Model of Care

Adults Accessing Talking Therapies while Attending Specialist Mental Health Services

HSE Mental Health Services

Version 1.0
Published Date: April 2021
ISBN: 978-1-78602-176-2
Health Service Executive

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Foreword

On behalf of HSE Mental Health Services and the Clinical Strategy and Programmes Division, I am delighted to present this Model of Care for adults accessing talking therapies while attending specialist mental health services.

The HSE has a longstanding commitment to the enhancement of talking therapy provision and the publication of this Model of Care marks another significant milestone. This Model of Care is evidence-based and has been developed in accordance with the HSE's National Framework for developing Policies, Procedures, Protocols and Guidelines. It has been put together in close collaboration with clinicians, service users and family members with experience of delivering or accessing talking therapy interventions. Co-production, inclusivity and transparency have been central to the entire process, as have a continuing focus on how talking therapies may best support the recovery journey of those who need our specialist mental health services.

I would like to thank all of those who contributed and gave so generously of their time to bring the Model of Care to conclusion, including members of the Model of Care Working Group and Sub-Groups, Steering Group and Advisory Committee. I also wish to thank staff and students in the University College Dublin Master's Programme in Psychology who contributed to the literature review, as well as all those who helped in other capacities, including by participating in our engagement events.

This Model of Care builds on a team-wide and multidisciplinary approach to the delivery of talking therapies, as a core offering within our specialist mental health services. When implemented it will ensure greater integration, consistency and equity of access to talking therapies, while maintaining opportunities for local innovation.

The HSE is prioritising investment to demonstrate this Model of Care across five Community Health Organisations with fifteen participating Community Mental Health Teams. Commencing in 2021, this will enable an evaluation of the Model of Care in different service structures, as well as in a range of socio-demographic and geographical settings.

I have no doubt the delivery of this Model of Care will enhance the service user experience, optimise clinical outcomes and further document the importance of continued investment in talking therapies.

Dr Amir Niazi

National Clinical Advisor and Clinical Programmes Group Lead – Mental Health

Message from the HSE National Director, Community Operations

Sharing the Vision sets out an ambitious programme for the continued development and enhancement of Irish mental health services. It is action-oriented, outcomes-focused and adopts a lifecycle approach that places the individual at the centre of service delivery.

From the development of *Sharing the Vision* and through engagements with our staff, service users and carers, we know that greater access to and choice of talking therapies has consistently been identified as a key development priority. This is reflected in *Connecting for Life*, Ireland's national strategy for suicide prevention, as well as in *Sharing the Vision*, which clearly states that talking therapies should be considered a first-line treatment option for most people who experience mental health difficulties. Talking therapies not only presents significant value for the individual service user, it is also clear that investing in this area offers benefits for the overall health service, as well as society as a whole.

It gives me great pleasure to present this Model of Care, as I see its implementation as central to the delivery of high quality mental health services with talking therapies as a fundamental component of our specialist mental health services. This model of care places the service user's individual recovery at the centre. It has a clear outcomes-focused approach and will be delivered by a range of disciplines. In line with *Sharing the Vision*, this Model of Care seeks to facilitate a cultural shift in the awareness and prioritisation of talking therapies within our specialist mental health services. Through leadership and continued collaboration at all levels, I am confident we will achieve this together.

Ms. Yvonne O Neill

Interim National Director, HSE Community Operations

Executive Summary

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

Sharing the Vision Ireland's Mental Health Policy (2020) states that all service elements should include access to talk therapies as a first-line treatment option for most people who experience mental health difficulties. It also states that talk therapies must be delivered by appropriately qualified and accredited professionals. Talking Therapies are an essential element to the effective treatment of mental health difficulties and should be considered a first-line treatment option for most people who experience mental health difficulties. This Model of Care follows a longstanding commitment in Irish mental health policy to enhance access to talking therapies across all areas of our mental health service. When implemented, it will ensure greater integration, consistency and equity of access to talking therapies in our specialist mental health services, while maintaining opportunities for local innovation.

- In addition to evidence of clinical effectiveness, there is now a substantial evidence-base for the significant economic value associated with investing in enhanced access to talking therapies.

- The evidence base including the NICE guidelines, the 'Matrix' (NES Scotland, 2014), the Irish Clinical Programmes for Mental Health and a New Zealand guide to evidence-based talking therapies (Te Pou o te Whakaaro Nui, 2016) offers a comprehensive and useful resource for practitioners working with service users and family members to determine the most appropriate therapeutic approach. Practitioners are also aware that the absence of an established evidence base for a specific talking therapy does not necessarily show it is ineffective, because in many cases there is an emerging evidence-base. This includes therapeutic approaches and the optimum duration of therapy for service users with severe and complex needs and those for members of the travelling community, other ethnic minorities, asylum seekers and refugees. There is a particular need for further research in these areas.

- Numerous variations of stepped or layered care models can be detected in the international literature where there is no one universally accepted model. The proposed key features for a collaborative layered care delivery model in an Irish setting are talking therapies that are easily accessible, evidence-based, recovery-oriented, and provide clear pathways to service users getting the right care in a timely manner. Such a delivery model should be structured around clearly defined levels, in accordance with the intensity of the interventions in question. Low-intensity interventions should primarily be provided at a primary care level. However, certain service users within secondary care could also benefit from low intensity interventions provided within the General Adult Community Mental Health Team (CMHT). High-intensity and specialist interventions should generally be provided in secondary or tertiary mental health services where required.

- It is critical that a thorough assessment of individual needs and case formulation is conducted to match the service user to the right level and type of talking therapy, and that routine measurement of clinical outcomes and ongoing review of interventions takes place, in collaboration with the service user and family members. Appropriate access to talking therapies at all levels and close coordination across the different tiers of service provision is fundamental to an effective layered care delivery model.

- All members of a General Adult CMHT may have a role to play in the delivery of Talking Therapies. A three tier framework is proposed to assist in the conceptualisation of the talking therapist's training and competency (Generic, Intermediate, Specialist). A number of factors should be considered when assessing suitability to practice a therapy, including professional qualification, clinical experience, training and qualification in a particular model of talking therapy, supervision since training and engagement in continuous professional development.

- Access to regular supervision by an appropriately qualified professional is critical to ensure safe, effective and efficient delivery of talking therapies. The frequency and duration of supervision should depend on an individual assessment taking into account time spent by the supervisee delivering talking therapies, size and complexity of the caseload, level of intensity of interventions provided, and the expertise of the supervisee in a particular area or therapeutic approach. Routine measurement of service user outcomes is a key component for the delivery of a high quality service and it is proposed this is done on the basis of agreed metrics and a minimum standard set of clinical outcome measures.

- It is suggested that the Model of Care is demonstrated in initial 5 CHOs with three participating General Adult CMHTs in each of the selected CHOs. As there are significant local variations, it is recommended that each demonstration site complete a mapping of existing service delivery and capacity within and across teams. There will be a need to ensure each of the fifteen participating CMHTs will have the necessary staff capacity and time to drive local implementation of the Model of Care. Within each CHO pilot site, there will furthermore be a requirement to establish a 'mini-hub', staffed by experienced and appropriately qualified talking therapists.

- It is proposed that an interim evaluation on how effective the Model of Care is in meeting service user needs is carried out once demonstration sites have been in operation for a 12-month period, with interim findings shaping the ongoing development of the service in response to feedback. A full formal review of the Model of Care should be conducted after three years in terms of quality, access and value for money in collaboration with all key stakeholders.

A Note on Terminology

Mental Health Difficulty

The term ‘mental health difficulty’ has been used throughout to describe the full range of mental health difficulties that might be encountered, from the psychological distress experienced by many people, to severe mental disorders that affect a smaller population.

Talking Therapies

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

Trauma-informed Care

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

List of Project Membership

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1. Introduction

Sharing the Vision, Ireland's Mental Health Policy (2020), states that all service elements should include access to talk therapies as a first-line treatment option for most people who experience mental health difficulties. It also states that talk therapies must be delivered by appropriately qualified and accredited professionals. The term 'talking therapy' is commonly used to describe any psychological therapy that involves talking, such as counselling or psychotherapy. Talking therapies involve talking to a trained therapist in order to support a person to deal with negative thoughts and feelings, and enable that person to make positive changes (Government of Ireland, 2020).

There is now widespread scientific consensus that talking therapies are an essential element to the effective treatment of mental health difficulties. The evidence of talking therapies is sufficiently robust that comparable healthcare systems (e.g. Australia, New Zealand, USA, England, Wales, Scotland) all highlight psychological interventions in their formal clinical guidelines as a central component of the evidence-based treatment of mental health conditions. Access to talking therapies is a core service offering within Irish specialist mental health services.

There is a longstanding commitment in Irish mental health policy to the development of talking therapies across our mental health services and this has been prioritised in successive HSE service plans. In 2018, HSE Community Operations - Mental Health initiated a national service improvement project. Overseen by a Steering Committee, chaired by the National Clinical Advisor and Clinical Programmes Group Lead - Mental Health, the project saw the development of this Model of Care for adults accessing talking therapies while attending specialist mental health services. The Model of Care has been developed in accordance with the National Framework for developing Policies, Procedures, Protocols and Guidelines (HSE, 2016). It is evidence-based and informed by service users, family members, staff and other key stakeholders.

In order to ensure completion of this project to the highest possible standard, the Steering Committee established a multi-disciplinary Working Group and a number of Sub-Groups in November 2018, which were comprised of clinicians, service users and family members with experience of delivering or accessing talking therapy interventions. Over a twelve month period, the Working Group and Sub-Groups conducted an assessment of the need for talking therapies, informed by stakeholder perspectives on current service offering and prevalence of common mental health difficulties. In collaboration with the HSE Library Service and students in the University College Dublin Master's Programme in Psychology, they reviewed evidence, international guidelines and outlined a collaborative layered care approach for access to talking therapies. They reviewed existing operational guidelines and recommended a delivery model for talking therapies provided by General Adult Community Mental Health Teams (CMHTs), including guidance in relation to competency requirements, supervision, clinical governance, and measurement of outcomes.

Consultation documents summarising initial findings were reviewed by an Advisory Committee with representation from the College of Psychiatrists Ireland, the Psychological Society of Ireland, Irish Institute for Mental Health Nursing, Irish Association of Social Workers, the Association of Occupational Therapists of Ireland and the Irish Association of Speech and Language Therapists. Feedback was subsequently sought from a range of stakeholders, including from General Adult CMHT staff, service users and family members, which has informed the final Model of Care.

When implemented, it will ensure greater integration, consistency and equity of access to talking therapies in our specialist mental health services, while maintaining opportunities for local innovation.

2. Background

Studies have consistently shown that about 75-80% of people who enter psychotherapy show benefit (Norcorss and Lambert, 2010). This robust finding applies across a wide range of disorders and therapy formats, including individual, couple, family and group therapies.

2.1 Prevalence of Mental Health Difficulties in Ireland

Prevalence of mental health difficulties is a measure of the number of people in the population at a single point in time (point prevalence), or within a given year (one-year prevalence), or at some point over their lifetime (lifetime prevalence) who are experiencing mental health difficulties.

Similar to a number of other countries, the availability of information on the prevalence of different mental health difficulties across the Irish population has historically been fragmented, partly due to a lack of large nationally representative epidemiological studies. However, over the past ten years, several significant population-wide studies have been completed, including the National Psychological Wellbeing and Distress Survey (Tedstone Doherty, D., et al., 2007; Tedstone Doherty, D., Moran R. , 2009).

Methodological variations, sample sizes and target populations make it difficult to compare and contrast findings, however, the larger Irish studies indicate similar point prevalence rates between 10 – 12% for psychological distress and common mental health difficulties , including depression and anxiety. This is in line with the World Health Organisation's estimate of a point prevalence of 10% (WHO, 2001). The levels of psychological distress indicated by these studies suggest a potentially very large group of service users, family members and carers for whom talking therapies are likely to be helpful.

2.2 Services Sought by Service Users, Family Members and Carers

Consultations conducted as part of the development of 'A Vision for Change' (VfC) highlighted the need for greater access to psychological or 'talk' therapies with the consensus among users and service providers being that these therapies should be regarded as a fundamental component of basic mental health services, rather than viewed as additional options that are not consistently available.

Since the publication of VfC, a number of listening exercises, surveys and face-to-face consultations with service users, family members and carers have taken place (Mac Gahann L et al, 2010; Mental Health Commission, 2011; NSUE, 2011 and 2012; IMG, 2012; Mental Health Reform 2015; HSE, 2016; Ó Féich P et al, 2019). They are all consistent in seeking greater access to talking therapies. Re-occurring themes include:

- Reported overreliance on medication
- Preference for greater choice of treatment, including choice of talking therapies
- Access to talking therapies is seen as an important element of the recovery journey
- Presence of barriers for accessing talking therapies, including lack of local availability and/or waiting lists

2.3 The Case for Investing in Talking Therapies

In addition to evidence of clinical effectiveness, there is also a significant evidence-base for the economic value associated with investing in enhanced access to talking therapies.

The evidence review conducted to inform 'Sharing the Vision', the successor policy to VfC concluded that 'there is now convincing evidence of the economic and human costs of mental health disorders' (Cullen, K. and McDaid, D., 2017). In Ireland, the overall cost of mental health difficulties was estimated to be over €3 billion in 2006. The direct health related costs accounted for less than one quarter of overall figure with the main costs occurring in terms of lost employment, absenteeism, lost productivity and premature retirement. This figure does not include the significant human and social costs associated with mental health difficulties and the real cost is therefore likely to be significantly higher (O'Shea, E. and Kennelly, B., 2008).

While talking therapies are clearly seen as having significant value for the individual service user, evidence also suggests that investing in this area offers significant value for money for the overall health service, as well as society as a whole (Layard et al, 2007).

Assessments concerning the economic value of talking therapies have generally focused on:

- Cost-benefit, i.e. the ratio between the costs and benefits associated with an intervention, measured in monetary units
- Cost-utility, i.e. the cost of achieving certain health outcomes, typically measured in cost per Quality Adjusted Life Year (QALY)
- Cost-effectiveness, i.e. the ratio of the cost of a particular intervention to a chosen unit of effectiveness (Zilberberg and Shorr, 2010)

Recent studies have reported very favourable cost-benefit, cost-utility and cost-effectiveness values when investing in talking therapies for service users with severe and long-term mental health difficulties (Te Pou, 2012; Rethink Mental Illness, 2014).

Most of the research in this area has focused on Cognitive Behavioural Therapy (CBT), however, it could be expected that talking therapies with similar levels of clinical effectiveness and costs if delivered will provide similar cost benefit to those indicated for CBT (Te Pou, 2012). Economic modelling within the NICE guidelines for the treatment and management of borderline personality disorder (CG78), and psychosis and schizophrenia (CG178) contain further evidence to support the cost-effectiveness of talking therapies for service users with severe and long-term mental health conditions.

