Report 32/03

A Strategic Framework for Mental Health in the Eastern Region

2003 – 2010

Please note that this is a draft document.

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Foreword

Summary

Section 1 – Introduction

Mental health is a serious public health issue. Mental ill health can affect many people in a variety of different ways throughout their lifespan. The Global Burden of Disease project's findings have demonstrated that the burden of psychiatric conditions has been severely underestimated. Of the ten leading causes of disability, four were psychiatric conditions and one was an addiction.

Action 25 of the National Health Strategy states that a new action programme for mental health will be developed. Action 52 states that provision will be made for the participation of the community in decisions about the delivery of health and personal social services for people with mental illness.

The following document is a strategic framework which will be used to develop the strategic plans for each Area Health Board. It is not intended to delineate the necessary service developments of all Catchment Area Mental Health Services in the East.

This framework will aim to describe; the potential public health burden of mental ill health, the particular capacity constraints in the Eastern region in operating a mental health service within a best practice model, the potential impact of legislative changes (e.g. Mental Health Act, 2001) on service delivery, a process to support infra-structural developments, the involvement of user and advocacy groups in the design and delivery of services, the arrangement and linkages required to respond to severe and serious psychiatric disorders, the human resource needs of services and the communication and information infra-structures necessary to support the effective delivery of services within and between different types of services.

Section 2 – Framework vision

The World Health Organisation has stated that there are particular needs of people and communities in relation to their mental health. These needs are; community needs that promote positive mental health and combat against discrimination, prevention and treatment services for those who may be suffering mental ill health, support for families and carers in supporting others in their everyday life and services to assist people with a mental health or psychiatric illness in returning to an independent life following an episode of mental ill health.

The development and delineation of a series of framework standards will assist in the development of the broader mental health services. These standards are:

- Standard area 1: Promotion of mental health
- Standard area 2: Access to mental health services in primary care
- Standard area 3: Services user involvement
- Standard area 4: Supporting carers
- Standard area 5: Preventing suicide and parasuicide.
- Standard area 6: Effective secondary care services for people with severe mental illness
- Standard area 7: Services that contribute to the health and well-being of population

Section 3 – Best Practice Service Model

Responding to mental health issues requires the development of a broad and complex range of services for the many and varied service users that require support during periods of mental ill health. There are strong referral links and interdependent relationships within the mental health services and between mental health (statutory and voluntary) and other health services. The relationship between mental health services and primary care / community health services is especially important in this context.

A clear vision and understanding of the core function of the different elements of a mental health service is key to the effective deployment of skills and competencies to best serve service user needs. A tiered model approach to the development of a response to mental health issues that is based on a clear need continuum is described in the framework. It is important to emphasise that the clear focus of the development of services is on responding to people with severe and / or enduring mental illness (Tiers 3,4 and 5). Similarly, the separation of tiers in this model is for illustrative purposes only. All tiers act in a con-joint manner in the provision of services; have flexible boundaries when dealing with groups with multiple needs and can simultaneously act in a step up or step down capacity. The best practice service model is configured based on the following tiers:

- **Tier 1:** Supports available to everyone services involve health and non-health agencies that promote positive mental health directly or indirectly.
- **Tier 2:** Primary care services are services provided to people with a mental health difficulty that assist in the detection and treatment of mental health difficulties. These services provide an initial response to emerging mental ill health or assist in the aftercare of persons following an episode with the Mental Health Service.
- **Tier 3:** Community Psychiatric Services are specialised mental health services located in the community that aim to respond to severe and enduring mental illness through an array of community based psychiatric services.
- **Tier 4:** In-patient and residential accommodation services including rehabilitation are treatment options and accommodations to provide services to respond to severe mental illness. These services are primarily provided as a component of Community Psychiatric Services.
- **Tier 5:** Services to meet the most complex and severe needs are services that respond to severe psychiatric disorders with a forensic component which require a high secure treatment response.

Section 4 – Supporting the delivery of services

To support the delivery of care and mental health services, a number of essential elements are required to work in concert with Mental Health Services. Each of these systems must play a role in supporting the delivery of care. These systems and processes include:

- A public health approach providing local and regional needs assessment information on issues relating to mental health and a communications strategy that enhances the visibility of mental health, promotes the importance of acknowledging and addressing mental ill health and promotes the work and successes in the provision of mental health services.
- A financial framework and a budgetary management system that allows front line managers the authority and responsibility to manage their resources effectively.
- Advocacy services that continually promote quality in the delivery of mental health services, highlight inadequacies in service delivery and work in partnership with all service providers to effect and monitor change.
- Planning systems based on effectiveness evidence, that identify and describe service needs and draw together essential elements to plot future service developments and re-engineer services to meet new and emerging needs.

- A human resource support system that addresses priority recruitment, retention and training issues promptly and effectively.
- A continuous quality improvement programme that includes the built environment, that makes explicit standards of care in the delivery of service and continuously monitors actual care and delivery against the specified standards.
- An information strategy that supports the delivery of pertinent management information and accountability requirements in relation to service activity levels, client outcomes and service user views of the quality of care. This will be backed by an information and communications technology infra-structure that supports closer and efficient working between multi-disciplinary professionals in geographically diverse areas, supports monitoring and evaluation and allows innovative approaches to service delivery to evolve.

Section 5 – Challenges in the provision of Mental Health Services

With the significant developments in the Irish economy over the past 10 years, the Mental Health Services in the Eastern Region have faced significant challenges and difficulties in the provision of existing services and the development of new services to meet new and emerging needs. Broadly, these challenges can be categorised into challenges arising from a lack of adequate and on-going investment in service developments and facilities, those due to the organisation of services and those anticipated challenges that will arise from recent policy and legislative developments.

Section 6 – Implementation Pathways

The focus of implementation of the framework elements will be through a number of groups. These are:

- Regional Group chaired by the Regional Chief Executive and comprising representatives from the E.R.H.A. management team and the Chief Executives of each AHB. The function of this group is to measure the implementation of the framework in line with agreed targets and to guide decisions on implementation issues arising from the framework.
- Implementation group chaired by one of the Chief Executives of the AHBs, which is charged with driving the implementation across the three AHBs. It would comprise representation of the management team of the E.R.H.A. and AHBs, appropriate service personnel and service user representatives. Modelled on the implementation of the strategic framework for Children and Families, it is envisaged that the work of this group would be guided by a number of core themes including finance, human resources, information and quality and is composed of a number of task groups which support the implementation process.
- Local implementation structures are a critical component in the overall implementation process. Such structures are important to ensure local collaboration and support for the framework to facilitate timely implementation and to allow for local adoption in line with critical priorities.

1 - Background

1.1 Introduction

Mental health is a serious public health issue yet it repeatedly fails to attract the attention that such an illness would warrant. For example, the Slán Health and Lifestyle (1999), demonstrated that the out of the top five requirements for bettering their health, the national population stated that they would like less stress (Figure 1.1). However, to date, many health initiatives have been launched (based on these surveys) that are aimed at reducing smoking, increasing exercise, making dietary regimens healthier, etc with few being targeted at coping with stress or mental health issues. Such reactions to mental health information are not unusual in Ireland.

The World Health Organisation now predicts that the collective burden of all mental health issues is very substantial and has been ignored due to our present methods of health status measurements that are grounded in mortality rates. In parallel, the level of funding to mental health services has fallen from 11% to 9% of the overall health budget despite full implementation of the Planning for the Future national policy document.

Figure 1.1: Top five requirements for bettering health (Slán Survey,1999)

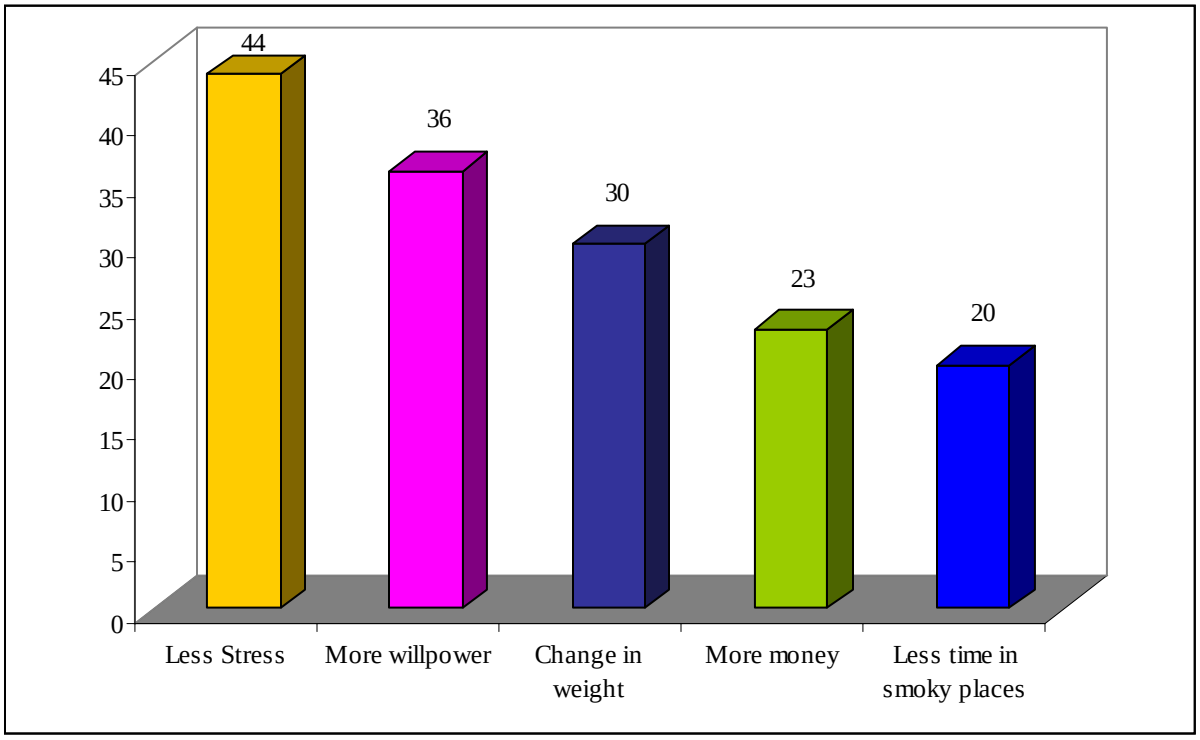
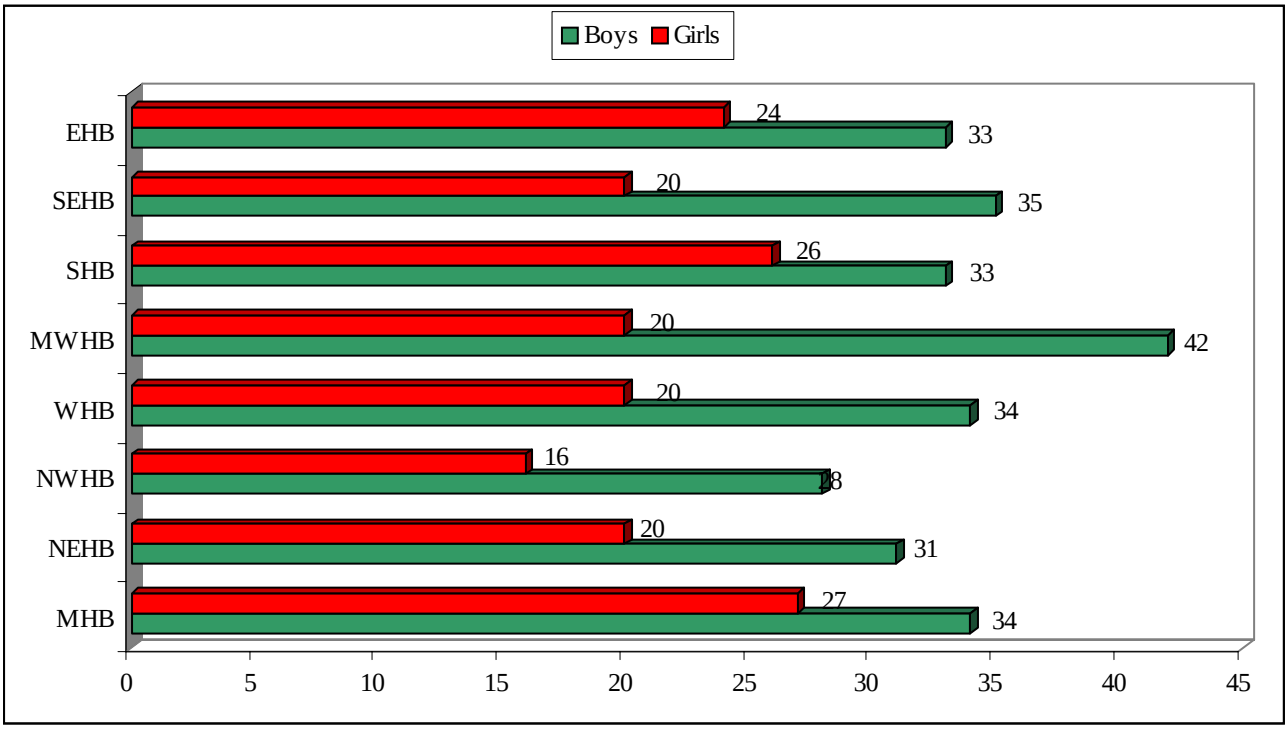


Figure 1.2 below shows that within the Eastern Region, only one third of boys and one quarter of girls aged 12-14 years reported being very happy. Again, such information appears to indicate that tackling and responding to issues related to mental health are of importance, not only to adults, but to children and adolescents. The challenge within the East is to place greater emphasis on the importance, promotion and maintenance of mental health.

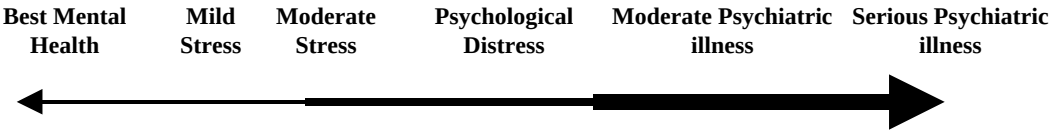
Figure 1.2: Percentage of boys and girls (aged 12-14 years) who reported that they were very happy (Slán, 1999)



The publication of the National Health Strategy: Quality and Fairness brings new opportunities for mental health. However, it is important to understand from the outset the spectrum of mental health / ill health and the importance of differentiating the appropriateness of response intensity at each point of this spectrum. Figure 1.3 shows that mental health ranges from best mental health to severe and serious psychiatric disorders. Thus it is important to recognise that:

- Although many external and environment factors impact on the health of an individual, people can play a significant role in the maintenance of their own mental health just as they can play a significant role in the maintenance of their own physical health through exercise, diet and lifestyle.
- Mental ill health impacts negatively on the quality of life of individuals. The collective impact of mental ill health on society is substantial because of its high prevalence. There are also substantial economic and social consequences for individuals with mental health difficulties.
- The promotion of positive mental health and the needs of people experiencing moderate psychological distress and mental illness are important components in an overall response to mental health.
- There is a long history of unease with acknowledging and dealing with mental ill health, both internationally and nationally
- Different competencies and services are required to intervene or assistant at different points on the spectrum.
- People with mental health difficulties will present to a variety of services (GPs, schools, workplace, A&Es etc) and therefore a variety of responses to mental health issues need to be developed.

Figure 1.3: Continuum of mental health and mental ill health from best to worst



1.2 Objectives of Framework

Action 25 of the National Health Strategy states that a new action programme for mental health will be developed. This framework is directly linked to Action 25 and Action 52 of the National Health Strategy (2001) which states that:
Action 25: A new action programme for mental health will be developed. This action will deliver:

- The establishment of the Mental Health Commission and implementation of the Mental Health Act 2001
- A policy framework for the modernisation of mental health services and a programme of on-going investment in the development of specialist services
- Development of services for older persons and community based alcohol treatment services
- Promotion of positive attitudes to mental health
- Encouragement and provision of resources for independent advocacy services
- Intensification of suicide prevention programmes

Action 52 of the National Health Strategy states that provision will be made for the participation of the community in decisions about the delivery of health and personal social services and the establishment of consumer panels. Under this Action, the strategy recommends that Regional Advisory Panels / Co-ordination Committees and consumer panels be established for people with mental illness to advise on the planning and prioritisation of services, quality of services and promotion of positive mental health initiatives.

Following from these actions, the objectives of the present framework are:

1. To develop a strategic framework for mental health for the Eastern Region for the period 2003 – 2010.
2. To develop an implementation pathway for the strategic framework that incorporates both users and service providers working in partnership.
3. To develop a monitoring system to track the implementation of the strategic framework.

This framework will aim to describe:

- The potential public health burden of mental ill health and the need for the establishment of national prevalence rates of mental illnesses and psychiatric disorders, their severity, duration and the accompanying effects of disability on the individuals, families and society.
- The particular capacity constraints in the region (as set out in the Acute Bed Study 1999) in operating a Mental Health Service within a best practice model, guidelines which afford choice and assuring a safe environment for users and providers.
- The potential impact of the Mental Health Act, 2001, the Mental Health Commission and other legislative changes and their associated resource needs, training requirements and changes to current service delivery.

- A process to establish the required infra-structural needs and their efficient use to meet the core psychiatric service requirements as set out in the Acute Bed Study and Inspector of Mental Health Services reports.
- Methods for incorporating the views and involvement of user and advocacy groups in the model of service delivery and in highlighting inequities.
- The core business of Mental Health Service in responding to severe and enduring psychiatric disorders.
- The human resource requirements in responding to mental health needs in the Eastern Region and a mechanism for responding to issues of recruitment, retention and training.
- The communication infra-structures necessary to support the effective delivery of services within and between different types of services.

Implementation of the framework will aim to build upon on the current strengths in the provision of statutory and voluntary services, capitalise on the community orientation of the provision of services and take advantage of the Clinical Director model of management that currently exists. The framework will also seek to continue to address all the challenges currently facing the mental health services.

1.3 Functions and scope of the framework

The following document is a strategic framework which will be used to develop the strategic plans for services within each Area Health Board. The framework will address the following:

- The vision, principles and overall objectives of a range of health services when responding to mental health
- The shape and design of a best practice service model that is able to respond and react to differing levels of need
- The support structures and implementation processes necessary to achieve the best practice model
- The key stakeholders, agencies and personnel that must work together in a co-ordinated manner to improve the mental health status of the population within the Eastern Region
- A range of other national policies that impact on the development of services (e.g. National Health Strategy, Primary Care Strategy, etc).

Currently, each Catchment area within the region differs in the range and type of available services. Dissemination of the strategic framework for mental health will allow local services in each area to compare their current complement of services to the best practice service model and plan for and prioritise the necessary and required service developments over the framework period. As a result, the framework provides for a high level of flexibility in its applicability and relevance to local services and should act as a focus for the co-ordination of many different health services that are provided by statutory and voluntary agencies..

The following framework document must be precise in the language it employs. To avoid confusion, the following terms will be employed:

- **Mental Health Service:** this term refers to all health services dealing with mental illness including services provided at primary, secondary and tertiary level. The term also covers services provided for treatment and rehabilitation purposes. In the interests of prescision and in certain instances, the term Psychiatric Services will be used to refer to specialised psychiatric care provided by in-patient and community psychiatric services.
- **Target Service Users:** Currently, the Adult Mental Health Services provides services to persons aged 16 years to 65 years and to those over 65 years who have had a prior mental health episode before this age.

