



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

National Mental Health Programme Plan

Consultation Document

Clinical Strategy and Programmes Directorate

Health Service Executive

November 2011

DRAFT

Preface

The HSE Clinical Strategy and Programmes Directorate (CSPD) was established to improve and standardise patient care throughout the organisation by bringing together clinical disciplines and enabling them to share innovative solutions to deliver greater benefits to every user of HSE services. The directorate has established a number of National Clinical Programmes. The Programmes are based on three main objectives

- To improve the quality of care we deliver to all users of HSE services
- To improve access to all services
- To improve cost effectiveness

The National Clinical Lead for Mental Health, Dr. Ian Daly was jointly appointed by the HSE and the Irish College of Psychiatry in November 2010. The Programme Project Manager, Ms. Rhona Jennings was appointed by the HSE in August 2011.

This Programme Plan is the result of a series of Group meetings held in the Irish College of Psychiatry from January to July 2011. Three Groups were established; Early Intervention for First Episode Psychosis, Early Intervention in Eating Disorders and the Management of Self Harm among Service users who present in Emergency Departments and members were drawn from mental health professionals, voluntary groups, research agencies and service users. A full listing is provided in Appendix 1.

In October 2011 a Working Group was established in accordance with the CSPD Governance Structure. The Working Group consists of service users, multi-disciplinary team members, General Practitioner and managers (Appendix 1). The Working Group reviewed the Programme Plan in advance of this consultation process.

As the Programme Plan moves towards implementation, groups will be established for each of the programme areas under the direction of the National Clinical Lead. The membership of these groups will reflect the core groups working within mental health services, service user groups and other relevant expertise as required. The groups will report their findings/recommendations to the National Clinical Lead and the National Working Group.

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Executive Summary

This document outlines the first stage in the development of a Programme Plan to reconfigure mental health services in Ireland in line with *A Vision for Change*. Three Clinical Programmes, the first in a series to be completed over a five year period, are outlined for development within the proposed new service delivery model.

Two central policy recommendations from *A Vision for Change* are focused on: the creation of effective community mental health teams (CMHT) and the identification of relevant clinical, psychological and psychosocial interventions which can be offered by the teams. These recommendations form the centrepiece of a re-configured, modern, high quality service.

National and International Policy influences are summarised and described as they will apply to the development of the Mental Health Programmes.

Four fundamental aims for new service development are identified: a preventive and early detection approach towards mental disorders; the management of disorders within an evidence-based framework which includes psychological and psychosocial interventions; a broad focus on outcomes which extends to the promotion of recovery and participation in the community, and the development of interventional partnerships with the voluntary and community sectors to ensure that outcomes are successful and relevant to the needs and aspirations of individuals.

Three board categories or strands of mental disorders are described, with a view to identifying the skills and capabilities required by community mental health teams – serious mental disorders, complex psychological conditions and common mental health problems including depression. Clinical Programmes representing each of these categories are described including an early intervention programme for psychosis, an equivalent programme for eating disorders and a programme for the successful management of self-harm presentations to hospital emergency departments.

The governance structures underlying the successful development of the Clinical Programmes includes three factors which are essential for success: the establishment of national clinical and academic leadership to promote best practice standards and guidelines and contribute to further service development; the critical leadership role of the Executive Directorates in ensuring the establishment of new team and network structures and in promoting partnerships with the voluntary and community sector; and, thirdly, an organisational process that can deliberately promote and foster the capacity of community mental health teams to function as strong high performance units enabled to see service users as customers with both voice and choice.

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Section 1: A National Mental Health Programme Plan

1.1 Introduction

This document is the first in a three stage Programme Plan (Table 1.1) which has the primary aim of implementing the Government policy document, *A Vision for Change*, over a five year period. The overall Programme Plan seeks to reconfigure our core service structures and mental health care delivery models. It does not seek to comprehensively address all aspects of Mental Health Care. Instead, it identifies the **critical** clinical programme developments that will ensure a modern, high quality National Mental Health Service. The first section outlines aims and principles and summarises the strategic direction of the full Programme Plan. The following three sections outline the major three Clinical Programmes being implemented in the first year:

- i. Early Intervention in Psychosis
- ii. Early Intervention in Eating Disorders
- iii. Management of Self Harm presentations in Emergency Departments

(Note on Terminology: **Programme Plan** refers to the overall development strategy for Mental Health as outlined in this section. **Clinical Programmes** refer to specified clinical interventions or objectives, for instance the development of an Early Intervention Programme for Psychosis).

1.2 Policy Context

1.2.1 Government Policy – *A Vision for Change*

A key objective of this plan is to outline a programme structure that will implement the recommendations of the Government policy document *A Vision for Change*. Although the number of psychiatric beds in Ireland has declined by some 85% since the 1960s, the general perception of our services is that they remain primarily institutional and custodial. This perception is linked to the lack of progress in implementing the recommendations of *A Vision for Change*. There are a number of reasons for this and the Independent Monitoring Group has identified key obstacles to implementation. These include the lack of a comprehensive implementation plan, failure to develop an appropriate community care delivery infrastructure, the impact of the moratorium, inadequate involvement of service users, and lack of clarity on governance structures including the roles of the Executive Clinical Directors for Mental Health.

The key recommendations from *A Vision for Change* can be summarised as follows:

Ensure implementation of the Policy:

- Develop a long-term strategy and resource plan
- Prioritise service needs
- Measure effectiveness
- Implement as a full plan

Create a Coherent Governance Structure:

- Develop national, regional and local governance structures
- Create links with primary care, voluntary and community groups
- Develop Information Technology infrastructure to support the programme.

Develop a Community Focus and Promote the Role of Community Mental Health Teams:

- Develop multidisciplinary teams capable of delivering multi-modal interventions
- Train and educate staff members to promote these capabilities
- Close remaining psychiatric hospitals and reconfigure the associated resources to develop community services

Focus on Service Users and the Achievement of Positive Outcomes for them:

- Involve Service Users in care planning
- Develop a Recovery orientation
- Promote mental health – enhance protection, decrease risk.

All four recommendations are critical to the success of future mental health services in this country. The first two recommendations include responsibilities for Government and HSE Corporate, in particular, the requirement to support the full implementation of *A Vision for Change*. The remaining two recommendations serve as guides towards the objectives of this Programme Plan - the creation of new team structures to deliver evidence-based mental health care, and the incorporation of a wider conception of care. Care is envisaged as including direct treatment of illness as well as the identification, with service users, of treatment aims that support their efforts at recovery and renewed social, occupational and community participation.

1.2.2 International Mental Health Policy Trends: Guidelines for Programme Development in Ireland

Mental disorders are a leading cause of disability worldwide and represent 15% - 20% of the global burden of disease within developed economies, greater than the burden from all cancers. There are significant personal, social and economic burdens and costs associated with mental illness - which relate to the early onset of some conditions as well as the high prevalence of others. Schizophrenia has been ranked as the third most disabling condition worldwide (WHO, 2001). The high social and financial costs of more common mental health problems such as depression lie in their widespread prevalence within our communities.

Our understanding of mental health priorities has undergone enormous change in recent decades and an international consensus is developing in relation to optimal mental health policies and priorities. In this way national plans and policies from countries such as Australia, Canada, England, Italy, New Zealand, Scotland and the United States are underpinned by two priorities, Evidence-Based Practice and the Recovery concept. Other common priorities include: the development of a wider public health perspective (with increased awareness of the prevalence and burden of mental health disorders); specialisation, including increased attention to the needs of children and of older adults; greater emphasis on the inclusion of marginalised groups, and the inclusion of a more diverse range of treatments and interventions directed towards meeting the expressed needs of service users.

These countries have faced similar challenges to Ireland in implementing national mental health programmes. The challenges include a lack of Governmental focus on mental health, scarce workforce resources and competencies which result in an insufficiently diversified range of services, barriers to equitable access and

insufficient involvement of service users and caregivers in service planning. Great variability in service provision and in the quality and effectiveness of care provided were also identified in these countries, complicated by a lack of coordination among agencies, and significant delays in the application of evidence-based practices, quality improvement tools and information technology. All seven countries have, in response to these issues, developed priorities within their national programmes which share certain similarities:

- Make mental health a public priority
- Promote evidence-based, measurable and accountable mental healthcare
- Improve access to and widen the range of available services
- Assure a competent and skilled workforce
- Make consumer involvement, response to individual needs, and recovery and wellness the focus of mental healthcare
- Integrate and link mental healthcare with general healthcare and other relevant sectors and services

1.2.3 Relationship to other National Programmes within Clinical Strategy and Programme Directorate (CSPD)

The mental health programme plan seeks to better align mental health care with general healthcare, which is itself undergoing modernisation. Mental health disorders are associated with significantly increased mortality and morbidity. It has been estimated that people with schizophrenia die, on average, 25 years earlier than the general population in the US. While one third of this is due to suicide, the majority of early deaths result from increased cardiovascular and cancer risks. Thus, the Mental Health Programme needs to be considered within a context of other related developments in healthcare in Ireland, including the Primary Care and Chronic Disease Programmes in the Directorate and the HSE Integration Programme, creating area based healthcare delivery systems underpinned by coordinated community and hospital services.

1.2.4 Relationship to Quality and Patient Safety Directorate (QPS)

The Quality and Patient Safety Directorate has been established in the HSE to ensure that high quality safe services are designed and delivered to service users, using a multi-agency approach under the auspices of the *Patient Safety First* initiative. The QPS has defined Clinical Governance as people receiving the right care, at the right time, from the right person in a safe, honest, open and caring environment. The QPS has developed a process to ensure that the principles of good clinical governance are incorporated in the national clinical programmes. This Programme Plan describes governance structures at all levels. Individual clinical programmes will further develop and implement clinical governance as they are developed.

These policy priorities inform this Mental Health Programme Plan. Certain policy concepts are discussed in more detail in the next section.

1.3 Policy Concepts for Improved Mental Health Care

Critical policy concepts including Recovery, Evidence Based Practice, Early Intervention, Quality and Patient Safety and Interventional Partnerships have been extracted from National and International Policy Documents and directly inform this Programme Plan. They are discussed below from an application perspective in this Programme Plan.

1.3.1 Recovery and Values Based Practice

The Recovery concept is an approach to mental health disorders that emphasises the potential for individual recovery within a quality of life conceptual framework. Recovery is about the person creating a meaningful life even in the presence of ongoing mental disorder. It is based on ideas of self-determination and self-management. People do not recover in isolation, and recovery requires social inclusion and participation. Implementing Recovery in clinical practice requires two tasks. The first task is to promote self-management skills through psycho-education and through the development of empowering relationships such as are formed by inviting service user participation in decision making. Empowerment and the promotion of self-management yields direct clinical benefits in the form of better outcomes and lower relapse rates. The second task is to focus on improving functional (along with symptomatic) outcomes across a range of dimensions. This task requires specific, relevant psychological and psychosocial interventions, sometimes carried out in association with family or community partners, directed towards attaining the particular goals relevant to the individual service user.

Values Based Practice has been described as an approach to working with complex and conflicting values in mental health practice. The National Institute for Mental Health: Framework of Values for Mental Health identified three guiding principles of values based practice; recognition, raising awareness and respect for diversity. Values based practice covers key practice skills, a model of service delivery that is user-centred and multidisciplinary, strong links with evidence based practice and partnership in all areas of health and social care.

1.3.2 Evidence-Based Practice

Evidence-based practice has been described as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research”. In clarifying “individual clinical expertise”, Sackett referred to the proficiency and judgement that individual clinicians acquire through clinical experience and clinical practice **and** to the “thoughtful identification and compassionate use of individual patients’ predicaments, rights and preferences in making clinical decisions about their care”.

In the health literature, Read was among the first to acknowledge the fact that people might need help to formulate their values before they could make complex choices. This observation underpinned the development of ‘decision aids’ designed to improve patient participation in clinical decision making. The use of decision aids, tools that help people participate in decision making about health care options, is receiving increased attention, as, for instance, in the International Patient Decision Aid Standards (IPDAS) Collaboration. A systematic review of decision aids indicated that they are more likely to be effective in promoting service user understanding if they are structured, tailored and interactive. Importantly, the review also indicated that values clarification exercises may be better than standard utility techniques for eliciting preferences in individual decision making. A recent Cochrane database review of their use in mental health practice uncovered only two RCTs involving a total of 518 participants. Although definite conclusions could not be drawn on the basis of just these two studies, one reported significantly improved patient satisfaction and, in addition, the studies indicated that interventions did increase service user participation while not increasing consultation times.

1.3.3 Early Intervention

A fundamental principle of early intervention for any health condition is that identification, diagnosis and treatment should occur as early as possible to maximise the likelihood that interventions will successfully minimise the burden of suffering and functional decline. This principle has not been applied routinely in mental health, a situation that is, perhaps, both a result of, and contributes to, the continuing stigma associated with many mental health conditions. Early intervention means “better access and systematic early delivery of existing and incremental improvements in knowledge rather than necessarily requiring dramatic and elusive breakthroughs”.