3. Rationale and Scope

The national mental health policy framework, 'Sharing the Vision' (2020), recommends that that 'all service elements [...] should include access to talk therapies as a first-line treatment option for most people who experience mental health difficulties' (Government of Ireland, 2020). In addition, one of the key actions in Connecting for Life (2015), Ireland's national strategy to reduce suicide, is to deliver accessible, uniform, evidence based psychological interventions, including counselling at both primary and secondary care levels (Department of Health, 2015). More recently, Sláintecare, the national ten-year programme for the development of health and social care services in Ireland, advocates further enhancement of access to talking therapies.

Significant progress has been made in terms of enhancing access to talking therapies; however, there is no overall agreed standard service delivery model or offering for adults who access talking therapies while attending specialist mental health services. While it is important to ensure that clinicians are free to use clinical judgement, a national Model of Care is required to ensure greater integration, consistency and equity of access to talking therapies, and to facilitate a co-ordinated service development nationally and across local services. This service development will include digital service delivery which has the potential to promote consistency and equity of access.

The Model of Care applies to all adults, including those over the age of 65 years, who are accessing talking therapies while attending General Adult CMHTs. While focusing on specialist mental health services, it also makes reference to talking therapy services in primary care and funded partner organisations. It outlines a collaborative layered approach for the delivery of talking therapies, as service users commonly move between different tiers of service provision in their healthcare journey.

4. Aims and Objectives

Building on the broad objectives for Irish Mental Health Clinical Programmes, the aims for the Model of Care are as follows:

Improved safety and quality in service delivery

- ✔ Improve clinical outcomes for service users by enabling enhanced access to a quality range of evidence-based talking therapies delivered by appropriately qualified talking therapists
- ✔ Enhance safety of talking therapy services through consistent access to supervision and access to support around complex case formulation and assessment

Enhanced access to services

- ✔ Enable implementation of multi-annual plans for training and professional development (within available funding constraints), informed by existing service delivery, therapy resources and capacity

- Enhance co-ordination across General Adult CMHTs to facilitate development of a broad suite of therapies at varying levels of intensity to meet service user needs
- Facilitate access to a range of digital therapies appropriate to varying levels of need including guided online therapy programmes and video enabled therapy

Improved cost-effectiveness and service user experience

- Liaison with other tiers of service within a collaborative layered care model, including Primary Care and funded partner organisations, to ensure the most effective use of available services
- Use evaluation data to inform individual care planning and on-going service development through routine measurement of clinical outcomes and service user experience

5. Core Values and Principles

FIGURE 1: Core Principles Underpinning Model of Care

6. The Effectiveness of Talking Therapies

A pluralistic approach was adopted for the appraisal of evidence in order to capture both evidence-based and practice-based research in support of the effectiveness and efficacy of talking therapies for adults attending community mental health services. The appraisal was based on interventions recommended by the National Institute for Health and Care Excellence (NICE), Irish National Clinical Programmes for Mental Health, the 'Matrix' (NES Scotland, 2014) and additional literature reviewed by the Working Group to address identified gaps in areas of particular relevance to an Irish context.

6.1 Current Evidence-base for Talking Therapies

There is a broad literature base which describes the evidence base for talking therapies. The NICE guidelines, the 'Matrix' (NES Scotland, 2014), the Irish National Clinical Programmes, and a more recent New Zealand guide to evidence-based talking therapies (Te Pou o te Whakaaro Nui, 2016) provide a comprehensive summary of the current evidence-base for the effectiveness of talking therapies. It is important to note that the absence of an established evidence base for a specific talking therapy does not necessarily show it is ineffective, because in many cases emerging evidence-bases exist and this is particularly true in the case of complex presentations.

NICE has produced a series of clinical guidelines, which aims to improve access to services and how mental health difficulties are identified and assessed by providing evidence-based guidance and advice. All guidelines relevant to the scope for this Model of Care were reviewed as part of the appraisal of evidence. However, NICE conducts regular reviews of the various guidelines and it is recommended accessing NICE.org.uk for the most up-to date guideline recommendations.

'The Matrix - A guide to delivering evidence-based psychological therapies in Scotland' provides a summary of the international evidence for the most common talking therapies. Developed by NES Scotland (2014), it is divided into two parts: Part 1, which provides information on the delivery of evidence-based therapies, including factors such as available expertise, training, strategic planning and sustainability of service delivery. Part 2 summarises and grades the evidence-base for common talking therapies and mental health disorders and acts as a guide for practitioners. As the 'evidence base for many common mental health difficulties has already been interrogated using a transparent and rigorous process in the production of the various SIGN and NICE guidelines', the 'Matrix' is primarily based on the available documents at the time of publication. A process of reviewing the Matrix document is currently underway, which is taking into account developments in the evidence for psychological interventions and therapies, and it is recommended accessing nes.scot.nhs.uk for up-dates.

The approach taken by the 'Matrix' and NICE guidelines in relation to grading of evidence for talk therapies is as follows; At least one randomised controlled trial, meta-analysis or systematic review is required for an intervention to be graded as 'highly recommended', while interventions that have been researched using well conducted clinical studies, but where no RCT studies are available, are considered 'Recommended'. Evidence is graded as level C for interventions for which there is no specific evidence but clinical/expert opinion suggests a therapy may be helpful.

Te Pou o te Whakaaro Nui, The National Centre of Mental Health Research, Information and Workforce Development in New Zealand, has developed a suite of tools to support planning and delivery of talking therapies using a stepped care approach. One of these tools is a guide to evidence-based therapies. While primarily referencing 'The Matrix', this guide includes two additional talking therapies commonly delivered in Aotearoa New Zealand, specifically Acceptance and Commitment Therapy and Solution-Focused Brief Therapy. These are not included in the Matrix, NICE or SIGN guidelines as the current evidence available does not reach their criteria for inclusion. Additionally, this guide provides information on the evidence base for talking therapies for cultural groups in New Zealand namely Maori, Pasifica and Asian groups in addition to asylum seekers and migrants. Rather than limit service user and practitioner choice to selected evidence-based approaches the New Zealand guidance advises practitioners to research the evidence base for any additional therapy types they may consider. This approach is consistent with the present Model of Care.

The Irish Mental Health Clinical Programme currently has four programmes, which are informed by a review of published literature to establish international best practice and clinical guidelines. At present three of those programmes recommend specific talking therapies, namely the programmes relating to eating disorders, first episode psychosis and ADHD. A Model of Care for Eating Disorders was published January 2019, which recommends access to CBT-E, Focal Psychodynamic Therapy, Cognitive Remediation Therapy and the Maudsley Model of Anorexia Treatment in Adults. In addition to competencies in these therapies, it is recommended each eating disorder team has a number of core mental health therapeutic skills (emotional regulation, group facilitation, Dialectic Behavioural Therapy skills), along with an understanding of psychodynamic principles, including dynamics of therapeutic relationship. A Model of Care for Early intervention for people developing first episode psychosis was published May 2019, which recommends that a range of psychological interventions should be made available routinely and promptly to service users depending on their clinical needs and engagement. These include CBT – P (Psychosis), Behavioural Family Therapy and Cognitive Remediation Training. It is further recommended that low-intensity psychological interventions such as psycho education, relapse prevention and problem-solving strategies should be offered to all services users with first episode psychosis during their recovery. Many low-intensity interventions can be delivered online and delivered as an adjunct to any more intensive services that are needed. The Model of Care ADHD in Adults was published in January 2021 and recommends ADHD specific CBT in group format.

6.2 Influence of Common Factors

It is widely accepted that a number of common factors play an important role for the overall effectiveness of talking therapies, including:

- Establishing a strong therapeutic alliance (Corrêa et al, 2016; Falkenström et al, 2013; Horvath, 2013)
- Process for formulating therapeutic goals and creating a supportive therapeutic environment (Lambert and Barley, 2001; Messer and Wampold, 2002; Norcross, 2011, Lingiardi et al, 2018)
- Readiness of service users to engage in talking therapies, motivation and access to social support (Bohart and Wade 2013; Clarkin and Levy, 2004; Nilsson et al., 2007)

- Significant events, such as problem clarification or a sense of empowerment that contributed to a better relationship between the service user and therapist (Timulak & Keogh, 2017).
- Therapeutic competence, ability to match therapeutic style to service users' needs, and problem-solving creativity (Beutler et al., 2004)
- Access to supervision and training for the therapist delivering talking therapies (Driscoll et al., 2003; Lambert and Ogels, 1997; Norcross, 2005; Roth and Fonagy, 2005)

There is extensive research supporting the common factors in talking therapies which are consistently found to be more important predictors of clinical outcome than technical or specific aspects of therapy (Laska et al 2014). The key issue is not which common factor is important but how they relate to each other so that they can be successfully tailored to meet specific service user needs (Norcross and Wampold, 2011). Ensuring coordinated service development given the need to tailor interventions is a key challenge.

A systematic review of qualitative common factors (Flanagan & Hennessy UCD, 2019) found that service users benefit from both specific treatment techniques (such as skills training, emotion processing) as well as common factor techniques such as empathy, non-judgemental listening) when these are utilised in a way that is tailored to the service user's specific needs, worldview, skills and resources (Leibert, 2011) and which supports service user choice in decision making about treatment. This requires a capacity on the part of the therapist to appreciate the needs and preferences of the service user and to adjust their practice approach early in the therapy and in a responsive way so as to facilitate positive outcomes in therapy (Duncan et al, 2010).

Therapists who integrate common factors research into their practice in a way that fits with service user perspectives and needs are more likely to develop stronger relationships with the service user, more collaboration and thus achieve more successful therapeutic outcomes (Timulak & Keogh, 2017).

6.3 Complex Psychological Needs

Complex psychological needs can take many forms including complex trauma or developmental trauma, personality disorders, and those with multiple diagnoses. It can also include people who experience moderate to severe mental health difficulties in a context of challenging systemic or environmental issues. Often people who present to specialist mental health teams have complex psychological needs which do not necessarily respond to a particular therapeutic pathway as set down in clinical guidelines. This means that clinicians need to draw on available research evidence, integrated knowledge and clinical experience as well as the broad perspective of the multidisciplinary team which is the mainstay of specialist services.

There are a number of approaches in the NICE guidelines and the Matrix which may be useful when working with complex psychological needs. Therapists working with people with these needs will need to have a comprehensive understanding of those therapies that have been shown to have some evidence with these kinds of difficulties e.g. DBT, mentalisation based approaches etc. There is also emerging evidence for additional approaches. There is growing consensus that a phased based approach to the provision of talking therapies may be required for service users who have experienced complex trauma (Cloitre et al, 2011; ISTS, 2018).

Length of Psychotherapeutic Input

It is important both clinically and economically, to distinguish between service users who may benefit sufficiently from short-term psychotherapy and those who may require longer term psychotherapy. (Leichsenring et al 2013).

There is a paucity of research in the area of optimum duration of talking therapy service provision for people with complex mental health difficulties (Robinson et al, 2019: Juul et al 2019). The available evidence suggests that service users experiencing complex mental distress, i.e. schizophrenia, chronic psychiatric disorders (defined as lasting at least a year), personality disorders or multiple psychiatric disorders (Leichsenring and Rabung, 2008) require longer and more intensive psychotherapy than those experiencing acute distress (Leichsenring and Rabung, 2008; Juul et al 2019). However, the appropriate psychotherapy duration for psychiatric disorders has not to date been systematically reviewed (Juul et al, 2019).

Most of research available around length of input has focused on people experiencing mild to moderate mental health difficulties. A systematic review of this data has indicated that 4 - 26 sessions may be necessary for people with such difficulties, with poly-symptomatic populations with more severe symptoms requiring more input (Robinson et al, 2019). Therefore, it is reasonable to assume that those presenting with more severe, chronic and complex difficulties such as trauma may benefit from longer term therapeutic inputs. The lack of conclusive research renders treatment planning and policy decisions regarding services in this area difficult. Services will need to be guided by the research evidence to guide them on optimal length of treatment using various approaches, and where service users are not responding as hoped, all factors impacting progress should be considered. These include service user and therapist factors and the match of intervention to the person's individual style. Clinical review and supervision should assist in guiding therapists to optimise the approach for a given service user.

6.4 Interventions that are Sensitive to the Cultural Needs of Specific Populations

Ireland has an increasingly diverse population. Consistent with the approach adopted by Te Pou, who make specific reference to the ethnic minorities of the Maori Pasifica and Asian people, the evidence base for the Traveller and Roma community, and refugees, asylum seekers and new migrants were therefore included. Key recommendations from the literature to assist effective engagement with Traveller and Roma people in health services and in therapy include:

- Health professionals should receive cultural competence training in Traveller and Roma issues, particularly in relation to death and bereavement (Van Cleempit et al, 2007).
- A proactive and collaborative approach between Traveller organisations and mainstream mental health services is required. (Pavee Point, 2018)
- Crisis intervention services are needed to fit in with the nomadic cultural traditions (Yin-Har Lau and Ridge, 2011),
- A gendered strategy needs to be adopted and men's health issues, including those around mental health, need to be addressed specifically. (AITHS, 2010)

6.5 Consideration of Unintended Potentially Adverse Effects of Psychotherapy

The vast majority of people who enter psychotherapy show benefit, however, outcomes are not exclusively positive. Studies have indicated that between 5 and 8.2% have negative outcomes, experiencing worse symptoms at the end of therapy than at the start of the process (Barkham et al., 2001; Hansen et al., 2002).

There is an important difference between an unsuccessful therapy and a harmful one. Therapeutic harm has been defined as "enduring negative effects directly caused by therapy" (Curran et al, 2019). Recently, researchers have recognised the need for further study of negative and harmful effects of therapy (e.g. Parry et al, 2016; Scott et al, 2016; Crawford et al, 2016).

Key considerations which should be factored when practicing psychotherapy include that the service user has a voice in the process of psychotherapy, there is on-going training, supervision and accreditation of competence in therapists and that there is sufficient clinical expertise in the assessment and formulation of the selected psychotherapy type.

6.6 Caseload Management

The management of therapists' caseloads is a difficult undertaking (Spernaes et al, 2017). Considering only the number of service users that a clinician has on their caseloads as a representation on their workload is insufficient. It is also necessary to take into account the complexity of the service users' presentations and the implications that this complexity may have on the clinician's resources. It also does not recognise the other activities that a clinician may carry out, e.g. consultation work, team meetings, supervision duties, training commitments, service development and travel (Spernaes et al, 2017).

