MHC
Coimisiún Meabhair-Shláinte
Mental Health Commission

Quality Framework

Mental Health Services in Ireland

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Foreword

Chairman's Introduction

The statutory mandate of the Mental Health Commission is to 'promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.' [Mental Health Act 2001, Section 33(1)]

An earlier publication *Quality in Mental Health – Your Views,* highlighted the commitment of the Mental Health Commission to working in partnership with the people who use mental health services, families, carers, advocacy and representative organisations, voluntary organisations involved in the area of mental health, statutory, voluntary and independent providers, the full range of professionals involved in mental health services, government agencies and the general public. The aforementioned report gathered the views and perspectives of all stakeholders as to what constitutes quality in mental health services. The *Quality Framework for Mental Health Services in Ireland* has built on the wealth of ideas expressed in that report.

Unprecedented reform of mental health services in Ireland is now underpinned by modern mental health legislation - the *Mental Health Act 2001* and modern national mental health policy - *A Vision for Change*. This publication *Quality Framework for Mental Health Services in Ireland* provides, for the first time in this country, a mechanism for services to continuously improve the quality of mental health services. It marks a real change in the way mental health services will work with people who experience mental health difficulties. It promotes an empowering approach to service delivery, where services facilitate an individual's personal journey towards recovery. The quality framework is non-prescriptive to ensure that it applies equally to all mental health services, irrespective of funding mechanisms or whether they are being delivered in the home, community settings or in approved centres.

I wish to record the Commission's appreciation to the members of our international expert panel whose advice and enthusiasm were invaluable to the successful development of the quality framework – Dr John Øvretveit, Director of Research, Medical Management Centre, Karolinska Institute, Stockholm, Sweden and Professor of Health Management, Faculty of Medicine, Bergen University, Norway and Dr Michelle Funk, Coordinator of Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse, World Health Organisation.

Developing, implementing and maintaining cost-effective mental health services of the highest quality presents a number of challenges that can only be addressed incrementally. 'Achieving together' through collaborations on quality initiatives will be paramount for services to reach full implementation of the *Quality Framework for Mental Health Services in Ireland.* This publication aims to serve as a useful resource for supporting continuous quality improvement.

Dr. John Owens
Chairman

1. Introduction

1.1 Mental Health Commission: Mandate

The Mental Health Commission is an independent statutory body established pursuant to Section 32 of the Mental Health Act 2001.

The principal functions of the Mental Health Commission under the Mental Health Act 2001, Section 33(1) are to *"promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act".* Furthermore, the Mental Health Commission *"shall undertake or arrange to have undertaken such activities as it deems appropriate to foster and promote the standards and practices referred to in subsection (1)* [Section 33(2)].

The Mental Health Commission's Strategic Plan 2006-2008 (Strategic Priorities 2006-2008, Appendix B) gives explicit expression to these key responsibilities.

In order to discharge its statutory duties to promote, encourage and foster high standards in the delivery of mental health services, the Commission has developed, following consultation with stakeholders, a quality framework for implementation within mental health services in Ireland. The quality framework for mental health services provides a mechanism for services to continuously improve the quality of mental health services. It promotes an empowering approach to service delivery, where services facilitate an individual's personal journey towards recovery.

The quality framework is applicable to all mental health services in the public, voluntary and independent sectors. It includes mental health services for children and adolescents, adults, older persons, persons with an intellectual disability and a mental illness, and forensic mental health services. It applies equally to all mental health services irrespective of whether they are being delivered within the service user's home, community settings, both residential and non-residential, or within in-patient facilities.

The quality framework incorporates the Mental Health Act 2001 (Approved Centres) Regulations 2006, prescribed by the Minister for Health and Children, which came into effect on 1st November 2006. The regulations set out minimum standards for approved centres[1], necessary in order to provide quality and safety in the provision of inpatient mental health services. The Minister has provided for the enforcement of these regulations by the Commission [Mental Health Act 2001 (Approved Centre) Regulations 2006, Reg. 35]. The quality framework is, however, much broader and more ambitious than the regulations, as it aims to deliver high standards and good practices across all mental health services.

[1] Approved centre: A "centre" means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. An "approved centre" is a centre that is registered pursuant to the Act.

1.2 International Context in relation to Quality and Healthcare

Professionals and their associations have long worked to improve the quality of their individual services. However, it is only in the last 20 years that modern organisational approaches to quality have been employed in health services. Internationally it is recognised that, given the complexities of health care and the many workers involved in service user care, good organisation and individual competence are essential. Without combination and coordination, specialisation becomes a danger to patients (Institute of Medicine, 2000).

The United States was the first country to make use of modern methods on a large scale in health care, following ground-breaking pilot projects in the late 1980s (Berwick *et al,* 1990). At the same time, in the UK, Canada and Australia, services were experimenting with using standards-based organisational assessment and development systems, such as accreditation (Shaw, 2001). In the early 1990s, there appeared to be conflict between standards-based approaches and continuous improvement approaches to quality both of which spread quickly in western health care systems. However, the late 1990s saw a convergence between standards-based accreditation and certification schemes requiring process improvement (Leland, 2002; ISO, 2000).

In 1994, the first substantial national strategy for quality in healthcare was developed in Norway (Statens Helsetilsyn, 1994, with a new 10 year strategy in 2006). This was rapidly followed by national strategies for other countries. In 1998, the British published and started a 10 year programme, which has been referred to by one quality expert as *"the largest quality programme in health care ever"* (Øvretveit, 2000a). This has had a major impact on improving all NHS services in the UK, including mental health services (Department of Health, 1998, 2001; Øvretveit, 2000a).

Mental health services across the western world also experimented with different quality improvement approaches during the 1990s and many countries adopted quality assessment schemes for different sub-services (Balog, 1991; Hansson, 1993; World Health Organisation, 1994). Quality standards, measurement, assessment and improvement in mental health became widespread from the late 1990s onwards. These areas were further developed by additional attention being paid to patient safety, patient/service user and relative participation in care, and more information and choice for patients/service users (Corrigan *et al,* 2000; American Hospital Association, 2004). Such changes also began to be introduced in some middle and lower income countries in the late 1990s, notably in Zambia, Russia, Peru, South Africa and Thailand (Øvretveit, 2002; Berwick, 2004).

Quality assessment, measurement and improvement, combined with professional development are now an integral part of most western health systems and services. These methods have been adopted by private healthcare to respond to increased competition and service user expectations and are increasingly being used to regulate quality. For public services, these methods are contributing to meeting the changing health needs and expectations of service users, and minimising any gaps that might exist between public and private care e.g. access to services. Health services have also discovered what commercial services have long known – that quality methods, skilfully applied, can reduce costs as well as increase patient satisfaction and clinical outcomes (Øvretveit, 2000b). With this background of experience and greater knowledge of which methods are effective, Ireland is now able to take a substantial initiative to improve quality for mental health service users.

1.3 National Context in relation to Quality and Healthcare

In Ireland, the quality dimension has been put on the agenda for health and personal social services by the government of the day (Department of Health, 1989, 1992, 1994, 1996, 1997; Department of Health and Children, 1998a, 1998b, 2001, 2006). The *Report of the Commission on Health Funding* suggested that:

> *"Any organisation involved in the delivery of services must be concerned with the consumer perception of the quality of services provided"* (1989)

Quality has become a central tenet of the Irish health service and was one of the main principles underlying the 1994 health strategy *Shaping a Healthier Future: A Strategy for effective Health Care in the 1990s.* The current health strategy published by the Department of Health and Children in 2001 entitled *Quality and Fairness: A Health System for You* is guided by four principles – equity, people-centeredness, accountability and quality. The Project Team and Steering Group that devised the Strategy stated that:

> *"It is now time to embed quality more deliberately into the health system through comprehensive and co-ordinated national and local programmes"* (Department of Health and Children, 2001, p.19)

The strategy also articulated that quality in health means that:

- *"evidence-based standards are set in partnership with consumers and are externally validated"*
- *"Continuous improvement is valued"* (p. 19)

In order to achieve the vision mapped out in the strategy, four national goals were set:

- Better health for everyone
- Fair access
- Responsive and appropriate care delivery
- High performance

The fourth goal of high performance has direct applicability to quality as it relates to quality of care, planning and decision-making, commitment to continuous improvement and full accountability. The objectives identified under high performance in the health strategy are:

- *"Standardised quality systems support best patient care and safety"*

This objective is concerned with ensuring that the quality and safety of care meet agreed standards and are regularly evaluated.

- *"Evidence and strategic objectives underpin all planning/decision making"*

This objective is concerned with ensuring that an evidence-based approach informs policy and decision-making and underpins the planning, management and delivery of health services.

The report of the Expert Group on Mental Health Policy published by the Department of Health and Children entitled *A Vision for Change* (2006) has been adopted by the Irish government as the policy framework for mental health services in Ireland for the next seven to 10 years. The report places the service user at the centre of care with a firm emphasis on recovery and facilitating active partnerships between service users, carers and mental health professionals. The quality framework for mental health services in this report complements the key recommendations of *A Vision for Change.* The recommendations and their 'fit' with the quality framework are outlined in Appendix C.

The Irish Health Services Accreditation Board

The Irish Health Services Accreditation Board (IHSAB) was established via Statutory Instrument in 2002 by the Minister for Health and Children. The main function of IHSAB is to operate acute hospital accreditation programmes and to grant accreditation to hospitals meeting standards set or recognised by the Board. The process of accreditation is voluntary.

The Interim Health Information and Quality Authority (iHIQA)

The Interim Health Information and Quality Authority was established via statutory instrument by the Minister for Health and Children in 2005 (S.I. No. 132 of 2005). The Health Bill 2006, when enacted, will establish the Health Information and Quality Authority (HIQA). In the meantime, the iHIQA are responsible for putting in place the structures and systems to enable the Authority to commence work as soon as the legislation is passed. The functions of HIQA, as stated in the Health Bill 2006, shall not encroach on the statutory functions of the Mental Health Commission [Health Bill 2006, Head 9(2)].

The functions of HIQA enunciated in the Health Bill 2006 are:

- Setting and monitoring standards on safety and quality in health and personal social services provided by the Health Service Executive (HSE) or on behalf of the HSE and advising the Minister and the HSE on the level of compliance with those standards
- Carrying out reviews to ensure the best outcomes for resources available to the HSE
- Carrying out assessments of health technologies
- Evaluating information on health and social services and the health and welfare of the population and advising the Minister and the HSE on deficiencies identified
- Setting information standards and monitoring compliance with those standards
- Undertaking investigations as to the safety, quality and standards of services where the Minister believes that there is serious risk to the health or welfare of a person receiving services.

It is intended that IHSAB and the Chief Inspectorate of Social Services will be integrated into the HIQA when it is established.

1.4 Consultation Process

The Quality Framework for Mental Health Services in Ireland is the Mental Health Commission's response to the stakeholder consultation on quality in mental health services entitled *Quality in Mental Health – Your Views,* which was published by the Mental Health Commission in 2005.

The publication of this report followed an extensive consultation process aimed at finding out from people with an interest in mental health services, their views on quality across the broad spectrum of mental health services from childhood through adulthood to later years. From the outset, the Commission was clear in its vision that a quality framework for mental health services is best developed in partnership with people who avail of mental health services, families, carers, advocacy and representative groups, voluntary organisations involved in the area of mental health, statutory and independent providers, the full range of professionals involved in mental health services, government agencies and the general public. The views identified in the report have been incorporated into the standards and criteria within the quality framework.

Quality in Mental Health – Your Views defines a quality mental health service in Ireland as one which encompasses the following eight themes:

- Facilitates respectful and empathetic relationships between people using the service, their families, parents and carers, chosen advocates, and those providing it
- Empowers peoplewho use mental health services and their families, parents and carers
- Provides a holistic, seamless service encompassing the full continuum of care
- Is equitable and accessible
- Is provided in a high quality environment, which respects the dignity of the individual, his/her carers and family
- Has effective management and leadership
- Is delivered by highly skilled multidisciplinary teams
- Is based on best practice and incorporates systems for evaluation and review

The framework and its associated standards and criteria are the result of the consultation process and the recommendations emerging from the report. Additionally, it has been informed by a review of quality frameworks in health systems in other countries, international principles for healthcare standards and professional liaison with international experts in the fields of healthcare quality and mental health care services. Details of the consultation process are included in Appendix A.

2. Quality Framework

2.1 Scope of the Framework

The themes, standards and criteria contained in the quality framework provide clear guidance for service users, their families/chosen advocates, service providers and the public as to what to expect from a mental health service.

A mental health service is defined as a service that provides care and treatment for a person suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist [Mental Health Act 2001, Section 2(1)]. As stated in the introduction, the quality framework is applicable to all mental health services including services for children and adolescents, adults, older persons, persons with an intellectual disability and a mental illness and forensic mental health services. It applies equally to all mental health services irrespective of whether they are being delivered within the service user's home, community settings both residential and non-residential, or within in-patient facilities.

The quality framework is flexible to allow for the diverse needs of service users as well as the different nature and scale of organisations involved in service delivery. Accordingly, the standards are broad and enabling. Understanding the intent of each standard and associated criteria will assist in applying it in a practical manner to particular services.

2.2 What the Framework should achieve

The achievements for the quality framework and its associated standards and criteria can be summarised as follows:

Service Users and their Families

The standards inform service users, their families/ chosen advocates and the general public as to what to expect from a mental health service. It also affords the opportunity for service users to provide feedback on the standards, which should be incorporated into the service planning process.

Mental Health Service Quality Improvement

A mental health service should use the standards as a guide to good service delivery and quality improvement. The framework facilitates the mental health service to monitor its own performance against the standards. The quality framework will also act as a driver for change in mental health policies, practice and structures at local, regional and national level. It is therefore a 'time positive' initiative for services, as it will see a move towards consistency nationally across services and across service providers. The quality framework will assist in generating a culture of continuous quality improvement by encouraging staff and the services to be pro-active about continually improving service quality. A quality improvement culture is present where people are continuously scrutinising their actions and the service in order to identify and solve problems as they arise.

The Use of Modern Quality and Safety Methods for Continuous Improvement

The framework encourages mental health services to train their staff and develop their organisation to support staff in using modern quality methods to improve their services. These methods are especially needed to solve quality problems arising between professions, services and sectors, and when service users are transferred. Improvement requires regular collection and use of quality and safety measures.