1.3.4 Quality and Patient Safety

The majority of errors in medicine do not result from individual recklessness or failure but are, more commonly, the result of faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them. This was the principal conclusion of a report by the U.S. Institute of Medicine in 1999. A subsequent report prepared by the Institute of Medicine in 2001 focused on quality assurance, noting the close relationship between risk and quality. Like the earlier report, it identified a situation where hospitals and professionals frequently operated in separate compartments or ‘silos’ with a high premium placed on medical autonomy and perfection. These environments work against interprofessional cooperation and effective communication. Yet, the non-transferability/availability of complete information about the patient’s condition, medical and service history were cited as creating poor quality and high risk. The IOM proposed that a “Put the Patient First” philosophy was essential not only to quality but to the safe delivery of health care and that patients and their family members/caregivers could play a key role in improving safety. A second key recommendation concerned the promotion of a cooperative team environment. “In an effective interdisciplinary team, members come to trust one another’s judgements and attend to one another’s safety concerns”

In Ireland the Report of the Commission on Patient Safety and Quality Assurance *Building a Culture of Patient Safety 2008*, identified similar elements of effective governance.

- Leadership, accountability and management
- Patient and public involvement
- Risk management
- Clinical research effectiveness
- Self management and welfare
- Education, training and development
- Information management

Since the publication of this report the HSE has established the Quality and Patient Safety Directorate (QPS) to develop and implement initiatives across the health services. Specific tools have been developed for the clinical programmes and will be used in the development of standards and guidelines within the mental health clinical programmes. Similarly, the Mental Health Commission (MHC), established under the Mental Health Act 2001, has a mandate to “promote, encourage and foster the establishment and maintenance of high standards and good practice in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres”. The Quality Framework for Mental Health Services published in 2007 provides a quality framework for service to continuously improve the quality of mental health services across eight themes. In addition the MHC has published codes of practice and research in line with best practice.

1.3.5 Interventional Partnerships

The provision of mental health care based on partnership across health sectors has a robust evidence base. The voluntary and community sector can complement the skills of the statutory sector, help to combat social exclusion and add value to statutory services by its user-focused approach to service user needs. These services offer practical help and can reach sometimes difficult to engage individuals. The sector often provides services that are user led or managed by service users themselves and therefore levels of user/service trust are high. The voluntary sector has the potential to engage the community through volunteering and is more likely to invest resources in volunteers, providing training and ensuring that the community is involved in decisions about service delivery.

Recognising and including the important contribution from the Community sector will be critical to the success of a mental health service that seeks to broaden its goals and outcomes to include restoration of personal and social functioning.

1.4 Aims and Principles of Mental Health Programme Plan

1.4.1. Four Fundamental Aims

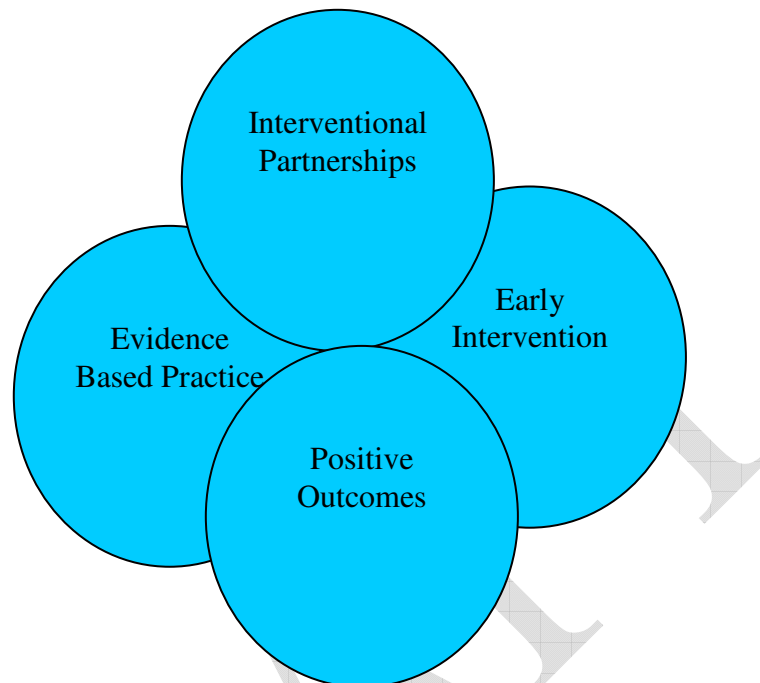


Figure 1.1: Mental Health Programme Aims

The Mental Health Programme Plan has the dual purpose of devising services to manage those with severe mental health disorders and contribute to the management of common mental health problems in the community. Four fundamental aims are identified with the objective of enhancing service delivery models:

1. The management of mental health disorders within an evidence based framework of service provision.
2. The adoption of an early intervention approach and of more assertive and effective illness intervention/prevention strategies.
3. The development of interventional partnerships with primary care and other voluntary and community services.
4. The promotion of positive outcomes for those with mental illness, including the allaying of suffering, the improvement of social functioning and the promotion of personal autonomy and well-being.

These aims reflect the principal objectives of *A Vision for Change* and have an empirical foundation in similar programme/policy development in Western developed economies. They identify best practice methods to help individuals to live optimally healthy lives in community settings. Early detection and prevention methods are stressed to identify and customise treatment strategies and to minimise the

incrementally incurred disabilities that afflict many with serious disorders. More broadly based positive outcome targets rather than symptomatic improvements alone are identified as the new targets towards which our CMHTs will work. Interventional Partnerships will support positive outcomes attainment in those with serious mental disorders and increasingly contribute to the effective management of common mental health problems.

1.4.2 Principles of the Mental Health Programme

To achieve the four principal aims outlined above they must be formulated as key programme elements. These elements or principles are set out below and are informed by Irish policy recommendations, experience from countries with similar mental health challenges and evidence from the clinical and academic literature:

1. ***Implementation of Policy:*** The programmes will implement government policy and continue to progress mental health care in line with ongoing policy development.
2. ***Individualised Care:*** Mental health care will be based on a newly defined set of relationships between service providers and service users, emphasising the central importance of the latter in contributing to the development of individual care strategies.
3. ***Improved access to Early Intervention and Prevention:*** The programmes will emphasise timely detection and phase-specific intervention in evolving serious mental health disorders.
4. ***Service Developments in accordance with Evidence-Based Practice:*** Interventions, clinical, psychological and social, will be based on best evidence or best practice as indicated by empirical sources and the relevant literature and approved or recommended by professional organisations and by service user groups.
5. ***Improved access to Psychological and Psychosocial Interventions:*** Definitions of care and of treatment interventions are extended beyond 'clinical' to include psychotherapeutic interventions from suitably qualified and accredited team members to provide more comprehensive and customised treatment strategies.
6. ***Recovery:*** The principal methods by which recovery can be supported within mental health services are empowerment and interventions to support social functioning. In essence recovery is provided for through the creation and sharing of hopeful expectancy for meaningful and satisfying achievement beyond the constraints of symptoms or diagnoses.
7. ***Interventional Partnerships:*** The contribution of the community and voluntary sector to positive mental health outcomes is recognised in terms of providing complementary services and in providing/promoting employment, education, recreation and social opportunities – all of which play a key role in preventing and ameliorating mental health problems. A range of interventional partnerships to be developed between the mental health and community/voluntary services are advanced as a means of promoting this alliance.
8. ***A Life Cycle Approach:*** The Programme Plan outlines clinical programmes that transcend the existing boundaries between the separate organisational units. Although the existence of specialisation within mental health delivery is recognised (and developed further within the programme), service units are challenged to recognise continuity of care as a critical component of successful care programmes.

1.5 Outline of Programme Plan for Mental Health

1.5.1 Plan Outline

This outline Programme Plan addresses itself to the two central recommendations contained within *A Vision for Change* which address the operational structure of the new service:

Well-trained, fully staffed, community-based multidisciplinary CMHTs (Community Mental Health Teams) should be put in place for all mental health services. These teams should provide mental health services across the individual's lifespan.

To provide an effective community-based service, CMHTs should offer multidisciplinary home-based and assertive outreach care, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families.

In brief, these recommendations are core to the purpose of *A Vision for Change* in outlining “a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness”.

In identifying the scope of work for CMHTs, and to ensure that sufficient capacities are in place to ensure their success, three broad strands of service delivery have been identified. The strands have been pragmatically created and serve the purpose of identifying relevant resource and training requirements. Broadly, then, the work of CMHTs can be seen to address itself to the following:

Strand 1: The management of serious mental health disorders such as schizophrenia. For this group of conditions CMHTs need to be able to deliver comprehensive care ‘packages’ so that persons with extensive symptoms and disabilities can be supported in their communities.

Strand 2: The management of complex psychological conditions such as eating disorders or borderline personality disorders. For this group of conditions, the primary requirements within CMHTs are the possession of sufficient skill and expertise in psychological therapies to address these complex and difficult-to-treat conditions.

Strand 3: The management of common mental health problems. In recent decades services have seen very large increases in referrals of people with less severe conditions the majority of which are depressive or mixed anxiety-depressive disorders and most of which have not required hospitalisation. A proportion of these cases are difficult to treat and, as a result, have tended to long-term out-patient attendance. For this group of conditions, consultation, ‘intermediate’ care and primary care liaison capacities need to be established within CMHTs in addition to capacity creation to address treatment resistant mood disorders.

A plan for the three-stage development of community mental health services incorporating these strands is outlined below:

Table 1.1: Outline Programme Plan

	Strand One	Strand Two	Strand Three
	Serious Mental Health Disorders	Complex Psychological Conditions	Common Mental Health Problems
Stage 1	Early Intervention in Psychosis	Early Intervention in Eating Disorders	Effective management of Suicide/Self-harm in Emergency Departments (EDs)
Stage 2	(1) Extension of interventions to wider relevant service user population. (2) Interventions for Severe Mood Disorders	Interventions for Borderline Disorder and other complex psychological conditions	(1) Extend Suicide/Self-harm programme to Primary Care. (2) Intermediate Care programme for common mental health problems
Stage 3	Integrate C&Adol, Forensic, MHID services	Programmes for cognitive/neurodevelopmental disorders	Continue programme development in Primary Care

The stages identified above should not be regarded as fixed or rigid. For instance, in some areas plans to integrate Mental Health for Intellectual Disability (MHID) services are already being developed.

The programmes encompass the full 'life cycle' and apply to all of the sub-speciality areas within Psychiatry. Parallel plans specific to each sub-speciality will also need to be developed.

1.5.2 Steps and Themes Common to all Clinical Programmes

The Programme Plan will be implemented through the creation of clinical programmes within each of the three strands, as can be seen from the table above. The following development steps will be common to each of the clinical programmes:

1. **Creating CMHTs:** an incremental approach to the construction of functioning Community Mental Health Teams.
2. **Creating Capacity and Capabilities:** identification of key areas for staffing and for education and training.
3. **Developing Governance and Organisational Structures:** governance and organisation structures to ensure the implementation of the programmes at national, regional and local levels.
4. **Developing service interfaces:** implementing a full Life Cycle perspective.
5. **Developing community interventional partnerships:** the promotion of social inclusion and participation.

1.6 Governance and Organisation Structure to Implement the Clinical Programmes: National, Regional and Local Levels

Governance and organisational structure at national, regional and local level are required to implement this programme. Common clinical governance structures that have been established by CSPD for all programmes include:

1. College of Psychiatry Clinical Advisory Group: Representing the College of Psychiatry of Ireland and other professional bodies.
2. Clinical Programme Leads supported by advisory teams, which include representatives from General Practice, Nursing, Allied Health Professions, Project and Programme Managers.
3. Working Group: Multidisciplinary group, representing professional bodies with expertise, and service user representatives.
4. Regional Leads – within the Mental Health Service, regional leadership is represented by Executive Clinical Directors of which there are fourteen nationally, thirteen geographical (corresponding to the thirteen Health Areas) and one National Forensic Directorate. These will play a key leading role in developing the new structures and services nationally.

Table 1.2: Governance Structures for Clinical Programmes

Governance Structures For Clinical Programmes	
Local	<ul style="list-style-type: none"> • Community Mental Health Teams are the point of entry for clinical presentations • Local interventional partnership developments with voluntary and community agencies
HSE Area (Executive Catchment Areas)	<ul style="list-style-type: none"> • Executive Clinical Directorates providing governance and oversight • Specialist (within generalist) clinical programmes • Area partnership developments with voluntary and community agencies
Regional	<ul style="list-style-type: none"> • Regional oversight (as relevant) • Regional development of certain relevant functions and teams • Regional partnership developments with voluntary and community agencies
National	<ul style="list-style-type: none"> • Guidelines and Standards development (in partnership with Professional Organisations) • National Clinical/Academic Leadership • National Partnership developments with voluntary and community agencies

The governance structure outlined in Table 1.2 is reflected in four layers which are outlined and then described in further detail:

- Layer 1: The Community Mental Health Team (CMHT) constitutes the core unit of clinical functioning and point of entry for service users as outlined in *A Vision for Change*.
- Layer 2: Certain specialist clinical programmes outlined in this plan will be delivered on a “specialist within generalist” framework. CMHT members with additional training in areas of specialist activity will collaborate to form part-time specialist teams.
- Layer 3: The majority of the specialist team functions will be developed at a Health Area (Executive Catchment Area) level. Some, for instance, eating disorder teams, will be more appropriately developed at Regional levels.
- Layer 4: National Clinical/Academic Networks comprising Clinical Leads and Regional/ECA team representatives and others will provide national clinical leadership and governance to the clinical programmes.