King et al (2004) identified seven factors that may impinge on caseload management. These included:

- Contact frequency – how often a service user uses the service.
- Response difficulty – the complexity of presenting service users' difficulties.
- Intervention type – whether this be group or individual, long-term or shorter-term interventions.
- Competence/seniority – individual therapist's attributes may be relevant.
- Caseload maturity – initial parts of the therapeutic process may require different time commitments to later ones.
- Location of service users – clinicians may have to travel to see service users, particularly in rural locations.
- Roles other than case management – clinicians hold many other commitments within mental health services including team meetings, consultation, supervision etc.

Various caseload management tools have been developed within mental health services in the UK (e.g. Butler, 2005; Spernaes et al 2017). Some consideration around the use of such a tool for psychotherapists may be useful in the mental health services in Ireland. An important point to consider in this area is the recognition of the psychological impact on clinicians of working with people who have experienced trauma. Many studies have demonstrated this (e.g. Cieslak et al, 2017, Thompson et al, 2014), and due consideration may benefit service provision in the area in the longer term.

7. Current Talking Therapy Services for Adults in Ireland

Information gathered as part of national service improvement programmes show that General Adult CMHTs, within existing resources, are offering a range of talking therapies to address service users' needs and that all disciplines to varying degrees are involved in the delivery of those therapies. In addition to therapies offered through specialist mental health services, the HSE also provides interventions to adults at primary care level, including Primary Care Psychology Services, Counselling in Primary Care and the National Counselling Service. Complementing services provided by directly employed staff, the HSE furthermore funds a number of partner organisations to deliver talking therapies. Many of these partner organisations have recently adopted a blended approach to service delivery modality by offering a choice of face to face, video-enabled or phone-based therapy.

'Sharing the Vision' (2020), recognises that no single service can cater for the diverse needs of a person with mental health difficulties. It points to the requirement for a 'stepped care approach' whereby the individual is enabled to avail of a range of mental health supports and services, as close to home as possible and at the level of complexity that corresponds best to their needs and circumstances. Similarly, the guidance document on 'Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services' (HSE, 2012), emphasised the importance of timely access to psychological and counselling therapies and recommended that a stepped care model of service should be evaluated and further developed. However, numerous variations of stepped care can be detected in the international literature, rather than one universally accepted model. This Model of Care outlines a collaborative layered care delivery model, incorporating elements from a number of different models, in order to best reflect the Irish health system, settings and platforms for accessing talking therapies. This approach acknowledges that service users commonly move between different tiers of service provision in their healthcare journey.

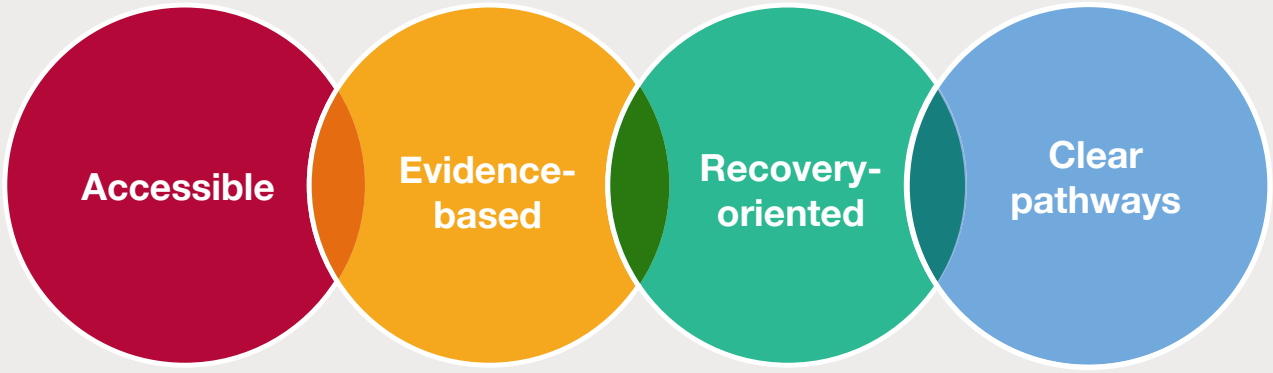
Historically, the development of talking therapies services in Ireland have been influenced by a number of factors, including the development of mental health services and its workforce, the mix of public and private healthcare provision, and the emergence of specific mental health charities. As a consequence, access to talking therapies can vary depending on where one lives and whether one has the financial resources to privately pay for a talking therapy. As emphasised in Sláintecare, there is a growing recognition that access to talking therapies need to be considered a core offering of the public healthcare system, without financial barriers and based on clinical need.

Appropriate access to talking therapies at all levels (primary/secondary/tertiary) and close coordination across the different tiers of service provision is fundamental to an effective collaborative layered care delivery model. Investment in new services will therefore need to be cognisant of where current deficits exist, both geographically and also across the different tiers of service provision, to ensure the best possible use of available resources. Where they are suitable to meet mental health need, digital supports offer the opportunity to transcend any geographical barriers to access while also representing scalable, value for money solutions.

7.1 A Collaborative Layered Care Delivery Model for Talking Therapies

The overarching key features for a collaborative layered care delivery model are that talking therapies in mental health services are *easily accessible, evidence-based, recovery-oriented and consist of clear pathways to service users getting the right care in a timely manner.*

FIGURE 2 Key Features of Collaborative Layered Care Delivery Model



EASILY ACCESSIBLE

- ✔ A single, clear referral process for referring individuals for talking therapies should be established and communicated to professionals both within and outside the mental health service.
- ✔ Information about the nature of talking therapies provided by the service should be communicated to all service users who access the service and should be in a form that is easily comprehensible (e.g. in a range of languages).
- ✔ Where appropriate, services should explore and create opportunities for family and carer involvement.
- ✔ Referral pathways should regularly be reviewed with all relevant stakeholders (including service user representatives) to ensure they are best meeting the needs of service users and involve minimal barriers.
- ✔ Internal referral pathways (e.g. service users already within mental health services being referred for taking therapies) should involve consultation between the referrer, the service user and the talking therapy service.
- ✔ Explicit criteria for accessing (focusing on entry rather than exclusion) talking therapies should be established and communicated.
- ✔ Wherever possible, talking therapies should be provided in a range of settings that facilitate ease of access and service user choice, while protecting the service user's privacy.

- When provided face-to-face, talking therapies should be delivered in inviting and comfortable settings to support a positive service experience
- Talking therapies should be offered in a range of modalities (including by phone and video) to facilitate ease of access and service user choice.
- Mental health services should work with community partners to minimise predictable practical barriers to attendance (e.g. childcare/ crèche facilities, mobility/assistance with travel).
- Mental health services should be mindful of the specific cultural needs of their communities in accessing talking therapies (e.g. availing of culturally sensitive-bilingual therapists/independent interpreters).

EVIDENCE-BASED

- Services should become aware of emerging knowledge concerning 'trauma-informed care'
- Talking therapies should be provided by practitioners, across disciplines, who are appropriately trained and competent in the safe and effective provision of the specific interventions.
- Routine measurement of clinical outcomes, and service user experience, should be undertaken with the resultant information audited and published as part of ongoing service evaluation.
- Robust clinical governance of the service should be provided by senior practitioners with advanced level expertise and experience of the provision and evaluation of talking therapies, and should include the regular provision of appropriate clinical supervision.

PATHWAYS TO THE RIGHT CARE

- The choice of appropriate talking therapy should involve a thorough assessment of individual needs and appropriate matching to a therapy or appropriate alternative supports. This should take into account a range of factors, including addiction and substance misuse
- However, cognisant of the stigma that can still be attached to availing of a service, and the distress involved in multiple re-telling of their difficulties, services should seek to minimise the number of assessments service users are asked to undertake to access appropriate treatment and care
- The appropriate 'layer' and level of intensity of intervention should be determined, in discussion with the service user, on the basis of the individual's needs, and best practice guidelines.
- A clear process should be developed whereby a person moves through a specific care pathway and interventions can be adjusted or alternative therapies undertaken, in response to ongoing clinical and service user feedback.
- Providers of talking therapies at the Primary Care tier, in reviewing their referral pathways, may find it helpful to examine the practice of certain services who have successfully, over many years, adopted a self-referral pathway to accessing support.
- Both Primary and Secondary Care providers of talking therapy should liaise closely to ensure integrated planning and care pathways for service users in their community.

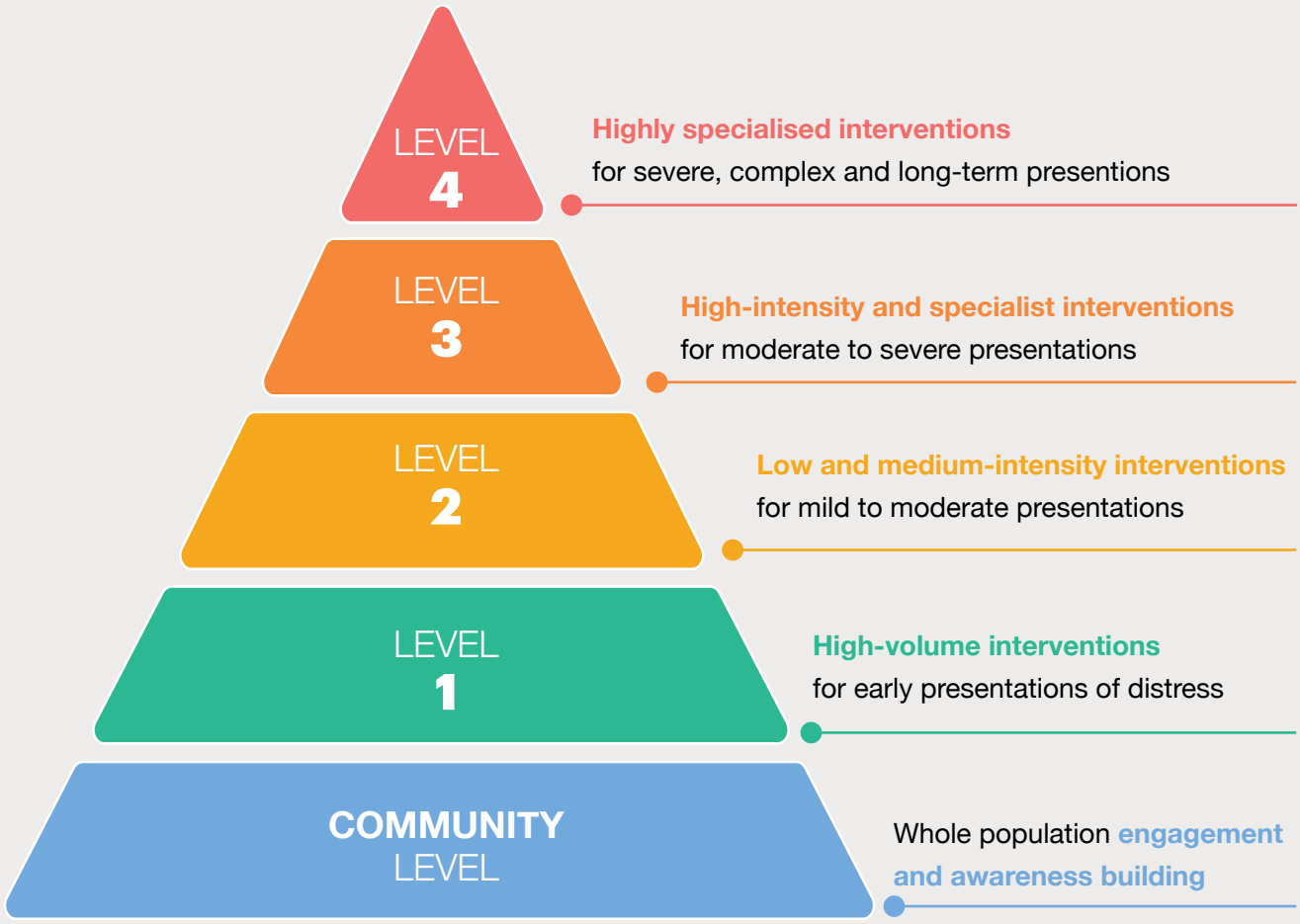
RECOVERY-ORIENTED

- Services should actively ensure the involvement and empowerment of service users, family members and carers in both accessing support and shaping the nature of service delivery.
- At assessment, services should actively facilitate the involvement of family members/carers/supporters, where desired by service users, and provide, as standard, information on the nature of the service.
- Services should explore the usefulness of meetings with family members/carers/supporters at different points throughout the service user's journey to build positive partnerships supporting care and treatment.
- Services should include, amongst the suite of therapies available, evidence-based options that actively involve family members/carers/supporters (e.g. systemic therapy, behavioural family therapy, behavioural couple therapy) such that, where appropriate and desired by the individuals involved, key partners in the individuals recovery can be actively engaged in therapeutic work.
- Talking therapies should centre on strong, collaborative therapeutic alliances with service users, built on the principles of co-production and recovery.
- Wherever possible, service users should be provided with a choice as to the nature of psychological intervention offered them.
- The provision of talking therapies should be as part of an individualised recovery-oriented care plan developed in collaboration with the service user.

7.2 Levels of Intensity of Talking Therapy

Figure 3 on the following page illustrates the varying levels of intensity in talking therapy interventions, as provided across the different tiers of service, settings and platforms.

FIGURE 3 Levels of Intensity of Talking Therapy



The tables below provide further detail on what type of intervention may be provided, who may benefit from such interventions, and who may provide them.