However, it should be noted that mental health services are also delivered to those under 16 years (i.e. by Child and Adolescent Psychiatric Services) and those over 65 years with a first mental health episode (i.e. by Psychiatric of Old Age / Later Life Services). Although this framework focuses specifically on adult mental health, the importance of both children and older persons is acknowledged. Similarly, the need to ensure appropriate linkages between child, adult and older persons mental health services should also be emphasised.

Where **no** associated psychiatric disorder is present, the Mental Services does not directly* provide services to the following target groups:

- Substance misuse addictions (including alcohol)
- Brain Injury
- Intellectual disability** (moderate, severe or profound)
- Persons with a physical or sensory disability
- Persons with personality disorder

* For clients with a possible co-morbid psychiatric disorder, a psychiatric liaison or consultation service will be arranged. It should also be noted that currently the Mental Health service does, in some circumstances, provide services to the above groups. Where services are reorganising their focus of operations (e.g. psychiatric in-patient units and alcohol), there may need to be transition phases where services continue to be provided while other services develop to take over service provision.

**Responding to the psychiatric needs of the Intellectually Disabled will be clarified at the implementation phase of this framework. While specific work is in progress through the National Disability Authority (NDA), specific consultation process will be engaged in on this issue.

1.4 Objectives of Mental Health Services in the Eastern Region

The Mission statement of the Mental Health Services in the Eastern Region is:

The Mental Health Services aim to achieve the best quality of life for each individual through the provision of high quality user–centred services. The Mental Health Services strive to provide a seamless service to all service users, measured by ease of access, appropriateness and responsiveness to the needs of the service user. Services aim to enhance mental well-being by minimising the effects of mental illness and to promote good mental health through appropriate prevention.

Following from this, it is apparent that the core business of the Adult Mental Health Services is to deal with severe and / or enduring mental illness.

There have been significant developments in psychiatric service provision, especially since the publication of the national policy document Planning for the Future (1984). This policy instigated a far-reaching set of changes including:

- Moving the provision of Mental Health Services to a more community orientated model
- Moving acute in-patient services from psychiatric hospitals to general hospitals
- Developing a tripartite management system with the direct involvement of clinicians in management

1.5 National Health Strategy and Mental Health

The publication of the National Health Strategy has heralded a new development period for the health services in Ireland. This Health Strategy sets out the national framework for the development and quality assurance of services in the Republic. However, it is important to note that although only a small number of actions are directly linked to mental health and the Mental Health Services in the strategy, many of the broader actions are applicable to either the Mental Health Services, the development of a mental health response by other health services or are actions that will eventually or indirectly affect the development of services. Within the present framework, it is of utmost importance that such actions be considered and their effects anticipated. Table 1.1 sets out a summary of the actions (and reference numbers) in the National Health Strategy that:

- Directly affect the organisation and delivery of care within the Mental Health Services
- Directly affect the organisation and delivery of mental health treatments by other health services
- Will need to consider mental health and the mental health services in the development of the action

The complete wording of each National Health Strategy action relevant to mental health is presented in Appendix A.

A number of national strategies and policy documents will also impact on the development of responses to mental health issues and on the provision and construction of Mental Health Services. Such documents include:

- Audit of Structures (Prospectus Report)
- National Anti-Poverty Strategy
- National Health Promotion Strategy
- Action Programme on People Management
- The Years Ahead: A policy for the elderly
- National Alcohol Policy & Taskforce Reports
- National Development Plan
- National Taskforce on Suicide
- National Children's Strategy
- National Strategy on Youth Homelessness
- Homeless Integrated Strategy
- National Spatial Strategy
- Financial Management (Brennan Report)
- National Drug Strategy
- Adolescent Health Strategy
- Women's Health Policy
- Services for People with Autism
- Status of People with Disabilities
- Primary Care Strategy
- Health Research Strategy
- Management Development Strategy
- Action Plan on Dementia
- Sustaining Progress Agreement
- Neglected Quarter (Amnesty Report)
- Review Group on Child & Adolescent Psychiatric Services

A number of national reviews, not cited here will also need to be considered (e.g. Medical Manpower Report, Commission on Nursing, NCHD working hours review, etc).

Table 1.1: National Health Strategy Actions affecting the delivery of mental health services

Actions directly effecting the organisation and delivery of care in the Mental Health Service	Actions directly effecting other health services where mental health will have to considered*	Actions where mental health will be an important factor or considered as part of the overall development
Improve child health (expansion of child & adolescent psy services)	Actions on major lifestyle factors in National Health Promotion strategy	Health impact assessment will be introduced
Improve health of homeless people (with a psychiatric disorder)	Promote healthy lifestyles in children	Statements of strategy of government departments will incorporate health
Improve the health of prisoners	A policy for men's health developed	A policy for men's health developed
A new action programme for mental health will be developed	Barriers for disadvantaged groups to achieve healthier lifestyles reduced	Implementation of Nat. Anti-poverty strategy to reduce health inequalities
Integrated approach to meeting the needs of ageing and older people	The Health of Travellers will be improved	Clear provisions on entitlements to health and social services
Action plan for rehabilitation services	Improve the health of homeless people	Eligibility for medical cards simplified
Policy for the provision of sheltered work for people with disabilities	Improve the health and well-being of drug misusers	Nursing Home Subvention Scheme and support for home care
Appointment planning arrangements made more flexible	The needs of asylum seekers / refugees addressed	Grant to cover respite care for dependent older persons
Waiting areas in health facilities upgraded	Improved access to hospital services for public patients	Financing of long term care of older people brought forward
National standardised approach to the measurement of patient satisfaction	Availability of information on entitlements	A review of medicines legislation and licensing of alternative medicines
Best practice models of customer care and complaints handling	Measures to make health facilities accessible	Health research continue to support information and quality initiatives
Support for individuals and families to be involved in the management of their own care	Community and voluntary activity in maintaining health supported	A National Hospitals Agency developed
Integrated approach to care planning will become consistent feature	Plan for high quality maternity care drawn up	Organisation and management of services enhanced to benefit of patients
Provision made for the participation of the community in decision's about delivery of health services	Review of paediatric services undertaken	Additional investment will be made in the health system
Initiatives to ensure care is delivered in most appropriate setting	Model of primary care will be developed and task force established	Capital funding allocated for the maintenance of facilities and planned replacement of equipment
Programme of investment to provide the necessary capacity in primary care, acute hospital and other services	Investment will be made in GP co-operatives and primary care teams	Public-private partnerships will be initiated to assist development of health infra-structures
Quality systems integrated and expanded	Additional acute hospital beds provided for public patients	Multi-annual budgeting introduced
Decisions across the health system based on evidence	A substantial programme of improvements in A&Es introduced	Other areas: Statements of funding and allocations Management of capital projects Workforce planning Extra health staff recruited Regulation of consultant posts Best practice in recruitment Action Plan for People Management Health Boards to drive change Health Info & Quality Authority Health Information Strategy ICT technologies exploited Electronic patient record
Accountability will be strengthened Service agreements between the health boards and voluntary sector extended and performance indicators introduced Greater inter-disciplinary working promoted		

* It is important to note here that it is intended that the Mental Health Services will not provide mental health services to facilitate each of the actions above. Such services will need to consider how the development of a mental health response as part of the overall service may be developed.

1.6 Legislation

Pertinent legislation relating to the operation of the Mental Health Services is:

- Mental Treatment Act 1945
- Mental Health Act 2001
- Criminal Law (Insanity) Bill 2002

However, legislation in a number of other areas also affects the provision of mental health and Mental Health Services. These areas include:

- Children
- Disability
- Social welfare
- Health and safety
- Regulation and licensing of medicines

A number of specific functions and requirements are provided for under the Eastern Regional Health Authority Act (1999) and include the planning, commissioning and overseeing of the provision of services within the East.

1.7 Population of the Eastern Region

The population of the Eastern Region in 2002 was 1.4 million, rising by 8% since the last census. Tables 1.2, 1.3 and 1.4 presents the population of the Eastern Region and the three Area Health Boards, the population of the East compared to other Health Boards and the Catchment Area Populations of each Area Health Board. Figure 1 presents the growth of the population in the Eastern Region from 1966 to 2001. As can be seen from Tables 1.1 and 1.2 and Figure 1.1, the population of this region has consistently increased and has grown dramatically since 1990. Current population projections (1996 to 2031) by the Central Statistics Office predict that the population of Dublin will be the fastest growing region and its population will rise by 56% to almost 1.7 million. As a result, significant planning and resource allocation will have to be secured from the Department of Health and Children to continually provide for an increasing (urbanised) population.

Table 1.2. Population in Eastern Region, Area Health Boards, Community Care Areas* 1996-2002

	1996	2002	2002	2002	Total	%
	Total	Total	Male	Female	Change	Change
ERHA	1,295,039	1,401,314	683,302	718,012	105,375	8.1
NAHB	454,899	486,305	237,356	248,949	31,406	6.9
SWAHB	520,669	581,551	286,450	295,101	60,882	11.7
ECAHB	320,371	333,458	159,496	173,962	13,087	4.1

* Community Care Areas do not exactly correspondent to Catchment Care Areas which provide mental health services

Table 1.3. Population of Health Board regions in Ireland 1986 -- 2002

					Change 1986 - 2002	Change 1986 - 2002
	1986	**1991**	**1996**	**2002**	**No.**	**%**
ERHA	1,232,238	1,245,225	1,295,939	1,401,314	169,076	13.7
SEHB	384,974	383,188	391,517	423,540	38,566	10.0
NEHB	302,035	300,183	306,155	344,926	42,891	14.2
SHB	536,894	532,263	546,640	580,605	43,711	8.1
MWHB	315,435	310,728	317,069	339,930	24,495	7.8
WHB	348,328	342,974	352,353	380,057	31,729	9.1
NWHB	212,745	208,174	210,872	221,376	8,631	4.1
MHB	207,994	202,984	205,542	225,588	17,594	8.5

Table 1.4: Population of the Eastern Region, each AHB and each Catchment Care Area

Area 1	Dun Laoghaire & Sth. East Dublin	population.	
Area 2	South East Dublin	population	**East Coast Area Board***
Area 10	Wicklow	population	**Total *333,458***
Area 3	Dublin S.C	population	
Area 4 & 5	Dublin West	population	**South Western Area Board**
Area 9	Kildare/W. Wicklow	population	**Total *581,551***
Area 6	Dublin North West	population	
Area 7	Dublin N.C	population	**Northern Area Board**
Area 8	Dublin North	population	**Total *486,305***

* The ECAHB provides services to a population of 40,000 of the SWAHB catchment population.

Figure 1.4: Population of the Eastern Region (1966 – 2001)

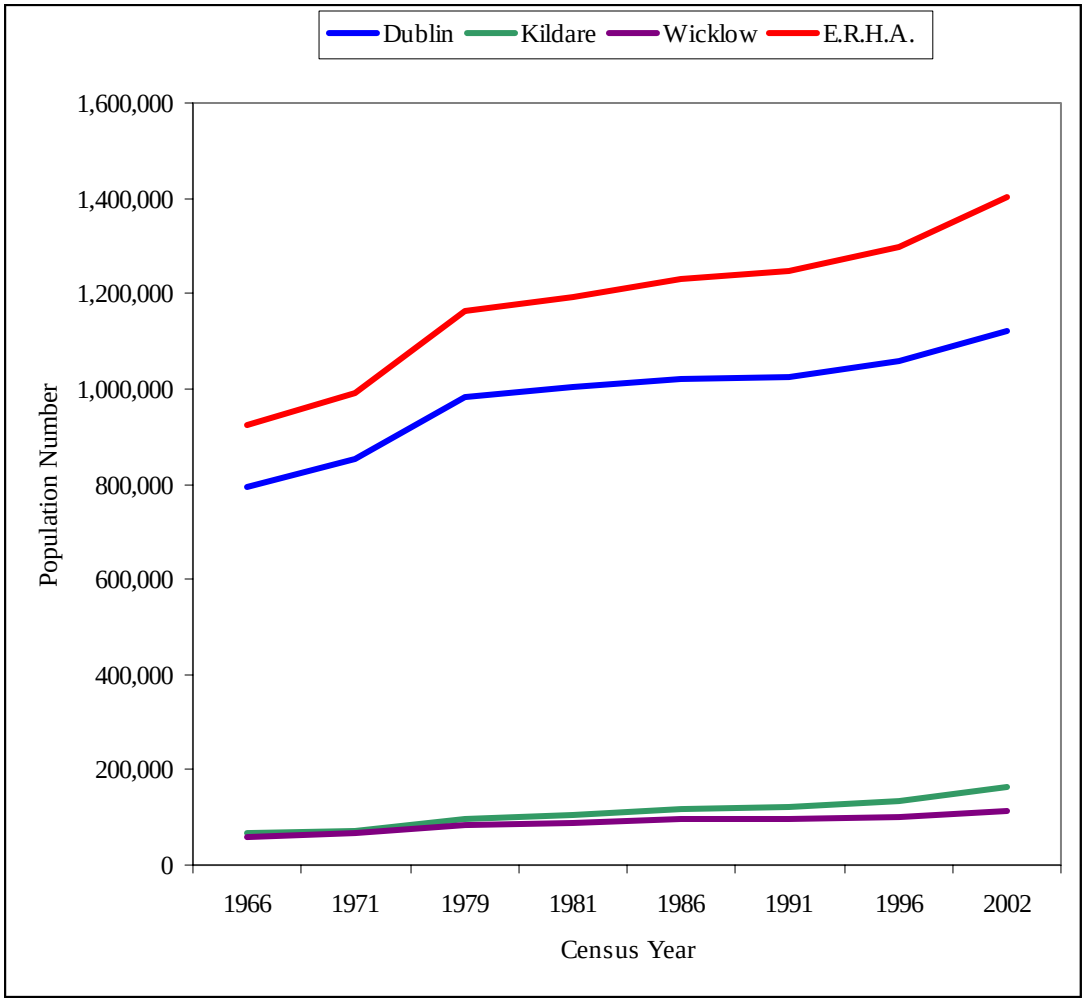
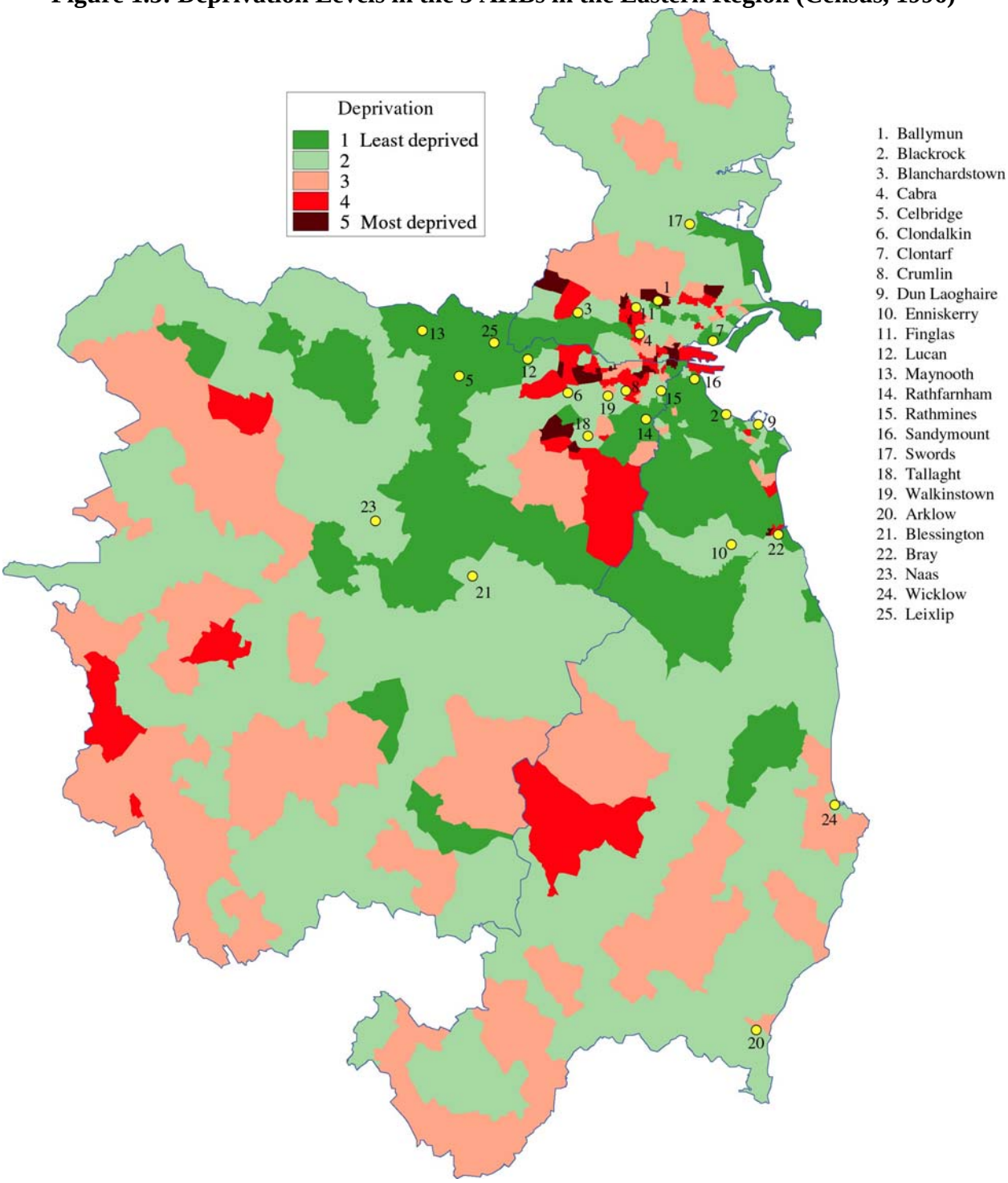


Figure 1.5 shows the deprivation levels in the Eastern Region*. Previous research has identified associations between socio-economic factors (e.g. social class and unemployment) and mental health difficulties (Jenkins et al., 1997). Significant planning to target services in areas of high deprivation will form a crucial component of this framework.

* More up to date information on deprivation levels in the Eastern Region was not available from Census 2002 information at the time of publication of this framework.