Layer 1: Local Structure-Community Mental Health Teams (CMHTs)

A Vision for Change laid out a framework to ensure co-ordinated mental health service delivery for catchment area populations of between 200,000 and 400,000. This geographical configuration has largely been attained with the setting up of the Executive Clinical Directorates which are co-terminous with the new Health Areas/Executive Catchment Areas. Within each Health Area/Executive Catchment Area, *A Vision for Change* also proposed the creation of Community Mental Health Teams (CMHTs) serving sector population units of 50,000. These sectors have been mapped, but the development of Community Mental Health Teams to deliver care in these sectoral areas remains rudimentary, with only a few services nationally having the requisite multidisciplinary teams.

Empirical guidance from the literature in relation to specific team construction is not clear. In the US, priority has been given to the development of ‘Assertive Outreach’ teams, which, in accordance with the original PACT programme of Stein in Wisconsin, served to deliver comprehensive care to identified groups of discharged service users. The evidence indicates that these teams have been broadly successful providing they adhere to the conceived models of team functioning. In the UK, CMHTs were set up with a boarder definition and function of care - to deliver services to everyone living in their catchment areas. Given this wider remit, it is understandable that findings relating to their effectiveness are less clear. Additional teams were later added to the CMHTs in the UK to specialise in areas such as Early Intervention, Assertive Outreach and Crisis Intervention and Home Care. These supplementary teams involve additional costs and it is not yet clear if they have been fully successful and/or cost effective. There is some evidence that Early Intervention brings additional benefit, but this has not been clearly established for the specialist areas. The lessons from these service structures in other countries suggests the importance of assigning clearly defined, rather than broad functions to CMHTs and, secondly, that the creation of separate special purpose teams does not necessarily ensure additional benefits. Team construction should therefore be kept relatively simple and based on geographical areas as outlined in *A Vision for Change*. To meet the needs of particular groups effectively, specialist capability and functions should be

identified and built into the overall team structure. In this way, this Programme Plan does not envisage the construction of separate specialist teams except in specific cases and then in a part-time capacity. The CMHT as outlined in *A Vision for Change* remains the core unit of service delivery around which these specialist functions are developed.

An important difference between team construction as proposed within these programmes and the recommendations from *Vision for Change* is in the size and potential diversity of the teams. Although some diversity is proposed (for instance, the creation of employment support workers), resource restrictions prevent full team development at this time, either in size or in the range of therapists envisaged within the government policy document.

In order to promote community participation implied in the concept of recovery, a range of additional community services will be required beyond direct 'clinical interventions'. Such interventions can be provided within the voluntary and community sector. Therefore, the maintenance of a recovery focus will require our community mental health teams not only to specify and directly provide interventions but also to develop shared specified interventions with the community and voluntary sector.

Layer 2: Health Area Specialist Services:

Specialist services will be developed within the overall executive directorate and community mental health team structure to support the delivery of specific services such as early intervention services for psychosis or eating disorders. Specialist teams will comprise staff from CMHTs with specialist training who will deliver day to day care to service users. The organising and co-ordinating functions of these teams will be the responsibility of senior team members including senior psychiatrist, nursing and allied health professionals.

The aims of the teams will be as follows:

- To provide multidisciplinary leadership and governance for specialist care within a directorate area.
- To develop specialist services for those with identified conditions, in accordance with the National Mental Health Programme Plan and supported by the National Clinical /Academic Lead.
- To oversee safe and accessible specialist care, meeting recommended quality standards.
- To deliver specialist interventions that are best organised at a Health Area or ECD level on a sessional basis.
- To liaise across sectors and services and within local communities to deliver coordinated comprehensive programmes.
- To provide training, education and professional support to team members delivering the specialist services.
- To ensure local conformity with procedures and standards as identified within the National Programmes and Clinical and Academic Leadership structures.

Layer 3: Regional Specialist Services and Networks:

Some services will have a unit of service delivery organised at a regional level for optimal impact, for instance, the Eating Disorders Clinical Programme. The regional governance of these programmes will be developed by the Executive Clinical Directors within each region in consultation with the Clinical Lead. The regional services will be structured in a similar fashion and will have similar aims to the Health Area specialist services.

Layer 4: National Clinical Governance

Guidelines and standards of care will be developed by the National Mental Health Lead in CSPD in consultation with the Irish College of Psychiatry, other professional bodies and representatives of Service Users and Carers. Clinical Leads will be appointed to the Clinical Programmes in consultation with the Irish College of Psychiatry and their function will be to:

- i. Take a lead role in developing standards and guidelines:
- ii. Ensure standardisation of service delivery nationwide:
- iii. Coordinate a clinical and academic learning network.

The National Clinical and Academic Network, under the coordination of the Clinical Lead, will promote a shared learning programme so that:

- i. Individual teams can share emerging knowledge and clinical experience
- ii. Services can be developed on an ongoing basis
- iii. Clinical status and outcomes are formally evaluated
- iv. Research and further development opportunities are identified on a national basis.

1.7 Mental Health Information System

IT has the potential to improve the quality, safety and efficiency of mental health care (as of health care overall). Cost and complexity of IT implementation have resulted in its slow and uncertain introduction into this sector. Given the right system, however, the ability to collect, store, retrieve and transfer information electronically brings great potential for service improvement. This Programme Plan proposes the use of an IT system to serve the following purposes.

- The creation of electronic paper records for one of our clinical Programmes – the Early Intervention in Psychosis Programme
- The creation of registers for two other programmes: Early Intervention in Eating Disorders and the Management of Self Harm in Emergency Departments
- The facilitation of the work of the clinical leads and of the Clinical and Academic Networks through the sharing and pooling of information.
- The incorporation of computerised provider order entry (CPOE) and decision support functions into the clinical programmes. COPE allows orders, for instance, for prescriptions drugs, to be entered into a computer system, minimising handwriting and other communication errors. CPOE is known to

have reduced prescribing errors by up to 60%. Decision support for clinicians embraces a number of functions such as individualised reminders or prescribing alerts.

- IT also offers the opportunity to use handheld devices to extend information to mental health professionals at the location of service delivery, thus improving safety and quality, particularly of community or outreach interventions.
- Telemedicine offers the potential for support or clinical care which can be delivered at a distance.

The Mental Health Programme is actively negotiating a suitable IT system.

Dependent on availability, the proposed strategy is to underwrite the success of the clinical programmes through the staged, progressive introduction of IT capability to community mental health teams.

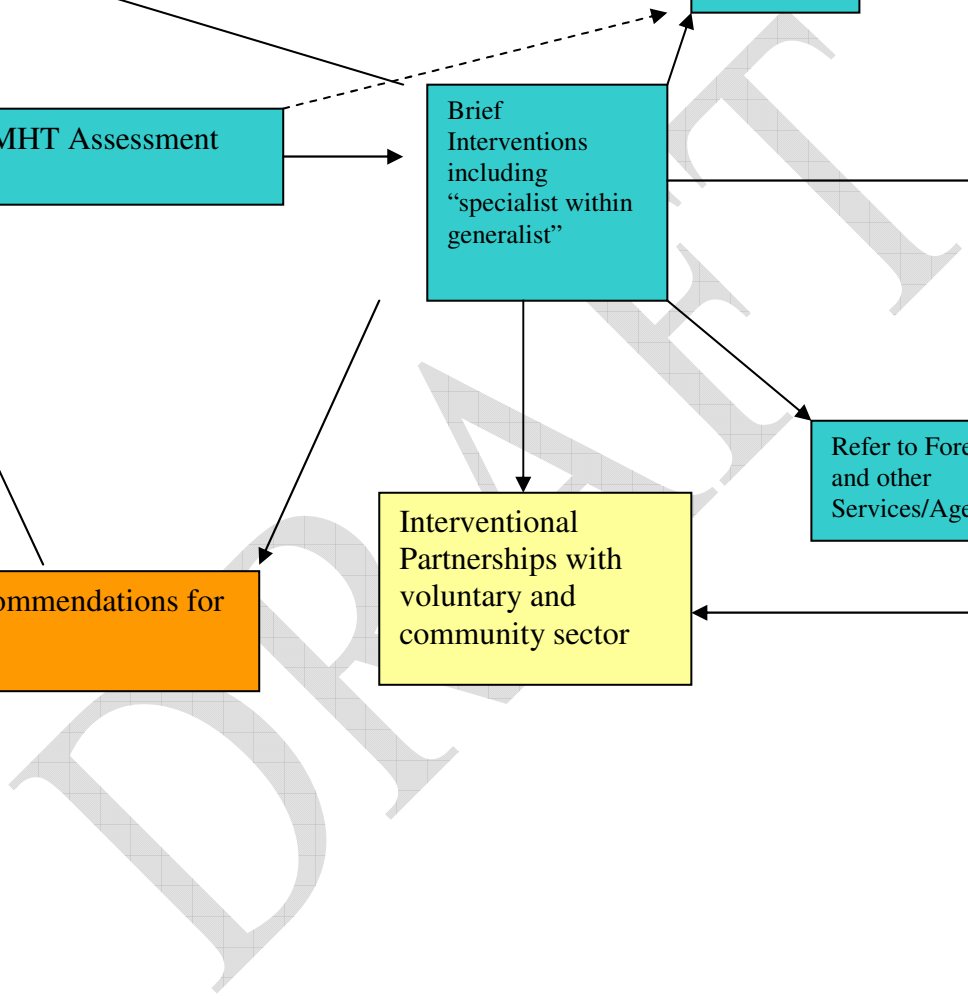
1.8 Generic Care Pathway for Mental Health

The generic care pathway (Figure 1.2) illustrates a few essential elements in the referral pathways that will be driven by this programme plan:

1. The CMHT represents the *single point of entry* to the service from Primary Care and it is also the *basic unit of service delivery*.
2. Although referral from the formal primary care service is the standard, other referral sources need to be considered to facilitate minority and other groups (such as homeless) who may be outside the primary care system. Early intervention services in some countries take direct referrals from alternative sources such as schools or clubs in order to improve access for young people. Finally, the development of partnerships with organisations such as Jigsaw is likely to widen pathways of entry to the Mental Health Services.
3. The CMHT needs to develop capacity to rapidly assess referrals that might formerly have gone directly to admission units. While crisis cases may present at ED, and perhaps be subsequently admitted, urgent cases will require the development of a rapid assessment capacity to meet the aims of early intervention and the provision of least intrusive care.
4. The concept of a 'specialist within generalist' team approach integrates specialist service provision with services provided by the existing CMHTs. These structures will be described in the relevant Clinical Programmes.
5. Delivering Recovery based care will increasingly be conducted in partnership with community and voluntary organisations. Community Mental Health Teams will need to develop these partnerships to ensure broad-based support systems to enhance and maintain recovery.

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graph TD; A[MHT Assessment] --> B[Brief Interventions including "specialist within generalist"]; A -.-> C[ ]; B --> C; B --> D[Interventional Partnerships with voluntary and community sector]; B --> E[Refer to Forensic and other Services/Agencies]; C --> F[Recommendations for ]; D --> F; E --> D;
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The flowchart illustrates the process of MHT Assessment. It begins with a box labeled "MHT Assessment". An arrow points from this box to a box labeled "Brief Interventions including 'specialist within generalist'". A dashed arrow points from the "MHT Assessment" box to a box labeled "Recommendations for ". Another arrow points from the "Brief Interventions" box to the "Recommendations for " box. From the "Brief Interventions" box, two arrows point to boxes labeled "Interventional Partnerships with voluntary and community sector" and "Refer to Forensic and other Services/Agencies". An arrow points from the "Refer to Forensic and other Services/Agencies" box to the "Interventional Partnerships" box. Finally, an arrow points from the "Interventional Partnerships" box to the "Recommendations for " box.



Section 2

An Early Intervention Clinical Programme for First Episode Psychosis

2.1 Introduction

In contrast to mainstream health care, a focus on early diagnosis and intervention has come late to the field of psychiatry. Over the last fifteen years, however, a global movement in this area has become well established and early intervention services have been developed in most countries with a number of studies reporting specific benefits. There are usually two components to these services: early detection and specialist, phase-specific treatment. The early detection component can itself be viewed from two perspectives – a reduced duration of active (confirmed) psychosis, and detection of psychosis at a prodromal stage, before the onset of active symptoms.

