Psychology Briefing Paper for the HSE Mental Health Division

The Heads of Psychology Services Ireland

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<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Table of Contents</td>
<td>i</td>
</tr>
<tr>
<td></td>
<td>Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>Section 1</td>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1.1 Collaboration</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1.2 Community centred</td>
<td>1</td>
</tr>
<tr>
<td>Section 2</td>
<td>Clinically excellent</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2.1 The evidence that psychology works</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2.2 The cost effectiveness of psychology</td>
<td>5</td>
</tr>
<tr>
<td>Section 3</td>
<td>Recovery focused</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>3.1 Psychological thinking promotes cultural change</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>3.2 Psychologists enable cultural change towards recovery values</td>
<td>7</td>
</tr>
<tr>
<td>Section 4</td>
<td>Centred on the wishes of service users and family/carers</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>4.1 Listening tools</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>4.2 Hearing and taking action</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>4.3 Providing leadership on mental health research</td>
<td>10</td>
</tr>
<tr>
<td>Section 5</td>
<td>Partnership with other agencies</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>5.1 Partnership with Primary Care</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>5.2 Partnership with Health and Wellbeing</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>5.3 Partnership with the Child and Family Agency</td>
<td>13</td>
</tr>
<tr>
<td>Section 6</td>
<td>Moving forward</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>6.1 Lead on change</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>6.2 Standardise what psychologists do</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>6.3 Add value in ‘New ways of working’</td>
<td>17</td>
</tr>
<tr>
<td>References</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Appendix A</td>
<td>Working group</td>
<td>24</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Sample of international guidelines that recommend psychological interventions as central to the treatment of a mental disorder</td>
<td>25</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Psychology staffing requirement</td>
<td>26</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Provision of overall governance of psychological therapies</td>
<td>27</td>
</tr>
</tbody>
</table>
Executive Summary

The psychology workforce in Ireland is well placed to lead on developing mental health services that are clinically excellent, recovery-oriented and service user-centred. This briefing paper outlines the evidence that psychological interventions are clinically effective, cost-effective, and valued by service users and their carers. The centrality of the recovery-ethos to the work of psychologists and their role in fostering cultural change is discussed. The means by which psychological work can embed the voice of the service user in mental health services is also set out, as are positive practice examples of how this is currently occurring in particular services in Ireland. How the psychology workforce can build on this and develop new practices and partnerships to further maximise its added value to our mental health services are presented in ten key recommendations.

1.0 Introduction

The core principles at the heart of psychological practice dovetail with those of the Mental Health Division Operational Plan 2014. These include the need for services that are:

- Clinically excellent
- Recovery-focused
- Centred on the wishes of service users and their carers
- Involve partnerships with other agencies

Underpinning these principals is an awareness of the need for psychologists to facilitate integrated service provision by working across the different HSE Divisions and with the communities in which our service users and their carers live.

1.1 Collaboration

There is a common acknowledgement that individual health services cannot operate in isolation from each other. Indeed, they must be functionally interdependent if they are to best meet the needs of service users and their carers. Principal Psychologist Managers, who typically manage psychology services across all of the HSE Divisions in their specific service areas, are well placed to support and integrate mental health services with our primary care, acute hospitals and other services. Individual psychologists, given their comprehensive training in developing and maintaining effective working alliances and their appreciation of the need to manage potential power imbalances, are also well-placed to work with service users and their carers in a co-producing manner, and with their professional and non-professional affiliated mental health colleagues.

1.2 Community-centred

Psychologists working with individuals and their carers in distress are acutely aware of the need to attend broadly to the community’s wellbeing through focusing on touchstone issues like suicide prevention, improving access to talking therapies and promoting psychological wellbeing in all.

2.0 Clinically Excellent

**Psychological interventions are effective; appreciated by services users; and save the health service money compared to treatment as usual. Positive practice examples are set out as exemplars of the clinically excellent services that service users and their carers deserve.**

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A working group (see Appendix A) consulted with Principal Psychologist Managers in our health services to produce this briefing paper.
2.1 The Evidence that Psychology Works

2.1.1 International Evidence
It is widely accepted that psychological interventions are central to the effective treatment of major mental disorders. Indeed, the evidence for psychological interventions is so robust that all equivalent healthcare systems (e.g., England, Wales, Scotland, Australia, United States of America) incorporate these interventions as core treatments for mental disorders in their formal clinical guidelines (see Appendix B).

2.1.2 Effective for a Range of Disorders across the Life-Span
Psychological treatments are effective for a wide range of disorders from mild-to-moderate depression and anxiety presentations\(^2,3\) through to complex mental health presentations such as schizophrenia.\(^4,6\) Psychological therapies are effective across the life-span, being equally recommended for presentations in children\(^7\) and older adults.\(^8\) Moreover, the sooner an individual receives an evidence-based psychological intervention, ideally in the context of multi-disciplinary team input, the better their long-term prognosis.\(^9,12\)

2.1.3 Current Resource
A Vision for Change\(^13\) recommended a total of 730 Whole Time Equivalent (WTE) psychologists for our various mental health services (see Table 5 in Appendix C). In contrast, despite recent recruitment, current WTEs total 225.50 (see Table 1 below). While A Vision for Change\(^13\) was aspirational in terms of the resources it recommended, it is still evident that the ongoing and significant psychology resource deficit will compromise meeting the needs of service users and their carers.

<table>
<thead>
<tr>
<th></th>
<th>CAMHS(^c)</th>
<th>Adult &amp; Old Age Mental Health(^d)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dublin Mid Leinster</td>
<td>9.60</td>
<td>38.20</td>
<td>47.80</td>
</tr>
<tr>
<td>Dublin North East</td>
<td>14.20</td>
<td>41.50</td>
<td>55.70</td>
</tr>
<tr>
<td>West</td>
<td>19.90</td>
<td>40.20</td>
<td>60.10</td>
</tr>
<tr>
<td>South</td>
<td>21.00</td>
<td>40.90</td>
<td>61.90</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>64.70</td>
<td>160.80</td>
<td>225.50</td>
</tr>
</tbody>
</table>

Psychologists work with individuals, with couples and with families, presenting with a wide range of presentations and levels of severity, in community and institutional settings. They utilise a range of evidence-based therapies including Cognitive Behavioural Therapy (CBT); psychodynamic psychotherapies; and systemic psychotherapies; as well as specialist psychotherapies developed for particular service user groups (e.g., Dialectic Behavioural Therapy [DBT] and Mentalisation-Based Therapy for Borderline Personality Disorder or Interpersonal Therapy for Depression).

