

Advancing Community Mental Health Services In Ireland

GUIDANCE PAPERS

Prepared by the
HSE National Vision for Change Working Group



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



A Vision for Change
ADVANCING MENTAL HEALTH
IN IRELAND



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Foreword

The past 6 years have seen Mental Health Services grapple with the challenge of re-orientating from a hospital and bed based focus to developing the structures and processes required for community based services in line with national policy as laid out in *A Vision for Change*. Current policy was adopted at a time of unprecedented national prosperity and reflects the expectation of substantial additional investment in mental health services in the lifetime of its implementation. While there has been a significant investment in infrastructure through capital projects in the intervening years the reorientation of services continues to face the challenges of a dwindling human resource base and depleting annual budgets. In the background the overall health service delivery infrastructure has continued to undergo continuous organisational restructuring resulting in a less than optimal platform for the support of the fundamental change management project required to move mental health service delivery from the bedside to the fireside.

Individual mental health services have been addressing the change agenda variously according to the circumstances and challenges particular to their different situations. Some are further along the road than others in developing a comprehensive infrastructure for the delivery of community based mental health services. The guidance contained in this publication borrows a great deal from the pioneering work being done by these services.

The HSE National Service Plan for 2012 commits to the re-investment of €35m in mental health services, largely accounted for in permission to recruit an additional 400 multi-disciplinary staff to professionally complete community mental health teams at both general adult and child and adolescent service level. This constitutes a significant opportunity to boost the capacity of community mental health teams and therefore the potential to re-orient services towards a community based delivery model.

In the context of such an investment it is important to set targets for expected changes in the configuration of local mental health services commensurate with national policy and the changing expectations of service users, carers and families, primary care services and other stakeholders in the mental health arena. Area Mental Health Management Teams will be expected to provide leadership, direction and support to services locally in the achievement of the targets and will be asked to report on progress on a regular basis.

Targets for change are:

1. Establishment of professionally complete community mental health teams
2. Rapid access to emergency assessment in the community and prompt access to routine assessment
3. Availability of day hospital care and treatment on a seven day week basis
4. Improved effectiveness and efficiency of care and treatment through the implementation of the clinical programmes in mental health
5. Significant reduction in acute inpatient admissions
6. Significant reduction in length of stay for acute inpatient admissions

These guidance papers have been in development by the National Vision for Change Working Group through a variety of sub groups in consultation with the National Strategic Management Group for Mental Health over the past year. Other guidance papers are still in development and will be published and distributed electronically as they are completed in the course of the year. It is our hope that the completed set of guidance papers will prove to be a useful resource to all services in the achievement of the targets set out above and the continuing work of developing the infrastructure for the delivery of high quality community based mental health services.



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May 2012

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Components of Acute Community – Based Secondary Mental Health Care



Prepared by a subgroup of the
National Vision for Change Working Group
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Executive Summary

Service users' needs will vary depending on whether they are in an acute, stabilisation, or recovery phase of their mental health presentation. To respond to these changing needs, and as highlighted in *A Vision for Change*, all stakeholders need to clearly understand both the function of the stand-alone elements of acute community-based secondary mental health care and how these interface with each other to provide a seamless continuum of care.

Chapter one of this resource document highlights the need for the culture of service planning and delivery to be underpinned by a variety of key principles including recovery; meaningful service user and carer involvement at all levels, community partnership and development, social inclusion and inter-disciplinary working.

Chapter two describes how Community Mental Health Teams (CMHTs) is the basic unit of service delivery and how this, and other elements of the continuum of care, need to work together to ensure that service users' needs are met in accordance with their phase of recovery.

Chapter three sets out the pivotal role of the service user and carer in the planning and development of services and some of the challenges that must be addressed in seeking to establish this role.

The respective chapters on assertive outreach and crisis resolution / homecare teams address two elements of service often confused and interchanged and seeks to clarify the distinction between them, and to indicate the role of both in the provision of comprehensive acute secondary community-based mental health care. This distinction is often further complicated by reference to the term 'home-based treatment', that we interpret as pertaining to the intervention of the mental health service that takes place in the home of the service user.

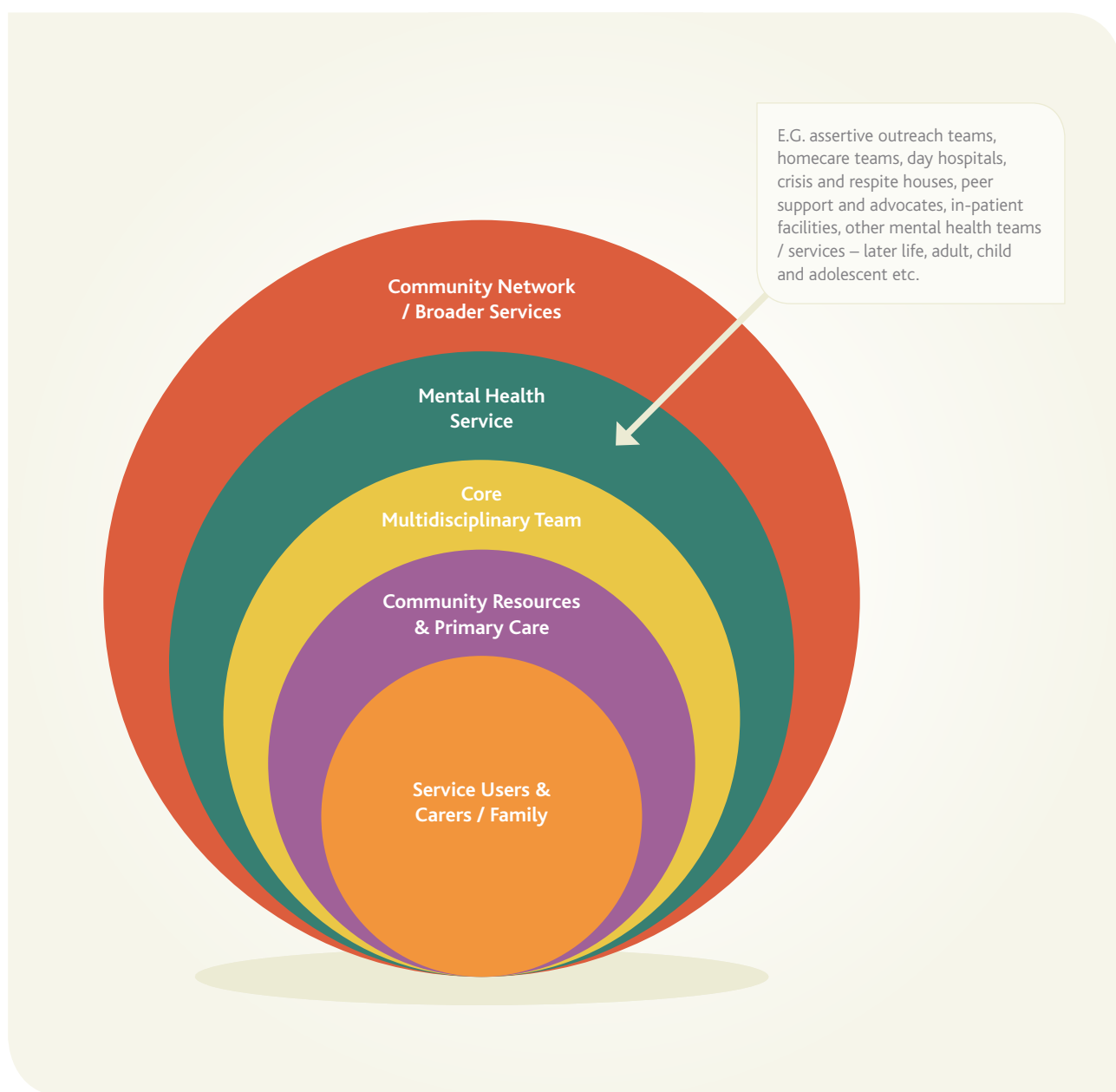
Chapter six outlines what a day hospital is and references outpatient clinics as a component of community-based service. Chapter seven delineates the parameters of a crisis house and considers the related matter of respite care. Chapter eight addresses how the purpose and function of the day centre might be reframed on a larger, more socially inclusive and recovery-oriented canvas.

Chapter 1: Introduction

It is considered good practice to provide care for individuals experiencing acute mental health difficulties in the least restrictive environment, with the minimum disruption to their lives. In the majority of cases, service users and carers prefer community treatment (Dunne, 2006; Hoult, 1986; O’Shea & Kennelly, 2008), though it is not necessarily cheaper or better. However, community-based care is supported by international literature and as a model is more accessible and facilitates full participation and integration of service users within the community (World Health Organisation; WHO, 2007).

A Vision for Change (Department of Health & Children, 2006) recommends that integrated care is provided to service users in the context of their local community and that this is delivered primarily through Community Mental Health Teams (CMHTs), each of which typically caters for a population of 50,000. For CMHTs to be effective, it is vital that the vision and goals of community-based treatment are shared by the team and reflected in its development (de Burca, Armstrong, & Brosnan, 2010). Teams need clearly defined goals and robust governance structures as well as agreement regarding their model of clinical responsibility to be effective (Byrne & Onyett, 2010).

Figure 1. Service users’ expanded environment (Byrne & Onyett, 2010).





Where CMHTs are in place, further developments in homecare, crisis resolution, assertive outreach and early intervention teams have begun to spread across the country. It is while those teams are in the developing stages that they need to ensure that the principles of recovery are central to their functioning (Care Services Improvement Partnership; CSIP, Royal College of Psychiatrists; RCPsych, & Social Care Institute for Excellence; SCIE, 2007; Shepherd, Boardman & Slade 2008).

Vision

Our vision (Department of Health & Children, 2006) is to facilitate and promote service user recovery. In the context of multi-disciplinary teams, this can be achieved by providing a continuum of stand-alone service elements that both integrate with one another and with the different systems within which service users live (see Figure 1).

Values and principles

To facilitate service users achieving recovery in a variety of life domains, the culture of our mental health services needs to be underpinned by a variety of key principles, particularly at the point of assessment and care planning:

Accessible

Services need to be accessible where and when required (e.g., outside of the traditional 9am-5pm working day).

Accountability

Services need to be answerable to service users, carers and the wider public.

Continuity

Services need to work with other health services, and with social and community services to ensure delivery of a seamless continuum of care.

Co-ordination

Individualised care plans developed in partnership with service users which outline clear goals and co-ordinated interventions are needed to meet the full range of service user and carer needs. Agreeing such plans will obviate the need for service users to have to negotiate a new set of assessments and approaches at each stage of their journey (RDO, HSE South, 2011).

Carer involvement

Mental Health Services are carer-centred. The term 'carer' no longer equates to just the families of service users. This term can also describe other significant social supports (e.g., a friend, the local newsagent; Byrne & Onyett, 2010). Carers play a crucial role in mental health service provision and this needs to be formally recognised and supported if service users consent to same.

- Carers need to be empowered as team members, receiving information and support as appropriate (MHC, 2008).
- Involve carers as equal partners in every aspect of service delivery and development. For example, they need to be meaningfully involved in the care planning process, discharge planning etc.

Community partnership and development

The community itself is a valuable resource (Department of Health & Children, 2006) with a range of community services required to augment the core interventions provided by CMHTs (see Figure 1). Many community services are supplied by the voluntary sector, including advice and information services, advocacy services, befriending and voluntary schemes, self-help groups and service user groups (Boardman & Parsonage, 2007).

The community development model promotes a partnership approach. CMHTs need to develop partnerships with their local community and voluntary groups as well as at a higher interagency level (Combat Poverty Agency, 2007). This partnership must include service users and due attention must be given to the process of this partnership to ensure it does not become hierarchical or therapeutic in nature (National Disability Authority, 2005).

Through partnerships, it is possible to reduce stigma, create new community-led resources and develop new connections between individuals, groups and organisations (Seebohm & Gilchrist, 2008):

- Multi-disciplinary team members need to:
- Establish a detailed understanding of all local resources relevant to the support of service users they work with.
- Develop positive partnerships and active communication with key agencies and voluntary groups in the community as well as mainstream health services (e.g., primary care teams and other referring agents); social welfare; education services and housing authorities (MHC, 2007).
- Spend time liaising with primary care staff in establishing referral practices and developing shared care for individuals with complex presentations (Burns, 2007).
- Regularly review these liaison arrangements (Burns, 2007).
- Build community capacity by developing the abilities and skills of the members of the public and organisations in such a way that they are better able to identify and help meet the needs of people using mental health services (Department of Health, 2005). This can include providing learning and training opportunities; helping develop structures and providing practical support e.g. to housing providers.

Comprehensiveness

Services need to address all those areas of an individual's life that are important to him / her (e.g. occupation/work, leisure, finance, housing, ongoing learning, community life and spiritual needs)

Effectiveness

Services need to meet the mental health requirements of service users and support requirements of carers by delivering the intended benefits of evidenced-based interventions.

Equity

Resources need to be distributed in proportion to service user and carer needs. Informed by local assessment of service users' needs (Department of Health, 2002), this includes ensuring mental health teams are appropriately staffed and have an adequate skill-mix to meet the diverse needs of local service users and their carers.



Inter-disciplinary working

All stakeholders, whether they work in secondary care mental health services, primary care and/or other health services, need to work in an inter-disciplinary manner or one where outcomes are a product of both individual and interdependent (or collective) outputs (Byrne & Onyett, 2010; Department of Health, 2005).

Recovery

Recovery is about building a meaningful and satisfying life, as defined by the service user, whether or not there are ongoing mental health symptoms or problems (Shepherd, Boardman, & Slade, 2008).

- › Community-based services need to acknowledge that:
- › Service users must lead their own recovery. This needs to be reflected in the routine practice of all staff and services, whereby service users are facilitated to make personal choices, have hope and personal control.
- › Recovery values and concerns of service users need to be centre stage.
- › A comprehensive individualised multi-disciplinary care plan needs to be drawn up in partnership with each service user and his/her carers.
- › All services and all staff interactions need to generate and sustain hope, and maintain the dignity of service users even in the midst of crisis (Mental Health Commission; MHC, 2008).
- › Services must enhance service users' social inclusion and opportunities to take on meaningful and satisfying roles in local community life. This highlights the importance of education, employment, housing, leisure etc.
- › Audit of services, including measuring recovery outcomes and whether training is provided as necessary, is crucial.