A recent Cochrane review, while indicating that there was “emerging, but as yet inconclusive evidence” of the benefits of early intervention programmes, also asserted that the “theoretical justification for early intervention is compelling” and, more specifically, noted significant literature support for phase-specific interventions focused on supported employment and family interventions. An important backdrop to the development of this programme is the pioneering work of the late Prof. Eadbhard O’Callaghan. Regarding his DETECT programme, the first Irish early psychosis intervention programme, there has been a steady flow of supportive evidence over the past decade. This evidence presents cumulatively compelling indications of a range of benefits from early intervention.

It is important to stress that introducing an early intervention programme should be understood as one component of a high quality, needs led comprehensive service strategy to manage all stages of psychosis and not be seen as an alternative or stand alone model of care.

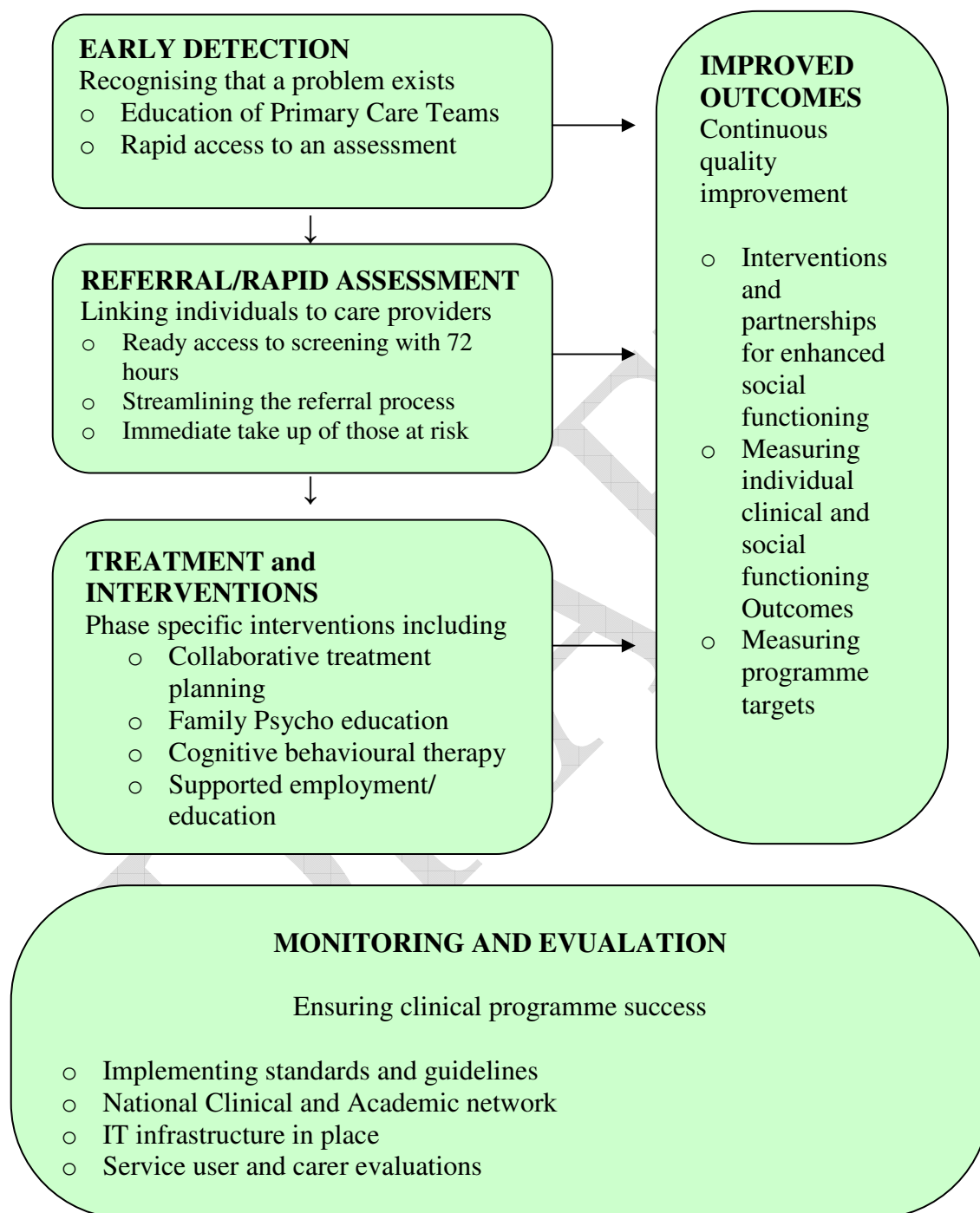
2.2 Policy Context

A Vision for Change noted the emerging evidence indicating a clear relationship between duration of untreated psychosis (DUP) and long-term outcome. It approved the provision of services “in environments that are least restrictive, intrusive and stigmatising” (p.99). It also acknowledged the movement in many western countries to establish specialist teams which were recovery-focused and employed innovative and youth-orientated approaches to engage young adults and their families.

The Clinical Programme for Early Intervention in Psychosis (EIP) is based on the recommendations of the Group set up under the joint auspices of the College of Psychiatry of Ireland and the HSE. The Group broadly follows the principles advocated jointly by the International Early Psychosis Association and the World Health Organisation and its recommendations reflect treatment guidelines as advanced by the National Institute of Clinical Excellence and other international guideline agencies. In particular it borrows from the decade long experience of the DETECT and DELTA projects in Dublin South originated by the late Prof. O Callaghan.

2.3 Fundamental Components of Early Intervention in Psychosis

Figure 2.1: Fundamental Components of Early Intervention in Psychosis



As figure 1 indicates, the fundamental component of the Early Intervention Programme begins with a focus on early detection and a reduction in the duration of untreated psychosis (DUP). In order for this to be effective two interventions are required – the education and training of GP’s in the recognition of early psychosis and an easily accessible screening programme within the Mental Health Service to ensure

rapid uptake of those at risk. Engagement and initial interventions that are regarded as helpful, active and flexible and that are delivered in least restrictive settings are critical to the development of strong therapeutic alliances and therefore improved outcomes. The interventions need to be phase specific and tailored to the individual's needs and circumstances. Those interventions with the strongest evidence based include psycho-education, CBT and supported employment. Psychotherapeutic interventions need not be restricted to these three, but they should represent a minimum in each service. Finally the capacity to remain connected with one's life and community is the essential goal of Recovery and therefore ongoing collaboration with the individual, with family members and with other community members is often required.

2.4 Objectives of the EIP Clinical Programme

The objectives of the clinical programme are outlined in Table 2.1 below. The benefits are to improve access, engagement and treatment, reduce duration of untreated psychosis, and to raise community awareness, to promote recovery, to improve family engagement and support, and to train practitioners in skilled interventions in this area.

Table 2.1: Early Intervention Psychosis Clinical Programme Year 1: Objective and Targets

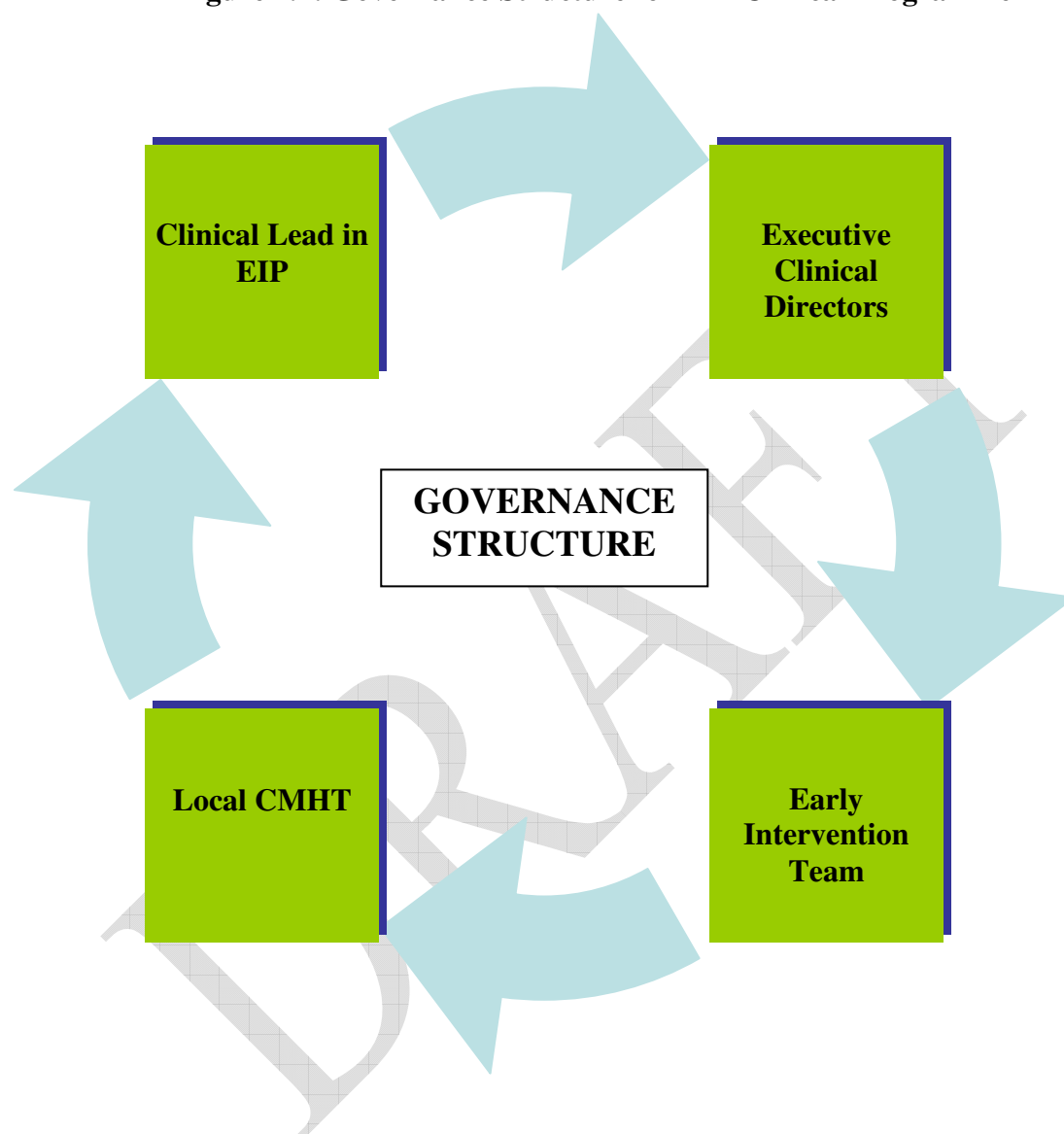
	Objective	Target
Quality	<ul style="list-style-type: none"> To establish a programme that promotes early detection and referral to specialist care of persons with emerging psychotic illnesses, thereby reducing the duration of untreated psychosis. 	<ul style="list-style-type: none"> Establish specialist within generalist team structure per 300,000 population (N=13) The initial target for untreated psychosis will be a median duration of less than 6 months initially, and the year 2 target will be a mean duration of less than 3 months.
	<ul style="list-style-type: none"> All primary care teams (PCTs) will receive educational sessions on the detection of early psychosis. All members of the CMHTs will receive training in the early intervention of psychosis 	<ul style="list-style-type: none"> All PCTs will receive educational sessions on detection of early psychosis from year 1. A MDT training programme will be delivered to CMHTs
	<ul style="list-style-type: none"> To establish a screening process for those with suspected early psychosis. 	<ul style="list-style-type: none"> Screen 200 -250 service users per 300,000 population at risk of psychosis Identify 75 new cases per year
	<ul style="list-style-type: none"> To provide early psychological and psychosocial interventions and to implement best practice interventions to enhance recovery, prevent relapse and minimise disability and social handicap. 	<ul style="list-style-type: none"> CBT – Range 400 hours - 900 hours per service user Family psycho education – Range 300 – 800 hours per family based on individual need. Supported employment/Education
	<ul style="list-style-type: none"> To develop national medication prescribing and monitoring algorithms 	<ul style="list-style-type: none"> Medication prescribing and monitoring algorithms in place
Access	<ul style="list-style-type: none"> To ensure a rapid access facility within 72 hours of assessment. 	<ul style="list-style-type: none"> All new referrals will be assessed within 72 hours
	<ul style="list-style-type: none"> To reduce hospital admissions for first episode presentation by 20% per year from year 2 	<ul style="list-style-type: none"> Decrease hospital admissions from 18 to 15 per 100,000 (HRB Data 2009)
Costs	<ul style="list-style-type: none"> To reduce the individual direct treatment costs for first episode psychosis by 33% from year 2. 	<ul style="list-style-type: none"> 33% reduction in individual treatment costs for first episode psychosis from year 2

2.5 Governance Structure

2.5.1 Governance Outline

As outlined in chapter 1 governance structures are required for each clinical programme. The proposed structure for this clinical programme is outlined in Figure 2.2 below

Figure 2.2: Governance Structure for EIP Clinical Programme



2.5.2 Clinical Lead in Psychosis

A Clinical Lead in Psychosis will be appointed in consultation with the College of Psychiatry of Ireland. The Clinical Lead will work with the Executive Clinical Directors (ECDs) and the Early Intervention Psychosis (EIP) Teams to design service provision across the country, identify national standards and guidelines and co-ordinate a Clinical and Academic Network.

