental health and building resilience at all stages in the lifecycle is required and should include tailored approaches for priority groups deemed to be at risk.

Central to all of this is empowerment, at both personal and community levels. At a personal level, individuals are empowered to take charge of their health and wellbeing and to access information to make informed decisions when possible. At a community level, empowerment is about having opportunities to participate in and influence decisions about access to local services and supports.

There is general agreement – at both national and international level – that mental health promotion can be improved by building on current infrastructure and embedding principles of mental health promotion into the existing fabric of communities. *The Healthy Ireland Framework* seeks to strengthen communities' capacity to foster mental health by addressing the environmental factors that contribute to mental health and wellbeing and the building of resilience in individuals. The Framework aims to build sustainable, nurturing communities by drawing on resources from all sectors of society, including health, education, employment and transport, to promote mental health. *Healthy Ireland* recognises that positive lifestyle changes can prevent mental health issues arising and seeks to build awareness about the benefits of good nutrition and diet on both mental and physical health and wellbeing, for example. To enhance this work, a National Mental Health Promotion Plan will be produced by *Healthy Ireland* that will be the framework of reference and the overarching context for all mental health promotion and campaign activity in Ireland.



Mental Health across the Lifecycle



'First 5', A Whole-of-Government Strategy for Babies, Young Children and their Families 2019–2028 was launched in November 2018 by the Department of Children and Youth Affairs (DCYA).⁸ Objective 6 of the strategy is that 'babies, young children and their parents enjoy positive mental health'. The aim of this objective is to improve the early identification of mental health difficulties among babies, young children and families, and to provide access to mental health supports and services that integrate into child-serving settings and the wider community. The Department of Health will continue to work with the DCYA to implement the actions outlined in the *First 5* policy. In addition to this work, special consideration will be given to the provision of additional supports for children who have been exposed to Adverse Childhood Experiences (ACEs) such as domestic violence, alcohol or drug abuse, mental health difficulties and bereavement. Prevention and early intervention are critical to the reduction of trauma

associated with these early events, which can lead to difficulties later in adult life if not addressed at an early age. The relevant recommendations of the *First 5* strategy under Objective 6 relating to primary prevention, early intervention and positive mental health should be implemented.

Schools and educational settings provide a powerful context for the promotion of wellbeing. In 2018, the Department for Education and Skills (DES) launched its *Wellbeing Policy Statement and Framework for Practice (2018–2023)* which recognised that the mental health and wellbeing of young people is critical to success in school and life. Within its policy statement and framework, the DES proposes a whole-school, multi-component, preventive approach to wellbeing and mental health promotion in education that includes interventions at both universal and targeted levels. It provides an overarching structure that encompasses existing and developing work in the area of wellbeing and mental health promotion in education, including the Junior Cycle wellbeing programme. The role of NEPS psychologists in the area of wellbeing promotion and early intervention will also be developed. As such, it will contribute strongly to the targeted outcomes in, and ambition of, this Domain of the refreshed AVFC policy. To reinforce the effectiveness of the DES framework, an effective structure for cross-sectoral collaboration in the area of wellbeing and mental health promotion will be incorporated into the National Mental Health Promotion Plan.

The National Youth Mental Health Task Force (YMHTF) was established in response to an undertaking in the *Programme for Partnership Government* to provide national leadership in the field of youth mental health and to ensure that the public, private, and voluntary and community sectors work together to improve the mental health and wellbeing of young people. In December 2017 the Task Force produced a set of ten recommendation areas that were distilled from 12 months of discussion and consultation. In its domain of education and prevention, the YMHTF report contains several key recommendations that are consistent with themes raised during the engagements and work done during the refresh process. While it is acknowledged

⁸ Government of Ireland. *First 5, A Whole-of-Government Strategy for Babies, Young Children and their Families 2019–2028* (Dublin: Government Publications, 2018) Available at: <https://assets.gov.ie/31184/62acc54f4bdf4405b74e53a4afb8e71b.pdf>



that there has been progress on many of the actions outlined in the report, it is important to maintain momentum and implement the report's remaining recommendations within the three-year timeframe identified.

Adults in Ireland take on various new responsibilities such as raising families, setting up a home, caring for ill parents, and maintaining employment. While many of these life transitions are positive life experiences, sometimes negotiating the many different roles and responsibilities can be challenging and stressful and act to the detriment of an individual's positive mental health. Many additional challenges can arise in the life of an adult. Unpredictable additional stressors such as unemployment or financial insecurity can cause anxiety and negatively impact on mental health. In addition, the *Healthy Ireland* Framework estimates that mental health difficulties cost the Irish economy €11 billion each year, much of it related to lost productivity in the labour market from both absenteeism and presenteeism, that is, functioning at less than optimum capacity while at work. Improved wellbeing reduces absenteeism and increases performance and productivity. Workplaces which allow for open discussion about mental health, including people's own personal experiences, can promote overall organisational and individual wellbeing. *Sharing the Vision* supports individuals by raising awareness of life influences that can lead to the development of mental health problems, but the policy also seeks to improve access to mental health supports in a variety of settings.

An important element of healthy ageing is the promotion of good mental health and wellbeing. As

Ireland's population over 60 is set to double before 2050 it is important to promote positive mental health among this population, many of whom are at risk of developing poor mental health. Older people are exposed to multiple risk factors that contribute to poor mental health such as reduced mobility, chronic pain, frequent illness, loneliness, loss and bereavement. The *Healthy Ireland* Framework makes a clear commitment to improving 'partnerships, strategies and initiatives that aim to support older people to maintain, improve or manage their physical and mental wellbeing by addressing risk factors and promoting protective factors to support lifelong health and wellbeing'. This commitment will support the goals of the *National Positive Ageing Strategy* by providing additional mental health training and supports for health professionals, home help teams and carers who provide services for older people. The Framework will also lead to increased mental health supports for those in long-term palliative care and the development of age-friendly services and settings in community and primary care settings.

It is important to acknowledge that throughout the lifecycle, an individual's mental health can also be influenced by other stressors, such as disability. People with disabilities, like everyone else, can experience mental health difficulties, and there can be an increased prevalence among people with certain conditions. It is important to include people with disabilities in mainstream public services and provide supports to maintain positive mental health that are disability-competent and accessible.

In terms of health care that should be available for the whole population, *Sláintecare* is the ten-year programme that seeks to transform our health and social care services. It is the roadmap for building a world-class health and social care service for the Irish people. The *Sláintecare* vision is to achieve a universal single-tier health and social care system where everyone has equal access to services based on need, and not ability to pay. It is hoped that over time, everyone will be entitled to a comprehensive range of primary, acute and social care services. This policy supports the main goals and objectives of *Sláintecare* and seeks to create easier access to multi-disciplinary, service user-centred supports at primary care level that will result in better outcomes. The *Sláintecare* Implementation Strategy was published in July 2018 and implementation will act as an enabler to support actions contained in this policy.

Mental health, priority groups and stigma

The population health approach that this policy advocates contains universal recommendations that benefit everyone in society, but also acknowledges that additional work is required to promote positive mental health and build resilience among specific priority groups deemed to be 'at risk'. The identification of priority groups displaying evidence of vulnerability to and increased risk of suicidal behaviour in *Connecting for Life (2015–2020)* is a useful reference point. Priority groups include members of the LGBTQ+ community; members of the Traveller community; people who are homeless; drug users; people who come in contact with the criminal justice system; people who have experienced domestic, clerical, institutional, sexual or physical abuse; asylum seekers; refugees; migrants and sex workers. This is not an exhaustive list and additional groups such as children in care, care leavers, people with disabilities, people who have severe-to-profound deafness and people with substance (drug and alcohol) misuse problems should also be reviewed. Tailored interventions to fulfil unmet needs and to build strengths among these groups, including targeted campaigns and preventive outreach work, should be done in partnership with organisations working with the priority groups to achieve increased effectiveness and impact.

A recurring theme arising out of the consultation process was that mental health stigma, self-stigmatisation, prejudice and discrimination are some of the main reasons why people experiencing mental health difficulties do not seek help. Reducing the stigma and discrimination associated with mental health difficulties is central to improved wellbeing at a societal level. The National Stigma-Reduction Programme (NSRP) will expand to promote awareness of the nature and extent of prejudice and discrimination in respect of all mental health conditions and focus on stigma-reduction initiatives for the general population, workplaces, health and social care settings, and other groups. The NSR Programme is therefore not a single intervention, but a portfolio of coherent and parallel stigma-reduction initiatives developed collaboratively and with shared responsibility across government and health services.

In addition, the *Connecting for Life strategy (2015–2020)*, which aims to reduce the loss of life by suicide and limit cases of self-harm, also maintains a health promotion agenda. This involves preventive and awareness-raising work throughout the entire population, supportive work with local communities and targeted approaches to priority groups. Local action plans play an important role in enhancing community capacity to reduce suicide and more widely in building the capacity of communities to support wellbeing and mental health. An interim review of *Connecting for Life* conducted in February 2019 requested that the lifetime of the strategy be extended to 2024. This ongoing focus will augment the prominence of national mental health promotion messages about stigma and suicide prevention.



Additional health promotion supports

Health Promotion Programmes

Historically, the participation of people with mental health difficulties in health promotion programmes has been lower than that of the general population. All health promotion programmes must be expanded to target people with existing mental health difficulties and promote their wellbeing and recovery. Staff in mental health and other services have a critical role to play in mental health promotion. There are now a number of national health promotion and improvement officers operating across HSE areas and the HSE must ensure a consistent focus on mental health promotion as well as physical health promotion by these officers to achieve parity of effort in the promotion of mental and physical health.

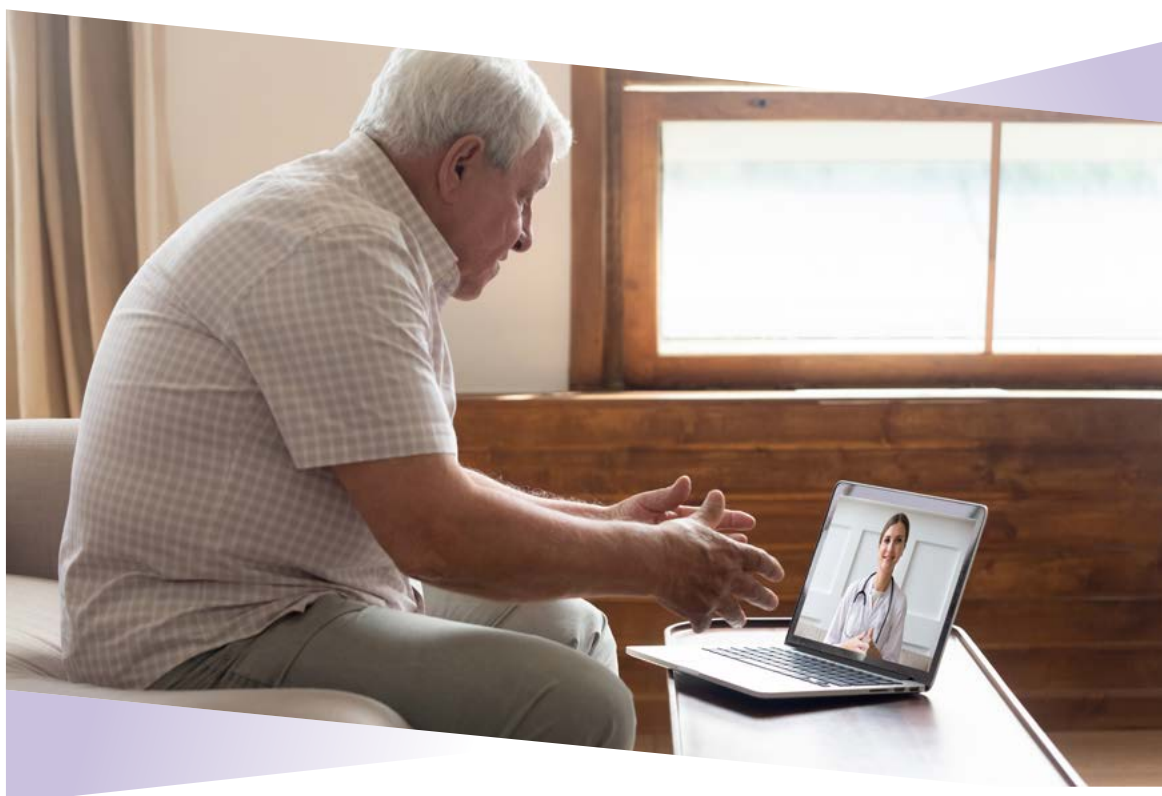
Voluntary and Community Sector

The Voluntary and Community Sector (VCS) engages in mental health promotion work and can play an important role in providing mental health support services for the communities with which it works by

tailoring national mental health promotion programmes to the needs, preferences and circumstances of those communities. It is therefore important that local community projects connect with a national mental health promotion agenda to ensure that their joint efforts are effective and appropriately resourced.

Digital Mental Health

Engagement with digital mental health technology is increasing in popularity and although it is acknowledged that this is a largely unregulated field, well-designed products can have beneficial impacts. The growth in e-health initiatives suggests that opportunities for mental health promotion, prevention and early intervention using digital channels and social media need to be considered and researched. It is proposed that digital developments will form part of the National Mental Health Promotion Plan underpinned by evaluation and quality assurance in relation to content and design.



Domain: Education, prevention, early intervention recommendations

1	<i>Healthy Ireland</i> already has a remit for improved mental health and wellbeing. To further strengthen this, a dedicated National Mental Health Promotion Plan should be developed and overseen within <i>Healthy Ireland</i> implementation frameworks, with appropriate resourcing. The plan should be based on the principles and scope described in Chapter 2 of <i>Sharing the Vision</i> .
2	Evidence-based digital and social media channels should be used to the maximum to promote mental health and to provide appropriate signposting to services and supports.
3	The Department of Health Women's Health Taskforce and the National Implementation Monitoring Committee will undertake a joint project within 12 months to outline an effective approach to the mental health of women and girls. The project should ensure that mental health priorities and services are gender-sensitive and that women's mental health is specifically and sufficiently addressed in the implementation of policy.
4	The work programme for health promotion and improvement officers should be reviewed to ensure parity of effort and emphasis on mental health promotion and physical health promotion.
5	New and existing community development programmes which promote social inclusion, engagement and community connectedness should be appropriately resourced and developed in line with the proposed National Mental Health Promotion Plan.
6	The proposed National Mental Health Promotion Plan and the existing work of <i>Connecting for Life</i> should incorporate targeted mental health promotion and prevention actions that recognise the distinct needs of priority groups.
7	A National Stigma-Reduction Programme should be implemented to build a 'whole community' approach to reducing stigma and discrimination for those with mental health difficulties. This should build on work to date and determine a clear strategic plan, with associated outcomes and targets across related strands of work.
8	Learning from innovations in improving outcomes for children and young people should be identified and should inform relevant mainstream service provision. This includes learning from prevention and early intervention programmes such as Tusla's Area Based Childhood (ABC) and Prevention, Partnership and Family Support (PPFS) Programmes as well as cross-border programmes addressing the impact of Adverse Childhood Experiences (ACEs).
9	All schools and centres for education will have initiated a dynamic Wellbeing Promotion Process by 2023, encompassing a whole-school/centre approach. Schools and centres for education will be supported in this process through the use of the Wellbeing Framework for practice and Wellbeing Resources which have been developed by the Department of Education and Skills.
10	A protocol should be developed between the Department of Education and Skills and the HSE on the liaison process that should be in place between primary/post-primary schools, mental health services and supports such as NEPS, GPs, primary care services and specialist mental health services. This is needed to facilitate referral pathways to local services and signposting to such services, as necessary.
11	The National Mental Health Promotion Plan integrated with the Healthy Workplace Framework should incorporate actions to enhance the mental health outcomes of the working-age population through interventions aimed at mental health promotion in the workplace. This should consider environmental aspects of the working environment conducive to supporting positive mental health and wellbeing.
12	A range of actions designed to achieve the goals of the National Positive Ageing Strategy for the mental health of older people should be developed and implemented, supported by the inclusion of mental health indicators in the Healthy and Positive Ageing Initiative's research programme.



Chapter 3

Service Access, Coordination and Continuity of Care Domain



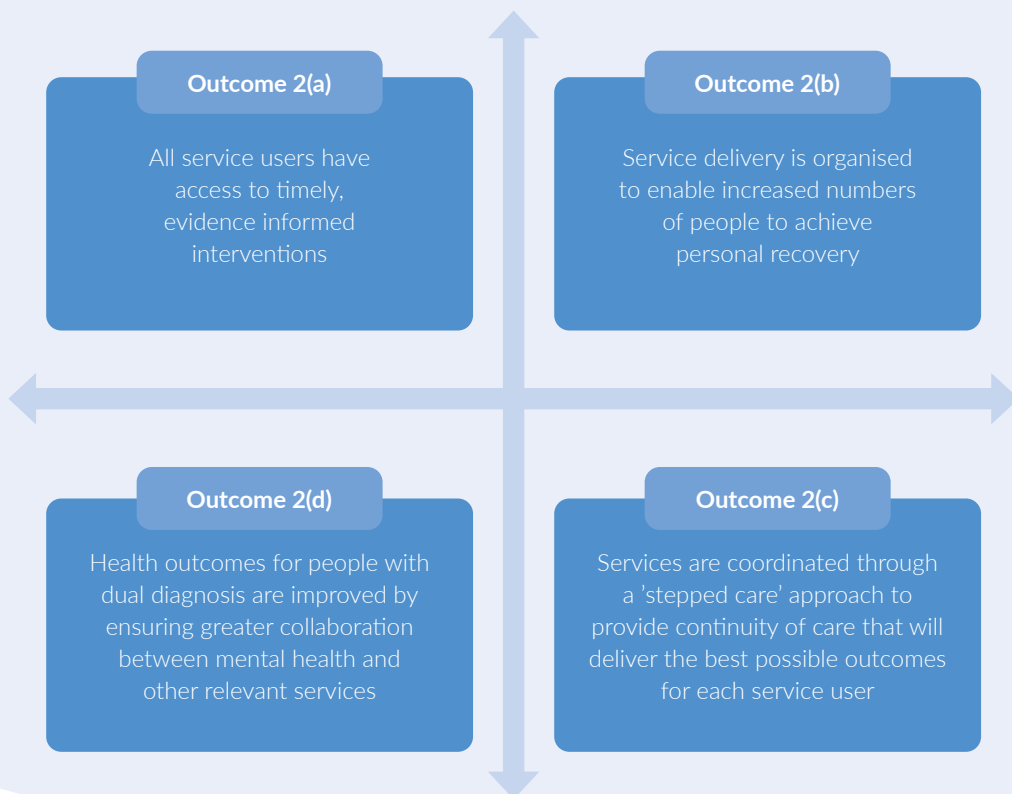
You said...
 Services need to be service user oriented and recovery plans must include service users, family members, carers and significant others.

We listened.

Introduction

The overriding intention in this domain is to ensure that service users and their families, carers and supporters (FCS) have timely access to evidence-informed supports, as a result of an outcomes-based focus that puts people before processes. In line with the core values and principles of this policy, mental health services will be evidence-informed and recovery-oriented and will adopt trauma-informed approaches to care, based on lived experience and individual need. Mental health services will be clinically effective, delivered in adherence to statutory requirements and based on an integrated multi-disciplinary approach. This effective partnership and interworking between different services and professionals along the care pathway will equip service users and their FCS to be better informed about the range of resources available, and remove barriers, in order to assist people to achieve personal recovery. The renewed focus on partnership in care will strive to ensure service users and FCS are central in the design, development and delivery of services and take a lead role in recovery planning. Figure 3.1 summarises the four high-level outcomes for Domain 2. The outcomes suggest what a service user or FCS might expect from the mental health services in the future. The recommendations set out for this domain are designed to contribute to the achievement of one or more of these outcomes.

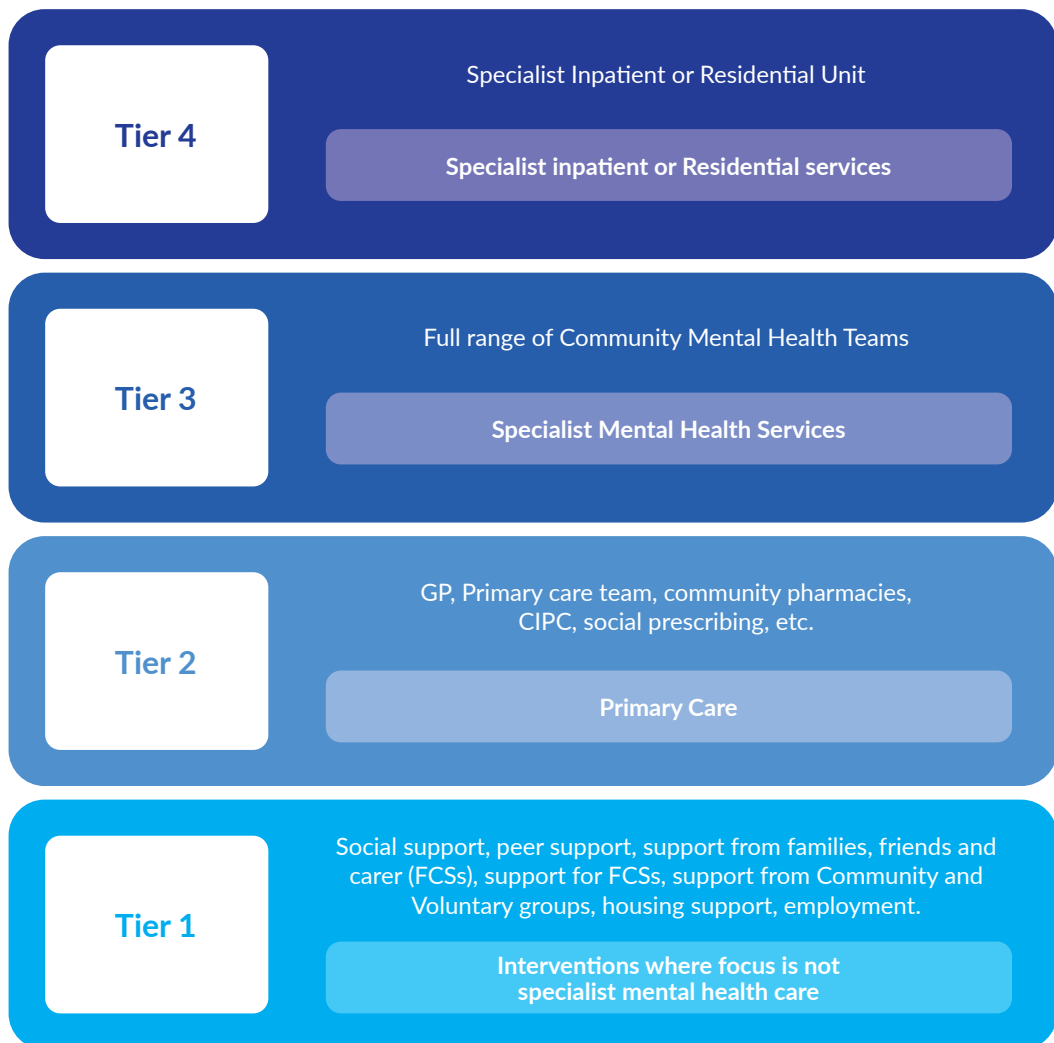
Figure 3.1: Outcomes: service access, coordination and continuity of care



This domain sets out proposals for the continuous range of integrated service elements needed in a modern recovery-oriented mental health system. All services will be coordinated through a 'stepped care'

approach to provide continuity of care (see Figure 3.2) in order to deliver the best possible outcomes for each service user.