Figure 1.5: Deprivation Levels in the 3 AHBs in the Eastern Region (Census, 1996)



From the above information, it is clear that the framework will need to address the consequences of the following population changes:

- Continued population growth placing greater demand on services
- Rapid expansion of populations in concentrated areas requiring the development of services in key population centres
- High concentration of homeless population in inner city Dublin

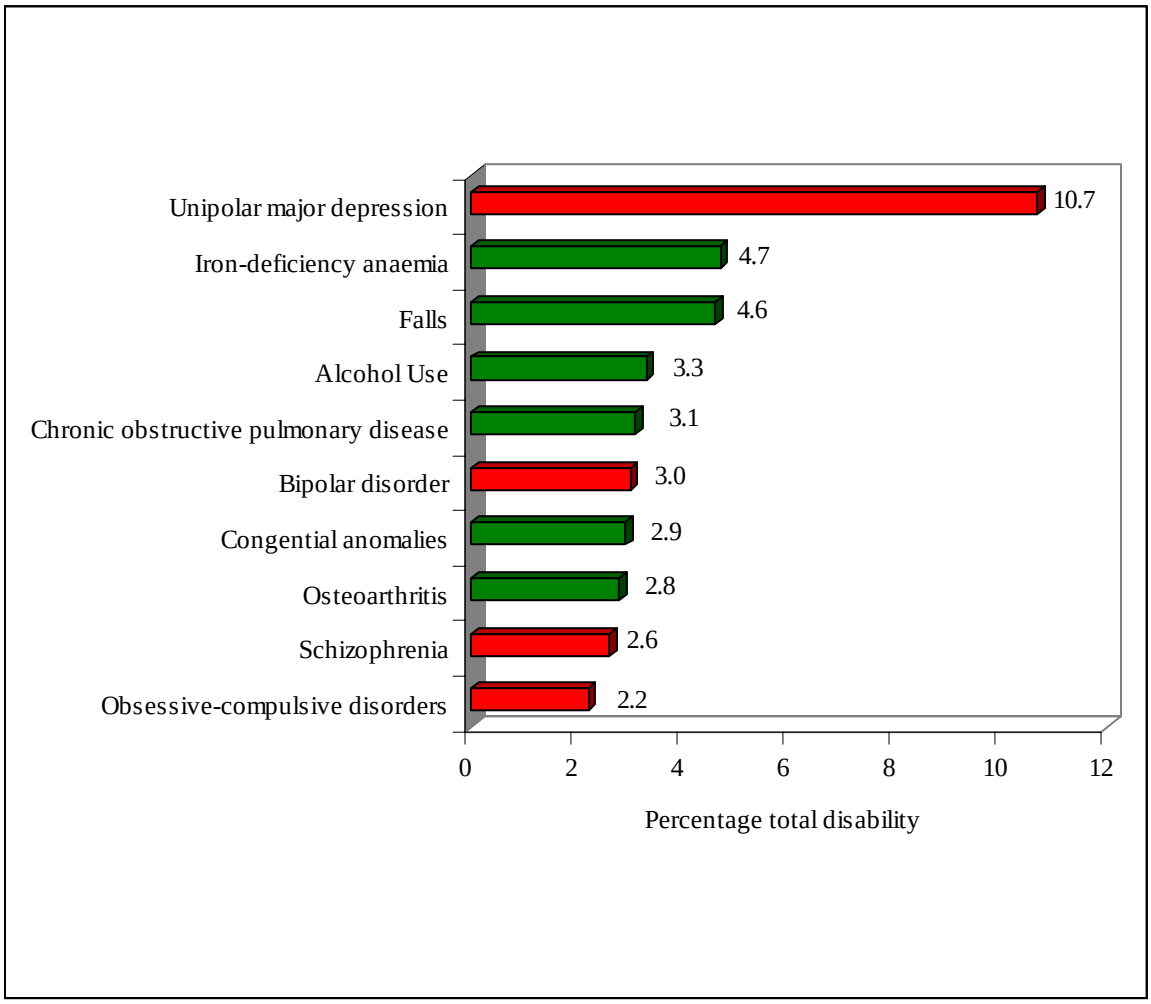
- Increasing life expectancy and increased need for services for longer periods
- Ageing population structure requiring intensive mental health supports in later life
- Increasing urbanisation of the Eastern Region presenting new challenges in responding to mental health needs
- Continuing pockets of deprivation across the region requiring more intensive development of services and higher levels of responses in certain areas
- Increasing multiculturalism requiring the development of sensitive and appropriate responses including differentiated access methods to services.

1.8 Extent of mental health problems and illness

The increasing importance of mental health as an integral part of overall health is finally being recognised. For example, the European Commission has supported a project entitled "Putting Mental Health on the European Agenda", which has recently led to the publication of the "Public Health Action Framework on Mental Health" (2000). This report clearly states that mental health is an indivisible part of public health and that mental health and its promotion should be integrated closely with all public health strategies (p10).

The Global Burden of Disease project's findings have demonstrated that disability plays a central role in determining the overall health status of a population. It has also shown that the leading causes of disability are different to the leading causes of death which casts doubt on the practice of judging a population's health solely from mortality statistics alone. Figure 1.6 presents the leading cause of disability in the world based on the number of years lived with a disability (YLDs). As can be seen, the burden of psychiatric conditions has been severely underestimated. Of the ten leading causes of disability, four were psychiatric conditions and one was an addiction. For example, unipolar depression alone was responsible for one in ten years of life lived with a disability worldwide and in total, psychiatric conditions accounted for 19% of the total disability.

Figure 1.6: Leading causes of disability: Global Burden of Disease Study, WHO (1990)



The prevalence of mental health and psychiatric difficulties is very individual and the broader usage of the term mental health may be misleading in this respect. To state that a certain percentage of the population is physically unwell on a certain day does not add much value or epidemiological understanding as the type of physical disorders may vary with some being more serious than others. Thus, it is important to be able to know the different types of mental health problems and psychiatric disorders that are present in a community at any time.

Table 1.5 presents a brief overview of the prevalence of a number of different mental health and psychiatric disorders. Using the 2002 Census information, it is possible to estimate (in crude terms) the possible and potential service needs that exist within the Eastern Region. For example, a recent Northern Ireland survey found that 12% of the population reported dealing with a great deal of stress or worry. Similarly, 27% reported dealing with quite a lot of stress or worry. Such information shows that potentially within the Eastern Region over 500,000 adults would benefit from mental health promotion activities.

A positive score on the General Health Questionnaire (GHQ) denotes the possible presence of psychiatric morbidity. Table 1.5 shows that within the Eastern Region, 288,000 people may potentially require mental health treatments provided by primary care services with more females than males requiring assistance.

The prevalence of serious psychiatric disorders (as detected by the U.K. General Household Surveys) also demonstrates that significant numbers of persons within the Eastern Region may be living with serious psychiatric disorders.

Table 1.5: Potential Service Needs for Persons with mental health difficulties and psychiatric disorders

	Prevalence	Potential Service Need*
Stress**		
Great deal of stress or worry	12%	168,157
Quite a lot of stress or worry	27%	378,354
+ GHQ Score**	Male: 17% Female: 24%	Male: 116,161 Female: 172,322
Neurotic disorder***	Male: 123 per 1000 Female: 195 per 1000	Male: 84,000 Female: 140,000
General anxiety disorder**	Male: 28 per 1000 Female: 34 per 1000	Male: 19,000 Female: 24,000
Depressive episode***	Male: 17 per 1000 Female: 25 per 1000	Male: 11,000 Female: 18,000
All phobias***	Male: 7 per 1000 Female: 14 per 1000	Male: 4,700 Female: 10,000
Obsessive-compulsive disorder***	Male: 9 per 1000 Female: 15 per 1000	Male: 6,100 Female: 10,700
Panic disorder***	Male: 8 per 1000 Female: 9 per 1000	Male: 5,400 Female: 6,400
Functional psychosis***	Male: 4 per 1000 Female: 4 per 1000	Male: 2,700 Female: 2,800

* Based on Census population (2001); Total population = 1,411,314 ; (male = 683,302; female = 718,012)
** General Health Questionnaire scores indicate signs of possible mental health problem; Northern Ireland Health and Social Well-being Survey 2001
*** Jenkins et al. (1997)

In conclusion, Figure 1.6 above illustrates that the burden of mental health problems has been consistently and significantly underestimated. Compared to illnesses that receive media attention (e.g. cardiovascular and cancer), mental illness is responsible for a substantially greater burden of illness. It has also been shown that within the East, there are substantial numbers of people in potential need of different types of services. Such services will range from population-based mental health promotion activities to mental health treatments available for mild to moderate conditions to services for the those with severe or enduring mental illness. It is important to note here that the present framework does not suggest that secondary care services (i.e. psychiatric care) should take the lead responsibility for the provision or funding of services designed to deal with mild or moderate mental ill health. Responses to such levels of mental ill health are recognised internationally to be most appropriately provided for within less intensive treatment services such as primary care.

1.9 Challenges facing Eastern Region

In addition to the population changes referred to in Section 1.8, other factors will also impact on the development of mental health services over the short, medium and longer term. Such changes include:

- Continuing social change with ongoing change from traditional values. Such changes have been accompanied by increasing levels of stress and pressurised lifestyles.
- Persons with different types of illnesses presenting for and requiring help from the mental health services.
- Changing patterns of presentation to services including decreased familiarity with services
- Decrease in the incidence of volunteerism and relative carers

- Increased willingness on the part of people to seek help for mental health issues as the stigma surrounding mental illness fades
- Changes in the organisational structure of health care delivery in the East with the creation of a Health Services Executive responsible for the commissioning and monitoring role of services.
- Changes in legislation governing mental health and the establishment of the Commission for Mental Health.
- Changes necessitated by accountability and value for money requirements and increased emphasis on evaluation and assessment.

The organisation of care delivery also faces many challenges over the short, medium and longer term. In 1996 the Department of Health commissioned the Health Research Board to investigate the provision of acute psychiatric beds in the Eastern Region. The Health Research Board published its report " We Have No Beds" in 1999, finding that while there were an adequate number of acute psychiatric beds in the region they were not available for that purpose due to:

- 45% of acute beds were occupied by non-acute patients. This created a shortage of acute beds for those who needed them.
- The inappropriate occupancy was due mainly to a lack of other services or inadequate provision of high support and other community accommodation.
- Inadequate rehabilitation places.
- Serious shortage of community – based continuing care residential places.
- Lack of an integrated provision of facilities.
- Shortage of day hospital places and lack of clarity of their role.
- Unequal geographic spread of community – based mental health centres and they were generally not used for assessment of patients.
- Community – based 24-hour crisis intervention services were generally unavailable.
- Limited availability of domiciliary and home care services.
- Limited provision of social worker, psychologists and occupational therapists.
- Insufficient homeless provision in appropriate facilities.
- Need for a psychiatric intensive care unit (PICU) that can respond to need.
- Insufficient focus on written admission and discharge policies.
- Admission decisions made by inexperienced staff in many cases (6 p.m. to 2 a.m.)
- Insufficient assessment of full condition before admission.
- Admissions often bypassed usual channels, e.g. sector assessment team, day hospital
- Insufficient data.

Planning envisaged in the strategic framework will assist in developing an effective response to the challenges highlighted above. It will also increase the mental health of the community and will achieve greater health and social gain. Paradoxically, success in one area of the framework, the removal of stigma from mental health, will increase the likelihood of people acknowledging mental health problems and seeking assistance from the mental health service, thereby putting further pressure on the need for responsive services.

2 – Framework Vision

2.1 Introduction

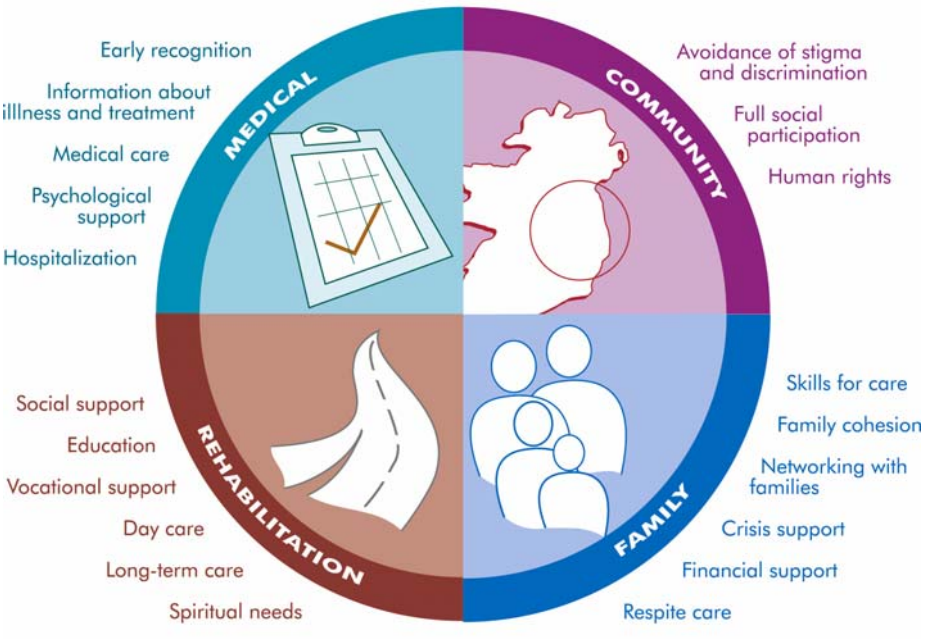
The following chapter will outline the Eastern Region's vision for the development of Mental Health Services. This vision will delineate the approach for the identification of services (in terms of needs assessment), the principles for the commissioning of services and the standards for the provision of quality services.

2.2 Mental Health Needs of the Population of the Eastern Region

The World Health Organisation has stated that there are particular needs of people and communities in relation to their mental health. These needs are presented in Figure 2.1:

- Community needs that promote positive mental health among its members and combat against discrimination for those who may have a mental health difficulty. Participation by individuals in their community strongly assists in the promotion of such positive mental health.
- Prevention and Treatment services for those who may be suffering mental ill health or more severe psychiatric disorders.
- Support for families, carers or concerned persons in supporting positive mental health among others in their everyday life and in assisting during the treatment, rehabilitation and return to independence of a family member or friend with a mental health difficulty.
- Services to assist people with a mental health or psychiatric illness in returning to an independent life following an episode of mental ill health or psychiatric illness.

Figure 2.1: Needs of people to deal with mental health issues (WHO, 2001)



2.3 Framework Vision

The Irish Government in its National Health Strategy 2001 "*Quality and fairness, a health system for you* " has laid out a vision for the future delivery of heath care which state that it wishes to develop a heath care system that:

- Supports and empowers you, your family, and your community to reach your full health potential
- Is there when you need it, that is fair, and that you can trust
- Encourages you to have your say, listens to you, and ensures that your views are taken into account

The strategy is built on the key principles of:

- Equity and fairness
- People centred services
- Quality of care
- Clear accountability

The challenge in developing this framework is to take the vision and underling principles, as stated in the Health Strategy (2001) along with the ten recommendations for action from the World Health Organisations Mental Health Report and best practice from around the world to deliver a modern Mental Health Service for the population of the Eastern Region.

Our person centred vision, therefore, for the delivery of modern Mental Health Services in the Eastern Region is that;

- Mental Health services in the Eastern Region will support and empower you, your family, and your community to reach your full mental health potential
- Mental Health services in the Eastern Region will encourage and empower you to have your say, listen to you, and ensure that your views are taken into account
- Mental Health services in the Eastern Region will be accessible, responsive, of high quality and trustworthy
- Mental Health Services in the Eastern Region will be an integrated part of the community and support communities in addressing the mental health needs of members of their community

Health services in the East will be continually tested against the person centred vision outlined above.

2.4 Principles

The framework's vision, key principles and standards are incorporated into the ERHA commissioning principles in line with the action plan from the WHO Mental Health Report 2001 and are as follows:

1. Identify appropriate service response structures at primary care level to treat appropriate mental health needs. (Primary care includes a range of professionals and services including general practitioners, pharmacists, counsellors and allied health and social services professionals.) The Voluntary sector is a key group at this level. [Action 53] *
2. Provide appropriate community psychiatric treatment, home treatments and rehabilitation facilities to address mental illness. These will be delivered, where appropriate, in the person's own home or at community level and supported by acute bed provision and a range of hostel, continuing care and social housing. [Action 30]*

3. Provide on-going education to the public on good mental health practices, the effects of mental illness and the promotion of strategies to de-stigmatise mental illness. This is primarily co-ordinated through the Mental Health Promotion Department in partnership with voluntary organisations and providers.
4. Involve community, family, users of services, their advocates and all sectors of mental health personnel in the development of policies and services throughout the mental health sector. This approach will ensure equal partnership between users, advocates, voluntary organisations, and services [Action 25 and 52].
5. Develop the human resource, intellectual capital and reservoir of knowledge of mental health services staff by the continual emphasis on the training and development of all health professionals and advocates at all levels.
6. Monitoring of the mental health status of the community through regular prevalence surveys and mental health needs assessment in co-operation with the Public Health Department.
7. Develop and continually update links with other key sectors that contribute to the mental health and well being of the community. Such key sectors include education, labour, justice, local authorities, social welfare and voluntary organisations addressing spiritual, cultural and leisure needs. The voluntary sector is a net contributor to the mental health of the community.
8. Capitalise on Information Technology and continually review business processes. [Action 120]*,
9. Advance the case for an ICT Strategy for Mental Health.
10. Implement National Policy / Programmes and Legislation.
11. Monitor and evaluate all services and the outcomes from treatment from mental health services to assist in the targeting of key quality initiative programmes. [Action 68] *

*** Action numbers refers to the National Health Strategy (2001)**

2.5 Framework Standards

The development and delineation of a series of framework standards will assist in the development of the broader mental health services by:

- Promoting an agreed set of standards and goals for the framework period. These standards and goals help to unify the focus of all personnel working in the services.
- Specifying the range and type of services needed to respond to mental ill health will assist in facilitating constant incremental changes over the framework period.
- Delineating a range of standards that provide a basis and goals for the implementation of quality initiatives.
- Describing in explicit terms, the framework standards by which services will be evaluated and monitored.

The Authority will work with all service providers in the Region in the implementation of the following framework standards over the framework period.

Standard Area 1: Promotion of mental health

1.1 Health and Social Care services will promote mental health for all, working with individuals and communities to encourage a sense of personal responsibility for one's mental health.

1.2 Health and Social Care services will combat discrimination against individuals and groups with mental health problems, and promote their social inclusion

1.3 The development of policies in key related sectors (e.g. education, housing, etc) will take account of the likely impact of that policy on the mental health of the population. The population includes people at risk, vulnerable groups and people with mental health problems.

Standard Area 2: Access to mental health services in primary care*

2.1 Any person with a mental health problem who comes into contact with primary care will have their mental health needs identified and assessed. It is acknowledged that persons may present with types of symptoms unrelated to mental health in the first instance.

2.2 Any person with a mental health problem who comes into contact with primary care will be offered effective treatments (in primary care where appropriate), including referral to specialist services for further assessment, treatment and care if they require it.

2.3 Any person with a mental health problem will be able to make contact round the clock with the local service appropriate to meet their needs and receive adequate care.

* primary care encompasses a range of professionals including general practitioners, counsellors, pharmacists, public health nurses, social workers, etc.

Standard area 3: Service user involvement

3.1 Systems will be developed that ensure that all mental healthcare and support is planned and delivered in partnership with service users and advocates.

3.2 All mental health and social care agencies will develop systems to enable services users to be supported to take an active and equal role in decision making at all levels of mental health services. These systems include the development of advocacy services.

3.3 All mental health and social care agencies will develop systems that ensure that the quality of mental health services is measured from a service user perspective

Standard area 4: Supporting carers

4.1 Individuals that provide regular and substantive care to a person who suffers from a severe mental illness will have the family burden or the individual impact on them, recorded in the overall care plan.

4.2 All carers will have access to information about supports available to them, either within the service accessed or through other carer support agencies/advocacy services

Standard area 5: Preventing suicide and parasuicide*

5.1 All local health and social care agencies will endeavour to prevent suicide and parasuicide by ensuring that staff are competent to assess the risk of suicide / parasuicide among individuals at greatest risk.