A National Clinical and Academic Network, under the coordination of the Clinical Lead, will develop a shared learning programme so that EIP Teams can

- share their developing knowledge and clinical experience
- further develop services
- formally evaluate clinical status and outcomes
- identify research and further development opportunities on a national basis.

2.5.3 Health Area/ ECD Area Clinical Governance*

Within each Executive Catchment Area, an early intervention clinical programme will be developed as a key responsibility of the Executive Clinical Director. The ECD will ensure that the clinical programme is implemented in accordance with the National Standards and Guidelines.

2.5.4 EIP Team Structure

A suggested Early Intervention Psychosis (EIP) Team structure is as follows:

- The teams will be developed on a sessional or part time basis
- One staff member(or WTE) from each of the Community Mental Health Teams comprising a Health Area/Executive Catchment Area will be identified as 'specialising' in early intervention within the team. (Note: All CMHT members will receive training in early intervention but the identified staff member will receive additional specialist training).
- Other posts from the disciplines of Psychiatry, Clinical Psychology, Social Work and Occupational Therapy (and/or other AHP as required locally) will be included in the team on a sessional basis.
- An Employment Support Officer post and one/two Early Assessment/Primary Care Educational specialist posts will be established and will complete the team, the size of which will come to approximately twelve persons.

From the above outline it can be seen that the EIP is not a full time team. The team will meet on a once/twice weekly basis to clinically review, to provide specialist interventions, and for training and research/evaluation purposes. Outside of these times team members will continue to carry caseloads within their CMHTs. They should however be available for consultation and advice.

Referrals for screening will come to the Assessment specialists who will conduct a screening assessment within 72 hours. Those with likely psychosis will be regarded as admitted to the service and will have their care (including further assessment and diagnosis) directly provided by the relevant CMHT. #

*The purpose of this model is to suggest a service deliver configuration that can ensure the standards, pathways and SOPs recommended by the Clinical Advisory and Working Groups. Local variations may be developed within any particular area, reflecting geographical, demographic or operational influences, and such variations are recommended, providing they continue to ensure national standards and remain consonant with the other areas of programme development. It may be that some areas would like to create full, early intervention teams, perhaps on a pilot basis as recommended in Vision for Change.

#A suitably trained WTE staff member will be required for each 50,000 population sector. In those areas where CMHTs already exist, this staff member(s) may be identified within the existing teams. Where such teams do

[National Mental Health Programme Plan](#)

The key aims of early intervention psychosis teams will be to:

- Provide agreed multi-disciplinary leadership and governance for Psychosis management at an Executive Catchment Area (ECA) level;
- Develop clinical services for those with early psychosis, supported by the national EIP programme, including adaptation of national templates and protocols to local circumstances.
- Ensure a rapid access facility (within 72 hours) for assessment,
- Ensure safe, effective and person-centred delivery of psychosis care, meeting recommended national standards, through the development of a clear individualised treatment care planning process between the person's wishes and needs, the EIP team and the persons CMHT.
- Ensure (a) a family and community focus in the provision of psychosis care, (b) a strengths-based recovery focus and (c) full occupational and community participation within the capacity of each individual.
- Participate in national clinical and academic networks, supported by appropriate IT infrastructure, so that services can continue to be developed as experience and knowledge allows.
- Develop additional phase-specific services based on evidence based practice.
- Provide certain group and other specialist clinical and support interventions that are best arranged on a catchment wide basis, and provide education and support to primary care teams.

Key Aims of EIP Teams
<p>Clinical Leadership and Governance</p> <ul style="list-style-type: none"> ▪ Develop local clinical policies and programme ▪ Emphasise a family & community focus ▪ Ensure a strengths based care planning process ▪ Provide occupational & community participation with a recovery focus
<ul style="list-style-type: none"> ▪ Rapid access within 72 hours to assessment
<ul style="list-style-type: none"> ▪ Support CMHTs in providing phase specific interventions
<ul style="list-style-type: none"> ▪ Provide specialist evidence based interventions
<ul style="list-style-type: none"> ▪ Participate in National Clinical & Academic Networks

not exist, this post will need to be created. It should be noted that the WTE position may be shared between more than one staff member. Indeed, there are advantages to shared posts including the provision of continuity of care during the absence through leave of a staff member.

Within those sectors where there is no existing CMHT, the creation of these posts will represent the first step in setting up a CMHT within each 50,000 sector. As the clinical programmes expand, and other WTEs are added in order to implement them, the CMHT will progressively take form.

2.5.5 Local Community Mental Health Team (CMHT)

The CMHT is the single entry point for service users and the basic unit of service delivery. All CMHT members will receive basic training in early intervention but some team members (one wte) will develop greater expertise. This person will work within the EIP team and be a key link to the CMHT. An essential task of the CMHT is to generate optimism and an expectation of positive outcomes and recovery among referred service users. The creation of responsive services that improve access and engagements and deliver care in less intrusive setting is critical to the success of early intervention programmes, in particular those for young people. Therefore CMHT members will need to become familiar with outreach methods of service delivery. These will include homecare programmes and the provision of everyday support and guidance to service users and family members to complement the more formal psychoeducation programmes delivered by the EIP teams. These settings also foster collaborative approaches and empowerment thereby promoting self management and relapse prevention skills.

Key Aims

- Participation in the specialist within generalist team structure
- Provision of safe effective day to day care
- Provision of home based care/effective out reach
- Provide family support/ structured family education
- Maintenance of physical health and well being
- Development of relapse prevention strategies

2.6 The Principal Interventions in the Management of Early Psychosis

2.6.1 Detection and Referral

- 1) Education to promote better detection and earlier referral of those with psychosis will be directed towards Primary Care Teams. A programme of education and training will be developed in conjunction with the respective Primary and General Practice Colleges and the National Clinical Programme Leads.
- 2) A rapid access assessment process (within 72 hours) will be developed and provided by the specified team members within the EIP team.

2.6.2 Treatment and Interventions

The principal interventions within the programme, in accordance with existing indications from the Early Intervention literature, will include

- Providing the least intrusive settings for clinical service delivery including avoidance of hospitalisation as much as is feasible. This will be achieved through the provision of 'alternatives to hospitalisation' programmes including home based and assertive outreach care and/or day hospital care.

- Providing a range of phase specific psychological assessments and treatments based on individual psychological formulation and guided by evidence-based practice, including CBT for psychosis and group interventions.
- Providing a range of family based interventions from family psycho-education, family support to family therapy guided by an assessment of need.
- Occupational therapy based psychosocial interventions including supported employment.
- Medication algorithms for the treatment of first episode psychosis,
- The routine utilisation of self-management care plans to augment treatment plans, designed to minimise service dependency, to promote autonomy and to enhance social functioning,
- The development of ‘interventional partnerships’ with community and voluntary agencies to enhance recovery and ensure community participation in occupational, educational, and recreational opportunities.

2.6.3 Recovery and Comprehensive Community Care

In order to foster recovery and independence the Programme supports comprehensive community-based involvement with representation from voluntary and community agencies. Specific recommendations will be made in relation to supported employment and supported education programmes as well as in relation to the development of peer-led, carer-led and volunteer-led care and support programmes.

2.7 IT Infrastructure

Plans for an IT programme are being developed to create a national clinical data-base to support conformity with national programme objectives and standards, provide decision support to clinicians and establish national platforms for clinical learning and for clinical translational research.

2.8 Resource and Education Requirements

Given existing regional resource variation and deficits, a high level plan to balance resources nationally on a revenue-neutral basis will be required. Proposals to develop workforce planning and training programmes are being developed. The proposals:

- will ensure the development of staff competencies relevant to the needs of service users and carers, and the aims of the EIP
- will be in-house and sustainable into the future
- will be sufficiently flexible to reflect the rapidly changing roles and skill mix arising from service redesign and reconfiguration.
- will be delivered within CMHTs

2.9 The Development of Service Interfaces:

1. The EIP service will be developed as a single clinical programme extending to all service users throughout the life cycle.
2. Interfaces with General Adult, Child & Adolescent, Later Life, Intellectual Disability and Substance Misuse will require joint working arrangements to provide population based arrangements for service delivery within each Executive Catchment Area.
3. Managing transitions between services is a key challenge and will require the development of co-working and cross-working arrangements to improve integration, provide more flexible services and avail of the expertise being developed within Executive Catchment Areas. In particular, these new working arrangements will be required in order to respond optimally to what has been termed “the surge of new morbidity” among young people and to minimise the risks of becoming lost in the system. The focus at all times should be on optimally meeting the needs of service users throughout the life cycle.

2.10 Implementation Plan

An implementation plan will be developed following this consultation process.

Section 3

A Clinical Programme for Early Intervention in Eating Disorders

3.1 Introduction

Eating Disorders represent a major challenge to general and mental health services. Data from the National In-Patient Reporting System (NPIRS) and from the Hospital In-Patient Enquiry (HIPE) shows an average of 165 annual admissions in recent years in Ireland for service users with eating disorders to psychiatric facilities, and nearly twice this number of admissions to general hospitals. Based on published international estimates the incidence of Anorexia is some 8.1 cases per 100,000 total population per year and 11.1 cases for Bulimia, equating to 850-900 cases nationally. Approximately 90% of all cases present in women, the majority within the 15-24 age group. There is evidence to suggest a significant increase in eating disorder presentations in the 11-15 year old age group.

Morbidity and mortality is significant in Eating Disorders. A relapsing course is common while some 30% or more become chronic. Depression is found in about one-third. Mortality can reach 20%, one of the highest death rates among psychiatric disorders. Medical complications are common and include acute electrolyte disturbances, osteoporosis and infertility. Depression, self-harm and impaired social relationships and functioning are all common with considerable pressures on family and carers.

3.2 Policy Context

Reflecting international evidence of significant benefits from early identification and treatment of Eating Disorders, associated guidelines suggest the development of frameworks and networks to ensure early identification, the creation of a continuum of care, and to ensure that service users are not lost to follow up care. Similarly, based on identified service provision gaps, *A Vision for Change* proposed various service provision elements (Table 3.1).

Table 3.1: Vision for Change - Identified service provision deficits and proposals.

Service provision gaps	Service provision proposals
<ul style="list-style-type: none"> • Only 3 designated specialist beds nationally. • Poor provision for the public sector in comparison to the private sector. • The use of specialist residential facilities in the UK, some of this being paid for by the HSE. • Markedly poor provision for those living outside the capital. • Poor specialist provision for children. • Little communication or cohesion between child and adolescent mental health services and adult mental health services in relation to service provision, early identification and continuity of care. 	<ul style="list-style-type: none"> • The creation of regional specialist teams (110 WTE in total). • The provision of regional beds (5 units). • The provision of specialist child and adolescent services. • Appropriate training for mental health professionals. • The development of prevention and promotion programmes including the provision of support to voluntary agencies.

As reflected in the National Institute for Clinical Excellence (NICE) guidelines for Eating Disorders, the great majority of those with eating disorders can be managed in primary care or by local services with access to specialist advice and support. Not only is early and appropriate intervention associated with a better prognosis but starvation is associated with progressively poor response to treatment and with profound adverse effects on mood and cognition. Therefore, identification and referral protocols that apply diagnostic criteria too narrowly risk delay and loss of the benefits of early intervention. Decisions need to be made on evaluation of overall risk rather than exclusively on measures such as body mass index (BMI) thresholds.

While the prevalence rates indicated above suggest that the average primary care practice will only have between 1 and 3 cases at any particular time, these rates refer to clearly established cases falling into the moderate-to-severe category. It is likely that significantly more mild-to-moderate cases will be present who could benefit from primary care level interventions. International guidelines emphasise early case identification and intervention at Primary Care level. Education programmes directed towards supporting primary care practitioners in early identification will be developed between the respective Colleges, Professional Bodies and National Clinical Leads.