Figure 3.2: Stepped care approach



Pathways to support

This policy recognises that no single service can cater for the diverse needs of a person with mental health difficulties. To improve a population's health and social care outcomes, a multi-sectoral, multi-stakeholder approach is required. The 'stepped care approach' enables an individual to avail of a range of supports and services as close to home as possible at the level of complexity that corresponds best to their needs and circumstances. This approach focuses on working to shape a continuum of mental health services in which local VCS groups have a recognised role, where primary care supports are closely linked to specialist mental health services and where mental health services across the lifespan are integrated and coordinated. Figure 3.3 sets out this envisaged continuum of mental health services and pathways.

Figure 3.3: Envisaged continuum of mental health services and pathways

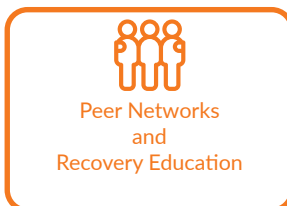
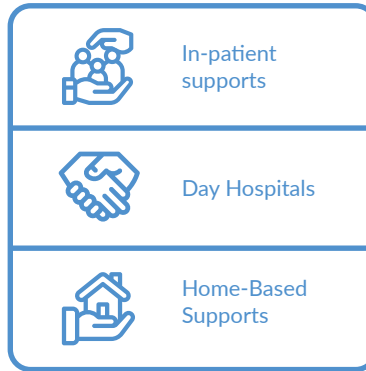


Care and Specialist Mental Health Services

Out-of-hours
crisis cafes

Emergency
department

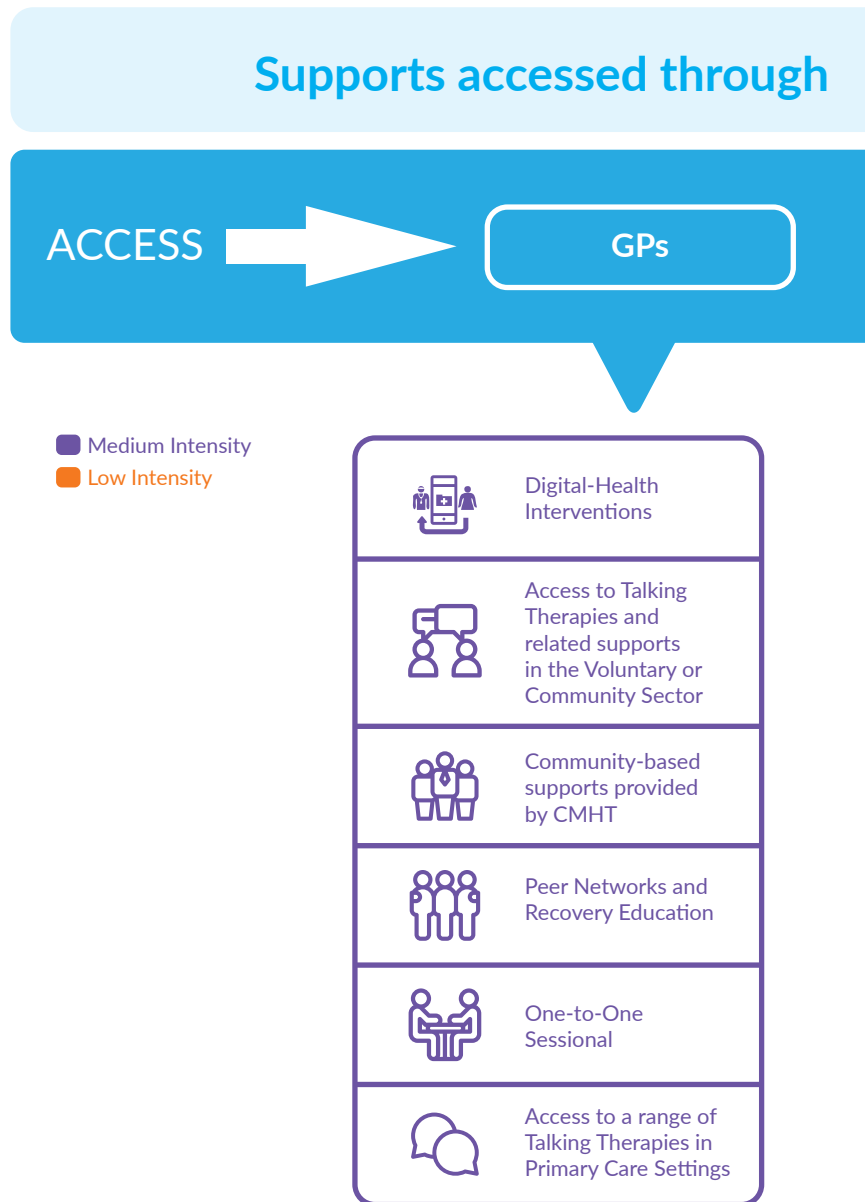
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The continuum builds on the progress with service reform in recent years. The service elements will integrate with one another and with the different contexts in which a service user may live to ensure that needs are met in keeping with their stage of recovery and individual wishes and preferences. In interpreting the continuum of care, it is important to recognise that an individual may need services and supports from one or more of the service elements at the same time, depending on their prevailing needs and preferences. The continuum aims to reduce the confusion between primary care and community-based care by providing clarity in terms of location, settings and levels of specialism.

In order to describe the different service elements in some detail and to propose recommendations, the continuum will be separated into supports accessed through primary care, VCS and self-referral, as shown in Figure 3.4, and referral pathways and specialist mental health services, as shown in Figure 3.5.

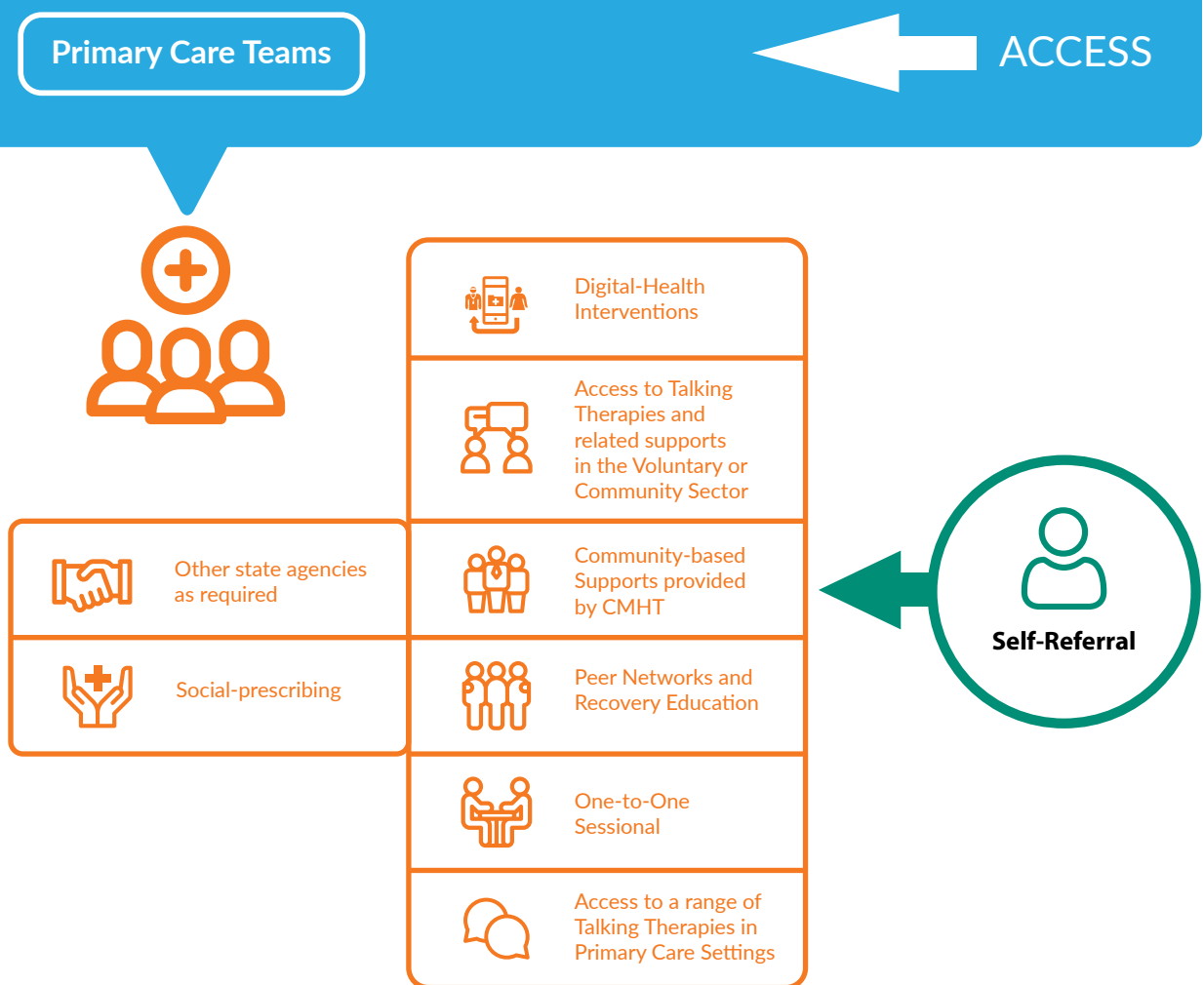
Figure 3.4: Supports accessed through primary care, the voluntary and community sector or self-referral



Talking therapies are psychological treatments. They involve talking to a trained therapist to support people to deal with negative thoughts and feelings. They help to make positive changes in an individual's life. Talking therapies can take place in: groups, one-to-one, using a computer or over the phone.

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

Primary Care, Voluntary & Community Sector or Self-Referral



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

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

Primary Care

You said...

There is a real need for additional supports in primary care that are accessible to people when and where they need help.

We listened.

General practitioners play a pivotal role as the first and continuing point of contact to patients but it is acknowledged that there is a requirement to scale up access to supports for common mental health difficulties in primary care settings. Over 90% of mental health needs can be successfully treated in a primary care setting, while the remaining 10% referred to secondary care services are greater and more clinically complex.⁹ In line with *Sláintecare*, this policy envisages an increasing role for the primary care sector which, if appropriately resourced and with appropriate governance, can provide a comprehensive range of interventions.

AVFC recommended increased access to primary care supports for people with mental health needs who do not require specialist mental health services. While initiatives such as Counselling in Primary Care (CIPC) have been introduced, there is still insufficient access to these types of supports in primary care. This, in turn, has contributed to an over-reliance on specialist secondary care systems, resulting in waiting lists for such care in various mental health services.

Consequently, this policy contains several recommendations advocating additional universal supports delivered by appropriately qualified therapists to provide care to individuals with mental health needs, including those presenting with co-existing health requirements such as addiction. The scaling up of access to supports in primary care should help to reduce the over-reliance on specialist mental healthcare. For example, developing further capacity for Attention Deficit Hyperactivity Disorder (ADHD) and autism-specific services will play a role in reducing the number of referrals into Child and Adolescent Mental Health Services (CAMHS). Furthermore, the recommendations also consider how best to utilise digital health interventions to facilitate increased availability and spread of supports.

More broadly, the revised policy seeks to improve collaboration between primary care, secondary mental health services and specialised services to facilitate integration of care for service users – a key theme in the original AVFC. The co-location of CMHTs and primary care teams in some areas, with the creation of a Team Coordinator role in some CMHTs, has contributed to reducing referrals of milder mental health difficulties to secondary services. This liaison model remains relevant and will be supported by additional recommendations relating to a 'shared care' approach to mental health in primary care.

⁹ HSE Mental Health Division. Delivering Specialist Mental Health Services 2017 (2018). Available at: <https://www.lenus.ie/bitstream/handle/10147/626957/2017%20Delivering%20Specialist%20Mental%20Health%20Report.pdf?sequence=1&isAllowed=y>

Integrated services



As set out in AVFC, it should remain the case that all users of specialist mental health services, including those in long-stay facilities, must be registered with their GP. However, registration in itself is insufficient and the physical healthcare of people with a mental health difficulty should be led by their GP. This is consistent with the priority in the *Sláintecare* report attributed to 'creating an integrated system of care, with healthcare professionals working closely together', bringing together physical and mental health services to improve the physical health of people with mental health difficulties and vice versa simultaneously.

VCS organisations should be key partners in the design and development of the HSE's mental health services at national and local level, as well as referral partners for primary mental healthcare. Their services extend to therapeutic and other recovery supports for individuals and FCS and can, therefore, help to reduce the use of inappropriate referrals to specialist mental health services. In addition, recognising that people's health is determined primarily by a range of social, economic and environmental factors, the VCS can be an active partner in the development of social prescribing –

sometimes called community referral – which is a way for GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Socially prescribed activities can include volunteering, engaging in the arts, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.

Many of the supports provided by the VCS sector are funded and/or provided through a service agreement with the public mental health system. To get the best value from the VCS sector and to draw upon the sector's strong position within communities, it is vital that public primary care and mental health services work in partnership with VCS groups, involving them in the design and delivery of integrated area support services. This partnership approach will allow those working in primary care and CMHTs to connect service users with VCS organisations and facilitate the integration of patients into their local community.

Figure 3.5: Secondary care and specialist mental health services

Referral Pathways and Specialist Mental Health Services

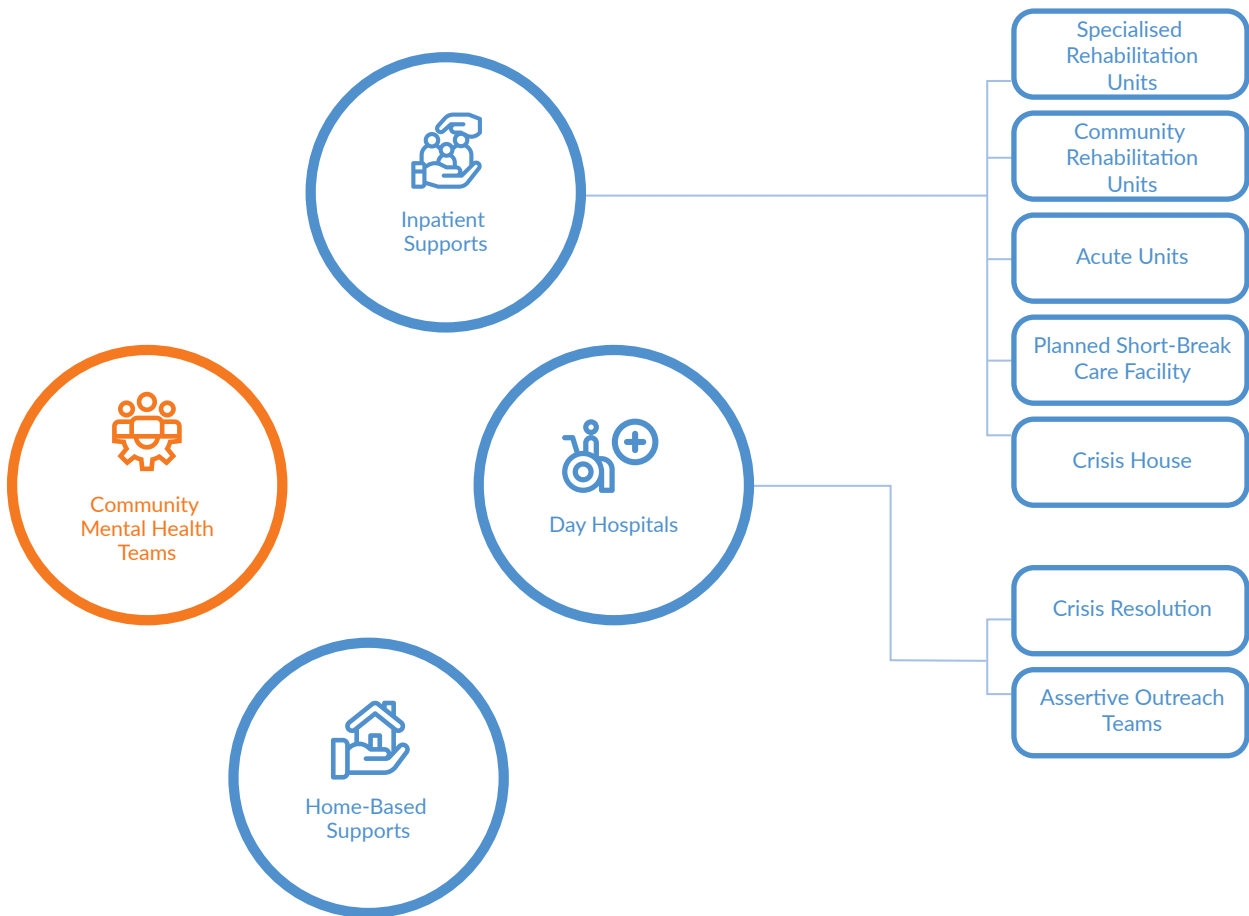
Recovery Colleges often focus on equipping students with new skills that can foster their recovery, as well as enhancing their overall capacities and capabilities. Common offerings include classes focused on self-care, life-skills, physical health, employment and information technology.

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

Assertive outreach teams provide intensive support for people with complex needs. The team aim to support individuals to get help from other services. This support can help people manage their condition better and reduce the chances of going back to hospital.

Talking therapy is a general term to describe any psychological therapy that involves talking. You may also hear the terms counselling or psychotherapy.





Community Mental Health Teams

You said...

Service users need to access coordinated care, maintain a person-centred care plan and have access to a keyworker who understands the system and assists individuals, family and carers to avail of all supports offered.

We listened.

The cornerstone of service delivery in secondary care will continue to be the multi-disciplinary Community Mental Health Teams (CMHTs). The multi-disciplinary nature of the CMHTs enables a variety of professional perspectives to be combined in case formulation, care planning and service delivery. Multi-disciplinary teamwork provides integrated care to service users, with the emphasis on supporting individuals to recover in their own community.

The prescribed composition of CMHTs in the original AVFC may have restricted the development of appropriate responses in some teams and for some patient groups. The CMHT should continue to include, but not necessarily be limited to, the core skills of psychiatry, nursing, social work, clinical psychology and occupational therapy. Given developments over the last decade and the emphasis on achieving recovery-oriented outcomes, there should be

additional competencies in teams such as dieticians, peer support workers, outreach workers, job coaches and others. Rather than specify absolute numbers of specific professionals that should be on the different teams, the approach in this policy is to emphasise the importance of determining the specific skills that are required by a team. Thus, the composition and skill mix of each CMHT should take into consideration the needs and social circumstances of its sector population, with flexibility as to how these needs are to be met. As well as the core skills this could include, for example, bringing in sessional workers with specific therapeutic skills and other professionals as required. The proposed model of mental health supports re-conceptualises the role of the outpatient clinic to a broader concept of community-based sessional support provided by mental health professionals and peer workers. The physical environment where these services are delivered and the locations of the CMHTs should be accessible, modern, fit for purpose and conducive to recovery. Such centres should also facilitate VCS provision to integrate CMHT and VCS supports, where appropriate. The location of CMHTs in physical environments of this kind will reinforce the access that individuals have to short-term assistance in their own community, drawing on a wide range of therapies and supports in the wider mental health system including access to e-health alternatives. All future new primary care building planning developments should therefore include appropriate settings for delivery of a mental health service.

CMHTs will link in with local VCS supports to build a sustaining network around the service user and their FCS. Together, CMHTs and the VCS should work to prioritise care planning with service users as key decision-makers in their own care or recovery plan. Such plans are important because they reflect the service user's particular needs, preferences, goals and potential, including community factors that may impede or support recovery. In many cases there may be more than one team member involved in the care of an individual; therefore, this policy re-emphasises the need for a key worker, that is, a member of the existing team through whom services could be personalised and coordinated. Team members must be trained adequately in active listening and be supported by their managers to talk to patients about their recovery.

Clinical leadership

The engagement for this policy indicates that models of leadership for the CMHTs should be reviewed in line with international practice. Clinical leadership, as described in AVFC 2006–16, was vested in the consultant psychiatrist role, in keeping with the requirements of legislation. Consideration should be given to amending legislation to facilitate the delivery of a shared governance model.

In the meantime, as described in AVFC, Team Coordinators should be in place in all CMHTs to facilitate enhanced intra-team management of referrals and clinical inputs as well as to create appropriate coordinated linkages into the community. Such a shared governance model necessitates a focus on team effectiveness, requiring each team member to work to the maximum of their scope of practice, as well as to develop shared team competencies. In this way, each member of the team takes responsibility for the effectiveness of the team so that there is appropriate service delivery and the outcomes set out in this policy are achieved.

The range of supports available through Community Mental Health Teams are set out in Figure 3.4. Access to CMHTs is generally through GP referral or it can occur following attendance at an emergency department (ED). Investment in acute medical emergency services under the HSE's Acute Medicine Clinical Programme needs to be prioritised to include the streamlining of the triage process so that access to the correct mental health assessment can be provided as early as possible.

Alternative Access Routes to Emergency Care

You said...

EDs are not suitable environments for children to wait for assessment and alternatives should be explored.

We listened.

Quite often, people in need of support or urgent care attend emergency departments (EDs) to access mental health treatment. While individuals are in many cases appropriately seen in an ED, it can be a challenging environment for some people with mental health difficulties. Specifically, the stakeholder consultations for this report prioritised the availability of non-ED-based out-of-hours alternatives offering referral to mental health services.

Out-of-hours crisis cafés are proposed as a new referral option, to support individuals to deal with an immediate crisis and to plan safely, drawing on their strengths, resilience and coping mechanisms to manage their mental health and wellbeing. Attendees would be able to access talk therapies, coping strategies and one-to-one peer support, provided by paid core staff assisted by a team of appropriately trained volunteers, working on a rota basis. The cafés may reduce demands on EDs by providing an environment more suited to the needs of some individuals who present. Moreover, appropriately and safely staffed crisis cafés can also be an alternative access point for children and adolescents. In addition,



tele-psychiatry models could be a way to provide 24-hour psychiatry consultations to service users of all ages, who can access supports from a variety of locations such as primary care centres, GP practices and VCS services.