Service user involvement at all levels

Community-based secondary mental health staff need to work effectively with service users as equal partners (SCMH, 2009):

- › Ensure services are centred primarily on providing the best possible support to service users and carers.
- › If they so desire, involve service users as equal partners in every aspect of service delivery and development. For example, they have the right and ability to make decisions and choices for themselves.
- › Enable the growth of a strong consumer voice and acknowledge that services must be built around the needs of the people using them.
- › Value the legitimacy of expertise related to personal and lived experience.
- › Assist service users in developing new skills and confidence to be equal partners.
- › Schedule regular forums and meetings between service users and staff.
- › Actively involve service user organisations (e.g., the National Service Users Executive, the Irish Advocacy Network) and other agencies.
- › Staff need to acknowledge service users self-defined priorities and create a culture within services that supports this.

Social inclusion

A community-based mental health service recognises that social and economic factors (e.g., housing, employment) all impact on mental health and recovery. Therefore, all community services need to work in an integrated manner (Minister of Health, 2005).

- Community outreach that integrates mental health services into ordinary health and other community settings e.g., libraries, homes and schools can reduce stigma associated with other forms of mental health care (Sainsbury Centre for Mental Health; SCMH, 2006).
- All community resources should be used effectively to maximise real inclusion (MHC, 2007).
- The importance of the ability to manage one's own life as well as good relationships, physical well-being, education, employment, alongside the reduction in clinical symptoms should be emphasised.
- Interventions resulting in access to education (formal / adult education), employment are particularly important (SCMH, 2009).
- Enabling and supporting service users access local community resources e.g. leisure centres, sports, cultural, faith centres, libraries is also important in promoting meaningful inclusion in local communities (SCMH, 2006).

Value-for-money

Resources need to be utilised in a way that maximises their impact. For example, rather than employing highly-paid specialist staff, secondary care services need to employ peer or mental health support workers to better support service users in achieving independent living and integration into their local communities (Department of Health, 2005; MHC, 2007).

Timely

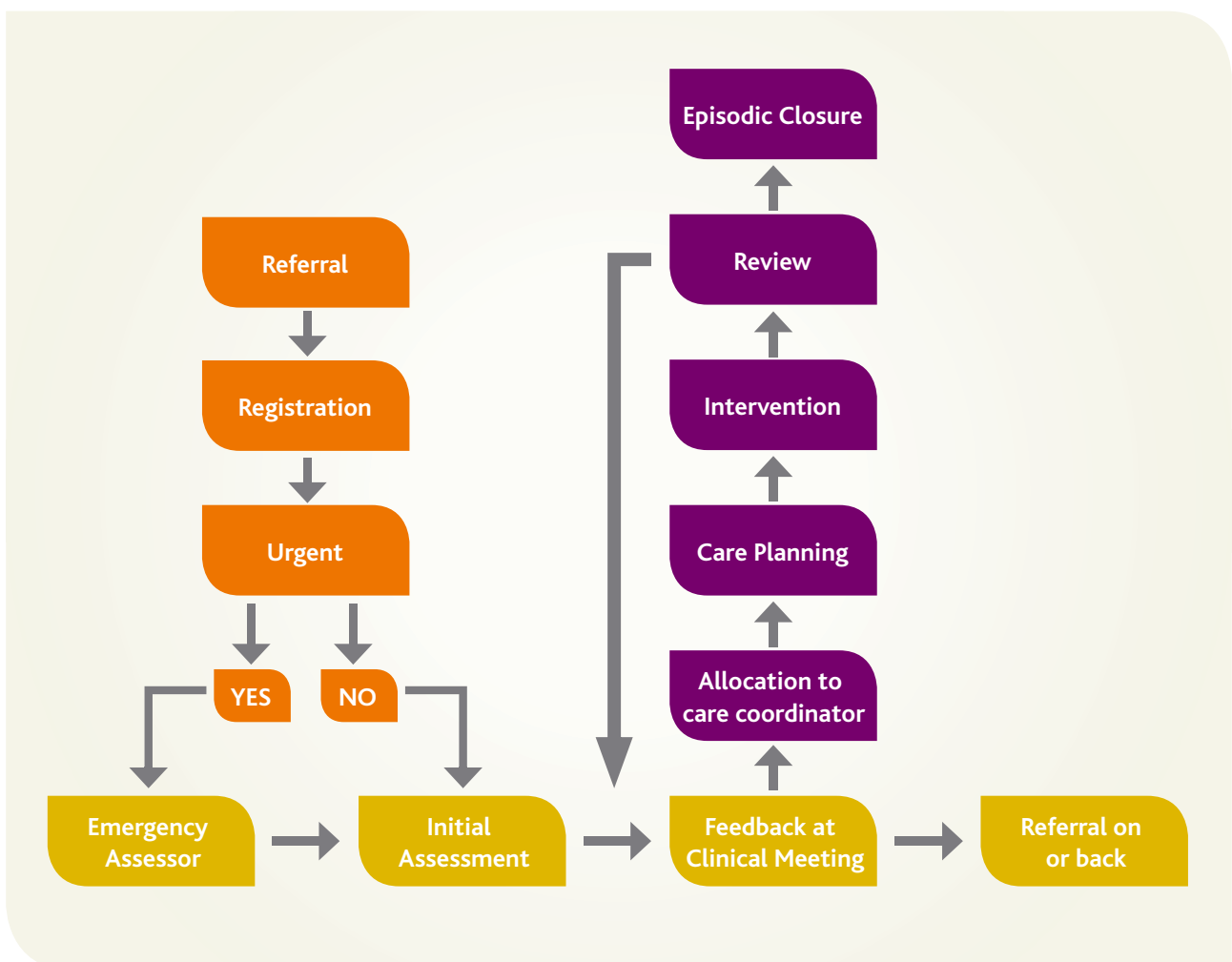
Services need to be provided as soon as possible in order to minimise dependency on services and ensure that opportunities to work with issues in context are fully realised.

Chapter 2: The Continuum Of Care Components

Community Mental Health Teams

The mainstay of any mental health service is the sector-based (generic) Community Mental Health Team (CMHT), each of which typically caters for a catchment population of about 50,000 (Department of Health & Children, 2006). Most CMHTs are likely to include representation from administration, clinical psychology, nursing, occupational therapy, psychiatry, social work and support workers. Along with vocational and benefit advisers, such input can be augmented via input from assistant grade professionals who can engage in a specific range of tasks under supervision. There may also be a need for the technical expertise of other professionals including addiction counsellors, psychotherapists, and speech and language therapists to fulfil team goals. All this needs to be informed by local needs assessments and by what other services are available locally (Byrne & Onyett, p.19).

Figure 2. Example of the process of work in a mental health team.



Subsequent to referral (e.g., by primary care or Accident and Emergency Department staff), CMHT team co-ordinators facilitate intra-team discussion of how to best manage referrals. Following initial assessment, service users enter into a process of negotiation with their care co-ordinator (or keyworker) regarding their care plan and what component(s) of service they might access. This process is influenced by what services are available locally. Intervention may involve a uni- or inter-disciplinary assessment, and/or further input from one or more professions. If there is clinical improvement, service users can be discharged back to primary care (see Figure 2; Byrne & Onyett, 2010).

Moving towards recovery-focused practices requires a significant shift in how the multi-disciplinary teams make collective decisions and how they collaborate to support service users' aspirations (Dunne, 2006). To promote partnership working, shared broad explanatory models of mental ill health are required so that the lived experience of service users is understood from all perspectives (e.g., service users, clinicians and carers; Randall et al., 2009). Ideally, teams will collaborate to support service users' strengths and enhance their coping skills, while also understanding how each individual professional team member contributes to the whole team service user collaboration process. To ensure effective collaborative working, training of professionals in a recovery ethos based on values is required (Lakeman, 2010).

Services working together

While the structure of this document may convey the perception of stand-alone service components, the needs of service users/carers will only be met to the extent that these services work in an integrated manner.

Some mental health services will be characterised by (generic) CMHTs co-ordinating a range of interventions in a variety of locations (e.g., out-patient clinics, day centre, home-based intervention, day hospital, crisis house, residential care) and interacting with and liaising with other services (e.g., primary care, voluntary organisations). Other more well-developed mental health services may have specialist stand-alone teams (e.g., assertive outreach teams, psychiatry of later life) in addition to their mainstay CMHTs (see Figure 3 on page 16). Where such specialist developments take place it is important that the work processes of the various teams mirror each other as closely as functionally possible to ensure minimum disruption to the service user and carer experience for those who have to navigate between them at various stages in the recovery journey.

To minimise the potential of different specialised teams or services providing fragmented care to the same group of service users (McGlynn & Flowers, 2006), robust intra- and inter-team communication is required along with regular reviews (e.g., MHC, 2010) to ensure that service users' changing needs are met (i.e. moving on to more appropriate services/facilities) in accordance with their phase of recovery (i.e., acute, stabilisation, stable, or recovery). Where the interface between the service components are clear, each component will have specified aims and objectives that when put together meet the requirements of the service user and therefore the whole service's objectives. There will be no duplication of roles and there will be clarity as to how the teams communicate with one another (see Table 1; McGlynn & Flowers, 2006). The appointment of team co-ordinators and the development of effective co-ordinating mechanisms are critical success factors for such interface management.

While some service users may require attendance at day centres to assist with recovery or maintaining well being, it is preferable that pro-active efforts are made to integrate them into their local community supports so that social support is provided in normative community facilities. As the spread and reach of community mental health services are developed, former mental health day care centre functions, where required, need to transfer to and be managed by, the voluntary sector so as to refocus service users' everyday lives within the community. To cater for those with more serious and enduring mental health presentations, community mental health services will seek to develop an assertive outreach function. If these service users present in crisis, services preferably will provide a crisis resolution and home treatment option, supported by day hospital facilities. If service users further decompensate, crisis and/or respite housing will be necessary to prevent in-patient admission (and as a step-down from the latter).



Figure 3. Continuum of mental health services.

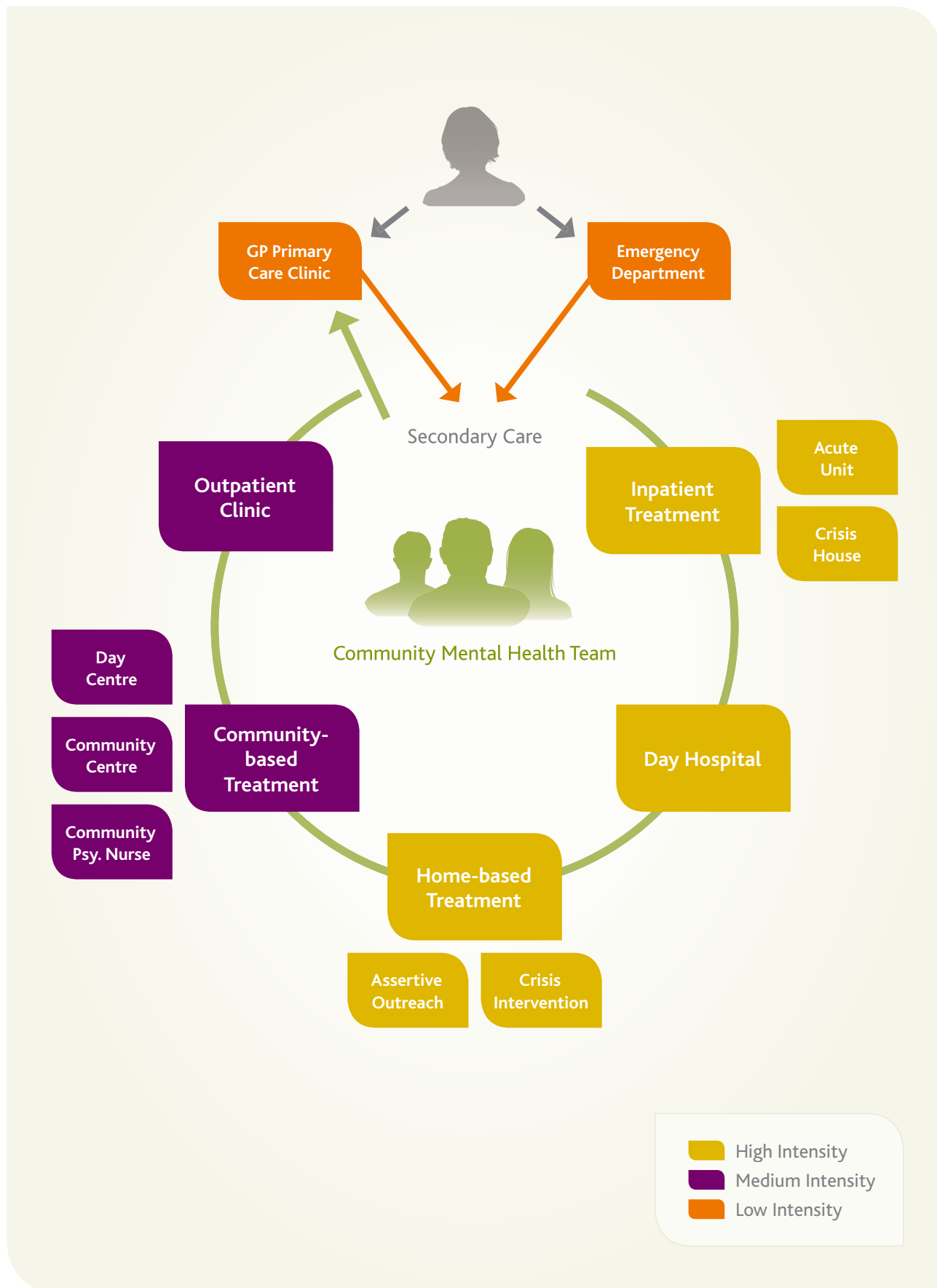


Table 1. Factors that promote communication and integration of care.

COMMUNICATION-ENHANCING FACTORS
All team members are aware of their own team’s role, purpose and target population, and also understand the same about the other teams in the system.
There are regular forums for face-to-face contact and case discussion between teams.
There is a written agreement about how communication will take place between teams. This protocol profiles pathways for communication at each stage of the unique interface between teams. For example, for a known case between the CRHT team and CMHT, the interfaces lay at the point of referral from the CMHT to the CRHT team, in the ongoing input from the CRHT team and at the point of transfer back to the CMHT. At each stage of this process, both teams need to negotiate how communication best takes place.

To summarise, Table 2 details the functions of the different components of acute community-based secondary mental health care. As highlighted above, the needs of service users/carers will only be met to the extent that these service elements work in an integrated manner.

Table 2. Components of acute recovery- and community-based secondary mental health care.