Irish Inpatient Data

There were 177 admissions of Eating Disorders to Psychiatric Services in 2009 of which 51 were first admissions (HRB Data). With regard to general hospital admissions the HIPE data recorded 119 principal diagnoses of eating disorders and 202 additional (secondary) diagnoses of Eating Disorders for the same year. These admission figures represent 90 and 155 patients respectively, amounting to a total of 422 patients nationally. The admission rates by hospital type and estimated costs for 2009 are shown in the table below:

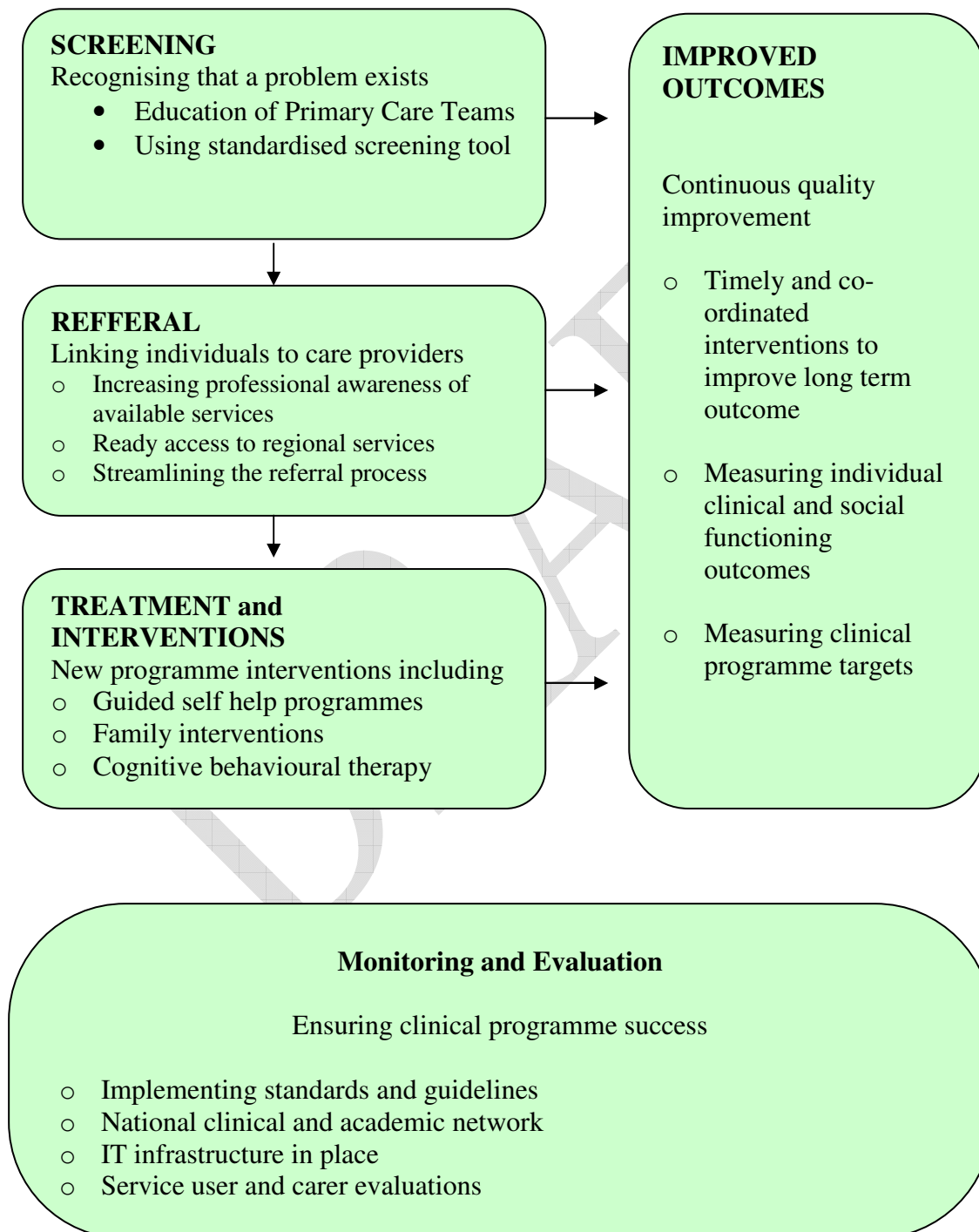
Table 3.2: Eating Disorders data per hospital type/admissions/cost - 2009

Data Sources	General Hospital (HIPE Data 2009)	Psychiatric Hospitals (HRB 2009 Data)	Acute Psychiatric Units Hospitals	Independent Providers	HSE Funded Treatment Outside Ireland	Total
Total Number of patients	245 patients (5,042) bed nights)	12	41	120	4	422
Total Estimated Cost	€3,025,200 (€600 per night)	€151,000	€0.500, 000	€3 million (based on a conservative 6 week stay)	€92,000	€6.7 million

3.3 Fundamental Components of Early Detection in Eating Disorders

The table below illustrates the key components of the eating disorder clinical programme.

Figure 3.1: Fundamental Components of Early Intervention in Eating Disorders



Just as with psychosis, the fundamental components of an early detection programme for eating disorders (Figure 3.1) begins with the identification of early cases as they present in primary care. Recognition will be aided by specific training programmes directed towards primary care practitioners supported by the use of relevant screening instruments. It is likely that further interventions in many such cases can remain low key, based on support and advice and ongoing observation. An important role for the voluntary sector can be identified at this point in the form of providing support and guided self help. It is important, however not to defer more intensive interventions if the primary outcome is not sustained, that is, the restoration of weight and the prevention of further weight loss. Psychotherapeutic support can be delivered within primary care teams, through specialist members of the primary care team or through shared care arrangements. If more intensive interventions are required it is essential that flexible arrangements are made to enable rapid access to regional team support.

DRAFT

3.4 Eating Disorders Clinical Programme Year 1 – Objectives and Targets

The objectives of the clinical programme are to establish access to an Eating Disorders service, increase detection rates and signpost service users to appropriate available evidence based services.

Table 3.3: Eating Disorders Clinical Programme Year 1 – Objectives and Targets

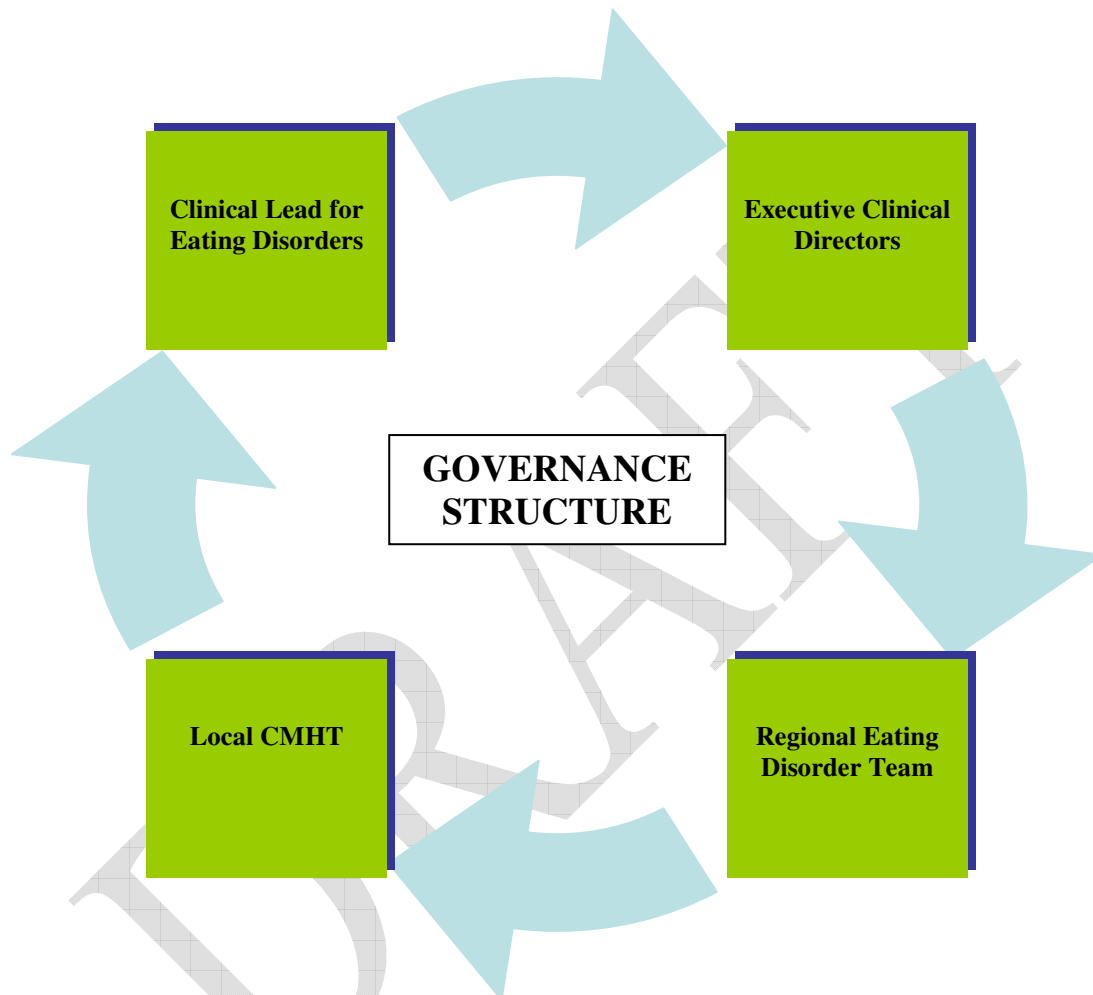
	Objective	Target
Quality	<ul style="list-style-type: none"> To establish a programme that promotes early detection, intervention and appropriate referral to specialist care of persons with eating disorders. 	<ul style="list-style-type: none"> Establish 4 HSE regional teams by end of second quarter Establish specialist capacity within each generalist team structure by end of 2012 To identify 800-900 cases per year nationally
	<ul style="list-style-type: none"> To provide a specific education programme on the detection of Eating Disorders to primary care team staff, and CMHTs 	<ul style="list-style-type: none"> All PCTs will receive educational sessions on detection of eating disorders from year 1. A MDT training programme will be delivered to CMHTs
	<ul style="list-style-type: none"> To support primary care team staff in using a discrete psychometric screening instrument for identifying eating disorders in the community. 	<ul style="list-style-type: none"> Identify a screening instrument for use by PCTs Screen up to 3% of at risk population
	<ul style="list-style-type: none"> To implement best-practice psychological and psychosocial interventions to enhance recovery and minimise the risk of progression to chronicity. 	<ul style="list-style-type: none"> 33,000 hours of specialist psychotherapeutic interventions nationally 80 WTEs required nationally for intensive home care treatments
	<ul style="list-style-type: none"> To establish four regional registers of individuals with eating disorders. 	<ul style="list-style-type: none"> 4 regional registers will be in place by end of year 1
	<ul style="list-style-type: none"> To create a national clinical care network 	<ul style="list-style-type: none"> National clinical care network will be in place by end of year 1
	<ul style="list-style-type: none"> All new referrals with eating disorders will have access to a specialist service according to need and no person will wait longer than 2 weeks. 	<ul style="list-style-type: none"> No person referred will wait longer than 2 weeks for an initial assessment
Access	<ul style="list-style-type: none"> Each CMHT will access to the regional specialist team. 	<ul style="list-style-type: none"> Wait time identified by need
	<ul style="list-style-type: none"> Each regional team will have access to 4 in-patient beds. 	<ul style="list-style-type: none"> Identify 6 inpatient beds for eating disorders within each HSE region
	<ul style="list-style-type: none"> Reduce in-patient costs as per Irish data 	<ul style="list-style-type: none"> Reduce in-patient costs by 25%
Costs		

3.5 Governance Structure

3.5.1 Governance Outline

A governance structure is required for each clinical programme. The proposed structure for this clinical programme is outlined in Figure 3.2 below

Figure 3.2: Governance Structure for Eating Disorder Clinical Programme



3.5.2 National Clinical Governance

A Clinical Lead in Eating Disorders will be appointed in consultation with the College of Psychiatry of Ireland. The Clinical Lead will work with the Executive Clinical Directors (ECDs) and the Regional Eating Disorders Teams to design service provision across the country, identify national standards and guidelines and co-ordinate a Clinical and Academic Network.

A National Clinical and Academic Network, under the coordination of the Clinical Lead, will develop a shared learning programme so that Eating Disorder Teams can

- share their developing knowledge and clinical experience
- further develop services
- formally evaluate clinical status and outcomes
- Identify research and further development opportunities on a national basis.

3.5.3 Regional Service Structure

Within each Region an early intervention Eating Disorders Programme will be developed as a key responsibility of the relevant Executive Clinical Directors who may act in concert or nominate one of their members to this leadership function. The ECD(s) will ensure that the clinical programme is implemented in accordance with the National Standards and Guidelines.

The Regional Specialist Teams, CMHTs and Primary Care Teams will form eating disorder networks supported by an appropriate IT system. A common register will be designed to ensure continuity of care and prevent the loss of service users from within the care system.

3.5.4 Regional Eating Disorder Teams

Four Regional Eating Disorders Specialist Teams (drawn from Child and Adolescent, and Adult services) will provide direct clinical care to moderate-to-severe cases and will provide clinical support and guidance to both Child and Adolescent and Adult CMHTs within the Network. Primary Care Teams will be supported in the early identification and frontline treatment of Eating Disorders presentations.

The aims of the Regional Eating Disorders Specialist Teams will be:

- To provide direct treatment to more severe cases.
- To maintain regional registers of all eating disorders cases in order to ensure a full continuum of care.
- To provide consultation, supervision and support to others members of the Regional Eating Disorder Network.
- To develop clinical programmes and policies within the region.
- To provide education and training to other members of the Eating Disorders network.
- To plan and provide community education, recognition and prevention programmes in conjunction with voluntary and community agencies.
- To partner with voluntary and community agencies in planning and delivering self-help and group self-help programmes to those with eating disorders.
- To establish an Eating Disorders Network that will provide access to dietetics, paediatric and general physician advice and support.