In proposing the continuum of services set out at Figure 3.3 as the vision for a modern recovery-oriented mental health system, it is recognised that the balance of emphasis across each service element may vary in HSE areas across the country, in line with prevailing needs and geographies. Every service element must be present in each Regional Integrated Care Organisation (RICO) area but each area would need to consider the best balance and models of delivery and service elements to meet their area needs, taking into account their staffing levels. These proposals include the proviso that all service elements in Figure 3.3 should include access to talk therapies as a first-line treatment option for most people who experience mental health difficulties.

Specialist mental health services across the lifecycle

This section details the mental health services that should be available for individuals accessing specialist services at different stages of the life cycle.

Child and adolescent mental health services

Child and adolescent mental health services (CAMHS) are the first line of specialist mental health services for children and young people who are directly referred to the CAMHS team from a number of sources. The CAMHS teams accept referrals for moderate-to-severe mental health difficulties of children and adolescents which cannot be managed within primary care. Referrals to CAMHS also support children and adolescents with a mental illness and intellectual disabilities. Where the child or adolescent presents with a moderate-to-severe mental disorder and autism, CAMHS teams provide appropriate multi-disciplinary mental health assessment and treatment for the mental disorder in partnership with other agencies including HSE Primary Care, Children's Disability Network Teams, and other agencies supporting children and adolescents.

The 0–25 cohort

The *Youth Mental Health Task Force Report* recommends that the age range for eligibility for CAMHS be increased to 25 in order to improve continuity of care and lead to better outcomes for service users, as the transition from CAMHS to adult services is complex. At present, young people make the transition to adult services at the age of 18. This can be an age in life when change, uncertainty and vulnerabilities prevail. Failure to secure a safe transition can lead to disengagement and ultimately to poorer health outcomes. There are considerable implications in this reconfiguration of services. A pilot reconfiguration of services that could ascertain the specific mental health needs of the 0–25 cohort should be established to inform the staffing requirements of CAMHS and General Adult Mental Health Service (GAMHS) teams.

It is recognised that it will take a number of years to provide the necessary training for a new cohort of mental health professionals to facilitate such a shift and therefore the current relevant professionals are required to be flexible and open to new approaches. In the medium term, it should be possible to provide a seamless, age-appropriate specialist mental health service for those aged up to 25 years. In the interim, an immediate priority is to ensure that short-term additional supports are available for individuals who are making the transition from CAMHS to GAMHS at age 18, given the issues and vulnerabilities that can prevail.

Although there has been an increase in the number of CAMHS inpatient beds since the original *AVFC* policy was published, it is acknowledged that there have been some challenges in accessing sufficient age-appropriate inpatient beds, exacerbated by staff availability issues and complexity of cases. Adult inpatient units are, generally speaking, not appropriate environments for children and adolescents. However, in the event that there is no CAMHS inpatient bed available and short-term admission to an adult unit is the only option, then a range of actions are necessary. These actions need to be consistent with the CAMHS inpatient standard operating guidelines to provide appropriate, effective and safe care.

One of the main challenges regarding access to inpatient or residential care concerns the small number of children and adolescents who have multiple needs,

including intellectual disability, autism or both, and who require high-intensity support. A specialist unit for such children and adolescents would not necessarily address the unique needs of each and would be geographically inaccessible for many. A preferred approach is to develop a bespoke set of supports that address the needs of each individual case in the most appropriate setting.

General adult mental health services (GAMHS)

Major life events occur more often during adulthood. Significant additional pressures such as unemployment, bereavement or lack of accommodation can contribute to poor mental health. As a result, the majority of services provided are designed to support the general adult population.

There are 114 General Adult CMHTs operating across the country with a staff in 2017 of 1,522 clinical whole-time-equivalents (WTEs) – about 76% of that envisaged in AVFC 2006–2016. It is worth noting that the adult population aged 18 to 65 years has been growing only modestly in recent times, averaging 0.8% each year between the 2011 and the 2016 censuses. A service improvement project in the HSE has been examining the service user’s journey through General Adult CMHTs to ensure consistency in user experiences and service offerings across the country. Key themes and priority areas have been identified which agree with many of the recommendations already made in Domain 2 and apply to and beyond General Adult CMHTs. These themes include information, education and signposting for patients; real multi-disciplinary working; greater links with external community services; FCS involvement and support; among many others. An implementation plan will be developed to this end.

In line with the legal obligations under the Disability Act 2005, general adult mental health services will be accessible to people with disabilities who do not require a more specialist service.

You said...

There should be supported respite facilities as an alternative to inpatient acute care to meet the needs of the service user. The provision of day services or home outreach should be considered.

We listened.

Adult inpatient capacity and alternatives to inpatient admission

Following stakeholder engagement and noting the recommendations contained within the Joint Oireachtas Committee on the Future of Mental Healthcare report, the Oversight Group report highlighted the need to consider the adequacy of acute inpatient beds provided for the general adult and older adult population. While there are currently more acute adult inpatient beds per 100,000 than the recommended number suggested in the original AVFC, occupancy levels in acute beds indicate that the acute inpatient system is under considerable stress. Consideration of capacity needs to take into account the availability or lack of other beds, such as those in forensic, mental health and intellectual disability, child and mental health services and other specialist provision where additional capacity is planned. Capacity must also look at the alternatives to acute inpatient care, such as home care teams, assertive outreach teams and day hospitals, as described below. The ambitious focus of this policy is to prioritise and

develop a full suite of services to operate alongside appropriate and effective acute inpatient care and then to consider the need for further acute inpatient beds. In this way, any need for additional inpatient beds will be considered against available local services. Added to this there is a responsibility for providers to examine the use of beds and ensure that acute beds are used as intended and that delayed discharges are reviewed. Systematic analysis of capacity requirements should be a normal component of our mental healthcare system's planning cycle and take into account international evidence to assist planning and provision. It is proposed in this policy that a committee be established in the short term to review acute inpatient capacity and patient flow. Recommendations from this group will feed into the implementation monitoring committee for consideration.

In addition, the continuum provides for additional **day hospitals and home-based care teams** to provide continuous integrated care in partnership with assertive outreach teams and **crisis resolution teams**. These services will operate according to agreed standard operating procedures that provide for a range of alternatives to inpatient care. These services will offer additional options to acute inpatient care and assist with patient flow from hospital wards to alternative suitable settings. Recovery colleges will augment both services by offering service users an opportunity to create education courses in partnership with mental health professionals with a focus on equipping service users and their families, carers and supporters with new skills that foster recovery, promote self-care and enhance resilience. Together, these services will provide valuable appropriate alternatives to the acute hospital setting.

AVFC recognised the role of day hospitals as an alternative to inpatient admission for some service users, thereby diverting admissions to acute units. The function of a day hospital is to provide intensive treatment equivalent to that available in a hospital inpatient setting for acutely ill individuals, where they typically attend from their home or care setting for assessment, care and support. In day hospitals, multi-disciplinary teams provide a range of therapeutic services including occupational, psychological and social therapy programmes. Service users have integrated recovery care plans and can access

individual or group support programmes. Day hospitals will require core staff in addition to CMHTs, and in order to meet varied geographic needs, flexibility of infrastructure should be considered, with day hospitals operating as a fixed facility with mobile staff, or mobile staff providing day hospital care in a number of facilities.

In addition to day hospitals, **home-based crisis resolution teams** provide intensive support to individuals with severe mental health difficulties or those with first incidence presentation who are in crisis. Crisis resolution teams also provide an alternative to inpatient treatment. Support from these teams is time-limited, providing intensive intervention and support with sufficient flexibility to respond to different service user or carer needs. Typically, this entails a range of therapeutic approaches, including medication management, cognitive and behavioural interventions and evidence-informed family interventions. The teams provide a rapid response and 24-hour service, with support provided in the service user's own environment and with the active involvement of service users and their family, carers and supporters, and liaison with local partners – GP and VCS services. Home-based crisis resolution teams could also play a role in supporting out-of-hours crisis cafés.

The Recovery College is another service element which has been developed more recently. The goal of a Recovery College is to create a culture of recovery, and to empower people with mental health problems, their families and friends and the broader community to improve quality of life and to promote community involvement through the provision of co-produced and co-facilitated learning and conversation.

Individuals who have multifaceted needs require high-intensity support – beyond those discussed in this section – and specialist units will not necessarily address their unique needs. In addition, some units are geographically inaccessible for many. The person-centred approach of this policy suggests that it might be more appropriate to design a special set of supports that address the needs of the individual in a suitable setting. To this end, AVFC sought the establishment of a number of **intensive care rehabilitation units (ICRUs)** for a small number of people with difficult-to-manage

behaviour. ICRUs are units which provide secure care for a small number of people on a longer-term basis.

In addition, there is also a continued need for short-term **psychiatric intensive care units (PICUs)** for a small number of people who cannot be accommodated in acute units due to the nature of their behaviour. Two psychiatric intensive care units to meet this need have already been developed in response to AVFC and it is proposed that two more units be developed and future capacity considered as part of the acute inpatient group. These will be discussed in further detail in the forensic mental health services section later in this chapter.

An alternative form of care to ICRUs and PICUs is the development of **individualised packages** of care for people whose behaviour and complexity of need requires a high level of care. Individuals may have other diagnoses as well as mental health difficulties. A preferred approach is to have a special set of supports that address the needs of each case in the best setting. This should also facilitate care for many who are currently on placements outside their area.

Mental health services for older people

As in other European countries, the population over 65 years is rising in Ireland. Mental health difficulties in later life are both common and treatable but when unrecognised and/or untreated are associated with increased morbidity and mortality. Dementia for example, affects 5% of people over 65 increasing to 20% of those over 80 years. People with dementia are typically referred to mental health services for older people teams when their diagnosis is associated with significant behavioural and/or psychological symptoms. Access to services for people with early onset dementia is inconsistent across the country. In addition, common and predictable life events such as bereavement should be provided for through identification of need and service access but also through strengthened, enhanced communities.

The expertise for the assessment and treatment of mental health difficulties in older people is found in mental health services for older people (MHSOP) teams. Access to these teams can be difficult. Older people who have mental health difficulties should have access to specialist expertise and joint care

arrangements should be put in place where expertise to meet the 'whole' needs of an individual is located in both the general adult teams and the mental services for older people teams. The age range for mental health services and general adult health teams needs to be reviewed to reflect the higher life expectancy and changing expectations of ageing in Ireland.

Home-based assessment and supports are particularly important for older people. Voluntary community sector (VCS) organisations can work with MHSOP teams and play an important role in connecting older people to activities in their local community. Given that one in three people over 65 regularly takes five or more medications, a combined focus on improving access to talk therapies for older people and on more effective medication management is a priority.

Tailored interventions

Forensic mental health services

The forensic mental health services (FMHS) are concerned with the treatment of people with mental health difficulties who have come in contact with law enforcement agencies, that is, An Garda Síochána, the courts and the Prison Service. The FMHS also provide expertise to other specialist mental health services on the assessment and management of people with mental health difficulties who have a propensity for violence and challenging behaviour. In this refresh it is important to repeat the commitment made in AVFC that services to this group should be based on the same values and principles applied throughout the policy. Thus this policy reinforces the need for every person with mental health difficulties coming into contact with the forensic system to have access to a comprehensive stepped (or tiered) mental health service that is recovery-oriented and based on integrated co-produced recovery care plans supported by advocacy services as required.

As with all other mental health services described in this domain, the stepped care approach applies to those in need of forensic mental health support and services. Access to prevention services, primary care mental health services, early intervention and specialist mental health services as described in earlier sections should be open to this group as to any other.

There are a number of forensic mental health initiatives that will work together to enhance mental health services over the lifetime of this revised policy:

- The development of a new state-of-the-art facility in Portrane, North County Dublin in 2020 will provide care for up to 170 individuals and will continue to provide services both in the community and in prisons. The facility will also have a forensic child and adolescent mental health service (FCAMHS) unit and an intensive care rehabilitation unit (ICRU).
- The 2015 *New Connections* report set out a series of recommendations for adequately meeting the psychological needs of the prisoner population. These include access to a range of talking therapies and the development of mental health peer supports in prisons. The recommendations of the *New Connections* report are promoted and endorsed in this policy.
- Court diversion schemes seek to ensure that offenders with a mental health difficulty do not get involved needlessly in the criminal justice system. When offending behaviour is clearly related to a mental health difficulty, a diversion scheme can allow offenders to be diverted to the care of the mental health services. In those circumstances, offenders do not go into the Prison Service, where there may be a delay in identifying and responding to their mental health needs.
- The national forensic mental health service (NFMHS) began its prison in-reach and court liaison service (PICLS) in 2007. The service aims to identify prisoners with a mental health difficulty as rapidly as possible and put in place practical solutions for appropriate mental healthcare.

While many countries have introduced specific and comprehensive mental health policy changes to provide for court diversion, Ireland does not yet have a specific policy to provide for court diversion to community settings or community treatment. The effectiveness of the service depends on ongoing resourcing and access to facilities and services in the community to which individuals can be diverted.

A small group of individuals each year who are found not guilty by reason of insanity (NGBRI) must be detained under the Criminal Law Insanity Act in a designated centre under the Act. An intensive care



rehabilitation unit (ICRU) will be built as an adjunct to the new forensic facility on the Portrane campus. This unit will have dual registration as an approved centre under the Mental Health Act and a designated centre under the Criminal Law Insanity Act. It will therefore be available to accept those who have NGBRI status but who do not require the level of care provided in the Central Mental Hospital (CMH). The operation of the new ICRU centre will be reviewed to determine the need for and effectiveness of this model of care and the possible location of further ICRUs.

Furthermore, the profile of the mental health needs of the prison population needs to be explored to gather data on the prevalence of autism, intellectual disability and needs relating to addiction and dual diagnosis, often not specifically catered for by an associated model of care (MOC) in prisons. Such data will allow for a more joined-up approach by all professionals delivering care in a prison setting. In an effort to support this joint approach, mental health advocacy groups could be encouraged and supported to connect into prison settings to ensure that individuals are aware of and can access the services they need to support them in their recovery.



Dual diagnosis

You said...

People with addictions should not be excluded from accessing mental health services. People with a dual diagnosis need to be able to get the best care available to assist their recovery.

We listened.

(a) One form of dual diagnosis is defined as the co-existence of mental health problems and significant substance – drug and alcohol – misuse problems in an individual. Drug and alcohol misuse frequently co-exist with mental health difficulties. Once mental health and drug and alcohol problems become established, they can negatively impact each other.

Access to primary care addiction services and existing mental health supports when there is a co-existing mental health/addiction problem remains complicated. It is recognised that there is significant overlap between these conditions and that an individual with an addiction has a right to access relevant mental health supports within primary care. The national policy on substance misuse, *Reducing Harm/Supporting Recovery*, describes how tiered levels of alcohol addiction supports are needed in order to develop effective mental health services for people with co-existing mental health difficulties and addiction or dual diagnosis. This tiered approach should extend to mental health supports within primary care. The HSE Dual Diagnosis Improvement Programme also emphasises the need for integrated services across

primary care and specialist mental health services. There is a need to further develop universal access to primary care addiction services that include associated models of leadership and governance.

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

AVFC recommended that specialist mental health services should support only individuals 'whose primary difficulty is mental health'. This recommendation is now reversed. Individuals with co-existing mental health difficulties and addiction to either alcohol or drugs should not be prevented from accessing mental health services. Consequently, it will not be necessary to establish whether a mental health difficulty is 'primary' for an individual to access the support of a mental health team. A shared case management approach may be required for particularly complex patients.

Collaborative working between mental health services and social inclusion addiction services has commenced with the development of shared areas such as alcohol liaison posts with acute hospitals and an emerging model of tele-psychiatry support for adolescents with both morbid mental health and addiction problems. This approach agrees with the recommendations of the national policy on substance misuse, *Reducing Harm/Supporting Recovery*, which are consistent with the aspirations of this mental health policy. In order to provide care with clear pathways, a model of care describing the tiered levels of support needs to be developed and, in fact, work is continuing in the HSE to prepare such a model. The model should provide for psychiatry support at primary care level, if required,

but developed as an ‘outreach’ service provided by dual diagnosis specialist mental health teams.

(b) Another form of dual diagnosis is where someone has an intellectual disability or autism and a concurrent mental health condition. It is accepted that mental health problems can be more common for people with autism spectrum disorder (ASD) than in the general population. In line with the stepped care approach and the continuum of care, primary care and Community Mental Health Teams need to have the training and skills required to support people with such dual diagnoses where that is the appropriate tier of care.

Mental health services for homeless people

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

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

Liaison mental health services

Liaison mental health services (LMHS) provide a critical specialist mental health service for everybody, young and old, attending emergency departments, as well as patients with both physical and mental health support needs who are inpatients in acute hospitals. Liaison mental health deals with the area

where physical and mental health meet and ensures that individuals in acute hospitals can access mental health services. *AVFC* recommended an increase from 9 LMHS teams to 13; however, service pressures in acute hospitals regarding the provision of liaison mental health services are emerging, specifically in the areas of psycho-oncology, perinatal mental health and the mental health of older people – not least in the context of the ageing population. Investment in the expansion of LMHS services is needed to address emerging liaison demands while responding to newer LMHS service developments.

Specialist needs-based services

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

To reflect the recovery ethos and the nature of the work in rehabilitation teams, it is proposed that rehabilitation and recovery services for people with complex mental health difficulties be re-named ‘intensive recovery support services’ (IRSS). These teams can be accessed by people who have complex and multiple needs and who require intensive support, often, but not always, on a long-term basis.

Emerging models of care recommend a range of alternative care structures and associated intensive recovery support services for service users across all Community Health Networks.¹⁰ These include specialised rehabilitation units (SRUs) providing an intensive inpatient rehabilitation programme for service users with the greatest need, and active medium-term recovery supports based on an integrated recovery care plan. Specialised rehabilitation units are included in the proposed ‘continuum of care’, together with community rehabilitation residences (CRRs). Units depend on a multi-disciplinary team to support and enable the person concerned to move towards independent community living accommodation. The full range of supports and services described in Figure 3.4 should be available to this group and include additional support from assertive outreach teams.

¹⁰ HSE. Model of Care for People with Severe and Enduring Mental Illness and Complex Needs (2019). Available at: <https://www.hse.ie/eng/services/list/4/mental-health-services/rehabilitation-recovery-mental-health-services/model-of-care-for-people-with-severe-and-enduring-mental-illness-and-complex-needs.pdf>

Assertive Outreach Teams

You said...

We need more outreach teams to meet people where they are; meeting people in their homes, nursing homes, asylum centres or homeless services should be available and should provide early intervention/prevention and support.

We listened.

Assertive outreach teams have a specific focus on rehabilitation and recovery and operate specialised mobile treatment. They work to reduce hospital admissions and readmissions, prevent relapse, and improve a person's chances of returning to employment, education or training, and, more generally, to enhance their quality of life. Such intervention involves a multi-disciplinary team that could include a range of professionals including clinical psychologists, nurses, occupational therapists, peer and mental health or social care support workers, psychiatrists and social workers. The emphasis must be on an assertive approach to maintaining contact with service users and on encouraging them to return to normal vocational and other life pursuits. The work of the assertive outreach teams and the intensive recovery support services will provide linkages

between patients and appropriate supports such as housing, employment and education. This policy advocates that assertive outreach teams be expanded so that specialist mental healthcare is accessible to those who might otherwise face difficulties accessing it.

Mental health services for early intervention in psychosis

The HSE *National Clinical Programme for Early Intervention in Psychosis* has the potential to transform the lives of people with emerging or first-episode psychosis. Where access to a specialist integrated service is not available, the risk and experience of long-term disability in this population is well known. The clinical programme published a model of care for early intervention in psychosis (MOCEIP) in June 2019. Following this model there has been extensive training of clinicians in behavioural family therapy (BFT) as well as ongoing work to provide specialist cognitive behavioural therapy (CBT) for patients with psychosis. This is enhanced by the development of an individual placement and support (IPS) service to facilitate progression or return to competitive employment. Three demonstration pilot sites have been activated and if positively evaluated, additional sites will benefit service users in other regions. The Social Reform Fund coordinates a similar IPS programme that works with Community Mental Health Teams; this is described in greater detail in Chapter 4, Social Inclusion, under the heading 'Employment supports'.



People with an intellectual disability

You said...

There are many groups in Ireland who have specific needs. Mental health services should be equipped and trained to deal with the multifaceted needs of these individuals.

We listened.

As described in *AVFC*, mental health and intellectual disability (MHID) teams should be developed to provide population-wide coverage and ensure fair and equal access to mental healthcare for people of all ages with an intellectual disability (ID). The tiered approach to patient care advocated in this policy will support people with intellectual disability in accessing mainstream services especially where the MHID model of care is not yet in place.

Significant mental health and intellectual disability service gaps remain across the country and a key objective ought to focus on further delivery of a national network of MHID teams – for adults and children – with clear catchment areas defined. A person-centred MHID team model of care is being formalised to ensure consistent service delivery. This model should be adopted and replicated nationally. A phased resource plan is in place to develop ‘baseline teams’ involving a consultant psychiatrist, a clinical nurse specialist, a psychologist and administrative support in areas where there is no existing team and to augment the existing teams as needed. Given the communication challenges that can exist for these patients, it is also important to include speech and

language therapists (SLT) as core members of the Adult-ID and CAMHS-ID teams.

AVFC recommended the development of acute beds and day hospital services for mental health and intellectual disability treatment. Investment in acute MHID services needs to be prioritised, as envisaged in *AVFC*, and developed as part of the HSE MHID service improvement programme and in conjunction with HSE social care and Section 38/39 social care voluntary agencies. Innovative acute treatment services need to be explored, which might include therapeutic respite for children with intellectual disabilities and significant mental health and behavioural support needs.

ADHD

While attention deficit hyperactivity disorder (ADHD) in children is a clearly recognised condition requiring a stepped care approach, as is evident in a growing body of clinical research, ADHD in adults is an impairing lifelong condition. It is a condition which is under-recognised and under-diagnosed, and one that leads to impaired quality of life, results in ongoing distress, and is often associated with inappropriate treatment interventions. Once diagnosed, adults with ADHD can benefit from mental health treatment, including psychosocial interventions. *Sharing the Vision* supports implementation of the HSE national clinical programme for adults with ADHD. This programme emphasises the need for appropriate specialist assessment and psychosocial interventions to support affected people as they move from children’s into adult mental health services.