2.1.4 Maximising the Service Provision Capacity of Psychologists
Increasingly psychologists have adopted a ‘stepped-care’ model of service provision to maximise their service provision capacity and the value they can offer. This involves offering service users the level of intensity of input (and resource) appropriate to the severity of their

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\(^a\) These figures do not include vacant posts.
\(^b\) These figures include the Mater CAMHS psychologists (9.5 WTEs) who transferred to the HSE (Dublin North City & County), but not those who work in St. John of God Lucena Services (Dublin South East/Wicklow service area) and the Brothers of Charity Services (Kerry).
\(^c\) These figures exclude the psychologist posts in Psychological Medicine, St. James’ Hospital, Dublin; the Cluain Mhuire Family Centre, Blackrock, Co. Dublin operated by St. John of Gods; and those in Saint Patrick’s Hospital, Kilmainham, Dublin.
presentation. This model of initially providing a ‘low-intensity, high throughput’ model of psychological interventions augmented, when necessary, by higher-intensity input, has been shown to be a highly effective way of offering a larger number of individuals the core treatments that they need.

Figure 1. Optimum organisation of psychology services.

In practice, typically primary care psychologists can initially offer high volume-low intensity services (e.g., guided self-help; group psycho-education, brief consultation) to those presenting with mild-to-moderate mental health presentations (see Figure 2). Both those presentations that do not respond adequately to these low intensity presentations, and a smaller minority of complex mental health presentations can be offered low volume-high intensity psychological services (e.g., Schema-focused CBT or Psychodynamic Psychotherapy for certain complex presentations, and to a lesser extent DBT/MBT for Borderline Personality Disorders).
Positive Practice Example 1

Access to Psychological Services Ireland (APSI)

Funded by the Office of the Assistant National Director of Mental Health, and building on a 4-year pilot, this stepped care service was launched in 2013 in Roscommon with the aim of providing an accessible primary care adult mental health service. APSI (www.apsi.ie) provides:

- A service in each of the six primary care centres in County Roscommon.
- Open access (i.e., acceptance of walk-in and self-referrals).
- Immediate assessment for walk-in referrals or within 24 hours for all other referrals.
- Effective low-intensity, high-throughput psychological interventions.
- Mental health promotion through whole population initiatives (e.g., public talks).
- A continuum of care through integrated working with Counselling in Primary Care staff; primary care and secondary care professionals; and community agencies.
- A commitment to monitor clinical- and cost-effectiveness through rigorous service evaluation (e.g., over 1,000 referrals have been processed since July 2013).
- A commitment to deliver savings by providing a high throughput service (in the context of a low cost base) and avoiding the use of costlier secondary care services.

Figure 2. Structure of APSI service and coordination with community services.

2.1.5 Providing Governance of Psychological Therapies

The provision of psychological therapies may be best governed by those with the most advanced competence in providing psychological therapies. Among the multi-disciplinary members of our mental health teams, psychologists are expected to be especially skilled and knowledgeable in this area and, as well as providing specialist psychological interventions, often provide a learning and supervisory resource for other team members. A positive practice example of the latter is detailed below.
Managing and Developing the Provision of Psychological Therapies

The Adult Mental Health Psychology Service at St. James’ Hospital provides a broad range of therapeutic interventions across several modalities to the Dublin South Central Integrated Service Area. The Principal Clinical Psychologist manages and supervises a team of clinical and counselling psychologists as well a number of sessional psychotherapists from a range of different modalities including CBT, Integrative & Humanistic Psychotherapy, Cognitive Analytical Therapy and Family Therapy. Other discipline colleagues within the service (e.g., Nursing; Occupational Therapy) who have had psychotherapy training are supervised within the department. Where appropriate, supervision is also provided to psychiatric registrars who wish to gain therapeutic experience.

Key features of this (secondary care) service model include:

- Rapid access for acute and urgent cases via emergency assessment clinics.
- All non-urgent referrals seen within 10 weeks (reduced from 18 months).
- Comprehensive assessment and matching of referrals to the appropriate level and type of intervention.
- Provision of weekly clinical supervision for all psychologists and psychotherapists.
- Weekly case management meeting and review of all new referrals.
- Provision of 200 individual therapy slots per week.
- Provision of 10 weekly group programmes including a daily inpatient process group, several psychosis groups, a DBT group and a Happiness and Well-Being Group.

2.2 The Cost Effectiveness of Psychology

Psychology benefits from the strong research and academic basis inherent to the science, and has a long history of closely evaluating clinical and service-level outcomes.

The standard metrics that are commonly used are based on the core values of accessibility, acceptability, effectiveness, efficiency and equity. Typical measures include:

- Service level – Demographic information; number of cases seen; waiting time to first appointment; number of sessions offered; number of DNAs / drop-outs.
- Outcome oriented: Symptom improvement (e.g., BDI; Y-BOCS; PHQ-9; GAD-7); General wellbeing (e.g., GHQ; CORE-OM); and service user qualitative and quantitative feedback.