Development of Mental Health Services

The standards provide a framework for the development of a mental health service, which could be used to change existing services or in establishing new services. Implementation of the quality framework will place emphasis on results, as well as on structure and process, and it will generate real improvements in mental health services. The quality framework is aligned to the national mental health policy – *A Vision for Change* (Department of Health and Children, 2006) that provides the strategic 'road map' for the development of mental health services over the coming years (Appendix C).

Monitoring by the Mental Health Commission

The Mental Health Commission will be using the standards and associated criteria to monitor the delivery of mental health services in the public, independent and voluntary sector. The framework provides service users and service providers with a transparent mechanism for evaluating the quality of mental health service provision in Ireland for the first time.

Implementation by Health Service Providers

Health service providers should incorporate the standards into service level agreements for the provision of mental health services and regularly monitor progress in relation to compliance.

Profile of Mental Health Services

The Mental Health Commission will use the quality framework as a platform for increasing the profile of mental health services in terms of national policies and priorities.

2.3 Format of the Framework

The quality framework comprises of eight themes, 24 standards and 163 criteria. The framework places the service user at the centre (see page 18). Six themes were identified in the consultation in response to the questions, *"what constitutes a quality service for people using mental health services?"* and *"what constitutes a quality mental health service for families/parents and carers?"* These six themes provide the basis for the standards that surround and impact upon the service user at the point of mental health service delivery.

Themes 1 to 6 are as follows:

1. Provision of a holistic seamless service and the full continuum of care provided by a multidisciplinary team
2. Respectful, empathetic relationships are required between people using the mental health service and those providing them
3. An empowering approach to service delivery is beneficial to both people using the service and those providing it
4. A quality physical environment that promotes good health and upholds the security and safety of service users
5. Access to services
6. Family/chosen advocate involvement and support

One theme was elicited in response to the question *"what is needed to deliver a quality mental health service?"*. This theme, theme 7, provides the basis for the second layer of standards.

Theme 7 is:

7. Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service

The standards falling under theme 7 relate to the systems and processes that are required to deliver the first layer of standards, which includes, for example, learning and using recognised quality and safety methods. From a mental health service provider perspective, the standards in relation to this theme are the ***enablers*** that are required in order for the service user to experience a quality mental health service. For example, if the staff of a mental health service do not have the education and skills (second layer) required to develop an individual care and treatment plan, then the service users will not be in receipt of care and treatment based on an individual care and treatment plan (first layer).

The third layer, which comprises of one theme, theme 8, provides for monitoring and evaluation of all of the standards.

Theme 8 is as follows:

8. Systematic evaluation and review of mental health services underpinned by best practice, will enable providers to deliver quality services

The outer layer, or final layer in this framework, acknowledges that mental health services cannot be looked at in isolation but are an intrinsic component of society and are consequently impacted upon by a broad range of societal factors, including general health services, political agenda, education, housing and employment.

2.4 Standards Format

The **themes** are stated in the framework with the relevant standards and related criteria.

The **standard** is a broad statement of the desired and achievable level of performance against which actual performance can be measured. The standard is the overall goal. It relates directly to the person receiving the mental health service and outlines the objective that is expected.

The **criteria** are measurable elements of service provision. Criteria relate to the desired outcome or performance of staff or services. The standard is achieved when all criteria associated with it are met.

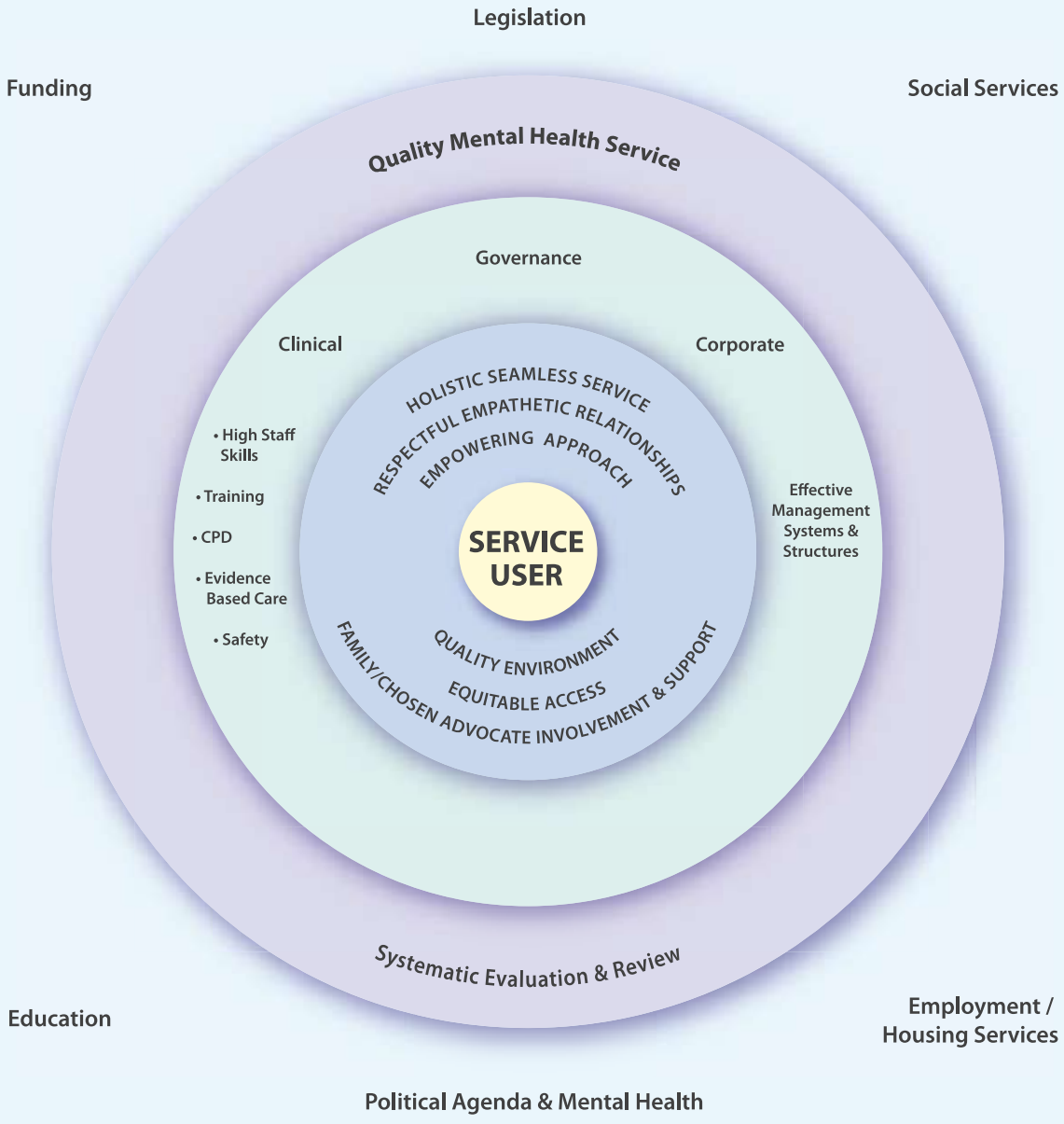
To assist in measuring attainment of standards and associated criteria, a toolkit has been developed to accompany the framework (Quality Framework for Mental Health Services in Ireland – Draft Audit Toolkit). The toolkit contains information on quality and safety tools, methods for self-assessment, and a proposed audit tool for the framework. The toolkit can be used by any mental health service wishing to evaluate its service in accordance with the standards and criteria contained in the framework.

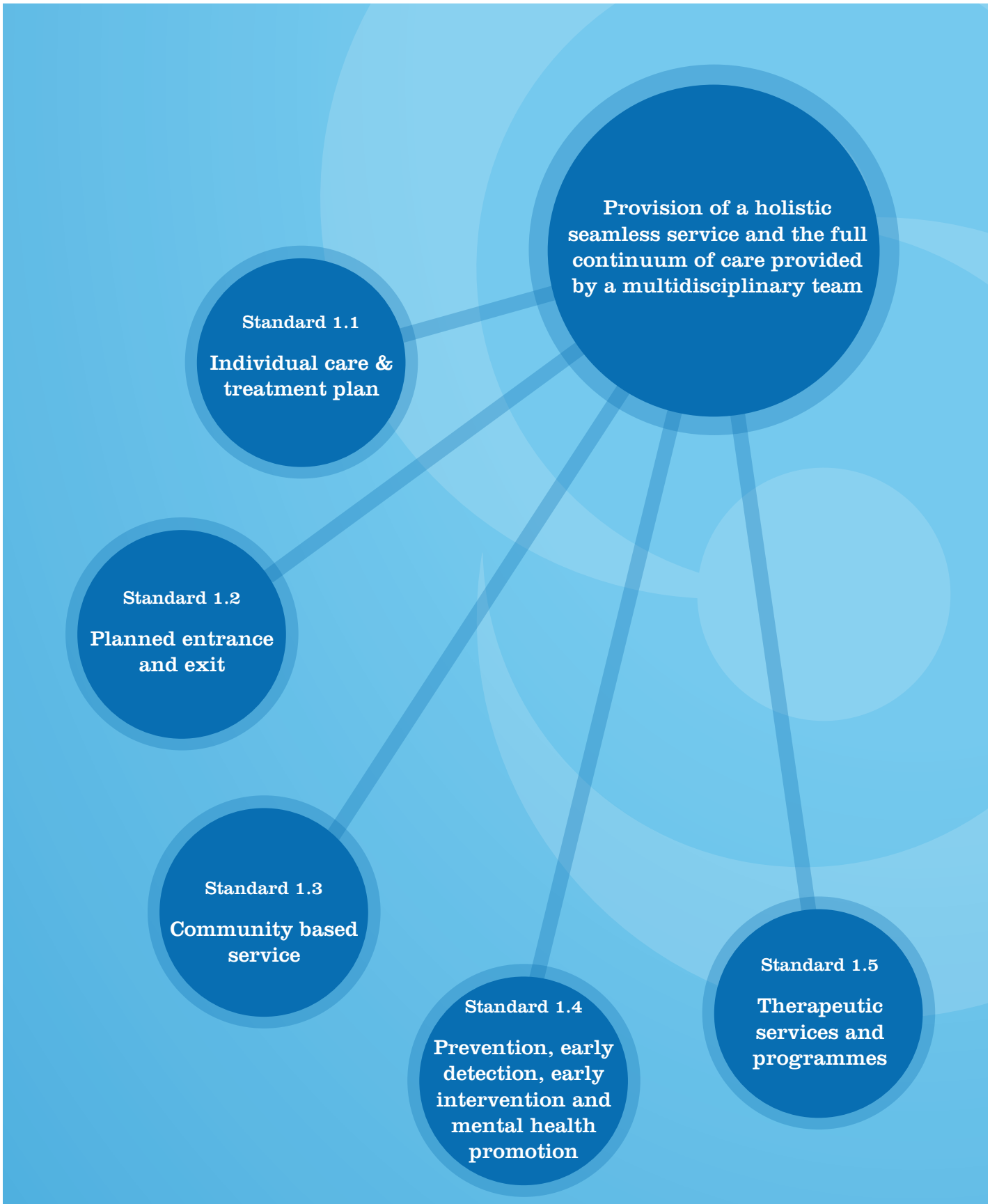
Summary Table

Theme	Standard
1. Provision of a holistic, seamless service and the full continuum of care, provided by a multidisciplinary team	1.1 Each service user has an individual care and treatment plan that describes the levels of support and treatment required in line with his/her needs and is coordinated by a designated member of the multidisciplinary team. (7 Criteria) 1.2 Each service user experiences a planned entrance to and exit from every part of a mental health service. (9 Criteria) 1.3 Each service user receives mental health care and treatment from a community based service that addresses the person's changing needs at various stages in the course of his/her illness and recovery process. (6 Criteria) 1.4 Each service user receives mental health care and treatment from a community based service that addresses prevention, early detection, early intervention and mental health promotion. (5 Criteria) 1.5 Therapeutic services and programmes to address the needs of service users are provided. (8 Criteria)
2. Respectful empathetic relationships are required between people using the mental health services and those providing them	2.1 Service users receive services in a manner that respects and acknowledges their specific values, beliefs, and experiences. (8 Criteria) 2.2 Service user rights are respected and upheld. (5 Criteria) 2.3 The mental health service promotes mental health and community integration of mental health service users. (5 Criteria)
3. An empowering approach to service delivery is beneficial to both people using the service and those providing it	3.1 Service users are facilitated to be actively involved in their own care and treatment through the provision of information. (8 Criteria) 3.2 Service users are empowered regarding their own care and treatment by exercising choice, rights and informed consent. (8 Criteria) 3.3 Peer support/advocacy is available to service users. (4 Criteria) 3.4 A clear accessible mechanism for participation in the delivery of mental health services is available to service users. (5 Criteria) 3.5 Service users experience a recovery-focused approach to treatment and care. (7 Criteria)

Theme	Standard
4. A quality physical environment that promotes good health and upholds the security and safety of service users	4.1 Service users receive care and treatment in settings that are safe, and that respect the person's right to dignity and privacy. (11 Criteria) 4.2 Service users in residential or day settings receive a well-balanced nutritious diet. (5 Criteria)
5. Access to Services	5.1. The mental health service is accessible to the community. (7 Criteria)
6. Family/chosen advocate involvement and support	6.1 Families, parents and carers are empowered as team members receiving information, advice and support as appropriate. (6 Criteria)
7. Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service	7.1 Service users receive care and treatment from quality staff with the appropriate skills. (10 Criteria) 7.2 The mental health service is managed and delivered by staff in receipt of planned training and continuous professional development. (8 Criteria) 7.3 Learning and using proven quality and safety methods underpins the delivery of a mental health service. (8 Criteria) 7.4 The care and treatment provided by the mental health service is outcome-focused. (6 Criteria)
8. Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services	8.1 The mental health service is delivered in accordance with evidence-based codes of practice, policies and protocols. (5 Criteria) 8.2 Mental health services are supported and informed by an integrated mental health information system. (5 Criteria) 8.3 Corporate governance underpins the management and delivery of the mental health service. (7 Criteria)

Quality Framework for Mental Health Services in Ireland




Provision of a holistic seamless service and the full continuum of care provided by a multidisciplinary team
Standard 1.1
Individual care & treatment plan
Standard 1.2
Planned entrance and exit
Standard 1.3
Community based service
Standard 1.4
Prevention, early detection, early intervention and mental health promotion
Standard 1.5
Therapeutic services and programmes

Provision of a holistic, seamless service and the full continuum of care provided by a multidisciplinary team

STANDARD 1.1 **Each service user has an individual care and treatment plan that describes the levels of support and treatment required in line with his/her needs and is co-ordinated by a designated member of the multidisciplinary team, i.e. a key-worker.**

RATIONALE: Individualised care planning was seen by all stakeholders as one of the key aspects of holistic service delivery (Mental Health Commission, 2005a, p46)

CRITERIA:

1.1.1 Approved centres adhere to Regulation 15 - Individual Care Plan, Regulation 17 - Children's Education, and Regulation 19 - General Health, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

1.1.2 The development of the individual care and treatment plan has input from the service user, the multidisciplinary team (MDT), and the family/chosen advocate, where appropriate.