Suicide prevention

Connecting for Life (CFL) (2015–2020) is a whole-of-society strategy to coordinate and focus national efforts in Ireland to reduce the loss of life by suicide and to reduce cases of self-harm. The strategy applies to the whole population and to specified priority groups. It involves preventive and awareness-raising work with the population as a whole, support work with local communities and targeted approaches to priority groups. The strategy notes that in high-income countries, mental health difficulties are present for up to 90% of people who die by suicide. It recognises that linking with *AVFC* is central to the success of the work outlined in *Connecting for Life*. This policy supports continued implementation of the *Connecting for Life* recommendations.

Eating disorders

Eating disorders are associated with high mortality and morbidity. The HSE *National Clinical Programme for Eating Disorders* (NCP-ED) is a collaborative initiative between the HSE, the College of Psychiatrists of Ireland and Bodywhys – the national support group for people with eating disorders. This programme applies across the age range, that is, child and adult, and has developed a model of care to introduce new services and to improve existing services for people with eating disorders. The eight recommendations on eating disorders made in AVFC are covered in the actions in the model and are endorsed in this policy.

Specialist perinatal supports

The perinatal period brings risks of mental health difficulties for some women. Perinatal mental health disorders include both new onset and a relapse or recurrence of pre-existing disorders.¹¹ Mental health difficulties at this sensitive time may affect the relationship between mother, child and family unit. This carries the risk of the later development of significant emotional and behavioural difficulties in the child. In its 2016 Service Plan, the HSE Mental Health Division, in recognition of the importance of perinatal mental health, included the development of a Model of Care for Specialist Perinatal Mental Health services that focus on the mother, the baby and their relationship in the context of the family. The Model of Care for Specialist Perinatal Mental Health should continue to be resourced and rolled out nationally.

Neuro-rehabilitation (including acquired brain injury)

Neuro-rehabilitation is the process of supporting individuals with brain or spinal injuries, who often experience significant mental health difficulties requiring specialist care. People with these types of injuries often experience significant difficulties in accessing appropriate services that require an integrated response from the health service. In 2019 the HSE published the *National Strategy and Policy for the Provision of Neuro-rehabilitation Service in Ireland – Implementation Framework (2019–2021)*, which provides for specific specialist mental health

services including neuro-psychiatry, an essential part of an effective neuro-rehabilitation service.¹² These mental health supports could be provided as part of the development of liaison mental health services and in the context of the proposed integrated Liaison Mental Health Model of Care. Implementation of the *National Strategy and Policy for the Provision of Neuro-rehabilitation Service in Ireland – Implementation Framework* should remain a priority and should include the essential mental health support components of this service development, in the context of the proposed Liaison Mental Health Model of Care.

Providing mental health services that recognise and respond to diversity

The AVFC policy recognised that there are groups of people in the population who have additional needs when they develop a mental health difficulty. Specifically, it recognised that service users from other countries and cultures, Travellers and the LGBTQ+ community may have specific vulnerabilities or difficulties that should be considered in the way mental health services are delivered. *Sharing the Vision* proposes that a more developed framework for the implementation of cultural, diversity and gender competency is required to respond to the needs of these groups as per the DCYA LGBTQ+ *National Youth Strategy, 2018–2020*.

Around seven per 10,000 people in the general population have severe-to-profound deafness at any one time and the prevalence of mental health difficulties among this group is much higher than in the general population. Mental health services must be culturally appropriate and accessible to members of the deaf community through the provision of training, supervision and support for staff. Allied to this there is a need to ensure that interpreters are appropriately qualified to work in a mental health service context. Outreach initiatives from mental health services to people who are deaf, live in the community and are at risk, or who are already living with a mental health difficulty, should also be available.

¹¹ The perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth: World Health Organization. 'Maternal, new-born, child and adolescent health: Maternal and perinatal health'. Accessed 17 February 2020. Available at: https://www.who.int/maternal_child_adolescent/topics/maternal/maternal_perinatal/en/

¹² HSE. National Strategy & Policy for the Provision of Neuro-Rehabilitation Services in Ireland: Implementation Framework 2019–2020 (2019). Available at: <https://www.hse.ie/eng/services/list/4/disability/neurorehabilitation/national-strategy-policy-for-the-provision-of-neuro-rehabilitation-services-in-ireland.pdf>



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

Access to advocacy

Advocacy is about having someone available to help a person make decisions about healthcare or other services such as access to social welfare, housing or other social entitlements or services. Advocates can also help an individual to make a complaint or seek redress, thereby holding public services to account. Advocates are people whose primary role is to support an individual around decision-making or having their voice heard. For a variety of reasons, people may not be able to advocate for themselves. People may need to advocate for themselves ('self-advocacy'), need support from a peer ('peer advocacy') or need someone to speak on their behalf ('representative advocacy').

AVFC, in Recommendation 3.2, recommended that 'advocacy should be available as a right to all patients in all mental health services in all parts of the country'. However, the research and engagement for *Sharing the Vision* showed that there are gaps in access to advocacy supports and that some needs are unmet. Challenges include a lack of awareness of existing advocacy supports. This is particularly relevant for people with mental health difficulties living in the community, relative to those being supported in acute units and longer-stay facilities.

The right to advocacy needs to be re-emphasised and the development of additional advocacy services pursued. There is also a need for research to determine the advocacy needs of people with a mental health difficulty living in the community, as knowledge of the scale and nature of need in this area is limited. When the Assisted Decision-Making (Capacity) Act is commenced, adults with a mental health condition will have the option to appoint an assistant to help them in making decisions in relation to their mental health treatment and in making Advance Care Directives in relation to anticipated future treatment.

Domain: Service access, coordination and continuity of care recommendations

13	Directories of information on VCS supports should be provided to staff working in primary care and CMHTs to ensure they are aware of and inform service users and FCS about all supports available including those from Voluntary and Community Sector organisations in the local area.
14	Where Voluntary and Community Sector organisations are providing services aligned to the outcomes in this policy, operational governance and funding models should be secure and sustainable.
15	Social prescribing should be promoted nationally as an effective means of linking those with mental health difficulties to community-based supports and interventions, including those available through local Voluntary and Community Sector supports and services.
16	Access to a range of counselling supports and talk therapies in the community/primary care should be available on the basis of identified need so that all individuals, across the lifespan, with a mild-to-moderate mental health difficulty can receive prompt access to accessible care through their GP/ Primary Care Centre. Counselling supports and talk therapies must be delivered by appropriately qualified and accredited professionals.
17	The mental health consultation/liaison model should continue to be adopted to ensure formal links between CMHTs and primary care with the presence of, or in-reach by, a mental health professional as part of the primary care team or network.
18	An implementation plan should be developed for the remaining relevant recommendations in <i>Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services (2012)</i> in order to improve integration of care for individuals between primary care and mental health services in line with emerging models and plans for Community Health Networks and Teams.
19	The physical health needs of all users of specialist mental health services should be given particular attention by their GP. A shared care approach is essential to achieve the best outcomes.
20	There should be further development of early intervention and assessment services in the primary care sector for children with ADHD and/or autism to include comprehensive multi-disciplinary and paediatric assessment and mental health consultation with the relevant CMHT, where necessary.
21	Dedicated community-based Addiction Service Teams should be developed/enhanced with psychiatry input, as required, and improved access to mental health supports in the community should be provided to individuals with co-existing low-level mental health and addiction problems.
22	The provision of appropriate environments for those presenting at emergency departments who additionally require an emergency mental health assessment should be prioritised.
23	There should be continued investment in, and implementation of, the National Clinical Care Programme for the Assessment and Management of Patients Presenting to emergency departments following self-harm.
24	Out-of-hours crisis cafés should be piloted and operated based on identified good practice. Such cafés should function as a partnership between the HSE and other providers/organisations.
25	The multi-disciplinary CMHT as the cornerstone of service delivery in secondary care should be strengthened through the development and agreed implementation of a shared governance model.
26	CMHTs' outreach and liaison activities with Voluntary and Community Sector partners in the local community should be enhanced to help create a connected network of appropriate supports for each service user and their FCS.

27	An individualised recovery care plan, co-produced with service users and/or FCS, where appropriate, should be in place for, and accessible to, all users of specialist mental health services.
28	All service users should have a mutually agreed key worker from the CMHT to facilitate coordination and personalisation of services in line with their co-produced recovery care plan.
29	Further training and support should be put in place to embed a recovery ethos among mental health professionals working in the CMHT as well as those delivering services elsewhere in the continuum of services.
30	CMHTs and sessional contacts should be located, where possible and appropriate, in a variety of suitable settings in the community, including non-health settings.
31	The potential for digital health solutions to enhance service delivery and empower service users should be developed.
32	The composition and skill mix of each CMHT, along with clinical and operational protocols, should take into consideration the needs and social circumstances of its sector population and the availability of staff with relevant skills. As long as the core skills of CMHTs are met, there should be flexibility in how the teams are resourced to meet the full range of needs where there is strong population-based needs assessment data.
33	The shared governance arrangements for CMHTs as outlined in AVFC 2006–16 should be progressed, including further rollout of Team Coordinators.
34	Referral pathways to all CMHTs should be reviewed and extended by enabling referrals from a range of other services, (as appropriate) including Senior Primary Care Professionals in collaboration with GPs.
35	A comprehensive specialist mental health out-of-hours response should be provided for children and adolescents in all geographical areas. This should be developed in addition to current ED services.
36	Appropriate supports should be provided for on an interim basis to service users transitioning from CAMHS to GAMHS. The age of transition should be moved from 18 to 25, and future supports should reflect this.
37	Nationally agreed criteria should be developed to govern and resource individualised support packages for the specific needs of a small cohort of children and young people who have complex needs.
38	In exceptional cases where child and adolescent inpatient beds are not available, adult units providing care to children and adolescents should adhere to the CAMHS inpatient Code of Governance.
39	The HSE should consult with service users, FCS, staff, and those supporting priority groups to develop a standardised access pathway to timely mental health and related care in line with the individual's needs and preferences.
40	Sufficient resourcing of home-based crisis resolution teams should be provided to offer an alternative response to inpatient admission, when appropriate.
41	A Standard Operating Guideline should be developed to ensure that sufficiently staffed day hospitals operate as effectively as possible as an element of the continuum of care and an alternative to inpatient admission.
42	Individuals who require specialist Mental Health Services for Older People (MHSOP) should receive that service regardless of their past or current mental health history. People with early onset dementia should also have access to MHSOP.
43	The age limit for MHSOP should be increased from 65 years to 70 years supported by joint care arrangements between GAMHS and MHSOP teams for individuals who require the expertise of both.

44	GPs, mental health service prescribers and relevant stakeholders should collaborate to actively manage polypharmacy.
45	The HSE should collate data on the number and profile of delayed discharges in acute mental health inpatient units and develop appropriately funded responses.
46	An Expert Group should be set up to examine Acute Inpatient (Approved Centre) bed provision (including PICUs) and to make recommendations on capacity reflective of emerging models of care, existing bed resources, and future demographic changes, with such recommendations being aligned with <i>Sláintecare</i> .
47	Sufficient Psychiatric Intensive Care Units (PICUs) should be developed with appropriate referral and discharge protocols to serve the regions of the country with limited access to this type of service.
48	A cross-disability and mental health group should be convened to develop national competence in the commissioning, design and provision of intensive supports for people with complex mental health difficulties and intellectual disabilities and to develop a set of criteria to govern the provision of this service.
49	Intensive Recovery Support (IRS) teams should be provided on a national basis to support people with complex mental health needs in order to avoid inappropriate, restrictive and non-recovery-oriented settings.
50	The development of a national network of MHID teams and acute treatment beds for people of all ages with an intellectual disability should be prioritised.
51	Speech and Language Therapists (SLT) should be core members of the Adult-ID and CAMHS-ID teams.
52	Investment in the implementation of the Model of Care for Early Intervention Psychosis (EIP), informed by an evaluation of the EIP demonstration sites, should be continued.
53	The phased implementation and evaluation of appropriate service responses to support adults with ADHD should be developed and resourced in line with the National Clinical Programme for Adults with ADHD.
54	Every person with mental health difficulties coming into contact with the forensic system should have access to comprehensive stepped (or tiered) mental health support that is recovery-oriented and based on integrated co-produced recovery care plans supported by advocacy services as required.
55	There should be ongoing resourcing of and support for diversion schemes where individuals with mental health difficulties are diverted from the criminal justice system at the earliest possible stage and have their needs met within community and/or non-forensic mental health settings.
56	The development of further Intensive Care Rehabilitation Units (ICRUs) should be prioritised following successful evaluation of operation of the new ICRU on the Portrane Campus.
57	A tiered model of integrated service provision for individuals with a dual diagnosis (e.g. substance misuse with mental illness) should be developed to ensure that pathways to care are clear. Similarly, tiered models of support should be available to people with a dual diagnosis of intellectual disability and/or autism and a mental health difficulty.
58	In order to address service gaps and access issues, a stepped model of integrated support that provides mental health promotion, prevention and primary intervention supports should be available for people experiencing homelessness.
59	Assertive outreach teams should be expanded so that specialist mental healthcare is accessible to people experiencing homelessness.



60	Continued expansion of Liaison Mental Health Services for all age groups should take place in the context of an integrated Liaison Mental Health Model of Care.
61	The HSE should maximise the delivery of diverse and culturally competent mental health supports throughout all services.
62	Building on service improvements already in place, individuals who are deaf should have access to the full suite of mental health services available to the wider population.
63	Persons in Direct Provision services and refugees arriving under the Irish refugee protection programme should have access to appropriate tiered mental health services through primary care and specialist mental health services.
64	Appropriately qualified interpreters should be made available within the mental health service and operate at no cost to the service user.
65	The HSE should ensure access to appropriate advocacy supports in all mental health services.



Chapter 4

Social Inclusion Domain

Introduction

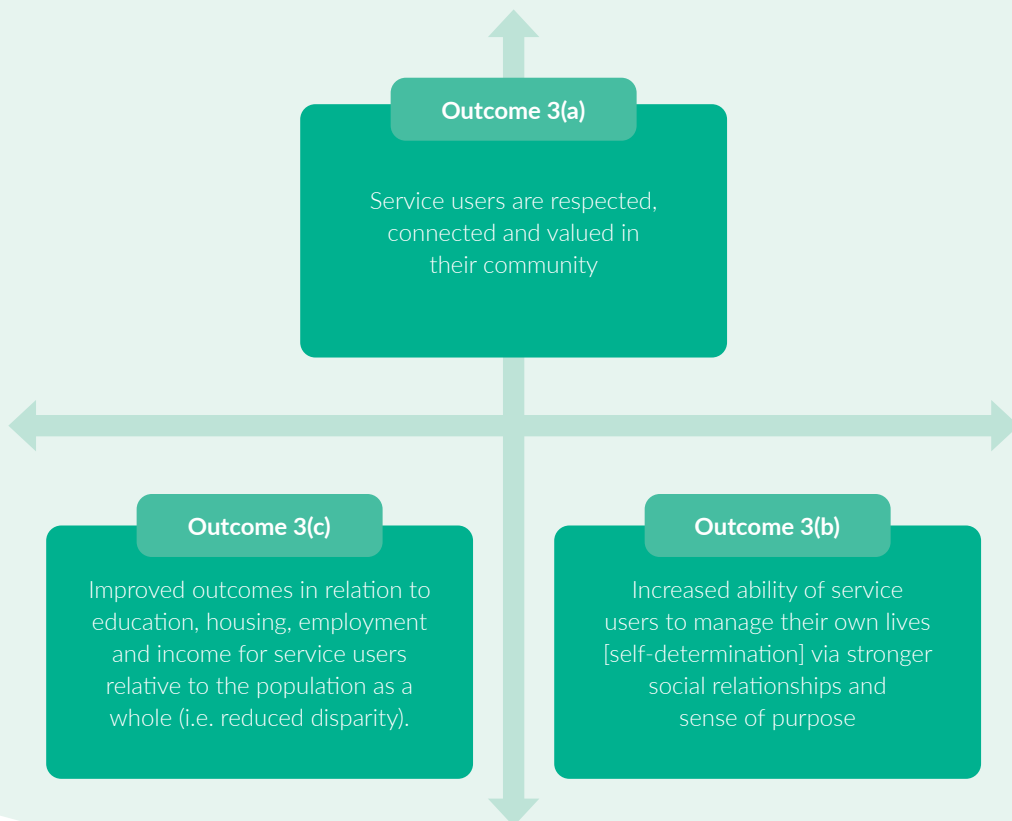
This domain focuses mainly on people living with complex mental health difficulties who are most vulnerable to social exclusion arising from stigma and discrimination, inadequate accommodation of their needs in workplaces, and insufficient access to income, housing, employment and training or education. The episodic nature of these mental health problems can lead to employment difficulties and challenges availing of social support systems.

People with disabilities, including mental health difficulties, often experience numerous barriers to employment and housing. There may also be barriers to more general social inclusion of people with mental health difficulties. Tackling stigma and discrimination, as outlined in Domain 1 (promotion, prevention and early intervention), can help to build social inclusion. Being empowered to live in one's own home and community, with additional supports where

appropriate, is a key factor in facilitating and sustaining recovery.

The various recommendations and interventions proposed in this domain are all aimed at enabling service users living with complex mental health difficulties and their family, carers and supporters to feel connected and valued in their community. This domain will facilitate improved outcomes for people with mental health difficulties in housing, employment, income and training or education. Better outcomes, brought about by building stronger social relationships and through developing and enhancing access to housing, employment, income and education or training, will nurture social inclusion and respect for diversity. These recommendations aim to empower service users by supporting them to achieve full and effective participation in society. Figure 4.1 shows the outcomes for the domain social inclusion.

Figure 4.1: Outcomes: social inclusion



Equality of access

AVFC recognised that individuals with mental health difficulties should have access to housing, employment and education or training on the same basis as every other citizen. The United Nations Universal Declaration of Human Rights recognises that people with disabilities should have equal rights to live in a community and that measures to facilitate their full inclusion and participation should be prioritised including access to education, health, employment and social protection. This policy incorporates the same fundamental principle of equality of access to housing, employment and training or education for people living with a mental health difficulty.

Housing supports

People with poor mental health require access to good-quality, secure and appropriate housing to facilitate and sustain their recovery. A lack of suitable housing as an alternative to institutional care can lead to an inefficient and expensive mental health system, with service users receiving unsuitable care. Housing supports for these people require effective collaboration between government departments, local authorities and social housing organisations. Apart from housing, there is also a need to ensure that those with complex mental health difficulties receive multi-disciplinary supports from health professionals and VCS organisations to improve their quality of life. Service users also require assistance to sustain tenancies and live independently. As a result, there must be effective liaison between mental health services and local authorities in the provision of social housing for patients who require it. Central to this is ensuring that people with complex mental health difficulties have equal access to housing allocations and that particular needs concerning their living environment are properly addressed.

AVFC highlighted that many people in HSE hostel accommodation would be better off living more independently in the community. It recommended that the housing and mental health sectors work together to achieve this and clarified the roles of the

two sectors. Important progress has been made and good practice developed through recent pilot projects that provide access to appropriate housing, as well as practical supports to sustain independent living, along with mental health rehabilitation supports.¹³ A joint protocol agreed by the DoH and the Department of Housing, Planning and Local Government (DHPLG) in consultation with key stakeholders is required to assist people living in HSE mental health service congregated settings to move to mainstream community-based living.¹⁴

Sustainable resourcing based on identified need for tenancy-related/independent living supports for patients with complex mental health difficulties must be considered for service users moving from HSE-supported accommodation to independent living and for individuals in hospital or homeless services identified as having a housing need.

Rebuilding Ireland – the Action Plan for Housing and Homelessness commits to delivering supports to homeless people with mental health and addiction issues. The plan recognises that homelessness is a complex phenomenon. It is usually the result of a number of interrelated issues, which can include mental health issues, addictions, relationship breakdown, family issues, domestic violence, financial loss, economic insecurity, rent arrears, tenancy issues, anti-social behaviour, crime, prisoner release and the vulnerability of migrants, among other factors. The plan therefore recognises that a successful 'whole-of-government' response is needed to such issues if the current homelessness crisis is to be tackled effectively. As such, recommendations in this policy need to be implemented together with various recommendations covered in chapter 3, including access to primary care services; supports for individuals with a dual diagnosis; and access to outreach mental health services for homeless people in emergency accommodation.

In 2016 new housing design guidelines were launched by the HSE and the Housing Agency to promote independent living and recovery for people living with mental health difficulties.¹⁵ The guidelines offer

¹³ Examples of collaborative pilot projects are the Doras and Slán Abhaile projects in North Dublin funded by the Genio Programme between 2012 and 2016.

¹⁴ A congregated setting is a place where ten or more people with a disability live together in a single living unit.

¹⁵ Áine O'Reilly, Emer Whelan, and Isoilde Dillon. Design for Mental Health – Housing Design Guidelines (Dublin: Housing Agency and HSE, 2016). Available at: <http://www.housingagency.ie/sites/default/files/publications/36.%20Design%20for%20Mental%20Health%20Housing-Design-Guidance-MAY-2017.pdf>

a perspective on housing type and design for people considering alternatives to congregated settings and should be a factor for all of the housing-related recommendations in this policy.

Employment supports

For individuals with enduring mental health difficulties, or those recovering from a once-off but significant mental health difficulty, the possibility of securing employment or returning to work can be a key factor in recovery. Employment is important to social status and identity as it provides social connection and promotes self-esteem, self-worth, increased confidence, responsibility and independence. Meaningful employment fosters hope, participation and a sense of a better and brighter future. In addition, employment can reduce and/or stabilise symptoms, increase self-worth and provide greater disposable income.

There are a number of employment and training initiatives that are important in terms of keeping people connected with other individuals and offering practical supports for gaining future employment. The individual placement and support (IPS) employment model helps people with a complex mental health condition to remain in or have access to work in mainstream settings while also supporting employers to address related recruitment and retention issues. As such, it differs from other vocational rehabilitation approaches that employ people in sheltered workshops and other non-mainstream jobs. The IPS model is internationally recognised as a cost-effective method of supporting people with severe mental health difficulties to achieve sustainable, competitive employment. The operation of the Social Reform Fund has provided an opportunity to roll out and implement the IPS model in all nine Community Healthcare Organisations (CHOs) and in the national forensic mental health service. IPS could be scaled up if that proves appropriate after a full positive evaluation has been completed.

Training and vocational education supports

The HSE's *New Directions – Personal Support Services for Adults with Disabilities Report* (2012) included

people with mental health difficulties, and the principles and models described in it are highly relevant for people with these difficulties.¹⁶ It commits to developing services that are person-centred and supporting the social inclusion of individuals in their community by building personal capacity and competencies. Where desired, services can provide bridging programmes to vocational training and other formal education and learning opportunities. Existing resources should be used by the HSE to reconfigure existing adult day supports for people with complex mental health difficulties, in line with the *New Directions* policy. Peer-provided and peer-led supports could have an important role to play in the range of services offered.