One common method of economic analysis is the cost-benefit analysis, whereby both the costs and benefits of a treatment are converted to monetary values and offset against each other to calculate the overall net gain of a treatment. A medical cost offset occurs when treatment success results in reductions/elimination of the usual costs of health services (e.g., reduced frequency of GP visits, or of outpatient or inpatient service usage). A wide range of studies have demonstrated that, compared to treatment as usual, psychological treatments are cost effective for a range of disorders including Depression, Anxiety, Schizophrenia and Bulimia Nervosa. A recent overview of this evidence in the UK outlined in practical terms the financial savings that accrue (see Table 2).
Table 2. Economic savings from interventions for mental disorders.\(^{30}\)

<table>
<thead>
<tr>
<th>Savings</th>
<th>Intervention</th>
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<tr>
<td>£1.75 for every pound spent</td>
<td>CBT for people with Medically Unexplained Symptoms (MUS), with NHS savings by year two.</td>
</tr>
<tr>
<td>£12 for every pound spent</td>
<td>Screening and brief interventions in primary care for alcohol misuse.</td>
</tr>
<tr>
<td>£8 for every pound spent</td>
<td>Training interventions for parents of children with conduct disorder.</td>
</tr>
<tr>
<td>£5 for every pound spent</td>
<td>Diagnosis and treatment of depression at work after one year.</td>
</tr>
<tr>
<td>£55,200 per participant</td>
<td>Early intervention for looked after children with mental disorder through multi-dimensional treatment foster care (MTFC) reduces crime by 18%, with associated net savings per participant of the equivalent of £55,220.</td>
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In Ireland we have similar examples of the savings that evidence-based, targeted psychological treatments can produce – see APSI (above) and DBT (below).

Positive Practice Example 3

**Dialectic Behaviour Therapy (DBT)**

Deliberate self-harm behaviour and suicidality continue to be a significant problem among Irish men and women. At present, DBT is the most robust evidence-based treatment (repeated clinical trials internationally) which is effective in working with this client population. There is a strong evidence base for its effectiveness among women and initial evidence supporting effectiveness among men.

A DBT service led by Clinical Psychologists in Cork has been closely evaluated. The data from year one of the pilot DBT project in North Lee, Cork, indicate significant savings.

**Table 3. Service use for participants in the Endeavour DBT Programme.**

<table>
<thead>
<tr>
<th>Service use</th>
<th>12 months before DBT</th>
<th>During 12 months DBT</th>
<th>3 months post DBT</th>
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<tr>
<td>Emergency Dept. visits</td>
<td>49</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Admissions to psychiatric unit</td>
<td>12</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Bed days used</td>
<td>207</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>Cost*</td>
<td>€144,900</td>
<td>€31,500</td>
<td>€700</td>
</tr>
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*Cost in bed days at conservative cost of €700.00 per person per night.

These findings along with the clinical outcome data, led to a detailed application to the National Office for Suicide Prevention to provide DBT services across Ireland targeted by population need. As a result, psychology is leading on a two-year funded national implementation of this evidence-based therapy. This initiative will train 16 teams (AMHS & CAMHS) and will monitor clinical outcomes, the quality of implementation, and a detailed economic evaluation (DBT vs. Treatment as Usual) will be carried out. The project has required multi-site ethical approval, organisation of training, and close liaison with clinical teams. This example shows how clinical psychologists have a role in identifying need, responding with appropriate evidence-based interventions, evaluating outcomes and cost-effectiveness, and leading change in organisational culture to appropriately meet clinical need.
3.0 Recovery-Focused

As outlined in the positive practice examples below, psychologists promote and enable cultural change towards a recovery-focused model by
(a) Moving services away from a symptom-focused, diagnostic model to services based on holistic, person-centred formulations; and by
(b) Developing new practices that embed service user participation in decision-making.

3.1 Psychological Thinking Promotes Cultural Change
Core to psychological interventions are holistic formulations of mental distress, person-centred rather than problem-centred, that by their nature expand how we understand an individual’s distress beyond the narrow confines of a simple diagnosis.

Moving beyond labels, psychological understandings or ‘formulations’ of mental distress emphasise how past and current life experiences contribute to present distress. The critical information they highlight may promote services to better support an individual’s recovery. Psychological formulations identify strengths and provide a practical roadmap as how an individual can achieve the form of recovery they desire. If diagnosis presents us with an individual that is a passive victim to a biological disease, psychological formulation presents us with pain that is meaningful in light of past and current experiences and examines distress in terms of its personal meaning to the individual. Psychological formulations can also identify a service user’s own strengths and expertise that are typically central to his/her recovery.

The further these ideas are embedded within mental health service provision, the greater the cultural change from a potentially paternalistic, symptom-focused approach to a more holistic, recovery-oriented partnership model.

3.2 Psychologists Enable Cultural Change towards Recovery Values
Psychologists have been at the forefront of the recovery movement in advocating for change and in designing the practical tools whereby change can be achieved.

- The ‘Implementing Recovery through Organisational Change’ (ImROC) model of change adopted by the ‘Advancing Recovery in Ireland’ initiative was designed and rolled out across the UK by Consultant Clinical Psychologist Dr. Geoff Shepherd.
- The means by which recovery-oriented change will be evaluated in Ireland is through the Recovery Context Inventory designed and brought to regional sites by Clinical Psychologists in the EVE team based in Dublin.
- At a service area level, psychologists in Ireland are leading on creating practical and innovative ways that services can embrace a recovery model (see Positive Practice Example 4 above).
Developed by joint leads (a Senior Clinical Psychologist and a Practice Development Coordinator), the Senate is ….

- A highly representative large group forum which debates and votes on the major initiatives to make mental health services more recovery-focused locally.
- It includes service users, service providers, family members, carers and voluntary organisations from every sector in the region.
- It meets 3-4 times a year.
- It is the decision-making forum of the local ‘Advancing Recovery in Ireland’ (or ARI) project and, as such, decides which key initiatives are undertaken.
- All decisions are taken to the Area Mental Health Management Team for discussion regarding the implementation of service-level changes.
- It is one of the few fora nationally in which the local community is able to have a strong voice in influencing the direction that the mental health service takes.

4.0 Centred on the Wishes of Service Users and Family/Carers

Psychologists can facilitate improvement in health service provision through engaging formally with service users and wide scale service-based research. Such engagement and research can lead to the development of practical programs (e.g., suicide prevention) to attend to the concerns of our communities. Positive practice examples of this are outlined.

4.1 Listening Tools

To respond to the wishes of service users and their carers, a service first needs to know what these wishes are.

Psychologists, with developed research and audit skills in qualitative and qualitative approaches, are well placed to access this information for services.
Psychologists can achieve this through:
- Service-level audits of teams’ involvement of service users in care planning.
- Qualitative interviewing of service users, their families and carers.
- Facilitated focus groups.
- Region-wide quantitative research on supports available to service users/families/carers.