1.1.3 The Care and Treatment Plan
- (i) Reflects the assessed needs of the service user as per the MDT rather than by any one professional group
- (ii) Is developed, implemented and reviewed in a timely manner
- (iii) Is signed by the service user and member of the MDT
- (iv) A copy is held by the service user (unless there are recorded reasons not to provide same)

1.1.4 The individual care and treatment plan is evaluated with the service user in a comprehensive and timely manner. Evaluations are:
- (i) Service user focused
- (ii) Documented
- (iii) Indicate the response to support/ intervention(s)
- (iv) Indicate progress towards meeting desired outcome(s)/goal(s).

1.1.5 (a) Approved centres adhere to Regulation 27 - Maintenance of Records, of the Mental Health Act 2001 (Approved Centres) Regulations 2006, in respect of the care and treatment plan.
- (b) The care and treatment plan is maintained in accordance with *Excellence in Mental Healthcare Records* guidance (Mental Health Commission, 2005b) and is maintained within the service user's clinical file.
- (c) The care and treatment plan is maintained in one composite set of documentation.
- (d) Service user records are comprehensive, factual and objective, provide a sequential account of the service user's involvement with the mental health service and reflect his/her journey through the service.

1.1.6 The mental health service has a policy in place regarding the implementation of this standard.

This shall include but is not limited to:
- (i) Roles and responsibilities of team members
- (ii) Timeframe for assessment, planning, implementation and evaluation of the individual care and treatment plan
- (iii) Monitoring of this standard

1.1.7 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

Provision of a holistic, seamless service and the full continuum of care provided by a multidisciplinary team

STANDARD 1.2 Each service user experiences a planned entrance to and exit from every part of a mental health service

RATIONALE: Stakeholders identify a seamless service as an essential component of a quality service. (Mental Health Commission, 2005a)

CRITERIA:

1.2.1 Admission, transfer and discharge of patients, where applicable, are compliant with the Mental Health Act, 2001.

1.2.2 Approved centres adhere to Regulation 18 - Transfer of Residents, and Regulation 36 - Closure of an Approved Centre, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

1.2.3 The Mental Health Commission's code of practice regarding admission, transfer and discharge to an approved centre, pursuant to Section 33 (3)(e) of the Mental Health Act 2001, is adhered to.

1.2.4 The mental health service provider facilitates planned referral, admission, transfer and discharge of the service user. This process is documented and clearly communicated to the service user and his/her family/chosen advocate, where appropriate.

1.2.5 The mental health service provider assesses, documents and minimises risks associated with each service users discharge or transfer or movement between service components, including expressed concerns of the service user and his/her family/chosen advocate, where appropriate.

1.2.6 Service user transition between components of the mental health service is facilitated by a designated member of staff who maintains contact with the service user.

1.2.7 The mental health service provider facilitates continuity of care and arrangements for review and follow-up.

1.2.8 The mental health service has a policy in place regarding the implementation of this standard.

1.2.9 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

Provision of a holistic, seamless service and the full continuum of care provided by a multidisciplinary team

STANDARD 1.3 Each service user receives mental health care and treatment from a community based service that addresses the person's changing needs at various stages in the course of his/her illness and recovery process

RATIONALE: Stakeholders have identified the provision of community based mental health care by a multidisciplinary team as a core element of a quality mental health service.

CRITERIA:

1.3.1 There is an integrated mental health service to serve each defined catchment/community area.

1.3.2 Multidisciplinary teams have core members drawn from psychiatry, clinical psychology, nursing, social work and occupational therapy. Additional members that reflect the service user's needs are also available.

1.3.3 The service user experiences receipt of care/treatment based on his/her identified needs as documented in the individual care and treatment plan. Such care is provided by identified members of the multidisciplinary team and is documented in the service user's clinical file.

1.3.4 Care and treatment in an approved centre is provided only when community based options, if appropriate to service user's needs, have been considered and implemented.

1.3.5 The mental health service has a policy in place regarding the implementation of this standard.

1.3.6 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

STANDARD 1.4 Each service user receives mental health care and treatment from a community-based service that addresses prevention, early detection, early intervention and mental health promotion

RATIONALE: "Mental health promotion should be available for all age groups to enhance protective factors and decrease risk factors for developing mental health problems" (Department of Health and Children, 2006).

CRITERIA:

1.4.1 Community mental health teams adopt a prevention, early detection and early intervention approach to underpin their systems of working.

1.4.2 A designated health promotion officer with formal links to the mental health service works with local voluntary and community groups.

1.4.3 Each service user experiences a prevention and health promotion component to his/her treatment and care.

1.4.4 The mental health service has a policy in relation to prevention, early detection, early intervention and mental health promotion.

1.4.5 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

Provision of a holistic, seamless service and the full continuum of care provided by a multidisciplinary team

STANDARD 1.5 Therapeutic services and programmes to address the needs of service users are provided

RATIONALE: Service user recovery is facilitated by the provision of appropriate programmes based on identified needs and delivered in the most appropriate environment.

CRITERIA:

1.5.1 Approved centres adhere to Regulation 16 - Therapeutic Services and Programmes, and Regulation 17 - Children's Education, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

1.5.2 Service users have access to a multi-disciplinary community mental health team and an appropriate mix of therapeutic programmes to address identified needs.

1.5.3 Meaningful individual programmes (using group or individual therapies) are used to evaluate, facilitate, restore and maintain an individual's abilities to meet demands in his/her life and are agreed with the service user and determined within the individual care and treatment plan.

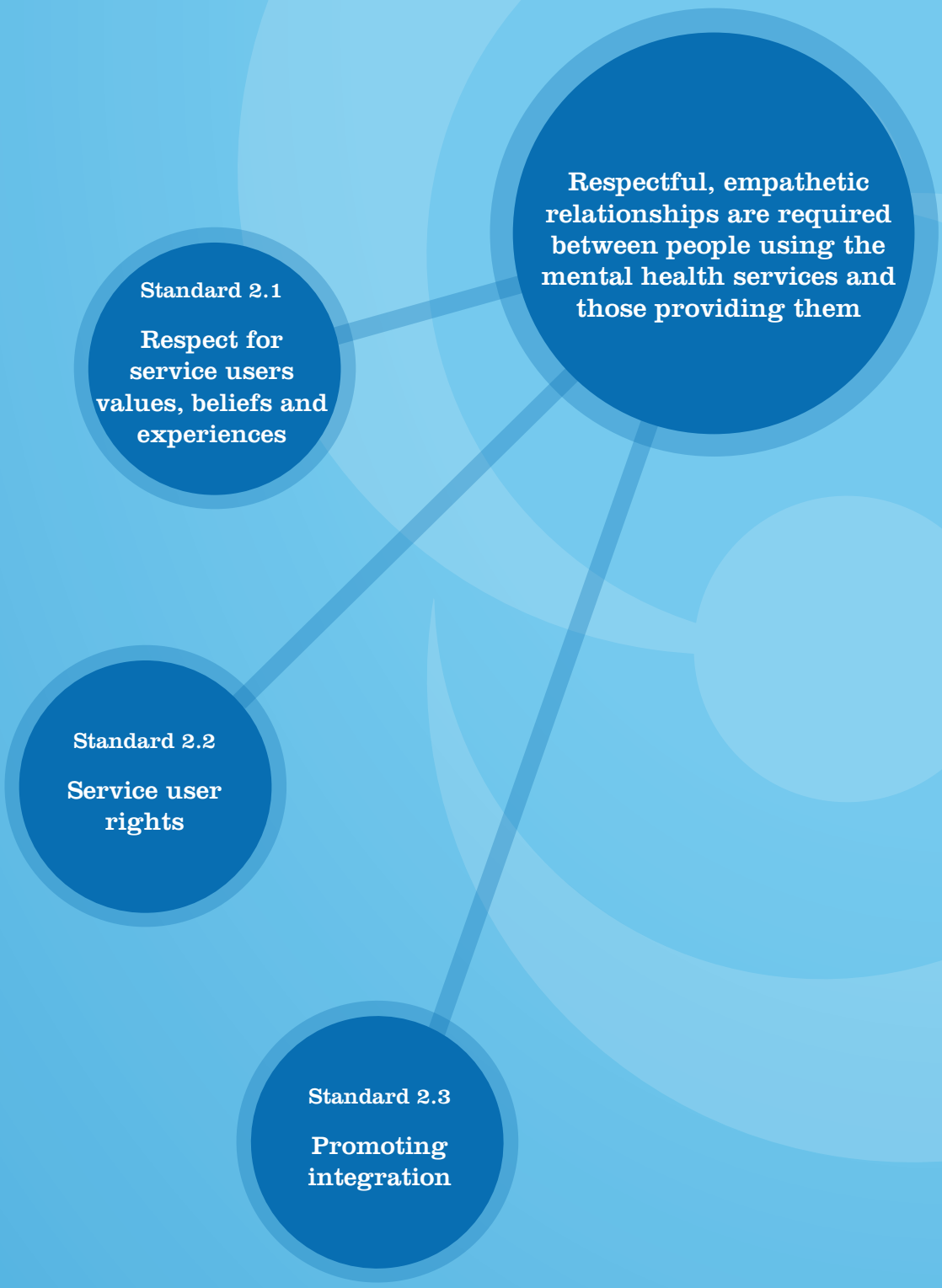
1.5.4 All therapeutic programmes will be reviewed and monitored at regular intervals both formally and informally to ensure that they are planned, consistent and needs-led.

1.5.5 The community mental health team will develop positive partnerships and active communication with key agencies in the community. All community resources should be used effectively to maximise real integration.

1.5.6 The mental health service has established formal links with:
(i) Mainstream health services
(ii) Social welfare services
(iii) Education services
(iv) Housing authorities

1.5.7 The mental health service has a policy regarding the implementation of this standard.

1.5.8 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.


Respectful, empathetic relationships are required between people using the mental health services and those providing them
Standard 2.1
Respect for service users values, beliefs and experiences
Standard 2.2
Service user rights
Standard 2.3
Promoting integration

Respectful, empathetic relationships are required between people using the mental health services and those providing them

STANDARD 2.1 Service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences

RATIONALE: TheMental Health Act, 2001 specifies that in making a decision about the care and treatment of a person due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy [Section 4(3)].

CRITERIA:

2.1.1 Approved centres adhere to Regulations 10 - Religion, 13 - Searches, 14 - Care of the Dying, 16 - Therapeutic Services and Programmes, 20 - Provision of Information to Residents, and Regulation 21 - Privacy, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

2.1.2 Service users are consulted regarding individual values and beliefs.

2.1.3 Service providers respond sensitively to the beliefs, value systems and experiences of the service user during service delivery, and provide appropriate privacy for service users to practice their cultural, religious and spiritual beliefs.

2.1.4 Service users have access to advocates acceptable to the service user.

2.1.5 Service users experience receipt of care that respects confidentiality, privacy, autonomy and dignity.

2.1.6 Service users experience receipt of care that is in compliance with equality legislation and prohibits discrimination on the grounds of gender, marital status, family status, sexual orientation, religion, age, disability, ethnicity, membership of the travelling community or social class.

2.1.7 The mental health service has a policy in place regarding the implementation of this standard.

2.1.8 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

Respectful, empathetic relationships are required between people using the mental health services and those providing them

STANDARD 2.2 Service user rights are respected and upheld

RATIONALE: Thefundamental principle underpinning mental health care as enshrined in the Mental Health Act 2001 is that the interests of service users are paramount [Section 4].

CRITERIA:

2.2.1 The mental health service complies with relevant legislation, regulations, professional standards and codes of ethics protecting and respecting the rights of the service user (Appendix D). This includes, but is not limited to:

(a) Regulations 7 - Clothing, 8 - Residents' Personal Property and Possessions, 11 - Visits, 20 - Provision of Information to Residents, 30 - Mental Health Tribunals, and Regulation 31 - Complaints Procedures, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

(b) The Mental Health Commission's rules governing the use of Electro-convulsive therapy (ECT), the rules governing the use of seclusion and mechanical means of bodily restraint, the code of practice on the use of physical restraint in approved centres, and the code of practice relating to the admission of children under the Mental Health Act 2001.

2.2.2 Information is communicated in a way that is easily understood by the service user, and repeated as required, being aware that explanations may be necessary on more than one occasion. Supportive written material is made available in a variety of languages, formats and media to meet communication needs at all levels in the mental health service.

2.2.3 The service user has access to responsive and fair formal complaints procedures.

2.2.4 The mental health service has a policy in place regarding the implementation of this standard.

2.2.5 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

STANDARD 2.3 The mental health service promotes mental health and community integration of mental health service users

RATIONALE: A survey of public attitudes to disability conducted for the National Disability Authority in 2001 showed most people (81-84%) had a high level of comfort with people with physical, sensory or learning disabilities living in their neighbourhoods, but only half would be very comfortable and a third would be uncomfortable with people with mental health difficulties living in their neighbourhood (National Disability Authority, 2001).