	SERVICE ELEMENT	FUNCTION OF
1	CMHT	Provide and co-ordinate a range of interventions in a variety of locations (e.g., out-patient clinics, home-based intervention, day hospital, crisis house, day centre) and interact with and liaise with other services.
2	Assertive outreach team	Provide a form of specialised mobile outreach treatment for those with more severe and enduring mental health presentations.
3	Crisis resolution and homecare team	Offer immediate, short-term, intensive treatment and support during a crisis period.
4	Day hospital	Provide a range of interventions for those in acute phase of illness including alternative to in-patient admission for a proportion of service users
5	Crisis house	Provide a community based short term alternative to hospital care in a safe, supportive and, family-like environment for service users in crisis.
6	Respite house	Provide a planned period of residential care, the aim of which is to prevent or delay hospitalisation while additionally providing relief for service users’ carers.
7	Community integration networks	Integrate service users into their local community supports so that social support is provided in normative community facilities.
8	Day centre	Provide social support for individuals who have chronic and enduring mental health presentations and to support their rehabilitation, social inclusion and recovery.

Chapter 3: Involving Service Users In Mental Health Services – Changing The Balance Of Power

What is 'Partnership working'?

Actively working with service users in terms of meeting their specific needs and for governance of mental health service generally, has significant practice implications for multidisciplinary team functioning going forward. Care is to be provided in the context that the service user and their relevant carers are 'experts by experience' with empowerment and enhancement of the person's recovery journey key partnership goals (Mental Health Commission, 2007). Thus, the former paternalistic culture where professionals were the expert advisers in care planning is replaced with person centred care as a guiding framework. This partnership approach also means that the knowledge and expertise of the service user combined with that of the professional care coordinator informs all planning and decision making.

Collaborative working with service users

The new partnership approach is visible when the service user is fundamentally in charge of their recovery care plan, when they experience a flexible, person-centred care system that actively seeks their goals and aspirations (McHugh & Byrne, submitted). Professionals working in a care coordination capacity will communicate an attitude of respect for, and faith in the service user's potential for recovery. Collaborative working infers that conditions that support recovery such as provision of hope, facilitating a meaningful life, fostering self-determination and developing supportive relationships are key care drivers (Onken et al., 2007). This means that service users will be encouraged to take the recovery journey, be actively supported in making personal choices and acknowledged as decision makers and in their ability to solve personal problems (Kartalova-O'Doherty & Tedstone-O'Doherty, 2010b; McCloughen, Gilles, & O'Brien, 2011). Collaborative working also means that the mental health environment is a respectful system that allows for the knowledge and expertise of both parties to inform the care planning process.

Involvement in service planning and development

It will soon be common for service users and their carers to be included in service-wide planning groups such as management teams, clinical governance committees and national and local Vision for Change implementation group meetings and all other aspects of service delivery. While this may be seen as a positive development, it is often fraught with problems. Service user/carers representatives:

- Are often selected on a rather haphazard basis ('I know someone who would be good...').
- Often have no means of tapping the views of constituencies that they are supposed to represent.
- May be reticent about contributing because they have little or no experience of committee work at this level and find the whole situation rather daunting and overwhelming (something they share with many more junior practitioners in the organisation).
- Are heavily outnumbered by senior professionals and managers who are experienced in getting their voices heard.
- Have little idea of the remit of the group and its sphere of influence.
- Have little understanding of where the particular group fits in the overall system and organisational structure.
- Have no way of influencing the agenda of meetings and are therefore only able to raise issues of concern to them in the last few minutes under 'Any Other Business' (AOB).
- May find their contributions ignored because it is asserted that they lack the necessary information or 'do not really understand the issues involved'.

All of the above undermines the ability of service user/carer representatives to influence what happens. The National Service Users Executive (NSUE) has developed a process that deals with the main caveats above, a copy of which is available on request.

An increasing number of publications describe how service providers might effectively involve service users in planning groups and committees. These emphasise the importance of honesty, clarity, a step-by-step approach and the celebration of success, and offer a comprehensive meetings checklist of things that mental health workers and managers need to do if they are inviting service users to meetings (see Table 3; with permission adapted from Perkins & Goddard, 2002).

Service users/carers that sit on committees need to have access to a constituency of the people they are supposed to represent. They also need to be considered appropriate representatives by these constituencies. It is therefore important to support – both financially and administratively – existing service user/carer forums/groups from which representatives can be drawn. NSUE has a large database of members they can use to contact individuals in any locality across the country.

It is also important for peer or mental health workers to offer to attend user meetings rather than always expecting service users to come to practitioner-organised meetings.

In order to maximise their influence, mental health professionals and managers need to adopt a number of strategies (with permission adapted from Pepper & Perkins, 2003). These may be equally important to service user/carer representatives if their contribution is to be optimised:

- > *Understanding the prevailing politics.* In any situation there are key players who have their own interests and agendas. There are also local and national policy directives to be considered. An understanding of both of these can be useful in deciding where 'windows of opportunity' might lie. The divergent interests of different stakeholders may offer opportunities for powerful alliances on specific issues.
- > *Being opportunistic.* Most stakeholders, including service users/families, have a number of different issues they want to raise. The key to success often lies in pursuing each at the most opportune time. National and local political imperatives and the area in which resources are likely to be available are important considerations in making such decisions.
- > *Understanding the decision making process.* Preparatory work outside meetings can be important. In order for a new idea to be accepted, it is often useful to canvas opinion among key people who will be involved in the decision making process. People do not generally like surprises, so gaining information about people's views can help refine answers to any objections that may be raised.
- > *Accepting that changes may be slow.* Revolutions are unlikely to happen in the health services. It is often necessary to 'start small' and gradually chip away at entrenched attitudes and practices.
- > Individual examples can be easily dismissed. Personal stories are important in enabling practitioners to understand the experience of using mental health services, but there are limitations to this approach. There is sometimes a rather voyeuristic quality in the response of professionals listening to such stories – a kind of modern day equivalent of viewing the 'lunatics' at the old 'mad houses'. Precisely because they are individual cases, they are too easily dismissed as being isolated and unrepresentative, for example, as a relic of the past 'that doesn't happen any more' or in comparison to someone else: 'I don't do things like that'.
- > Often a 'percentages' or 'vignettes' approach can be more persuasive, i.e. supplementing individual, emotive accounts with figures that indicate how many people have had similar experiences. For example, we recently attended a meeting at which a service user told how, when she was an in-patient, her purse, containing the last remaining picture of her much-loved grandmother, as well as money, had been stolen because staff were unable to find a key for her locker. She then proceeded to describe a survey that her group had conducted that revealed that some 30% of lockers were without keys.

Table 3. *Involving service users in meetings.*

DIMENSION	ACTION POINTS
Membership	<p>Ensure that each service user representative is actually using and in current contact with the service. This is in preference to involving people from voluntary sector organisations speaking on their behalf, although these groups may be represented separately, if appropriate, to speak about their own needs.</p>
Support	<ul style="list-style-type: none"> • Pay service users and carers for attending meetings. All staff are paid to be there and other participants need to be similarly recompensed for contributing their time and expertise. • Pay travel costs on the day of the meeting. Many service users/carers are living on small incomes and can ill afford to wait for payment of expenses they incur. • Service users/carers need to have the resources they need to consult with others and to feed back to them on issues raised at the meeting. • Produce papers including the next agenda soon after the meeting (rather than just before the next one) so that representatives can consult others. • Avoid unnecessary paperwork.
Power and decision making	<ul style="list-style-type: none"> • Clarify the purpose and limits of the committee. • Clarify where the power to make decisions lie. • Do not assume that there are areas in which service users/carers are not competent to take part, and that there are areas where it is not appropriate. • Do not pass the buck of difficult or controversial decisions to service users. • Be wary of staff trying to get service users/carers to adopt their agenda.
At the meeting	<ul style="list-style-type: none"> • Avoid jargon. Attending practitioners and managers need to take responsibility for challenging the use of jargon as well as being open to challenges from service users present. • Make statements about the equality of everyone's contribution at the meeting. • Clarify issues of confidentiality. • Ensure that practitioners, managers and service users/carers understand that no one will be discriminated against for taking part in meetings. Fear of possible consequences can sometimes prevent service users/carers from saying what they wish to say. • Provide refreshments (e.g., many psychotropic medications dry the mouth). • Practitioners need to be prepared for the fact that meetings may take longer than usual. • Practitioners need to be prepared for strong emotional expression – even anger – and not to interpret such expressions as symptoms. • Ensure that meetings are held in 'user friendly' and public transport accessible places (or transport provided) and at times that are convenient to those involved. All need to be consulted about these things. • All participants need to remain cognisant that service users/carers may also have physical impairments. Meetings need to be accessible in this sense as well.

Chapter 4: Assertive Outreach Teams

A Vision for Change (Department of Health & Children, 2006, p.104-112) highlights the need for rehabilitation and recovery CMHTs and proposes that the principal modality through which these teams work are Assertive Outreach Teams (AOTs). Also known as assertive community treatment (ACT), these teams provide a form of specialised mobile outreach treatment for people with more severe and enduring mental health presentations.

These teams aim to reduce relapse and readmission rates, and to improve service users' chances of returning to employment, education or training, and more generally, to enhance their future quality of life. Such intervention involves a multi-disciplinary team that could include a range of professionals (e.g., clinical psychologists, nurses, occupational therapists, peer/mental health/social care support workers, psychiatrists, social workers). The emphasis is on an assertive approach to maintaining contact with the service user and on encouraging a return to normal vocational and other life pursuits.

In the UK, evidence has shown that this type of intervention can reduce relapse and readmission to hospital, and improve quality of life, through improved accommodation and occupation, and increase service user satisfaction (Knapp, McDaid, & Parsonage, 2011; O'Shea & Kennelly, 2008, p.70; Thornicroft & Tansella, 2003). Assertive outreach is one of the most widely researched mental health service provision models, with a strong evidence-base for its effectiveness (Graley-Wetherell & Morgan, 2001). The SCMH (2006) sees the challenge for new AOTs as being how far they can build a culture in which people have more choice over the care and support they are offered, and over where it is delivered, and whether they are offered it when needed.

Purpose and function

What is Assertive Outreach for (Graley-Wetherell & Morgan, 2001; MHC, 2008b; Rethink, 2011)?

- To improve engagement in mental health services through the building of a relationship with each service user in a flexible, creative and needs-focused way that enables the delivery of a health and social care plan that reflects each service users' specific needs.
- To reduce hospital admissions and prevent relapse.
- To reduce length of stay when hospitalisation is required.
- To increase stability in the lives of service users and their carers. This includes stabilising symptoms and psycho-education with service users/carers.
- To improve service users' social functioning and daily living skills, money management, employment etc.

Target population

Assertive outreach is targeted at service users who meet a selection of eligibility criteria (Graley-Wetherell & Morgan, 2001; Rethink, 2011; see Table 4). These may vary across different geographical areas depending on local clinical need and existing mental health services. Additionally, in areas with a high demand for assertive outreach, only the most vulnerable service users with a range of complex needs may be referred (Rethink, 2011).

Table 4. Eligibility criteria for AOTs.

ELIGIBILITY CRITERIA
18 – 65 age range. However, as this 'ageist' criterion discriminates against those of retirement age, services may be better provided on the basis of need rather than age (Reay, McCabe, Paxton, & Turkington, 2011).
Those with a severe and persistent mental health disorder associated with a high level of disability (e.g., psychosis, bi-polar disorder).
A history of high use of in-patient or intensive home-based care (e.g., more than 2 admissions or more than 6 months in-patient care in the past 2 years).
Difficulty in maintaining lasting and consenting contact with services.
Multiple and complex needs including a number of the following: <ul style="list-style-type: none"> • 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 (2001) on at least one occasion in the past 2 years. • Unstable accommodation or homelessness.

Interventions

The AOT needs to directly provide all services – assessment, intervention, support and rehabilitation. These need to be comprehensive and flexible. Interventions need to be provided at locations comfortable to the service user (e.g., home, café, workplaces). As many of this service user group may have accommodation issues, homeless units, nursing homes, and friends homes or wherever service users give as an address, should be considered their home and visited as required (while having due regard to staff safety).

When considering interventions, some primary questions teams need to ask include 'How are we going to reduce this person's vulnerability in the community?' and 'What are their priorities' (Graley-Wetherell & Morgan, 2001, p.11)? With these in mind, the most frequent activities do not necessarily come directly from the research literature but tend to be much more practical in nature. The interventions also need to foster a valuing of the persons lived experience and regard the different view points and cultural perspectives as a resource to be utilised (CSIP, RCPsych, & SCIE, 2007).

An assertive outreach service focusing on service users' recovery needs may include the following (Graley-Wetherell & Morgan, 2001), as profiled in individualised recovery care plans:

- All service users need to have a detailed assessment that considers their strengths and aspirations, as well as their needs. There needs to be a 'living' written care plan that is reviewed every 6 months or as often as required.
- Help with daily living such as shopping, budgeting, domestic chores. Living skills training may be given to promote independence.
- As profiled in care plans, an assessment of carers' needs including practical support and, if required, family psycho-education and therapy.
- Help in taking medication including reviews and help with side effects.
- Psychological therapy.

- Help with substance abuse including referral to a specialist services if needed.
- Help to increase social networks and reduce isolation.
- Help to improve physical health.
- Support in finding suitable education, employment and training opportunities.
- Help in finding and keeping suitable accommodation.
- Development of a relapse prevention plan that considers triggers and symptoms, as well as action points for service users and carers.
- Rapid crisis intervention to prevent hospital admission or, if necessary, the provision of in-patient care.
- Liaison with carers, statutory and voluntary agencies, Gardai, GP's and other relevant stakeholders.
- A 'no close' policy whereby once a service user has been accepted for long-term support, the team will maintain their involvement for as long as is necessary.

Staffing

A Vision for Change (Department of Health & Children, 2006, p.107) recommends that rehabilitation and recovery CMHTs in the principal form of AOTs cater for a catchment population of 100,000 (Department of Health & Children, 2006), preferably on a 24-hours-a-day, 7-days-a-week basis. Caseloads will be small, with 10-12 the optimum number of service users per staff member or care co-ordinator.¹

Each AOT will include clinical psychologists, mental health nurses (e.g., community psychiatric nurses, those in day hospitals and day centres), occupational therapists, psychiatrists, and social workers (Department of Health & Children, 2006, p.107). Along with the MHC (2007), the former recommends staffing these teams with mental health support workers. However, these staff require training, supervision and quality assurance (Boardman & Parsonage, 2007). Social care workers can also supplement the work of AOTs, and while few in number, there is also a case for Authorised Officers under the Mental Health Act 2001 being attached to these teams.

In addition to all CMHT staff adopting an assertive outreach approach to their service delivery, they need to have the skills required to adopt recovery principles. These include (Borg & Kristiansen, 2004):

- Openness.
- Collaboration as equals.
- A focus on service users' inner resources.
- Reciprocity.
- A willingness 'to go the extra mile'.
- Relationship skills.
- Encouragement of responsible and positive risk taking.
- Positive expectations of the future.

¹ The term 'care co-ordinator' is used in preference to 'keyworker' as it better describes the care co-ordinating nature of this role, including co-ordinating care across a range of services (as opposed to within just one service as typifies the role of keyworker).