Income protection and social welfare

In *AVFC*, measures were put forward to protect the income of individuals with mental health difficulties that centred on informing them about the benefits to which they are entitled. *AVFC* also recognised that help and advice are needed to ensure such individuals are supported by the social welfare system, including the flexible provision of social welfare payments. These issues are still prevalent, and a crucial requirement is that income supports be flexible to allow people enter or leave the workforce in times of illness with confidence and security.

Peer-led, peer-run and community development projects

Peer-led and peer-run projects in the community are important ways to promote the social inclusion of people with a mental health difficulty. Specifically, there are key social and community activities that can enhance positive mental health by generating social capital and promoting an individual's social inclusion and mental health recovery. Such networks are a buffer against stress, while creating opportunities for meaningful social engagement and personal development. Several peer-led projects exist but are mainly volunteer-led initiatives that do not have access to reliable funding streams. It is important to fund peer-led projects, but funding must be informed by project evaluation and have standard operating guidance (SOG) in place.

¹⁶ National Working Group New Directions. *New Directions – Review of HSE Day Services and Implementation Plan 2012–2016 – Working Group Report* February 2012 (2012). Available at: http://www.inclusionireland.ie/sites/default/files/documents/Reports/new_directions.pdf

Domain: Social inclusion recommendations

66	Tailored measures should be in place in relevant government departments to ensure that individuals with mental health difficulties can avail, without discrimination, of employment, housing and education opportunities and have an adequate income.
67	Local authorities should liaise with statutory mental health services to include the housing needs of people with complex mental health difficulties as part of their local housing plans.
68	The Department of Health and the Department of Housing, Planning and Local Government, in consultation with relevant stakeholders, should develop a joint protocol to guide the effective transition of individuals from HSE-supported accommodation to community living.
69	In conjunction with supports provided by the HSE including Intensive Recovery Support teams, sustainable resourcing should be in place for tenancy-related/independent living supports for service users with complex mental health difficulties.
70	The housing design guidelines published by the HSE and the Housing Agency in 2016 to promote independent living and mental health recovery should be a reference point for all housing-related actions in <i>Sharing the Vision</i> .
71	A sustainable funding stream should be developed to ensure agencies can work effectively together to get the best outcomes for the individual using the Individualised Placement Support model, which is an evidence-based, effective method of supporting people with complex mental health difficulties to achieve sustainable, competitive employment where they choose to do so.
72	The current HSE funding provided for day centres should be reconfigured to provide individualised supports for people with mental health difficulties and be consistent with the <i>New Directions</i> policy.
73	In line with the strategic priorities of the Comprehensive Employment Strategy for People with Disabilities, the way people come on/off income supports should be streamlined to maximise entry or re-entry to the workforce with confidence and security. This should happen without threat of loss of benefit and with immediate restoration of benefits where they have an episodic condition or must leave a job because of their mental health difficulty.
74	The HSE should continue to develop, fund and periodically evaluate existing and new peer-led/peer-run services provided to people with mental health difficulties across the country.



Chapter 5

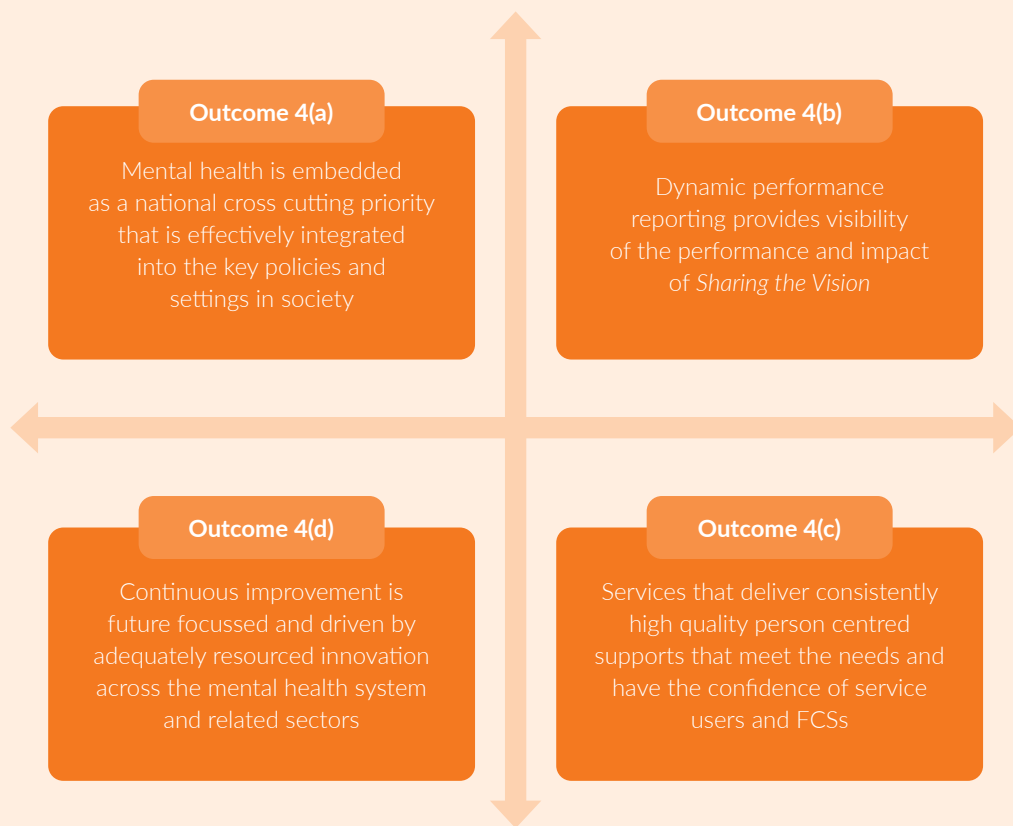
Accountability and Continuous Improvement Domain

Introduction

Positive mental health is not a matter for the health sector alone but sits in a much broader context of decisions made across the relevant public services. These can impact positively or negatively on the wellbeing of the population generally, as well as on the mental health of individuals living with a mental health difficulty. Mental health policy must therefore be an integral national cross-cutting priority. As such it needs to be integrated into all key and relevant policies and settings in society. This domain focuses on the organisational processes needed to implement and track delivery of the reforms proposed with an emphasis on innovation and continuous improvement.

As part of the implementation planning, all recommendations and associated actions have assigned lead responsibilities across relevant government departments and agencies, as set out in the Implementation Roadmap (Appendix III). Such governance will be reinforced by the setting up of the National Implementation Management Committee, representative of cross-sectoral interests as well as patients, FCS and peer organisations. Figure 5.1 shows the outcomes for the domain accountability and continuous improvements.

Figure 5.1: Outcomes accountability and continuous improvements



Accountability and continuous improvement

The need to build a more accountable and transparent health service is a focus of *Sláintecare* and is also a key objective for *Sharing the Vision*. Patients, FCS and the wider public need to have confidence in the information available so that they can judge the pace and impact of this refreshed policy and the difference it makes to the health and wellbeing of patients. Policy implementation and reform in the future must maintain the effort and build on the evidence of 'what works' in the present. Continuous improvement and the capacity to address new challenges depend on innovation and new ways of working across systems and sectors.

There are a number of established national initiatives to support innovation in replicating 'what works'. The emphasis now must be on future-focused, continuous improvement driven by adequately resourced innovation while activating the processes and skills to support change. The focus on continuous improvement must extend to other sectors contributing to the wellbeing of the population, supporting people living with a mental health difficulty while they recover.

Governance leadership and organisation

AVFC recommended that a National Mental Health Directorate be established under the leadership of a national director to prioritise the mental health agenda and to drive it centrally within the HSE. This was achieved with the appointment of the first HSE national director in 2013. As part of structural changes announced in 2016, a new national director of community health service operations subsumed the operational roles of the existing national directors for primary care, social care, health and wellbeing, and mental health. These changes enabled the existing national directors to work closely with the chief strategy and planning officer to plan the integration of acute care, primary care, social care, mental health and health and wellbeing. The changes introduced by the HSE were designed to enhance performance and management across the health service and to integrate HSE services to deliver the health priorities outlined in the *Programme for Government*.

There is an ongoing need for a dedicated focus on

mental health strategy, with national-level leadership, to give the required attention to operational issues and to maximise integration across care groups. Health Areas will operate on an integrated basis delivering services based upon population needs. Mental health services will no longer be seen as a separate service within a larger structure where integration and cohesion are aspired to but not always delivered. The model for delivery of care proposed suggests that mental health services should align to existing and emerging health structures to enable the provision of community health and social care services across primary care, social care, mental health, and health and wellbeing in a more coordinated and integrated way. Consequently, Mental Health Services will fully participate in the *Sláintecare* programme reforms and be at the centre of the new structures of healthcare delivery. The move to collaborative and cross-boundary working in Community Health Networks (CHN), operating at lower population levels within Regional Health Areas, will encourage primary and secondary care to be aligned and delivered closer to the community.

AVFC stipulated that for general adult mental health services there should be one community mental health team (CMHT) for sector populations of approximately 50,000. This remains valid and provides a good basis for synergy with the CHN model, which also operates to a catchment population of 50,000, thereby providing scope for 'co-terminosity' of service delivery. Effective organisational structures are essential to deliver integrated mental health services and to bring about the reform and implementation of the associated recommendations proposed in this revised policy. But there is a need to prioritise the implementation of recommendations and actions that will directly impact on the lives of people with mental health difficulties as soon as possible and not to wait until all structural changes are finalised.

In order to reconcile full integration of mental health services within the *Sláintecare* reforms with the need for governance and an evidence-based approach, the implementation of *Sharing the Vision* will be overseen by the National Implementation and Monitoring committee. As the *Sláintecare* programme evolves, it will be the work of the National Implementation and Monitoring Committee to reconsider and re-evaluate how to ensure governance for mental health services within the programme.

Patient Safety

In November 2015, the Government approved a major programme of patient safety reforms which included the establishment of a National Patient Safety Office (NPSO) in the Department of Health. The NPSO was established in December 2016 to oversee a programme of patient safety measures.

Ensuring the delivery of high quality and safe health and social care is a top priority of the Department and the NPSO. The patient is at the core of policy decisions and the Department is committed to working with the HSE and other key stakeholders in driving the delivery of a major programme of patient safety reforms. These are enabled by developing and introducing effective patient safety policies and legislation that –

- are founded upon improving understanding of safety by drawing intelligence from multiple sources of patient safety information,
- promote engagement and involvement of service users and providers to improve patient safety throughout the whole system,
- ensures providers deliver effective and sustainable change in the most important areas,
- promotes collaboration to achieve health priorities and contribute to wider social and economic goals, so that policy aligns with national initiatives such as *Sláintecare*
- promotes a positive culture of patient safety where there is good teamwork, openness, patient-centred approaches and support for learning.

The work of the NPSO includes progressing a programme of patient safety legislation, the establishment of a national Patient Safety Advocacy Service, setting up an Independent Patient Safety Council, extending the clinical effectiveness agenda, the measurement of patient experience, and the introduction of patient safety surveillance.

HSE's Patient Safety Strategy

The *HSE Patient Safety Strategy 2019-2024*, launched by the HSE Board in December 2019, sets out strategy commitments and actions to improve the safety of all patients by identifying and reducing preventable harm within the health and social care system in Ireland. It recognises that key to patient safety and person-centred care is a culture where patients, carers, families, advocates and health care

professionals work together in partnership to ensure positive patient experiences, maximise positive health outcomes and minimise the risk of error and harm. The goal is to achieve a culture that welcomes authentic patient-partnership in their care and in the process of co-producing, delivering and improving care.

Leadership in Safe, High Quality Mental Health Care

Leadership, governance, clinical commitment and clinical effectiveness approaches are required to deliver safe, high quality mental health care at national, regional and local level. There is a need for investment in capacity development for quality and patient safety in our mental health services.

This requires that each service has a dedicated patient safety and quality leadership and oversight function, which encompasses both patient safety elements (e.g. complaints procedures, advocacy, and management of risk and adverse events) and quality elements such as standards, clinical effectiveness guidelines, audit and key performance indicators.



Disadvantage and service planning

AVFC highlighted the need to take account of local deprivation patterns in planning and delivering mental health services. There is a need for a continued emphasis on this not just to promote greater accountability and transparency in resource allocation, but also to support the achievement of some of the outcomes regarding access to services and social

inclusion. Taking deprivation figures into account, areas that have poor levels of provision for specific services relative to other areas will be prioritised. This means that when new resources become available, they will be allocated based on need. This allocation model should include the skill mix in mental health human resources. Skill mix analysis should be carried out to determine the optimum number and type of health and social care professionals in any given service. The emphasis will be on meeting the needs of patients rather than filling quotas for any single professional group.

Physical infrastructure for mental health services

As noted in Domain 2, *Sharing the Vision* envisages greater use of appropriate mainstream premises, such as family resource centres, schools and community centres in the delivery of a more individualised and recovery-oriented mental health service. Modern primary care centres and other new-build facilities should be used where possible to provide a good-quality built environment for people accessing and staff working in mental health services. Approved centres or acute units are a particular part of the mental health infrastructure needing special attention. Many psychiatric units in acute hospitals were not purpose-built and were designed as standard hospital wards and simply designated as psychiatric units. This environment did not take into account the needs of people with mental health difficulties, particularly for access to outside space, and, indeed, more space generally.

A key element of continuous improvement is therefore the provision of physical environments which are conducive to recovery and which create a good working environment for professionals delivering services. As a general principle, multi-stakeholder service design methodologies should be employed when mental health premises and inpatient units are being designed or refurbished.¹⁷

Measuring performance

To establish targets, allocate resources and set mental health priorities, standardised performance indicators (PIs) and targeted service outcome data are required. These must be set at national level, led

and coordinated by the Department of Health. The format of progress reporting should also facilitate the capture of unique issues in RICO areas. An important component of measuring and monitoring performance is regular tracking of the views of service users about their experiences with the mental health system and the impact of these experiences on their health and wellbeing outcomes. It is also important to capture the experiences of FCS to ensure that they understand the support being accessed by their relative or friend and the expected outcomes.

Complaints represent a valuable source of information on the performance of a system and can offer useful guidance for service improvement. Dealing effectively with complaints can be a powerful way to provide a visible response in relation to continuous improvement. During the consultation process, a common theme that emerged suggested that at times people with mental health difficulties may find it difficult to make a complaint. Models for complaints handling that include better quality information and training in making complaints do exist. Each HSE region has an independent complaints system but there needs to be awareness of the 'your service your say' complaints process, and this process must be clear about how to make a complaint and must support individuals who do not know how to make a complaint.

Capturing and embedding innovation

The mental health division of the HSE has been working in partnership with the Centre for Effective Services (CES) since 2015 to implement change and wider reform in line with AVFC. This partnership has resulted in the co-establishment of a Strategic Portfolio and Programme Management Office (SPPMO).¹⁸ A core function of this partnership is fostering innovation and the application and adaptation of evidence-informed methods to secure sustainable implementation and improvement in delivering mental health services. Patient and FCS engagement is integral to all service improvement projects, with a consistent focus on the development of recovery-focused services through co-production.

A further initiative to foster innovation and continuous improvement is the social reform fund (SRF). This was

¹⁷ Public Service Design. Available at: https://www.socent.ie/wp-content/uploads/2015/10/PSD_manual_UK_LR.pdf. (Accessed 14 February 2020).

¹⁸ MHD SPPMO Background: Mental Health Division Strategic Portfolio and Programme Management Office". HSE. Accessed 14 February 2020. Available at: <https://www.hse.ie/eng/staff/resources/mentalhealthdivisionsppmo/>

intended to support the reconfiguration of services towards more person-centred supports which are also transparent, accountable and cost-effective. The mental health component of the SRF has focused on three areas: advancing and embedding recovery practices, implementing employment supports for people living with a mental health difficulty through delivery of the IPS model outlined in Domain 3 (social inclusion), and community-based living, which supports people with mental health difficulties to identify and address their housing needs and to make the best of their opportunities to live independently in the community.

There are other areas of innovation in the mental health services and the wider mental health system. It is important that information is gathered on all innovations so that learning can be shared and replicated, and duplication avoided. All innovation in mental health services should be driven by the Strategic Portfolio and Programme Management Office, so that proven innovations can be introduced more widely and the practices or services which they supersede can be ceased or modified appropriately.

Meeting standards in quality frameworks and best practice guidelines

In 2008 the Department of Health and the HSE committed to the development of a health service charter. The National Healthcare Charter, *You and Your Health Service*, was developed by patient advocacy groups and other interest groups to describe what patients can expect when using health services in Ireland. The charter focuses on eight principles that underpin high-quality, people-centred care to inform and empower individuals, families and communities to look after their own health and influence quality healthcare in Ireland. Mental health principles must be part of the charter so that people using mental health services know what to expect from those services. These principles can be included in staff contracts and in induction to encourage quality in mental health service delivery.

The *Quality Framework for Mental Health Services in Ireland* (Mental Health Commission, 2007), the *Judgement Support Framework* (Mental Health Commission, 2015), and the *Best Practice Guidance*

for Mental Health Services (HSE, 2017) all play an important role in continuous improvement and measurement/monitoring of desired standards and practices in mental healthcare in Ireland. These reports will augment the work of the National Implementation and Monitoring Committee and consideration of their recommendations will aid the development of standardised improvement systems that are aligned to the outcomes focus in this policy.

Enablers

New policy recommendations are implementable and achievable when there are overarching 'enablers' to support and encourage change. The following enablers will be important levers for implementation:

(1) Resource allocation

Recent health system thinking has emphasised the need to move away from traditional incremental budgeting arrangements, often in block sums, and towards a more strategic approach to investing in health promotion, early prevention and care services. *Sláintecare* sets out a very extensive agenda of strategic planning and commissioning reform to support the goal of a single-tier integrated universal healthcare system. *Sláintecare* seeks to:

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

For many sectors of the health and social care system these approaches will mark a significant departure from the traditional resource allocation methodologies at national, regional and service-provider level. Building on the original AVFC recommendations, a national mental health resource allocation system is now in place which informs decisions on the prioritised allocation of available resources. It represents a valuable platform on which to build the comparative cases for the investment required in the service and, ultimately, to demonstrate the outcomes achieved.

(2) Mental health information systems

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

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

(3) ICT enabled health systems

The establishment of the Mental Health Division in 2013 led to the inclusion in the 2014 Service Plan of an interim Data-Gathering Solution Project with the aim of supporting the CMHTs to manage the performance information required of them for reporting on the Service Plan. As part of the Interim Data-Gathering Solution Project, a proof of concept initiative was conducted with three Community Mental Health Teams across CAMHS, General Adult, and Psychiatry of Later Life (PoLL) services. This initiative led to an agreement with the Office of the Chief Information Officer for a framework for ICT-enabled supports for the mental health services which included three projects:

- National Mental Health ICT Infrastructure Improvement Project
- National Mental Health e-Rostering Project
- National Electronic Mental Health Record Project.

Progress in all of these areas must be prioritised to contribute strongly to the ambition outlined within this policy for ongoing reform and continuous improvement.

(4) Digital technologies

Throughout *Sharing the Vision*, the potential for application of digital technologies has been recognised as an aid to core service delivery. The use of digital technologies can support individualised care, provide online professional development and enhance online therapeutic support interventions. Digital interactions can involve direct interaction between a health professional and the patient. It also encompasses mental health professionals supporting primary care providers with expertise with various consultations. Mental health care can be delivered in a live, interactive communication. It can also involve recording medical information (images, videos, etc.) and sending this to a distant site for later review. Digital health helps meet patients' needs for convenient, affordable and readily-accessible mental health services. It can benefit patients in a number of ways, such as:

- Improve access to mental health specialty care
- Help integrate behavioural health care and primary care, leading to better outcomes
- Reduce the need for trips to hospitals
- Reduce delays in accessing care
- Improve continuity of care and follow-up

However, when promoting the potential of utilising digital health interventions, it is acknowledged that safety and risk issues need to be considered.

(5) Mental health research

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

As part of the process of developing a strategy, research priorities for mental health PH&HS research should be identified. All those working in the mental health services should be encouraged to get involved in mental health PH&HS research and there should be

a continuing focus on ensuring that people with lived experience of mental health difficulties are involved at every stage of the research process. The allocation of research funding in this area should reflect parity of esteem for mental health compared to other health conditions.

(6) Legislative reform

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

A programme of continuous legislative reform underpins the modern mental health system articulated within this policy. Legislation in various areas is being updated at present. The Mental Health Act 2001 is currently subject to review; the Assisted Decision-Making (Capacity) Act 2015 is being updated; and a new decision support service is being established.

Self-determination is a vital part of successful treatment and recovery. The Assisted Decision-Making (ADM) Capacity Act creates the right for a person whose capacity may be in question to be supported to make their own decisions, and there is an obligation on services to fulfil this right. The guiding principles of the ADM Capacity Act include the presumption of capacity and the requirement that a person should be given all possible support to make their own decision. The Act provides for two categories of assistance to people with capacity issues to make their own decisions – a decision-making assistant, and a co-decision-maker, who would be a substitute decision-maker. For children, managing positive risk-taking requires a collaborative approach where the family, the child and mental health professionals work out a positive risk-taking strategy as part of the care planning process.

Safeguarding vulnerable people

The national safeguarding policy, *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures* (2014), applies to all HSE and HSE-funded services.¹⁹ It recognises that all vulnerable people have a right to be protected against abuse and to have concerns about abusive experiences addressed. It highlights that it is the responsibility of all service providers, statutory and non-statutory, to ensure that patients are treated with respect and dignity, and that they receive support in an environment in which every effort is made to promote their welfare and to prevent abuse. The implementation of the policy is underpinned by the work of the HSE National Safeguarding Office. An adult safeguarding health sector policy is being developed by the Department of Health. This policy will cover all health services and it should inform the delivery of care in mental health services when it is complete.

Service users, self-harm and suicide

For health and support services to effectively respond to suicide and self-harm in the community, there must be access to timely and high-quality data on suicide and self-harm. The collection and reporting of incidents of suicide should be reviewed and revised, to provide timely data for enhanced and focused suicide prevention actions in the community. This is consistent with the *Connecting for Life strategy*.

Other countries have recognised the potential of strategically focusing on levels and patterns of self-harm and suicidality among people attending mental health services as an effective means of potentially reducing levels of morbidity and mortality through strategic service enhancements and responses based on the availability of good data.