CRITERIA:

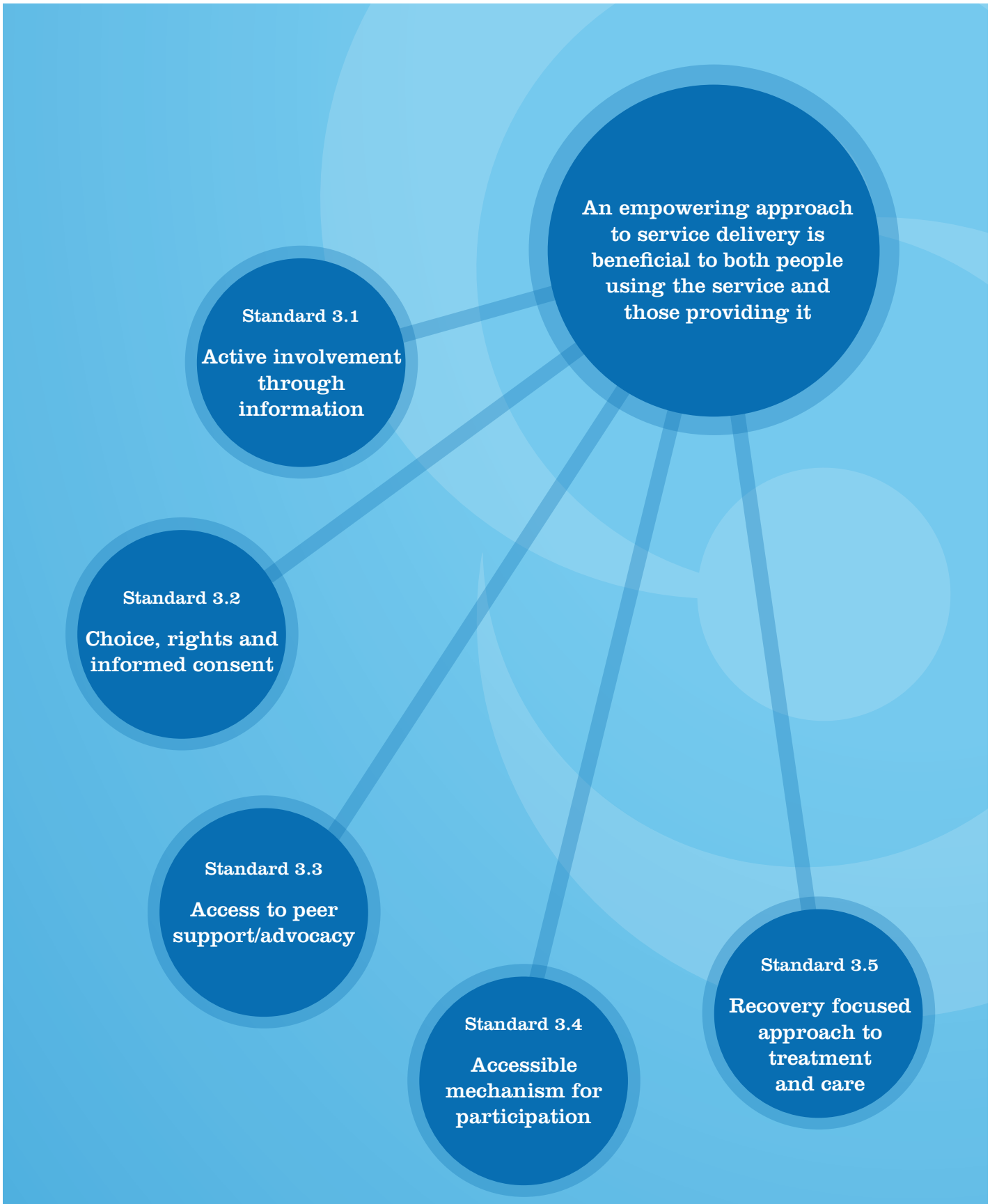
2.3.1 The mental health service works with service user groups and community agencies to promote meaningful integration within local communities.

2.3.2 The mental health service works with staff to promote positive working relationships in accordance with agreed national policies/ guidelines.

2.3.3 The mental health service implements mental health promotion activities.

2.3.4 The mental health service has a policy in place regarding the implementation of this standard.

2.3.5 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.


An empowering approach to service delivery is beneficial to both people using the service and those providing it
Standard 3.1
Active involvement through information
Standard 3.2
Choice, rights and informed consent
Standard 3.3
Access to peer support/advocacy
Standard 3.4
Accessible mechanism for participation
Standard 3.5
Recovery focused approach to treatment and care

An empowering approach to mental health service delivery is beneficial to both people using the service and those providing it

STANDARD 3.1 Service users are facilitated to be actively involved in their own care and treatment through the provision of information

RATIONALE: Knowledgeand information about all aspects of a service users mental health options are essential if service users are to actively participate and lead their own recovery programme.

CRITERIA:

3.1.1 Approved centres adhere to Regulation 20 - Provision of Information to Residents, and Regulation 34 - Certificate of Registration, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

3.1.2 Mental health services make accessible information available to service users on their services.

3.1.3 Mental health services provide service users with accessible information on the care and treatment they receive.

3.1.4 Where necessary, service users have access to interpretation services (including sign language translators).

3.1.5 In relation to a proposal to make a recommendation or an admission order in respect of a person, or to administer treatment to a person under the Mental Health Act 2001, the provisions of Section 4(2) are complied with.

3.1.6 Mental health services have systems in place to ensure that service users and family/chosen advocates, where appropriate, have information about formal complaints procedures that is clear, unambiguous and easy to navigate.

3.1.7 The mental health service has a policy in place regarding the implementation of this standard.

3.1.8 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

An empowering approach to mental health service delivery is beneficial to both people using the service and those providing it

STANDARD 3.2 Service users are empowered regarding their own care and treatment by exercising choice, rights and informed consent

RATIONALE: A quality service was seen by all stakeholders as one which empowers service users. "It will accord them equality of status within the relationship, enable them to take as much responsibility for their own health and well-being as they can take, and provide them with the supports they need to maximise autonomy, choice and self-determination." (Mental Health Commission, 2005a, p65)

CRITERIA:

3.2.1 Service users are provided with written and verbal information on their rights on entering the mental health service.

3.2.2 Service users are actively consulted, involved and offered choices in relation to their own care and treatment.

3.2.3 Where a service user's choice is not provided, clear explanations are given to the service user as to the reasons and these reasons are recorded in the person's clinical file.

3.2.4 (a) Valid consent is obtained from service users in relation to care and treatment and the provision of confidential information.

(b) In the absence of patient consent to treatment, the provisions of Sections 59 (Electro-convulsive therapy), 60 (Administration of medicine), and 61 (Administration of medicine to a child) of the Mental Health Act 2001, must be complied with.

(c) In the case of a child, informed consent is obtained from the parents (either of them), or the legal guardian, or the Courts. The view of the child is taken into consideration.

3.2.5 The Mental Health Commission's Code of Practice relating to Admission of Children under the Mental Health Act 2001, pursuant to Section 33 (3) (e) of the Act, is adhered to.

3.2.6 The mental health service respects the rights of service users by providing services that are compatible with relevant rights-based legislation.

3.2.7 The mental health service has a policy regarding the implementation of this standard.

3.2.8 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

An empowering approach to mental health service delivery is beneficial to both people using the service and those providing it

STANDARD 3.3 Peer support/advocacy is available to service users

RATIONALE: Havingaccess to peer support and peer groups is an important part of the recovery process. (Mental Health Commission, 2005a, p66)

CRITERIA:

3.3.1 (a) Approved centres adhere to the relevant sections of Regulation 20 - Provision of Information to Residents, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

(b) Service users are provided with clear, written information on advocacy services and on how to access such services.

3.3.2 Mental health services provide service users with access to advocacy training.

3.3.3 The mental health service has a policy regarding the implementation of this standard.

3.3.4 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

STANDARD 3.4 A clear, accessible mechanism for participation in the delivery of mental health services is available to service users

RATIONALE: Bothindividual service users and service user groups identified the need for formal mechanisms through which people using mental health services can be partners with providers both at an individual level and collectively. (Mental Health Commission, 2005a, p66)

CRITERIA:

3.4.1 Service users are active participants in the planning, implementation, evaluation and review of their own care and treatment.

3.4.2 Mental health services provide a mechanism for obtaining collective feedback from service users at service/multidisiplinary level.

3.4.3 Mental health services provide a mechanism for service user involvement in the development and evaluation of mental health service planning.

3.4.4 The mental health service has a policy regarding the implementation of this standard.

3.4.5 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

An empowering approach to mental health service delivery is beneficial to both people using the service and those providing it

STANDARD 3.5 Service users experience a recovery-focused approach to treatment and care

RATIONALE: Arecovery-focused approach to treatment and support/care is important for people using mental health services. (Mental Health Commission 2005a, p76)

CRITERIA:

3.5.1 Mental health services are recovery-oriented in their approach to care and treatment.

3.5.2 Service users experience a recovery approach to care and treatment that focuses on self-determination, empowering relationships based on trust, understanding, respect and meaningful roles in society.

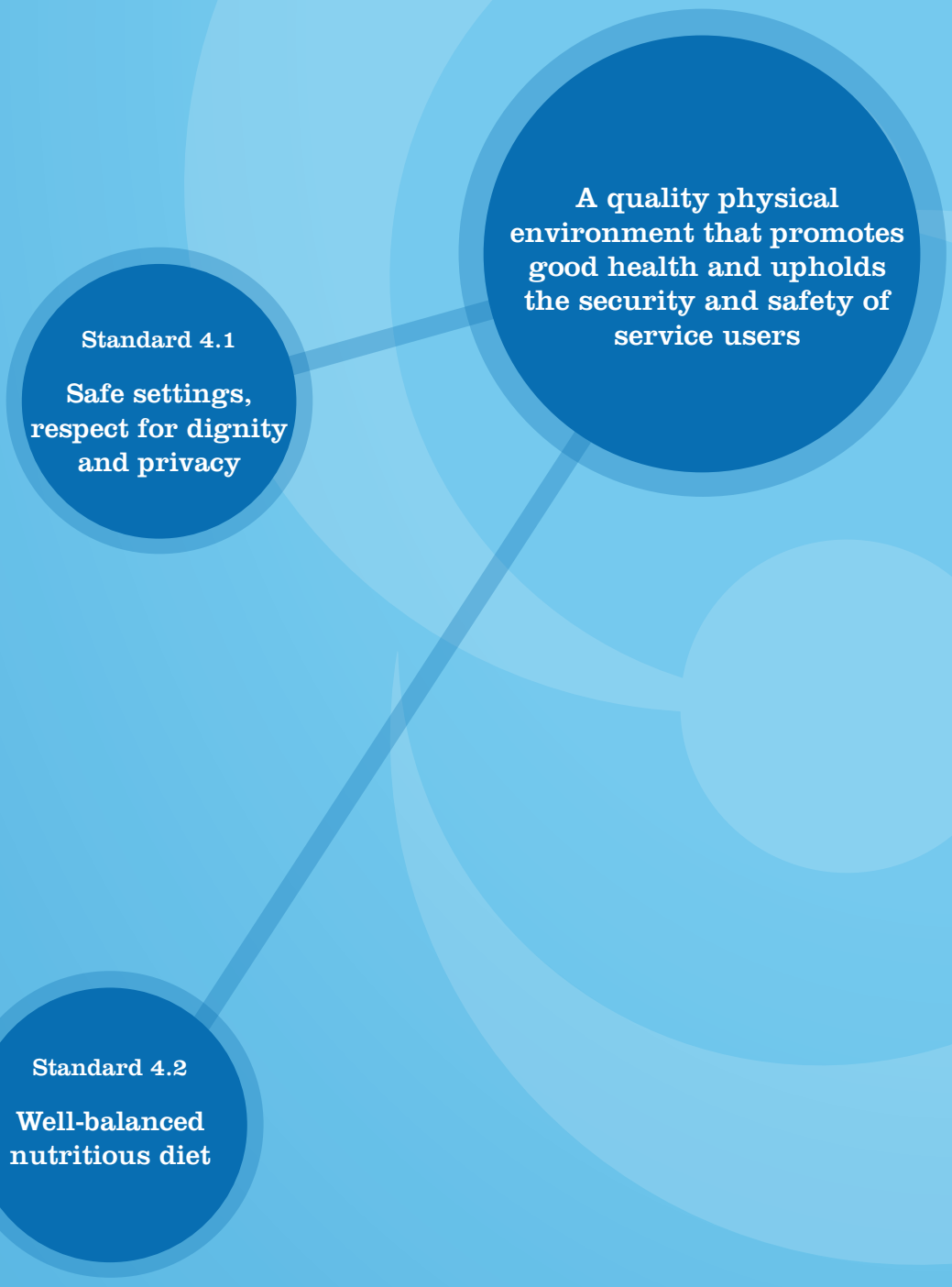
3.5.3 Staff are skilled in the recovery approach of the mental health service.

3.5.4 Service users receive a mental health service in settings that foster and maintain links with his/her community and retain as much control over his/her life as possible.

3.5.5 Service users and families/chosen advocates, where appropriate, are involved in planning and evaluation of recovery-focused approaches to care, treatment and support services.

3.5.6 The mental health service has a policy regarding the implementation of this standard.

3.5.7 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.


A quality physical environment that promotes good health and upholds the security and safety of service users
Standard 4.1
Safe settings, respect for dignity and privacy
Standard 4.2
Well-balanced nutritious diet

A quality physical environment that promotes good health and upholds the security and safety of the service users

STANDARD 4.1 Service users receive care and treatment in settings that are safe, and that respect the person's right to dignity and privacy

RATIONALE: Stakeholders see the quality of the physical surroundings as having a strong impact on those using mental health services and on their recovery processes. (Mental Health Commission, 2005a, p70)

CRITERIA:

4.1.1 Approved centres adhere to Regulations 6 - Food Safety, 7 - Clothing, 8 - Residents' Personal Property and Possessions, 9 - Recreational Activities, 11 - Visits, 12 - Communication, 13 - Searches, 14 - Care of the Dying, 18 - Transfer of Residents, 20 - Provision of Information to Residents, 21 - Privacy, 22 - Premises, 24 - Health & Safety, and Regulation 25 - Use of Closed Circuit Television, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

4.1.2 Service users receive care and treatment in an environment that is clean, tidy, peaceful, safe and well-maintained.

4.1.3 Waste is properly managed to minimise risks to service users, families, staff and any individual who comes in contact with the mental health service.

4.1.4 Bedrooms, where shared, provide for the privacy and dignity of service users.

4.1.5 Service users have access to facilities to keep their property safe.

4.1.6 Service users are supported in exercising control over their belongings and personal space in in-patient or community residential settings.

4.1.7 The mental health care and treatment setting complies with statutory building, fire safety and other relevant legislation.

4.1.8 The mental health service demonstrates evidence of a managed environment, which ensures as far as is reasonably practicable, the safety, health and welfare of service users, visitors, staff and all who come into contact with the service.

4.1.9 The environment in which the service user is accessing a mental health service is appropriate to those using the service.

4.1.10 The mental health service has a policy regarding the implementation of this standard.

4.1.11 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

STANDARD 4.2 Service users in residential or day settings receive a well-balanced nutritious diet

RATIONALE: A well-balanced nutritious diet is a factor in maintaining mental health.