Chapter 5: Crisis Resolution And Home Treatment Teams

Home-based treatments began in the United States in the 1960s and the first homecare service in Ireland started in Clondalkin in 1989. Crisis resolution and home treatment (CRHT) teams were established to offer immediate support to people with severe mental health problems in a crisis. They aim to provide an alternative to in-patient admission and to 'gate keep' admissions to hospital (Dublin West South West Mental Health Services, 2009). They give short-term, intensive treatment and support during the crisis period to those who are not admitted to hospital' (Boardman & Parsonage, 2007, p.31-32). In a crisis resolution context, a 'crisis' is defined as the breakdown of an individual's normal coping mechanisms. Crises may vary in form – they may be developmental, situational, or a result of severe trauma (SCMH, 2001).

The benefits of home treatment can include the maintenance of family systems and the support of members of social systems. It is seen as more acceptable and therefore less intrusive and traumatic to service users and carers. It is also less likely to lead to institutionalisation (McGlynn & Flowers, 2006).

Purpose and functions

The multiplicity of names in the literature (e.g., Acute home treatment; Crisis services; Early intervention services; Home-based crisis services; Home treatment services; Out-of-hours services; Rapid response services; SCMH, 2001) mirrors the diverse aims and objectives of different homecare teams (see Table 5 overleaf; Hout, 2006, p.15-17; McGlynn & Flowers, 2006; McGlynn & Smyth, 1998; SCMH, 2001). This may reflect the fact that many developed in geographical areas where a specific need was being addressed e.g., the context of the closure of a large institution, higher demand for in-patient beds, service users that have repeat admissions and those that cannot be safely discharged. Even within the same mental health service, different local homecare teams can have different priorities depending on the unmet needs of the catchment area they are serving.

Target population

Homecare teams target those aged 18 and over with serious mental health presentations or those with first incidence presentation who are in crisis and are candidates for in-patient admission. Where hospitalisation has occurred, proactive discharge planning (e.g., providing intense home-based support to enable early discharge) is important. As some people with serious mental health presentations are likely to be unemployed, living in poverty and at-risk of homelessness, for many 'home' will be a shelter or living on the streets. Therefore, 'home' needs to be defined broadly so that mental health homecare services can be delivered in these alternate settings (Centre for Addiction and Mental Health, 2011).

Interventions

Home treatment teams can provide a wide variety of interventions (see Table 6 overleaf; McGlynn & Flowers, 2006; SCMH, 2001) as informed by ongoing assessment.

Table 5. *Aims and objectives of different home treatment teams.*

AIMS AND OBJECTIVES
Provide immediate assessment and intervention 24 hours a day, 7 days a week to individuals experiencing a mental health crisis. In view of the acute nature of their difficulties, service users/carers need someone they can turn to should a difficulty arise, especially in the middle of the night when people feel most alone. If they know they can get immediate help at any time of the day or night, they will be more willing to accept home treatment.
Provide a service in service users' own environment with minimal disruption to their normal routine. There are some who will not come to a clinic or a Centre or an Accident and Emergency department, despite efforts to get them there, because they do not believe they need help, or they do not want help. Engaging people in their own environment allows them to behave more naturally, more of their social network is likely to be involved, and staff can evaluate the circumstances in which intervention is to take place.
Provide a service that accepts that mental health difficulties cannot be isolated from an individual's social system. Therefore their social system needs to be part of the assessment, intervention and ongoing care. 'The network can give important information about the client that the client does not disclose...CRHT teams in turn should inform, advise, educate and generally support the social network'.
Provide an alternative to hospital admission for individuals experiencing acute mental health difficulties.
Ensure inter-disciplinary assessment and decision making at the point of referral for hospital admission. The value of this approach is in broadening the scope of the assessment and the provision of a range of crisis interventions. However, this may necessitate a change in work practices for a number of disciplines.
Act as gatekeeper to hospital beds by ensuring that every individual referred for in-patient admission receives a comprehensive inter-disciplinary assessment before a decision is made about intervention location.
If intensive support is available to service users in the community, discharge from hospital can occur at an earlier stage than had previously been possible
Having resolved a particular crisis, these teams need to ensure that service users/carers are, where necessary, linked into ongoing care and that they have access to further assistance, on a 24-hour basis, if required.

Table 6. *Interventions provided by home treatment teams.*

INTERVENTIONS PROVIDED
Rapid response following referral
Time-limited and intensive intervention and support with sufficient flexibility to respond to different service user/carer needs.
A range of therapeutic interventions including medication management, cognitive and behavioural interventions, and evidence-based family interventions.
Active involvement of service user/carers, and liaison with multiple stakeholders (e.g., General Practitioners, and voluntary and community services).
Short-term respite accommodation i.e. crisis houses may be offered if the home environment becomes too stressful. They can provide alternatives to hospitalisation as well as respite for service users and their carers/families



Staff

The required size for a CRHT team depends on variables including population size and degree of unmet clinical need in a catchment area, the level of hospital admissions for that area and the profile of in-patient stays. Allowing for periods of leave and sickness, a team needs to have the capacity to maintain an adequate service provision rota and to ensure strong intra-team communication as well as external communication with other services.

United Kingdom policy implementation guidelines (Department of Health, 2001) recommend 14 clinical staff per 150,000 population (i.e. a team leader plus up to 13 others) that includes approved social workers, clinical psychologists, community psychiatric nurses, consultant psychiatrists, occupational therapists, support workers, and an administrative assistant. However, local circumstances may necessitate that individual teams will need different staff and skill mixes (Boardman & Parsonage 2007; Hoult, 2006). The Dublin West South West Homecare service provides a 7-day service from 9am to 5 pm. Some of the Homecare teams are multi-disciplinary, while others access required competencies (e.g., of clinical psychologists, occupational therapists, social workers) from the local (generic) CMHT.

In urban areas, the most appropriate model may be a discrete crisis resolution team that exists alongside other services such as mainstream CMHTs, AOTs and acute in-patient units. In rural areas or less densely populated areas, where a discrete crisis resolution service may not be cost effective, crisis resolution workers may be included within another appropriate service. For example, one or more generic CMHTs might provide a crisis resolution service through either dedicated specialists within the team and/or a rota of staff (Hoult, 2006; SCMHT, 2001).

Governance

To minimise the potential of different specialised teams or services providing fragmented care to the same cohort of service users (McGlynn & Flowers, 2006), robust intra- and inter-team communication is required. For example, all team members of the homecare service in HSE Dublin West South West attend the local CMHT meetings. This facilitates discussion around referrals, how service users are progressing, and discharges. In addition, a senior representative of the homecare team attends the weekly ward round or in-patient meeting. This assists in identifying and facilitating the early discharge of service users.

The quickest way to demonstrate the impact of a CRHT service is via reduced admissions and bed use. Such data collection is both straight forward and resource neutral. However, CRHT teams need to collect data on a broader range of performance indicators so that they can monitor their progress, identify blockages and plan for the future (e.g., Lakhani, 2006, p.58):

- Number of admissions: by consultant psychiatrist/sector
- Average length of stay: by consultant psychiatrist
- Number of referrals from the in-patient units: by consultant psychiatrist/sector
- Number of these referrals accepted for early discharge
- Early discharge cases – proportion of CRHT team workload.

Comparison with assertive outreach teams

Given that their functions are similar, Table 7 details how crisis resolution differs from assertive outreach (SCMH, 2001, p.4).

Table 7. How crisis resolution differs from assertive outreach.

	CRISIS RESOLUTION	ASSERTIVE OUTREACH
Length of involvement	Short term, usually 2-3 weeks	Longer term, frequently several years
Service users	May have no previous contact with psychiatric services	Established mental health history
Referrals	Accepted from GPs, A&E department and service users themselves (if already known)	Usually require referral from secondary service
Hours of operation	Always 24 hour	Usually more limited
Service delivery	Rapid response – usually within one hour	Longer response time, especially for service users not previously known to service
Other	Act as gatekeepers to in-patient beds	Usually no gatekeeping role

Chapter 6: Day Hospitals

What is a day hospital?

Acute day hospitals are among the earliest forms of psychiatric community care. The first day hospital was opened in Russia in 1933 because of bed shortages in the local psychiatric hospital (Dzhafgarov, 1937). The programme consisted mostly of 'work therapy', with service users treated for approximately 2 months. In the UK, the first day hospitals appeared in 1948 and their focus was on those recently discharged from hospital (Bierer, 1951). However, over the succeeding decades the therapeutic emphasis changed to providing care for those who were acutely unwell, and soon their potential for providing an alternative to hospital admission was recognised.

Purpose and function of day hospitals

Planning for the Future (Department of Health, 1984, p.34) noted that 'the function of the day hospital is to provide intensive treatment equivalent to that available in a hospital inpatient setting for acutely ill patients'. *A Vision for Change* (Department of Health & Children, 2006, p.96) expanded on this, highlighting that 'day hospitals offer an alternative to in-patient admission for a proportion of service users', estimating that proportion to be 25% to 33% of those who would otherwise be admitted to hospital. The report of the Inspector of Mental Hospitals for 2010 (MHC, 2010) –recognises and supports the fact that day hospitals are being used to divert acute admissions from acute mental health units. Properly functioning day hospitals therefore can be used as an alternative to in-patient admission, as a means of facilitating faster discharge from an in-patient unit and as a means of providing a graded discharge programme from an in-patient facility.

Marshall's (2001) systematic review identified 9 randomised controlled trials of acute day hospital treatment involving 2,268 service users. The review found that treatment in day hospitals was feasible for at least 23%, and at most 38%, of service users admitted to hospital and led to cost reductions ranging from 20.9% to 36.9% over in-patient care. Other research suggests that between 30% and 40% of acutely ill service users could be solely treated in the day hospital (Creed, Tomenson, Anthony, & Tramner, 1997; Kluiters, Giel, Nienhuis, Rüphan, & Wiersma, 1992; Schene, Van Wijngaarden, Poelijoe, & Gersons, 1993) and Harris (1963) showed that day hospitalisation can be an effective alternative to in-patient admission for over 66% of those traditionally hospitalised with psychotic symptoms.

Multi-disciplinary therapy can be provided in a day hospital setting, although cognisance needs to be given to providing services based on need rather than 'one-size fits all' service provision. The 2010 Inspector's Report (MHC) showed that a range of services are accessible in day hospitals nationally (although to varying degrees), including individual and group input, anxiety management, CBT, healthy-living skills, psycho-education, recovery programmes and relaxation. Notable in the report was the fact that while most day hospitals had access to multi-disciplinary staff and held regular MDT meetings, there was minimal multi-disciplinary care-planning. Addressing this deficit was a key recommendation of the report.

Day hospitals can reduce overall in-patient admission numbers by 30% (Marshall, 2001; Wiersma, Kluiters, Nienhuis, Rüphan, & Giel, 1995). Those with a focus on acutely ill service users who would otherwise be admitted to an acute in-patient facility need to have a fixed number of places available and require service users to attend for a minimum number of hours daily at least 5 days per week (Priebe, 2011).

The HRB document 'Psychiatric Day Care – An Underused Option?' (Hickey, Moran, & Walsh, 2003) recommends that day hospitals be located in the largest population centre of a sector area and be in the same building as a community mental health centre or a generic health centre. However, they note that ideally psychiatric out-patient clinics will not be held in the day hospital premises. This would lead to a large volume of people passing through the building, utilising common areas and would remove the focus from the therapeutic aspect. In some settings, day hospitals are now utilised as community headquarters for multi-disciplinary teams, and provide a single point of referral to the team and a range of services to people with acute mental health problems.

It is important to distinguish day hospitals from day centres. The primary focus of day centres is to provide social support for individuals who have chronic and enduring mental health presentations and to support rehabilitation, social inclusion and recovery (Doherty et al., 2007; Hickey, Moran, & Walsh, 2003; Lockett, Seymour, & Pozner, 2008; SCMH, 2010). Although the two terms are sometimes used interchangeably, these facilities cater to different target populations and provide distinctly different services.

Interventions provided

Day hospitals need to be regularly audited to determine if they are adhering to agreed admission and discharge policies (Hickey, Moran, & Walsh, 2003). Working within these, the first basic intervention is an inter-disciplinary assessment to determine a service user's needs and formulation of a care plan.

A comprehensive range of short-term time-limited treatments needs to be made available. A selection of staff (e.g., clinical psychologists, consultant psychiatrists, nurses, occupational therapists and social workers) need to provide a range of therapeutic services including occupational, psychological and social therapy programmes, and medication management (Department of Health & Children, 2006, p.96). Prior to discharge, it is important that service users are prepared adequately for their transition to living at 'home' and that any supports such as community mental health nursing visits are arranged.

Target population

While the target population of a day hospital can be divided into two categories (see Table 8; Department of Health & Children, 2006; Hickey et al., 2003), this setting is sometimes the first contact that service users will have with community mental health services (e.g., initial assessment by a CMHT member).


Are day hospitals necessary?

At present, in the United Kingdom and elsewhere, there is a growing preference for acute home-based care delivered by a specialised crisis team as an alternative to hospital admission. According to a recent systematic review, home-based care is thought to be feasible for about 55% of service users who would otherwise be admitted. Such care also appears to reduce costs and increase satisfaction (Joy, Adams, & Rice, 2000). Although home-based care and acute day hospital care have not been compared directly, one would expect the former to be cheaper given the infrastructure costs of day hospital care.

Table 8. Day hospital target population.

POPULATION	ACTION POINTS
Acutely ill	Those who are acutely ill and who would be admitted to in-patients in the absence of a day hospital, but who do not pose a risk to self or others nor need 24-hour care.
Non-acute	Those who are ready for discharge from in-patients.
	Those who are not acutely ill but require sessional input (e.g., those attending CBT groups or relaxation classes).

The demand for clinical care is growing as a result of new complex interventions and an increasing emphasis on safety, which in mental health terms usually translates into closer, or indeed sometimes statutory, supervision of service users in the community. In part, this demand will have to be met by greater efficiency in the use of mental health's human resources, given the growing shortage of doctors, nurses, and psychologists (Dowie & Langman, 1999). In the context of this need for efficiency, experience shows that acute home-based care faces two significant problems. Firstly, concerns



for staff safety mean that clinicians cannot visit service users at home on their own, so that 2 or more clinicians end up caring simultaneously for the same service user. Secondly, these small groups of clinicians are obliged to drive through congested towns and cities, spending time bumper-to-bumper that could be spent in face-to-face contact with service users.