5.2 All local health and social care agencies will endeavour to prevent suicide and parasuicide by developing local systems for suicide audit (post vention), to learn the lessons and take any necessary remedial action.

5.3 All local health and social care agencies will endeavour to prevent suicide and parasuicide by adopting a planned approach to suicide and parasuicide prevention, intervention and post vention, identifying target populations vulnerable to suicide and develop a standardised risk assessment tool to assess the risk of suicide/ parasuicide among individuals at greatest risk.

* Parasuicide is any non-fatal act which an individual deliberately undertakes knowing that it may cause them physical harm or even death. It includes acts involving varying levels of suicidal intent including definite attempts at suicide and acts where the individual had no intention of dying.

Standard area 6: Effective secondary care services for people with severe mental illness

6.1 All people with a severe mental illness will receive care within a multi-disciplinary environment, which optimises engagement, prevents or anticipates crisis and reduces risk. This is done in the least restrictive environment, that provides for the safe and effective delivery of treatment. Care delivery will be based upon the needs of the service user and take cognisance of any special needs.

6.2 All people in secondary care with a severe mental illness or referred to specialised psychiatric services will have a written* care plan which covers all aspects of need (i.e. medical and psychosocial, rehabilitation and vocational training). This plan will be drawn up in consultation with the service user and is regularly reviewed by their care plan co-ordinator**. This plan will include actions to be taken in a crisis by the service user, their carer, their advocate or their care plan co-ordinator who advises their GP how they will respond if the service users needs additional help.

6.3 All people with a severe mental illness will be able to access a mental health service whenever it is needed.

6.4 Each service user who is assessed as requiring a period of care away from his / her home, will have timely access to an appropriate hospital bed or alternative respite place which is in the least restrictive environment consistent with the need to protect him / her and the public as close to their community as possible.

6.5 Each services user who is assessed as requiring a period of care away from their home will have a written care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care planner co-ordinator and specifies the action to be taken to anticipate a further similar crisis or preferably prevent it occurring. This plan should be drawn up in consultation with the service user, their carer and advocate (if required).

6.6 Each service user will be supported during their recovery and transition to independence and inclusion. Such supports include

- encouragement of individuals to make the transition from mental health care to independent living by the provision of an individualised plan based on an assessment of their needs
- facilitated collaboration with other health / non-health service providers (specifically G.Ps.) to ensure the inclusion of the needs of people with a mental health difficulty.
- timely access to a range of options in both specialised and mainstream educational, training, work and employment programmes.

6.7 All service users will be made aware of advocacy services in their catchment area and have access to an independent advocacy service.

* Cognisance of literacy and illiteracy will have to be taken into account in the provision of written care plans
** Care plan co-ordinator: a nominated person on the multidisciplinary team)

Standard area 7: Services that contribute to the health and well-being of population

7.1 Mental Health Services will be planned and developed based on the needs of the total population in the Eastern Region. Targeting of present users will however, take precedence.

7.2 All mental health services will be aware of their role in contributing to a positive outcome for users of their services.

7.3 The effectiveness of services will be measured by assessing the contribution of a service towards a positive outcome for the user.

3 – Best Practice Service Model

3.1 Introduction

Responding to mental health issues requires the development of a broad and complex range of services for the many and varied service users that require support during periods of ill health. Many health and social services unrelated to mental health have also begun to develop mental health and psychological supports as core elements of their major service provision (e.g. cancer services, childcare services, older persons, cardiac rehabilitation, etc). Similarly, there are strong referral links and interdependent relationships between closely allied services such as the primary care services, addiction services, learning disability services, homeless services and aspects of community health services.

The development of a response to mental health requires the co-ordination of a number of different approaches. These include:

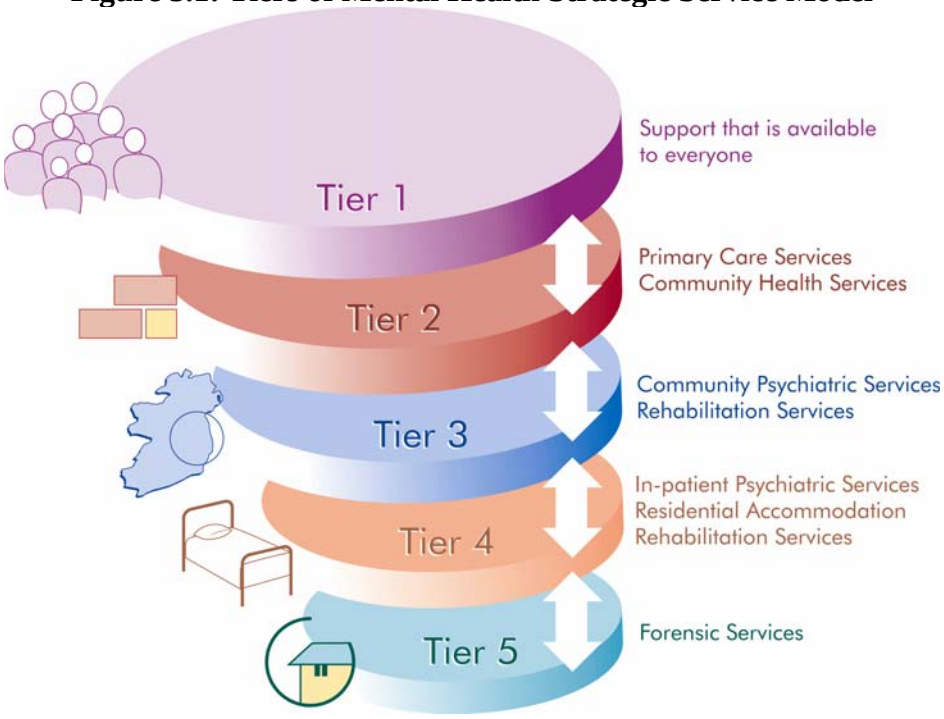
- A biological approach
- A psychosocial approach
- A rehabilitative approach

3.2 Strategic Service Model (Tiered Framework)

A clear vision and understanding of the core function of the different elements of a mental health service is key to the effective deployment of skills and competencies to best serve needs. Such a model serves to focus planning and implementation activities on increasing local strengths and decreasing local service deficiencies to best meet the total spectrum of needs in communities across the Eastern Region. Figure 3.1 presents a tiered model approach to the development of responses to mental health issues that is based on a clear need continuum. Although Figure 3.1 below presents the tiers from 1 to 5, it is important to emphasise that the clear focus of the development of services within the Mental Health Service is on the psychiatric component which deals with severe and / or enduring mental illness (Tiers 3,4 and 5). It is also important to note that the graphics in this figure do **not** represent the magnitude of resources dedicated to or needs of clients presenting to such services. These graphics only protray a diagramic representation of the decreasing numbers of persons who are referred to the outlined services.

A Tiered model approach seeks to develop a range of services and proactive intervention strategies to respond to differing levels of need. However, the separation of tiers is for illustrative purposes only. All tiers act in a con-joint manner in the provision of services (e.g. Tiers 3 and 4), have flexible boundaries when dealing with groups with multiple or special needs and simultaneously act in a step up or step down capacity. The geographical unit for the provision of health services in the future will be the Community Care Area (CCA). It is therefore imperative that the delivery of mental health services is co-teriminus with future CCA boundaries and services are developed that have clear geographical boundaries of responsbility.

Figure 3.1: Tiers of Mental Health Strategic Service Model



- **Tier 1:** (Supports available to everyone) services involve health and non-health agencies that promote positive mental health directly or indirectly (e.g. unemployed persons have higher rates of mental ill health).
- **Tier 2:** (Primary care, Community Health and Voluntary Organisational services) are services provided to people with a mental health difficulty that assist in the detection and treatment of mental health difficulties. These services provide an initial response to emerging mental ill health or assist in the aftercare of persons following an episode with the Mental Health Service.
- **Tier 3:** (Community Psychiatric Services) are specialised mental health services located in the community that aim to respond to severe and enduring mental illness through an array of community based psychiatric services. These services are delivery through a multi-discplinary team approach in consultation with service users.
- **Tier 4:** (In-patient and residential accommodation services including rehabilitation) are treatment options and accommodations to provide services to respond to severe mental illness. These services are primarily provided as a component of Community Psychiatric Services in responding to severe psychiatric disorders.
- **Tier 5:** (Services to meet the most complex and severe needs) are services that respond to severe psychiatric disorders with a forensic component which require a high secure treatment response.

A tiered model approach allows for the following:

- Promotion of a greater understanding of the factors outside of health that impact on the maintenance of positive mental health
- An appropriate response to the need and severity of the condition presenting.
- The core function, responsibility and resource need of different tiers can be clearly specified and understood by services and professionals across each tier.
- Different tiers can develop in an integrated fashion and develop different types of working relationships (e.g. Tier 3 and 4 working as a specialist psychiatric service and Tier 2 and 3

working as partners in the provision of health services in a community (as defined by their core roles)).

- The provision of treatment and care specific to the diagnosis and needs of each individual including interventions relating to long-term disability. This includes the development of multi-disciplinary teams in each CCA as a core componement of mental health services.

3.2.1 Description of Service under Tiered Framework

The following sections will describe the strategic function of services within each tier. To ensure precision of service delivery, each service element will be described as follows:

- **Introduction:** a brief outline of the context of the need for the service
- **Standard Area:** The standard of service provision that is to be achieved with the implementation of the service element. These standards have been outlined in Section 2.5.and are under 7 headings:
  - Standard area 1: Promotion of mental health
  - Standard area 2: Access to mental health services in primary care
  - Standard area 3: Services user involvement
  - Standard area 4: Supporting carers
  - Standard area 5: Preventing suicide and parasuicide.
  - Standard area 6: Effective secondary care services for people with severe mental illness
  - Standard area 7: Services that contribute to the health and well-being of population
- **Function:** the defined strategic intention of the service and principles of care / service delivery
- **Target User:** the key user groups for whom the service is intended.

3.2.2 Tier 1: Supports available everywhere and to everyone

This tier describes the support that every one needs to maintain their mental health. It includes the support every one receives from families, friends and acquaintances, as well as the more global concepts of the effects of environment, employment, and housing on mental health. This tier also deals with social inclusion and the effects of discrimination and how mental health is portrayed in the media, at school, college, and the workplace. In short, this tier describes the support all reach for when they begin to feel distress.

Initiatives and services within this tier will address the following standards:

Standard Area 1: Promotion of mental health

- Promotion of mental health
- Combat discrimination, sense of stigma and marginalisation
- Impact on mental health of policies in key related sectors

Standard Area 5: Prevention of suicide and parasuicide

Mental health promotion activities will be developed within the present health promotion model. This will primarily be facilitated through the AHB and DoHC health promotion services and structures.

Discussions in mental health tend to focus on mental ill health encompassing depression, suicide, anxiety and stress. This framework will concentrate on developing mental health promotion activities aimed at systematically raising awarenss of the importance of good mental health and reducing barriers to achievment of this status.

It is important to highlight from research evidence (Heer and Woodhead, 2002) that certain groups of soceity are likely to experience a greater impact of mental ill health upon their lives and people with a

mental illness experience high levels of poverty yet mentally healthy people are more likely to remain in employment for life. Thus, poverty is both a cause and consequence of mental ill health. Thus, in promoting mental health, the following groups may need to be specially considered; women and men, persons from certain ethnic groups, younger and older persons, gay / bisexual / transgender men and women, people with disabilities, those who are unemployed, homeless persons, those with substance miuse problems and carers / concerned persons.

The framework will encourgage the development of mental health promotion activities based on two broad strategies*:

- Raising awareness of conditions that improve the (mental) health and well being (e.g. meaningful employment, conditions of local environment, tackling social exclusion, low levels of crime, etc)
- Specific targeted health promotion and health protection activites (e.g. suicde prevention measures, lifeskills and coping strategies, parenting

* Implementation of these strategies will be based on a partnership approach by assisting local communities to develop responses within their own communities to these issues.

3.2.3 Tier 2: Primary Care Services

It is generally recognised that 20% of the population at any one time are affected by some sort of mental distress and that approximately 40% of the average GP's time is spent dealing with metal health issues and 90% of these cases are cared for solely within primary care. Following the publication of the National Primary Care Strategy, new opportunities now exist to examine how primary care services can support and play an important role in the response and treatment of mental health. This National Strategy will play an important role in facilitating multi-disciplinary and inter-agency responses to mental health.

Initiatives and services within this tier will address the following standards:

- Standard Area 2: Access to mental health services in primary care
  - Mental health assessment and treatment services in primary care facilities
  - Referral to specialist psychiatric services

The following are the main target service users of Tier 2 Services

- Persons suffering from mental distress (without presence of psychiatric disorder; primarily mild or moderate anxiety or depressive disorders or emotional difficulties)
- Persons with a psychiatric disorder staying with their G.P. for treatment
- Persons recovering from a psychiatric episode and returned to their G.P. from the Psychiatric Services (at Tier 3, 4 or 5)
- Persons requiring information about mental health / mental illness

The following professionals and competencies will be considered in the development of Tier 2 Services:

- General Practitioners
  - Competent in mental health assessment and treatment techniques
  - Knowledgeable of local voluntary and peer support services
  - Knowledgeable of available local counselling services
  - Knowledgeable of local psychiatric services and referral protocols
- Pharmacists

  - Providing information on the range and effects of mental health medication
  - Complementing the provision of treatment services with General Practitioners
- Community Health Services
  - Competent in detection of possible mental health difficulties
  - Knowledgeable in referral techniques to General Practitioners
  - Knowledgeable of local voluntary and peer support services
- Voluntary Services (Mental Health)
  - Complementing the provisoin of primary care mental health services
  - Providing information and peer support
- Private mental health professionals (e.g. counsellors, psychotherapists, etc)
  - Certified to provide a quality counselling and mental health support services
- Education and training professionals
  - Competent in training and facilitation techniques to support GPs, pharmacists, PHNs and CWOs in mental health work

Figure 3.2 below describes a model for the development of mental health treatments in primary care. This model states that a training and educational professional within the primary care sector is required to assist primary care professionals in developing their knowledge and skills in relation to mental health. Similarly, the current post-graduate and continuing education initiatives of professionals bodies would also need to include a strong component of mental health treatment education. The primary function of such a service would be:

- To provide GP, pharmacists and other primary care professionals with appropriate information on possible responses to presenting mental health issues.
- To ensure knowledge of the availability of voluntary mental health services and psychiatric services in local areas among primary care and community health services.
- To develop links between local mental health services (voluntary and statutory) and facilitate the development of referral protocols and care sharing arrangements at the primary care level.

Figure 3.2: Tier 2: Strategic Service Model: Primary Care Element

3.2.4 Tier 3: Community Psychiatric Services

The provision of Mental Health Services within the community is an important component of locally accessible services. Similarly to primary care, which is considered the gatekeeper of the health services, the Community Psychiatric Services (Tier 3; Figure 3.3) should act as a gatekeeper for the specialist and resource intensive care provision services at Tier 3 and 4 (e.g. acute intensive care, continuing care beds, hostel and sheltered housing provision).

The service elements of Tier 3 Community Psychiatric Services are:

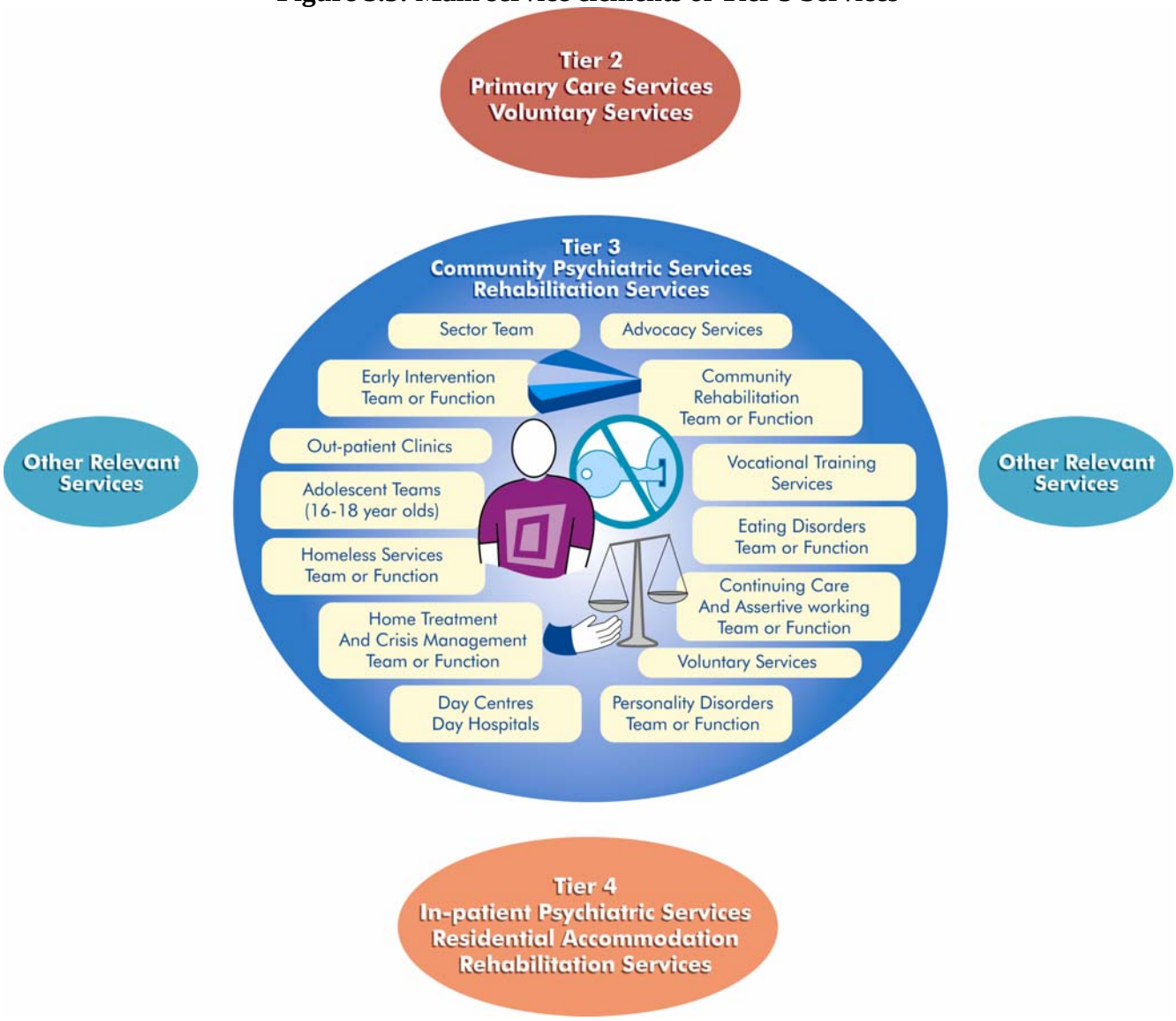
- Multi-disciplinary sector teams that provide an integrated, comprehensive, individualised system of care and support responsive to the needs of the individual
- Peer advocacy services that assist in empowering service users during their contact with the Mental Health Service
- Voluntary services that provide a range of complementary and collaborative services
- Home Treatment and Crisis Response Team that ensures that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment
- A Continuing Care and Assertive Working Team that aims to contact people with severe mental health problems with complex needs who have difficulty engaging with services and often require repeat admission to hospital.
- An Early Intervention Service that aims to ameliorate the course of the disease, prevent initial problems and improve long-term outcomes.
- A range of specific treatment facilities such as day hospitals, day centres and outpatient clinics.
- Services catering for groups with special needs such as adolescents, homeless persons with a psychiatric disorder, eating disorders, personality disorders and those with dual diagnosis.
- Rehabilitation services to assist with recovery and transition to independent living

The relationship between Primary Care and the comprehensive range of Community Psychiatric Services needs to be clearly mapped for each sector and catchment area service. This is the level where assessments, information exchange, advice and support is given to maintain a seamless support for the user, while maintaining the integrity of the sector team (Community Psychiatric Team) to focus its attention on responding to people with serious mental illness.