CRITERIA:

4.2.1 Approved centres adhere to Regulation 5 - Food and Nutrition, and Regulation 6 - Food Safety, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

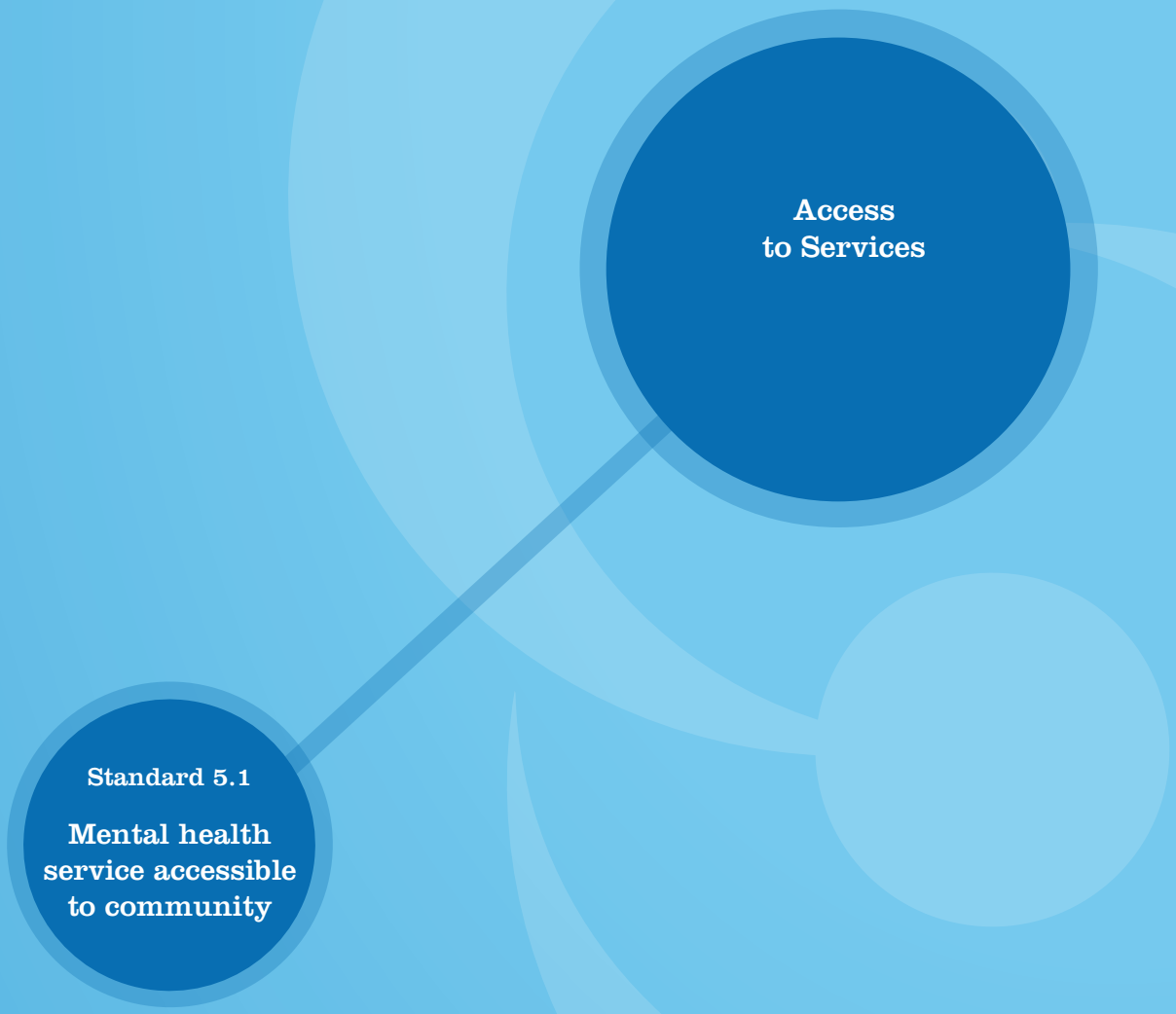
4.2.2 Service users' dietary needs are assessed and addressed in residential or day settings.

4.2.3 Service users in residential or day settings receive a well-balanced diet that incorporates choice of menu and is available at time intervals appropriate to the service users identified needs.

4.2.4 The mental health service has a policy regarding the implementation of this standard. This policy should make reference to the reception, storage, preparation and distribution of food to prevent food borne illnesses.

4.2.5 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

Theme 5


Access
to Services
Standard 5.1
Mental health
service accessible
to community

Access to services

STANDARD 5.1 The mental health service is accessible to the community

RATIONALE: Stakeholdersshare the view that quality and access cannot be separated. (Mental Health Commission, 2005a, p72)

CRITERIA:

5.1.1 The mental health service ensures equality in accessing a service regardless of the service user's gender, marital status, family status, sexual orientation, religion, age, disability, ethnicity, membership of the traveller community or social class.

5.1.2 Members of the general public, primary care services, service users and families/chosen advocates, receive information about:

(i) What services are available

(ii) How they work

(iii) How to access them, especially in a crisis

5.1.3 Information is available in ways that are accessible to people from minority groups including refugees, asylum seekers, homeless persons, travellers, and persons who are deaf.

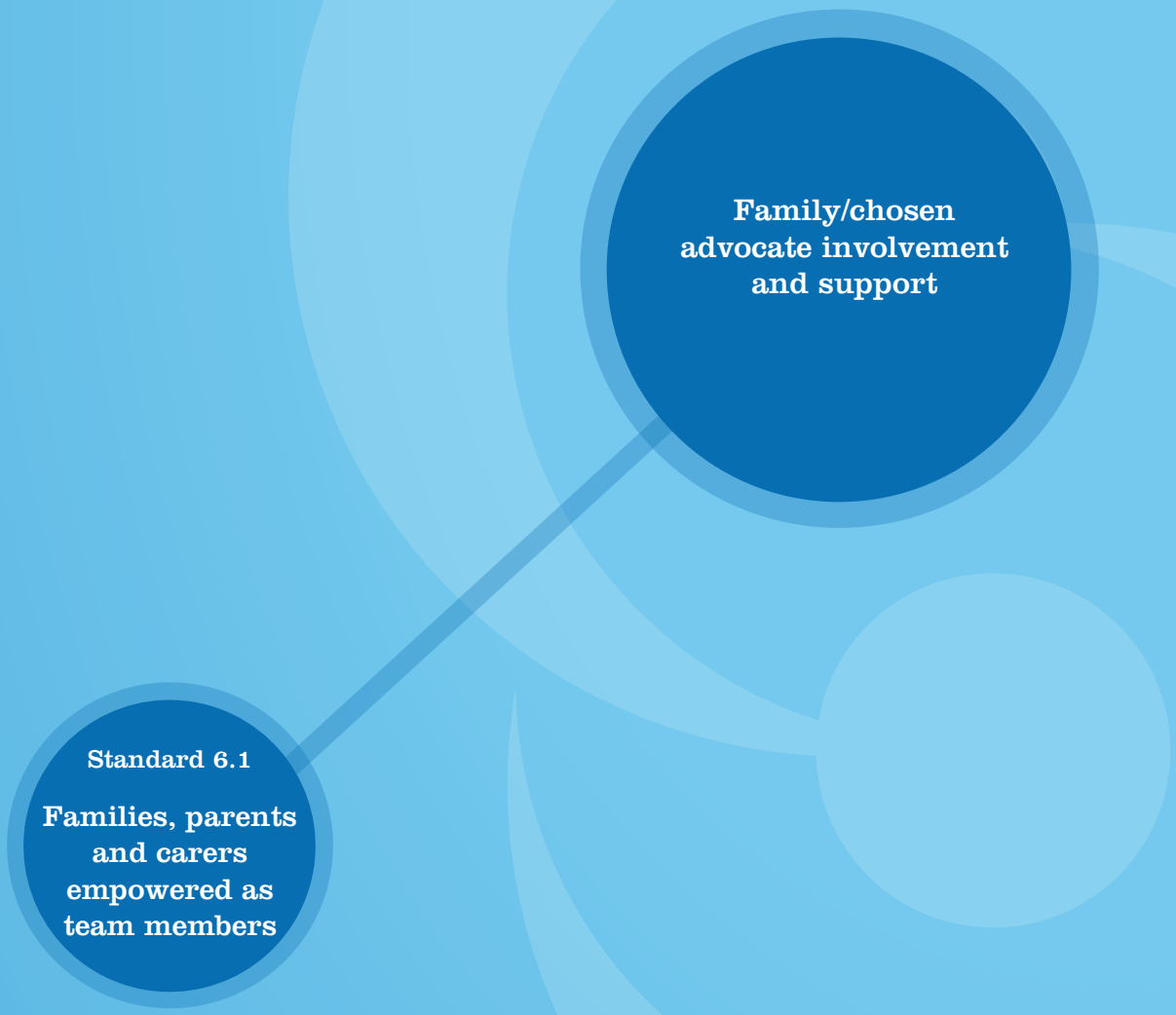
5.1.4 The mental health service is available on a 24-hour basis, seven days a week.

5.1.5 The mental health service location is accessible both geographically and physically.

5.1.6 The mental health service has a policy regarding the implementation of this standard.

5.1.7 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

Theme 6


Family/chosen advocate involvement and support
Standard 6.1
Families, parents and carers empowered as team members

Family/chosen advocate involvement and support

STANDARD 6.1 **Families, parents and carers are empowered as team members receiving information, advice and support as appropriate**

RATIONALE: Familiesindicated that they require support at every stage of the person's illness and recovery process. (Mental Health Commission, 2005a, p88)

CRITERIA:

6.1.1 Clear boundaries are in place regarding family involvement, and communication between families and the mental health service is in accordance with the wishes of the service user.

6.1.2 Families/chosen advocate receive information about:

(i) What services are available

(ii) How they work

(iii) How to access them, especially in a crisis

6.1.3 (a) Families/chosen advocates experience support from the mental health team through an assigned member of staff. The level of support required is provided based on identified need.

(b) Families/chosen advocates have access to the service user's key worker subject to service users' consent.

6.1.4 Specific outcome criteria for child services are as follows:

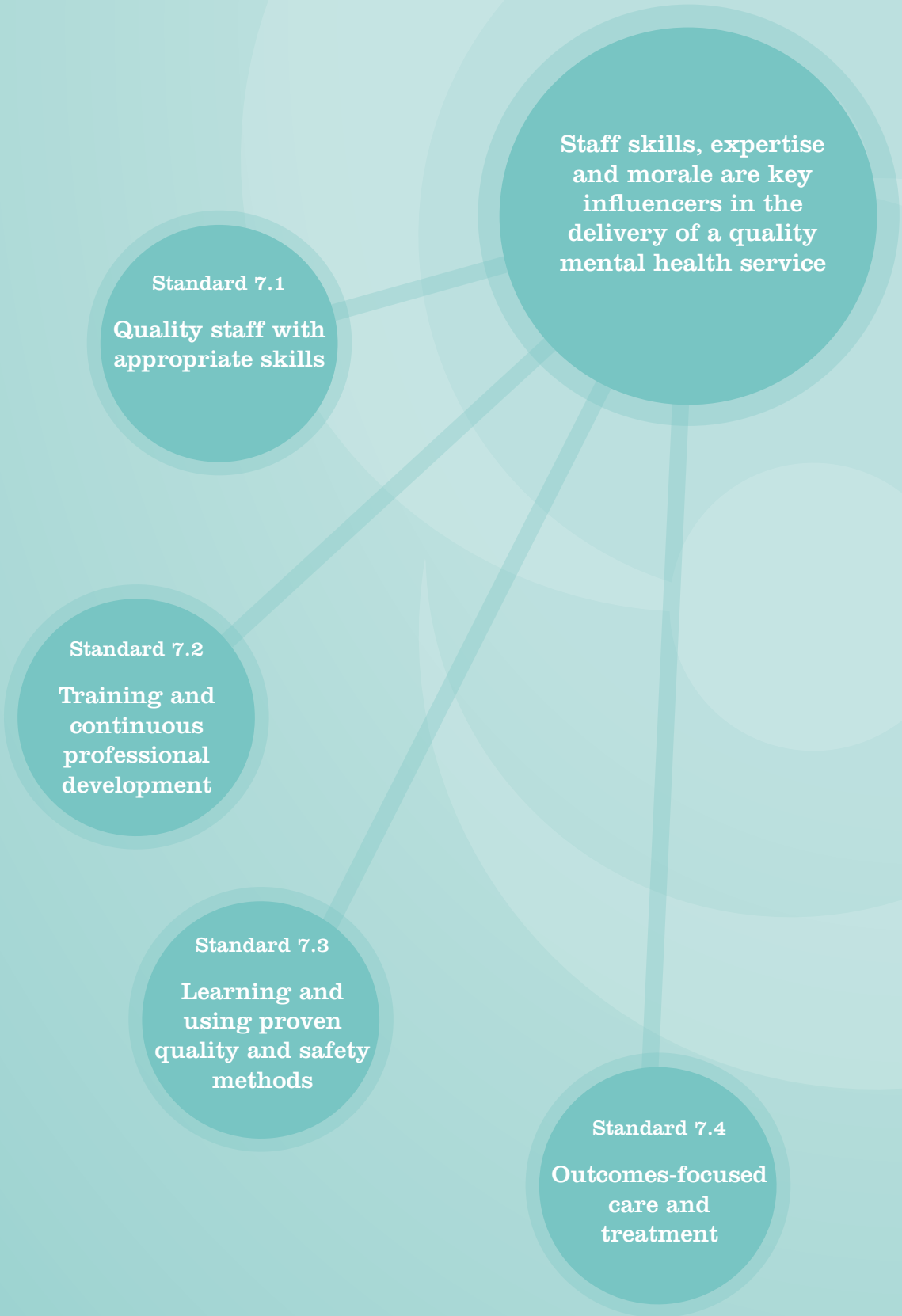
(i) Parents/guardians are partners in the treatment process

(ii) Parents/guardians receive clear information about treatment processes

(iii) Follow-up and outreach services are available for parents

6.1.5 The mental health service has a policy regarding the implementation of this standard.

6.1.6 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.


Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service
Standard 7.1
Quality staff with appropriate skills
Standard 7.2
Training and continuous professional development
Standard 7.3
Learning and using proven quality and safety methods
Standard 7.4
Outcomes-focused care and treatment

Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service

STANDARD 7.1 **Service users receive care and treatment from quality staff with the appropriate skills**

RATIONALE: A key message from *Quality in Mental Health – Your Views* was that, above everything else, the staff delivering the mental health service influenced the quality of the experience (Mental Health Commission, 2005a, p94)

CRITERIA:

7.1.1 Approved centres adhere to Regulation 26 - Staffing, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

7.1.2 A rigorous recruitment process is in place to attract quality staff to the mental health service.

7.1.3 The mental health service has a retention policy in place and conducts exit interviews.

7.1.4 The mental health service provides flexible, family-friendly working arrangements taking account, as far as possible, staff choice regarding where they wish to work.

7.1.5 The mental health service ensures equality in recruitment and retention of staff regardless of their gender, marital status, family status, sexual orientation, religion, age, disability, ethnicity, membership of the traveller community or social class.

7.1.6 Workload management is in place to ensure that staff carry manageable caseloads and staff burnout is prevented.

7.1.7 Multidisciplinary teams include staff with the appropriate skills mix and expertise to address the assessed needs of the population being served.

7.1.8 An interdisciplinary working approach (team working) is adopted and supported within multidisciplinary teams.

7.1.9 The mental health service has a policy regarding the implementation of this standard.

7.1.10 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service

STANDARD 7.2 The mental health service is managed and delivered by staff in receipt of planned training and continuous professional development

RATIONALE: Trainingis a key element in the delivery of a quality mental health service. (Mental Health Commission, 2005a, p98)

CRITERIA:

7.2.1 Staff receive formal induction to the mental health service.

7.2.2 The mental health service ensures regular formal and informal professional supervision is available to staff.

7.2.3 Mental health service staff participate in education and professional development programmes.

7.2.4 Service users and advocates are involved in delivering training programmes for staff.

7.2.5 (a) Approved centres adhere to Regulation 27 - Maintenance of Records, of the Mental Health Act 2001 (Approved Centres) Regulations 2006, in respect of staff records.

(b) The mental health service keeps an accurate record of staff training, qualifications and supervision received.

7.2.6 Non-clinical staff receive training to develop an understanding of mental ill-health and its impact on the person concerned and his/her family.

7.2.7 The mental health service has a policy regarding the implementation of this standard.

7.2.8 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service

STANDARD 7.3 Learning and using proven quality and safety methods underpins the delivery of a mental health service

RATIONALE: A safe, quality mental health service will flourish where a culture of quality improvement is encouraged by using quality and safety methods which adopts a whole-system approach.

CRITERIA:

7.3.1 The mental health service complies with relevant legislation and regulations governing the provision of safe mental health interventions and facilities.

7.3.2 Approved centres adhere to Regulation 4 - Identification of Residents, 6 - Food Safety, 11 - Visits, 12 - Communication, 13 - Searches, 18 - Transfer of Residents, 19 - General Health, 23 - Ordering, Prescribing, Storing & Administration of Medicines, 24 - Health & Safety, 25 - Use of Closed Circuit Television, 26 - Staffing, 28 - Register of Residents, 32 - Risk Management and 33 - Insurance, of the Mental Health Act 2001 (Approved Centre) Regulations 2006.

7.3.3 The mental health service has a whole systems approach to safety that ensures clinical risks are addressed, at all levels, from the point of care delivery up to and including board level consideration of risk management.

7.3.4 The mental health service has an effective risk management system that includes but is not limited to the following:

(i) Captures information on service user safety, including near misses and adverse events

(ii) Uses the information from (i) to learn from and to develop safer mental health services

(iii) Is in accordance with any code of practice or guidance issued by the Mental Health Commission in this regard

7.3.5 Mental health service staff receive training in quality improvement and safety methods.

7.3.6 Mental health service staff have access to a resource to assist in the development of capacity to use modern quality and safety methods and indicators.

7.3.7 The mental health service has a policy regarding the implementation of this standard.

7.3.8 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service

STANDARD 7.4 The care and treatment provided by the mental health service is outcomes-focused

RATIONALE: "In order to improve the quality of mental health services it was widely agreed that services need to be monitored and evaluated to establish what is working and what needs to be done differently" (Mental Health Commission, 2005 a, p104)

CRITERIA:

7.4.1 The mental health service integrates formal outcome measures in multi-disciplinary team practice.

7.4.2 Approved Centres adhere to Regulation 31 – Complaints Procedures, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

7.4.3 The mental health service routinely monitors the health outcomes of service users. This may include and is not limited to:

(i) Service user satisfaction survey

(ii) Quality of life measures

(iii) Consultation with service users on the relevance of various outcome measures

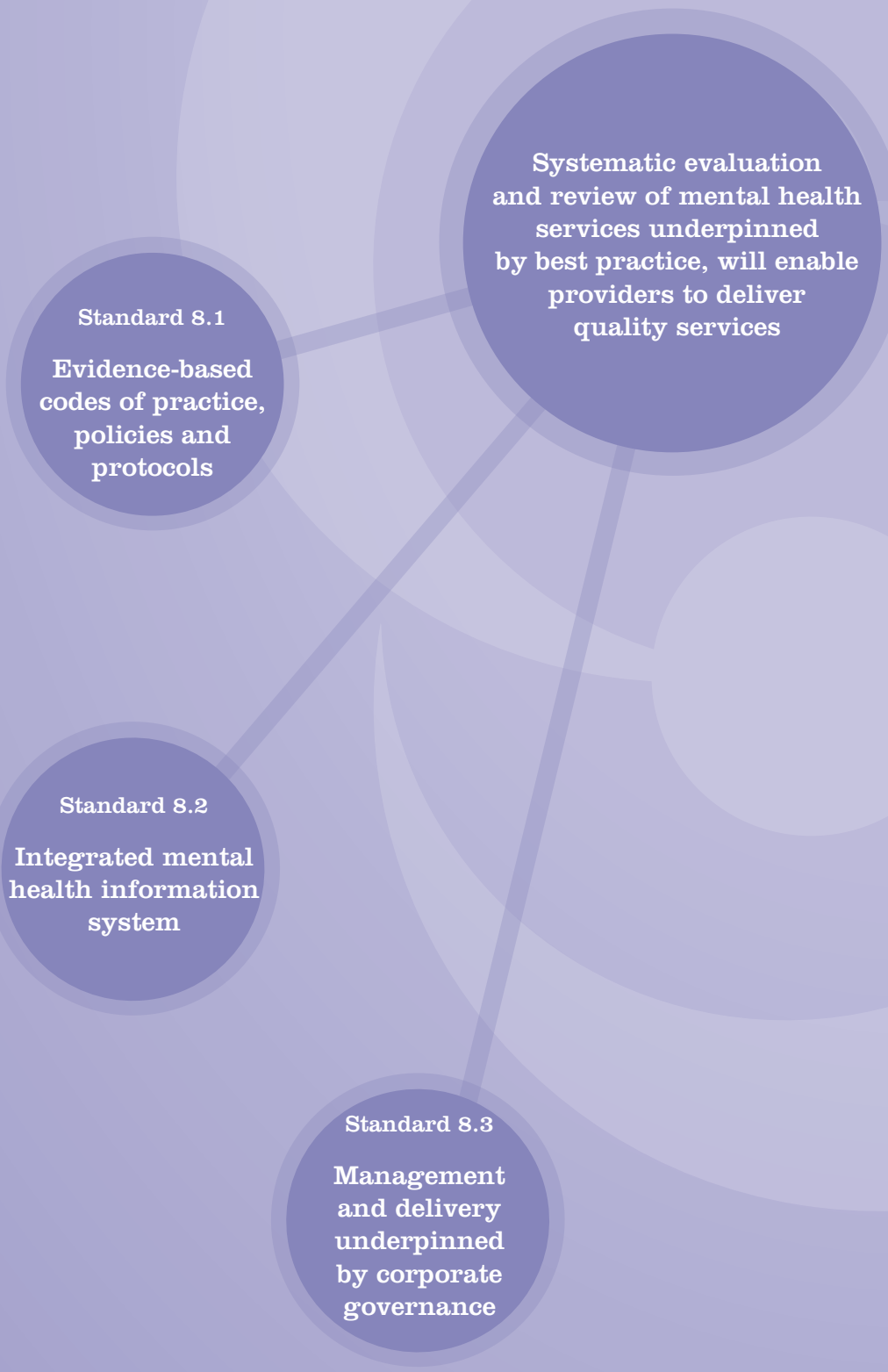
(iv) Measures of change in the health status and individual functioning of the service user

(v) Accounts of an individual's mental health service experience

7.4.4 The mental health service uses evidence-based mental health research to inform practice as part of a continuous quality improvement initiative.

7.4.5 The mental health service has a policy regarding the implementation of this standard.

7.4.6 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.


Systematic evaluation and review of mental health services underpinned by best practice, will enable providers to deliver quality services
Standard 8.1
Evidence-based codes of practice, policies and protocols
Standard 8.2
Integrated mental health information system
Standard 8.3
Management and delivery underpinned by corporate governance

Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services

STANDARD 8.1 **The mental health service is delivered in accordance with evidence-based codes of practice, policies and protocols**

RATIONALE: All mental health services should be striving towards evidence-based codes of practice. (Mental Health Commission, 2005a, p101)

CRITERIA:

8.1.1 The mental health service complies with all relevant Codes of Practice issued by the Mental Health Commission under Section 33 (3)(e) of the Mental Health Act 2001.

8.1.2 The mental health service has evidence-based policies and protocols to underpin practice.

8.1.3 The mental health service has uniform policies across service areas.

8.1.4 Approved Centres adhere to Regulation 29 - Operating Policies & Procedures, of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

8.1.5 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.

Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services

STANDARD 8.2 Mental health services are supported and informed by an integrated mental health information system

RATIONALE: The National Health Information Strategy (Department of Health and Children, 2004) noted that health information systems are essential to plan, manage, deliver and evaluate services on a person-centred basis. In 2005, the Report of the Inspector of Mental Health Services (Mental Health Commission, 2005c) highlighted the issue that data is not captured in a consistent manner and the lack of information systems was highlighted as a key issue which inhibits the collection of necessary data. A recent report on mental health information systems recommended that the first step to implementing a national mental health information system is to establish a national minimum data set, with governance structures to ensure data is captured in a consistent manner (Mental Health Commission, 2006e).

CRITERIA:

8.2.1 A National Mental Health Information Framework that will ensure coherent, efficient and effective management of mental health information for policy-makers, government departments, mental health service providers, service user representative groups, advocacy organisations and non-governmental organisations is developed.

8.2.2 World Health Organisation (WHO) recommendations on mental health information systems (World Health Organisation, 2005) are adopted and include the following:

(i) Start small, but keep the big picture in view – progressive development of an information system has the greatest chance of success

(ii) Use indicators – a mental health information system (MHIS) should provide the raw data for a well defined set of indicators

(iii) Establish a minimum dataset – MHIS should gather the minimum required information

(iv) Make the MHIS user-friendly – the purpose for which information is being gathered should be clear, consistent and accessible

(v) Clarify the relationship with information systems in the general health sector

(vi) Consult with all stakeholders to maximise participation in its implementation

(vii) Link MHIS development to wider service development

(viii) Consider routine and non-routine data

(ix) Ensure high standards of information governance – all measures necessary should be taken to ensure privacy and confidentiality of information. Clear policies should also be in place governing access to information and consent

8.2.3 A national mental health minimum data subset is established.

8.2.4 A governance model should be completed prior to initiation of work on the national mental health minimum data subset.

8.2.5 An agreed set of national mental health performance indicators addressing needs, inputs, processes and outcomes is developed. The indicators must:

(i) Meet the needs of all stakeholders for planning, evaluating and monitoring mental health services

(ii) Be clearly defined, unambiguous and measurable

(iii) Have clear and agreed upon data standards and format

Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services

STANDARD 8.3 Corporate governance underpins the management and delivery of the mental health service

RATIONALE: Inorder to improve the quality of mental health services, it was widely agreed that services need to be monitored and evaluated to establish what is working and what needs to be done differently. (Mental Health Commission, 2005a, p104)

CRITERIA:

8.3.1 (a) The mental health service has a documented organisational structure that identifies lines of accountability and authority for allocating and devolving resources and planning.

(b) The mental health service management structure reflects the membership of the multidisciplinary team.

8.3.2 The mental health service facilitates service user involvement at all stages of policy and service development, delivery and evaluation.

8.3.3 The mental health services' service plan is developed through a process of consultation with service users, staff and the funding authority. The plan shall be consistent with Department of Health and Children, funding agency policies and strategic directions.

8.3.4 The mental health service has operational plans based on the service plan which establishes timeframes, responsibilities and targets for implementation.

8.3.5 (a) The mental health service manages its budget in accordance with nationally accepted accounting practices.

(b) The mental health service allocates a portion of its budget for the provision of staff development and for the participation of service users in the service.

8.3.6 (a) The mental health service has a documented quality improvement plan and associated continuous quality improvement programme.

(b) The mental health service implements the quality improvement plan on an ongoing basis and regularly monitors its performance against it.

8.3.7 The mental health service implements a clinical governance system for improving clinical practice. This may include but is not limited to:

(i) Risk management

(ii) Clinical audit

(iii) Education and training

(iv) Evidence-based care and treatment

(v) Legal compliance

Implementation

3. Implementation

3.1 Introduction

3.1.1 The WHO (2003) has outlined a process for quality improvement in mental health care. The Quality Framework for Mental Health Services in Ireland describes a framework for continuously improving quality in mental health services provision that incorporates the WHO process (figure 1 on page 54). The themes, standards and criteria in the quality framework provide clear guidance for service users, their families/chosen advocates, service providers and the general public as to what to expect from a quality mental health service.

3.1.2 The implementation of the quality framework is a critical success factor that must be adhered to if mental health services are going to transform and provide a modern mental health service as described in the current national mental health policy entitled *A Vision for Change* (Department of Health and Children, 2006). The Quality Framework for Mental Health Services in Ireland provides mental health services with the quality tools to turn the 'vision' into a 'reality'. The Quality Framework for Mental Health Services in Ireland (Appendix C) provides a comparative analysis of the alignment between the Quality Framework for Mental Health Services in Ireland and *A Vision for Change*.