Involuntary detention

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

People with a diagnosis of mental illness have the same human rights as everyone else, including a civil right to liberty and autonomy. According to the National Disability Authority, the purpose of the

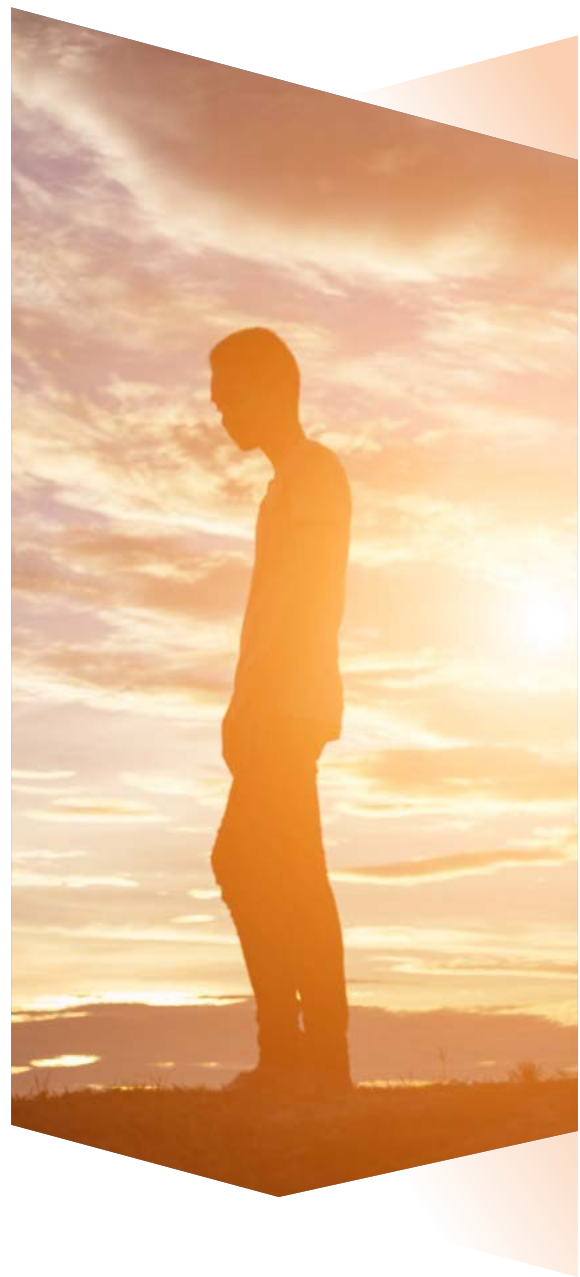
¹⁹ Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures : incorporating services for elder abuse for persons with a disability. Social Care Division, HSE. (2014)

Convention on the Rights of Persons with Disabilities is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. It applies established human rights principles from the UN Declaration of Human Rights to the situation of people with disabilities. It covers civil and political rights to equal treatment and freedom from discrimination, and social and economic rights in areas like education, healthcare, employment and transport. These rights continue to apply for people who are detained on an involuntary basis.

Restrictive interventions are still in use in Ireland in various approved centres regulated by the Mental Health Commission (MHC). The MHC recognises that any intervention employed that may compromise a person’s liberty should in all instances be the safest and least restrictive option of last resort necessary to manage the immediate situation.²⁰ Such intervention ought to be proportionate to the assessed risk and employed for the shortest possible duration. Four main areas of seclusion and restraint are currently in use in approved centres:

Seclusion	When a person is left alone in a room at any time where the exit door is locked, preventing person from leaving.
Physical restraint	When a person is prevented from free movement due to physical force applied by one or more persons.
Involuntary medication	When a person receives intramuscular or intravenous medication against their will.
Mechanical restraint ²¹	When a bodily restraint involving a device or special clothing is used to limit an individual’s free movement.*

While a zero restraint and seclusion service may not always be achievable due to safety requirements of service users and staff, there are examples where major reductions in the use of restraint are working effectively. Therefore, a high-level aim of this policy is to reduce the use of restraint and seclusion.



²⁰ Code of Practice on the Use of Physical Restraint in Approved Centres Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001. Code of Practice Mental Health Commission (2009).

²¹ Mental Health Commission. Seclusion and Restraint Reduction Strategy. Dublin, 2014. Available at: <https://www.mhcirl.ie/File/Seclusion-and-Restraint-Reduction-Strategy.pdf>

* Mechanical Restraint use Ireland is actively being phased out and is used only in very rare circumstances.

Domain: Accountability and continuous improvement recommendations

75	The organisation of mental health services should be aligned with emerging integrated care structures under <i>Sláintecare</i> reforms including the proposed six Regional Health Areas and within these the Community Health Networks corresponding to populations of about 50,000.
76	Implementation of this policy over the next ten years should achieve a re-balancing of resources and take account of population deprivation patterns in planning, resourcing and delivering mental health services.
77	A standardised set of performance indicators (PIs) directly aligned with the desired outcomes in <i>Sharing the Vision</i> and agreed standards of care and quality frameworks should be developed by the Department of Health and the National Implementation Monitoring Committee accounting for quantitative and qualitative delivery of intended outcomes.
78	Regular surveys of service users and FCS should be independently conducted to inform assessments of performance against PIs and target outcomes in this <i>Sharing the Vision</i> .
79	Information on the process of making a complaint, including necessary contact details, should be visible, accessible and widely available in a variety of media, languages and formats for maximum accessibility in all mental health service settings and in other fora.
80	A culture of open disclosure to support patient safety is embedded in mental health services.
81	Training should be provided for services users and staff on making and dealing with complaints.
82	Mental health services should ensure that the principles set out in the National Healthcare Charter, <i>You and Your Health Service</i> , are embedded in all service delivery.
83	Future updates of the Quality Framework, the Judgement Support Framework and the Best Practice Guidance should be consistent with the ambition and the specific outcomes for the mental health system set out in this policy.
84	The relevant bodies should come together to ensure that the measures for the Quality Framework, the Judgement Support Framework, the Best Practice Guidance, <i>Sharing the Vision</i> PIs and performance system, and any future measurement systems are aligned and that the required data is derived, where possible, from a single common data set.
85	The work underway at national level to develop a cost and activity database for health and social care in Ireland should prioritise mental health services to leverage developmental work already underway and support the evolution of outcome-based resource allocation.
86	A National Mental Health Information System should be implemented within three years to report on the performance of health and social care services in line with this policy.
87	The Department of Justice and the Implementation and Monitoring Committee, in consultation with stakeholders, should determine whether legislation needs to be amended to allow for greater diversion of people with mental health difficulties from the criminal justice system.
88	Training and guidance should be provided to staff on the practice of positive risk-taking, based on the principles of the Assisted Decision-Making (Capacity) Act 2015, where the value of promoting positive risk-taking is recognised by the Mental Health Commission regulator.

89	Access to safeguarding teams and training should be provided for staff working in statutory and non-statutory mental health services in order to apply the national safeguarding policy.
90	The Justice and Health sectors should engage with the coroners, the Garda Síochána, the National Office for Suicide Prevention, the CSO and research bodies in relation to deaths in custody, recording deaths by suicide and open verdicts, to further refine the basis of suicide statistics.
91	Significant improvements should be made in the monitoring and reporting of levels and patterns of self-harm and suicidality among people attending mental health services, to inform a comprehensive and timely service response to effectively reduce levels of harm and death.
92	In keeping with the evolving understanding of human rights to empower people and improve quality of care in mental healthcare facilities, legislation must be updated and additional supports put in place.
93	A National Population Mental Health Services Research and Evaluation Strategy should be developed and resourced to support a portfolio of research and evaluation activity in accordance with priorities identified in the research strategy.
94	In order to bring about change, a strategic approach is required involving the necessary skills in change management. This approach has been developed in the former HSE Mental Health Division Strategic Portfolio and Programme Management Office and should be mainstreamed and embedded in the wider HSE.
95	The initiatives under the former Mental Health Division Strategic Portfolio and Programme Management Office (SPPMO) and the ongoing Social Reform Fund (SRF) should be gathered together and made available both to encourage further innovation and to avoid duplication in the public service and NGO sectors.
96	Innovations which have good evidence for clinical and/or social and cost effectiveness should be rolled out nationally. This will require the changing of practices and modification or cessation of services which are superseded by the new form of delivery.
97	Mental health services should make use of other non-mental health community-based physical facilities, which are fit for purpose, to facilitate community involvement and support the implementation of the outcomes in this policy.
98	Capital investment should be made available to redesign or build psychiatric units in acute hospitals which create a therapeutic and recovery supportive environment. It is essential that all stakeholders are involved in a structured service design process for all redesigns or new builds.
99	A national 'whole-of-government' Implementation Committee should be established with strong service user and VCS representation to oversee the implementation of the recommendations in this policy and to monitor progress.
100	A joint review of the two specialist training programmes by the Irish College of Psychiatrists of Ireland and the Irish College of General Practitioners should be undertaken to develop an exemplar model of mental health medical training and integrated care.



Chapter 6

Implementation



Introduction

A Vision for Change (2006) contained no implementation plan and this resulted in poor measurement of outcomes. The extensive process of consultation, review and validation undertaken by the Oversight Group underlined the need to ensure effective implementation of the revised policy. Therefore, underpinning the delivery of the key outcomes envisaged by *Sharing the Vision* is performance management. The Northern Ireland Audit Office published a good practice guide and states that performance management occurs within six key areas (Figure 6.1).²² This policy recognises the need for continuing monitoring and performance management.

Figure 6.1: Good practice guide – key areas for performance management

Understanding the environment	Establish priorities, with service user input, that are relevant to the outcome-focused recommendations contained in this policy.
Setting priorities	Implement recommendations that matter to the service user not the organisation (outcomes as opposed to outputs).
Allocating resources and understanding levers for action	Move away from high-level decisions about funding and towards a focus on the outcomes being achieved. Align spending with delivery plans built upon inter-agency consultation.
Performance managing projects	Work with key partners to share the vision with all service providers, encouraging a culture of reporting both positive performance and poor performance.
Monitoring of progress	Effective performance that is monitored regularly and reviewed against criteria that measures implementation.
Making improvements	Put mechanisms to evaluate good performance or under-performance in place. Implement fluid resource allocation and move to support services that perform well. Capture poor performance trends to determine required corrective actions.
Making improvements	Put mechanisms to evaluate good performance or under-performance in place. Implement fluid resource allocation and move to support services that perform well. Capture poor performance trends to determine required corrective actions.

²² Northern Ireland Audit Office. Performance Management for Outcomes: A Good Practice Guide for Public Bodies (2018). Available at: https://www.niauditoffice.gov.uk/sites/niao/files/media-files/NIAO_performance%20management%20for%20outcomes.pdf

National Implementation and Monitoring Committee

As set out in the Introduction to this document, a National Implementation and Monitoring Committee (NIMC) is to be established to oversee implementation of the policy and monitor progress at national level and strategically across the HSE. The Committee will be mandated to drive reconfiguration, monitor progress against outcomes and deliver on the commitments made in this policy. It is expected that the Committee will work with partners to evaluate performance against the key performance indicators, check overall progress guided by research and learning from best practice, and gather information on examples of both good and bad practice. It is only when these mechanisms are in place that the system will be in a position to respond effectively to support the mental health needs of the whole population.

It is envisaged that the NIMC will be fully representative of those stakeholders principally involved in ensuring effective delivery of the policy recommendations, including strong service user and VCS representation. We outline below the indicative composition of the NIMC membership:

- Service users/advocacy organisations
- HSE
- Department of Health/*Sláintecare*
- Department of Justice and Equality
- Department of Education and Science
- Department of Housing, Planning and Local Government
- Department of Employment and Social Protection
- Housing Agency
- Reception and Integration Agency
- Health Research Board
- College of Psychiatrists of Ireland
- Irish College of General Practitioners
- National Office of Suicide Prevention.

The NIMC will meet regularly and publish a progress report on the implementation status of *Sharing the Vision*.

HSE *Sharing the Vision* structure

To ensure ongoing operational implementation of recommendations contained in *Sharing the Vision* on a day-to-day basis, it is proposed that the HSE establish a structure to assist the NIMC in driving implementation over the term of the policy. The HSE structure will report to, and participate in, the NIMC and will ensure that the policy programmes are delivered in line with the implementation plan agreed with the NIMC to include key performance indicators and regular progress reports as required.

Implementation roadmap

Sharing the Vision includes an Implementation Roadmap with outcome indicators that will encourage alignment between different services. The roadmap allocates ownership of recommendations to lead agencies and sets time-bound implementation targets against each recommendation.

Focusing on early initiation and completion targets, the roadmap is based on an analysis of each of the 100 recommendations in the policy. It:

- indicates where recommendations are already complete
- assigns a proposed completion timeframe to every recommendation/associated action that is either
 - short (18 months)
 - medium (36 months) or
 - long (36 months – 10 years).

Some of the 99 recommendations are far reaching and so smaller actions are assigned to enable implementation. This work has also provided the basis for a cost analysis and budgeting exercise, focusing on the recommendations targeted for completion over the next 18 months. The full list of recommendations and their associated implementation and completion timeframes is included at Appendix III of this document.

The HSE *Sharing the Vision* structure and the National Implementation and Monitoring Committee will:

- Develop a detailed implementation plan to ensure that the delivery of all recommendations is planned and managed effectively with appropriate
 - lead responsibility allocation

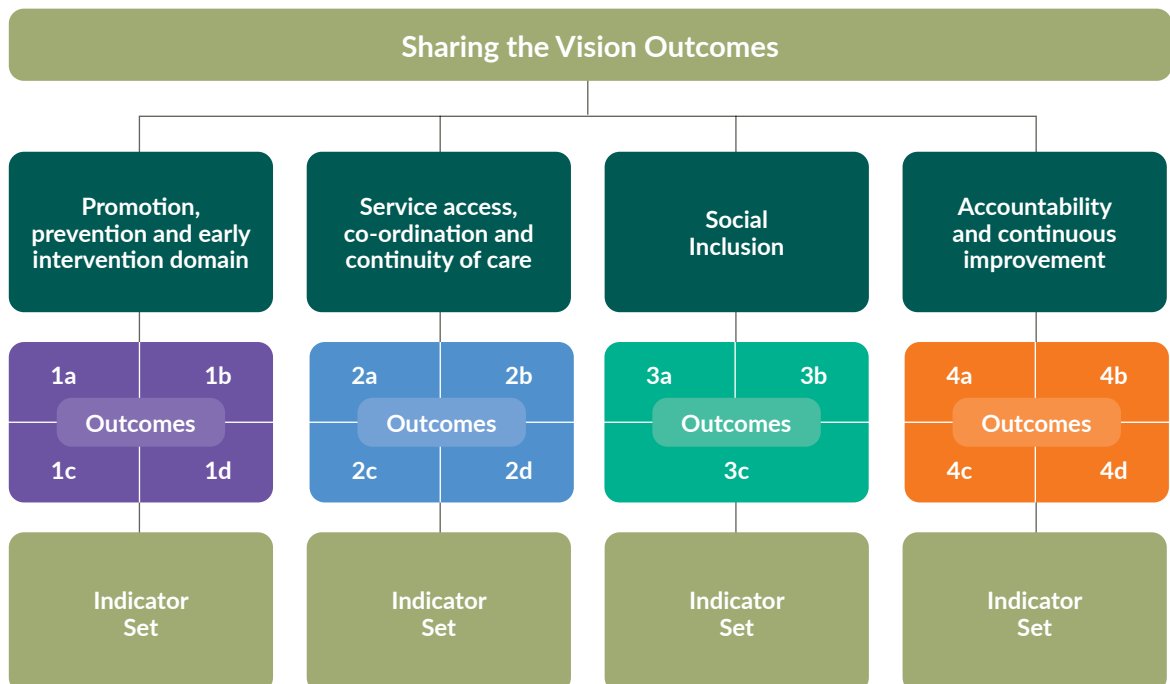
- actions
- outputs
- outcomes
- prioritisation
- timelines
- key performance indicators.
- Ensure that implementation actions are kept under review for ongoing appropriateness.
- Develop an Outcomes Framework to allow for ongoing evaluation of the impact of *Sharing the Vision*.
- Assess on a continual basis the existing capacity and range of services available to deliver on the objectives of *Sharing the Vision*.
- Develop a risk register and mitigation plan.
- Identify and foster the dissemination of innovative high-quality mental health practice in Ireland.
- Research international best practice models to serve as benchmarks of mental health services in Ireland.
- Be accountable to government for overall delivery of the recommendations of *Sharing the Vision*.

recommendations; these will be incorporated into the Implementation Plan at an early stage to ensure that the delivery of the policy is fully costed. Additionally, it should be noted that the implementation of the policy over the medium- and long-term will be subject to securing resources in the annual estimates.

Recognising the outcomes focus which was at the heart of *Sharing the Vision*, it is considered that the development of the Outcomes Framework is an essential component in the implementation and evaluation of the revised policy. The four domains chosen and the 15 domain-based high-level outcomes identified in earlier sections of this policy form a very useful basis for the development of a fully-fledged Outcomes Framework. Work on this framework, which will be a priority for the *Sharing the Vision* implementation structure, will look to identify in particular sets of tangible indicators which can be used not just by managers and policymakers but also by the wider public to assess the ongoing impact of *Sharing the Vision*. Figure 6.2 is a schematic version of how the Outcomes Framework aligns with the overall policy.

The HSE *Sharing the Vision* Structure will provide costings for all medium- and long-term

Figure 6.2: Sharing the Vision Outcomes Framework



While it will be the responsibility of the NIMC to bring strategic insight, external rigour and a multilateral perspective to oversight of the delivery of the actions arising out of the recommendations, the health system itself will need to recognise the importance of collaborative working to meet the needs of its specific defined population. Understanding the mental health needs of the population being served, defining local

and regional priorities and making decisions about resource allocation will be a catalyst for targeted mental health service delivery.





Appendices

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Appendix I:

Terms of Reference for the Oversight Group

A Vision for Change – Part II

1. Review and update the existing mental health policy *A Vision for Change* (2006) having regard to the Expert Evidence Review of international best practice, progress on current service developments in Ireland and the requirement of the Public Spending Code²³, with a particular focus on:
 - (a) primary prevention, early intervention and positive mental health, including having regard to the work underway with the Pathfinder Project and the Youth Mental Health Taskforce;
 - (b) integration of care and delivery systems between primary and secondary services taking account of the move to appropriate 24/7 service supports;
 - (c) development of e-mental health responses;
 - (d) workforce planning, forecasting and skill mix including mechanisms to attract and retain staff within existing national HR policy;
 - (e) emerging needs of vulnerable groups, people with co-morbidities and specialist needs informed by the relevant clinical programmes; and
 - (f) development of research, data and evaluation capability to ensure achievement of best mental health outcomes can be demonstrated with the resources available.
 - (g) proposing policy changes that will benefit all those engaging with mental health services. A particular emphasis on social inclusion and the needs of vulnerable groups should be incorporated with a focus on reducing stigma and discrimination.
2. Identify and consult on cross-sectoral and cross-societal responsibilities in the context of (1) above.
3. Align as far as possible the refreshed policy with existing national policies and implementation arrangements that have been developed since the publication of *A Vision for Change* (2006).
4. Conduct a consultative process with key stakeholders to inform proposals.
5. Produce, for submission to the Department of Health, an updated draft policy framework which sets out current and future service priorities within a time-bound implementation plan, for consideration by government as a successor policy to *A Vision for Change* (2006).

²³ In accordance with the Public Spending Code, all Irish public bodies are obliged to treat public funds with care, and to ensure that the best possible value for money is obtained whenever public money is being spent or invested. The Public Spending Code imposes obligations at all stages of the project/programme lifecycle, with the stages of the project defined as follows:

- Appraisal: assessing the case for a policy intervention
- Planning/Design: a positive appraisal should lead on to a considered approach to designing how the project/programme will be implemented
- Implementation: careful management and oversight is required for both capital and current expenditure. Ongoing evaluation should also be a feature of current programmes
- Post-Project or Post-Implementation Review: checking for delivery of project objectives, and gaining experience for future projects.

Appendix II:

Membership of the Oversight Group

Mr Stephen Brophy	DoH (November 2018–March 2019)
Dr Amanda Burke	Consultant Psychiatrist
Mr Greg Canning	DoH (January 2018–October 2018)
Mr Colm Desmond	DoH (October 2017–December 2017)
Dr Philip Dodd	National Clinical Lead
Ms Martha Griffin	Expert by Experience Lecturer DCU
Mr Liam Hennessy	Head of Mental Health Engagement
Mr Hugh Kane	Chairperson
Dr Fiona Keogh	NUI Galway
Mr Leo Kinsella	HSE Mental Health Lead
Mr Dave Maguire	DoH (March 2019–June 2019)
Dr Shari McDaid	Mental Health Reform
Mr John Meehan	HSE Mental Health/NOSP
Ms Stephanie Morrow	Research
Mr Tom O'Brien	DoH
Ms Yvonne O'Neill	HSE Mental Health Division
Dr Brian Osborne	General Practitioner

Secretariat	
Mr Martin O'Dwyer	DoH
Ms Emily Flaherty	DoH
Ms Anna Wallace	DoH

The Department of Health acknowledges the additional support provided by the Work Research Centre, MorrowGilchrist and Prospectus, who assisted the Department to gather research, interpret data and support the drafting of the Implementation Roadmap. The Department also acknowledges the many stakeholders who contributed to the process and those individuals who made time to attend advisory

group sessions. Those invited to attend the advisory sessions are detailed below. It is very important that the Department thank the many service users and family carers who engaged with us and shared their experiences so honestly to ensure this policy begins positive change for how mental health services are delivered in Ireland.

Alzheimer Society of Ireland	DoH units (Healthy Ireland/Primary care, etc.)
Association of Occupational Therapists	DoJE
Association of Professional Counsellors & Psychotherapists (APCP)	Family Carers
Association for Psychoanalysis and Psychotherapy (APPI)	Gateway
Barnardo's	Housing Association for Integrated Living
BeLonG To	HSE
Bodywhys – the Eating Disorders Association of Ireland	HSE Mental Health Heads of Service
CAIRDE	Institute of Guidance Counsellors
DCYA	Irish Advocacy Network
DEASP	Irish Association for Counselling and Psychotherapy
DES	Irish Association of Speech and Language Therapists
DHPLG	Irish Council for Psychotherapy

Irish Forum of Psychoanalytic Psychotherapy (IFPP)	PCHEI
Irish Institute of Mental Health Nursing	Peer Support Workers
Irish Nutrition and Dietetics Institute	Psychological Counsellors in Higher Education Institutes
Irish Society of Chartered Physiotherapists	Recovery College Coordinators
Jigsaw	Rehab
Mental Health Engagement Leads	Samaritans
Mental Health Nurse Managers Ireland	Simon Communities of Ireland
National Advocacy Service for People with Disabilities	Soar Foundation
National Association for Pastoral Counselling and Psychotherapy	Social Care Ireland
National Family Support Network	SpunOut.ie
National Social Work Organisation of Ireland	Threshold Training Network
NEPS	

Appendix III: Implementation Roadmap

The Implementation Roadmap below provides additional actions and outcome indicators for each recommendation to support the National Implementation and Monitoring Committee with its work. Not all partners are defined and only 'lead agencies' are listed. However, a cohesive partnership approach is essential and will be the focus of the

NIMC during the implementation phase. In addition, the timeframes below pertain to actions – not recommendations.