Positive Practice Example 5

The Family Connections Programme

Family Connections (FC) is an evidence-based multi-family group intervention for family members/significant others of people with a diagnosis of Borderline Personality Disorder (BPD). Developed by psychologists in the U.S.A., FC aims to educate family members about BPD and family functioning, build skills to manage their emotional responses, and provide peer support.

Clinical Psychologists in Cork have been trained to deliver the FC programme which has been implemented since 2011. Their outcome research has shown FC to be an effective intervention, with significant improvements in feelings of burden, grief, and depression, and personal mastery over time, mirroring international findings.

The Clinical Psychologists have collaborated with family members who have completed the programme to discuss ways to improve the quality of the programme and access to learning. Eight family members have trained as FC leaders and have now begun to co-facilitate the programme with mental health staff. Further collaboration has led to the development of an FC DVD/online teaching resource in association with a programme originator, to further refine and enhance the learning of skills for family members, and to facilitate the sharing of their learning with extended family and friends.

4.2 Hearing and Taking Action

Research with service users and their carers has repeatedly highlighted that service users want greater access to psychological therapies; want an active role in designing their care plans; want their goals to receive the same priority as those of the professionals working with them; and want practical support when struggling as parents.

Initiatives such as APSI, ARI and Positive Parenting programmes (outlined above) – in which psychologists are playing a leading role – are attempting to attend to these findings. However, of particular concern, is research that highlights the fear and emotional pain that suicides have on our local communities.
4.2.1 Suicide Prevention

Aware of the devastating impact of suicide, some psychological services have introduced a range of related interventions. While APSI and DBT are good exemplars (see the positive practice examples above), given that no one model may suit every community, psychology services have also invested their resources in additional ways to combat suicide locally (see Positive Practice Example 6 below).

Positive Practice Example 6

The North Dublin Assessment and Treatment of Suicidality Project

There are a very limited number of published clinical studies that demonstrate that a specific therapeutic intervention reduces suicidality. Two interventions with demonstrated effectiveness for decreasing suicidal behaviours are DBT and the Collaborative Assessment and Management of Suicidality (CAMS).

CAMS is one of a handful of suicide-specific manualised assessment and treatment approaches.\(^\text{32}\) It is a therapeutic framework which is applied until suicidality resolves. The model is designed to enhance the therapeutic alliance, to target and treat suicidal ‘drivers’ and ultimately eliminate suicidal coping. The CAMS model allows professionals to utilise existing skills sets, while also including suicidality specific elements in the intervention. International evidence supports the efficacy of the model.

North Dublin Mental Health Psychology Services provide clinical and operational inputs to the multi-disciplinary DBT service. The psychology service has also developed a recovery-orientated suicide assessment and treatment service based on the CAMS model. CAMS can be a stepping stone to the North Dublin multi-disciplinary DBT service for some service users, but it is often sufficient in itself to decrease the risk of suicide.

The North Dublin psychologists utilise additional hours under the Haddington Road Agreement to provide a CAMS service to a limited caseload. An immediate response is provided for accepted referrals. CAMS referrals are identified by CMHTs and the acute inpatient unit staff. The psychology service has provided training and support in the delivery of the CAMS model to other mental health professionals; thus increasing service capacity through indirect as well as direct provision.

The effectiveness of the CAMS service provided in North Dublin is under evaluation locally, with the support of the CAMS Suicide Prevention Lab in CUA in Washington USA. The value for money impact of this service provision is currently being assessed.

4.3 Providing Leadership on Mental Health Research

As different health services will vary on a number of important factors (e.g., clinical pressures and priorities, distribution of professions, technology etc.), as might the profile service user populations, a mental health service or therapy in one country may not necessarily be effective or appropriate for another country. It is also important that there is not a dependence on ‘research’ by external consultants who may recommend large-scale top-down reform on the basis of less-than-comprehensive data that is collected over insufficient periods of time. Hence, it is critical that we build an adequate level of research capacity within our mental health services. Doing so will accrue many benefits including identifying areas of service provision inefficiencies and opportunities for improvement. As outlined in Positive Practice Example 7 (see below), psychologists have a strong track record of leading on mental health research in Ireland.
How Psychologists Lead on Mental Health Research

Throughout Ireland, psychology departments are leading on various research projects of national significance. These include:

- The Happiness and Well-Being Study that is a randomised controlled trial of a group-based CBT-positive psychology programme for adult outpatients with major depressive disorder.\(^3\)
- The resource paper on teamwork within our mental health services\(^4\) that is widely used by CMHTs.
- Leading on evaluating our (national) Enhancing Teamwork Project\(^5\) that is using the Mental Health Team Development Audit Tool as the primary measure of teamworking.\(^6\)
- Guidance on suicide prevention.\(^7\)
- Guidance on formulating and using performance metrics in mental health services.\(^8\)
- Guidance on the economic evaluation of our mental health services.\(^9\)
- A randomised controlled trial of computerised CBT.\(^10\)
- The Recovery Context Inventory\(^11\) designed by EVE to support people in mental health recovery.

5.0 Partnership with Other Agencies

Psychologists employed across HSE Divisions and different agencies in Ireland use their disciplinary-links to collaborate together in an essential way to ensure care becomes ‘joined-up’ and no service users ‘fall between the gaps.’ Positive examples of further developing these links are outlined.

While significant organisational change is imminent,\(^12\) psychologists are well placed to promote integrated service provision among the different HSE Divisions and with other external agencies such as the Child and Family Agency.

5.1 Partnership with Primary Care

The majority of mental disorders present to and are treated at a primary care level. These include the significant costs to service users and society of the co-morbid mental health presentations of those with chronic physical conditions (e.g., chronic fatigue, chronic pain, medically unexplained symptoms, and obesity). There is robust evidence that such conditions respond to low-intensity / structured psychological interventions.\(^13\) Psychologists are well-placed to develop and provide such interventions for both chronic mental health and physical conditions.

Core to the successful health care of individuals with mental distress are functional partnerships between our Primary Care and Mental Health Divisions. Psychologists can play a central role in this through:

- **Departmental Liaison**
  Liaison between psychologists working in our Primary Care and Mental Health Divisions provide an obvious avenue for ensuring close relationships between services that reduce the risk of service users ‘falling between the gaps.’
• **Leading on Stepped Care**
  Service developments such as APSI (see Positive Practice Example 1 above) provide a cross-divisional care pathway that ensures service users and their carers get the ‘right level of service, at the right time, in the right place’.