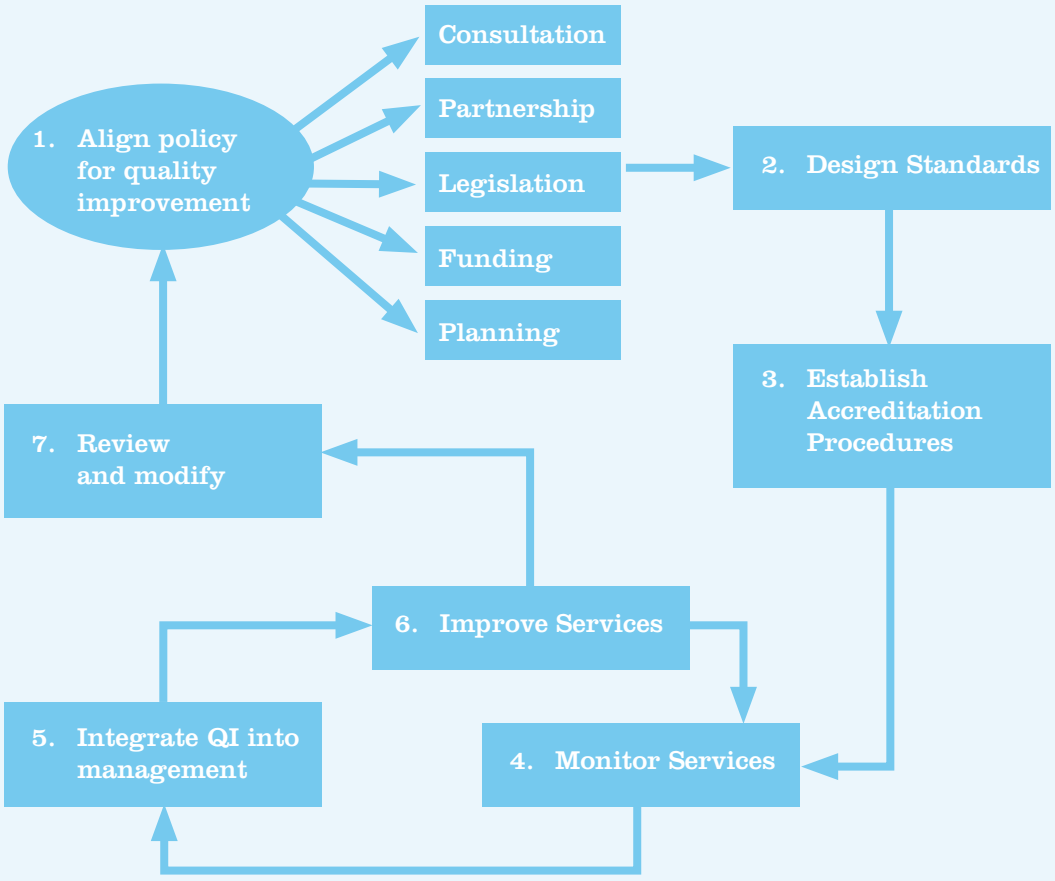
3.2 Context for Continuous Quality Improvement (CQI)

3.2.1 In addressing implementation issues, it is worthwhile to ask why quality programmes that involve change within large organisations/systems are successful in some organisations/countries and not in others. There are many models and methods of implementing change. The implementation plan for the quality framework has been informed by the lessons learnt by others internationally regarding the necessary conditions for large-scale programmes to succeed.

"Organisational change is a process that can be facilitated by perceptive and insightful planning and analysis and well crafted, sensitive implementation phases, while acknowledging that it can never be fully isolated from the effects of serendipity, uncertainty and chance"

(Dawson, 1996).

Figure 1 - Quality Improvement in Mental Health Care (World Health Organisation, 2003)



3.2.2 **Receptive Context for Change**

A key requirement for change identified in a major international programme of transformational change in healthcare service provision, initially developed by the Institute for Healthcare Improvement in the United States is the development of a 'receptive context' for change. Receptive context describes the degree to which organisations/groups adopt change and new ideas. Organisations with a high receptive context are seen as ripe for change in that they quickly adopt innovative concepts to meet the challenges they experience (Pettigrew *et al*, 1992). Mental health services in Ireland are undergoing unprecedented levels of change with the introduction of new mental health policy and reforming legislation. Ongoing monitoring of the receptive context for change is essential in ensuring that mental health services are supported to incrementally address the challenges that such changes present.

The co-operation received by the Mental Health Commission since its establishment in 2002 from service users, mental health care professionals and mental health service providers is testimonial to Ireland's 'receptive context' for change. Mental health service users and mental health care professionals delivering mental health services in Ireland are ready to embrace change as they have been awaiting change for a considerable number of years. The commencement in full of the Mental Health Act 2001 on 1st November 2006 provides modern mental health legislation for all stakeholders with an interest in mental health services. This reforming legislation has been supported at all stages of its development. It is evident to the Commission that all key stakeholders are ready and keen to press forward with the continuing development of a quality mental health service and that such a development requires appropriate supporting mechanisms, resources, including funding, and a realistic timeframe for such achievement.

The Commission acknowledges that quality improvement, although a requirement of professionals and managers alike in relation to the delivery of mental health services, can be a daunting task that requires challenging ways of working that have been considered effective in the past. All involved in the necessary change process need to be enabled and supported in change initiatives to be able to provide the best possible care and treatment. It is important to note that all change initiatives, including those with less positive outcomes, are beneficial in that they provide valuable learning that is useful when shared. A useful medium for the sharing of information is via the Irish Mental Health Research Network (www.mhcresearchnetwork.ie) and Database (www.mhcresearchdatabase.ie). Quality improvement initiatives may be included in the Annual Report of the Mental Health Commission which also includes the Annual Report of the Inspector of Mental Health Services. Section 51(1)(b)(iv) of the Mental Health Act 2001 specifies the content that must be included in the report of the Inspector of Mental Health Services.

3.2.3 **Clear Plan**

A second requirement for the successful implementation of change is a clear plan that identifies the critical success factors to be attained within achievable specified timeframes along the journey to a quality mental health service. Such a plan must be multilayered so that critical success factors at the levels of service user, professional and managerial quality are addressed. In order to align policy with practice the quality framework should be implemented in tandem with *A Vision for Change*. The timeframe for full implementation of the

recommendations in *A Vision for Change* is stated as seven to ten years. A detailed time bound and costed implementation plan is required. Many of the recommendations of the previous national mental health policy *Planning for the Future* (Department of Health, 1984) remained outstanding twenty years post publication and the absence of an implementation plan may have been a key factor in this regard.

The Commission views that the implementation plan for the Quality Framework in Mental Health Services in Ireland is best developed collaboratively with the key stakeholders – service users, advocates, mental health care professionals, Health Service Executive, the Independent and Voluntary providers of mental health services and the Department of Health and Children. Mechanisms for monitoring and evaluation are essential components of the plan.

3.2.4 Provision of Infrastructure to Facilitate Sustainability

A third important requirement for the attainment of quality mental health services is the provision of an infrastructure to facilitate the sustainability of mental health services quality improvement. Sustainability refers to maintaining improvements in terms of set targets and also sustaining the changes that enable teams to learn from and work on quality issues. Financial systems should be aligned so that they maximise quality and do not become an obstacle to quality improvement. Ineffective quality activities are a waste of resources and should not be sustained. Continuous quality improvement requires the supporting of effective quality activities and ceasing the activities that have been shown to be ineffective. The publication of *A Vision for Change* was accompanied by an announcement of additional resources for mental health services. A clear relationship exists between quality and resources and failure to discuss the issues damages the credibility of many quality initiatives (Øvretveit, 2000). Costing for quality has been little used in publicly funded healthcare organisations. One reason suggested for this lack of attention may be because some costing methods are overly complex. Additional reasons are identified in Appendix E. Whatever the historical reasons for the lack of costing for quality, it is recommended that the Quality Framework for Mental Health Services in Ireland is costed by the Mental Health Commission in association with mental health service providers as a matter of priority; so that realistic time bound action plans are developed and implemented.

The proper management of resources and a sound financial standing enables organisations to achieve their aims and objectives. It is recommended that as a matter of quality corporate governance, mental health service budgets are devolved so that the necessary decisions regarding expenditure are made at the most appropriate levels within the health system.

Context for Continuous Quality Improvement – Summary
1. Receptive context for change
2. Clear plan (a) Critical success factors (b) Achievable specified timeframes (c) Multilayered (i) Service user (ii) Professional (iii) Managerial
3. Provision of infrastructure to facilitate sustainability (a) Maintaining improvements in terms of targets (b) Sustaining the changes (c) Aligning financial systems (d) Discontinuing ineffective quality initiatives

The phases of continuous quality improvement are outlined in Appendix F.

3.2.5 The Commission realises that full integration of a continuous quality improvement approach in mental health service delivery is hard work, takes a long time and should therefore be considered an incremental process. The synergy created from people achieving together within teams on an important project is usually enough to sustain enthusiasm and support, even through difficult times. The development, implementation and maintenance of high quality mental health services presents a number of opportunities and challenges and the need to share ideas across the country is essential.

3.3 Implementation Plan 2007 for Quality Framework for Mental Health Services in Ireland

3.3.1 As stated in 2.2.5 the National Mental Health Policy document *A Vision for Change* has a seven to ten year lifespan. As illustrated in the Quality Framework for Mental Health Services (Appendix C), the Quality Framework for Mental Health Services in Ireland provides an ideal medium for the attainment of a substantial number of the recommendations in *A Vision for Change*. The next requirement is a detailed plan for implementation within the context of continuous quality improvement as per sub-section 2.2 and the phases for achieving CQI as per Appendix F.

3.3.2 The Mental Health Commission has consulted with all key stakeholders in the process to date and the development of the detailed implementation plan also involves a collaborative process. It is acknowledged that there are key standards that should be implemented as a matter of priority within year 1, and that simultaneously during year 1, the priorities for implementation of the rest of the framework and associated standards over the following years are identified collaboratively by the key stakeholders.

3.3.3 The Quality Framework for Mental Health Services in Ireland comprises of 24 standards that have been identified by service users, carers, mental health professionals and other key stakeholders with an interest in mental health service provision. It is proposed that **14 of them** are **commenced in 2007** (table 1 on page 59). It is acknowledged that this target is ambitious and hence it is considered unreasonable to expect that all of the 14 standards will be fully complied with in 2007. Mental health services will be expected to begin to address each of the aforementioned standards in 2007 and it is suggested that through consultation in 2007 the Commission will, in partnership with the key stakeholders, set challenging albeit realistic timeframes for full compliance. The achievement of the first standard, number 1.1 incorporates in part, eight of the remaining 13 standards scheduled for commencement in 2007, i.e. standards number 2.1, 2.2, 3.1, 3.2, 3.3, 4.1, 4.2, and 6.1.

The Mental Health Act 2001 (Approved Centres) Regulations 2006 are in place since 1st November 2006. The regulations are a statutory requirement for approved centres and must be complied with. The regulations have been incorporated into the quality framework and they feature in the 14 standards that are prioritised for implementation in 2007 (table 1, page 59).

The Implementation process includes monitoring and evaluation. The Quality Framework for Mental Health Services will include self-assessment by mental health services and external assessment of the standards and criteria by the Inspector of Mental Health Services as part of the inspection process for approved centres and mental health services. An audit toolkit has been designed to assist mental health services in auditing their own service to determine levels of attainment of the standards and also to aid services in understanding what needs to be done to achieve the standards. When assessing a mental health service's level of attainment of the standards it is emphasised that meeting the standards is not an end in itself, rather it should be viewed as a part of a process of continuous quality improvement.

It is essential that there is a realisation that the implementation of safety and quality mechanisms take time and that it is preferable to commence with a small number of standards and, at the same time, build the mechanisms for sustainability of continuous quality improvement, and then move on to implement the remaining standards within challenging yet realistic timeframes. The implementation of the quality framework is however a 'time positive' activity for both service providers and staff, since it involves continuous quality improvement, which supports effective quality activities and ceases ineffective quality activities that are a burden on resources.

Implementation of Standards in 2007			
Number	**Standards**	**Commence**	**Completion by** [to be decided in consultation with stakeholders]
1.1	Each service user has an individual care and treatment plan that describes the level of support and treatment required in line with his/her needs and is co-ordinated by a designated member of the multidisciplinary team	✓	
1.3	Each service user receives mental health care and treatment from a community based service that addresses the persons changing needs at various stages in the course of the his/her illness and recovery process	✓	
1.5	Therapeutic services and programmes to address the needs of service users are provided.	✓	
2.1	Service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences	✓	
2.2	Service users rights are respected and upheld	✓	
3.1	Service users are facilitated to be actively involved in their own care and treatment through the provision of information	✓	
3.2	Service users are empowered regarding their own care and treatment by exercising choice, rights and informed consent	✓	
3.3	Peer support/advocacy is available to service users	✓	
4.1	Service users receive care and treatment in settings that are safe, and that respect the person's right to dignity and privacy	✓	
4.2	Service users in residential or day settings receive a well-balanced nutritious diet	✓	
6.1	Families, parents and carers are empowered as team members receiving information, advice and support as appropriate	✓	
7.3	Learning and using proven quality and safety methods underpins the delivery of a mental health service	✓	
8.1	The mental health services is delivered in accordance with evidence-based codes of practice, policies and protocols	✓	
8.3	Corporate governance underpins the management and delivery of the mental health service	✓	

Table 1 - Implementation of Standards in 2007

3.3.4 **Implementation of the Structures and Processes to support implementation of the Quality Framework for Mental Health Service in 2007.**

The Mental Health Commission's priorities for 2007 are as follows.

1st Quarter

- Commence discussions with:
  (a) The Department of Health and Children
  (b) Senior managers within the Health Service Executive (HSE)
  (c) Senior managers from other sectors (Independent/Voluntary providers)
- Publish the Quality Framework for Mental Health Services in Ireland
- The Inspection template incorporates monitoring of compliance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, the Rules pursuant to Sections 59(2) and 69(2) of the Mental Health Act 2001 and any Codes of Practice prepared by the Mental Health Commission in accordance with Section 33(3)(e) of the Act
- Ensure that costing of the quality framework is commenced

2nd Quarter

- Provide information sessions/workshops for all
- Commence implementation of standards (Table 1).
- Mental Health Commission consults with stakeholders to identify and prioritise timeframes for implementation
- The Inspection process incorporates monitoring of compliance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Rules pursuant to Sections 59(2) and 69(2) of the Mental Health Act 2001 and any Codes of Practice prepared by the Mental Health Commission in accordance with Section 33(3)(e) of the Act
- Commence training to support the implementation of the quality framework
- Development of costed implementation plan is completed.