Initiatives and services within Tier 3 will address the following standards:

- Standard Area 3: Service User involvement
- Standard Area 4: Supporting carers
- Standard Area 6: Effective secondary care services for people with severe mental illness
  - Anticipation of crises and reduction of risk
  - Care based on written plans covering all needs
  - Access to service, as needed
  - Supported during recovery and transition to independence
  - Access to independent peer advocacy services
- Standard Area 7: Services that contribute to health and social well-being of population
  - Service delivered based on assessed need
  - Contribution to a positive outcome

Figure 3.3: Main service elements of Tier 3 Services



The following services will be considered in the development of Tier 3 Services:

A. Sector Teams

Multi-disciplinary sector teams are the core of community based psychiatric services. The teams provide integrated, comprehensive, individualised systems of care and support responsive to the needs of the individual within their community. The teams have three distinct functions:

- To provide advice and consultation on the management of mental health problems to other professionals, in particular, advice to primary care and a triage / screening function enabling appropriate referral.
- Provide treatment and care for those with acute disorders who can benefit from specialist interventions prior to referral to their G.P. and discharge.
- Providing treatment and care for those with more complex and enduring needs.
- Facilitate the management of the sector service and report to the Catchment Area Management Team

The teams are multi-disciplinary in nature being broadly made up of medical staff, psychiatric nurses, social workers, occupational therapists, clinical psychologists, and administration working some extended hours with flexible out of hours working around specific tasks (e.g. evening support groups). These teams are organised on a sectorised basis, within a unit of management and geographic population. Broadly, these areas are co-terminus with the Community Care Areas with some variations in specific areas. These teams link closely with Advocacy Services which will play a key role in empowering clients in their dealings with the Sector Team.

B. Advocacy Services to clients

Advocacy services and in particular, peer advocacy services continue to grow within the Eastern Region. Although the key roles and functions of advocacy services are still at an early definitional stage, the potential inclusion of service users and advocates into all aspects of decision making represents an exciting development for the future. It is important to distinguish here between the role of advocacy services at the individual client and other levels. Although advocates undertake important public education and lobbying functions, this section of the framework only covers functions with individual service users which will potentially include:

- Promoting self-advocacy amongst service users
- Assist and support service users, where requested, during and after their contact with mental health services by providing information and support. This service will include assisting service users to understand their rights as citizens and as defined in mental health legislation and educating service users about the operation of mental health services (e.g. complaints mechanisms). Such services could also be targeted at particular vulnerable service user groups.
- Assisting service users in finding health and community resources that they may require
- Supporting clients during a Review Tribunal convened by the Mental Health Commission

Target Users of Advocacy Services:

- All service users presently or previously in contact with mental health services

C. Out-patient Clinics

Out-patient clinics provide a vital service delivery link for mental health services and provide an important link with primary care services. The core functions of out-patient clinics are:

- To provide an assessment, diagnosis and treatment resource for persons with severe or enduring mental illness
- To link with primary care and voluntary services on the treatment of service users

Target Users of Day Hospitals and Day Centres

- Commonly adults (16 to 65 years old) with a mental illness.

D. Day Hospitals and Day Centres

Following publication of the Health Research Board report "Psychiatric Day Care – An underused option" (Hickey et al., 2003), the role of day care options will be an important service element within the delivery of community care services. Day hospital will aim to:

- Treat acutely and severely ill service users using intensive treatments equivalent to that of hospital in-patient setting
- Provide brief partial hospitalisation for the chronically ill during a period of relapse
- Provide a range of short-term time-limited treatments and therapeutic activities
- Provide non-medical treatments such psychotherapy and psychological services
- Link with primary care and voluntary services, where appropriate, relating to the care of the service user

Day Centres will aim to:

- Provide social care for service users
- Provide rehabilitation and activation services

Target Users of Day Hospitals and Day Centres

- Commonly adults (16 to 65 years old) with severe mental illness (e.g. schizophrenia, manic depressive disorders, severe depressive disorder).

E. Early Intervention

Intervening early in the course of the illness can prevent initial problems and improve long-term outcomes. If treatment is given early in the course of the illness and services are in place to ensure long-term concordance (co-operation with treatment), the prospect for recovery is improved. An early intervention service should be able to:

- reduce the length of time young people remain undiagnosed and untreated
- develop meaningful engagement, provide evidence-based interventions and promote recovery during the early phase of illness
- increase stability in the lives of service users, facilitate development and provide opportunities for personal development
- reduce the stigma associated with mental illness and improve professional and lay awareness of the symptoms of psychosis and the need for early assessment.
- provide a user centred service (i.e. a seamless service available for those from age 14 to 35 that effectively integrates child, adolescent and adult mental health services. It should work in partnership with primary care, education, social services, youth and other services at the end of the treatment period, to ensure that the care is transferred thoughtfully and effectively).

The following principles of care should be incorporated into service development and provision:

- Culture, age and gender sensitive
- Family orientated support
- Meaningful and sustained engagement based on assertive outreach principles
- Treatment provided in the least restrictive and stigmatising setting
- Separate, age appropriate facilities for young people
- Emphasis on normal social roles and service user's development needs, particularly involvement in education and achieving employment
- Emphasis on managing symptoms rather than the diagnosis.

Target Users of Early Intervention Team:

- People aged between 14 and 35 with a first presentation of psychotic symptoms
- People aged 14 to 35 during the first three years of psychotic illness

F. Home Treatment and Crisis Management

People experiencing severe mental health difficulties should be treated in the least restrictive / most appropriate environment with the minimum of disruption to their lives. The Acute Bed Study "*We have no beds*…" identified 40% of acute admissions occurred between 6 p.m. and midnight, with a further 7% between midnight and 8 a.m. Almost half of these patients did not receive a full psychiatric assessment prior to admission. The report identified the need for community-based assessments to be available on a 24 hour, 7 day a week basis. One third of referrals for admission came from sources other than the G.P. or psychiatric service (i.e. self / relative or Gardaí). It should be noted that not all service users benefit from home treatment approaches and it will not be a universal treatment panacea.

Home Treatment as an option can be provided in a range of settings and offers an alternative to inpatient care. The majority of service users and carers prefer community-based management and treatment and research (e.g. Homecare teams Clondalkin & Swords, Dublin) has shown that clinical and social outcomes achieved by community-based management are at least as good as those achieved in hospital. The functions of a Home Treatment and Crisis Management Service are:

- Act as a 'gatekeeper' to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service
- For individuals with acute, severe mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary, community based treatment 7 days a week
- Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment
- Remain involved with the user until the acute episode has resolved and the service user is linked into appropriate on-going care, within the community psychiatric spectrum of services, (e.g. day hospital, day centre, outpatient departments, etc)
- If hospitalisation is necessary, be actively involved in discharge planning and provide such intensive care at home to enable early discharge
- Reduce service users' vulnerability to crisis and maximise their resilience

Target Users of Home Treatment and Crisis Management Service

- Commonly adults (16 to 65 years old) with severe mental illness (e.g. schizophrenia, manic depressive disorders, severe depressive disorder) with an acute psychiatric crisis of such severity that, without the involvement of Home Treatment and Crisis Management hospitalisation would be necessary.

G. Continuing Care and Assertive working

Within any population, there are a small number of people with severe mental health problems with complex needs who have difficulty engaging with services and often require repeat admissions to hospital. Working assertively can improve engagement with services, reduce hospital admissions and length of stay when hospitalised, increase stability in the lives of service users and their carers / family and improve social functioning while promoting cost effectiveness. The Continuing Care and Assertive Working function should be able to:

- Develop meaningful engagement with service users, provide evidence-based interventions and promote recovery
- Increase stability within the service users' lives, facilitate personal growth and provide opportunities for personal fulfillment
- Provide a service that is sensitive and responsive to service users' cultural, religious and gender needs
- Support the service user and his / her family / carers for sustained periods and provide links to appropriate service user support groups. Family education programmes are essential to increase the understanding of the illness and, consequently, reduce tensions and anxieties around the burden of care for families
- Promote effective interagency working
- Ensure effective risk assessment and management

Target Users of Continuing Care and Assertive Working function are adults aged between 16 and approximately 65 with the following:

- A severe and persistent mental disorder associated with a high level of disability
- A history of high use of in-patient or intensive home based care (for example, more than two admissions or more than 6 months of in-patient care in the past two years)
- Difficulty in maintaining lasting and consenting contact with services
- Multiple, complex needs including a number of the following:
  - History of violence or persistent offending
  - Significant risk of persistent self-harm or neglect
  - Poor response to previous treatment
  - Dual diagnosis of substance misuse and serious mental illness
  - Detained under Mental Health Act on at least one occasion in the past 2 years
  - Unstable accommodation or homelessness due to mental illness

H. Community Rehabilitation Services

The aim of rehabilitation teams is to focus on housing, income, occupational and social needs of persons with a mental illness. Community Rehabilitation Services will integrate fully the provision of services with Rehabilitation Services at Tier 4 (see Section 3.2.5). Rehabilitation will be developed upon the following principles of care:

- Rehabilitation is a structured, developmental process whereby individuals are facilitated to practically realise their potential for independent, community living.
- Rehabilitation involves engaging and working collaboratively with individuals to progress along a continuum from dependence to independence.
- Rehabilitation aims to empower people with the knowledge, practical skills and confidence to access the social, cultural and economic benefits of life in line with their aspirations.

- Rehabilitation is an entitlement of all those who come in contact with the Mental Health Services and provision is tailored to meet the complex range of service user needs.

The functions of Community Rehabilitation Services are:

- Assisting service users in sourcing suitable accommodation (where required)
- Providing meaningful daily activities and increasing social skills (where necessary)
- Providing and sourcing work and educational opportunities
- Assisting service users with any issues relating to their social networks of families and friends
- Providing recreational opportunities
- Assisting service users to access health services

Target service users of Community Rehabilitation Services:

- Adults aged 16 to 65 years referred from the Mental Health Services

I. Vocational Training Services

Vocational training services aim to increase the quality of life of those with mental health difficulties. This is achieved through the provision of services targeted at employment training, job placement and accessing vocational qualifications. The function of vocational training services are:

- To assist service users return to full or part time work or college
- To provide training programmes
- To provide transitional or supported employment programmes

Target service users of Community Rehabilitation Services:

- Adults aged 16 to 65 years referred from the Mental Health Services

J. Services to homeless persons with a psychiatric disorder

The Government Strategy on Adult Homelessness: *Homelessness – an Integrated Strategy (May 2000*) focuses on addressing the needs of people who are homeless and in assisting them to move to accommodation that is more suitable to their needs.

A key element of this integrated strategic approach is to focus on prevention of homelessness. To that end, the implementation of the *Homeless Preventative Strategy* (February 2002) makes recommendations in relation to "patients leaving hospital and mental health care" (Page 17) and the work required by all psychiatric services in preventing patients becoming homeless.

- A person can drift into homelessness because of a particular life event and, consequently may experience mental health problems which should, in the first instance, be assessed by the Primary Care Team. When a person is referred to the psychiatric team and has been diagnosed with a mental illness s/he should have equity of access to mainstream acute care, rehabilitation and community supports in the same way as the general population.

- To support this group immediate treatment at point of contact should be provided and, where necessary, the patient will be referred to the appropriate mainstream service.

- Some homeless patients may require access to specialist services and, where indicated, they should be supported by joint care plans with the designated mainstream services.

- Protocols for the Homeless Psychiatrically Ill will need to be agreed by the three Area Health Boards. The homeless group within the psychiatric service should be subject to specific performance indicators by each board.

- A preventative approach including working protocols with local authorities and other relevant statutory and voluntary services should be developed as a matter of priority. .

- Because of the immediate psychological and social deficits surrounding the presentation of homeless persons and their difficult social circumstances it is envisaged that additional resources will be required to ensure that health and social gain is achieved as early as possible.

K. Services to persons with an eating disorders

Eating Disorders (Anorexia Nervosa, Bulimia Nervosa and binge eating) area serious and common condition with among the highest standardized mortality ratios of any psychiatric disorder. Services to respond to eating disorders should be planned together with services for patients with psychiatric disorder to offer both a primary and secondary care response.

In their less severe forms, these disorders produce stress with physical, psychological and social morbidity and secondary psychiatric disorder, mainly depression. In the most severe forms, they lead to chronicity, disablement and, at times, death and, consequently, some conditions can be dealt with partly or fully by generic services, with support from specialist services.

It has been demonstrated that specific treatments, delivered by experts, can greatly improve prognosis in severe cases, while there is a clear role for primary and secondary care in the early detection of cases.

L. Services to adolescents aged 16-18 years

It is recommended that mental health services be developed to meet the specific needs of 16-18 year olds.

In the further development of the Child & Adolescent Psychiatric Service, commencing in 2004, priority should be given to the recruitment in each health board area of a Consultant Child & Adolescent Psychiatrist with a special interest in the psychiatric disorders of later adolescence. This consultant should have the support of a full Multi-Disciplinary Team.

Arrangements should be made with the relevant Adult Psychiatric Services for the admission to acute psychiatric units of persons aged 16-18, under the care of the Consultant Child & Adolescent Psychiatrist with a special interest in the psychiatric disorders of later adolescence, where such a Consultant is available.

The Consultant Child Psychiatrist and team with a special interest in the psychiatric illnesses of later adolescence would work closely with the Child Care Services and would provide a consultative psychiatric service to the local High Support / Special Care Unit.

The current arrangements, whereby the adult services provide a service to their catchment area, including the 16-18 age cohort, should continue on an interim basis.

Following the establishment of the special interest posts, consideration must be given to the development of specialist in-patient adolescent units.

A comprehensive database is required and should be established as soon as possible in order that the number of 16 and 17 year olds referred to and attending outpatient clinics and other psychiatric services be collected. This information is required in order to establish how many people with a severe mental illness are current users of the psychiatric services. It will also highlight any particular service deficiencies by area and facilitate the development of services for this age group in the future.

It is recommended that all mental health services, child, adolescent and adult, should be managed under the one management structure within the health boards.

It is proposed that the recommendations of the Department of Health and Children Second Report of the Working Group on Child & Adolescent Psychiatric Services be reviewed mid 2008.

M. Services to persons with personality disorder

The International Classification of Diseases (ICD-10) outlines the diagnostic criteria foe personality disorder. Several characteristics of emotional instability exist and, depending on the diagnosis, the person's own self-image, aims and internal preferences are often unclear or disturbed. There can be chronic feelings of emptiness.

The above description may be ascribed to a person with what is termed borderline type personality disorder which is said to respond well to an approach piloted in the Eastern Region, Dialectical Behaviour Therapy (DBT). The therapy was developed in a context of treating specific problems and problem behaviours within an overall diagnostic group with the aim of reducing parasuicidal acts, the number of inpatient days over the years of treatment and, more importantly, allow for appropriate, focused and effective treatment response to improve the person's quality of life.

It is estimated that approximately 1% of the general population has borderline personality disorder, but that up to 15% of psychiatric outpatients have the condition.

This model should be explored further at implementation phase.

N. User Led Services

Clubhouse Model

- **Definition:** Clubhouse is an innovative, member-led community based model for people with mental health difficulties. The clubhouse offers life-long membership and support to members in leading a socially and economically productive life in the community. (Note: Mental Health Commission Annual Report p.20 endorsement of this service model).

Outcomes to date

- This service model has demonstrated its capacity to support its members in all aspects of their communities addressing personal, social and work skills.
- It **has achieved accreditation** to international standards.
- It **has** demonstrated its capacity to cater **flexibly** and **responsively** to the needs of people with mental health difficulties who otherwise do not choose to engage in existing service models.
- The attendance patterns and life long membership commitment **has increased the capacity** of this service to respond to greater numbers of people which is not possible with the alternative Rehabilitation Training model.
- Significantly, clubhouse addresses the issue of job retention as it provides ongoing support on a needs basis to the member in employment.
- The outreach service also supports members to live productively in their community and maintain the skills which are learned in the dynamic training process which occurs in clubhouse.
- Clubhouse actively empowers members to take responsibility for their own rehabilitation and this maximises opportunities for success.

O. Voluntary services

Voluntary services for mental health, disability and general health and social care provide an important complementary and supplementary provision of services in the overall care of persons with mental health difficulties. Many voluntary mental health service providers are members of a number of umbrella groups (e.g. Mental Health Alliance, Disability Federation of Ireland) that provide an effective combined voice for voluntary services in the East.

In consultation with voluntary service providers in the East, the mental health framework will aim to ensure that:

- Statutory and voluntary agencies provide a seamless provision of care to service users
- Statutory and voluntary agencies provide services that complement the recovery of persons with mental illness
- Statutory and voluntary agencies provide high quality information on the availability of services and the treatment of mental illness in Ireland
- Voluntary agencies are integral to the planning and development of mental health services in the East

During the framework period, it is intended to align the provision of both statutory and voluntary mental health services in each area to ensure that the strengths of the different services are capitalised upon. This process will ensure that a comprehensive mix of services is available which aims to maximise choice for service users.

P. Liaison Psychiatry

Liaison Psychiatry refers to the provision of mental health services in a General Hospital setting, including Emergency Departments. Psychiatric disorders are significantly more prevalent in General Hospital inpatients and outpatients then in the general population.

Anxiety and depressive disorders occur in 12% - 16% of general medical patients. Medically unexplained symptoms occur in 25% to 50% of new medical outpatients. Approximately 20% of general hospital inpatients meet diagnostic criteria for either alcohol misuse or dependency.

In the Emergency Department, approximately 5% of attenders preset with mental health problems. The Emergency Department is also the location where most people present following deliberate self-harm. It is estimated that up to 20% of all admissions to Psychiatric Units are via Emergency Departments.

Patients attending Emergency Departments are not aware of geographical boundaries, which determine service provision. Particular difficulties are experienced with the large number of homeless people living in inner city areas. Also non district patients present particular difficulties because of problems with transfers and escorts.

Every General Hospital should have a dedicated, multidisciplinary liaison psychiatry service, including Consultant Psychiatrist, Junior Hospital Doctors, Liaison Nurses, Clinical Psychologist, Social Worker and Secretarial support.