By contrast, assuming they are accessible by public transport or other means, day hospitals can deliver value-for-money. Here, comparatively small numbers of nurses can maintain a high level of input to substantial numbers of service users, in a safe environment for one-to-one intervention. Consultant psychiatrists can be available as required. Instead of a small group of clinicians treating each individual service user, a single healthcare professional can deliver complex interventions to several service users simultaneously through group therapy. A combination of day hospital, outreach services for those who fail to attend, and short-term crisis beds for those who need them could offer a powerful alternative model to home-based care.

Performance indicators

The literature suggests a number of different performance indicators for day hospitals. The regularity and duration of day hospital attendance, the need for transfer to in-patient care and the return to employment of unemployed service users were used as outcome measures by Vidalis and Baker (1986). However, Shergill, Ebrahim, and Greenberg (1997) focused on changes in clinical measures, as found by repeating rating scales at admission, during admission to the day hospital and at discharge. Appropriate screening measures include the Beck Depression Inventory (Beck, Ward, & Mendelson, 1961) and the Brief Psychiatric Rating Scale (Overall & Gorham, 1962) to name just two.

Chapter 7: Crisis And Respite Houses

Mental health services will ideally maintain service users in their natural environment (e.g., independent accommodation). However, some will occasionally need access to crisis or respite houses.

CRISIS HOUSES

What is a crisis house?

A crisis² house is an ordinary community residence where mental health professionals and support staff provide 24 hour care for those experiencing acute mental health difficulties (WHO, 2010). Such services cater primarily for those service users who otherwise may require in-patient care. However, crisis houses do not seek to replicate, or provide a 'watered-down' version of hospital care. Rather, a key objective is the provision of a safer, less stigmatising alternative to hospital care that provides a more communal, family-like environment.

Why are crisis houses needed?

Crisis houses are designed for those who are in need of acute intervention but do not require hospital care. While home treatment could be provided, this may be problematic for several reasons (Johnson, Gilbert, Lloyd-Evans, & Slade, 2007). The increased potential for self-harm and neglect may necessitate professional input while exposure to family conflict, an abusive parent or a spouse may exacerbate service user mental health difficulties. Crisis houses have the advantage of providing a place of refuge and support, where individuals in crisis can escape the stressors of their social environment (Agar-Jacomb & Read, 2009). Research on crisis services suggest they do provide a safe, supportive environment that is less stigmatising than hospital care (Hawthorne, Green, Folsom, & Lohr, 2009; Johnson et al., 2004).

Given the substantial costs associated with in-patient care, it is important that service users are not unnecessarily admitted to these services. There is evidence to suggest that potentially over a quarter of service users in in-patient units could be treated in alternative accommodation (Beck, Croudace, Singh, & Harrison, 1997; Sledge, Tebes, Rakfeldt, Davidson, Lyons, & Druss, 1996). Crisis houses represent a suitable alternative that have demonstrated equivalent clinical outcomes in a more cost-effective way (Fenton, Hoch, Herrell, Mosher, & Dixon, 2002).

How do crisis houses operate?

The first operational priority is the provision of an efficient assessment and admission procedure to ensure that service users can be accommodated in their time of crisis (Lloyd-Evans et al., 2010). To facilitate meeting this goal, the administrative burden of excessive paperwork needs to be minimised. With regard to the functioning of crisis houses, there is much variation in the operational details, with no standard policy. In terms of the duration of stay, some crisis houses average about 30 days (Johnson et al., 2009). In contrast *A Vision for Change* (Department of Health & Children, 2006) recommends much briefer stays (e.g., 24 to 72 hours). This policy document suggests that once service users' acute problems have stabilised, they need to be referred onto more appropriate supports or admitted back into the community with the provision of follow-up support.

The services within a crisis house need to meet the diverse range of needs of the residents (Department of Health & Children, 2006). Access is required to a range of interventions including counselling, family therapy, psychology, social work and various holistic options. Currently there is much inconsistency in the staff composition of crisis houses. In some houses, basic ongoing care may be provided by nursing and social care staff with potential daily input from clinical staff including psychologists and psychiatrists (Lloyd-Evans et al., 2010). In one particular crisis house, a consultant psychiatrist visited the service on a weekly basis and then liaised with other services to organise service users' care (Meiser-Stedman, Howard, & Cutting, 2006). An analysis of a sample of crisis houses found that 42% of staff consisted of nurses, while 50% of the services had a psychiatrist with a direct role in the service (Johnson et al., 2009). Most of the houses analysed also provided service users with core medication interventions.

² The word 'crisis' could be used as an acronym for 'Community Response and Special Intervention Service'.



Many crisis houses adopt a user-centred model of care (Mental Health Foundation, 2002). Some services not only involve service users in their own treatment but also in the running of the service. One analysis found that approximately half of the crisis houses sampled included service users in management-level decisions (Johnson et al., 2009). At a more informal level, users tend to participate in the basic running of the house and in general there tends to be a more communal atmosphere. It is likely that this service user-focused, communal environment is one of the reasons users tend to rate their experience of crisis houses so positively.

Linkages with other services

Referrals to crisis houses usually come from other social and health services. For example, a referral may come from a service user's care co-ordinator, or it may come from primary care. Some crisis houses accept self referrals, but this is usually from those who have already used the service (Hodgson, Carr, & Wealleans, 2002). In other services, the referral net may be limited to a Home-based treatment team.

With regard to primary care services, it is important that professionals such as General Practitioners are aware of the presence of these services and recognise the service user type best suited to crisis houses. It is important to establish and nurture close links (e.g., bi-directional referral) with general and mental hospitals (WHO, 2010). For example, crisis houses need to be able to efficiently transfer service users to hospital care if their status deteriorates (e.g., they become high risk). Early discharge from acute wards may also be facilitated by transfer to crisis houses. Adherence to robust admission and discharge policies is also needed to protect against using crisis houses to deal with overspill from wards (Lloyd-Evans et al., 2010).

Crisis houses represent one of a range of community services, and it is important that crisis houses form strong links with these other community services. For example, a service user may be referred onto another CMHT to provide aftercare. Such teams may also provide advice and support to crisis houses as well as providing training to staff (Lloyd-Evans et al., 2010). In some cases, crisis care facilities may be integrated with other forms of community care (e.g., Mezzina & Vidoni, 1995).

Target population of crisis houses

Crisis houses are designed to provide care to individuals in an acute crisis who without a community alternative may require in-patient intervention. Exclusion admission criteria need to ensure that those who require the high intensity support of in-patient hospital facilities are not admitted. The latter would include those in need of medical assessment, with co-morbid medical and mental health presentations, with strong suicidal tendencies and those with neuro-psychiatric conditions (Thornicroft & Tansella, 2003).

Governance

A crisis house needs to first clarify its specific goals and vision, and how these are operationalised (in an operational policy document). In consultation with wider team members, a co-ordinator then needs to manage the running of the service including service users' length of stay and whether the appropriate service users are being referred to the service.

Given that crisis houses are designed to create a safe and supportive environment, the in-house power structure needs to be carefully managed. If there is a highly stratified hierarchical structure, it may debase the communal environment these services seek to provide. In general, the power structure of crisis houses tend to be less hierarchical compared to hospital environments (Lloyd-Evans et al., 2010). For example, staff tend to have much more autonomy. The power relationship between staff and service users is also crucial. Many crisis houses adopt a user-centred approach (Mental Health Foundation, 2002) whereby service users are considered key decision-makers in their treatment, and in some cases may even contribute to management-level decisions (Johnson et al., 2009).

Performance indicators

At present, alternative residential services like crisis houses are poorly defined and there is a lack of consistent terminology (Lloyd-Evans et al., 2009). This makes it difficult to both research crisis houses and integrate research in this clinical area. Existing research is also limited by the heterogeneity of intervention groups and therapies used within the various services (Lloyd-Evans et al., 2009). What is needed is research of crisis houses that examines a specific group of service users (e.g., anxiety disorders) or that use specific therapies or intervention models (e.g., recovery model). So there is a need to standardise both research (e.g., terminology, methods) and the functioning of the houses themselves.

Another problem with much of the research on crisis houses is that it tends to be naturalistic and retrospective. This can give rise to many problems when interpreting available data. For example, in assessing the clinical outcomes of crisis houses, service users are often used as their own controls. This is a significant problem for crisis houses, in that service users will usually be accessing the service at a period when their mental health difficulties are at their worse. Thus, any clinical improvements may be largely influenced by a simple regression to the mean (Hodgson et al., 2002). Ideally, randomised controlled trials (e.g., Fenton, Mosher, Herrell, & Blyler, 1998) would address such issues but there are obvious ethical risks that need to be considered when conducting such studies.

Given that they are ultimately designed to provide a more cost-efficient alternative to hospital care, cost-effectiveness tends to be a key dimension on which crisis houses are measured. However, dimensions of healthcare like acceptability and accessibility are as equally important. With regard to the former, it is important that crisis houses provide an adequately safe and supportive environment. A combination of qualitative measures and quantitative measures (e.g. the Ward Atmosphere Scale; Moos & Houts, 1968) may be required. With regard to the accessibility dimension, key performance indicators related to the referral process may be analysed to ensure that service users can efficiently access the service in their time of crisis.

RESPIRE HOUSES

Crisis houses aim to meet the immediate needs of individuals in an acute phase of mental health distress. In contrast, respite houses provide a more planned period of residential care, the aim of which is to prevent or delay institutionalisation while additionally providing relief for service users' carers. Certain types of service users (and carers) may be particularly in need of respite (Nankervis, Rosewarne, & Vassos, 2011) including those with high levels of dependency, high behavioural disturbance and low communication ability. Those with intellectual disabilities and elderly individuals with psychological difficulties would also be suited. Respite houses however, would not be appropriate for individuals whose mental state is significantly unstable (e.g., those experiencing psychotic symptoms) where high support units or hospitalisation would be more appropriate. Carers in most need of respite include those experiencing high emotional strain, low levels of social supports, poor health and are often of low socio-economic status (Nankervis et al.). Furthermore, carers who are required to engage in a wide range of care-giving tasks and who live with their care recipient may be greatly in need of such services (Jardim & Pakenham, 2010).

Residential respite services will usually provide longer stays for service users than crisis houses. For example, in the Greenbank Crisis House in Carlow, those in need of respite stay an average of 2-3 weeks while those in crisis will usually access the service for a maximum of 72 hours (MHC, 2010). Respite and crisis houses will ideally be located in different buildings. As with crisis houses, residential respite services need to advocate a user-centred approach. This may also involve the empowerment of the service user's carer or his/her family. Residents are encouraged to engage in independent living (e.g., become involved in recreational activities in their community, participate in the running of the residence). Otherwise, they may become dependent on professional care. To further facilitate independence, respite houses could be managed by one or more voluntary housing agencies.



Benefits of respite houses

Residential respite benefits service users through both increased social interaction and variety in their daily routine (McConkey, Truesdale, & Conliffe, 2004). It also reduces the burden on carers (Jeon, Brodaty, & Chesterson, 2005). In promoting cost-effectiveness, residential respite is designed to prevent the entry of service users into more expensive institutional services. For example, residential respite has been found to delay nursing home placement (Kosloski & Montgomery, 1995). If respite duration is proactively managed (e.g., by implementing robust discharge planning), savings can be significant relative to other modalities of care. However, cost efficiency must not compromise the quality of care. Carers may become particularly reluctant to use such services if they perceive that they are under-resourced or that their staff lack the necessary skills (Jeon, Brodaty, O'Neill, & Chesterson, 2006).

Chapter 8: Community Integration Networks

Supporting daily living

Statutory mental health services alone cannot meet the support requirements of persons living with chronic and enduring mental health presentations (Argentzell, Leufstadius, & Eklund, 2011; MHC, 2005). Our understanding of how recovery happens has revealed that non-medical aspects of care that promote social inclusion are key ingredients for meaningful social activity and enhanced quality of life (Bryant, Craik, & McKay, 2005). Everyday community networks can provide dynamic options for support and opportunities to enable the service user to have more confident participation in mainstream, community life (Department of Health & Children, 2006; SCMH, 2010). These social networks and confiding relationships have been found to be protective against relapse and re-hospitalisation for those with long-term mental health problems (Cathy, Goddard, White, & Burns, 2005). Hence, rather than considering day centre placements, the provision of social support in normative community facilities will assist service users in rebuilding their lives so as to prevent social isolation and exclusion (Dunne, 2006; Kartalova-O’Doherty & Tedstone Doherty, 2010a).

Facilitating community integration

Where a service user is unable to engage in work or recreation pursuits without assistance, then care co-ordination facilitation can be provided by the mental health services as part of the social recovery and rehabilitation care pathways (Department of Health & Children, 2006; Higgins, 2008). To facilitate a recovery continuum, the care co-ordinator will collaborate to identify the community systems that will best support social inclusion and self-determination for the service user. The support should function to enable service users to be with others, to learn, to grow and to participate in decision making (Catty, Goddard, White, & Burns, 2005). To facilitate service user integration, shared care policies that allow for active communication and positive partnerships between voluntary partners, community centres, rehabilitation services and CMHTs will be required (MHC, 2010).

What type of social support is required?

To live a meaningful life in the community, service users require access to community activities that targets their strengths and abilities, not their deficits (Rapp & Goscha, 2007). It is important that they have a central role in the choice of activities they engage in so that they feel a reconnection with life in ways that empower their personal self (Kartalova-O’Doherty & Tedstone Doherty, 2010a).

Recovery processes can be facilitated where community networks provide *positive integration experiences* (see Table 9; Lockett et al., 2008), along with exposure to the arts, opportunities for volunteering, access to meaningful community leisure pursuits and participation in local community networks (National Economic & Social Forum, 2007). In this way, mental health management will be a part of a person’s life experience while living in the community, as opposed to attending a mental health day centre to survive with mental illness.

Table 9. Summary of positive integration experiences.

INTEGRATION EXPERIENCES
Self-esteem enhancing social, educational and peer support.
Group work that promotes positive and validated engagement with others.
Active self-management through education.
Choices for community participation.
Partaking in work activities in a community centre.



What type of facilities support service users?

There are a variety of social support service models. These have been described as Clubhouses (Pernice-Duca & Onaga, 2009); Peer Support Centres/Networks (Solomon & Draine, 2001); and Social Care Community Day Services (SCMH, 1998, 2010). The core philosophy common to all these services is that they function on the belief that its participants can live meaningful and personally satisfying lives in the community. The common denominator is that activities allow the service user to be supported and act as a supporter of others, facilitates the sharing of life experiences, expands their social network and reconnects the person with support for normal everyday life in the community.

Clubhouses

Adame and Leitner (2008) describe the clubhouse as a recovery community that offers the service user a place where they can find meaningful daily work, friendships and a sense of belonging and support. The clubhouse provides opportunities, social/recreational activities and may also serve as a 'drop-in centre' for people experiencing stressful living conditions. The clubhouse is operated by a board of directors and has its own budget. In Ireland, for example, there are several Eve Clubhouses in the Dublin region and their overall commitment is to the provision of 'hope-inspiring recovery-oriented services' (Eve Clubhouse Forum, 2008, p.1).