COMMUNITY LEVEL

Presentations Who May Benefit	Whole population
Intervention	Community information and 'resilience building' e.g. positive mental health articles in local newspapers/ local radio / stalls at community events / awareness building on identifying distress and sources of support / contributing to directories of local support, using social media and mobile apps in a coordinated way to ensure widespread reach
By whom	NGOs/funded partner organisations, Primary Care Psychology, online platforms, HSE Public Health, NOSP, yourmentalhealth.ie

LEVEL 1 High-volume Interventions

Presentations Who May Benefit	Focus of intervention is on the source of the mild level of distress, (e.g. stress brought on by changing life circumstances). There is general stability in the presentation, can engage with, and benefit from a self-directed, low intensity intervention
Intervention	High-volume interventions, such as active listening and monitoring, psycho-education, self-care programmes, e.g. stress and anxiety management, WRAP, self-directed online CBT, social prescribing and self-help groups
By whom	In Primary Tier (as the main treatment): GPs/Primary Care Teams, NGOs/funded partner organisations, Primary Care Psychology, online platforms In Secondary/Tertiary Tier General Adult CMHT staff and mental health staff in specialist services, where appropriate and as a small part of an overall care package

LEVEL 2 Low and Medium-intensity Interventions

Presentations Who May Benefit	Focus of intervention is on the source of the mild to moderate level of distress. The distress may be persistent and impairing daily functioning. The individual is open to engaging with regular sessions of psychological therapy
Intervention	Brief, evidence-based, and predominantly single theory talking therapies, guided online therapy
By whom	In Primary Tier (as the main treatment): CIPC, NCS, primary care psychology services, NGOs/funded partner organisations, therapist-assisted online platforms In Secondary/Tertiary Tier General Adult CMHT staff and mental health staff in specialist services, where appropriate and as a small part of an overall care package

LEVEL 3 High-intensity and Specialist Interventions

Presentations Who May Benefit	Focus of intervention is on the source of the moderate to severe level of distress. The distress is causing significant impairment in functioning. There may be co-existing problems, a history of complex and long-term problems, and/or may not have responded to previous interventions
Intervention	High-intensity and specialist interventions
By whom	Accredited talking therapists in General Adult CMHTs with intermediate/advanced competency in the psychological treatment of moderate to severe mental disorders

LEVEL 4 Highly Specialist Interventions	
Presentations Who May Benefit	Focus of intervention is on the severe, complex and/or long-term source of the distress. The level of impairment on functioning is severe and longstanding. Co-existing problems may be present and/or have not responded to previous interventions
Intervention	Highly specialist interventions
By whom	Accredited highly experienced talking therapists in General Adult CMHTs with advanced competency in the psychological treatment of severe, complex and long-term presentations

7.3 Assessing Need, Formulation and Matching to Therapies

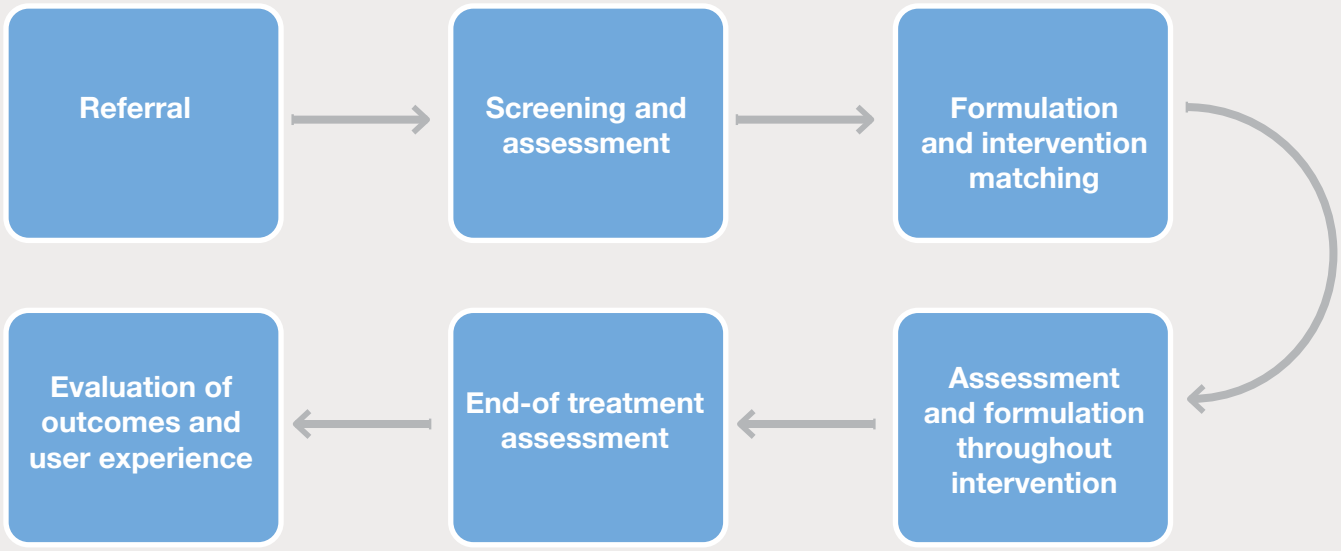
Within a layered care model for accessing talking therapies, it is critical to ensure a service user is matched to the right level and type of therapy to ensure his or her needs and preferences are being met. This is based on assessing and reviewing a range of factors. These factors may change over time and it is therefore advisable not to base the review/assessment on rigid criteria (NES Scotland, 2014). In addition it is important to note the recommendation in Sharing the Vision (2020) that service users are enabled to be key decision-makers in their own care or recovery plan.

Factors to consider include:

- Cultural issues
- Identification of presenting problem and level of distress
- Mental health and addiction assessment and screening
- Person's strengths, choices and goals
- Readiness and motivation for change
- Clinical and therapist opinion
- Issues of risk
- Co-existing problems
- Involvement of family
- Evidence-based talking therapy and availability of resources (TePou o TeWhaakaro Nui 2015)
- Developmental history (i.e. important childhood, educational and occupational milestones and experiences including important relationships and trauma)

Assessment, formulation, monitoring of outcomes and review of interventions/therapeutic approach is a continuous process throughout the service user journey, as shown in the visual below.

FIGURE 4: Assessment and Formulation Process



Cultural issues

The cultural appropriateness of screening and assessment tools requires consideration to ensure understanding and accuracy of assessment. The screening and assessment tools may not be accessible to some populations for many reasons such as, literacy issues, language barriers and differences in cultural norms. Overcoming linguistic barriers could be achieved via an interpreter. The interpreter should be knowledgeable of mental health terminology, be familiar with the concepts and purposes of the assessment interview, and be unknown to the service user. Some studies have noted to avoid asking family members or friends of the service user to serve as interpreters (SAMSHA 2014).

Presenting problem and level of distress

'Screening is often the first contact between the service user and the treatment provider, and the service user forms his or her first impression of treatment during this intake process. Thus, how screening is conducted can be as important as the actual information gathered, it sets the tone of treatment and begins the relationship with the service user' (SAMSHA TIP 57, 2014).

The person's presenting problem(s) and/or disorder(s) and level of distress need to be understood and clarified. Assessment will determine the appropriate level of therapy (TePou o TeWhaakaro Nui 2015). Assessment needs to take into account other potential causes of low mood or depressive symptoms such as undiagnosed physical illnesses.

Mental health and addiction assessment and screening

The term "dual diagnosis" refers to cases when a person has one or more mental disorders as well as one or more substance use disorders. Co-occurring disorders are common among individuals who have a history of mental illness. Assessment and screening can be carried out through brief verbal discussion, formal assessment tools or full specialist assessment. It is recommended that all people presenting with mental health problems should be screened for substance use (TePou o TeWhaakaro Nui 2015).

Strengths, choices and goals

Collaboration is vital in setting out a clear pathway for someone accessing talking therapies within the Model of Care. It is important to incorporate a person's strengths, choices and goals into the assessment process. These need to be respected as they help to direct the choice of support and therapy and may influence therapy effectiveness (Lambert and Barley, 2001; Messer and Wampold, 2002; Norcross, 2011, Lingiardi et al, 2018) Good engagement and a positive therapeutic relationship between the practitioner and the person is one of the best predictors of successful outcomes (Corrêa et al, 2016; Falkenström et al, 2013; Horvath, 2013). This is further improved by mutually agreed upon goals and the ongoing feedback the person gives regarding any support and therapy they are receiving (TePou o TeWhaakaro Nui, 2015).

Readiness and motivation for change

As part of the assessment, it is important for the clinician to consider the motivation and readiness of service users to engage in talking therapies. There is broad consensus in the literature that this, alongside the strength of the therapeutic relationship, are important predictors for the effectiveness of any intervention (Bohart and Wade 2013; Clarkin and Levy, 2004; Nilsson et al., 2007).

Clinical and therapist opinion

The clinical and therapeutic opinion and recommendations of the assessing and/or treating practitioner needs to be used in conjunction with information from any screening and assessment measures to determine the type and level of therapy. Information from other teams or practitioners may also provide useful opinion. Scores on screening and assessment tools are only one source of information. It is important not to solely rely on such measures when matching to a level of therapy, such as, when working with different cultural groups (NHS Scotland, 2014; TePou o TeWhaakaro Nui, 2015).

Issues of risk

Where indicated, risk to the health of the person needs to be assessed. Health risks may be the deterioration of mental health, a problem with alcohol or other substances and/or gambling, risk of self-harm or suicide or harm to others, or physical health problems. This may require further assessment and consultation. Crisis intervention and stabilisation of mental health or addiction issues may be needed before referral for therapy (NHS Scotland, 2014; TePou o TeWhaakaro Nui, 2015).

Co-existing problems

Practitioners need to consider co-existing problems that may be contributing to problems or distress. These may require assessment and referral to other services. Issues can include speech, language and communication issues, substance misuse, criminal involvement, financial difficulties and physical illness.

Broader social challenges affecting mental health may include family responsibilities, stress, poverty, unemployment, housing, social or immigration/cultural displacement. (TePou o TeWhaakaro Nui 2015). The presence of trauma and/or interpersonal violence needs to be assessed for. Research suggests that co-occurring disorders are common among individuals with a history of trauma, in particular for those with mental and substance use disorders (Najavits, 2004).

Involvement of family

Where appropriate, involvement of family members and carers should be explored and supported service user journey, in order to support them in processing and making sense of the mental health difficulties experienced by their loved one, and help them address their own individual needs (WHO, 2013; Crane and Payne, 2011).

Evidence-based talking therapy

The NICE guidelines, the 'Matrix', the Clinical Programmes for Mental Health and a recent New Zealand guide to evidence-based talking therapies (Te Pou o te Whakaaro Nui, 2016) summarise the current evidence-base for the clinical effectiveness of talking therapies in a specialist mental health setting. As noted above, these offer a comprehensive and useful resource for practitioners working with service users and family members to determine the most appropriate therapeutic approach. However, the absence of an established evidence base for a specific talking therapy does not necessarily show it is ineffective, but in many cases that there is an emerging evidence-base.

Developmental History

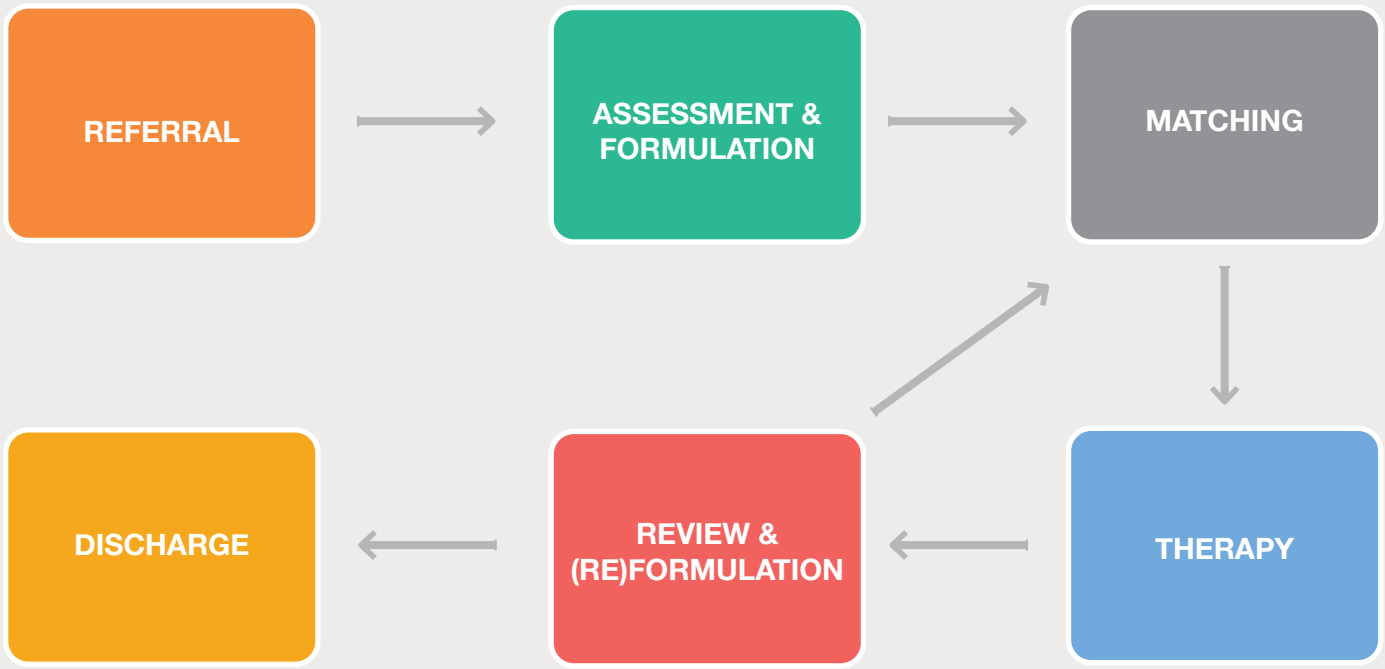
Developmental experiences including the quality of childhood attachment and adverse childhood experiences, are predictive of the quality of adult relationships (Feeney & Noller, 1990; Van Ijzendoorn, 1995; Riggs & Kaminski, 2010). These are also associated with the risk of developing mental health difficulties in adulthood (Merrick et al, 2017; Dozier, 2008; Edwards et al, 2003). Experiences of past trauma (including abuse) increases the risk for, and can help explain the nature of, many mental health difficulties experienced in adulthood (Read & Bentall, 2012). A comprehensive developmental history looking at developmental milestones as well as the quality of childhood experiences including important relationships and past psychological trauma can provide a solid basis upon which to base a psychological formulation of the current difficulties. This will also assist the therapist to determine when other issues eg. those relating to speech and language or cognitive difficulties should inform the formulation.

Formulation and Intervention Matching

Case formulation brings together the different pieces of information gained in assessment to develop a coherent understanding of the basis of someone's distress and readiness for change. Individualised case formulations, in guiding the choice of psychotherapeutic intervention, will be informed by the body of psychological knowledge and models that underpin the psychotherapeutic work (e.g. learning theory, attachment theory, unconscious processes, impact of trauma etc). Such an understanding, in collaboration with the service user, then guides the choice of intervention best suited to alleviate the individual's distress. As such, formulation is the lynch-pin for a successful intervention matching.

Mental health teams commonly see a diverse range of presentations and service users often have quite varying personal recovery goals. Consequently, it is crucial that there is adequate expertise within team to formulate using a range of psychotherapeutic models to ensure the treatment plan is bespoke to the individual's needs and recovery goals. Effective formulations can also help inform the broader team's input to service users as well as the choice of talking therapies. More complex presentations will require the expertise of more senior talking therapists experienced in formulating more complex presentations from a range of psychotherapeutic models.

FIGURE 5: Service User Journey within Collaborative Layered Care Delivery Model



A layered care approach for delivery of talking therapies, building on close collaboration across the various tiers of service provision, will involve routinely measuring clinical outcomes to support the service user journey into, through, and out of services. A review of progress can help assess if the therapeutic goals have been met, and whether the service user is experiencing symptom relief, a decrease in distress and increase in wellbeing (TePou o TeWhaakaro Nui 2015).