3.2.5 Tier 4: Specialised support provided to meet complex and severe mental health needs

This tier describes psychiatric services that usually have a residential component and provide specialised care and support for people whose needs for a short period of time cannot be met in the community. The aim within the model is to develop a number of different residential care options for people. To ensure a capacity of residential units that meet clients with differing needs, it is necessary to provide a range of the following services:

- Acute in-patient beds
- Crisis houses and other user led residential services
- Low secure units
- Rehabilitation facilities
- A spectrum of supported living options (provided by both statutory and voluntary service providers)
- Psychiatric Intensive Care Units (PICU) / Special Care Units

A. Acute inpatient unit

These units already exist within the current system but as the 1999 Acute Bed study revealed, these are not operating at the required 85% occupancy level to cater for emergency presentations. The framework will to address this situation with the increased provision of step down and step up environments. The function of the in-patient unit is:

- to provide a high standard of treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness. It should be for the benefit of those service users whose circumstances or acute care needs are such that they cannot, at that time, be treated and supported appropriately at home or in an alternative, less restrictive residential setting.

The following principles of care should be incorporated into service provision:

- appropriate day programmes providing meaningful activities within the ward environment
- age and ability appropriate activities provided within the ward during the evenings and weekends
- built environment appropriate to needs of service users
- provide for points of welcome to the ward
- controlled in and out movements without the need for locked doors.

Target Users of In-patient unit:

- People aged between 16 and 65 years in the most acute and vulnerable stages of their illness and who cannot have their care needs met in the community.
- People needing detention under the Mental Health Act (2001)

B. Spectrum of supported living options

Currently all health boards provide a number of high, medium and low support community accommodation and some group homes. The primary function of the supported living options is:

- To provide medium to long term supported living options for people with long-term mental health needs that enable service users to live life as independently as possible.

Target User for supported living options:

- People between 16 and 65 years with long term mental health needs that require supported accommodation

To assist in the provision of such living options, the framework will seek to ensure that each Area Health Board will develop a strategic partnership with its local authority and voluntary housing services. These partnerships will aim to develop a long term plan for the provision of supported care environments for people with mental health needs based on the demographics of each locality.

C. Psychiatric Intensive Care Units (PICUs)

PICUs deliver long term intensive, comprehensive, multidisciplinary treatment and care by qualified staff for service users who demonstrate disturbed behaviour in the context of serious mental disorder. Such service users typically require a provision of security, usually under the Mental Health Act or other such legal restrictions. PICUs are underpinned by the principles of rehabilitation and risk management. Such units aim to provide a homely secure environment, which has occupational and recreational opportunities and links with community facilities. The primary functions of PICUs are:

- To provide a secure environment providing medium to long term care for service users who demonstrate disturbed behaviour in the context of serious mental disorder
- To act as gatekeeper to and step-down from the forensic services (see Section3.2.6)

Target Users of PICUs:

- People between 16 an 65 years who demonstrate disturbed behaviour in the context of serious mental disorder and who require a provision of security that could not be provided by another care provider
- People between the 16 and 65 years who no longer need the total security of the Forensic Service but who demonstrate disturbed behaviour in the context of serious mental disorder and who require a provision of security that could not be provided by another care provider

D. Rehabilitation

Rehabilitation services have previously been discussed in Section 3.2.4. Rehabilitation services at Tier 4 will be required to integrate closely service provision with services at Tier 3.

Specialist rehabilitation services are aimed primarily at individuals with severe and enduring mental illness and a high level of disability. Rehabilitation settings include:

- The Home Environment
- Day Centres, Day Hospitals and Resource Centres
- Training & Education Services
- Sheltered Occupational Services
- Employment Opportunities

Collectively, these services provide a holistic range of goal directed, client-focused interventions which include life, social and work skills training, positive mental health management, personal development and occupational therapy. Recognition is given to individuals who need on-going support and interventions to maintain their mental health and community integration.

Individuals who are identified as having the potential to progress from the Mental Health Services are offered intensive, short-term rehabilitation as an integral part of their care planning. An individual, person-centred assessment leading to an individualised rehabilitation plan will assist the individual explore and identify their choices and preferences. Interventions are focused on facilitating access to community based and mainstream opportunities including housing, education, training and employment support services.

All mental health teams and services are encouraged to integrate a rehabilitative approach to care planning and interventions with the aim of optimising recovery and social inclusion for all service users.

E. Psychiatric Intensive Care Units (PICUs) / Special Care Units

Psychiatric Intensive Care Units (PICUs) are secure environments for patients who are in an acute disturbed phase of serious mental disorder. There is associated loss of capacity for self-control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a general open ward. The function of Psychiatric Intensive Care is:

- To provide a high standard of assessment, treatment and care in a safe and therapeutic setting for patients whose loss of capacity for self-control, with a corresponding increase in risk, does not enable their safe, therapeutic management and treatment in a general open ward.

Target User of Intensive Care:

- People aged between 16 and 65 years in the most acute and vulnerable stages of their illness and who cannot have their care needs met in an open ward

3.2.6 Tier 5: Forensic Services

The Central Mental Hospital provides a national high and medium secure psychiatric service and an outreach psychiatric service for the Irish Prisons Service. This is in keeping with the size and morbidity levels of the Irish population. At present the Central Mental Hospital also provides acute and long-term low security beds.

Initiatives and services within Tier 5 will address the following standards:

- Standard Area 6: Effective tertiary care services for people with a severe mental illness
- Standard Area 7: Services that contribute to health and social well-being of population

The development of Forensic Services will be based on the following principles of service delivery:

- Prisoners are entitled to the same standards of health care as would be available to the rest of the community.
- Access to Forensic Services within the Psychiatric Services is equitable.
- Healthcare and Psychiatric Services in prison should be integrated into and compatible with national health policy
- Compulsory treatment is justified only when it is sufficiently resourced to be capable of leading to a restoration for mental capacity and autonomy and where it provides a level of care essential to the care and preservation of human dignity.
- Mentally disordered offenders should be cared for under conditions of no greater security than is justified by the degree of danger they present to themselves or to others.

Developing an agreed model of services will be an important component of the framework implementation process. The nature of the reforming agenda for the National Forensic service is outlined in draft format in Appendix D.

This reforming agenda would have to acknowledge that, to be effective, the capacity constraints within the Community Psychiatric Services will have to be addressed.

The reforms will take place in consultation with the Management Teams of the existing services.

The Forensic model of service delivery will require close collaboration between the Forensic and the local Community Teams to ensure optimum care for users of services.

4 – Supporting the delivery of Services

4.1 Introduction

To support the delivery of care and Mental Health Services, a number of essential elements are required to work efficiently and effectively in concert. Each of these systems must play a role in supporting the delivery of care. These systems and processes include:

- A public health approach providing local and regional needs assessment information on issues relating to mental health. In parallel, a communications strategy that enhances the visibility of mental health, promotes the importance of acknowledging and addressing mental ill health and promotes the work and successes in the provision of Mental Health Services is required.
- A financial framework and a budgetary management system that allows front line managers the authority and responsibility to manage their resources effectively.
- Advocacy services that continually promote quality mental health service delivery, highlight inadequacies in service delivery and work in partnership with all service providers to effect and monitor change.
- Planning systems grounded in effectiveness evidence and best practise promotion. Such systems identify and describe service needs and draw together essential elements to plot future service developments and re-engineer services to meet new and emerging needs.
- A human resource support system that addresses priority recruitment, retention and training issues promptly and effectively.
- A continuous quality improvement programme that includes the built environment, that makes explicit standards of care in the delivery of service and continuously monitors actual care and delivery against the specified standards. This improvement process will contain internal (regional) and external (Inspector of Mental Health Services) agents of change.
- An information strategy that supports the delivery of pertinent management information and accountability requirements in relation to service activity levels, client outcomes and service user views of the quality of care. This will be backed by an information and communications technology infra-structure that supports closer and efficient working between multi-disciplinary professionals in geographically diverse areas, supports monitoring and evaluation and allows innovative approaches to service delivery to evolve.

4.2 Current Strengths in the Provision of Mental Health Services

In implementing the mental health framework, a key cornerstone of development will be building upon the existing strengths and initiatives currently underway. These strengths are:

- Highly motivated and skilled staff across all disciplines within the Mental Health Service who are highly committed to providing an excellent service and embracing change. This includes the development of specialisation with services and professionals (e.g. Advanced Nurse Practitioner).
- The development of mental health specific advocacy initiatives (encompassing service users) is and will lead to a strong pool of service user advocates to assist with the policy making, planning and delivery of services.
- Mental Health Services based on a multi-disciplinary team and working approach. This approach facilitates a more holistic response to service users.

- A good base currently exists in each catchment area for the future development of Community Psychiatric Services.
- A Clinical Director and management structure that integrates medical, nursing, administration and allied health professionals as a management unit
- A growing awareness of the importance of mental health as a factor in overall health and quality of life.
- A number of key opportunities and initiatives within the health system that will be beneficial to mental health.
- The implementation of the Primary Care Strategy and the National Health Information Strategy will present further opportunities for the Mental Health Services and the development of mental health responses
- A strong and rich pool of expertise exists in the Eastern Region to assist in the development of the mental health services. The East benefits as the primary headquarters of many mental health organisations are within Dublin city or the greater Dublin area.
- Liaison Psychiatry as a speciality continues to grow and provides an effective support for mental health in acute general hospital services.
- Continuing education programmes have a positive impact on staff retention.
- Strong integration between academic teaching institutes and staff within the Mental Health Services. This includes active research programmes centred on services users and service development initiatives.
- There are strong links between Mental Health Service staff and academic centres. Such links foster educational links and the prompt introduction of new technologies and techniques into services and assist in the pursuit of a strong research agenda within services.

4.3 Systems and processes to support the delivery of services

4.3.1 Needs assessment approach

The most crucial planning information required is that which specifies the mental health needs of the Eastern Region (Figure 2.1). A needs assessment approach will be developed in consultation with users of services, voluntary organisation representatives, service providers and public health during the framework period.

A needs assessment approach will aim to:

- Assess the incidence and prevalence of the major psychiatric disorders in each AHB for children / adolescents, adults and older persons.
- Assess the level of psychological disorders in each AHB for children / adolescents, adults and older persons.
- Assess the needs of the population of the Eastern Region using a standardised mental health need assessment instrument.
- Assess the community's knowledge of good mental health practices and personal care and to assess the sources of common day stresses.
- Assess the community's knowledge of local mental health services and how they operate.

Associated with the development of a needs assessment approach will be the development of a Health Impact Assessment approach, to ensure the implications of health policies and policies from other key sectors are understood in terms of mental health.

Based on the assessment of need and profiling of services available, it should be possible to describe the total service response in terms of:

Unmet need	→	**where no service* exists in an area to respond to an identified need**
Undermet need	→	**where an insufficient supply of service* exists in an area to respond to an identified need**
Met need	→	**where a sufficient service* exists in an area to respond to an identified need**
Overmet need	→	**where an over provision of service* exists in an area to respond to an identified need**

*** such services are not necessarily confined to mental health services and can include other health and non-health services**

4.3.2 Advocacy

There are a number of important advocacy systems associated with mental health. These are:

- Self and Peer Advocates
- Carers of persons with mental health difficulties
- Voluntary Organisations
- Umbrella and Alliance Organisations
- Health Professionals working within the system.

Any advocacy system will work most effectively when all these agents are acting in concert.

The framework will seek to ensure that advocacy services will work with service providers to:

- Assist in the planning and decision making related to the development of mental health services
- Provide perspectives on the quality of service provision
- Promote the importance of mental health as an important factor in overall health
- Highlight inequities in resource provision to respond to mental health
- Ensure that care planning is service user based and effective, especially for persons with severe mental illness

Advocacy services will work with individuals, where necessary or requested to promote and facilitate the relationship between health service provider staff and service users (see Section 3.2.4). Such services should be available to all service users where requested but may not be necessary for all service users.

4.3.3 Financial Management System

It is acknowledged that there is a need to achieve value for money in the development and delivery of health services and to devise systems that provide for devolved budgetary management and accountability structures at the appropriate level. The Value For Money Report made a number of observations and recommendations including reference to achieving efficiencies in relation to Mental

Health Services. Within the timeframe of the framework it is intended to develop a more efficient financial management system building on the work already conducted. This financial system will promote innovation through responsibility. The aims of this financial management system will be to:

- Make cost estimates for assessed need relating to both infra-structural and revenue requirements.
- Improve the financial management information systems.
- Ensure a process of delegated financial accountability for key decision makers in mental health services reflecting best practice.
- Develop an activity based costing system which will include a schedule of all major services provided and their associated costs by agency and type of service.

4.3.4 Human Resource and Workforce planning processes

Health Services including the Mental Health Services is a labour intensive activity. From this, it is apparent that people and staff are the one of the most valuable components in service delivery. To ensure that each element of the framework is implemented, it is important that human resource and workforce planning become an important support system in the delivery of care. A number of important framework initiatives will need to address the following:

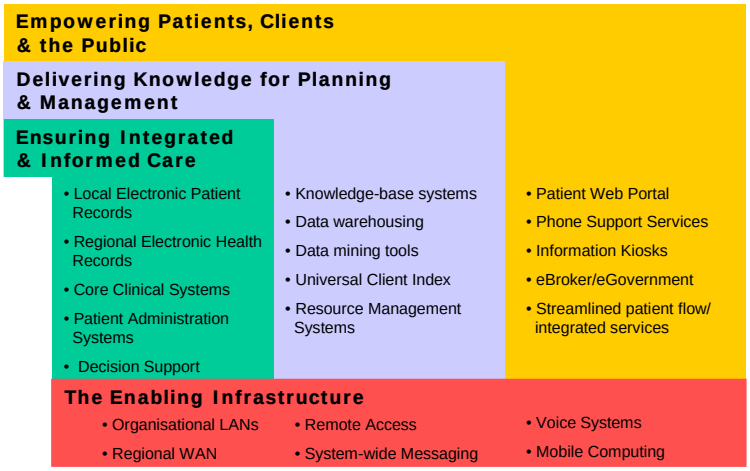
- A system of ensuring the efficient recruitment of staff.
- A system of ensuring the effective retention of staff.
- A system of ensuring that the needs of service users are thoroughly reflected in the roles and responsibilities of those delivering services.
- The development of training needs assessment and delivery programmes that aim to increase specialist skills amongst Mental Health Service staff.

Figure 4.1: Key Themes of the Action Plan for People Management

Support for human resource and workforce planning activities within the framework will be primarily associated with the Action Plan for People Management which is based on seven key themes (Figure 4.1): The Medical Manpower report and its recommendations on consultant staffing, deployment of nurses and the extension of hours of treatment services will need to be incorporated into the development of human resources within the Mental Health Services.

4.3.5 Information and Communications Technology (ICT)

The development of information and communications technologies will serve to greatly enhance the integration of Mental Health Services across the region. The ICT strategy envisages the following as the way forward:



The aim of the ICT component of framework will differ according to the needs of tier:

Tier 1 Services

- Access to information on mental health issues, effective mental health treatments and directories of services in the Eastern Region in information centres such as libraries, citizen information bureau's, social welfare offices, health centres, GP surgeries, pharmacies and other health services. Such access will aim to capitalise on present information system structures.
- Incorporation of appropriate information and fields on mental health into hospital and primary care information systems.

Tier 2, 3 & 4 Services

The primary targets for ICT developments in the Mental Health Service will be:

- Facilitation of access to information on mental health for users of services, health professionals working in the Mental Health Service and primary care health professionals treating mental illness.
- The implementation of the E.R.H.A. ICT Strategy
- The continued expansion of PC Hardware in Catchment Area Mental Health Services and continued networking of Community Psychiatric Services
- The continued expansion of e-mail and internet access facilities to all staff
- The implementation of a common Mental Health Information and integrated electronic patient record in the Mental Health Services
- The monitoring of ethical and secure practices in relation to information on users of the psychiatric services

- The training of Mental Health Service in the operation of current and new technologies

4.3.6 Capital Development Projects and Facility Management

The National Development Plan (NDP) 2000-2006 indicated allocations towards the Mental Health Service. The amounts indicated, however, would need to be augmented by !ring-fencing! The proceeds of specific assets sold to meet capital requirements.

A difficulty arises where there are competing capital projects for the indicated resources available. The implementation process should identify an agreed schedule of accommodation to meet identified needs indicating the capital required to provide for that need.

4.3.7 Community Accommodation

To support a modern psychiatric service there is a need to develop an appropriate community infrastructure. An essential component of this infrastructure is community accommodation providing appropriate levels of care.
During the framework period in order to meet community accommodation needs services will:

- concentrate on developing collaborative partnerships with local authorities to ensure equitable access to housing
- concentrate on developing collaborative partnerships with social housing service providers to ensure equitable access to sheltered accommodation for persons with psychiatric disorders. Such housing agencies include HAIL and Mental Health Ireland.
- ensure the maintenance of the current stock of residential accommodation provided by statutory services
- work with homeless services in the prevention of homelessness amongst users of the Mental Health Service.

4.3.8 Continuous Quality Improvement Processes

Quality has always been the essential basis of professional health care standards. This framework's emphasis, however, will be on **continuous** improvement and incremental change and one which switches the focus from quality practised within professions to the whole service itself. It will do this by challenging traditional methods of planning, delivering and monitoring of services and facilitating organisations to adopt innovative practices. It will also encourage front line staff to be actively involved in the decision making process which will promote greater opportunities for creativity.

Continuous Quality Improvement (CQI) in mental health will embrace not only measurement and assessment of the service but the commitment to take action, which results in the monitoring and evaluation of service quality to the client. CQI processes within the Mental Health Service will need to be:

- Internally driven and based on the pathway of a client through the system
- Based on staff empowerment and involvement
- Focussed on processes with clear milestones of successes
- Based on integrated analysis from multiple perspectives

Close working relationships with the Mental Health Commission and Inspectorate of Mental Health Services will both guide and lead this process. In parallel a number of national and local quality initiatives will be incorporated into the delivery of mental health services. These include:

- National Health Strategy initiatives
- ERHA legislation (3 year agreements on standards, monitoring and evaluating role on the efficiency and effectiveness of the service)
- New Health and Information Quality Authority involvement in standard setting
- Mental Health Commission and the extended new role of the Inspectorate of Mental Hospitals
- Internal self-monitoring, external peer review, audit procedures
- User involvement (satisfaction and complaints system improving advocacy)
- National Performance Indicators
- Risk Management and governance arrangements
- Hospital Accreditation and its potential extended role to community services

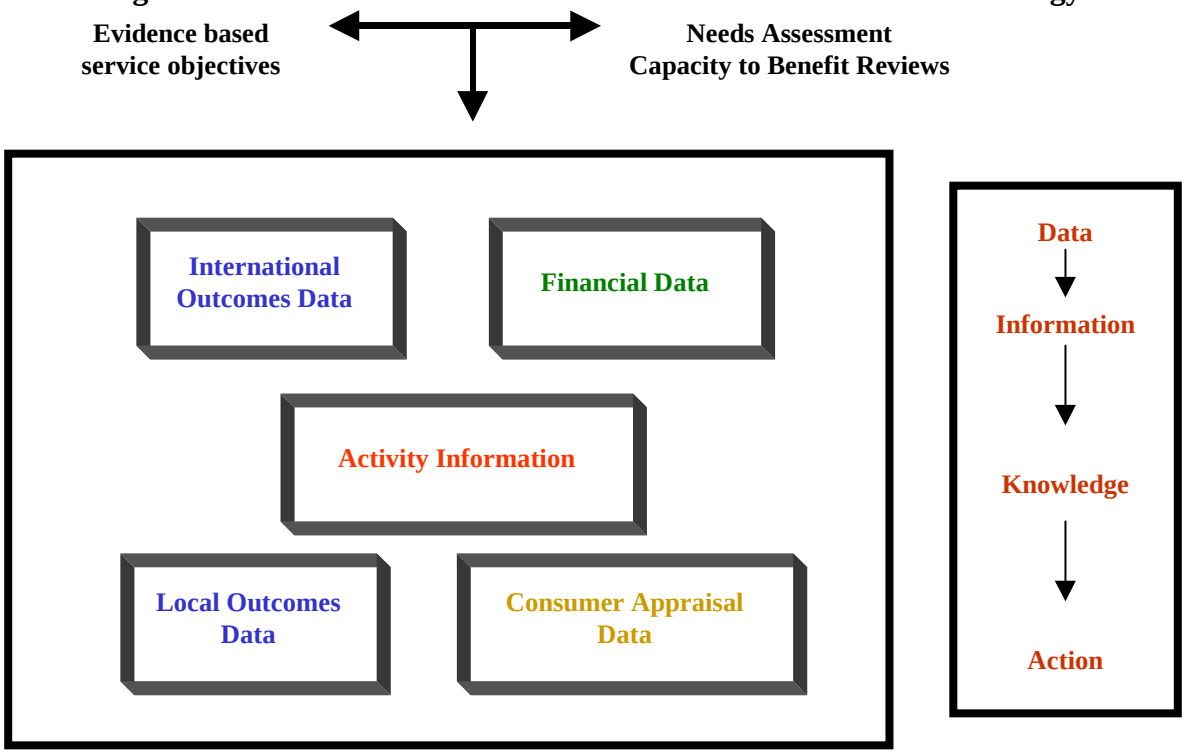
4.3.9 Mental Health Information Strategy

Information is of critical importance to the planning and development of psychiatric and mental health services. Figure 4.2 presents the key elements of the mental health information strategy which will seek to measure service user appraisals of service, their outcomes compared to international benchmark and the activity levels of services.