• **Consultation**
  Research\(^4^3\) demonstrates the value of training and ongoing consultation to primary care practitioners by mental health professionals. Psychologists are well placed to contribute to building the mental health competence of our primary care professionals. Given that psychological interventions are the first-line treatment of choice, further to training, empowered primary care professionals can appropriately support service users and their carers.\(^4^4\)

While there are primary care consultation-liaison demonstration sites,\(^4^5\) not all service users need to be seen by relatively expensive and full-to-capacity secondary care staff. However, such sites have resulted in:

- Reduced ‘Did Not Attend’ (DNA) rates.
- Reduced inappropriate referrals to secondary care services, leading to:
  - A reduction in the overall level of resource required to appropriately support service users.
  - An improved service user satisfaction.

### 5.2 Partnership with Health and Wellbeing
Internationally mental health services recognise that promoting mental wellbeing is better for communities and more cost-effective than dedicating the bulk of resources exclusively on treating pathology. Psychologists within the Mental Health Division can play a critical partnership role.

#### 5.3.1 Generating Health Intelligence
Collecting, analysing and evaluating outcome data in a systematic fashion to inform future resource allocation. Psychologists, often as a consequence of their high level of training in research, have been to the forefront in evaluating the outcomes of health-related interventions both from clinical and economic perspectives.\(^3,\(^7\)

#### 5.3.2 Providing Health Promotion and Protection
By undertaking a wide range of psychological and psychosocial interventions, psychologists can promote psychological wellbeing in all. There is an increasing body of evidence that such interventions prevent and reduce the incidence of mental distress in communities including:

- Parenting programmes\(^4^6\)
- School-based interventions (e.g., anti-bullying programmes)\(^4^7\)
- Positive psychology initiatives (e.g., self-esteem, mindfulness groups)\(^4^8^\)\(^5^1\)
- Building resilient communities (e.g., Mens Sheds, Townhall Talks)

#### 5.3.3 Providing Effective Health Interventions
(a) Providing an Understanding of Health-related Behaviour that Leads to Effective Interventions.
Psychologists employ empirically supported psychological models of how biological, sociological and environmental or ‘life event’ factors impact on individuals to affect behaviour and psychological well-being. These models have been utilised to guide the design of interventions central to most health promotion and protection campaigns. These include:

- Health Belief Model\(^5^2\)
- Stages of Change Model\(^5^3\)
- Theory of Planned Behavior\(^5^4\)
- Precaution Adoption Process Model\(^5^5\)
(b) Designing Interventions and Tools that Work.
Psychologists, particularly Health Psychologists and Clinical Psychologists, have been instrumental in designing local and national interventions – and tools for evaluating these interventions – with a high degree of effectiveness (e.g., the Increasing Access to Psychological Therapies [IAPT] programme in the UK;\textsuperscript{56,57} Work of NHS Smoking Cessation Co-Director Professor Susan Michie\textsuperscript{58}).

5.3 Partnership with Child and Family Agency
Psychologists working in the different HSE divisions are acutely aware of how protecting our children, supporting our parents and fostering wellbeing in our families contributes to the health of our communities.

In our Mental Health Division, initiatives that can further develop our partnership with the Child and Family Agency include:
1. Some prioritisation of adult service users who are parents.
2. Consultation to child and family services around best supporting parents with mental health difficulties.
3. Close intra-departmental liaison between psychologists to ensure those working with children work closely with their psychology colleagues in adult services offering input to parents with mental difficulties.

6.0 Moving Forward

Five key challenges currently facing psychology services are outlined. Ten recommendations are made on how psychology services can increase their value to the health service by:
(a) Leading on change within mental health services;
(b) Standardising their current work practices (to maximise their value);
and
(c) Providing additional value to the health service through incorporating ‘New Ways of Working’ with a teamwork and consultation focus.

In planning for the future, there are five key points facing the psychologist workforce in Ireland.

1. The prevalence of mental disorders and level of need in Ireland is substantial.
2. The widespread consensus from research evidence that the vast majority of mental health disorders can benefit from psychological interventions.
3. There is substantial evidence that service users want better access to psychological interventions than is presently available.\textsuperscript{13}
4. The inadequacies of diagnosis alone to inform adequate care planning particularly in relation to prognosis and the response to treatment of co-morbid and complex presentations.\textsuperscript{59,60}
5. The reality that the current psychology workforce, if engaged in direct psychotherapeutic work alone, will reach only a small minority of the cases in need of psychological intervention.
To respond to these realities psychologists need to (a) lead on change within our mental health services; (b) standardise our own work practices (to maximise our value); and (c) add additional value to the health service through incorporating ‘New Ways of Working.’

### 6.1 Lead on Change

Psychologists are well positioned to lead on the roll-out of training in psychological therapies associated with our Clinical Care Programmes; on quality assurance within our mental health teams; and on the overall governance of psychological therapies within our mental health services.

#### 6.1.1 Lead on Clinical Care Programmes

Psychological interventions are a core element of our mental health clinical care programmes. Considerable resources are and will be invested in the development and roll-out of these programmes. There is a significant risk, however, of this resourcing providing little benefit to service users if the governance and structure of these initiatives are inadequate. In particular if these resources are invested in the training of individuals without pre-existing foundation-level psychological expertise; no protected time to practice such skills; no commitment to use such skills post-training; or no adequate long-term supervision strategy, then such investment may provide minimal return and potentially lead to unsafe clinical practice.

Psychologists, with their advanced competence in psychological interventions and already playing a central role in community mental health teams, could manage the above risks by leading on the governance of the psychological treatment elements of our clinical care programmes. Such leadership⁶ could involve:

- Regional audit of pre-existing skills.
- Establishment of organisational commitment to supervision and skill usage.
- Establishment of supervision networks.
- Provision of training in a focused, strategic fashion (e.g., ‘train the trainers’ first, prioritising roles most likely to be able to use these skills).
- Monitoring of skill usage/service provision and supervision post-training.