This will assist in determining whether a service user would benefit from:

- Continuing at the same tier, stepped up or down a tier
- Being discharged from therapy if it is completed
- Being referred to another type of therapy, therapist or service

Alongside measurement of outcomes, it is important that the clinician listen, observe and talk to the person to understand their experience and situation. This may include talking to family members and other carers. These discussions facilitate the continuous formulation of a person's difficulties such that the team's understanding of the distress, and what may alleviate it, continues to evolve and develop in light of feedback. This process of continuous formulation is crucial to implementing a layered care approach that is sensitive and responsive to feedback coming from the service user.

8. Delivery Structure for Talking Therapies in Specialist Mental Health Services

Within the collaborative layered care delivery model, high-intensity and specialist interventions should generally be provided in secondary or tertiary mental health services where required. However, given the multi-faceted nature of the needs of many service users in secondary care, it is recognised that certain service users within secondary care will also benefit from low-intensity interventions such as those that can be delivered via mobile app or online as an adjunct to mental health service support.

As a result, the implementation of the Model of Care will involve enhanced delivery of high-intensity and specialist interventions, as well as low-intensity and high-volume interventions within General Adult CMHTs. When fully implemented, all members of a General Adult CMHT may have a role to play in the delivery of Talking Therapies as part of their work.

In order to enable and support General Adult CMHTs in implementing and evaluating the Model of Care, there will be a requirement to establish Talking Therapy Hubs.

8.1 Talking Therapy Hub

Reporting to the Area Mental Health Management Team, Talking Therapy Hubs will have a supportive role and work in a collaborative manner with talking therapists within the CMHT to provide clinical mentorship, facilitate professional development and access to supervision, offer support around assessment and formulation of complex talking therapy needs, deliver highly specialist interventions and support evaluation of interventions and the Model of Care. The Talking Therapy Hub staff will be

expected to work collaboratively as a team, based on mutual respect for each staff member's role and expertise. This collaborative working will facilitate each team member to take responsibility for the effectiveness of the team (as described in Sharing the Vision) which will be essential to the delivery of talk therapies throughout the hub and spoke model.

It is anticipated the Hub will have dedicated premise(s) in order to foster team cohesion and integration. However, in order to make the best possible use of the limited staff resources available, Hubs are encouraged to explore digital solutions to augment face to face meetings both within teams and in the delivery of supervision, training, closed online support groups (both for staff and service users) and talking therapies.

Line management and statutory governance arrangements for the care of the individual service user will remain unchanged.

'Sharing the Vision' (2020) emphasises the importance of a shared governance model, which necessitates a focus on team effectiveness, requiring each team member to work to the maximum of their scope and practice, as well as to develop shared team competencies. In this way each member of the team takes responsibility for the effectiveness of the team.

FIGURE 6: Proposed Functions of Talking Therapies Hub

CLINICAL MENTORSHIP

- ✔ Champions Talking Therapy development and the safe and efficient delivery of interventions, in keeping with Model of Care
- ✔ Supports co-ordination across General Adult CMHTs to facilitate development of a broad suite of therapies at varying levels of intensity to meet service user needs, in collaboration with family members and carers
- ✔ Collaborates with senior management on how best to support talking therapists in delivering a high quality range of interventions
- ✔ Supports liaison and communication with other tiers of service within a collaborative layered care model, including Primary Care, NCS and funded partner organisations, to ensure the most effective use of available services

PROFESSIONAL DEVELOPMENT AND SUPERVISION

- ✔ Leads on the implementation of a multi-annual plan for training and professional development (subject to local and/or national funding), informed by existing service delivery, therapy resources and capacity
- ✔ Arranges and facilitates training and opportunities for professional development (internal and external) for all members of the participating CMHT and Hub
- ✔ Ensures appropriate access to supervision based on individual needs, making the best possible use of available resources and technology

COMPLEX ASSESSMENTS AND INTERVENTIONS

- Offers support around complex case formulation and assessment, as requested by the CMHT, through use of supervision and opportunities for reflective practice, as appropriate
- Provides additional specialist interventions not available within the CMHT, in line with service user needs and expertise within the Hub team
- Consults with staff in in-patient services around delivery of talking therapies

GOVERNANCE AND EVALUATION

- Enables, reviews and evaluates implementation of Model of Care
- Supports routine measurement of clinical outcomes and collection of other evaluation data
- Facilitates access to IT and administrative infrastructure (subject to local and/or national funding) that supports data analysis and guides ongoing service development and quality assurance
- Liaises with National Implementation and Evaluation Team for Model of Care

GA CMHT and Talking Therapies Hub Interface

It is recommended that each Community Health Organisation (or successor structures) completes a mapping of existing service delivery, therapy resources and capacity within and across General Adult CMHTs.

This should result in a development plan to support and enhance services, including interventions that require a greater population base, as well as effective arrangements for provision of supervision utilising available expertise and technology. Guided by the Model of Care and identified priorities in the development plan, the Talking Therapies Hub will need to collaborate with CMHTs in their area to develop Policies, Protocols, Procedures and Guidelines (PPPGs) in keeping with the local context describing the interface between Hub and teams, such as:

- Mechanism for planning, coordinating and reviewing the provision of talking therapies in a safe and effective manner that aligns with local needs
- Plans for training and professional development, in line with agreed priorities. It is expected that at least some of the general training programmes will involve all members of the CMHT, as well as the Hub team
- Access to talking therapy supervision
- Care pathways for service users accessing talking therapies (including situations where the Hub is providing interventions), which are agreed with the CMHTs and discussed with referral agents

- Matching protocols and/or decision trees, ensuring clarity on roles and responsibilities
- Collection of clinical outcome measurements and evaluation data
- Communication and collaboration with service users, family members and carers
- External communication with referral agents and other service providers

In addition to facilitating complex case formulation forums and training events, it is recommended the Hub facilitates regular meetings with talking therapists within CMHTs. The purpose of these meetings is to review progress on the local talking therapy development plan, CMHT and Hub interface, and other matters relating to the implementation and evaluation of the Model of Care.

A bespoke online platform should be considered as a virtual interface between GA CMHTs and Therapy Hubs. Such a platform would have the functionality to facilitate secure file upload, a closed text-based forum for information sharing and scheduled closed groups (text / voice / video) for more formal meetings and workshops.

Talking Therapy Champions

Within CMHTs there is commonly a range of pre-existing psychotherapeutic expertise. This can include both knowledge of delivering talking therapies and of providing consultation, training and supervision in this domain. Utilising this expertise will be crucial in supporting teams in implementing a collaborative, layered care model that significantly increases access to talking therapies. Ultimately, this Model of Care will promote a team-wide multidisciplinary approach to delivering talking therapies.

CMHTs implementing this model will need their advanced talking therapists to increasingly use their supervisory, training and consultative skills to support the team in increasing its capacity to safely deliver talking therapies. It may be advisable to allocate a proportion of any additional resources to further enable talking therapists within CMHTs to provide such support. The team's clinicians will work with any additional resource and the Hub to ensure the team has the adequate training, support and supervision it needs.

As the Model of Care is seeking to facilitate a cultural shift in the awareness and prioritisation of talking therapies within CMHTs, its implementation will require support within national, CHO and area management, as well as locally within CMHTs. It may be useful for participating CMHTs to identify one or more 'talking therapy champions'. Working in collaboration with the Talking Therapies Hub and the CMHT, their function will be to support talking therapy delivery, promote best practice and lead a focus on enhanced access to talking therapies, in keeping with the Model of Care. The function, impact and potential further development of talking therapy champions will be considered as part of the evaluation of this Model of Care.

8.2 Service User Journey

The service user journey for adults accessing talking therapies while attending specialist mental health services will not differ significantly from the general service user journey. As when accessing other types of interventions, the main stages on the journey will include access and referral; assessment and individual care planning; interventions and service offerings; and discharge and follow-up. However, it is important that activities completed throughout the service user journey will be of relevance to and inform talking therapy assessment, formulation, matching, delivery and review.

Appendix A summarises the service user journey as relevant to talking therapies, including the role of talking therapists within General Adult CMHTs and the Talking Therapies Hub.

8.3 Clinical Governance

Clinical governance is central for the overall service user experience, and for maintaining and continuously improving quality of care. Clinical Governance has been defined as:

A framework through which (...) organisations are accountable for continuously improving their services and safe-guarding high standards of care by creating an environment in which excellence of clinical care will flourish" (Scally G and Donaldson LJ, 1998).

The scope for the operational guidelines presented in this document is confined to situations where adults access talking therapies (e.g. psychological therapy, psychotherapy, counselling) delivered by members of a General Adult CMHT. In identifying the key pillars underpinning clinical governance for this Model of Care, the following national frameworks were considered:

- Best Practice Standards for Mental Health Services (HSE, 2017)
- A National Framework for Recovery in Mental Health (HSE, 2018)
- National Clinical Programmes: Checklist for Clinical Governance (HSE, 2011)
- Framework for Improving Quality in our Health Service (HSE, 2016)
- Standards for Clinical Practice Guidance. National Clinical Effectiveness Committee (DOH, 2015)
- Achieving Excellence in Clinical Governance: Towards a Culture of Accountability (HSE, 2010)
- Quality Framework for Mental Health Services in Ireland (Mental Health Commission, 2007)
- Excellence in Mental Healthcare Records (Mental Health Commission, 2007)
- Code of Governance Framework for the Corporate and Financial Governance of the HSE (HSE, 2011)
- HSE National Framework for Developing Policies, Procedures, Protocols and Guidelines (HSE, 2016)
- MHC Guidance Document on Individual Care Planning Mental Health Services (2012)

In line with the principles outlined in these frameworks, a number of key pillars have been identified in order to ensure that clinical governance and quality improvement is maintained and developed as the Model of Care is implemented.

FIGURE 7: Pillars for the Clinical Governance for Model of Care (Talking Therapies)

Co-production and empowerment of service users, family members and carers

Service users, family members and carers will be empowered and actively involved in the implementation and evaluation of the Model of Care at national, CHO, team and individual level. Section 8.4 in this document includes an overview of the different ways involvement will be facilitated in keeping with the national recovery and co-production framework.

Clinical effectiveness and evidence-based practice

In formulating this Model of Care, the Working Group has sought to review and reference the most up to-date international guidelines and research available to identify best practice.

Routine measuring of outcomes

Measuring service user outcomes is a key component for the delivery of a high quality service and is a critical feature of a layered care delivery model. As outlined in section 8.7, the Model of Care recommends routinely measuring outcomes of talking therapy, using agreed methods, in order to track a person's progress and recovery over time.

Competence, training and professional development

All team practitioners' knowledge, skills, therapeutic alliance and relationship with the person will have an important impact on the success and efficacy of the talking therapy (Wampold, 2001). This Model of Care builds on the principle that all members of a multi-disciplinary team may have a role to play in the delivery of talking therapies. Section 8.5 in this document outlines a high-level competency framework, including guidance for what is required of staff with generic, intermediate and advanced talking therapy competencies.

In order to maintain their level of competence, practitioners will require on-going professional development. Within each CHO, oversight of a training and development programme for General Adult CMHT staff delivering talking therapies will be required, which will include identifying and addressing potential gaps.

Access to regular supervision

Access to regular supervision by an appropriately qualified professional, is a fundamental part of ensuring clinical effectiveness and best practice (Crane et al., 2012). In order to provide supervision to others, practitioners require a high level of competency, experience and training. As outlined in 'The Matrix. A Guide to delivering evidence-based psychological therapies in Scotland' (NHS, 2015), supervision can:

- Promote and ensure safe practice
- Promote adherence to the evidence-base, and to the talking therapy model
- Provide support and advice where there is complexity or risk of harm to self or others
- Provide training and skills development
- Encourage reflective practice
- Improve treatment effectiveness when it is outcome focussed

Clinical audit and evaluation

Monitoring access and activity to talking therapies is important to maintaining good clinical governance. Section 8.7 outlines a high-level monitoring and evaluation framework, which will facilitate and support service improvement, professional development and learning. This framework builds on the following principles:

- Centred around the key objectives for Model of Care, i.e. i) better service user experience, ii) improved safety and quality in service delivery, iii) enhanced access to services, iv) improved cost effectiveness
- Produces clinically meaningful data to assess service user outcomes, so that clinicians in collaboration with service users and family members can evaluate, reflect and improve the clinical effectiveness as part of their standard practice
- Tracks activity levels, in order to monitor implementation and enable resources to be used most effectively in order to maximise access and efficiency across services
- Incorporates a holistic/360 approach to the overall evaluation, i.e. impact as assessed by clinicians, service users, family members, planners etc.

8.4 Co-production and Empowerment of Service Users, Family Members and Carers

Access to talking therapies is an important part of a service user-focused and recovery-oriented mental health service, as outlined in the National Framework for Recovery 2018 – 2020. Recovery-orientated services promote working in a holistic and respectful manner ensuring that everyone is valued and acknowledged for their unique experiences. This offers a way of working where the expertise of service users, family members and service providers is accepted equally and valued to ensure better recovery outcomes for all (HSE, 2018).

Among the key principles underpinning the National Framework for Recovery are the centrality of the service user lived experience and the co-production of recovery promoting services. Through co-production, service users, family members and service providers become active participants and equal partners at all levels within service design and delivery. The Co-Production in Practice Guidance Document 2018 – 2020, highlights that '*Co-production in practice requires each stakeholder to understand and offer the distinctive contribution that they bring to the process. It also requires them to be generous in facilitating the other stakeholders in making their distinctive contribution to the process*' (HSE, 2018).

Within this Model of Care, co-production will occur on several levels:

- **Co-production between:** Co-production at an individual level, which will involve the service user working alongside their multi-disciplinary team to:
  - Consider the benefits of engaging in a talking therapy as part of their individual care plan
  - Make an informed choice of therapeutic approach
  - Set therapeutic goals
  - Actively engage in the delivery of agreed talking therapy
  - Collaborate in assessing progress and reviewing need to make adjustments
- **Co-production between and with:** Co-production with the support network, which may involve the wider mental health community in order to help themselves and others in their recovery journey through the use of experiential knowledge and narratives
- **Co-production at an organisational level:** This will involve service users, family members and service providers collaborating to:
  - Deliver and evaluate talking therapy services, in line with the Model of Care, through Area Management Teams, Local/Area Forums, and other local engagement structures
  - Ensure continued focus on the service user, family member and carer experience, as part of future efforts to review and evaluate the implementation of the Model of Care

In order to support co-production at all levels and ensure service users, family members and carers are enabled to play an active part in delivery of talking therapies, it is critical that information is readily accessible on local services.

8.5 Competencies and Professional Development

While *general clinical competencies* represent what the mental health practitioner should know and be able to do in accordance with the requirements of their professional body, meta-competencies is knowledge about the availability and use of one's own competencies to optimise learning and problem solving behaviour. It includes the ability to assess what one knows and what one doesn't know. This is dependent on self-reflection and self-assessment (Weinert, 2001). Clinical supervision, peer review, personal therapy and reflective practice groups are examples of how to maintain one's meta-competences.