Over the framework period, it will be necessary to:

- Review all information collection systems and assess their applicability for present and future planning and management information requirements.
- Streamline all data collection processes within the Mental Health Service to minimise the administrative burden of data collection systems.
- Provide regular data collection training to data collection staff.
- Agree and implement validation and audit procedures for information collected.
- Regularly review the information needs of the E.R.H.A., AHBs and other key stakeholders and regularly assess the information requirements of external agencies (e.g. Department of Health and Children, Mental Health Commission, Health Research Board, etc).
- Ensure the accessibility of information by all key stakeholders and the active promotion of information in decision making
- Lobby for increased research into the field of mental health including the development of a National Mental Health Policy Research Centre linked to one or more academic centres and strengthen research links with key academic institutions.

Figure 4.2: Essential elements of the mental health information strategy



4.3.10 Mental Health Commission & Inspector of Mental Health Services

To complete

4.3.11 Communications Strategy

A comprehensive communications strategy is required to promote the importance of positive mental health and to ensure the effective and continuous flow of information about the operation and success of the mental health services. The development of a communications strategy for mental health will be concentrate on the following areas:

- Communications and information aimed at raising the visibility of mental health
- Communications aimed at assuring the population that mental health ill health can be both prevented and treated
- Communications and information about services for mental health or mental ill health
- Communications and information for the training of all health professionals in responding to mental health issues
- Communications and information that facilitates the provision of seamless mental health services between health professionals and service providers
- Communications and information about the achievements of services in addressing mental health issues
- Communications and information that are necessary for the operation of services

5 – Challenges in the delivery of Mental Health Services

5.1 Introduction

The following sections will outline the current and future challenges that mental health services face. Fundamental to these challenges are the continuous changes related to population growth, demography, structures in society, the changing ethnic profile of the region, changes within the organisation of the health service and obtaining the necessary resources to sustain the required changes to respond to the needs of the population of the East.

Planning for the Future (1984) instigated a series of innovations within the Mental Health Service to modernise the delivery of care. Many of the changes implemented were aimed at re-orientating services in different settings. Resources to expand or deliver on other aspects of this policy have been limited. This has impacted on the pace of developments and has concomitantly resulted in an uneven distribution of the total complement of community based mental health services nationally. It is therefore imperative that a true acknowledgement of the required task and resource provision for the needs of people with mental health issues is assessed and such resources are forthcoming.

Future challenges for the development of services will also be felt as the health services realises the impacts of the structural changes as envisaged with the Health Services Agency and the Hanley Report on Medical Manpower. These structural changes will alter the organisation of management arrangements and the clinical staffing of mental health services into the future.

5.2 Addressing equity in service provision

The provision of Adult Mental Health Services (Tier 3, 4 & 5) has not been equitably resourced when viewed in the context of the burden of illness it is responsible for (see Section 1.8). The Adult Mental Health Service budget nationally (Appendix B and C) represents approximately 9% of the total health spend. Within the Eastern Region, the spend on Adult Mental Health Services (as set out in the Inspector of Mental Hospital Report, year ending 2001) was €115.27m. This figure constitutes the core revenue budget and makes provision for a range of services. The Acute Bed Study (1999) "We have no beds", set out starkly the contrasting nature of the provision of acute psychiatric beds and residential places between the Eastern Region and the other seven health boards.

Table 5.1: Provision of In-patient and Community Psychiatric Services nationally

Health Board	Beds		Community Residential Places	
	N	Rate*	N	Rate*
Eastern (EHB)	1,029	110.8	765	82.4
North Eastern	329	153.9	199	93.0
North Eastern	253	167.8	226	149.9
Mid Western	463	204.3	240	106.0
Southern	823	209.6	396	143.0
Midland	370	225.0	208	143.4

Western	725	289.3	496	197.9
South Eastern	962	347.4	329	83.3
Total	4,954	191.3	2,859	110.6

* per 100,000

Table 5.1 above shows:

- The Eastern Region has the lowest provision of psychiatric beds nationally
- The Eastern Region has the lowest provision of community residential places nationally
- The Eastern Region provides such services against a backdrop of large areas of deprivation and increasing urbanisation compared to other Health Boards

The implementation process of the framework will seek to identify:

- Future prioritised mental health infra-structural requirements.
- Mechanisms for reviewing the national allocation to mental health to ensure that all allocations are targeted on a needs based approach.
- Mechanisms for increasing the health allocation to allow for equitable access to resources for mental health both within the Eastern Region and nationally.

Table 5.2 overleaf details the current provision of in-patient and Community Psychiatric Services in the Eastern Region by catchment area. Currently there are 426 acute psychiatric beds commissioned by the E.R.H.A. in the East.

Table 5.2: Provision of In-patients & Community Psychiatric Services in the Eastern Region

			Inpatient Provision					Hostels								
CCA Name Population		No. of Sectors	Acute Beds	Intensive Care	Rehab	Psych of Old Age	Cont Care	High Supp	No. of Places	Med. Supp	No. of Places	Low Supp	No. of Places	Day Cntr Place	Day Hosp Place	Other
Area 1																
171,933	Cluain Mhuire		42				20	1	20	1	15	3	15	68	35	
Area 2		3	51			91		1	14	1	14	1	7	32	45	
99,579	SVH - Elm Park		22													
	Vergemount		29													
Area 10		3	35				35			5	60	4	22	161	20	
100,004	Newcastle Hosp															
	ECAHB Total		128				55	2	34	7	89	8	44	261	100	0
Area 6		4	62	46	20	102		10	138	3	24	6	51	85	10	
160,346	JCMH		22			40(+62)		4	69	3	24	3	32	85	10	
	St. Brendan's		40					6	69			3	19			
Area 7		5	55				52	2	32	1	8	4	32	185	50	
138,000	SVH - Fairview		40				52									
	Mater		15													
	NAHB															
Area 8		5	50				141	3	22	4	30	1	8	55	85	
202,157	St. Ita's Hosp															
	NAHB Total		167	46	20	102	193	15	192	8	62	11	91	325	145	0
Area 3		2	51			34		2	20	1	10	5	17	13		
100,000	St. Patricks / St James															
Area 4/5		4	50		22		54	3	43	4	43	6	31	70	59	
258,028	St. Loman's / AMNCH															
Area 9		4	30					2	30	1	6	3	16	22	32	
179,000	Lakeview															
	SWAHB Total		131		22	34	54	7	93	6	59	14	64	105	91	0
Eastern Region	Total		426	46	42	136	302	24	319	21	210	33	199	691	336	0

5.3 Current and Future Challenges in the Provision of Mental Health Services

Following developments in the Irish economy over the past 10 years, the Mental Health Services in the Eastern Region have faced significant challenges and difficulties in the provision of existing services and the development of new services to meet new and emerging needs. These difficulties have existed despite the publication of Planning for the Future (1984) by the DoHC and mounting evidence on the role played by mental health in overall health.

Broadly, these challenges can be categorised into challenges arising from a lack of adequate and on-going investment in service developments and facilities, those due to the organisation of services and those anticipated challenges that will arise from recent policy and legislative developments.

5.3.1 Investment and resource challenges

- The flow of new service development resources to the Mental Health Service from the Department of Health & Children can fluctuate from year to year.
- There has been a decline in the potential available capital development resources. This trend is not likely to be reversed in the short term.
- Distributions of resources to mental health from the current national health budget is inequitable given the demonstrated burden of mental illness.
- Distribution of resources to mental health from the national health budget has only recently recognised the rapid population expansions within the East.
- Allocation procedures do not take into account the impact of deprivation, increased multiculturalism and an ageing population on service demand. Such factors are associated with a need for higher levels of service provision.
- Capacity pressures in Mental Health Services are reducing immediate access to services.
- Some current infra-structure would now be deemed unsuitable for new and emerging needs.
- Health and safety legislation is imposing ever higher standards on the quality and maintenance of buildings and equipment. This has significant resource implications.
- Health and safety requirements have concomitant effects on staffing requirements.
- Continuous minor capital investment is required to maintain the extensive property portfolio of the Mental Health Services, which is not provided for under Department of Health & Children capital allocation procedures. The poor upkeep and institutional appearance of many of the community buildings adds to the stigma of being associated with the Mental Health Services – for both staff and service users. Many facilities are not currently accessible to people with physical or sensory disabilities.
- Resources are needed for the structural upkeep and refurbishment of secure care environments. Demands in this area are likely to be accelerated by implementation of the Criminal Law (Insanity) Bill.
- To date, the Mental Health Service has invested significant capital development resources across the region on residential accommodation and has not exploited other accommodation alternatives
- There is a requirement for significant investment in technological infrastructures for the Mental Health Service and for an agreed process to introduce new health technologies.

5.3.2 Organisation Challenges

- Service users have high and growing expectations of all health services and there is a constant need to respond to new and emerging needs.
- There are significant recruitment difficulties for the Mental Health service and there are substantial vacancies within the service filled on an acting basis or unfilled. There are also substantial delays in the recruitment cycle within the Shared Service model.
- There is a need to complete the development of a range of community teams and facilities in each Catchment area.
- There is a current and immediate future deficit in the number of health professionals graduating from training schools within the Republic.
- Services within the Eastern Region have lost significant numbers of experienced staff to growing provincial services.
- The Mental Health Services have inherited many treatment facilities that are outmoded and stigmatising with little investment to modernise or design for the purpose.
- Changing work practices require increased time input from management and professional staff reducing the amount of available clinical time for face to face work
- Public perception of mental health services is generally poor and there is a significant amount of stigma associated with receiving assistance from Mental Health Services. Such stigma can delay early engagement with services and reduce the effectiveness of early intervention initiatives.
- There is a severe shortage of step down facilities from acute care.
- There are capacity difficulties within the acute, community and intensive care psychiatric services.
- There is a limited choice of treatment options for users .
- Inconsistent gate-keeping procedures can leave vulnerable individuals failing to access appropriate services and also leads to an unacceptable level of inappropriate referrals.
- A tendency to attempt to respond to the totality of needs of presenting users results in inefficient use of core psychiatric service expertise.
- The East currently provides free psychiatric medications to patients attending psychiatric Services. This system discourages patients from seeking to be discharged back to their primary care service.
- Primary care services in the East are experiencing capacity problems and may have difficulty improving the level of service available to those with mental illness.
- Links between the Mental Health Service and other key agencies (e.g. housing and employment agencies) need to be significantly strengthened.
- Historically inherited information collection systems do not match modern day planning information needs. The framework will require the extension of information systems to cover both hospital and community activities.
- There is a need to work closely with local communities in the East on the location of community based treatment and residential facilities.
- Although there are active research programmes associated with the Mental Health Service, no formal research agenda or programme exists.

5.3.3 Impact of future policies and legislation

- The impact that a National Hospitals Office upon the joint planning of acute and community psychiatric services is as yet unknown.

- The Mental Health Commission will introduce and report on quality standards, which are likely to effect the organisation of services. Work related to the tribunals of the Mental Health Commission will place extra pressure on clinical and administrative staff and the requirement of second opinion of a Consultant Psychiatrist will necessitate the scheduling of extra clinical time.

- Implementation of the Mental Health Act 2001 will require changes in current procedures and protocols especially those relating to involuntary admissions and detentions.

- The Criminal Law (Insanity) Bill will impact on the National Forensic Service and on the Adult Mental Health Services.

- The impact of the Brennan, Prospectus and Hanley reports will bring about changes in the organisation of service delivery and clinical staffing.

- The proposed Disabilities Bill may also impact on the organisation and delivery of services in the future.

6 – Framework Implementation Pathways

6.1 Introduction

Of critical importance to any planning process is the delineation of a clear and unambiguous implementation process. In this context, a number of key elements to the implementation process are:

- Need for the E.R.H.A. (in conjunction with the Area Health Board) to have systems in place to satisfy itself that the framework is being implemented at local level
- Provision for local adoption and implementation of the framework
- Development of structures and mechanisms to ensure strong user involvement and meaningful participation in decision making
- The universal adoption of the quality agenda as an integral part of the implementation process

A number of critical factors will be key to the successful implementation of the framework:

- Clear communication and ownership of the vision and the change process at all levels and services (i.e. statutory and voluntary providers). This will include recognition of the task and effort of all staff at all levels.
- Securing appropriate resources from the Department of Health and Children to continue the innovations and service developments in line with the business plan of the framework. This process will also aim to promote a more equitable distribution of resources within the mental health allocation and within the overall health allocation.
- A prioritisation process that will ensure the distribution of resources to key service developments at different points during the framework period. A number of prioritisation processes will be undertaken to ensure that the importance of responding to mental health is emphasised (e.g. at health promotion level, at primary care level, etc).
- The reengineering of current service delivery, care provision and resource use in line with the strategic service model.

6.2 Focus of Implementation

The focus of implementation of the framework elements will be through a number of groups. These are:

- Regional Group chaired by the Regional Chief Executive (of the E.R.H.A.) and comprising representatives from the E.R.H.A. management team and the Chief Executives of each AHB. The function of this group will be to measure the implementation of the framework in line with agreed targets and to guide decisions on implementation issues arising from the framework.
- Implementation group chaired by one of the Chief Executives of the AHBs, which is charged with driving the implementation across the three AHBs. It would comprise representation of the management team of the E.R.H.A. and AHBs, appropriate service personnel, service user and voluntary group representatives. Modelled on the implementation of the strategic framework for Children and Families, it is envisaged that the work of this group would be guided by a number of core themes including finance, human resources, information and quality and is composed of a number of task groups which support the implementation process.
- Local implementation structures are a critical component in the overall implementation process. Such structures are important to ensure local collaboration and support for the framework to facilitate timely implementation and to allow for local adoption in line with critical priorities.

A number of processes and functions will directly contribute to the implementation of the framework. These are:

- Provider Planning processes and Section 65 arrangements
- Financial and budgetary management systems (Finance Directorates of E.R.H.A. and AHBs)
- Inspector of Mental Health Services and the Mental Health Commission
- Primary Care Strategy Implementation programme for Eastern Region
- Human Resource Forum within Eastern Region
- The ICT bidding process for ICT resources from the DoHC annually (E.R.H.A. led)
- Mental Health Information Strategy (partnership between E.R.H.A., AHB and user representatives)
- Quality and risk management structures (through existing E.R.H.A. and AHB structures)
- Capital development projects will be facilitated through the capital section of the E.R.H.A.
- Communication Officers of the Authority and AHBs

6.3 Involvement of services and agencies in the framework implementation pathways

6.3.1 Tier 1 Services – General Community

The Authority will liase with the following government departments and their relevant agencies on the promotion of mental health:

- Department of Health and Children
- Department of Social and Family Affairs
- Department of the Environment and Local Government
- Department of Education and Science
- Department of Community, Rural and Gaeltacht Affairs
- Department of Enterprise, Trade and Employment
- Department of Justice, Equality and Law Reform

Within each Area Health Board, implementation of Tier 1 initiatives of the framework will be assisted by:

- Departments of Health Promotion
- Directors of Care

A number of other key agencies will play a role in promoting mental health within their spheres of influence. These include:

- Voluntary Health Services
- Employer groups
- Employee groups
- Lobby groups
- Professional bodies

6.3.2 Tier 2 Services – Primary Care

Within each Area Health Board, implementation of Tier 2 initiatives will be assisted by:

- Public Health personnel
- Directors of Primary Care
- Directors of Metal Health and Addiction
- General Practice Unit Managers
- General Managers for Community Care

A number of other groups will play a key role in implementing Tier 2 initiatives. These include:

- Advocacy Groups
- Voluntary Bodies

The following representative bodies will play a significant influencing role during the framework period:

- Irish College of General Practitioners
- Pharmaceutical Society of Ireland
- Irish College of Psychiatrists
- Irish Nurses Organisation

6.3.3 Tier 3 – Community Psychiatric Services

Within each Area Health Board, implementation of Tier 3 initiatives will be assisted by:

- Directors of Mental Health and Addiction
- Clinical Directors and Catchment Area Management Teams

A number of other key services provided by or within each Area Health Board will also important in the implementation of the framework. These include:

- Addiction Services (including Alcohol Treatment Services)
- Homeless services
- Disability services
- Community Health Services

A number of other key groups will play a key role in implementing Tier 3 initiatives. These include:

- Voluntary and non-statutory organisations and in particular:
  - Irish Advocacy Network
  - Mental Health Alliance (and its composite voluntary groups)
  - Disability Federation of Ireland (and its composite voluntary groups)

The following representative bodies will play a significant influencing role during the framework period:

- Irish College of Psychiatrists
- Psychiatric Nurses Association
- Irish Nurses Organisation
- Psychological Society of Ireland
- Occupational Therapists
- Social Work

- National Disability Authority

Access to important associated services will need to be provided by a number of other agencies. It will be important that the provision of such services is timely and accessible. Such services include:

- Housing Services
- Educational Services (including access to third level institutions)
- Employment Services

6.3.4 Tier 4 – Acute Unit, PICU, and the range of other resident options

In conjunction with the agencies specified above (Tier 3), the following services will also be involved in the implementation of the framework

- Acute General Hospitals with a psychiatric unit
- Nursing Homes and respite facilities
- Housing agencies (statutory and other)
- National Hospitals Office
- Health Information and Quality Authority
- Irish Health Services Accreditation Body

6.3.5 Tier 5 – Forensic Services

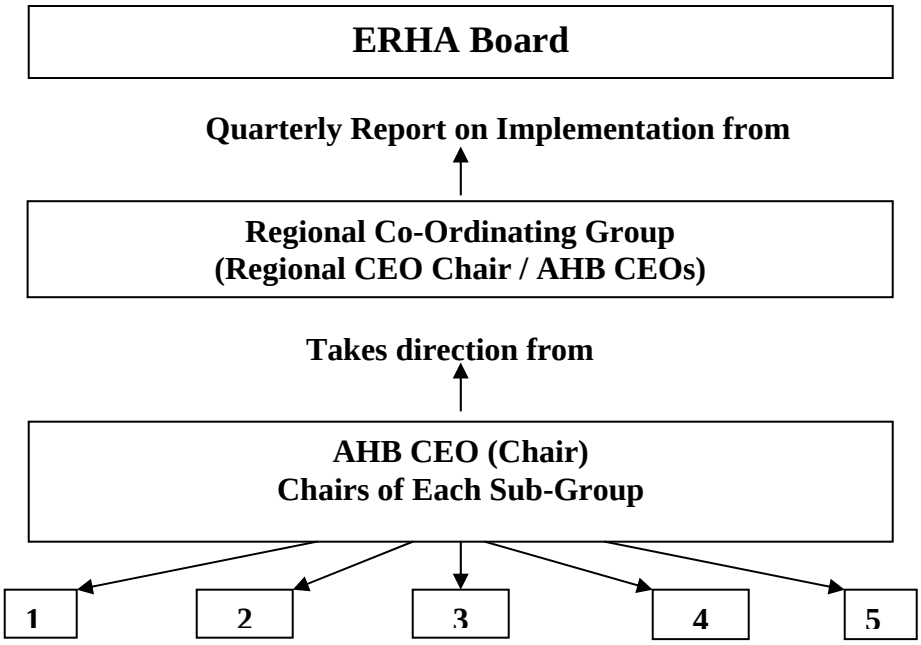
The following agencies will be integral to the development of Tier 5 Services. These include:

- Department of Health and Children
- Central Mental Hospital and other forensic psychiatric services
- Department of Justice, Law Reform and Equality

6.4 Implementation Milestones

PROPOSAL

Framework for Implementation Pathways for Mental Health



Note: Initial draft proposal to be confirmed following next meeting with the Regional CEO Group

Chapter 1 Demography of region and epidemiology – **mapping all services** that provide / support mental health and identify gaps

Chapter 2 Framework Standards – **Standards and Quality Group**

Chapter 3 **Model of Service Delivery** and Interface with all other agencies / services

This is a substantial sub-group and could be further divided to focus around the 5 tiers set out in Chapter 3, and target contentious issues, such as Homelessness, Forensic Services, Learning Disability Psychiatry.