- **Short** = 0–18 months
- **Medium** = 18–36 months
- **Long** = 36 months–10 years

Domain 1 Promotion, Prevention and Early Intervention					
<p>Outcome 1a Positive mental health, resilience and psychological wellbeing among the population as a whole Outcome 1b Positive mental health, resilience and psychological wellbeing among priority groups ... through targeted promotion and preventive mechanisms Outcome 1c Reduced stigma and discrimination arising through improved community-wide understanding of mental health difficulties Outcome 1d Reduced prevalence of mental health difficulties and/or reduced severity of impact(s) through early intervention and prevention work</p>					
Recommendation	Actions/Tasks	Lead	Outcome Indicators	Target Timeframe	Outcome
<p>1 <i>Healthy Ireland</i> already has a remit for improved mental health and wellbeing. To further strengthen this, a dedicated National Mental Health Promotion Plan should be developed and overseen within <i>Healthy Ireland</i> implementation frameworks, with appropriate resourcing. The plan should be based on the principles and scope described in Chapter 2 of <i>Sharing the Vision</i>.</p>	<p>Develop a National Mental Health Promotion Plan. Establish a mental health promotion policy priority programme in HSE in line with <i>Healthy Ireland</i> implementation.</p>	Doh/ <i>Healthy Ireland</i>	Fully completed plan in place with appropriate resources.	Short	1a
<p>2 Evidence-based digital and social media channels should be used to the maximum to promote mental health and to provide appropriate signposting to services and supports.</p>	<p>Utilise digital and social media to promote mental health awareness Apply resources to further develop evidence on the extent of the positive mental health, resilience and psychological wellbeing of the population including the relevant impact of social media. Co-produce evidence on improvements in the mental health of the population including those accruing through the use of social media. Build on evidence emerging from The Irish Longitudinal Study on Ageing (TILDA) and the <i>Healthy Ireland</i> Survey.</p>	HSE	<p>Digital and social media used to positively influence MH promotion. Increased public engagement in online mental health initiatives. Reportable evidence of the positive mental health of the population. Evidence on impact of social media on mental health. TILDA indicators for Older Persons and their MH wellbeing embedded in cross govt frameworks and strategies, HI – Outcomes Framework, DCYA Outcomes Framework.</p>	<p>Medium Medium</p>	1a
<p>3 The Department of Health Women's Health Taskforce and the National Implementation Monitoring Committee will undertake a joint project within 12 months to outline an effective approach to the mental health of women and girls. The project should ensure that mental health priorities and services are gender-sensitive and that women's mental health is specifically and sufficiently addressed in the implementation of policy.</p>	<p>Ensure that Women's Health Task Force and National Implementation Monitoring Committee develop a project to focus on: mental health priorities and services that are gender-sensitive; work to ensure women's mental health is specifically and sufficiently addressed in the implementation of policy; and work to empower all mental health service users and their families equitably.</p>	Women's Health Task Force	Fully completed plan in place with appropriate resources.	Short	1b

4	The work programme for health promotion and improvement officers should be reviewed to ensure parity of effort and emphasis on mental health promotion and physical health promotion.	Review and amend existing job specification.	HSE/Healthy Ireland	Mental Health Promotion Plans incorporate the distinct needs of priority groups.	Short	1a, 1b
5	New and existing community development programmes which promote social inclusion, engagement and community connectedness should be appropriately resourced and developed in line with the proposed National Mental Health Promotion Plan.	Ensure the funding for new and existing community development programmes enhances community connectedness and mental health promotion. Design and deliver health promotion initiatives so they include and are accessible to people with disabilities	HSE/Healthy Ireland	Appropriately funded community development programmes demonstrating enhanced community connectedness and mental health promotion.	Medium	1a
6	The proposed National Mental Health Promotion Plan and the existing work of <i>Connecting for Life</i> should incorporate targeted mental health promotion and prevention actions that recognise the distinct needs of priority groups.	Ensure the National Mental Health Promotion Plan incorporates the distinct needs of priority groups. Support <i>Connecting for Life</i> to deliver targeted mental health promotion and prevention actions that recognise the distinct needs of priority groups. <i>Healthy Ireland/DoH/NOSP</i> Mental Health Promotion Plans incorporate the distinct needs of priority groups.	Healthy Ireland/DoH/NOSP	Mental Health Promotion Plans incorporate the distinct needs of priority groups. <i>Connecting for Life</i> delivers mental health promotion actions that incorporate the distinct needs of priority groups. Short	Short Short	1b, 1d
7	A National Stigma-Reduction Programme (NSRP) should be implemented to build a 'whole community' approach to reducing stigma and discrimination for those with mental health difficulties. This should build on work to date and determine a clear strategic plan, with associated outcomes and targets across related strands of work.	Develop a strategic whole community NSRP plan for publication and annual review with specific outcomes and targets. Department of Health should extend the timeframe and funding for the strategy for <i>Connecting for Life</i> (CFL) to 2024.	HSE/DoH	NSRP plan evaluated to measure its beneficial impact across the population. Extended timeframe and associated funding for <i>Connecting for Life</i> until 2024.	Medium	1a, 1b, 1c, 1d
8	Learning from innovations in improving outcomes for children and young people should be identified and should inform relevant mainstream service provision. This includes learning from prevention and early intervention programmes such as Tusla's Area Based Childhood (ABC) and Prevention, Partnership and Family Support (PPFS) Programme as well as cross-border programmes addressing the impact of Adverse Childhood Experiences (ACEs).	Ensure the What Works initiative delivered by DCYA seeks to capture and disseminate this learning to inform effective policy, provision and practitioner responses to the needs of children and young people.	HSE	Evidence of integrated responses to vulnerable families informed by ACE and learning from pilot programmes.	Medium	1d
9	All schools and centres for education will have initiated a dynamic Wellbeing Promotion Process by 2023, encompassing a whole-school/centre approach. Schools and centres for education will be supported in this process through the use of the Wellbeing Framework for practice and Wellbeing Resources which have been developed by the Department of Education and Skills.	Implement Wellbeing Policy Statement and Framework for Practice in all schools and centres for education, as well as NEPS, with appropriate resourcing.	DES	Wellbeing Policy Statement and Framework for Practice implemented in all schools and centres for education supported by adequate resources.	Medium	1a, 1d

10	<p>A protocol should be developed between the Department of Education and Skills and the HSE on the liaison process that should be in place between primary/post-primary schools, mental health services and supports such as NEPS, GPs, primary care services and specialist mental health services. This is needed to facilitate referral pathways to local services and signposting to such services, as necessary.</p>	<p>Establish working group with appropriate representation to develop liaison protocol between schools and mental health services and supports.</p>	DoH	<p>Protocol in place which facilitates referral pathways to local services and signposting to NEPS, GPs, primary care services and specialist mental health services.</p>	Medium	1d
11	<p>The National Mental Health Promotion Plan integrated with the Healthy Workplace Framework should incorporate actions to enhance the mental health outcomes of the working-age population through interventions aimed at mental health promotion in the workplace. This should consider environmental aspects of the working environment conducive to supporting positive mental health and wellbeing.</p>	<p>Develop action plan to enhance the mental health outcomes of the working-age population, with prioritisation of those working in mental health services through collaboration with DoH <i>Healthy Ireland</i> and relevant partners.</p> <p>To reinforce the effectiveness of the DES framework, an effective structure for cross-sectoral collaboration in the area of wellbeing and mental health promotion will be incorporated into the National Mental Health Promotion Plan.</p>	HSE	<p>Action plan in place supporting the positive mental health and wellbeing of the workforce. Starting with the mental health workforce.</p> <p>Develop wellbeing and promotion with cross sectoral collaboration and incorporate into national mental Health Promotion Plan.</p>	Medium	1a, 1d
12	<p>A range of actions designed to achieve the goals of the National Positive Ageing Strategy for the mental health of older people should be developed and implemented, supported by the inclusion of mental health indicators in the Healthy and Positive Ageing Initiative's research programme.</p>	<p>Develop specific mental health actions to achieve the goals of the National Positive Ageing Strategy.</p> <p>Identify mental health indicators to be included in the Healthy and Positive Ageing Initiative's research programme.</p>	DoH	<p>Actions in place to achieve the goals of the National Positive Ageing Strategy.</p> <p>Mental health identifiers in place in the Healthy and Positive Ageing Initiative's research programme.</p>	Short	1d

Domain 2 | Service Access, Coordination and Continuity of Care

- Outcome 2a** All service users have access to timely, evidence-informed interventions
- Outcome 2b** Service delivery is organised to enable increased numbers of people to achieve personal recovery
- Outcome 2c** Services are coordinated through a 'stepped care' approach to provide continuity of care that will deliver the best possible outcomes for each service user
- Outcome 2d** Health outcomes for people with dual diagnosis are improved by ensuring greater collaboration between mental health and other relevant services

	Recommendation	Actions/Tasks	Lead	Outcome Indicators	Target Timeframe	Outcome
13	Directories of information on VCS supports should be provided to staff working in primary care and CMHTs to ensure they are aware of and inform service users and FCS about all supports available including those from Voluntary and Community Sector organisations in the local area.	Map available supports. Provide staff working in primary care and CMHTs with information about available supports such as 'yourmentalhealth.ie'.	HSE	Community asset map in place. All service users and FCS are made aware of supports including those in the Voluntary and Community Sector.	Short	2a
14	Where Voluntary and Community Sector organisations are providing services aligned to the outcomes in this policy, operational governance and funding models should be secure and sustainable.	Maximise the use of existing and emerging operational governance and funding models to support collaborative alignment with required outcomes.	HSE	Collaboratively agreed operational governance and funding models in place which maximise reliable, secure and sustainable funding linked to outcomes.	Medium	2a, 2b
15	Social prescribing should be promoted nationally as an effective means of linking those with mental health difficulties to community-based supports and interventions, including those available through local Voluntary and Community Sector supports and services.	Enable the development of service user-led and responsive social prescribing through identified community links and supports.	HSE	The expanded use of service user-led and responsive social prescribing.	Short	2a, 2c
16	Access to a range of counselling supports and talk therapies in community/primary care should be available on the basis of identified need so that all individuals, across the lifespan, with a mild-to-moderate mental health difficulty can receive prompt access to accessible care through their GP/Primary Care Centre. Counselling supports and talk therapies must be delivered by appropriately qualified and accredited professionals.	Increase range and ease of access to counselling supports and talk therapies in the community. Assess current services and ensure future counselling and talk therapy services are provided by appropriately qualified and accredited professionals.	HSE	Access to counselling supports and talk therapies available based on identified need. Completed assessment of the level of qualification and accreditation of current providers. Counselling and talk therapies are delivered by appropriately qualified and accredited professionals.	Medium	2a, 2c
17	The mental health consultation/liaison model should continue to be adopted to ensure formal links between CMHTs and primary care with the presence of, or in-reach by, a mental health professional as part of the primary care team or network.	Ensure that the development of the CHN and PCT operating models adopt the mental health consultation/liaison model.	HSE	CHN and PCTs utilising mental health consultation/liaison model with CMHTs.	Short	2b, 2c

18	An implementation plan should be developed for the remaining relevant recommendations in <i>Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services</i> (2012) in order to improve integration of care for individuals between primary care and mental health services in line with emerging models and plans for Community Health Networks and Teams.	Develop an implementation plan with updated recommendations from <i>Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services</i> (2012).	HSE	Appropriate recommendations from <i>Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services</i> (2012) are implemented.	Short	2b, 2c
19	The physical health needs of all users of specialist mental health services should be given particular attention by their GP. A shared care approach is essential to achieve the best outcomes.	Ensure any person using a specialist mental health service has access to GP and primary care services on the same basis as other citizens. Develop a shared physical health protocol for mental health service users presenting to GPs.	HSE	A shared physical healthcare protocol for mental health service users in place with GPs. Mental health patients access primary care services with support as required.	Short	2c
20	There should be further development of early intervention and assessment services in the primary care sector for children with ADHD and autism to include comprehensive multi-disciplinary and paediatric assessment and mental health consultation with the relevant CMHT where necessary.	Develop agreed early intervention and assessment services in primary care for children with ADHD and autism through collaboration of PC and MH services.	HSE	Children with ADHD and autism receiving agreed model of early intervention/assessment in primary care.	Medium	2a
21	Dedicated community-based Addiction Service Teams should be developed/enhanced with psychiatry input, as required, and improved access to mental health supports in the community should be provided to individuals with co-existing low-level mental health and addiction problems.	Assess current available response towards development/enhancement of integrated community-based addiction teams with required level of mental health service input.	Primary care/HSE/DoH (local drug taskforces)	Integrated community-based addiction teams with appropriate mental health service input in place.	Medium	2a, 2b
22	The provision of appropriate environments for those presenting at emergency departments who additionally require an emergency mental health assessment should be prioritised.	Assess current available environment and develop improvement plans for provision of suitable emergency mental health assessment facilities.	HSE	Appropriate mental health assessment facilities in emergency departments are provided.	Short	2a, 2b
23	There should be continued investment in, and implementation of, the National Clinical Care Programme for the Assessment and Management of Patients Presenting to Emergency Departments Following Self-Harm.	Implement the National Clinical Care Programme for the Assessment and Management of Patients Presenting to EDs Following Self-Harm.	HSE	Implemented funded care programmes. Demonstrated improved outcomes for patients attending EDs following self-harm.	Medium	
24	Out-of-hours crisis cafés should be piloted and operated based on identified good practice. Such cafés should function as a partnership between the HSE and other providers/organisations.	Develop and pilot model in line with good practice for out-of-hours crisis café.	HSE	Out-of-hours crisis cafés piloted and evaluated.	Short	2a
25	The multi-disciplinary CMHT as the cornerstone of service delivery in secondary care should be strengthened through the development and agreed implementation of a shared governance model.	Develop and agree a shared governance model for implementation by all CMHTs.	HSE	Operation of CMHTs is strengthened by use of a shared governance model.	Medium	2a, 2b

26	CMHTs' outreach and liaison activities with VCS partners in the local community should be enhanced to help create a connected network of appropriate supports for each service user and their FCS.	Co-design enhanced outreach and liaison activities to help create a connected network of appropriate supports for each service user and their FCS.	HSE	A co-designed connected network of appropriate supports for each service user and their FCS is in place through CMHTs.	Medium	2b
27	An individualised recovery care plan, co-produced with service users and/or Families, Carers and Supporters, where appropriate, should be in place for, and accessible to, all users of specialist mental health services.	Ensure consistent use of co-produced individualised recovery care plans for all users of specialist mental health services.	HSE Mental Health	Consistent use of co-produced individualised recovery care plans for all users of specialist mental health services.	Medium	2b
28	All service users should have a mutually agreed key worker from the CMHT to facilitate coordination and personalisation of services in line with their co-produced recovery care plan.	Ensure service users are supported through the provision of a mutually agreed key worker.	HSE Mental Health	All service users have a mutually agreed key worker.	Short	2b
29	Further training and support should be put in place to embed a recovery ethos among mental health professionals working in the CMHTs as well as those delivering services elsewhere in the continuum of services.	Design training and support programme to embed a recovery ethos in mental health professionals. To ensure disability competence, ensure that appropriate training in accommodating and supporting people with autism and with other forms of disability is undertaken by team members.	Strategy & Planning HSE/Síaintecare partners	Training will be delivered nationally and include recovery as an integral component. Training will also be delivered to support people with disabilities.	Short	2b
30	CMHTs and sessional contacts should be located, where possible and appropriate, in a variety of suitable settings in the community, including non-health settings.	Review locations of CMHTs and sessional contacts.	Strategy & Planning HSE/Síaintecare partners	Completed review and optimised locations.	Medium	2a, 2b
31	The potential for digital health solutions to enhance service delivery and empower service users should be developed.	Identify and develop potential digital solutions.	Strategy & Planning HSE/Síaintecare partners	Deliver and develop digital interventions nationally and evaluate efficacy to measure impact.	Medium	2a
32	The composition and skill mix of each CMHT, along with clinical and operational protocols, should take into consideration the needs and social circumstances of its sector population and the availability of staff with relevant skills. As long as the core skills of CMHTs are met, there should be flexibility in how the teams are resourced to meet the full range of needs, where there is strong population-based needs assessment data.	Empower local managers to review composition and skill mix of CMHTs appropriate to the local needs of the population. Include non-mental health professionals in CMHTs (e.g. employment specialists can promote employment as an aspect of recovery). Develop flexible clinical and operational protocols.	Strategy & Planning HSE/Síaintecare partners	CMHTs are delivering timely interventions defined by the specific needs of their population.	Medium	2a
33	The shared governance arrangements for CMHTs as outlined in AVFC 2006-16 should be progressed, including further rollout of Team Coordinators.	Progress shared governance arrangements.	Strategy & Planning HSE/Síaintecare partners	Shared governance arrangements implemented nationally. Team Coordinators in place.	Medium	2a, 2b
34	Referral pathways to all CMHTs should be reviewed and extended by enabling referrals from a range of other services (as appropriate) including senior primary care professionals in collaboration with GPs.	Review and extend referral pathways to incorporate a range of other services.	HSE Mental Health Services	Evidence of enhanced referral pathways.	Medium	2a

35	A comprehensive specialist mental health out-of-hours response should be provided for children and adolescents in all geographical areas. This should be developed in addition to current ED services.	Develop a comprehensive specialist mental health out-of-hours model using a tiered approach.	HSE Mental Health Services	Implemented comprehensive specialist mental health out-of-hours model with evidence of tiered approach in all areas.	Short	2a
36	Appropriate supports should be provided for on an interim basis to service users transitioning from CAMHS to GAMHS. The age of transition should be moved from 18 to 25, and future supports should reflect this.	Convene an Expert Group to: Develop a reconfiguration plan which will facilitate the provision of age-appropriate specialist mental health services up to age 25. Provide appropriate supports for individuals transitioning from CAMHS to GAMHS at 18 years. Identify required additional supports for individuals transitioning from CAMHS to GAMHS at 18 years. Produce transition plan in line with CAMHS COG. Put in place a nominated key worker to support the transition plan. Additional training provided to up-skill nominated keyworkers.	DoH	Plan in place which facilitates the provision of age-appropriate specialist mental health services up to age 25. Supports identified and in place for all individuals transitioning from CAMHS to GAMHS.	Short	2b
37	Nationally agreed criteria should be developed to govern and resource individualised support packages for the specific needs of a small cohort of children and young people who have complex needs.	Develop national criteria for individualised support packages for the specific needs of a small cohort of children and young people who have complex needs. Secure resourcing for the required support packages.	HSE	Children and young people who have complex needs in receipt of fully resourced support packages in line with national criteria.	Short	2a
38	In the exceptional cases where child and adolescent inpatient beds are not available, adult units providing care to children and adolescents should adhere to the CAMHS inpatient Code of Governance.	Ensure adherence to the CAMHS inpatient Code of Governance nationally.	HSE Mental Health	Evaluation to ensure CAMHS inpatient code of Governance is applied nationally.	Short	2a, 2b
39	The HSE should consult with service users, FCS, staff, and those supporting priority groups to develop a standardised access pathway to timely mental health and related care in line with the individuals' needs and preferences.	Develop standardised access pathway to timely mental health and related care through a comprehensive consultation process.	HSE	Standardised access pathway in place.	Short	2a, 2b
40	Sufficient resourcing of home-based crisis resolution teams should be provided to offer an alternative response to inpatient admission, when appropriate.	Develop and resource home-based crisis resolution teams.	HSE Mental Health	Reduced levels of inpatient admissions due to alternative crisis intervention.	Medium	2a, 2b
41	A Standard Operating Guideline should be developed to ensure that sufficiently staffed day hospitals operate as effectively as possible as an element of the continuum of care and as an alternative to inpatient admission.	Develop and publish Standard Operating Guideline. Provide additional staffing in day hospitals.	HSE Mental Health	Circulated Standard Operating Guideline. Adequately staffed day hospitals.	Medium	2a, 2b
42	Individuals who require specialist Mental Health Services for Older People (MHSOP) should receive that service regardless of their past or current mental health history. People with early onset dementia should also have access to MHSOP.	Develop and publish Standard Operating Guideline ensuring equal access for relevant individuals to specialist Mental Health Service for Older People.	HSE Mental Health	Access to specialist Mental Health Service for Older People is provided regardless of mental health history.	Short	2a, 2b

43	The age limit for MHSOP should be increased from 65 years to 70 years supported by joint care arrangements between GAMHS and MHSOP teams for individuals who require the expertise of both.	Include the revised age limit in the new Standard Operating Guideline for MHSOP.	HSE	Age limit increased to 70 years.	Short	2a, 2b
44	GPs, mental health service prescribers and relevant stakeholders should collaborate to actively manage polypharmacy.	Support collaboration between GPs, mental health service prescribers and relevant stakeholders based on informed action plan and training programme.	HSE	Polypharmacy is actively managed.	Short	2b
45	HSE should collate data on the number and profile of delayed discharges in acute mental health inpatient units and develop appropriately funded responses.	Collate data on the number and profile of delayed discharges in acute mental health inpatient units. Develop appropriate funding and service responses to minimise delayed discharges.	HSE	Data is available and delayed discharges are appropriately managed.	Medium	2c
46	An Expert Group should be set up to examine Acute Inpatient (Approved Centre) bed provision (including PICUs) and to make recommendations on capacity reflective of emerging models of care, existing bed resources and future demographic changes, with such recommendations being aligned with Slaintecare.	Set up an Expert Group to examine Acute Inpatient (Approved Centre) bed usage and develop recommendations.	HSE Mental Health	Appropriate level and usage of Acute Inpatient (Approved Centre) beds.	Short	2c
47	Sufficient Psychiatric Intensive Care Units (PICUs) should be developed with appropriate referral and discharge protocols to serve the regions of the country with limited access to this type of service.	Develop Psychiatric Intensive Care Units (PICUs) to meet identified need. Agree updated referral and discharge protocols.	HSE	Sufficient Psychiatric Intensive Care Units (PICUs) in operation.	Long	2a
48	A cross-disability and mental health group should be convened to develop national competence in the commissioning, design and provision of intensive supports for people with complex mental health difficulties and intellectual disabilities and to develop a set of criteria to govern the provision of this service.	Convene cross-disability and mental health group to develop national competence and criteria for the provision of this service.	HSE	Appropriate services are in place for people with complex mental health difficulties and intellectual disabilities.	Short	2a, 2b, 2c, 2d
49	Intensive Recovery Support (IRS) teams should be provided on a national basis to support people with complex mental health needs in order to avoid inappropriate, restrictive and non-recovery-oriented settings.	Develop IRS teams to provide targeted supports to individuals with complex mental health needs on a national basis.	HSE	Recovery-oriented community-based supports in place for individuals with complex mental health needs.	Long	2a, 2b, 2c
50	The development of a national network of MHID teams and acute treatment beds for people of all ages with an intellectual disability should be prioritised.	Develop national network of MHID teams and acute treatment beds.	HSE	Equitable access to mental health services for people of all ages with an intellectual disability.	Medium	2a, 2b
51	Speech and Language Therapists (SLT) should be core members of the Adult-ID and CAMHS-ID teams.	Put in place Speech and Language Therapy as a core part of the Adult-ID and CAMHS-ID teams.	HSE	Speech and Language Therapy available to service users with MHID support needs.	Medium	2a, 2b
52	Investment in the implementation of the Model of Care for Early Intervention Psychosis (EIP), informed by an evaluation of the EIP demonstration sites, should be continued.	Invest in the implementation of EIP service delivery. Evaluate EIP demonstration sites.	HSE Mental Health	EIP services available in line with EIP Model of Care.	Long	2a, 2b