Outcome research in talking therapies has consistently indicated two key factors associated with better outcomes; the centrality of a good quality therapeutic relationship between therapist and service user, and the competence of the therapist in the intervention they are delivering (Wampold, 2001).

The utilisation of the psychological and psychotherapeutic knowledge and skill involved in the delivery of talking therapies is not confined to professionally qualified psychologists or to those with training in counselling and psychotherapy. It is used by a wide range of mental health practitioners. The degree to which disciplines apply psychological and psychotherapeutic techniques is variable; some make no explicit use of these while others, in particular tasks, operate at an advanced level.

A three tier framework is often used to assist in the conceptualisation and description of the talking therapist/clinician training and competency, and to assist in differentiating what the service user might experience differently dependant on what 'tier' they interact with. In some circumstances service users may be availing of more than one tier at a time, e.g. attending a skills group and individual therapy.

GENERIC Talking Therapy Competence

The following generic therapeutic competences are required by staff;

- ✔ Knowledge and understanding of mental health problems
- ✔ Understanding of recovery principles and awareness of the National Recovery Framework
- ✔ Knowledge of, and ability to operate within, professional and ethical guidelines
- ✔ Ability to understand and work with cultural difference
- ✔ Working within framework of a care plan
- ✔ Awareness of systemic factors
- ✔ An understanding of psychological principles
- ✔ Ability to engage the service user
- ✔ Ability to establish and maintain a therapeutic alliance
- ✔ Ability to manage endings with service users

- Ability to assess risk and to manage risk of self-harm
- Ability to recognise the limitations of one's skills
- Ability to make use of supervision and team/peer support
- Ability to use questionnaires and commonly used rating scale for anxiety and depression and level of functioning

In general, interventions are low intensity and high volume, e.g. skills-based psycho-education, WRAP and anxiety management. Therapy is often delivered in a group setting. However, lower level psychological activities may not occur in the context of a formal, systematic arrangement for delivering a psychological therapy, and is often used in contexts such as in consultations and other interactions with members of the mental health team.

While some training in the above competencies and activities may have been acquired within the core trainings of the various disciplines on the team, team training in the above could be considered as a core activity for all multi-disciplinary team members in secondary care mental health service settings.

INTERMEDIATE Talking Therapy Competence

In addition to generic competencies this involves undertaking or working towards circumscribed/or predominantly single theory informed psychological therapies in a formal and systematic way:

- Knowledge of the principles of the specific model and rationale for treatment
- Ability to assess a service user's suitability for model of therapy
- Ability to develop a collaborative formulation with the service user
- Ability to engage the service user in the model
- Ability to manage the therapeutic frame and boundaries
- Ability to understand and use the specific skills and theory of the model
- Awareness of scope of practice under appropriate clinical supervision

These activities may be prescribed by protocol and are generally at a moderate level of intensity. At this level there should always be awareness of the criteria for referral to a level three service intervention where the service user's needs are particularly complex.

ADVANCED Talking Therapy Competence

In addition to generic and intermediate competencies, advanced competencies involve the capacity to deliver specialist assessment, formulation and psychotherapeutic interventions, in circumstances where there are deep-rooted underlying influences (individual and/or systemic), or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complicated presenting problem. Interventions are usually intensive and may involve a combination of group and individual interventions.

Flexibility to adapt and combine approaches is the key to competence at this level coming from a broad, thorough and sophisticated understanding of a range of psychological knowledge and theory. To ensure that the mental health clinician develop and maintain the necessary competencies, continuous engagement in professional development is essential through supervision, peer review and education.

Determining Suitability to Practice Talking Therapies

A number of factors should be considered when assessing suitability to practice a therapy, including:

- Professional qualification
- Clinical experience in secondary mental health services
- Training and qualification in a particular model of talking therapy
- Supervision since training in a specific talking therapy
- Engagement in continuous professional development (CPD)

Mental health clinicians of various disciplines may have developed an interest in talking therapies in the course of their clinical work and may deliver psychotherapy under supervision from an accredited supervisor. This provides an important opportunity for interested practitioners to develop their skills and provides a potential pathway for the practitioner to access formal training in a specific psychotherapy modality if they so wish.

All mental health professionals are bound by codes of ethics which specify that they must always work within the limits of their competency and must not misrepresent the extent of their expertise. The minimum level of competency necessary to practice particular talking therapies have been set out in some detail by professional organisations and in the professional literature (e.g. UCL competency frameworks) which may act as helpful guides to teams considering this issue.

Training and Accreditation

The accreditation and recognition of disciplines involved in the delivery of talking therapies is currently self-regulatory by professional organisations, rather than statutory mechanisms although it is anticipated that these activities will be regulated by CORU in coming years. In the current self-regulatory system recognition requirements are typically that an individual is personally accredited and has completed a recognised and accredited course.

Accredited Psychological/talking therapy training programmes need to include a sufficient academic programme, a programme of supervised clinical practice and a self-development programme (often personal therapy). Training programmes may vary in length, ranging from brief programmes in specific therapeutic techniques to those that take a considerable number of years to complete.

The competences that are outlined in this document are guidelines only. Each training institution/ professional body provides its own list of competencies required to maintain registration.

8.6 Supervision

Access to regular supervision by an appropriately qualified professional is an important mechanism for ensuring the safe, effective and efficient delivery of talking therapies, and for reducing potentially harmful variations in practice (Crane et al., 2012; NHS Scotland, 2014). Supervision is critical, both for qualified talking therapists and for those undergoing training.

Supervision has been defined as a 'process in which one worker is given the responsibility of working with another worker(s) in order to meet certain organisational, professional and personal objectives. These objectives are competent accountable performance, continuing professional development and personal support' (Morrison, 2005).

Supervision has both a quality assurance, supportive and development function (Proctor, 1988) by:

- Promoting adherence to the evidence-base, and to the talking therapy model
- Providing support and advice where there is complexity or risk of harm to self or others
- Supporting the supervisee's well-being and self-care
- Ensuring that the supervisee is practising to ethical and professional standards
- Contributing to professional development

Members of professional bodies will typically be required to receive a certain amount of on-going supervision, as a necessary part of maintaining their membership and accreditation.

All disciplines on a General Adult CMHT have a role to play in the delivery of talking therapies and it is important to distinguish between line management and talking therapies supervision. While talking therapies supervision may be provided by the line manager, supervision will in many cases be cross-disciplinary, determined on the basis of the requirements of the supervisee and the competency, experience and training of the supervisor.

Supervision may be provided in different complementary formats, including:

- **Individual supervision** between the supervisee and an appropriately qualified supervisor
- **Group supervision,** facilitated by an appropriately qualified supervisor, which may complement individual supervision and enable supervisees to reflect on their clinical work in a group setting
- **Peer supervision,** typically a reciprocal arrangement, that provides a learning environment in which peers work together to facilitate developmental feedback, learning and evaluation

Regardless of the format in which supervision is provided, it is considered best practice to agree a contract for this engagement, which should be shared with the relevant line manager. The supervision process should be subject to on-going evaluation, based on a format agreed between the supervisor and the supervisee.

A log book of sessions and brief notes of all sessions should be kept, including key reflections and actions. At the outset of meetings the individuals involved will negotiate how the sessions will be recorded, by whom and how much of the content will be recorded. This agreement should form part of the above mentioned supervision contract.

The clinical supervisor carries no direct responsibility for the professional conduct of the supervisee. If a supervisor has concerns about the way a particular case is handled, or has doubts about the professional conduct of a supervisee, s/he should address this with the supervisee directly at first. If a satisfactory solution cannot be found at this level, the supervisor is obliged to communicate this difficulty to the supervisee's line manager.

In order to provide supervision to others, practitioners require a high level of competency, experience and training. This should include formal supervision training, ideally completed prior to commencing as a supervisor or as soon possible afterwards. Mental health services will have responsibility for ensuring that there are enough adequately trained supervisors within the wider system and the capacity for regular supervision of both trainees and practising staff.

In an operational environment with competing demands and finite resources, local services will need to carefully consider how to provide supervision in the most effective manner, including:

- Different complementary supervision formats
- Location, travel and impact on service delivery
- Available expertise and technology within the service
- Reciprocal arrangements with other services

The frequency and duration of supervision should depend on an individual assessment taking into account time spent by the supervisee delivering talking therapies, size and complexity of the caseload, level of intensity of interventions provided, and the expertise of the supervisee in a particular area or therapeutic approach. While it should always depend on an individual assessment, staff employed full-time in the delivery of talking therapies on General Adult CMHTs as general guidance should have access to a minimum of 1 – 2 hours of individual supervision every month by a suitably qualified supervisor.

8.7 Evaluation and Measurement of Outcomes

An evaluation of the Model of Care will among other things be informed by routine measurement of service user outcomes, collection of metrics, and the experiences of those involved in planning, delivering and accessing talking therapies.

The key principles underpinning the evaluation are:

- Enable monitoring against key objectives for the Model of Care, i.e. i) better service user experience and outcomes, ii) improved safety and quality in service delivery, iii) enhanced access to services, iiii) improved cost effectiveness
- Collect clinically meaningful data to assess service user outcomes
- Track access and activity metrics in order to monitor implementation

- Systematically review qualitative feedback, incorporating feedback from clinicians, service users, family members, planners and other key stakeholders as part of a holistic approach

Measuring Outcomes of Talking Therapies

A layered care approach for delivery of talking therapies, building on close collaboration across the various tiers of service provision, will involve routinely measuring clinical outcomes to support the service user journey into, through, and out of services.

Alongside outcomes measures, ongoing collaboration with the service user in relation to their lived experience of the service provided will be a central element of any evaluation. This may include talking to family members and other carers, as outlined in the position paper for a layered care approach.

Routinely measuring outcomes can help:

- Enhance clinical effectiveness by providing a basis for evaluating the effectiveness of the practitioner and the type of intervention provided
- Support coordination across services
- Complement other assessment methods to enhance understanding of the person, their situation, strengths and recovery goals
- Evaluate progress and assist in determining whether the service user is being offered the most appropriate intervention
- Inform service development.

Using Mental Health and Addiction Progress and Outcome Measures Well

For service users, family members and carers
✔ Ask for clarification if there are questions, statements or terms you do not understand
✔ Use the information to regularly assess progress with your talking therapist
✔ Work with your talking therapist to consider whether it would helpful to make adjustments
For practitioners*
✔ Use measures repeatedly on admission to the service, during treatment and at discharge.
✔ Use measures consistently in the same way each time with a person, with the same explanation, in the same form (paper/online) and with the same scoring.
✔ Use the information you collect to review progress for the person (changes in scores), to show any actual changes (for example, suicidality, deteriorating mood, substance use or gambling) and for clinical decision making and team discussion. This is important to make good decisions about the level or type of care needed (such as in stepped care).
✔ Talk with the person about the results to clarify issues and support positive change. Where there may be a concern, consult with your team or a senior practitioner.
✔ Seek appropriate training and ensure the manual is always read and understood. Some measures require in depth training or may need to be administered by a psychologist or specifically trained practitioner.

For service leaders and managers*

- ✔ Address considerations for the use of progress and outcome measures such as: what are the key issues to be measured or decisions to be made; how is the investment justified; how to get staff involved; and how will the information be used?
- ✔ Have information systems that make clinical information available fast and which is highly relevant, easy to understand and clearly shows changes over time.
- ✔ Establish clinical processes that encourage use of information by supporting practitioners to routinely use progress and outcome measures, having multidisciplinary team review processes and championing good use of standard measures information.

* Taken from 'Te Pou o te Whakaaro Nui. (2016). Review: Progress and outcome measures to support talking therapies delivery'.

In developing guidance around measurement of outcomes, including the use of a minimum set of standard measures that could be used across primary and secondary services, the Working Group has considered the following criteria:

- Relevance of the measures to those accessing services and to clinicians
- Reliability, including a reasonable balance between avoiding 'questionnaire overload' and providing information that will support the service user in his/her recovery
- Validity, i.e. that it measures what it is supposed to
- Ease of use and cost

Building on these criteria and taking into account the adaptability of tools currently used, table 1 below summarises the recommended minimum set of standard measures. It is important to note this is not an exhaustive list and that clinicians may decide to use additional tools or instruments as relevant to the service user in question. Deviation from the agreed standard measures is acceptable at an individual service user level where there is sound clinical justification.

TABLE 1: Recommended Minimum Set of Clinical Outcome Measures

- ✔ Service User Satisfaction Questionnaire/Service User Experience Questionnaire

AND

- ✔ CORE 10/34 PROM of global distress used as pre and post clinical outcome measure
- ✔ CORE Therapy Assessment Form CROM
- ✔ CORE End of Therapy Form CROM

AND

- ✔ HoNOS Health of Nation Outcome Scale

AND

- ✔ Symptom-specific measures as appropriate

Access and Activity Metrics

While significant data is being collated through the National Clinical Programmes for Mental Health and other relevant national programmes, including the National DBT Project Ireland, metrics are currently not collected in a systematic manner at national level in relation to the delivery of talking therapies by General Adult CMHTs**.**

In order to facilitate implementation evaluation of the Model of Care against the key objectives, Table 2 below summarises the recommended access and activity metrics:

TABLE 2: Recommended Minimum Set of Access and Activity Metrics

Number of assessments
• Attended
• Did Not Attend
• Total number of assessments offered/Attendance rate
Gender of assessment (Male/Female/other)
Number of individual sessions
• Attended
• Did Not Attend
• Total number of sessions offered/Attendance rate
Number of service users attending individual sessions
Average number sessions per service user
Number of group sessions
Number of individuals attending group sessions
Average number of individuals per group session
Open Case Load
• High-volume interventions
• Low and medium intensity interventions
• High-intensity and specialist interventions
• Highly specialised interventions

Number of cases closed
Waiting times to be seen
• <1 month
• 1 – 3 months
• 3 – 6 months
• 6 – 12 months
• 12 months<
Duration of treatment from referral to discharge
• <1 month
• 1 – 3 months
• 3 – 6 months
• 6 – 12 months
• 12 months<

Data Collection Process

As part of the implementation of this Model of Care, a consistent and co-ordinated data collection process should be put in place. Any such data collection processes should be electronic as far as possible and be consistent with any recommendations or service initiatives arising from the work of the National Telehealth Steering Group.