In this area, there are already a number of groups focussing on specific areas:

- Mental Health Promotion Officers in each Health Promotion Department
- Primary Care Group with a Project Leader linked with the ICGP

- Psychosocial Group looking at A&E presentations (estimated that 20% of all admissions in psychiatry come through A&E)

- Homeless Forum with a sub-committee looking at homelessness and mental health

An implementation process of the Acute Bed Study (1999) and Inspector of Mental Hospitals Reports 2001/2002, could be used to identify some of the resources already indicated as required for Tier 3,4 and 5

Chapter 4 Supporting the Delivery of Service

Information and Communications Technology (ICT) (genesis of models exist in SWAHB / St. John of Gods)

Financial Management Systems – ERHA commenced this process with Directors of Finance in each AHB – to be expanded

Human Resources and Workforce Planning – to include Bacon and Hanly Reports

Capital Development Projects – including facility management and the development of community accommodation, sheltered housing, etc.

Chapter 5 **Innovations Group** – to respond to the challenges facing mental health services

Suggest that each sub-group would look at establishing pilot site / area (to be co-ordinated by Regional Implementation Group to implement a working model of the proposed implementation approach) – all CCAs should have a pilot site

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Mental Health Act

Criminal Law Insanity Bill

Appendix A: Actions related to mental health in the National Health Strategy

Actions directly effecting the organisation and delivery of care in the Psychiatric Service

Action Number	Action
14	Initiatives will be taken to improve children's health (including expansion of child & adolescent psychiatric services)
21	Initiatives to improve the health and well being of homeless people (with a psychiatric disorder) will be advanced
24	Initiatives to improve the health of prisoners will be advanced
25	A new action programme for mental health will be developed
26	An integrated approach to meeting the needs of ageing and older people will be taken
30	An action plan for rehabilitation services will be prepared
35	A national policy for the provision of sheltered work for people with disabilities will be developed
46	Appointment planning arrangements will be reviewed to provide greater flexibility
47	Waiting areas in health facilities will be upgraded
48	A national standardised approach to the measurement of patient satisfaction will be introduced
49	Best practice models of customer care including a statutory system of complaints handling will be introduced
50	Individuals and families will be supported to be involved in the management of their own care
51	An integrated approach to care planning for individuals will become consistent feature of the system
52	Provision will be made for the participation of the community in decision about delivery of health and personal social services (including Regional Co-ordinating Committee for mental health)
53	Initiatives developed to ensure care is delivered in most appropriate setting
55	A programme of investment to provide the necessary capacity in primary care, acute hospital and other services will begin
63	Quality systems will be integrated and expanded throughout the health system
68	Decisions across the health system will be based on best available evidence
70	Accountability will be strengthened through further development of the service planning process
71	Service agreements between the health boards and voluntary sector will be extended to al service providers and associated performance indicators introduced
104	Grater inter-disciplinary working professionals will be promoted

Actions directly effecting other health services where mental health will have to considered*

Action Number	Action
5	Actions on major lifestyle factors targeted in National Health Promotion strategy will be enhanced
8	Initiates to promote health lifestyles in children will be extended
15	A policy for men's health and health promotion will be developed
19	Initiates to eliminate barriers for disadvantaged groups to achieve healthier lifestyles will be developed and expanded
20	The Health of Travellers will be improved
21	Initiatives to improve the health and well being of homeless people will be advanced
22	Initiatives to improve the health and well-being of drug misusers will be advanced
23	The needs of asylum seekers / refugees will be addressed
43	Improved access to hospital services for public patients
44	Availability of information on entitlements including use of information technology
45	All reasonable steps to make health facilities accessible will be taken
54	Community and voluntary activity in maintaining health will be supported
58	A plan to provide responsive high quality maternity care will be drawn up
59	A review of paediatric services will be undertaken
74 & 75	A new model of primary care will be developed and a national primary care task force established
77	Investment will be made in GP co-operatives and primary care teams
78	Additional acute hospital beds will be provided for public patients
86	A substantial programme of improvements in accident and emergency departments will be introduced

* It is important to note here that it is intended that the Mental Health Services will not provide mental health services to facilitate each of the actions above. Such services will need to consider how the development of a mental health response as part of the overall service may be developed.

Actions where mental health will be a component, a factor of importance or considered as part of the overall development

Action Number	Action
1	Health impact assessment will be introduced as part of the public policy development
2	Statements of strategy and business of government departments will incorporate explicit comments to improving health status
15	A policy for men's health and health promotion will be developed
18	A programme of actions will be implemented to achieve National Anti-poverty strategy to reduce health inequalities
36	New legislation to provide for clear statutory provisions on entitles to health and social services will be introduced
37	Eligibility arrangements for medical cards will be simplified
40	Nursing Home Subvention Scheme will maximise support for home care
41	Introduction of a grant to cover 2 weeks respite care per annum for dependent older persons
42	Proposals on the financing of long term care of older people will be brought forward
64 & 65	A review of medicines legislation will be undertaken and the licensing of alternative medicines will be examined
73	Health research will continue to be developed to support information and quality initiatives
80	A National Hospitals Agency will be developed
84	The organisation and management of services will be enhanced to the greatest benefit of patients
92	Additional investment will be made in the health system
93	Capital funding will be allocated for the regular maintenance of facilities and planned replacement of equipment
94	Public-private partnerships will be initiated to help in the development of health infra-structures
95	Multi-annual budgeting will be introduced for selected programmes
96	The allocation process will be reviewed by the Department of Health and Children
98	Annual statements of funding processes and allocations will be published
99	The management of capital projects will be strengthened
100	Integrated workforce planning will be introduced on a national basis
101	The required number of extra health staff ill be recruited
102	Regulation of the number and type of consultant posts to be streamlined
103	Best practice in recruitment and retention will be promoted
108	A detailed Action Plan for People Management will be developed
110	Health Boards will be responsible for driving change, including a stronger focus on accountability linked to service plans, outputs and quality standards
111	An independent Health Information and Quality Authority will be established
115 & 116	The National Health Information Strategy will be published and implemented and there will be a sustained programme of investment in health information systems
117	Information and communications technologies will be fully exploited in service delivery
118	The electronic patient record will be introduced on a phased basis
121	Health information legislation will be introduced

Appendix B: National Psychiatric Service Budgets

Health Board	Provider Agency	Population	Budget 2001 (2002 Report)	Budget 2000 (2001 Report)
			€m	€m
NAHB	St Brendans (CCA 6)	0.065788	25.00	18.41
	JCMH (CCA 6)	0.063000	6.70	6.09
	SVH Fairview (CCA 7)	0.138000	15.67	15.36
	Mater (CCA 7)			
	North Co. Dub (CCA 8)	0.201617	25.14	23.11
	NAHB Total	**0.468405**	**72.51**	**62.97**
SWAHB	St James/St. Patricks (CCA 3)	0.097000	8.89	5.33
	Tallaght/St Lomans (CCA 4/5)	0.258028	18.90	17.14
	Kildare (CCA 9)	0.171000	7.50	5.33
	SWHB Total	**0.526028**	**35.29**	**27.80**
ECAHB	Cluain Mhuire (CCA 1)	0.170000	8.30	7.49
	Elm Park (CCA 2)		1.90	1.78
	Vergemount (CCA2)	0.099577	9.90	8.13
	Wicklow (CCA 10)	0.089713	8.40	7.11
	ECAHB Total	**0.359290**	**28.50**	**24.50**
ERHA Total		**1.353723**	**136.30**	**115.27**
National Forensic Service	CMH	3.600000	10.00	8.38
Midlands	Laois/Offaly	0.111878	12.40	11.68
	Longford Westmeath	0.095200	13.00	13.71
	Midlands Total	**0.207078**	**25.40**	**25.39**
Midwest	Clare	0.094006	17.30	16.63
	Limerick	0.165042	20.90	21.46
	MidWest Total	**0.259048**	**38.20**	**38.09**
NEHB	Cavan/Monaghan	0.103000	15.70	14.09
	Louth/Meath	0.200074	17.00	20.77
	NEHB Total	**0.303074**	**32.70**	**34.86**
NWHB	Donegal	0.121412	15.36	12.70
	Sligo/Leitrim	0.089648	14.00	13.58
	NWHB Total	**0.211060**	**29.36**	**26.28**
SEHB	Carlow/Kilkenny	0.041597	13.43	9.01
	Kilkenny	0.060300	11.58	8.25
	Tipperary	0.135620	15.24	12.19
	Waterford	0.106529	9.80	10.16
	Wexford	0.104371	13.29	11.43
	SEHB Total	**0.448417**	**63.34**	**51.04**
SHB	Kerry	0.126130	14.73	14.47
	Nth Cork	0.071234	17.90	15.49
	Nth Lee	0.145233	14.70	10.28
	Sth Lee	0.167638	8.30	4.57
	West Cork	0.050914	4.20	3.55
	SHB Total	**0.561149**	**59.83**	**48.37**
WHB	East Galway	0.091619	26.20	26.66
	West Galway	0.100000	7.60	7.24
	Mayo	0.111000	15.30	16.63
	Roscommon	0.052726	10.20	9.65
	WHB Total	**0.355345**	**59.30**	**60.18**
	National Total	**3.698894**	**454.43**	**407.86**

Appendix C: Budget allocations per capita in the mental health services

		ERHA *									
	NAHB	**SWAHB**	**ECAHB**	**MHB**	**MWHB**	**NEHB**	**NWHB**	**SEHB**	**SHB**	**WHB**	**Total**
Population (m)	0.468945	0.519028	0.35929	0.207078	0.259048	0.306086	0.213412	0.448035	0.550772	0.355345	3.687039
Mental Health Services	**0.745**	**0.745**	**0.745**	0.720	0.700	0.760	0.650	0.775	0.790	0.970	6.110

"The basis for the funding of individual services on a comparative basis has always been on historical rather than on scientific or epidemiological grounds, taking account of measures of population characteristics such as deprivation and disadvantage. One of the principal items not taken into consideration is the number of catchment area persons holding medical cards on the one hand and those utilising private services on the other. When budgets to population in various catchments are calculated, discrepancies as high as fivefold emerge. In general terms, services in the eastern region suffer most in this matter of differential funding, although within the ERHA itself, there are considerable discrepancies, with inner city and disadvantaged suburbs doing badly by comparison with two services in the south of the region with low levels of medical card holders faring much better. For example, the level of medical card holders as of September 2002 showed considerable variation — from 23.68 per cent in Co Kildare to 49.12 per cent in Co Donegal. The figure for Dublin City and County at 25.46 per cent conceals much variation within catchment areas in the Dublin region. However, in interpreting expenditure data on a per capita basis across catchment areas, it must be borne in mind that gross figures do not take into account historical factors such as that many services are still maintaining an old mental hospital, however reduced in size, and that in the cost figure is the budget for, in some areas, many elderly and some intellectually disabled persons still resident in them, while in some more recently established services there is no such legacy of the past. A more appropriate basis for comparison would be the cost of acute in-patient and community services, but such data are generally unavailable. Of course, this is always a difficult matter to change, in that the distribution of limited funding necessarily entails the taking from some to give to others. Another approach to the problem is to re-align catchment areas, to equalise their size or equalise social and economic deprivation between them by re-drawing boundaries. This is difficult because it may mean crossing county or health board areas of responsibility."

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Appendix D: Model of Service Delivery in the Forensic Services

Forensic services currently represent a highly specialised, national tertiary service providing conditions of special security (high and medium security), which can only be provided for a population of over three million. It is essential therefore to recognise the need for free flow between levels of security in particular from local secure services to national medium and high secure as well as from prisons back to community services.

It has been shown that enhanced availability of local psychiatric services reduced demand on forensic services in Ireland (Footnote O'Neill et al, 2002) and it has been shown that enhanced availability of local PICU reduces demand for medium and high secure services (McCrone et al, 2001; Coid et al, 2001). There is also evidence that availability of high quality high intensity community psychiatric services including the use of community treatment orders prevents revolving door admissions through the forensic as well as general psychiatric services. In practice however these facilities are not available in the Irish mental health services and unlikely to become available in the medium term. Over the period of the framework, the Forensic Services must aim to provide services to the mentally ill in prison, which are accessible, equitable and effective. Over the long time, the aim of the Forensic Services is to add the element of re-integration into local services.

The Forensic Services aims to provide a mixed integrated and parallel community after-care service for those discharged from the Central Mental Hospital after long admissions.

The Forensic Service will be designed based on a network of local low-secure units relating to the National Forensic Psychiatry Service by a hub-and–spoke system with free movement of patients between levels of therapeutic security according to need.

- The National Forensic Psychiatry Service will provide a service to the prisons within reach of Dublin with additional assessment and liaison services to all other Irish prisons.
- The Forensic Service will be closely linked to local Psychiatric Intensive Care Units (PICUs).
- The Forensic Services over the longer term will need access to local longer-term low-security units, though the need for these is less easy to quantify without good local and population-based needs assessment.
- Local secure units are intended to provide a service mainly for civilly detained patients who require treatment in conditions of security. Patients detained under forensic mental health legislation or transferred from the prisons are likely to be most appropriately treated at the Central Mental Hospital. For some appropriate patients, onward movement to a local secure unit rather than a community service may on occasions be beneficial.
- There is a need to develop parallel follow-up service for longer-term forensic patients returned to the community (Snowden et al 2000). An outpatient clinic and sheltered workshop currently exists at Usher's Island.
- The cabinet has given a commitment to end the use of padded cells for mentally ill prisoners in order to comply with recommendations of the Committee for the Prevention of Torture (CPT). The CPT has also been critical of the continued use of slopping out at the Central Mental Hospital due to the lack of modernised buildings there.
- There will be a need over the longer term for the additional development of therapeutic secure services for adolescents with mental illness, learning disabled and dual diagnostic patients.

The service model is to provide Outpatient and Community Psychiatric Nurse services as an in-reach services into prisons to see inmates identified on reception screening as high-risk or mentally disordered. Following this, a number of options may be followed:

- Those requiring hospital treatment will be transferred to the CMH.
- Those released by the courts are re-integrated into their Catchment area psychiatric service.
- Patient returned from the CMH to prison are followed up assertively.

These in-reach teams hold weekly ward rounds with the prison nurses, medical orderlies, general practitioners, probation and welfare, psychology and chaplainry staff. It should be noted that funding has been allocated for forensic psychiatry posts in Cork and Limerick to serve the prisons in these regions. Contact and liaison between these services will be served through the hub and spoke model.

It is proposed to re-organise the existing service and to deploy new resources so as to enter into a Service Level Agreement as follows:

- The existing patients at the Central Mental Hospital will be accommodated in sixty-four beds in the 1850 building plus the ten-bed hostel. The existing unit 1 will continue to function as an admission unit, admitting two patients per week from the sentenced population, Guilty But Insane verdicts and (in rare cases) transfers from Health Board Hospital.
- Existing Units A and B will be resourced as "new" units to provide two admission units with a capacity for four admissions (two each) per week. These new units will admit only remand prisoners.
- Prisoners will be treated for acute psychoses until they are well enough to return to the prison population where they will be managed by in-reach teams, in effect providing ACT services while the prisoner remains in the prison.
- Every effort will be made to re-engage the mentally ill person with their Catchment area service.
- Psychotic, disturbed or otherwise high risk persons in the remand committal prisons and in any of the Irish Prisons, if placed in seclusion for their own protection will be reviewed by a General Practitioner within twenty four hours, by a psychiatrist within forty eight hours and will be transferred to the Central Mental Hospital within three days maximum.
- Any person with a severe mental illness unmanageable in the prison will be transferred to the Central Mental Hospital within the same time scale.
- At the Central Mental Hospital, patients will receive intensive and high quality multi-disciplinary assessment, care and treatment. It is expected that the great majority of those treated will be able to return safely to the prison system with assertive in-reach care and treatment until they are released by the Courts or come to the end of their sentence.
- The mean length of stay in "new" units will have to be kept at or below sixty days in order to continue admitting at a constant rate in those units of four per week. Any other legal or clinical structure, which placed a limit on discharge date, would lead to silting up.
- The Criminal Law (Insanity) Bill may increase the number of transfers with a view to fitness to plead or insanity. Such a situation would have a serious impact on the normal flow of clients into and out of the service
- Court diversion schemes could be devised which would be acceptable to all. These would permit Courts to act in effect as the applicant under the Mental Act (2001) with the recommendation of an independent doctor (General Practitioner, Prison Doctor or Forensic Psychiatrist) followed by an assessment by the Clinical Director or Consultant Psychiatrist at

the receiving hospital before the Order could be completed. However for the time being this scheme can go forward without such a scheme.

- The introduction of Community Treatment Orders would allow an even better system for those coming before the Courts to receive compulsory treatment in the community from community services. This would prevent "the revolving doors" hospital and prison circuit.