Psychologists could ensure that such resources lead to sustainable returns for the organisation through providing governance, oversight and monitoring on how such programmes are provided ‘on-the ground’ in their local regions and teams.

**Recommendation 1:** Assign a Principal Psychologist⁷ in each service area to lead on the roll-out of training in psychological therapies associated with our Clinical Care Programmes.

#### 6.1.2 Lead on Quality Assurance within Teams

With their strong academic and research competencies psychologists are well placed to lead on assessing and reporting on quality metrics within our mental health teams. This could include:

- Auditing evidence-based practice (adherence to clinical care programmes).
- Auditing service user feedback.
- Auditing, at a service area level, staff satisfaction/team cohesion.

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⁶ Such leadership would have no line management implications for multi-disciplinary team members; would only pertain to clinical issues; and could be clearly defined through a service level agreement to deliver supervision, to report on poor practice and to offer guidance in the choice and implementation of psychological interventions.

⁷ The term ‘Principal Psychologist’ pertains to both Principal Psychologist Managers and Principal Clinical Psychologists (in Mental Health).
• Auditing mental health team functioning.\textsuperscript{35}
• Developing annual action plans to respond to highlighted deficits.
• Presenting such information and associated recommendations to the Area Mental Health Management Teams. To increase efficiencies, much of this work could be undertaken by Research Assistants, as is the case with the current national evaluation of our Enhancing Teamwork Project.

\begin{tabular}{|p{0.9\textwidth}|}
\hline
\textbf{Recommendation 2}: Assign to Principal / Senior Psychologists in each team responsibility for assessing the service’s performance on core quality measures; using this performance data formulate an annual report with recommendations; and present this to the local Area Mental Health Management Team. \\
\hline
\end{tabular}

6.1.3 \textit{Lead on the Overall Governance of Psychological Therapies}
In the context of the under-utilisation of psychologists’ knowledge and skills,\textsuperscript{61} the provision of psychological therapies in our mental health teams may be best governed by psychologists. If this is agreed, this may entail psychologists stepping out of their discipline-specific structures to take on responsibility for the safety and quality of psychological interventions offered by other disciplines. Reciprocally, this would mean other disciplines acknowledging the importance of adhering to a shared, multi-disciplinary, service-wide code of practice around the provision of psychological therapies. This could also entail psychologists identifying unmet need in relation to psychological interventions, and liaising with senior colleagues across disciplines to ensure that such needs are met.

Our Principal Psychologists, and in particular those who are members of our Area Mental Health Management Teams, may be the professionals best suited, within the organisation, to hold overall responsibility for the provision of psychological therapies within their region. This would entail auditing what therapies are being provided; highlighting unmet needs; formulating a feasible action plan to improve services to remedy these; and presenting this plan to the Area Mental Health Management Team (see Appendix D for more details).

\begin{tabular}{|p{0.9\textwidth}|}
\hline
\textbf{Recommendation 3}: That the Principal Psychologist in each service area hold responsibility for the governance of psychological therapies offered by their area; and that a Principal Psychologist within the Integrated Service Area hold overall responsibility for the provision of psychological therapies within that service area. \\
\hline
\end{tabular}

6.2 \textit{Standardise What Psychologists Do}

6.2.1 \textit{Develop Efficient, Standardised Work Processes}
An acknowledgement of the shortfall between existing resources and the demand for psychological therapies brings with it an obligation both to make the case for the resourcing set out by \textit{A Vision for Change}\textsuperscript{13} (see Recommendation 10) but also to maximise use of our current resources.

A range of measures have been explored and researched towards achieving this latter goal.\textsuperscript{7,33} These have focused on:

(a) Improved prevention services. Working at a community level to improve psychological wellbeing in our communities.

(b) Systems to best match ‘the right level of intervention with the right presentation’ in a timely fashion based on high quality assessments. These systems have included:
- A standardised referral system (e.g., formulation and implementation of agreed inclusion / exclusion criteria);
- Standardised initial assessments; and
- A standardised waiting list management system.

(c) Systems to maximise the value a community receives from the limited psychotherapy resource by implementing measures such as:
- Stepped care models of service input;
- Providing guidance on efficient work activities (e.g., appropriate time allocated to consultations /supervision/training, appropriate clinical caseload sizes); and
- Providing guidance on the existing evidence on what presentations need greater or lesser resource allocation to bring about therapeutic change.

6.2.2 Develop a Standard Operating Procedure, ‘Role Description’ for How Psychologists can Add Value for the Service in which they Work.

Services may struggle to understand the wide range of skills and capacities that psychologists bring to their service provision role. This can result in their being under-utilised and restricted to a narrow psychotherapeutic or psychometrician role within their service.

Providing a more detailed outline of what psychologists can offer different services has the potential for expanding their role within our health services in a manner that would increase their value to the service and improve the variety and quality of their work.

**Recommendation 4:** Help maximise the capacity of individual psychology services by producing a suite of guidance on good practice as relates to operating procedures and that standard operating procedures or ‘role descriptions’ are formulated for each of the different services within which psychologists work.

6.2.3 Develop a Core Suite of Metrics.

Psychologists have historically been acutely aware of the need to justify the importance of their work through undertaking rigorous evaluations at both clinical trial and local service levels. It is as a consequence of this commitment to a scientist-practitioner model\(^G\) that such a body of evidence supporting psychological interventions now exist.

Nevertheless, it is important that the compilation of service level data is not undertaken in different ways across services, thereby precluding any meta-analysis. It is therefore important that a core suite of metrics is compiled for every psychology service.

In addition to standard measures such as waiting time for first appointment and type of intervention offered, it is important to have performance metrics such as frequency and type of supervision (offered and received); amount and type of CPD undertaken; and quantity of consultation / training to other professionals provided. Clinical outcome data related to service user satisfaction and the meeting of service user goals may also be relevant to every service. It would be ideal to have a designated research assistant WTE post assigned to regularly conduct online surveys so that this data is collected.