3.5.5 Local Service Structure

Each CMHT will designate a whole-time equivalent to provide a range of clinical services including:

- One-to-one intervention to those with mild-to-moderate disorders;
- Home-based interventions (e.g., family psycho-education, family support);
- Liaison with Primary Care team members; and
- Shared care with Regional Specialist Teams for those with more established disorders.

The role of CMHT members of the Regional Eating Disorders Team:

- To plan and provide local promotion, education and prevention programmes in order to facilitate the early identification and recognition of those with developing eating disorders.
- To support, educate and assist primary care clinicians in screening, assessing and referring eating disorders cases.
- To provide, directly or in partnership with primary carer clinicians, psychotherapeutic interventions to those with mild-moderate eating disorders.
- To provide follow-up and support to those being treated or discharged from treatment provided by regional specialist teams.
- To provide outreach and home support where this is required locally.

3.6 The Principle Interventions in the Management of Eating Disorders

3.6.1 Screening, recognition and assessment

Education and the use of a simple opportunistic screening instrument such as SCOFF is likely to considerably increase the detection of those at risk of developing eating disorders. The Clinical Programme will ensure that primary care practitioners are adequately supported in the identification and assessment of early cases.

3.6.2 Treatment and Interventions

The principal interventions within the programme, in accordance with existing indications from the Eating Disorder literature, will include

- The provision of a specialised service for eating disorders at local and regional level (inpatient and out patient interventions).
- The provision of a range of phase specific psychological assessments and treatments based on individual psychological formulation and guided by evidence-based practice, including CBT for Bulimia Nervosa and family interventions for adolescents.
- The provision of self help and guided self-help CBT interventions which have been shown to have a good evidence base particularly for Bulimia Nervosa
- The involvement of families through home visits and psycho-education.
- The development of 'interventional partnerships' with community and voluntary agencies to enhance recovery and ensure community participation in occupational, educational, and recreational opportunities.
- The management of general health care and monitoring of risk which is required at all stages in the course of treating eating disorders. Risks are particularly elevated in certain situations such as the presence of diabetes or pregnancy.
- The management of psychiatric co-morbidity which will frequently require the support of the CMHT. In particular, co-morbid alcohol or substance misuse is more likely than in the general population and the potential damage from such abuse is also potentially more severe.

3.6.3 Recovery and Comprehensive Community Care

Partnerships with voluntary agencies (such as Bodywhys) will be developed in order to increase awareness, promote early identification and intervention, and promote self-help at early stages.

3.7 IT Infrastructure

Plans for an IT programme are being developed to create a national clinical data-base to support conformity with the clinical programme objectives and standards, provide decision support to clinicians and establish national platforms for clinical learning and for clinical translational research.

3.8 Resource and Education Requirements

A significant programme of education and training will be required in order to support the implementation of the Eating Disorder clinical programme.

3.9 The Development of Service Interfaces

- The Eating Disorder Service will be developed as a single clinical programme extending to all service users throughout the life cycle.
- Interfaces with General Adult, Child & Adolescent, Later Life, Intellectual Disability and Substance Misuse will require joint working arrangements to provide population based arrangements for service delivery within each Executive Catchment Area.
- Managing transitions between services is a key challenge and will require the development of co-working and cross-working arrangements to improve integration, provide more flexible services and avail of the expertise being developed within Executive Catchment Areas.

3.10 Implementation Plan

A plan will be developed this consultation process for the development and implementation of the Eating Disorders Clinical Programme.

Section 4

A Clinical Programme for the Management of Self-Harm among Service Users Presenting to Hospital Emergency Departments

4.1 Introduction

Suicide is a leading cause of death for all ages and the leading cause of death among 25-34 year olds in Ireland. As many as one in ten suicides are by people who had presented to an Emergency Department (ED) at some time in the previous two months. Approximately 12,000 presentations due to self-harm were seen in Irish Hospital Emergency Departments in 2009. Twenty-one per cent of all cases were due to repeat acts, and the highest proportion of these occurred within three months of original presentation. A small group of approximately 450 people were each responsible for ten or more self harm acts, accounting for nearly 11% of the total. These figures match international research findings of elevated post-discharge rates of death by suicide (66-fold increase over general population figures), of further suicide attempts and of readmissions to acute care services.

Large scale differences in Irish hospital admission rates of those who attempt suicide suggest variation and inconsistency in assessment and next care management. Across our hospitals between 6% and 16% of DSH service users leave Emergency Department without being assessed at all. International studies suggest an overall non-attendance rate to follow-up care of about 50%.

Yet, within the suicide prevention literature the strongest evidence of a reduction in the number of deaths by suicide has been based on interventions with high-risk populations after discharge from acute care services. In particular, early initiation of treatment combined with straightforward interventions and continuity-of-care strategies have been shown to reduce rates of repeat acts and to save lives.

This clinical programme outlines a strategy to ensure consistency of assessment and management within Emergency Departments across the country and to develop a strategy for continuity of care and of follow-up. The programme includes developing partnerships with voluntary and community organisations which have been playing an increasingly important role in the community response to the tragedy of suicide in our society.

The programme is the first in a three-stage process that will extend to the management of suicide risk in primary care and that will devise programmes of intervention for specific high-risk groups.

4.2 Policy Context

A Vision for Change makes four critical recommendations in relation to suicide prevention. Three of these directly inform the development of this programme. The first seeks to develop protocols to engage those at high risk. The second seeks to involve the voluntary and community sector in the implementation of suicide prevention initiatives. The third recommendation is an endorsement of the strategy proposals in Reach Out, the HSE national strategy document on suicide prevention which proposes, among other recommendations, the development of service initiatives aimed at improving intervention and the standardising of assessment and pre-discharge planning. A fourth recommendation from *A Vision for Change* relates to the identification of high risk mental health service users. A number of such individuals will present repeatedly to Emergency Departments.

International policy and guideline documents, such as those produced by the National Institute of Clinical Excellence and the American Association of Suicidology, underscore the importance of:

- Training for all relevant staff.
- Structured and effective triage processes.
- Interventions to minimise programme drop-out.
- Assessing risk of repetition beyond stated intention or presence of mental illness.
- Special considerations for children, adolescents and older persons.
- Intensive, assertive early (three-month) follow-up for those at high risk of repetition.

4.3 Fundamental Components of Self Harm Clinical Programme

The figure below illustrates the key components for this clinical programme

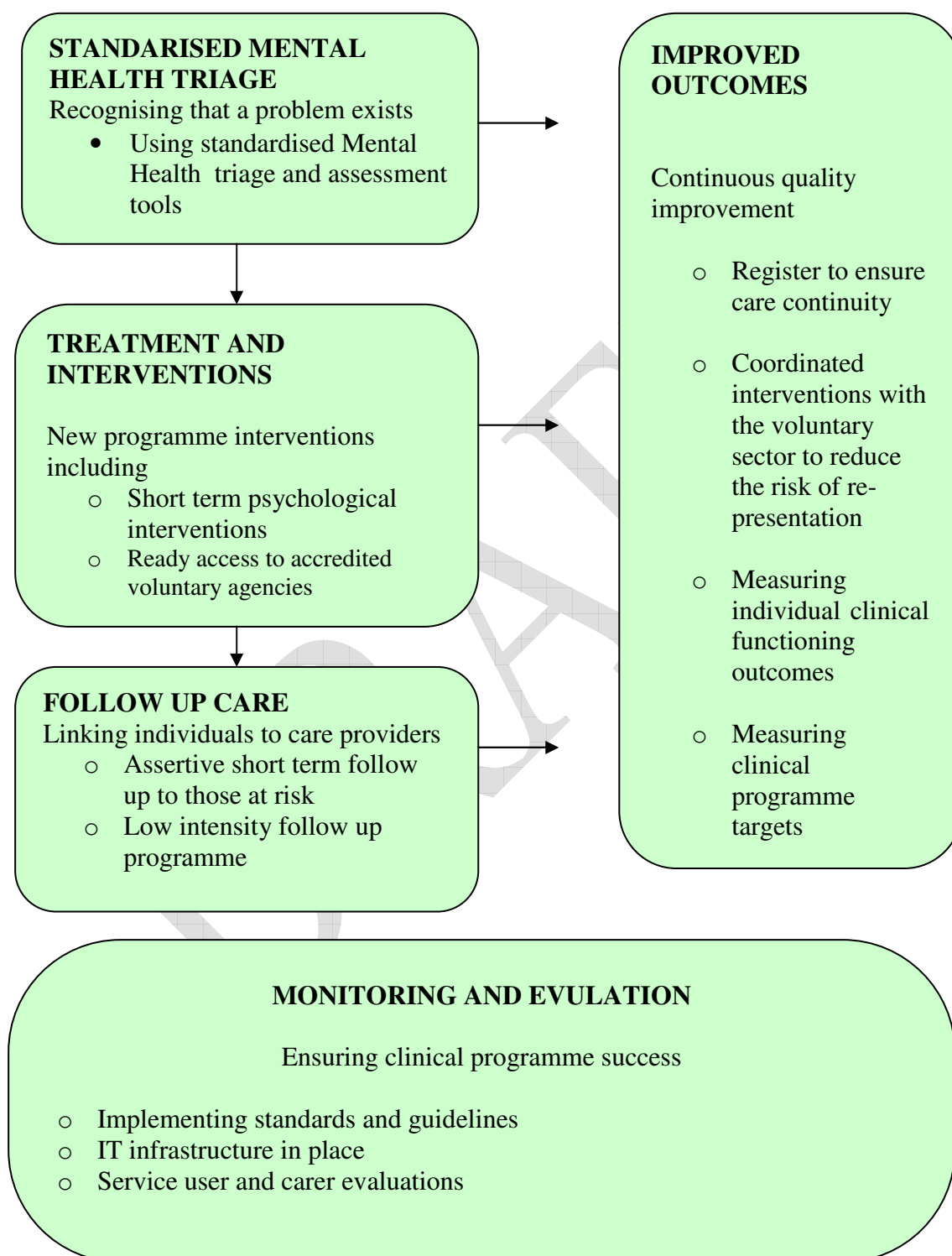


Figure 4.1: Fundamental Components for the Management of Self Harm presentations to EDs

There are 3 components to the clinical programme for the management of self harm presenting to Emergency Departments:

1. Standardised mental health triage and assessment, and assertive follow-up/referral of those at continuing risk ;
2. Interventional Partnerships with voluntary organisations;
3. Follow-up programme to reduce risk of subsequent episodes of self harm.

In order to minimise the risk of repeat self harm acts adequate triage and psychosocial and mental health assessment is required. It is proposed within this programme that a National Standard be developed. Standards will also need to address other relevant factors including over-long waiting times and the associated risk of service users leaving before assessment. Since risk is maximal during the days and weeks following initial presentation of self harm, assertive follow up, monitoring and referral to appropriate interventions will need to be standardised.

A number of individuals will require care from Mental Health Services. It is likely however that a larger number will not require psychiatric intervention, but will benefit from psychotherapeutic assessment and support. A number of voluntary and community organisations provide this form of psychotherapeutic care. This programme proposes the development of partnerships with these agencies directed towards promoting access to such interventions for this vulnerable group.

The risk of repeat self harm behaviour is highest in the first 3 months and declines gradually thereafter. The purpose of the follow-up programme is to ensure that ready support is made available to persons at risk of repetition of self harm acts and to ensure that such persons are reminded of the availability of this support. A 12 months cut-off period represents a pragmatic and practicable period to aim for in providing the follow-up monitoring programme.

The programme consists of low intensity, low intrusion reminders in the form of phone calls, texts or postcards, depending on requirements and permission available from service users. The creation of a register to ensure care continuity is fundamental to this purpose. Once individuals have been, with their permission, entered on to the register, they should be 'signed off' when the adjudged appropriate period of follow-up has expired. No person should 'fall' out of the register, that is, be inadvertently lost to follow-up contact. The register would be maintained by the self harm specialist. Ideally, in the interests of continuity and preservation of confidentiality, follow-up contacts should be provided by the persons who delivered the earlier interventions.

4.4 Objectives of Self-Harm Clinical Programme

The objectives of the clinical programme outline a strategy to ensure consistency of assessment and management within Emergency Departments and to ensure continuity of care and follow-up.