Peer Support Networks

A number of voluntary organisations provide peer support networks that specifically support individuals with mental health difficulties. Grow, a community mental health organisation, holds regular weekly meetings, the goal of which is to enable its members to take control of their problems and gain positive mental health. Another national organisation with branches throughout the country providing peer support is Mental Health Ireland. Their volunteers provide befriending support, which can include social outings, linking service users to local support networks or supporting the development of individual hobbies. The Irish Advocacy Network also provides a peer-led, peer support network throughout Ireland, visiting hospitals and community mental health services to make contact with service users. Each of these groups use a community development approach and are ideally placed to support the social integration of service users.

Social Care Community Day Services

Alongside these 'mental health' specific social support facilities and networks, local/parish community centres provide an eclectic mix of activities and meals for its participants and are often ideally placed to support individuals with mental health presentations. This community development approach aims to strengthen communities as a whole and may in the longer term reduce the stigma of mental health difficulties. To support service user integration, mental health services and their primary care partners need to have a good working knowledge of community services and ensure, as part of care provision, that service users are engaged with such networks.

Where limited community services are available in a region, advocacy through service user and voluntary networks will need to be mobilised and supported by the mental health services so as to enable collaborative partnerships that can provide daily support to service users. Such services will be managed by voluntary services partnerships in collaboration with service users (and not the statutory mental health services). In some situations, it may be that existing day centre buildings provide a starting point for volunteer groups who may be interested in establishing local Clubhouses or Peer Support facilities. Going forward, former mental health day care centre functions, where required, need to transfer to and be managed by the voluntary sector so as to refocus service users' everyday lives within the community. In rural areas in particular, transport may be required to enable service users to participate in social support networks.

Who needs social support networks?

Service users who require social support in their communities are those with chronic and enduring mental health presentations who have difficulty accessing open employment and recreational activities (Department of Health & Children, 2006). Where there is a requirement to establish a social support facility, approximately 30 places per

catchment area will be required for adults up to 65 years of age with the population density determining whether one or two facilities are needed (Department of Health & Children, p.109). However, service users will ideally access existing local community support structures and facilities in their home area. There are many examples of such existing resources including the Link-Up project in Kilkenny (see Table 10 for other examples).

Table 10. *Projects that involve the community at large in mental health developments.*

COMMUNITY GROUPS
S.T.A.N. (South Tipperary Action Network).
Recovery and Reconnect network in Ennis.
The Rainbow project and the Gateway project in Dublin.
Consumer panels in Mayo, Galway, Limerick, Wexford, Waterford, Monaghan, Tallaght, Crumlin, Letterkenny.

How can we determine impact of social support on the service user?

The key outcome in engaging service users with their wider social support networks is the development of personal social niches (National Economic & Social Forum, 2007). Such niches will in the longer term enhance service users' quality of life as they become integrated into the local community (Argentzell et al., 2011). For community integration to occur, the service user will have access to a range of activities that are user-led and -friendly. The following outcomes indicated by the UK Care Services Improvement Partnership (CSIP; 2006) offer mental health services a template when considering voluntary services that might best support service users' recovery lifestyles including:

- The service has a focus on community partnerships.
- It assists in reducing social isolation and is person-centred.
- Provides opportunities for peer support.
- The service user has both choice and control over centre activities.
- There is a diverse group attending the facility.
- Easy to access.
- Service users are central to the centre's decision making process.

The recovery agenda for mental health services means that service users need professional assistance in learning to live with their mental health presentations, while also receiving social community support to enable them to focus on the positive aspects of life and living. This suggests that social inclusion needs to be a core element of each person's recovery continuum in that they are respected as individual citizens and empowered to integrate as members of their local community. In this regard, the voluntary mental health support networks and community service providers need to be supported by the statutory mental health services to enable them to facilitate social inclusion.

Abbreviations used in Guidance Paper

AOT	Assertive Outreach Team
CMHT	Community Mental Health Team
CRHT	Crisis Resolution and Home Treatment
MHC	Mental Health Commission
SCMH	Sainsbury Centre for Mental Health

Sub group of National Vision for Change Working Group: Components of Acute Community- Based Secondary Mental Health Care

NAME	POSITION	ORGANISATION
Mary Begley	Assistant Director of Nursing	HSE
Leonie Boland	Senior Occupational Therapist	HSE
Michael Byrne	Principal Psychology Manager	HSE
Rita Donovan	Administrator	HSE
Anne Landers	Consultant Psychiatrist	HSE
Tony Leahy	National Planner MH	HSE
Celine O Connor	Social Work Team Leader	HSE
John Redican	CEO	National Service Users Executive (NSUE)



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GUIDANCE PAPER 2

Reporting Structures, Membership, Functions, Structures and Processes of Area Mental Health Management Teams



Developed by
The National Vision for Change Working Group



A Vision for Change
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IN IRELAND



Introduction

In addressing the management and organisation of mental health services *A Vision for Change* sets out some of the challenges that have prompted the new policy:

“The current structure of services has encouraged isolation of catchments from each other and has hindered the development of specialist services. There is considerable variation across catchments in service planning and innovation, with consequent variation in admission rates, certification rates, availability of specialisms, use of treatment procedures and in the range and availability of community and home based treatment options and facilities.”

It proposes the development of larger catchment or service areas primarily on the basis of scale, efficiency and the provision of a comprehensive range of services:

“The larger catchments proposed here are essential to provide for the full range of specialty services required to produce a comprehensive mental health service, and to allow coordination and continuity of care.

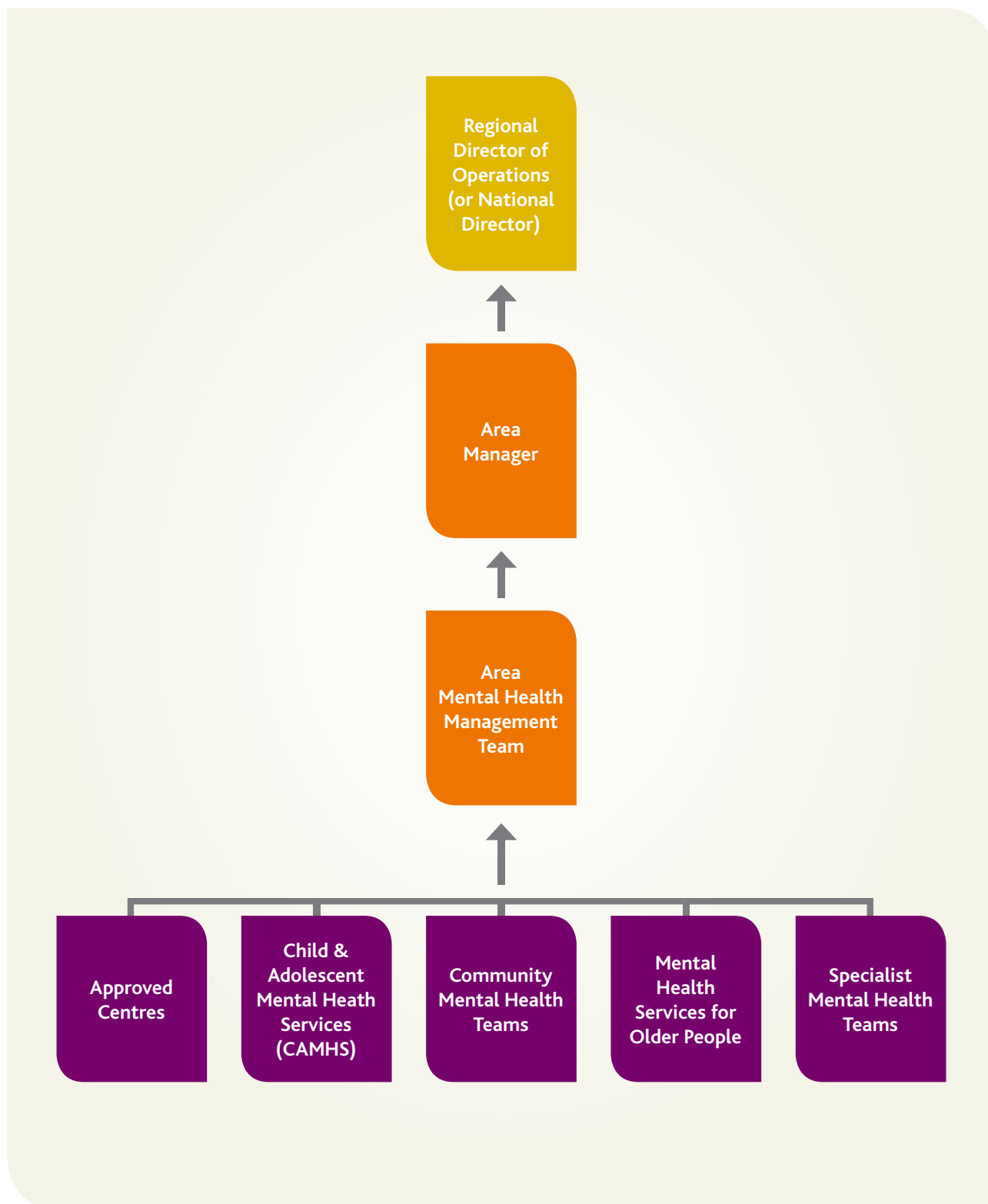
Catchments of this size are also required to allow the efficient placement of a range of facilities which these various specialty services require. These include acute in-patient units, community mental health centres, day hospital and day centre accommodation and community residences.”

Area mental health services (mental health catchments) as currently being configured are substantially larger than heretofore and the Area Mental Health Management Team (Area MHMT) envisaged for these services are considerably different to what currently prevails in composition and function. This guidance document sets out the reporting structures, the membership of the management team, the functions for which it is accountable to the HSE Area Manager, and team structures and teamwork processes.

A. Reporting Structures

In order to progress the recommendations of Vision for Change, the new Area MHMT will replace all existing mental health management structures in its HSE Service Area, as has already happened in some Health Service Areas. As illustrated in Figure 1 below, each Area MHMT will report to the Area Manager who in turn will report to the Regional Director of Operations (RDO) or, if appropriate, the National Director of Mental Health Services.

Figure 1. Reporting structure



B. Membership of the Area Mental Health Management Team (MHMT)

The membership of the Area MHMT will reflect the range of principal stakeholders in lifespan mental health service delivery as outlined in *A Vision for Change*.

1. The Area MHMT will have the minimum number of team members required to manage its mental health services. While team size will ideally not exceed seven members, teams will aspire to approximate this number as best they can.
2. Reflecting the ethos of Vision for Change, the membership of the Area MHMT will be multi-disciplinary in nature.
3. Using criteria such as competencies, knowledge, interest and availability, the HSE Service Area Manager will nominate a vice-Chairperson and the members of the Area MHMT.
4. While the vice-Chairperson will hold his/her position for a period of two years, different disciplines will have the opportunity to fill this rotating role.
5. Operating from a singular management structure, each discipline will be represented on the Area MHMT.
6. Each Area MHMT member will have the authority to make decisions on behalf of his/her discipline.
7. Vested with authority from the HSE Service Area Manager, the composition of the Area MHMT will include a:
 - (1) Business Manager
 - (2) Clinical Psychologist
 - (3) Director of Nursing
 - (4) Executive Clinical Director (Chair)
 - (5) Occupational Therapist
 - (6) Service User
 - (7) Social Worker

Other individuals may be invited to the Area MHMT meetings as service needs determine.

C. Functions of the Area Mental Health Management Team

The new Area MHMT will have overall responsibility for all specialised mental health service provision in its HSE Service Area. This service provision will be integrated, person-centred, accessible and reflective of a broad recovery-oriented model of mental health, with special emphasis on the involvement of service users and their families.

Strategic management

1. Develop HSE strategies to meet local mental health needs.
2. Lead business planning (and prioritisation) around service delivery for (generic and specialist) services within the Service Area.




3. As appropriate, plan goals, indicators and targets against which performance can be measured.
4. Ensure team plans for each (generic and specialist) mental health team are approved and adapted as necessary to reflect recommendations from the (national) Vision for Change Implementation Group.

Operational management

5. Be accountable to the local HSE Service Area Manager.
6. Meet on a monthly basis. Where urgent service delivery decisions need to be made (e.g., relating to risk or particular incidents), these will be addressed by the relevant mental health teams.
7. Not meet unless a quorum (of half of the total number of Area MHMT members plus one) exists.
8. Make meeting minutes available to all Area MHMT members.
9. Make decisions democratically but aspire to consensual decision making.
10. Provide leadership, guidance and support in the implementation of Vision for Change, taking recommendations from the (national) Vision for Change Implementation Group into account.
11. Agree overall HSE Service Area priorities, plans and mental health budget with the Service Area Manager.
12. Ensure that relevant legislation, HSE regulations and policies and procedures are adhered to within the local mental health services.
13. Ensure the recommendations of the Inspectorate of Mental Health Services are implemented and support the Inspectorate and the Mental Health Commission in fulfilling their role.
14. Incorporate best-practice guidelines as recommended by the various Mental Health Commission publications.
15. Ensure that local (generic and specialist) mental health teams are delivering agreed service programmes in an effective and efficient manner.
16. Monitor the achievements of agreed objectives and targets for mental health services within the HSE Service Area, and report on same as required.
17. Support the HSE Service Area Manager by informing and updating him/her with relevant reports to facilitate strategic decision making.
18. Consult with stakeholders (especially local mental health teams) and engage in objective decision-making in order to enhance mental health services.
19. Take lead responsibility for the completion of specific projects.
20. Should the need arise, assist in the process of conflict resolution relevant to local mental health services.
21. Working with local (generic and specialist) mental health teams, ensure the delivery of integrated mental health services with primary care services.

Resource management

22. Advise the HSE Service Area Manager on the effective utilisation of the mental health services budget in line with agreed business plan priorities.
23. Present the annual financial budget / employment control report, and quarterly and deviation reports to the HSE Service Area Manager.

- 
24. To ensure optimum use of resources and that the skill mix within (generic and specialist) mental health teams has the capacity to meet local clinical need, and as informed by submissions from these teams, manage budgets for each team, particularly those relating to the sanctioning and filling of team posts, in accordance with HSE policies and procedures.
 25. Promote the effective use of physical infra-structure and advise on future requirements.

Quality assurance

26. Ensure that a high quality service is provided throughout the service by introducing a range of quality systems (e.g., adherence to best practice guidelines, risk management protocols, staff / customer surveys, clinical audits and all HSE policies and procedures).
27. Commission and approve clinical research where appropriate.
28. Ensure continued professional development is supported within the service to provide that professional standards are maintained and developed.