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\(^G\) Core tenets of the this model included in the current Boulder Model include giving psychological assessment, testing, and intervention in accordance with scientifically based protocols; accessing and integrating scientific findings to make informed healthcare decisions for patients; questioning and testing hypotheses that are relevant to current healthcare; building and maintaining effective cross-disciplinary relationships with professionals in other fields; research-based training and support to other health professions in the process of providing psychological care; and contributing to practice-based research and development to improve the quality of health care.\(^61\)
Recommendation 5: A core dataset is compiled by every psychology service in the HSE, encompassing measurement of factors such as waiting times for psychological therapies; type of intervention offered; service user clinical outcomes; and supervision, training and consultation provided. Psychologists should also lead on researching other economic data (e.g., cost of treating each service user; medical offset costs).

6.2.4 Develop Standardised Professional and Ethical Guidelines for Best Practice Working within Mental Health Services and Structures for Raising Concerns

Mental health service provision is complex and staff are often challenged to make decisions in uncertain and ambiguous situations. Central to guiding all multi-disciplinary team members in such a context has to be the provision of a set of core professional and ethical guidelines to which all team members can refer. These would include guidance on the appropriate means of formally raising concerns when these arise.

While professional-specific codes of ethics can usefully provide overarching principles, multi-disciplinary team members working in diverse contexts can benefit from more explicit guidance on how such principles may apply in their service area. Moreover, any code of ethics by its nature requires interpretation and in this regard team members would benefit from guidance on how best to apply such principles to specific situations.

Recommendation 6: To best protect service users and guide multi-disciplinary team members, and in keeping with overarching ethical guidelines, formulate principles of best practice relating to each service area. An ethics panel including Principal / Senior Psychologists should be established to provide ethical guidance to individual practitioners in relation to specific situations.

6.3 Add Value in ‘New Ways of Working’

6.3.1 Train and Supervise Others in Psychological Interventions

It is apparent that only by working closely with multi-disciplinary colleagues can the volume of need for psychological interventions be met.

Many low-intensity interventions can appropriately be undertaken by disciplines other than clinical psychologists. Clinical psychologists’ time dedicated to interventions that can be undertaken by other professionals invariably results in less resources being available to consult and engage with service users with more complex presentations.

A clear distinction in a stepped-care model needs to be established, and formalised in assessment tools, between psychological interventions that can be undertaken by those with generic training (e.g., psycho-educational groups) and those required specialist psychotherapeutic skills. The overall level of expertise in common psychological interventions in mental health teams needs to be developed and supported by psychologists in the team. The development of formal training programmes may aid this process.

Recommendation 7: A central element of all psychologists work should be the training and ongoing supervision/support of others in generic psychological interventions not requiring specialist psychotherapeutic input.

6.3.2 Provide Consultation to Teams – Formulate Complex Presentations

The recognition that diagnosis alone is inadequate to guide adequate care planning (particularly in complex presentations) for service users has highlighted the importance of
individualised formulations. Psychological formulations are typically critical to developing individualised, practical care plans that aid teams immensely in their work with service users.

While many multi-disciplinary team members already use assessment data to develop case formulations, by developing multidisciplinary formulation workshops (e.g., on a weekly or fortnightly) psychologists may contribute to increasing the capacity of teams to formulate on cases, especially those that are complex. Already operating in many service areas, such workshops are widely valued.

**Recommendation 8:** Psychologists should develop processes (e.g., formulation workshops; case consultations where presentations are complex) to facilitate mental health teams increasing their capacity to formulate cases in a psychological manner.

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### 6.3.3 Develop Recovery-Oriented Services through Innovative Service Developments

Psychologists’ robust training in holistic understandings of mental distress leave them well placed to play a key role in fostering recovery-oriented services. Examples of good practice have been highlighted above but to enhance the overall impact of such skills it would be important that all psychologists actively promote the provision of recovery-oriented mental health services.

**Recommendation 9:** Psychologists should lead on fostering recovery-oriented services as a central part of their role within teams.

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### 6.3.4 Develop a National Workforce Plan.

There is a need to develop a National Workforce Plan capable of meeting these New Ways of Working though enhanced training and increased training numbers until compliant with *A Vision for Change* recommendations. The significant shortfall between current workforce numbers and that set out as required by *A Vision for Change* is stark and places at risk much of the potential value that psychology can bring to our health service. However, the training of clinical psychologists will also need to take into account the renewed emphasis on the consultation, training, supervision and leadership skills required of psychologists, in addition to their traditional psychotherapeutic, research and psychometric skills. A national workforce planning document could both set out how best to sustainably increase numbers to that set out by *A Vision for Change* and also enhance training to meet these additional requirements.

**Recommendation 10.** Develop a national workforce plan on how best to meet the workforce numbers required to be compliant with Vision for Change and to advise on training requirements for the next generation of psychologists.
References


Appendix A – Working Group

Eamonn Butler  Principal Psychologist Manager, HSE Mid-West
Dr. Michael Byrne  HSE Lead for Psychology / Principal Psychologist Manager, Laois / Offaly ISA, HSE Dublin Mid-Leinster
Prof. Alan Carr  Professor of Clinical Psychology / Head of the School of Psychology, University College Dublin
Dr. Padraig Collins (Lead Scribe)  Advancing Recovery in Ireland (ARI) National Project Manager, HSE / Senior Clinical Psychologist, Adult Mental Health Services, Galway/Roscommon ISA, HSE West
Dr. Linda Finnegan  Principal Psychologist and Psychotherapist, St. James’ Hospital, HSE Dublin Mid-Leinster
Donna McGinley  Principal Psychologist Manager, North Dublin ISA, HSE Dublin North East
Dr. Eddie Murphy  Principal Psychologist Manager, Carlow / Kilkenny ISA, HSE South
Appendix B – Sample of International Guidelines that recommend Psychological interventions as central to the treatment of a mental disorder

Table 4. Sample literature recommending psychological interventions.