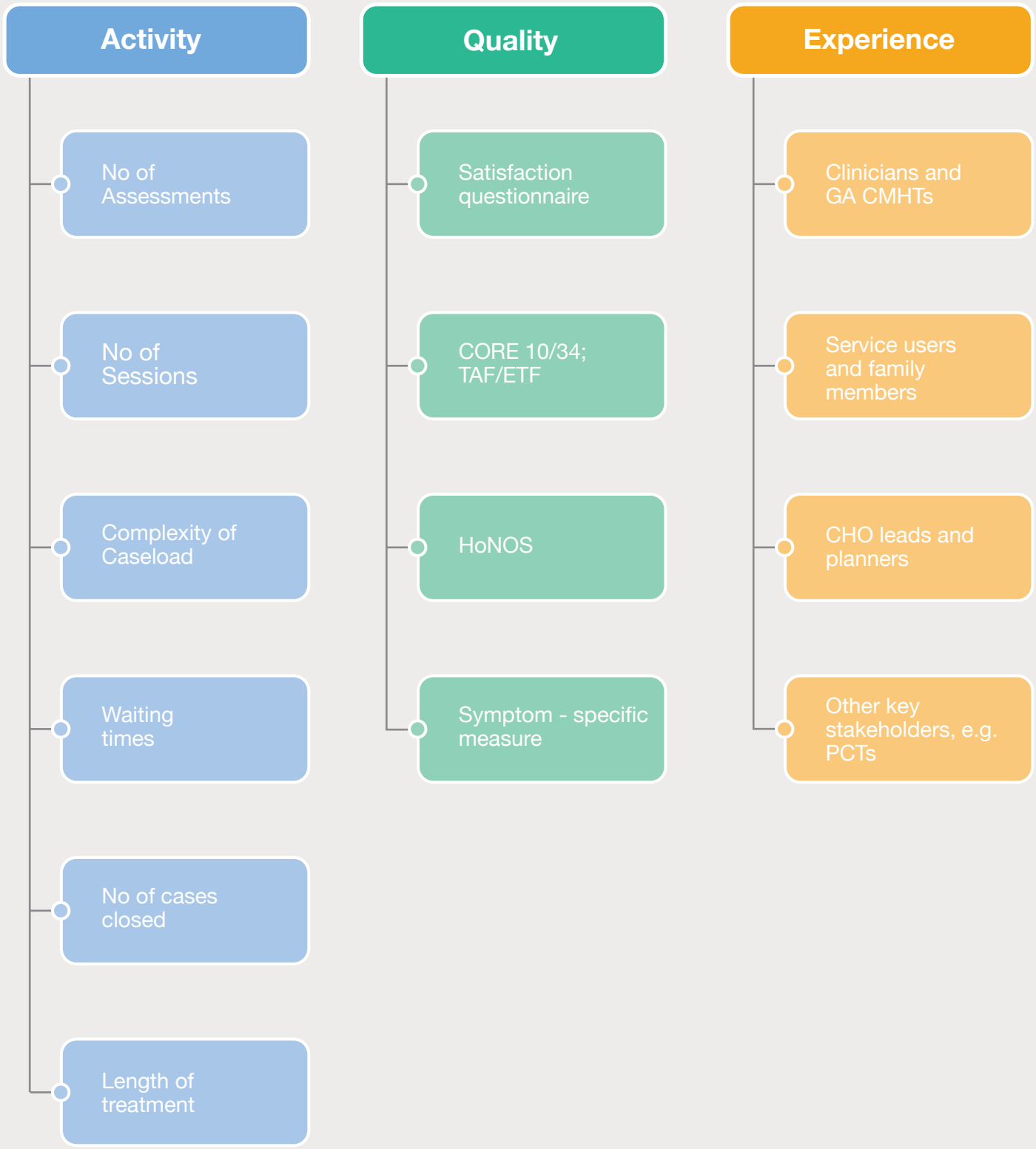
Building on the agreed process, clinicians who are delivering talking therapies will have responsibility for collecting data in accordance with the proposed minimum outcome measurements. A member of the General Adult CMHT should have responsibility for co-ordinating and supporting data collection within the team, including metrics, as relevant to the delivery of talking therapies. It should be noted, however, that the evaluation metrics will be reported at a team-level acknowledging the team's collective responsibility to ensure it provides adequate access to talking therapies.

Use of paper-based questionnaires requires substantial clinical time for data entry. As a result, there is a significant risk that much of the data collected in this manner may not be used appropriately or wasted in terms of informing on-going evaluation and service improvement. Therefore, and as stated above, it is recommended that an electronic format for data collection is used, in order to facilitate efficient data entry and analysis.

Evaluation and Review of Model of Care

As outlined in the visual below, it is proposed that the implementation evaluation of the Model of Care will incorporate a quantitative and qualitative dimension, as well as feedback from those involved in planning, delivering and accessing talking therapies.

FIGURE 8: Implementation Evaluation



Activity and access metrics collected by each General Adult CMHT will provide a quantitative measure of the service improvement.

Routine measurement of clinical outcomes by individual clinicians and service users will contribute towards measuring how effective the Model of Care is in meeting service user needs, e.g. recovery rates, improvements in health and wellbeing and reductions in level of distress.

Capturing the experiences of clinicians, service users and family members, planners and other key stakeholders will provide an additional perspective to implementation evaluation.

It is suggested that the Model of Care is demonstrated in initial 5 Community Health Organisations with three participating General Adult CMHTs in each of the selected CHOs. This will enable demonstration and evaluation of the Model of Care in different service structures, as well as in a range of socio-demographic and geographical settings.

Each of the proposed five participating CHOs and 15 CMHTs will be required to drive local implementation and cultural change, and to participate fully in the evaluation of the Model of Care.

The selection of demonstration sites should take into consideration:

- Demonstrated need on the basis of existing resources, population base and socio-demographic profile
- Geographic balance (urban – rural)
- Leadership and capacity to implement service improvement programmes within the relevant area

A detailed evaluation framework should be developed and agreed as early as possible in the process, based on the parameters outlined above.

It is proposed that an interim evaluation on how effective the Model of Care is in meeting service user needs is carried out once demonstration sites have been in operation for a 12-month period, with interim findings shaping the ongoing development of the service in response to feedback.

A full formal review of the Model of Care should be conducted after three years in terms of quality, access and value for money in collaboration with all key stakeholders.

9. Requirements to Deliver Model of Care

CMHTs are, within existing resources, offering a range of talking therapies and all disciplines are to varying degrees involved the delivery of those therapies. Any additional resources allocated to a demonstration and implementation of the Model of Care will complement and enhance existing services.

As there are significant local variations, it is recommended that each CHO completes a mapping of existing service delivery and capacity within and across teams. Such mapping may need to be cognisant of the broader access to talking therapies that exists in the local region across primary, secondary and tertiary tiers from both statutory and non-statutory bodies.This should result in a plan to support and enhance services, including interventions that require a greater population base, as well as effective arrangements for provision of supervision utilising available expertise and technology.

The full implementation of this Model of Care will require additional multidisciplinary talking therapy staff and infrastructure resourcing (including digital infrastructure).

Staffing Requirements

There will be a need to ensure General Adult CMHTs have the necessary staff capacity and time to drive local implementation of the Model of Care, including access to any identified core offerings. There will be a requirement to allocate the equivalent of 3 WTEs to each of the CHO demonstration sites, which may be used to fund new posts or back-fill, depending on outcomes of the mapping.

Within CHOs, there will be a requirement to establish Talking Therapy Hub(s) staffed by experienced and appropriately qualified (advanced) talking therapists drawn from existing teams. Each Talking Therapy Hub will support three General Adult CMHTs, i.e. an approximate population of 150,000 people.

FIGURE 9: Staffing of Talking Therapies 'Mini-Hub'

Discipline/Grade	WTE
Consultant Psychiatrist/Medical Psychotherapist	0.2
Principal Psychologist	0.5
Advanced Nurse Practitioner/Senior Social Worker/	
Senior Occupational Therapist/Counsellor Therapist/Speech and Language Therapist	1.0
Clerical Officer (IV)	0.5
Total	**2.2**

IT Requirements

The implementation of the Model of Care will require access to IT and a shared platform in order to collect and analyse agreed minimum set of clinical outcome measurements. This infrastructure is also needed to enable CMHT to collect activity metrics and KPI data.

In addition to any technology costs, initial training and capacity building should be made available within each CMHT and Hub, alongside on-going support.

Training Requirements

The Talking Therapy Hub will be responsible for developing and leading on the implementation of a multi-annual plan for training and professional development. This plan will be informed by existing service delivery, therapy resources, capacity, and identified priorities. At least some of the general training programmes will involve all members of the CMHT, as well as the Hub team.

It is expected that some of the training required can be facilitated internationally in collaboration with experienced CMHT talking therapists. In addition, each Hub will require annual funding to resource training programmes in their area.

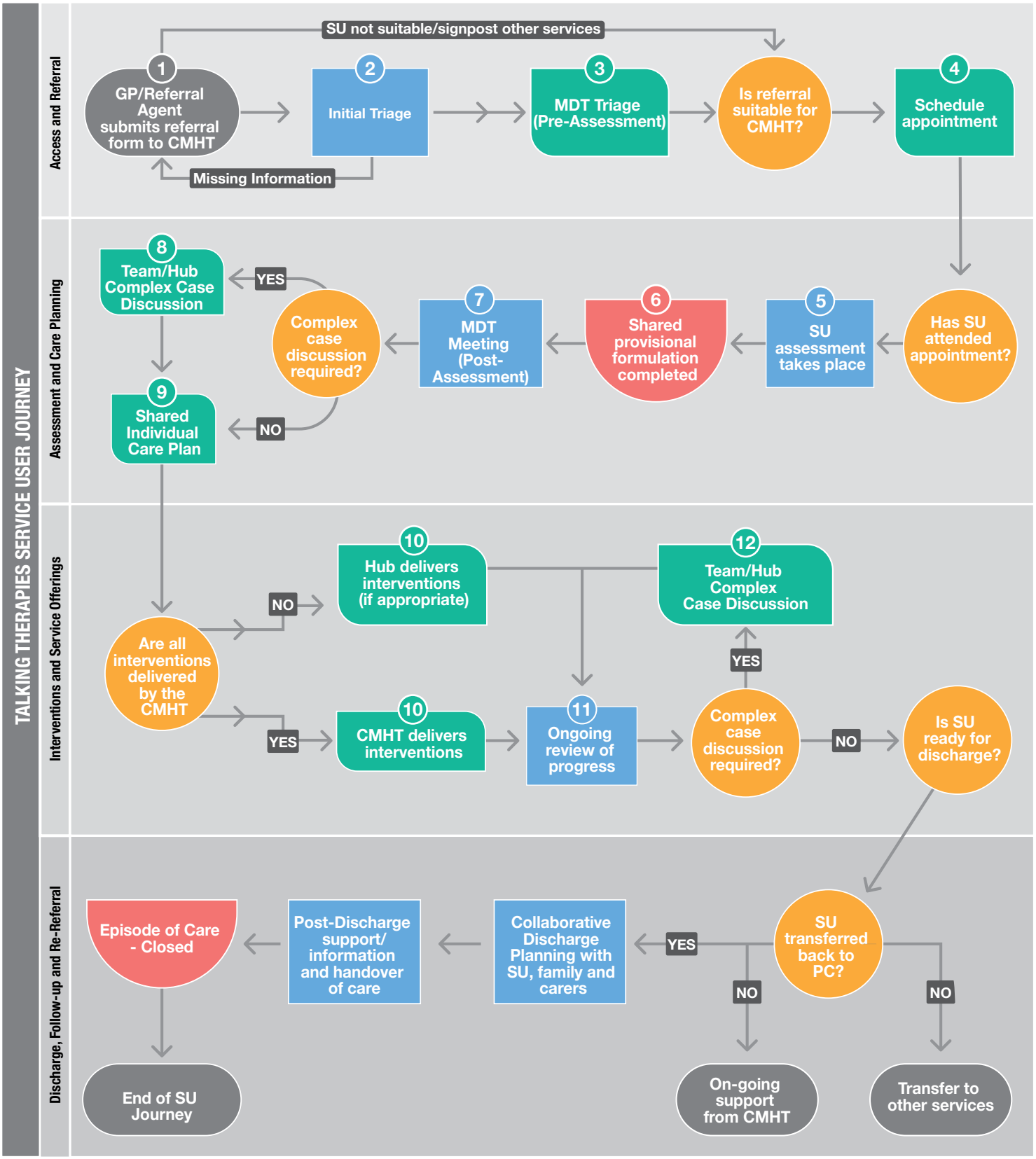
Supervision Requirements

Access to regular supervision by an appropriately qualified professional is critical for ensuring the safe, effective and efficient delivery of talking therapies. The Talking Therapy Hub will have responsibility for overseeing appropriate access to supervision based on individual needs, making the best possible use of available resources and technology.

Talking Therapists with advanced talking therapy competence working as part of General Adult CMHTs or within the Talking Therapy Hub should be facilitated in providing supervision. Reciprocal arrangements with other services should also be considered. However, funding will be required to facilitate situations where external supervision is essential.

Appendices

Appendix A: Service User Journey for Adults Accessing Talking Therapies while Attending Specialist Mental Health Services



Appendix B: Guidelines for Online Talk Therapy

In recent times, there has been increasing flexibility with regard to different modalities in health service delivery, for example, through the use of online platforms to provide support and therapy. This appendix is included as a broad overview with general guidance about the delivery of online talk therapy. The guidance included here is not specific to HSE services but it will be of relevance as different modalities become more commonly used in health service delivery.

Overview of Online Therapy

Online video-based platforms are becoming increasingly popular as a means of delivering talking therapy. Using this technology may improve access to therapy by removing some of the barriers which currently exist for traditional face-to-face services. With the growth in the area of online therapy, it is imperative that any individual or organization providing online therapy does so safely and securely.

The guidelines presented below aim to provide information on the safe and secure provision of online talking therapy. This content was first published in 2015 by ReachOut Ireland and much of it is based on information from the Online Therapy Institute and in particular from the article *"Ethical framework for the use of technology in mental health"* (accessed on January 5th 2021 http://onlinetherapyinstitute.com/ethical-training/).

At the outset, it is important to note that different approaches, with varying degree of interaction, can be applied in delivering online talking therapy. Carlbring and Andersson (2006) highlight the following categories:

- Mainly therapist led.
- Active, but minimal, therapist contact.
- Mainly self-administered with assessment or guidance by a therapist.
- Entirely self-administered (including mobile apps).

Therapist led interventions can include either synchronous or asynchronous online counselling. Advantages of this type of service include ease of access for the user who can receive support without any requirement to travel or attend a service in unfamiliar surroundings.

In the case of *asynchronous* counselling, which would generally be based on written communication, disadvantages include the remoteness of the therapist and the potential for misunderstandings or misinterpretations not being addressed in a timely way. For people at risk, this approach to service provision does not provide an immediate response. Care must be taken in managing expectations as to the potential for this approach to service delivery. Where appropriate, low-intensity support can be provided at significant scale to meet lower levels of mental health need, or, as an adjunct to more intense mental health service intervention.