Communication

29. Ensure that there is effective communication throughout the mental health services.
30. Respond promptly (via the Chair) to the need for information and data from the local Regional Director of Operations and the National Vision for Change Working Group as required.
31. Ensure that the interface with other stakeholders (e.g., Primary Care services, voluntary agencies) is well managed.
32. Minute all monthly Area MHMT meetings and all communication between the Chair and external stakeholders.
33. Promote public confidence in mental health services and strive to reduce stigma by promoting a balanced image of mental health and mental health services throughout the HSE and the community as a whole.
34. Promote harmonious industrial relations through working in a partnership approach.

D. Team structures and teamwork processes

The effectiveness of the Area MHMT will depend on having both the right mix of competencies and skills among the membership and the establishment of agreed effective team structures and teamworking processes and practices.

Getting started

Rather than building the Area MHMT in an incremental manner, and while geographical representation is a consideration, the HSE Service Area Manager will nominate to the Area MHMT individuals that have the competencies required to actively contribute to managing the functions assigned to these teams. To facilitate more effective complex decision making, Area MHMT member numbers need to be kept to a minimum and, at least initially, team member continuity needs to be promoted.

Once Area MHMT membership has been established, each team needs to discuss, agree and formulate the functions of their team, and thereafter, the associated processes. Each team needs to embrace the challenge of openly discussing and working with divergent viewpoints. Doing so will create greater clarity of roles, and a more realistic consensus regarding core issues such as how the team makes decisions and the division of labour. This consensus needs to balance assigned responsibilities (see Table 1 overleaf) with distributing responsibility throughout the team so that members effectively draw on their knowledge, skills and experience to realise team goals (i.e. partnership working). Regarding the latter, and in line with Vision for Change, collaborative working with both primary care and health promotion services needs to be prioritised.

Table 1. Area MHMT member responsibilities.

TEAM MEMBER	RESPONSIBILITIES
All members	Ensure that the functions outlined in Section B above are achieved and each assumes lead roles as assigned through an agreed team process.
Business Manager	Lead responsibility for the planning, organising and provision of the business processes that facilitate the smooth operation and effective delivery of services by the Area mental health service.
Clinical Psychologist, Occupational Therapist, Social Worker	Lead responsibility for discipline-specific clinical governance, supervision, effectiveness and development of the discipline service.
Director of Nursing	Lead responsibility for managing and deploying nursing and care staff and for the planning and delivery of accessible and responsive nursing care services and all clinical governing matters pertaining to nursing.
Executive Clinical Director	Team leader with overall responsibility for service delivery, clinical governance, team functioning and the strategic development of the service.
Service User	Lead responsibility in presenting service user perspectives.

Consolidating and moving forward

Once effective Area MHMT structures and processes have been established, each Area MHMT will document these in a team operational policy document (see Table 2 overleaf). Thereafter, each team will focus on 'getting the job done' or ensuring it undertakes its functions in as efficient a manner as possible.

Table 2. Sample headings for an Area MHMT operational policy document.

	HEADING	SUB-HEADINGS
1.	Introduction	
2.	Team aims and strategy	<ul style="list-style-type: none"> • A statement of values and principles • Essential service standards • Specific team goals • Business planning
3.	Team membership	
4.	Governance structure	
5.	Model of clinical responsibility	
6.	Resource management	<ul style="list-style-type: none"> • Financial budget / employment control reports • Approve posts
7.	Performance management	<ul style="list-style-type: none"> • Audit performance of teams
8.	Quality assurance	
9.	Communication	<ul style="list-style-type: none"> • Decision making • Minuted clinical meetings • Confidentiality • Liaise with external stakeholders • Conflict management
10.	Appendices	

GUIDANCE PAPER 3

**Proposed Job Specification For:
Business Manager,
Area Mental Health Management Team**



Business Manager – Area Mental Health Management Team Proposed Job Specification

The National Mental Health Policy document *A Vision for Change* (2006) recommends the establishment of Multidisciplinary Mental Health Catchment Area Management Teams (in future to be referred to as Area Mental Health Management Teams [Area MHMT]) consisting of senior representatives of the clinical professions, an experienced business manager and a service user representative. It is envisaged that over time Mental Health Catchment Areas will be fully aligned and co-terminus with emerging HSE Areas.

To support the establishment of Mental Health Management Teams and the development of mental health services as an integrated component of local health service delivery expressions of interest are invited from staff at Grade VII³ and above, and equivalent grades and levels in other grade categories currently working in the HSE (*Name region*) to apply for the post of Business Manager – Mental Health Management Team of (*Name Area*)

JOB TITLE: Business Manager – Mental Health Management Team

REPORTS TO: Executive Clinical Director (ECD) – Mental Health

WORKS CLOSELY WITH: Heads of Discipline
Medical Staff
Senior HSE Managers
Regional Mental Health Specialist
Service User & Carer Representatives
Statutory and Voluntary Bodies

KEY RESPONSIBILITIES:

The Business Manager will be responsible for:

- Providing business management to the development, negotiation and implementation of annual and multi-annual business plans for the Area Mental Health Service including required initiatives to ensure the development of a full range of services in line with recommendations outlined in *A Vision for Change* (2006).
- Financial planning and budgetary management.
- Management of the Area MHMT estate and ancillary functions
- Line management of allied health professionals, administrative, catering, maintenance, transport and related support staff⁴
- Leading or support as appropriate on human resource planning and related activities including industrial relations.
- Leading on monitoring and reporting on the achievement of objectives and targets by the Area MHMT to include the performance of the community mental health teams.
- Providing support to the ECD on ensuring that agreed standards for service delivery are established and maintained within agreed budget.

³ In the context of changing organisational structures it is necessary to ensure that the post holder is party to decision making at a sufficiently senior level to enable them to discharge the responsibilities of the post.

⁴ The range of staff categories line managed by the business manager will vary according to current local organisational arrangements and is without prejudice to any evolution of management structures that may occur within Area Mental Health Management Teams or in relation to specific disciplines.

- Providing the Area MHMT and HSE Area Manager with information and reports on service and financial performance as appropriate
- Leading on ensuring compliance with HSE policies, procedures, protocols and guidelines in respect of all business and non clinical processes with particular focus on the area of Quality, Safety and Risk.
- Providing support to the ECD on ensuring compliance through the Area MHMT with legislative requirements including the Mental Health Act, 2001; the Criminal Law Insanity Act, 2010; the Health, Safety and Welfare at Work Act, 2005, the Child Care Act 1991 and any other relevant legislation.
- Supporting day to day management of the functions of the Registered Proprietor as outlined in the Mental Health Act 2001 and Approved Centre Regulations
- Ensuring the availability of appropriate information management systems for the Area MHMT
- In collaboration with other team members, establishing and maintaining good relationships with other service providers, service users and carers and their representative bodies, voluntary organisations and other agencies as required.
- Promoting a culture that values diversity and respect in the workplace.
- Engaging as appropriate in disciplinary, grievance and other procedures in accordance with HSE policies e.g. absenteeism.
- Representing and advocating on behalf of the Area MHMT as appropriate at Area, Regional and National level within HSE
- Promoting and facilitating the integration of Mental Health Service delivery with other components of health care such as Primary Care, Disability Services, Children and Family Services, Older Persons Services and Acute Hospital Services to include where required and feasible participation in cross care group projects at the request of the Area Manager.

The above responsibilities are not intended to be a definitive list of all the duties. The post holder may be required to carry out other duties as appropriate or as assigned from time to time by the ECD / ISA Manager.

GUIDANCE PAPER 4

National Guidance on the Implementation of the Team Co-ordinator Role within Community Mental Health Teams



Prepared by a subgroup of the
National Vision for Change Working Group



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1. Introduction

This guidance was compiled by the National Vision for Change Working Group, to provide guidance for all mental health services in establishing the role of team co-ordinator on Community Mental Health Teams (CMHT's), as outlined in the national mental health policy *A Vision for Change* (DOHC, 2006).

A number of services already have team co-ordinators in place and notwithstanding some differences in their roles and responsibilities, there is clear evidence of the positive contribution that this role has made in terms of triaging referrals and liaising with primary care services. However, there is an opportunity for the team co-ordinator to play an even more significant role in the future, as we face the challenge of developing an effective recovery orientated mental health service within financial constraints.

This guidance document is divided into three parts. Firstly, it will outline what the role of the team co-ordinator entails; secondly, it will examine why we need a team co-ordinator; and thirdly, it will provide advice on how to establish the role of team co-ordinator. A key component of the document is the recommended job specification, which is aligned, insofar as is possible, to the description in *A Vision for Change*. The current financial climate means that the team co-ordinator role will need to be filled from within the existing staff complement and the successful applicant's existing duties will be reconfigured to enable them to take on this important role.

2. What is the role of the Team Co-ordinator?

A Vision for Change emphasises the importance of an enhanced multidisciplinary CMHT, which includes the core skills of psychiatry, nursing, social work, clinical psychology and occupational therapy, in order to provide comprehensive multidisciplinary interventions to address the range of needs of mental health service users. To ensure appropriate governance of the CMHT, it proposes a shared governance model comprising clinical leadership, team co-ordinator and practice manager.

According to *A Vision for Change* the role of Team Co-ordinator includes:

- The administration and triage of referrals in consultation with the consultants and other team members;
- The management of waiting lists;
- The organisation of team meetings, and
- Liaising with GPs and primary care professionals, local community agencies, and self-help and other community resources.

A Vision for Change also recommends that,

"All referrals to the CMHT should be through a single point of entry, clearly identified to primary care services. This function may be assigned to the team co-ordinator, who will bring each new referral to the regular scheduled CMHT for discussion." (AVFC, p81)

The National Vision for Change Working Group is unequivocal in recognising the importance of the team co-ordinator's role, as enshrined in *A Vision for Change*, in facilitating the effective day to day operation of the CMHT and organising and co-ordinating CMHT members' clinical activities.

The Mental Health Commission's publication *Teamwork within Mental Health Services in Ireland* (Byrne and Onyett, 2010) provided another resource in describing the team co-ordinator's role. Chapter four of the document outlines the

shared CMHT governance structure and responsibilities, which emphasises that both the clinical leader and the team co-ordinator have a shared responsibility for providing vision and direction for service development, and that they can motivate and encourage team members to transcend professional self-interests for the greater good of realising team goals.

The document suggests that the Team Co-ordinator's responsibilities are to:

- Provide vision and direction for service development
- Achieve optimum levels of performance
- Co-ordinate processing of referrals
- Organise team meetings
- Liaise with external agencies
- Profile critical skill gaps
- Co-ordinate clinical inputs
- Monitor members' workloads
- Facilitate equitable work-burden distribution
- Co-ordinate members' leave
- Ensure clinical records are adequately maintained
- Profile need for, and organise, teamwork training
- Promote evidence-based team working practices
- Facilitate internal and external conflict resolution
- Lead in formulating operational policy
- Organise team reviews of practice / clinical audit
- Lead in assessment of local clinical need
- Communicate relevant clinical matters and team activities

The National Vision for Change Working Group also agreed that significant preparatory work will need to be undertaken, by the multidisciplinary mental health catchment area management team, to agree CMHT protocols in relation to these responsibilities, so as to ensure that:

- Each professional discipline participates fully in the process;
- The distinct skills and knowledge unique to each professional discipline are recognised within the overall implementation framework;
- Best outcomes for service users are achieved.

3. Why is there a need for a Team Co-ordinator?

There is no doubt that effective leadership is central to ensuring the full realisation of the core functions of the CMHT, which *A Vision for Change* describes as follows:

- To provide support and advice to primary care providers on the appropriate management of individuals in the community, who are experiencing mental health difficulties, and to facilitate referrals to specialist mental health services, as appropriate;
- To provide prompt assessment and treatment of individuals with complex mental health needs;
- To provide a range of interventions for service users with specific mental health needs, drawing on evidence-based and best-practice interventions, and to ensure provision and co-ordination of any additional specialist care required;
- To gain a detailed understanding of the mental health needs and priorities of the local population and establish a database of local resources available to service users, carers and families;
- To assist service users, carers and families in accessing relevant agencies and community supports, so that they can maximise their recovery, and achieve and sustain maximum re-integration in the community.

Over the past decade there has been an increase in the number of CMHTs, including the creation of community, home care and assertive outreach teams. Most teams now have at least some representation from each of the core multidisciplinary mental health professional disciplines of medicine, nursing, occupational therapy, psychology and social work; while some teams also include other professionals such as speech and language therapists, dieticians and counsellors. *A Vision for Change* recommends the establishment of a shared governance model so as to deliver best practice in community based care. However, *A Vision for Change* also recognises that CMHT members “*can find themselves torn between allegiance to their independent professional roles and to function collaboratively with others to realise team goals*” (DOHC, 2006, p82).

The National Vision for Change Working Group acknowledge that the management of CMHTs has become more challenging as teams have expanded, with multiple lines of accountability, and with service responsibility distributed across a number of managers, with no single, clearly identified person responsible for co-ordinating the team. Research has indicated that, in such circumstances, friction can develop regarding workload allocation as there is unlikely to be any objective mechanism to monitor and evaluate individual team members’ workloads.

The findings of a recent survey, conducted by the HSE Primary Care and Mental Health Working Group in 2010, indicate a need to improve communication between staff in Primary Care and Mental Health to ensure co-ordination and continuity of care. The Working Group recommended that this identified need can be most effectively addressed by establishing a model of shared care that meets the needs of both the primary care team and mental health service providers. The model of mental health service provision proposed in *A Vision for Change*, describes a single point of access for GPs wishing to refer individuals to mental health services, or seeking advice and guidance on the management of individuals experiencing mental illness. The proposed model also requires identification of a single point of access for when a crisis response is needed.

Via their professional body, the Irish College of General Practitioners, GPs have expressed the view that having the opportunity to discuss cases of concern with mental health professionals, prior to making a referral, would be very helpful. Other primary care team members have also highlighted the benefit of having a designated contact person to discuss cases of concern. The National Vision for Change Working Group recognise the benefits of having a named team member within the CMHT to advise primary care team colleagues and other relevant services, and suggest that the team co-ordinator is the most appropriate person to put the necessary arrangements in place.

Inter-disciplinary training has also become more common in recent years, including training in respect of the Mental Health Act, risk management, suicide prevention (ASIST), HR policies (e.g. Trust in Care and Dignity at Work) and cognitive behavioural therapy. The Group believes that interdisciplinary training for CMHT members should, where possible, become the norm and that the team co-ordinator, in partnership with relevant line managers, can play a vital role in maintaining a register of the training required, and undertaken, by each team member.