| National Institute for Clinical Excellence (NICE) – England & Wales | Depression<sup>43</sup>  
Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults<sup>64</sup>  
Common mental health disorders<sup>2</sup>  
Social anxiety disorder<sup>65</sup>  
Depression in adults with a chronic physical health problem<sup>66</sup>  
Computerized cognitive behaviour therapy for depression and anxiety<sup>67</sup>  
Post-traumatic stress disorder<sup>68</sup>  
Obsessive Compulsive Disorder<sup>69</sup>  
Eating Disorders<sup>70</sup>  
Bipolar Affective Disorder<sup>71</sup>  
Schizophrenia<sup>72,73</sup> |
| --- | --- |
| Scottish Intercollegiate Guidance Network (SIGN) - Scotland | Non-pharmaceutical management of depression<sup>74</sup>  
Management of schizophrenia<sup>75</sup>  
Management of perinatal mood disorders<sup>76</sup>  
Management of patients with dementia<sup>77</sup>  
Bipolar affective disorder<sup>78</sup> |
| U.S. Preventive Services Task Force (USPSTF) - USA | Screening for Depression: Recommendations and Rationale<sup>79</sup>  
Screening for Illicit Drug Use<sup>80</sup>  
Counselling and Interventions to Prevent Tobacco Use and Tobacco-Caused USPSTF Disease in Adults and Pregnant Women<sup>81</sup>  
Screening and Behavioral Counselling Interventions in Primary Care to Reduce Alcohol Misuse<sup>82</sup>  
Screening for Dementia: Recommendations and Rationale<sup>83</sup>  
Screening and Treatment for Major Depressive Disorder in Children and Adolescents: Recommendation Statement<sup>84</sup>  
Screening for Suicide Risk: Recommendation and Rationale<sup>85</sup> |
| National Health and Medical Research Council (NHMRC) - Australia | Depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period<sup>86</sup>  
Management of Borderline Personality Disorder<sup>87</sup>  
Clinical Practice Points on the Diagnosis, Assessment and Management of ADHD in Children and Adolescents<sup>88</sup>  
Clinical Practice Guidelines: Depression in Adolescents and Young Adults<sup>89</sup> |
### Appendix C – Psychology Staffing Requirement

Table 5. Psychology staffing requirement using 2013 census data

<table>
<thead>
<tr>
<th>Team / Unit</th>
<th>Total population per team</th>
<th>Number of teams</th>
<th>Psychologists per team</th>
<th>Number of psychologists</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General CMHT</td>
<td>1 per 50,000</td>
<td>92</td>
<td>2</td>
<td>184</td>
<td></td>
</tr>
<tr>
<td>Eating disorders CMHT</td>
<td>1 per 1,000,000</td>
<td>4.5</td>
<td>2</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation CMHT</td>
<td>1 per 100,000</td>
<td>46</td>
<td>2</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Early intervention CMHT</td>
<td>2 teams</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Adult liaison service</td>
<td>1 per 300,000</td>
<td>15</td>
<td>2</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Neuro-psychiatry</td>
<td>2,000,000</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>323</td>
</tr>
<tr>
<td><strong>Child &amp; adolescent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMHTs</td>
<td>50,000</td>
<td>92</td>
<td>2</td>
<td>184</td>
<td></td>
</tr>
<tr>
<td>Liaison teams</td>
<td>8</td>
<td>8</td>
<td>2</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Eating disorder team</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>In-patient service</td>
<td>20 beds per unit</td>
<td>5 units</td>
<td>4</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Substance misuse &amp; dependency</td>
<td>1,000,000</td>
<td>4.5</td>
<td>1</td>
<td>4.5</td>
<td>226</td>
</tr>
<tr>
<td><strong>Mental health of ID CMHTs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMHTs – Adult</td>
<td>2 teams per 300,000</td>
<td>31</td>
<td>2</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Children &amp; adolescents</td>
<td>1 team 300,000</td>
<td>15</td>
<td>2</td>
<td>30</td>
<td>92</td>
</tr>
<tr>
<td><strong>Mental health services for older people</strong></td>
<td>1 per 100,000</td>
<td>46</td>
<td>1</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td><strong>Difficult to manage patients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive care rehab teams</td>
<td>1,000,000</td>
<td>4.5</td>
<td>2</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td><strong>Forensic mental health services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forensic teams</td>
<td>1,000,000</td>
<td>4.5</td>
<td>2.5</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Forensic teams – Child &amp; adolescent</td>
<td>2 teams</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Forensic teams – ID</td>
<td>1 team</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td><strong>CMHTs for people with co-morbid mental illness &amp; substance abuse</strong></td>
<td>1 per 300,000</td>
<td>15</td>
<td>1</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td><strong>Mental health services for homeless people</strong></td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>730</td>
</tr>
</tbody>
</table>

1. Abbreviations: CMHT=Community Mental Health Team. ID=Intellectual Disability.
2. As applied to population of 4,593,100.90
Appendix D – Provision of Overall Governance of Psychological Therapies

While governance arrangements would need to be negotiated to meet the needs of all multi-disciplinary team members, the below illustrates one potential configuration of same with respect to Recommendation 3.

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HPSI Representative / National Lead</strong></td>
<td>• Responsibility for developing appropriate policy on psychological interventions in particular clinical care programmes and their roll-out.</td>
</tr>
<tr>
<td><strong>Principal Psychologist on AMHMT</strong></td>
<td>• Responsibility for developing appropriate policy on how psychological interventions are to be implemented in that ISA as per CCP or evidence-based guidelines. Policy to encompass areas such as adequate training, supervision and support for practitioners. Policy to be signed off by AMHMT.</td>
</tr>
</tbody>
</table>
| **Senior Psychologist in CMHT**           | • Responsibility for leading on providing supervision/support as per ISA and national policy on particular psychological interventions.  
• Responsibility for auditing local compliance with recommendations (to feedback to AMHMT). |
| **Individual Practitioner**               | • Responsibility for individual clinical work.  
• Responsibility for being aware of limits of competency and seeking support/supervision when appropriate.  
• Responsibility for responding appropriately to any advice/direction provided.  
• Responsibility for acting within professional and ethical guidelines. |

At each point the level and limits of responsibility would have to be clearly defined. For example, Senior Psychologists would not be responsible for an inappropriate clinical decision by a nursing CBT therapist, but would be responsible for offering fortnightly group supervision (if that was the ISA policy); and Principal Psychologists would not be responsible if a Senior Psychologist decided to ignore the policy on providing group supervision but they would be responsible if no such policy existed around supporting practitioners.