Synchronous online counselling, typically delivered via video, mitigates against some of these disadvantages although the lack of direct human engagement in a shared physical environment may not suit some people.

An emerging area, informed by multi-disciplinary research across the world, is the area of self-administered online therapy programmes and applications. This includes programmes delivered online and mobile applications. There is a growing evidence base supporting the efficacy of these interventions for dealing with less severe mental health problems. Some of these interventions can be accessed for free online. Most are based on the principles of cognitive behavioural therapy. It should be emphasised that these programmes are likely to benefit those with less severe problems. Examples of this type of service include Beating the Blues, Mood Gym.

While self-guided support may be of benefit to some people with lower levels of mental health need, this model of care recommends use of online programmes with some level of therapist input rather than fully automated or self-directed programmes.

Recommended Requirements for Online Therapists

Many of the principles that apply to face-to-face therapy apply to online therapy. While these suggestions are not legally required (as the sector is not yet regulated), organisations should strive to meet the following requirements:

- Online therapists should be fully trained or be in the process of becoming fully trained.
- Online therapists should have achieved a minimum level of educational qualification (e.g. Level 8 or 9 QQI) and be accredited with a recognised accreditation body such as the Irish Association of Counselling and Psychotherapy, Irish Council for Psychotherapy or the Psychological Society of Ireland.
- Therapists have a primary ethical obligation to provide professional services only within the boundaries of their competence based on their education, training, supervised experience, consultation, study, or professional experience. In the practice of online therapy therapists are required to adhere to the code of ethics of their professional body
- Therapists should have a good understanding of the technology used in the delivery of services - this is especially important if something goes wrong with the technology.
- Online therapists should be in receipt of regular clinical supervision by an accredited clinical supervisor, delivered either face-to-face or via secure methods online.
- Self-employed therapist should confirm that their professional liability insurance covers practicing online.

Information to be Communicated to Service Users

As mentioned at the outset of this appendix, the suggested guidance here is general and applies to a wide range of organisations. It is not specific to the HSE and some suggested guidance may not be relevant to any online therapies delivered directly by the HSE.

In general, organisations and individuals offering online talking therapy should make the following clear for potential clients:

- Information about their therapists i.e. name, short biography, areas of special interest and training and accreditation details.
- Clients can request a change of therapist in the event of a mismatch between therapist and client
- Contact information; email, telephone number and postal address for formal correspondence.
- Where email is used as a method to communicate with service users, the amount of time an individual may wait for an email response. Best practice indicates a maximum of two business days for therapeutic inquiries.
- Who can/will benefit from the online therapy being offered?
- The minimum age for service uptake and the need for parental consent / involvement.
- Details of the service's policy with regards to the provision of therapy to under 18 year-olds.
- Is there a fee? If so how much, and how can it be paid securely.
- The kind of technology the client needs to access the online therapy.
- Privacy and confidentiality agreements.
- What a potential client should expect from a first session – it can be helpful to have this content in different formats, including short videos.
- Crisis situations protocols. Organisations and individuals offering online counselling should display emergency support information clearly – within the HSE this would include standardised advice and direction relating to emergency services.

Informed Consent

Consent must be sought from all potential clients before they access online therapy. This process begins when the client contemplates accessing services. The informed consent process should include a formal acknowledgement from the client to the therapist. This should be revisited during the course of therapy as necessary.

Recommended Information for Clients

The following topics should be addressed to ensure the client can provide informed consent. This information should be made available to prospective clients before they sign up to any sessions.

Time should be allocated in the first session to discuss these topics and to ensure all the client's questions have been answered.

- **Advantages and disadvantages of online therapy:** The pros and cons of online therapy should be discussed. Possible disadvantages can be a lack of visual and auditory cues (an issue especially in the context of risk assessment), and advantages including easy scheduling, time management and lack of transportation costs.

- **What happens if the technology breaks down**: The client needs to be informed about what t o do if there is a connection error or the technology fails to work during a session, e.g. "If there is a connection error or technical failure the therapist will attempt to reconnect after five minutes. If the session cannot be resumed the therapist will send a text message to reschedule the session". The plan in response to a breakdown in technology may vary depending on the modalities in use, e.g. video, voice and / or text (including email).

- **Cultural specifics that may impact online therapy:** Therapists should discuss cultural differences and language barriers that may impact the delivery of services. The client's expectations should be discussed with the therapist ensuring their understanding and taking into account different cultures that can have very different understandings of these matters.

- **Professional boundaries:** Therapists should discuss with clients the expected boundaries and expectations about forming relationships online, other than that of the therapist/client relationship. Clients should be informed that requests for "friendship", business contacts, social media connections or blog responses will be ignored to preserve the integrity of the therapeutic relationship and protect confidentiality. If the client has not been formally informed of these boundaries, the therapist should ignore any requests and explain why in subsequent interaction with the client.

- **Emergency contact:** Service users should be provided with specific information for emergency contact and the protocols relating to disclosures of distress outside of scheduled therapeutic times e.g. (emails communicating distress in the middle of the night).

- **File storage procedures:** The client should be provided with information about the service records retention and destruction policy.

- **Privacy policy:** the informed consent process should include details of the service privacy policy including information about how email addresses and client records are used, shared or stored.

- **Encryption:** An explanation about the use of encryption for therapy sessions should be made available to clients and information on the lack of encryption when unencrypted methods (e.g. standard email or texting) are used for issues such as appointment changes and cancellations should be made clear to the client.

Setting

- The therapist's office/room should be appropriate to establishing a therapeutic alliance.
- All personal items or distractions in the background should be removed.
- The room should be well lit, e.g. a window behind the screen might cast a shadow or create low visibility.
- Ensure phone is turned to silent.
- It is important for the therapist to log-in to the session ten minutes prior to the appointed time to ensure a readiness to begin at the scheduled time.
- If possible during video counselling the therapist camera should be placed at the same elevation as the eyes with the face clearly visible to the client.
- Therapists should consider using a headset or earphones with a built-in microphone to improve call quality and confidentiality.
- Therapists should ensure they are appropriately dressed, as they would be for an in person session.

Assessment and Online Therapy

The importance of assessment at the outset is highlighted by Carlbring and Andersson who point out that 'if proper assessment is not done before commencing treatment, there is a significant risk that someone with for example, panic disorder symptoms, but who actually has a physical disorder (e.g. hyperthyroidism), tries psychological self-help without any success' (2006, p.549).

An initial screening and intake process should be carried out prior to proceeding with online therapy. This should include

- **Client identity:** Clients are required to provide details of their identity such as first and last name, age, home address, and phone number for emergency contact.
- **Client age:** Clients must confirm that they are 18 years old or over. At present, online therapy is not typically offered to those under 18 years old in Ireland. If online therapy is made available to those under 18 then parental consent should be sought, along with informed user consent from the under 18 year old. Some organisations offering online therapy to under 18 year olds include a parent or guardian in the delivery of the sessions.
- **Level of technology skills:** The client's experience with email, forums, social networks, texting etc. should be considered. Where possible, the client should be familiar with and comfortable using the platform proposed to deliver the therapy.

- **Client's language skills:** Therapists should screen for language skills from initial contact through the first few exchanges. Appraisal of language barriers, reading and comprehension skills as well as cultural differences is part of the screening process. Text-based therapy may require assessment for keyboard proficiency.

- **Presenting issue:** Therapists should screen to ensure the presenting issue is within their scope of practice and is appropriate to online therapy. Screening around issues of suicidality and immediate crisis should be undertaken in line with service policy.

- **Clinical concerns:** Concerns regarding mental state should be addressed- e.g. whether the client is currently experiencing hallucinations or delusions; is actively abusing drugs and alcohol; and any medical or physical issues that might impact on therapy or require a different approach, e.g. disability that impairs typing. Any assessment instruments used should be approved for online or computer-assisted use according to the author/publisher.

Risk Assessment: Suicide and homicide risk needs to be considered by the therapist if there are more general clinical concerns regarding the client's mental state.

Computers/Laptops/Tablets/Smartphones Used for Delivering Online Therapy Should:

- Be password protected
- Have anti-virus protection
- Have back-up systems in place; records and data that are stored on the practitioner's hard drive are backed up either to an external drive or remotely using a cloud-based solution
- Be firewall protected, while ensuring the firewall does not block video connections. Some organisations do not recommend firewalls if a service delivered via iOS (Apple) platforms.
- Store records using encrypted folders or on an external drive that is safely stored.
- Have minimum upload/download speed for Internet of 2 Mbps
- Have an up-to-date operating system with relevant security patches: e.g. Windows, IOS
- Have an up-to-date browser: e.g. Edge, Chrome, Firefox, Safari
- Have other software using the device camera disabled as multiple active software might cause severe interference with a session: e.g. disable Zoom and MS Teams etc.

In addition:

- It is recommended practice to shut down devices after work/therapy has been completed, not just close the lid. Mobile devices, including tablets, should be shut down and restarted at least once per week.

Resources

While the guidance here in this appendix is general and not specific to HSE services, the following HSE links may be of general interest and relevance as they relate to delivering talking therapy online:

HSE Virtual Health Page can be accessed at:
https://healthservice.hse.ie/staff/coronavirus/working-from-home/virtual-health/virtual-health.html

HSE Information Technology/Acceptable Usage Policy can be accessed at:
https://www.hse.ie/eng/services/publications/pp/ict/i-t-acceptable-use-policy.pdf

HSE Data Protection Policy can be accessed here:
ttps://www.hse.ie/eng/gdpr/hse-data-protection-policy/hse-data-protection-policy.pdf

HSE Standards and Recommended Practices for Healthcare Records Management, QPSD-D-006-3 V3.0. further information can be accessed at:
https://www.hse.ie/eng/about/who/qid/quality-and-patient-safety-documents/v3.pdf

HSE (April 2020) Secure Video and Audio: Consultations Clinical Aspects during the Emergency Measures to address Covid 19 can be accessed here:
https://healthservice.hse.ie/filelibrary/staff/clinical-telehealth-governance-guidance.pdf

Glossary of Acronyms

ADHD	Attention Deficit Hyperactivity Disorder
CBT	Cognitive Behavioural Therapy
CHO	Community Healthcare Organisation
CIPC	Counselling in Primary Care
CMHT	Community Mental Health Team
DBT	Dialectical Behavioural Therapy
GA	General Adult
MDT	Multidisciplinary Team
MHC	Mental Health Commission
NCS	National Counselling Service
NGO	Non-Governmental Organisation
NICE	National Institute for Health and Care Excellence (UK)
NOSP	National Office of Suicide Prevention
PCT	Primary Care Team
PPPG	Policies, Procedures, Protocols and Guidelines
RCT	Randomised Controlled Trial
SIGN	Scottish Intercollegiate Guidelines Network
SU	Service User
VfC	Vision for Change
WRAP	Wellness Recovery Action Plan

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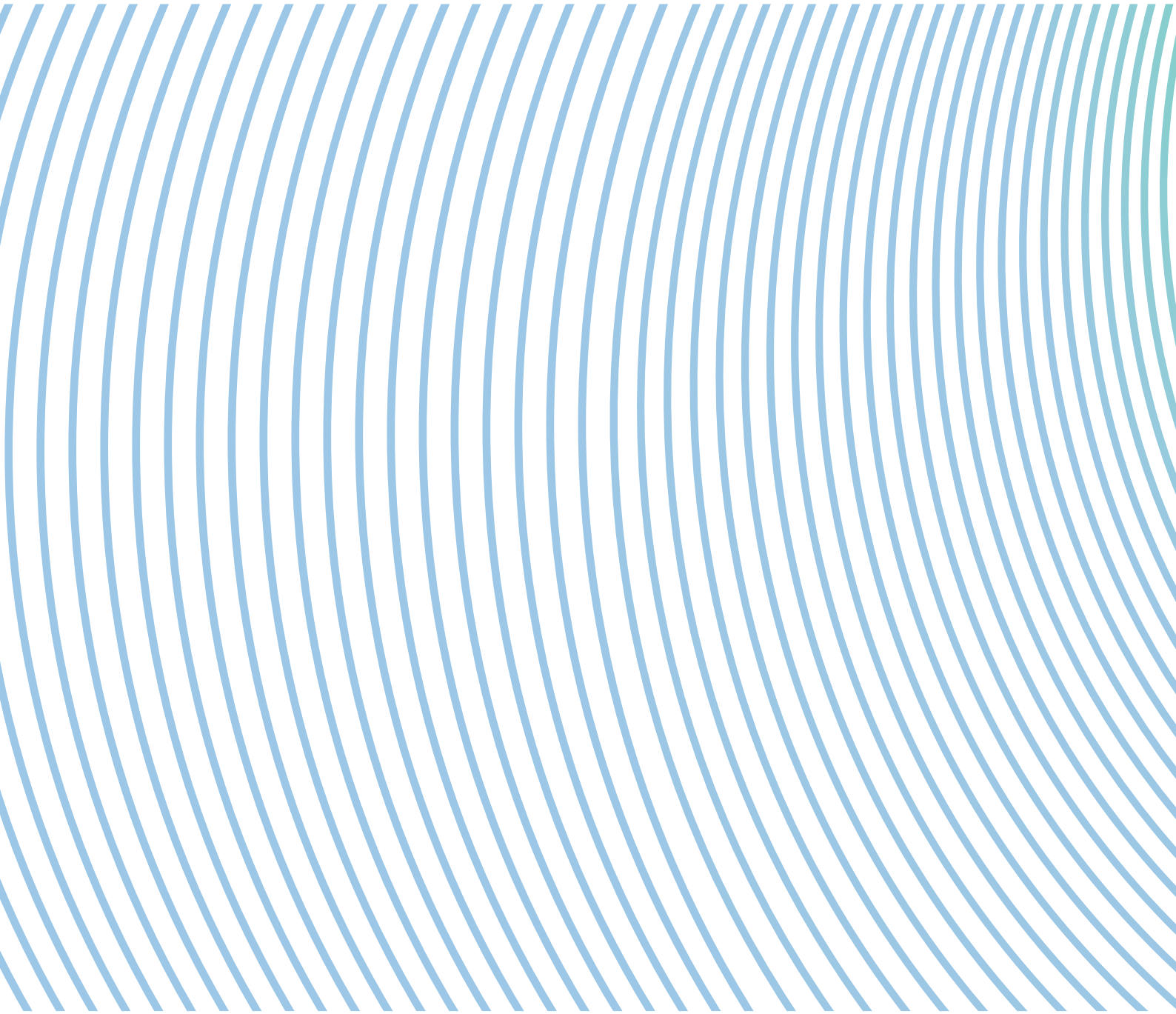

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