53	<p>The phased implementation and evaluation of appropriate service responses to support adults with ADHD should be developed and resourced in line with the National Clinical Programme for Adults with ADHD.</p>	<p>Develop an implementation plan for the National Clinical Programme for Adults with ADHD. Undertake phased implementation and resourcing of plan. Undertake evaluation of demonstration sites.</p>	HSE	Provision of appropriate services for adults with ADHD.	Medium	2a, 2b
54	<p>Every person with mental health difficulties coming into contact with the forensic system should have access to comprehensive stepped (or tiered) mental health support that is recovery-oriented and based on integrated co-produced recovery care plans supported by advocacy services as required.</p>	<p>Complete mental health needs analysis of the prison population. Develop a comprehensive tiered forensic mental health model of care. Deliver phased implementation of the tiered mental health service.</p>	HSE/Prison Service	Access to appropriate mental healthcare for service users within the forensic service nationally.	Medium	2a, 2b
55	<p>There should be ongoing resourcing of and support for diversion schemes where individuals with mental health difficulties are diverted from the criminal justice system at the earliest possible stage and have their needs met within community and/or non-forensic mental health settings.</p>	<p>Provide ongoing resourcing and support for diversion schemes.</p>	DoJE/HSE	Diversion schemes in place and in use.	Medium	2b
56	<p>The development of further Intensive Care Rehabilitation Units (ICRUs) should be prioritised following successful evaluation of operation of the new ICRU on the Portrane Campus.</p>	<p>Carry out a comprehensive evaluation and review of the ICRU on the Portrane Campus. Develop a national plan for the development of ICRUs. Undertake phased implementation of the national ICRU development plan.</p>	HSE/Prison Service	Appropriate ICRU provision for the relevant population.	Medium	2b
57	<p>A tiered model of integrated service provision for individuals with a dual diagnosis (e.g. substance misuse with mental illness) should be developed to ensure that pathways to care are clear. Similarly, tiered models of support should be available to people with a dual diagnosis of intellectual disability and/or autism and a mental health difficult.</p>	<p>Develop a specific service improvement framework across HSE Primary Care/Mental Health/Acute Hospitals to advance this recommendation. Develop a tiered model of care. Develop demonstration sites of the tiered model of care, with evaluation. Develop phased implementation of comprehensive service.</p>	HSE	Tiered model of service provision developed and available.	Medium	2a, 2d
58	<p>In order to address service gaps and access issues, a stepped model of integrated support that provides mental health promotion, prevention and primary intervention supports should be available for people experiencing homelessness.</p>	<p>Develop a stepped and integrated model of support for people experiencing homelessness. Develop an implementation plan which includes evaluation of new service developments.</p>	HSE/Housing Agency	Stepped model of support is available nationally.	Medium	2a

59	Assertive outreach teams should be expanded so that specialist mental healthcare is accessible to people experiencing homelessness.	Carry out needs analysis to define service deficit. Develop an implementation plan in line with the stepped model of mental health support for the homeless population. Advance the phased expansion of the existing service.	HSE/Housing Agency	Outreach teams expanded and in place.	Medium	2a
60	Continued expansion of Liaison Mental Health Services for all age groups should take place in the context of an integrated Liaison Mental Health Model of Care.	Develop an integrated Liaison Mental Health Model of Care. Develop an implementation plan which includes evaluation of service developments. Support phased expansion of services.	HSE	Comprehensive and integrated Liaison Mental Health Services are available in all relevant acute hospitals	Medium	2a, 2b
61	The HSE should maximise the delivery of diverse and culturally competent mental health supports throughout all services.	Gather service user and service delivery feedback regarding culturally appropriate service provision. Provide diverse and culturally competent supports across all services.	HSE	User feedback indicates that services are delivered in a diverse and culturally competent manner.	Medium	2a
62	Building on service improvements already in place, individuals who are deaf should have access to the full suite of mental health services available to the wider population.	Conduct an evaluation of the National Specialist Service and Model of Care for mental health services for the deaf community. Based on evaluation findings, develop a gap analysis and service improvement plan. Support phased service development and improvement. Ensure that staff working in mental health services have the appropriate skills and knowledge to work with the deaf community. Carry out a training needs analysis to inform the training requirements of mental health staff working with the deaf community. Develop and implement a training, support and supervision plan for mental health staff working with the deaf community.	HSE	Deaf community with mental health support needs can access comprehensive tiered mental health services. Based on targeted feedback from deaf mental health service users, mental health staff are competent to support the deaf community attending mental health services.	Short	2a,2b

63	<p>Persons in Direct Provision and refugees arriving under the Irish refugee protection programme should have access to appropriate tiered mental health services through primary care and specialist mental health services.</p>	<p>Convene an Expert Group (with service user co-production) to advise on best practice for the adequate provision of tiered mental health supports to those in Direct Provision and refugees who have significant issues relating to trauma.</p> <p>Develop an implementation plan of Direct Provision mental health support across HSE Primary Care and Mental Health with clear evaluation targets.</p> <p>Resource phased implementation.</p>	HSE/Reception & Integration Agency	Persons in Direct Provision can access the same supports as the wider population.	Medium	2a
64	<p>Appropriately qualified interpreters should be made available within the mental health service and operate at no cost to the service user.</p>	<p>Develop guidance on the appropriate tendering and commissioning of interpretation services and evaluate the process once it is in place.</p> <p>Resource high-quality interpreter services for mental health service users.</p>	HSE	High-quality interpreter services are available at no cost to service users.	Medium	2a
65	<p>The HSE should ensure that access to appropriate advocacy supports can be provided in all mental health services.</p>	<p>Conduct a gap analysis of advocacy supports needs.</p> <p>Develop an implementation plan for advocacy services.</p> <p>Resource phased implementation with appropriate evaluation.</p>	HSE	Accessible advocacy supports in place.	Medium	2a

Domain 3 | Social Inclusion

Outcome 3a Service users are respected, connected and valued in their community

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

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

	Recommendation	Actions/Tasks	Lead	Outcome Indicators	Target Timeframe	Outcome
66	Tailored measures should be in place in relevant government departments to ensure that individuals with mental health difficulties can avail, without discrimination, of employment, housing and education opportunities and have an adequate income.	Develop multi- departmental initiative to ensure measures are in place for individuals with mental health difficulties to avail, without discrimination, of employment, housing and education opportunities and have adequate income.	DoH	Equal opportunities for individuals with mental health difficulties to avail of employment, housing and education opportunities and to have adequate income.	Medium	3b, 3c
67	Local authorities should liaise with statutory mental health services in order to include the housing needs of people with complex mental health difficulties as part of their local housing plans.	Include the housing needs of people with complex mental health difficulties as part of local housing plans, with associated resources.	Housing Agency/local authorities	Housing needs of people with complex mental health difficulties are met.	Long	3c
68	Department of Health and Department of Housing, Planning and Local Government, in consultation with relevant stakeholders, should develop a joint protocol to guide the effective transition of individuals from HSE-supported accommodation to community living.	Develop a joint protocol to guide the effective transition of individuals from HSE-supported accommodation to community living.	DoH/DHPLG	Implementation of agreed joint protocol.	Short	3a, 3b, 3c
69	In conjunction with supports provided by HSE including Intensive Recovery Support teams, sustainable resourcing should be in place for tenancy-related/independent living supports for service users with complex mental health difficulties.	Develop sustainable resourcing supports for individuals with complex mental health difficulties.	HSE/Housing Agency/local authorities	Service users with complex needs provided with appropriate tenancy/independent living supports.	Medium	3a, 3b, 3c
70	The housing design guidelines published by the HSE and the Housing Agency in 2016 to promote independent living and mental health recovery should be a reference point for all housing-related actions in this policy.	Use housing design guidelines as basis for all housing-related actions.	HSE/Housing Agency/local authorities	Housing design guidelines are incorporated, where possible, in all housing-related recommendations contained in STV.	Short	3a, 3b, 3c
71	A sustainable funding stream should be developed to ensure agencies can work effectively together to get the best outcomes for the individual using the Individualised Placement Support model, which is an evidence-based, effective method of supporting people with complex mental health difficulties to achieve sustainable, competitive employment where they choose to do so.	Develop a sustainable funding stream to support the IPS model.	DoH/HSE	IPS model evaluated and expanded supported by a sustainable funding model.	Medium	3a, 3b, 3c
72	The current HSE funding provided for day centres should be reconfigured to provide individualised supports for people with mental health difficulties and be consistent with the New Directions policy.	HSE to engage in evaluation of current funding provided and reconfigure services where necessary.	HSE	Funding reconfigured to effectively support individualised support in line with New Directions policy.	Medium	3a, 3b, 3c

73	<p>In line with the strategic priorities of the Comprehensive Employment Strategy for People with Disabilities the way people come on/off income supports should be streamlined to maximise entry or re-entry to the workforce with confidence and security. This should happen without threat of loss of benefit and with immediate restoration of benefits where they have an episodic condition or must leave a job because of their mental health difficulty.</p>	<p>Streamline the way individuals come on/off income supports to maximise entry or re-entry to the workforce with confidence and security.</p>	DEASP	<p>Processes for individuals coming on/off income supports maximise the entry or re-entry to workforce.</p>	Medium	3c
74	<p>The HSE should continue to develop, fund and periodically evaluate existing and new peer-led/peer-run services provided to people with mental health difficulties across the country.</p>	<p>Evaluate peer-led/peer-run services for people with mental health difficulties. Develop new and support existing evaluated peer-led/run services for people with mental health difficulties.</p>	HSE	<p>Evaluated peer-led/peer-run services supported and expanded.</p>	Short Medium	3a, 3b

Domain 4 | Accountability and Continuous Improvement

- Outcome 4a** Mental health is embedded as a national cross-cutting priority that is effectively integrated into the key policies and settings in society
- Outcome 4b** Dynamic performance reporting provides visibility of the performance and impact of *Sharing the Vision*
- Outcome 4c** Services that deliver consistently high-quality person-centred supports that meet the needs and have the confidence of service users and FCS
- Outcome 4d** Continuous improvement is future-focused and driven by adequately resourced innovation across the mental health system and related sectors

	Recommendation	Actions/Tasks	Lead	Outcome Indicators	Target Timeframe	Outcome
75	The organisation of mental health services should be aligned with emerging integrated care structures under <i>Sláintecare</i> reforms including the proposed six Regional Health Areas and within these the Community Health Networks corresponding to populations of about 50,000.	Ensure the dedicated line of authority is visible in the structures at regional level.	HSE	Visible line of authority for integrated mental health services.	Medium	4a, 4c
76	Implementation of this policy over the next ten years should achieve a re-balancing of resources and take account of population deprivation patterns in planning, resourcing and delivering mental health services.	Use population deprivation patterns in planning, resourcing and delivering mental health services. Rebalance resourcing of mental health services on this basis.	HSE	Mental health service resourcing targeted to support the specific needs of the population.	Medium	4a, 4b, 4c
77	A standardised set of performance indicators (PIs) directly aligned with the desired outcomes in STV and agreed standards of care and quality frameworks should be developed by the Department of Health and the National Implementation Monitoring Committee accounting for quantitative and qualitative delivery of intended outcomes.	Develop appropriate performance indicators aligned to STV outcomes.	DoH	Performance indicators in place assessing standards of care and quality per agreed frameworks.	Medium	4b
78	Regular surveys of service users and FCS should be independently conducted to inform assessments of performance against PIs and target outcomes in STV.	Conduct and report on regular surveys with service users and FCS. A national mental health service experience survey proposal should be developed to be considered for inclusion under the National Care Experience Programme.	HSE	Services planned and developed in line with finding of surveys.	Medium	4b
79	Information on the process of making a complaint, including necessary contact details, should be visible, accessible and widely available in a variety of media, languages and formats for maximum accessibility in all mental health service settings and in other fora.	Publish clear and accessible complaints procedure.	HSE	Clear and visible complaints procedure.	Short	4b
80	A culture of open disclosure to support patient safety is embedded in mental health services.	Mental health services align open disclosure to service users and FCS with national policy and legislation.	HSE	Open disclosure to service users and FCS is aligned to national policy and legislation.	Ongoing	4c

81	Training should be provided for services users and staff on making and dealing with complaints.	Provide complaints training for service users and staff.	HSE	Training provided on improved use and management of the complaints process.	Short	4b
82	Mental health services should ensure that the principles set out in the National Healthcare Charter, <i>You and Your Health Service</i> , are embedded in all service delivery.	Embed the principles set out in the National Healthcare Charter.	HSE	Principles embedded.	Short	4c
83	Future updates of the Quality Framework, the Judgement Support Framework and the Best Practice Guidance should be consistent with the ambition and the specific outcomes for the mental health system set out in <i>Sharing the Vision</i> .	Ensure future updates of the Quality Framework, the Judgement Support Framework and the Best Practice Guidance are consistent with <i>Sharing the Vision</i> .	DoH/HSE	Future updates of the Quality Framework, the Judgement Support Framework and the Best Practice Guidance completed in a manner consistent with <i>Sharing the Vision</i> . All funded contracts for service delivery in mental health in future should embed the core principles and guidance from these frameworks, as streamlined and relevant.	Medium	4c
84	The relevant bodies should come together to ensure that the measures for the Quality Framework, the Judgement Support Framework, the Best Practice Guidance, <i>Sharing the Vision</i> Pls and performance system and any future measurement systems are aligned and that the required data is derived, where possible, from a single common data set.	Agree and align the measures and performance measurement including that of the Quality Framework, the Judgement Support Framework, the Best Practice Guidance.	DoH/HSE	Single common data set and measurement system is in place.	Medium	4c
85	The work underway at national level to develop a cost and activity database for health and social care in Ireland should prioritise mental health services to leverage developmental work already underway and support the evolution of outcome-based resource allocation.	Prioritise mental health services in the work underway at national level to develop a cost and activity database for health and social care in Ireland.	HSE	Development of the mental health service cost and activity database underway.	Short	4d
86	A national mental health information system should be implemented within three years to report on the performance of health and social care services in line with this policy.	Implement a National Mental Health Information System.	HSE	National Mental Health Information System implementation in progress.	Medium	4a, 4d
87	The Department of Justice and the Implementation Monitoring Committee, in consultation with stakeholders, will determine whether legislation needs to be amended to allow for greater diversion of people with mental health difficulties from the criminal justice system.	Assess the need for amended legislation for diversion of people with mental health difficulties from the criminal justice system and amend if necessary.	DoJE	Appropriate legislation is in place for diversion of people with mental health difficulties from the criminal justice system.	Medium	4a, 4d
88	Training and guidance should be provided to staff on the practice of positive risk-taking, based on the principles of the Assisted Decision-Making (Capacity) Act 2015, where the value of promoting positive risk-taking is recognised by the regulator.	Provide training and guidance to staff on the practice of positive risk-taking, based on the principles of the Assisted Decision-Making (Capacity) Act 2015.	HSE	Training and guidance is provided on the practice of positive risk-taking, based on the principles of the Assisted Decision-Making (Capacity) Act and approved by the regulator.	Short	4c

89	Access to safeguarding teams and training should be provided for staff working in statutory and non-statutory mental health services in order to apply the national safeguarding policy.	Provide access to safeguarding teams and training for mental health services.	HSE	Mental health staff are fully trained and supported in implementing the national safeguarding policy.	Short	4c
90	The Justice and Health sectors should engage with the Coroners, the Garda Síochána, NOSP, CSO and research bodies in relation to deaths in custody, recording of deaths by suicide and open verdicts, to further refine the basis of suicide statistics.	Refine suicide statistics through engagement with coroners, the Garda Síochána, NOSP, CSO and other research bodies.	DoJ/DoH	Refined suicide statistics for deaths in custody, recording of deaths by suicide and open verdicts.	Short	4c
91	Significant improvements are required in the monitoring and reporting of levels and patterns of self-harm and suicidality among mental health services to inform a comprehensive and timely service response to effectively reduce levels of harm and death.	Review current reporting and monitoring of levels and patterns of self-harm and suicidality among people attending mental health services.	HSE	Appropriate monitoring and reporting processes of levels and patterns of self-harm and suicidality among people attending mental health services are in place.	Short	4c
92	In keeping with the evolving understanding of human rights to empower people and improve quality of care in mental healthcare facilities, legislation must be updated and additional supports put in place.	Progress a 'zero restraint, zero seclusion' action plan, which should be developed in partnership with mental health services. Prioritise comprehensive legislation to reform the Mental Health Act in line with this policy and in line with international human rights law. In keeping with the evolving understanding of human rights, particularly the UN Convention on the Rights of Persons with Disabilities, ensure that involuntary detention is not used except in a life-saving emergency. Make available a range of advocacy supports including both peer and representative advocacy as a right for all individuals involved with the mental health services. A range of advocacy supports including both peer and representative advocacy should be available as a right for all individuals involved with the mental health services.	DoH/DoJE	Completed review of Mental Health Act. Representative advocacy available to all individuals. Develop an action plan for 'zero restraint, zero seclusion' in mental health services.	Short	4b, 4c
93	A National Population Mental Health and Mental Health Services Research and Evaluation Strategy should be developed and resourced to support a portfolio of research and evaluation activity in accordance with priorities identified in the research strategy.	Develop a National Population Mental Health and Mental Health Services Research and Evaluation Strategy.	Health Research Board	Published and resourced National Population Mental Health and Mental Health Services Research and Evaluation strategy.	Short	4d
94	In order to bring about change, a strategic approach is required involving the necessary skills in change management. This approach has been developed in the former HSE Mental Health Division (MHD) Strategic Portfolio and Programme Management Office and should be mainstreamed and embedded in the wider HSE.	Embed the strategic approach to change management utilised in the former MHD Strategic Portfolio and Programme Management Office in the HSE.	HSE	Visible, quantifiable change management projects delivered in mental health services.		4d

95	<p>The initiatives under the former Mental Health Division Strategic Portfolio and Programme Management Office (SPPMO) and the ongoing Social Reform Fund (SRF) should be gathered together and made available both to encourage further innovation and to avoid duplication in the public service and NGO sectors.</p>	<p>Collate and align all initiatives from SPPMO and SRF to support further innovation.</p>	HSE	<p>Innovation supported in mental health services across all providers.</p>	Short	4d
96	<p>Innovations which have good evidence for clinical and/or social and cost effectiveness should be rolled out nationally. This will require the changing of practices and modification or cessation of services which are superseded by the new form of delivery.</p>	<p>Roll out innovations that demonstrate clinical and/or social and cost effectiveness including de-commissioning of services no longer fit for purpose.</p>	HSE	<p>New effective innovative services are promoted and existing services with limited efficacy replaced.</p>	Medium	4d
97	<p>Mental health services should make use of other non-mental health community-based physical facilities, which are fit for purpose, to facilitate community involvement and support the implementation of the outcomes in this policy.</p>	<p>Evaluate current and future use of non-mental health community-based facilities and make recommendations on how they could be better used to deliver mental health services.</p>	HSE	<p>Wide range of facilities used as appropriate to support the effective delivery of mental health services.</p>	Medium	4c
98	<p>Capital investment should be made available to redesign or build psychiatric units in acute hospitals which create a therapeutic and recovery supportive environment. It is essential that all stakeholders are involved in a structured service design process for all redesigns or new builds.</p>	<p>Invest in co-produced redesign and/or building of psychiatric units in acute hospitals. Include in all future primary care new building developments appropriate settings for delivery of a mental health service.</p>	DoH/HSE	<p>Refurbished/new co-designed psychiatric units in place for patients.</p>	Long	4c
99	<p>A national 'whole-of-government' Implementation Committee should be established with strong service user and VCS representation to oversee the implementation of the recommendations in this policy and to monitor progress.</p>	<p>Establish 'whole-of-government' Implementation Committee with service user and VCS representation to oversee the implementation of the recommendations in <i>Sharing the Vision</i>. Prioritise sustainable, continuous investment and financial resourcing over the 10-year life of this policy to ensure that the wider mental health system can deliver optimum outcomes for people with mental health difficulties. Ensure that, throughout the lifetime of this policy, ongoing communication and engagement take place to ensure that implementation plans are consistent with the priorities identified by multiple stakeholders. Conduct and publicly report an independent review of the implementation of <i>Sharing the Vision</i> every three years over the lifetime of this policy.</p>	DoH	<p>Whole-of-government National Implementation and Monitoring Committee in place overseeing progress of <i>Sharing the Vision</i>.</p>	Short	4a, 4b
100	<p>A joint review of the two specialist training programmes by the College of Psychiatrists of Ireland and the Irish College of General Practitioners should be undertaken to develop an exemplar model of mental health medical training and integrated care.</p>	<p>Undertake a joint review of mental health medical training and integrated care to ensure registered practitioners who have attained approved Mental Health Education are provided with specialist psychiatric training to increase capacity.</p>	ICGP/ICP	<p>Specialist mental health medical training for GPs and psychiatrists delivered.</p>	Medium	4a, 4d

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For more information contact:

Department of Health, Block 1, Miesian Plaza,
50 - 58 Lower Baggot Street , D02 XW14

Website: www.gov.ie/health

Email: info@health.gov.ie

Phone: (01) 6354000



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