Finally, the team co-ordinator also has the potential to play a lead role in ensuring services are planned, delivered and evaluated in a recovery-orientated manner and to the required standard, so that service users experience a recovery focused approach to treatment and care in accordance with the Mental Health Commission's *Quality Framework for Mental Health Services in Ireland* (MHC, 2007).

4. How to establish the Team Co-ordinator role?

The National Vision for Change Working Group is cognisant of the potential obstacles to implementing change, and of the culture in some CMHTs, for team members to align themselves with their professional discipline rather than the CMHT. There may be a perception among some professional disciplines, that more dominant or prolific disciplines may not always appreciate the particular skill set of other team members and may, in the absence of support from their own professional discipline assign them role that could limit their potential contribution to the team, to the detriment of service users.

The Group reviewed a number of useful resources, published by the Sainsbury Centre for Mental Health, on assimilating different disciplines into an effective team. In particular, *The Capable Practitioner* (SCMH, 2001) states that all mental health professionals require specific skills, knowledge and a particular attitude to work effectively with both service users and carers. Of particular interest to the Group, was the fact that the values, knowledge and skills required for each team member are, for the most part, common to all professional disciplines.

Where the role of team co-ordinator does not currently exist, the National Vision for Change Working Group makes the following recommendations in relation to establishing the role:

1. The multidisciplinary mental health catchment area management team (MHCAMT) should clearly communicate its commitment to establishing the role of team co-ordinator on each and every CMHT within their area of responsibility and to emphasise to all staff the valuable contribution that this role can make to service delivery;
2. The MHCAMT should encourage suitably qualified and experienced staff to submit an expression of interest, emphasising the opportunity for personal and leadership development, and role extension;
3. Notwithstanding that, in the current financial environment, this post will need to be filled from within the current staff complement; the MHCAMT should prioritise the establishment of the team co-ordinator role as an action in their local service plan;
4. A service specific 'Expression of Interest' notice should be issued to all relevant staff and the team co-ordinator role should be assigned to the most appropriate team member following skills match meetings;
5. The team co-ordinator role should be clarified for all team members and relevant service and CMHT level protocols agreed by MHCAMT to support the role. For example, the team co-ordinator will, in his or her absence, need to delegate specific responsibilities to other team members, and this needs to be agreed in any such protocols. Duties such as allocating cases, attending primary care network meetings, offering advice to GPs and other primary care team members.

5. Recommended Job Specification

The National Vision for Change Working Group recommends that each mental health catchment area management team prioritise the selection of a suitable individual on each CMHT, to undertake the role of team co-ordinator, where the role does not currently exist. The Group has developed a recommended job specification to assist mental health services in this process. It is important that the selection process itself is open and transparent.

RECOMMENDED JOB SPECIFICATION TEAM CO-ORDINATOR		
1	Reporting Relationship	The Team Co-ordinator will report to the relevant Line Manager for their professional discipline.
2	Essential Requirements Qualifications and Experience	Recognised Professional Qualification in Nursing, Occupational Therapy, Psychology or Social Work. At least 3 years experience of working in a multidisciplinary mental health setting. Previous management experience and/or a relevant management qualification would be highly desirable.
3	Salary	The role of Team Co-ordinator will be remunerated in accordance with the post holder's existing salary scale and terms and conditions.
4	Purpose of the Post	As an integral part of the shared management structure within the multidisciplinary Community Mental Health Team, you will work towards achieving: <ul style="list-style-type: none"> • A recovery orientated value base among team members; • Effective clinical governance and risk management processes within the team; • Good liaison with the continuum of primary care services, for which you will have a lead role; • The required standards of care and treatment outlined by the Mental Health Commission through a process of clinical audit, performance monitoring and evaluation.
5	Principal Duties and Responsibilities (Continued on next page)	<i>(In accordance with the CMHT's operating protocols and procedures as agreed by the CMHT consultants and the relevant heads of discipline);</i> <ul style="list-style-type: none"> • The Team Co-ordinator will report to the lead consultant in relation to clinical issues, such as, the triaging and prioritisation of referrals. • Informed by team discussion and service user care co-ordinators, ensure routine referrals are processed efficiently in accordance with the team's operational policy. • Ensure meaningful service user, and where appropriate, carer involvement in clinical decisions. • Liaise with Primary Care Teams (GPs and primary care professionals), and other relevant local community services, external agencies, self-help and other community resources. • Take the lead role in organising all relevant team meetings. • Co-ordinate agreed CMHT clinical inputs and communicate the resources required, to the Executive Mental Health Service Management Team. • Monitor team members' workloads in line with agreed discipline-specific workload guidelines (as agreed with relevant heads of discipline) in order to facilitate equitable workload distribution and appropriate service throughput. • Co-ordinate team members' leave, in accordance with the protocols agreed with relevant line managers so as to ensure that there is an adequate number of staff on duty to deliver the required level of service.

5	Principal Duties and Responsibilities (Continued)	<ul style="list-style-type: none"> • Organise on-going audit of clinical records and integrated care plans, and teamwork practice, and address any emerging concerns. • Promote, and ensure progression towards, evidence-based, optimal team working practices. • Develop and update the CMHT's operational policies and monitor clinical activity levels in line with nationally agreed key performance indicators, monthly Health Stat measures and the HSE's National and Regional Service Plans. • Take a lead in establishing the clinical needs of local service users / populations. • Profile the need for, and organise, teamwork training. • Ensure services are planned, delivered and evaluated in a recovery-centred manner, to the required standard within the HSE's organisational philosophy and service delivery framework. • In collaboration with the lead consultant and area business manager, be responsible for strategic and operational planning and identifying new initiatives to facilitate the development of the service. • Manage all allocated resources and formulate, implement and evaluate service plans and budgets in co-operation with the wider healthcare team. • Promote a culture that values diversity and respect in the workplace. • Ensure compliance with the legal requirements of the Mental Health Act, 2001 and any other relevant legislation. • Participate in disciplinary, grievance and other procedures in accordance with HSE policies e.g. attendance management, Dignity at Work etc. • The Team Co-ordinator will report to the Area Mental Health Management Team on matters relating to team co-ordination and team working issues and in this regard, will provide a quarterly written report on progress towards evidence-based, optimal team working practices within the CMHT.
6	Other Professional Duties and Responsibilities	<p>While this is a key post within the CMHT' shared management structure, the post holder will also be required to carry a limited caseload, to provide a clinical service within the CMHT and to maintain their own professional competence.</p>
7	Supervision/ Professional Development	<p>As a member of the shared management structure you will offer advice and support to all members of the CMHT and ensure that all team members have access to relevant professional clinical supervision and continuing professional development planning. In addition, you may have supervisory responsibilities for professional staff within your own discipline</p>

This Job Specification is not intended to be a comprehensive list of the duties and responsibilities pertaining to the role of Team Co-ordinator, which is likely to evolve over time, in the context of the further future implementation of *A Vision for Change* and continued reconfiguration of the Irish healthcare system.



Membership of the Team Co-ordinator Working Group

Frank Browne	Principal Social Worker, Dublin West/South West
Dr Michael Byrne	Principal Psychology Manager, Roscommon
Ber Cahill	Specialist Mental Health
Esther Crowe Mullins	Occupational Therapy Manager, East Galway
Tony Leahy	National Planning Specialist
John Meehan	Specialist Mental Health
Padraig O'Beirne	Director of Nursing, Cavan and Monaghan
Janet Malone	Specialist Mental Health
Dr Noel Sheppard	Executive Clinical Director, Waterford and Wexford

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GUIDANCE PAPER 5

Outline Support Plan to Assist with the Team Functioning of Area Mental Health Management Teams and Professionally Complete Community Mental Health Teams and with the Roll Out of Clinical Care Programmes in these Teams



A Vision for Change

ADVANCING MENTAL HEALTH
IN IRELAND



Introduction

The HSE Service Plan for 2012 commits to the completion of multidisciplinary mental health service management teams, the expansion of community mental health teams (child and adolescent and adult) to ensure the full range of multidisciplinary representation and the preparation of a detailed plan for the implementation of agreed clinical care programmes. The provision of these resources will not of themselves guarantee optimal service user outcomes. Effective team working will be a critical success factor. Particularly where teams are being reconfigured or considerably changed due to the influx of new members or where the work of the team is likely to undergo significant change through the introduction of the new clinical programmes a focus on the development and implementation of agreed robust team processes will be critical in optimising service user outcomes and experience.

Who is this for?

Plans for the completion of Area Mental Health Management teams and the appointment of 400 mental health professionals to professionally complete Community Mental Health Teams and the introduction of the new clinical programmes between them constitute a very considerable change management project. In that context a plan to support change management focussed on team functioning seems appropriate. We recognise that team working is not new and that there are many fine examples of effective team working in mental health services in both inpatient and community mental health settings and hope that this experience and expertise can be made available to assist new, emerging and reconfigured teams. This support plan is intended for all teams but should initially be targeted at those teams who do not work effectively as teams at present or who are being newly reconfigured or significantly altered by the addition of new members or whose current work will be considerably impacted by the introduction of the new clinical programmes and the challenges of operating a recovery oriented service.

Plan

1. Each team is encouraged to use the Mental Health Commission publication *Teamwork within Mental Health Services in Ireland* (2010) as the key reference text and tool to assist it in setting its teamwork agenda and work plan.
2. Each team is recommended to plan three half day team work planning sessions with a facilitator external to the team to identify its team working agenda and establish a plan for designing and developing robust team processes and a governance structure to enable it to deliver effective and efficient mental health services to its target population.
3. The process should commence with all team members completing a teamworking audit (see tool in MHC publication) and submitting to the facilitator in advance of the first facilitated session to guide initial agenda.
4. As team co-ordinators are critical to the effective and efficient delivery of services by the team, a co-ordinator network should be established at Area mental health management level with the purpose of providing a measure of mentoring (12 month period) and peer support (ongoing) and, where there is an identified gap, enhanced teamwork facilitation skills.
5. It is envisaged that the roll out of the clinical programmes within teams will be reliant on the guidance and direction of specialists in the particular clinical area within teams. Specialist networks should be established at Area or Regional level as appropriate to provide a measure of mentoring (12 month period) and peer support.

Some practical considerations

Every new Area Mental Health Team should commit to the plan in relation to its own functioning and work.

Responsibility for determining the sequencing of the roll out of the plan rests with the Area Mental Health Management team following consultation with the teams. Area Mental Health Management Teams should support community mental health teams in the roll out.

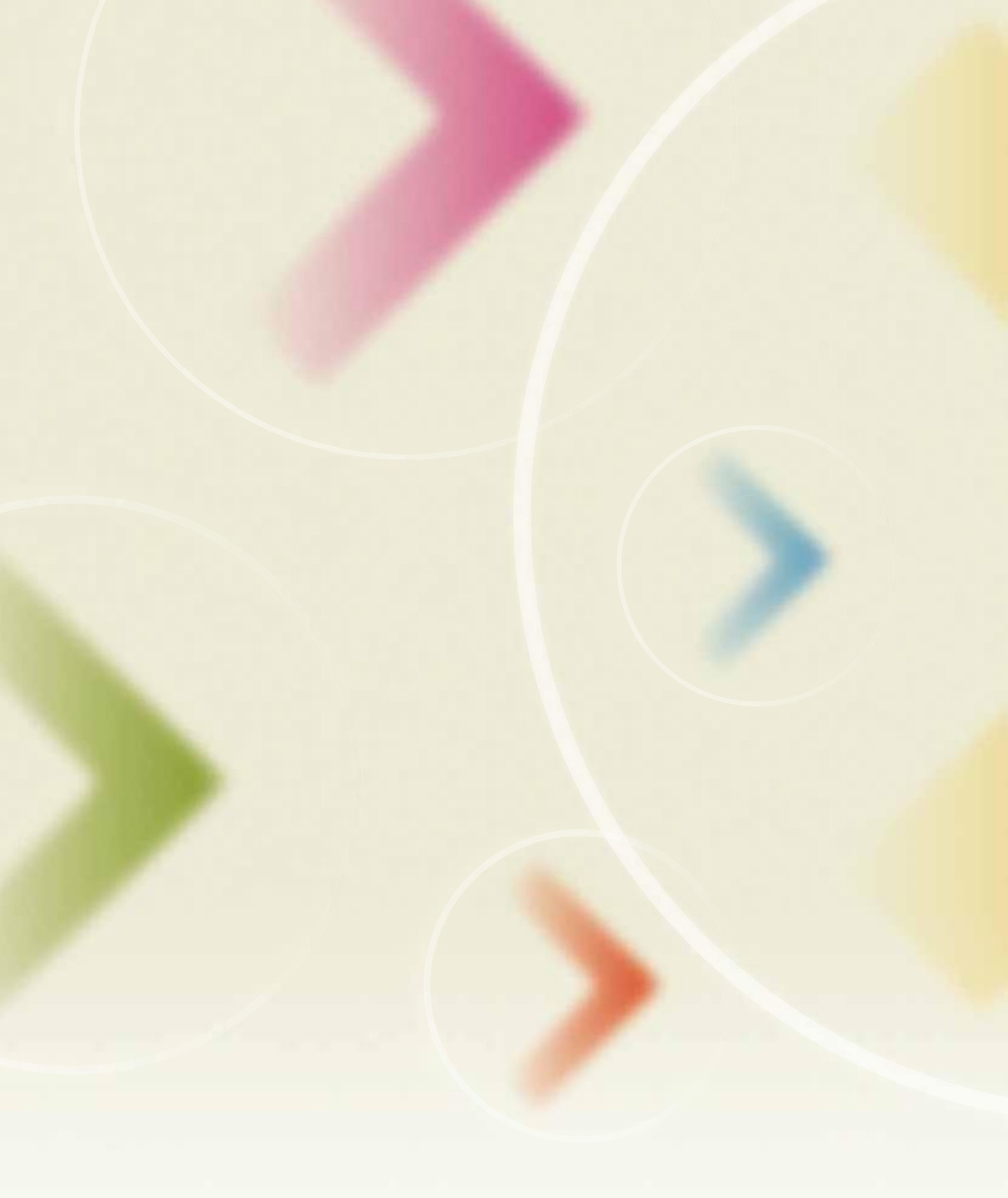
Identification of appropriately skilled facilitators to assist teams in the discharge of the support plan will be addressed in consultation with Succession Planning and Talent Management in the HSE and should, where possible, be sourced from within HSE services.

Planning sessions should be scheduled at intervals appropriate to allow for the achievement of tasks requiring to be undertaken in the intervening time but in any case all three sessions should be completed within a 6 month timeframe.

It is envisaged that the support plan as outlined here is by way of a starting point for what we hope can become a rolling programme at team level to embed required team and skills development in community mental health teams.

Expenses (to be specified and clarified) in relation to the implementation of the plan will be funded by a support plan budget at Regional level and will be available within the current financial year.

Notes



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