Table 4.1: Self Harm Clinical Programme Year 1 – Objectives and Targets

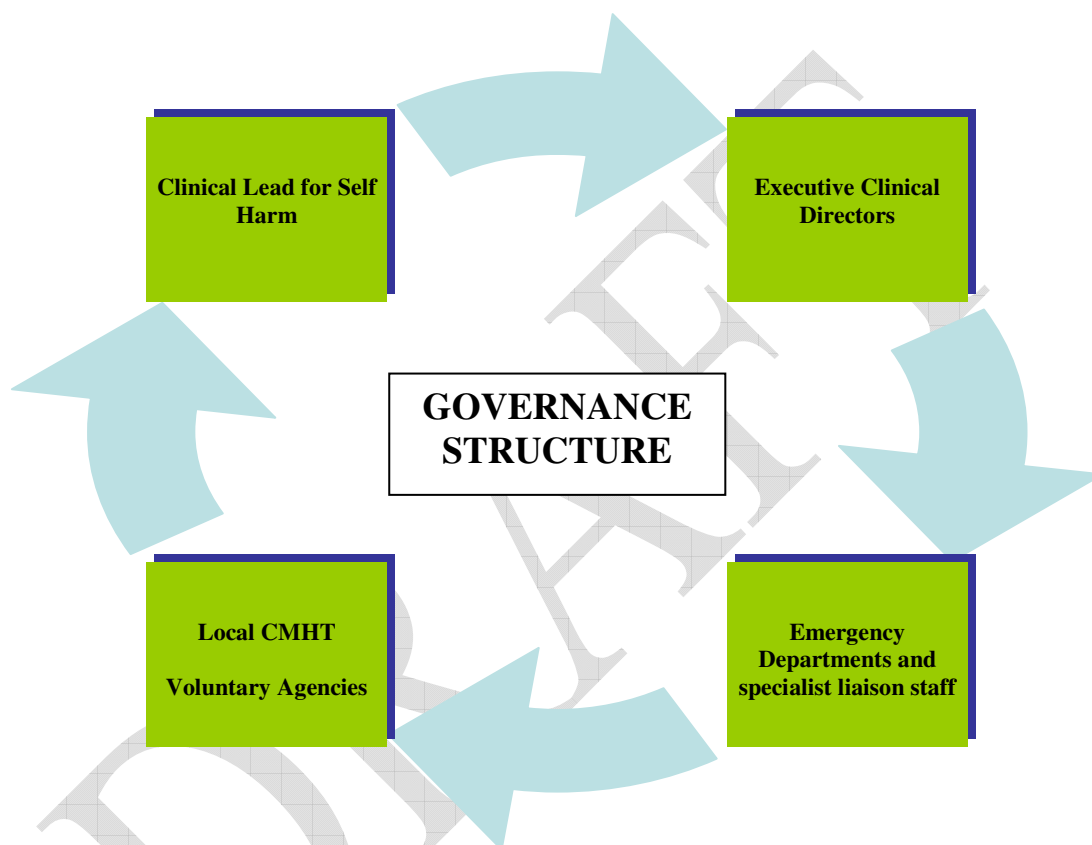
	Objective	Target
Quality	Provide an initial standardised national emergency mental health triage for all service users.	<ul style="list-style-type: none"> Each ED will have a standardised triage system in place.
	Ensure a comprehensive structured mental health assessment within 24 hours.	<ul style="list-style-type: none"> All service users will receive a structured MH assessment within 24 hours
	Develop a partnership framework with community and voluntary services to provide a standardised stepped-care service provision.	<ul style="list-style-type: none"> Each HSE area will develop a local operational framework document.
	<ul style="list-style-type: none"> Provide evidence-based care (including psychotherapeutic interventions) based on systematic assessment of need and risk. 	<ul style="list-style-type: none"> All new referrals will receive expanded range of evidence based psychological and psychosocial interventions
	<ul style="list-style-type: none"> Reduce the 3-month re-presentation rate to EDs of those engaging in self harm by 20%. 	<ul style="list-style-type: none"> Each area will reduce their baseline data figures by 20% (variation across the country)
	<ul style="list-style-type: none"> Halve the rate of those who leave the ED before a care pathway is developed. 	<ul style="list-style-type: none"> 17% to 9% target for those who leave before a care pathway is developed
	<ul style="list-style-type: none"> Provide a standardised training programme to all ED staff on the recognition and treatment of self harm. 	<ul style="list-style-type: none"> All ED staff will receive educational sessions on self harm from year 1.
	<ul style="list-style-type: none"> To establish a register within each Health Service Area to ensure comprehensive follow-up. 	<ul style="list-style-type: none"> All service users (who consent) will be entered onto a local register
Access	<ul style="list-style-type: none"> All those who present will initially undergo mental health triage. 	<ul style="list-style-type: none"> 100% of service users will have access to a mental health triage
	<ul style="list-style-type: none"> All those who present with self harm will receive a subsequent standardised mental health assessment. 	<ul style="list-style-type: none"> All service users will receive a structured MH assessment within 24 hours
	<ul style="list-style-type: none"> Ensure that at least 50% of those who are triaged receive a 24-hour telephone review 	<ul style="list-style-type: none"> Target to be set post consultation
Costs	<ul style="list-style-type: none"> To reduce the number of bed-nights from X to Y 	<ul style="list-style-type: none"> Target to be set post consultation
	<ul style="list-style-type: none"> The number of bed days used throughout the country will be reduced. 	<ul style="list-style-type: none"> Each area will establish local baseline data for bed day usage and set target for reduction based on NSRF data Achieve a reduction of 1,000 acute hospital bed days nationally.
	<ul style="list-style-type: none"> Reduce the 3-month re-presentation rate by 20%. 	<ul style="list-style-type: none"> Target to be set post consultation

4.5 Governance Structure

4.5.1 Governance Outline

A governance structure is required for each clinical programme. The proposed structure for this clinical programme is outlined in Figure 4.2 below

Figure 4.2: Governance Structure for Management of Self Harm in EDs Clinical Programme



4.5.2 National Clinical Governance

A Clinical Lead in Self Harm Management will be appointed in consultation with the College of Psychiatry of Ireland. The Clinical Lead will work with the Executive Clinical Directors (ECDs) and the Local Hospital/Emergency Department Services to design service provision across the country, identify national standards and guidelines (in particular, establish a standardised triage process) and co-ordinate a Clinical and Academic Network.

A National Clinical and Academic Network, under the coordination of the Clinical Lead, will develop a shared learning programme so that service representatives can :

- share their developing knowledge and clinical experience
- further develop services
- formally evaluate clinical status and outcomes
- identify research and further development opportunities on a national basis.

4.5.3 Regional/ECA Governance

Within each Executive Catchment Area, a Self Harm Management Programme will be developed as a key responsibility of each Executive Clinical Director. The ECD will ensure that the clinical programme is implemented in accordance with the National Standards and Guidelines and will ensure the establishment of Hospital and Area-wide policies and procedures. Networks will be developed to ensure full-time availability of mental health assessment to those with self harm presentations. Care pathways will be developed to ensure access to full Mental Health Triage and Assessment for all service users within the relevant catchment areas. ECDs will negotiate 'interventional partnerships' with voluntary and community agencies to provide psychological support services to those with relevant needs. A confidential register will be created within each ECA to ensure continuity of care and minimise the risk of gaps in service follow up.

4.5.4 Local Hospital/ED Governance

Hospital Liaison and ED teams will develop agreed governance arrangements to ensure adherence to developed standards around the process of triage and psychosocial and mental health assessment. They will also need to develop processes to reduce the waiting period before psychosocial and mental health assessment in order to minimise the risk of service users leaving before assessment. The use of the self harm register will allow them to gather extended data to improve future service provision and minimise repeat self harm behaviours.

Two specialist staff members in Self Harm will be appointed to each ECA who will work the Mental Health Liaison Teams and also with the CMHTs and community partners to:

- Assist with mental health triage and assessment;
- Establish an assertive short-term follow-up programme appropriate to risk level
- Ensure the appropriate level of next treatment and intervention
- Ensure uninterrupted transition between service units and community agencies providing therapeutic interventions
- Provide brief supportive interventions;
- Manage, maintain and protect the confidentiality of the shared register.

ECD GOVERNANCE

- Shared Mental Health/ ED Clinical Governance
- Care pathways to ensure full access
- Standardised triage and assessment
- 24/7 service provision across full age span
- Establish confidential shared register

4.5.5 Interventional Partnerships with Voluntary and Community Agencies

The Clinical Programme is developing a structure to partner with voluntary organisations in the provision of care and support to those with self harm. The principles of this arrangement are as follows:

- Development of partnerships with the voluntary and community sector to deliver care and support to those who self harm;
- The creation, in partnership with the agencies, of rapid access short-term stabilisation and, where required, longer-term therapy;
- Governance of affiliated organisations within this programme will be through the Irish Association of Suicidology (Accreditation Model);
- Matters relevant to clinical governance of shared register use - referral, confidentiality and data protection - will be clarified prior to commencement of this programme.

4.6 IT Infrastructure

Plans for an IT programme are being developed to create local clinical data-bases to support conformity with the clinical programme objectives and standards, provide decision support to clinicians and establish national platforms for clinical learning and for clinical translational research.

4.7 Resource and Education Requirements

In association with the College of Psychiatry of Ireland and other relevant organisations the programme will develop and implement a training programme for all Emergency Department staff so that they can provide appropriate quality evidence-based services.

4.8 Integrated Care Pathways Map

An integrated care pathway for suicide/self-harm presentations to Emergency Departments will be developed including an algorithm for referral and for intervention, specifying the relevant guidelines. Local services may develop their own pathways reflecting specific contexts while conforming to the national guidelines.

4.9 The Development of Service Interfaces:

4. The management of Self Harm presentations to ED will be developed as a single clinical programme extending to all service users throughout the life cycle.
5. Interfaces with General Adult, Child & Adolescent, Later Life, Intellectual Disability and Substance Misuse will require joint working arrangements to provide population based arrangements for service delivery within each Executive Catchment Area.
6. Managing transitions between services is a key challenge and will require the development of co-working and cross-working arrangements to improve integration, provide more flexible services and avail of the expertise being developed within Executive Catchment Areas.

4.10 Implementation Plan

An implementation plan will be developed following this consultation process.

DRAFT

Appendix 1

Irish College of Psychiatry Group Meetings (January 2011 – July 2011) - Membership

Early Intervention in First Episode Psychosis

Name	Background
Ms. Anne Clohessy	Pharmacist/Lecturer
Ms. Audrey Purcell	Pharmacist
Mr. Clement McLoughlin	Occupational Therapist, Manager
Dr Caroline O' Connor	Clinical Psychologist
Dr Dominic Fannon	Consultant Psychiatrist
Dr Ena Lavelle	Consultant Psychiatrist
Dr John Lyne	NCHD Psychiatry
Dr Karen O Connor	NCHD Psychiatry
Dr Linda Finnegan	Principal Clinical Psychologist
Dr Meave Rooney	Consultant Psychiatrist
Dr Michael Byrne	Principal Clinical Psychologist
Dr Nicolas Ramperti	NCHD Psychiatry
Dr Paddy Power	Consultant Psychiatrist
Mr. Niall Turner	DETECT – Project Manager
Professor Paul Fearon	Clinical Professor of Psychiatry, St Patrick's University Hospital
Mr. Paul Guckian	Principal Social Worker

Early Intervention in Eating Disorders

Ms. Aileen Garrihy	Senior Occupational Therapist
Ms. Anne Clohessy	Pharmacist/Lecturer
Ms. Audrey Purcell	Pharmacist
Dr Annemarie Waldron	Consultant Psychiatrist
Dr Caroline Maher	Consultant Psychiatrist
Dr Deirdre Dunne	Principal Clinical Psychologist
Dr Linda Finnegan	Principal Clinical Psychologist
Dr Michael Byrne	Principal Clinical Psychologist
Ms. Jacinta Hastings	CEO, Bodywhys
Ms. Leslie Morrissey	Occupational Therapist
Ms. Ruth Kilcawley	Senior Dietician

Management of Self Harm Presentations among Service users to Emergency Departments

Ms. Anne Clohessy	Pharmacist/Lecturer
Ms. Audrey Purcell	Pharmacist
Mr. Declan Behan	Director, Irish Association of Suicidology
Dr Eugene Cassidy	Consultant Psychiatrist
Dr Faraz Jabbar	Psychiatrist
Dr Helen Keeley	Consultant Psychiatrist
Dr Jackie Montwill	Consultant Psychiatrist
Dr John Tobin	Consultant Psychiatrist
Dr Julie Anne Reidy	Consultant Psychiatrist
Dr Justin Brophy	Consultant Psychiatrist/ Executive Clinical Director
Dr Linda Finnegan	Principal Clinical Psychologist
Dr Michael Byrne	Principal Clinical Psychologist
Dr. Ella Arensman	Director of Research, National Suicide Research Foundation
Mr. Geoff Day	Director, Office for Suicide Prevention HSE
Dr. Mairi Keenleyside	Clinical Psychologist
Ms. Miriam Noonan	Occupational Therapist
Ms. Joan Freeman	CEO, Pieta House

Members of the Working Group

Name	Nominating Organisation/Group
Dr. Ian Daly	National Clinical Lead
Ms. Rhona Jennings	Programme Project Manager
Mr. John Redican	National Service Users Executive
Ms. Carol Ivory	Office Assistant National Director for Mental Health
Mr. Paul Longmore	Irish Association of Social Workers
Ms. Mary Gregor	HSE – Allied Health Professional Representative
Dr. Brid Hollywood	Irish College of General Practitioners
Dr. Linda Finnegan	Heads of Psychological Services of Ireland
Dr. Michael Byrne	Heads of Psychological Services of Ireland
Mr. Patrick Benson	Mental Health Nurse Managers Ireland
Mr. Colum Bracken	Mental Health Nurse Managers Ireland