3rd and 4th Quarters

- The Inspection process incorporates monitoring of compliance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Rules pursuant to Sections 59(2) and 69(2) of the Mental Health Act 2001 and any Codes of Practice prepared by the Mental Health Commission in accordance with Section 33(3)(e) of the Act
- Continue training to support the implementation of the quality framework
- Develop and publish plans for the following based on an analysis of the information elicited through the consultation process in the 2nd quarter:
  (a) Timeframes for completion of the standards commenced in 2007
  (b) Implementation of the quality framework in 2008
  (c) Audit toolkit
- Commence implementation of the quality framework monitoring and reporting structures and processes

3.4 Implementation Plan Critical Success Factors

The critical success factors that impact upon the attainment of the implementation plan include the following:

- Attainment of 'buy in' at senior management levels and commitment from all stakeholders to the quality framework
- Provision of appropriate resources in accordance with the costed implementation plan
- Devolved budgets to enable effective decision making and resource utilisation
- Effective planning that permeates from the macro/strategic level to the point of service delivery
- Strong leadership at all levels to implement the changes required

Glossary, References, Bibliography & Appendices

Glossary

Access

Ability of a potential service user to obtain a service when needed within an appropriate time.

Approved centre

A "centre" means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. An "approved centre" is a centre that is registered pursuant to the Act. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Act.

Choice

The power to express preferences, make decisions and retain control over one's own life. It also depends on the service user having access to relevant information, discussion with chosen advocate(s) and mental health professionals, and a sense of working in partnership.

Clinical governance

It is a system for improving the standard of clinical practice and includes clinical audit, education and training, research and development, risk management, clinical effectiveness and openness.

Corporate governance

The way in which a mental health service is directed and controlled so as to achieve its organisational goals and to deliver accountability, transparency and probity.

Criteria

Measurable elements of service provision. Criteria relate to the desired outcome or performance of staff or services. The standard is achieved when all criteria associated with it are met.

Mental health service

A service which provides care and treatment to a person suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist [Mental Health Act 2001, Section 2(1)].

Patient

A person to whom an admission order or renewal order relates pursuant to the Mental Health Act 2001.

Quality framework

It is a framework for evaluating and continuously improving the quality of services. It shows key concepts and the relations between them to guide analysis or other actions.

Resident

Is defined in Section 62 of the Mental Health Act 2001 as a person receiving care and treatment in an approved centre.

Risk

The chance of something happening that will have an impact on objectives.

Risk management

The culture, processes and structures that are directed towards realising potential opportunities while also managing adverse effects.

Service user safety

Ensuring service users do not suffer as a result of receiving healthcare or as a result of not receiving healthcare which they should have received.

Service user

A person who uses mental health services.

Standard

A broad statement of the desired and achievable level of performance against which actual performance can be measured. The standard is the overall goal. It relates directly to the person receiving the mental health service. The standard outlines the objective that is expected.

Team working

The members of a multidisciplinary team working together and sharing expertise in order to deliver a holistic mental health service.

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Appendix A

Consultation Process

Background

In line with the Mental Health Commission's mandate as outlined on page 7, the Commission decided to develop a quality framework for mental health services to support continuous improvement in the quality of mental health services. The Mental Health Commission is strongly committed to consultation with all stakeholders in mental health services. Thus, in order to develop the framework, it was decided to consult widely with all key stakeholders. The Commission engaged Prospectus in 2004 to design and manage the consultation process.

The overall objective of the consultation process was to gather the views and perspectives of all stakeholders to establish what constitutes quality in mental health services.

Methodology

The consultation process involved an initial planning and design phase undertaken by Prospectus in partnership with the Mental Health Commission.

The actual consultation involved:

- Eight consultation workshops, attended by 66 people from groups representative of key stakeholders
- A call for written submissions, which led to the receipt of 239 written submissions from a wide range of stakeholders
- Two focus groups designed to elicit the views of people who have no specific contact with mental health services

A review of recent consultative processes and strategies was also undertaken.

Consulting with Stakeholders

The consultation was designed to gather a wide range of perspectives on what constitutes a quality service for people using mental health services and what constitutes a quality service for families, parents and carers. It aimed to ensure an inclusive approach by inviting groups who would be in a position to bring perspectives on quality for adult service users, children and young people, people with disability and mental illness, and groups who may have particular needs on account of cultural or ethnic minority status, or difficult personal circumstances, the families, parents and carers of people using mental health services, service providers, organisations with an interest in mental health services (such as government departments and agencies) and members of the general public.

For detailed information on the consultation, please refer to the consultation report entitled "Quality in Mental Health – Your Views: Report on Stakeholder Consultation on Quality in Mental Health Services" (Mental Health Commission, 2005a).

Appendix B

Mental Health Commission: Strategic Plan 2006-2008

Strategic Priorities 2006 – 2008

Strategic Priority Number One

To promote, develop and evaluate the implementation of high standards of care and treatment within the mental health services.

Strategic Priority Number Two

To promote and protect the rights and best interests of persons availing of mental health services as defined in the Mental Health Act 2001.

Strategic Priority Number Three

To promote and enhance information, knowledge and research on mental health services and treatment interventions.

Strategic Priority Number Four

To advocate for the integration and participation in society of people who experience or have experienced mental illness.

Strategic Priority Number Five

To maintain and enhance the organisation's systems and capacity to ensure the provision of a quality service by the Mental Health Commission.

Strategic Priority Number One

To promote, develop and evaluate the implementation of high standards of care and treatment within the mental health services.

CONTEXT: The Mental Health Act 2001 mandates the Mental Health Commission to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services [Section 33(1)]. This statutory responsibility will be fulfilled by the development of a quality framework for mental health services in Ireland. The quality framework will be the foundation to support continuous improvement in the quality of mental health services. This quality framework will cover the broad spectrum of mental health services from childhood to adulthood to later life and various other specialisms within mental health including mental health services for people with an intellectual disability, and the forensic mental health services.

Objectives	Targets
1.1 To continue to lead the process in the development of high standards of care within the mental health services in Ireland.	1.1.1 Develop and enact the Quality Framework for Mental Health Services.
1.2 To comply with our statutory obligations under the Mental Health Act 2001	1.2.1 Prepare and publish rules pursuant to Sections 59 and 69, Mental Health Act 2001. 1.2.2 Prepare and publish codes of practice in consultation with the stakeholders as per Section 33(3)(e) Mental Health Act 2001. 1.2.3 Establish and maintain the register of approved centres, in compliance with regulations issued as per Section 66 Mental Health Act 2001. 1.2.4 Continue and develop the programme of inspection and review of mental health services by the Inspectorate of Mental Health Services and publish the report of inspections and review annually. 1.2.5 To monitor the implementation by stakeholders of the recommendations of the Inspector of Mental Health Services and any Inquiry established as per Section 55 Mental Health Act 2001.
1.3 To continue to consult and work collaboratively with the stakeholders in the development of a quality mental health service.	1.3.1 Work collaboratively with all stakeholders to facilitate the implementation, monitoring and evaluation of the quality framework. 1.3.2 Provide appropriate training to assist in establishing and maintaining high standards of care within mental health services. 1.3.3 Continue to build on the current programme of information on the provisions of the Mental Health Act 2001. 1.3.4 Publish position papers on multidisciplinary team working, recovery approach in mental health services and forensic mental health services.

Strategic Priority Number One To promote, develop and evaluate the implementation of high standards of care and treatment within the mental health services.	
Objectives	**Targets**
	1.3.5 Publish discussion and position papers on child and adolescents mental health services and mental health services for people with an intellectual disability.
1.4 To continue to support the development and ongoing sustainability and audit of quality initiatives in mental health services.	1.4.1 Develop a uniform learning system on the reporting of adverse events in the mental health services.
1.5 To foster an environment that respects and recognises the role of current and former service users and their families in their own care, in service planning and service delivery.	1.5.1 Establish systems within the Mental Health Commission that ensure service user Involvement.

Strategic Priority Number Two To promote and protect the rights and best interests of persons availing of mental health services as defined in the Mental Health Act 2001.	
CONTEXT: The Mental Health Commission is mandated to take all reasonable steps to protect the interests of persons detained in approved centres under the Act [Section 33(3)(1)]. The Mental Health Act 2001 introduces an automatic independent review system for all people admitted involuntarily to approved centres, thereby bringing Irish mental health legislation into conformity with the European Convention on Human Rights and Fundamental Freedoms. The Mental Health Act 2001 states that in making decisions under the Act, the best interests of persons shall be the principal consideration (Section 4). This includes having due regard to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.	
Objectives	**Targets**
1.1 To ensure that only those who require treatment on a compulsory basis are admitted involuntarily and such admissions are for the minimum period necessary.	1.1.1 Support the development of mental health services that promote care and treatment on a voluntary basis.
1.2 To ensure that involuntary admissions are in compliance with the provisions of the Mental Health Act 2001.	1.2.1 Establish the independent review system for involuntary admission as per the Mental Health Act 2001. 1.2.2 Prepare a code of practice on the admission of children pursuant to the Mental Health Act 2001. 1.2.3 Prepare a report for submission to the Minister for Health and Children within 18 months of the commencement of Part 2 Mental Health Act 2001[Section 42 (4)].
1.3 To review and monitor involuntary admissions.	1.3.1 Conduct and publish an annual audit of involuntary admissions to approved centres.

Strategic Priority Number Two

To promote and protect the rights and best interests of persons availing of mental health services as defined in the Mental Health Act 2001.

Objectives	Targets
1.4 To provide information to the public, service users and their carers on the Mental Health Act 2001 in an accessible format.	1.4.1 Develop and provide a programme of training and information for all those involved in the independent review system.
1.5 To foster the promotion and protection of the rights of persons who are unable to give informed consent.	1.5.1 Support the introduction of appropriate legislative provisions and advocacy for people who require support in making decisions.

Strategic Priority Number Three

To promote and enhance information, knowledge and research on mental health services and treatment interventions.

CONTEXT: Information, knowledge and research on mental health services are essential for effective strategic planning and service delivery. The lack of reliable robust management information systems within the mental health services and how this impacts on service delivery has been highlighted by the Inspector of Mental Health Services and in the report "A Vision for Change". Information systems within the Irish health services in general are poorly developed, but this absence is even more acute within mental health services. The Mental Health Commission, in recognising the importance of high quality mental health research, published its research strategy in 2005. This report provides the strategic direction for the Mental Health Commission in relation to mental health research.

Objectives	Targets
1.1 To continue to promote high quality epidemiological and service research in relation to mental health services in Ireland.	1.1.1 Continue to implement the Research Strategy. 1.1.2 Review the effectiveness of the Research Strategy.
1.2 To support national and international cross agency research links and networks.	1.2.1 Publicise and expand the Irish Mental Health Research Network and Database
1.3 To promote and support the development of a national mental health information system.	1.3.1 Engage with stakeholders on the development of a national mental health information system. 1.3.2 Ensure the accessibility and relevance of mental health information data collected by the Mental Health Commission and continue the active engagement with people involved in data collection within the mental health services.

Strategic Priority Number Four

To advocate for the integration and participation in society of people who experience or have experienced mental illness.

CONTEXT: Respecting and promoting the human rights of people with a mental illness and ensuring the removal of barriers to full participation in society are key challenges. Consultations with stakeholders conducted by the Mental Health Commission have highlighted the ongoing prevalence of stigma and discrimination of people with a mental illness and for their families/carers.

Objectives	Targets
1.1 To promote and support the empowerment of service users within the mental health system and wider society.	1.1.1 Continue to develop and integrate the input of service users in the work of the Mental Health Commission.
1.2 To promote a recovery orientated approach in mental health services.	1.2.1 Publish position paper on recovery approach in mental health services and foster initiatives in this area.
1.3 To work collaboratively with stakeholders in promoting citizenship and social inclusion for all people with mental health problems, and highlighting mental health in the public health agenda.	1.3.1 Form strategic alliances with relevant agencies committed to researching, and promoting citizenship and social inclusion. 1.3.2 Engage with the media on issues of integration and inclusion and on the appropriate presentation of mental health issues. 1.3.3 Promote World Mental Health Day held annually on 10th October.
1.4 To facilitate the development of a mental health service that is responsive to our multi-cultural society.	1.4.1 Continue to provide information from the Mental Health Commission in an accessible and understandable format.

Strategic Priority Number Five

To maintain and enhance the organisation's systems and capacity to ensure the provision of a quality service by the Mental Health Commission.

Objectives	Targets
1.1 To provide a high quality service response to our customers in line with the Customer Charter.	1.1.1 Publish the Mental Health Commission's Customer Charter. 1.1.2 Develop and publish the Mental Health Commission's Customer Action Plan for the period 2006 – 2008. 1.1.3 Continue to promote and develop a learning culture within the organisation
1.2 To further develop the communication, information and technology (ICT) systems within the organisation.	1.2.1 Implement report on the internal information systems required within the Mental Health Commission.
1.3 To continue to ensure compliance with corporate governance requirements and relevant legislation.	1.3.1 Publication of Annual Reports and other Reports as required by the Mental Health Act 2001. 1.3.2 Review and monitor compliance with the corporate governance requirements.

Appendix C

Comparative Analysis of Quality Framework for Mental Health Services and "A Vision for Change"

The table overleaf highlights the overlap between the current Government mental health policy "A Vision for Change" published by the Department of Health & Children in January 2006 and the Mental Health Commission's Quality Framework for Mental Health Services in Ireland.

The recommendations made in *A Vision for Change* were compared with the themes and standards enunciated in the quality framework and any commonality between the two frameworks was noted. Numerous similarities were observed as is evident from the table, thus it may be said that both documents share a common vision for mental health services.

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
1.1	The principles and values described here and underpinning this policy should be reflected in all mental health service planning and delivery.		Throughout
3.1	Service Users and carers should participate at all levels of the mental health system.	1, 2, 3, 5, 6, 7, 8	1.1, 1.2, 1.3, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 3.4, 3.5, 5.1, 6.1, 7.2, 7.4, 8.2
3.2	Advocacy should be available as a right to all service users in all mental health services in all parts of the country.	3	3.3
3.3	Innovative methods of involving service users and carers should be developed by local services, including the mainstream funding and integration of services organised and run by service users and carers of service users.	1, 2, 3, 5, 6, 7, 8	1.1, 1.5, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 3.4, 3.5, 5.1, 6.1, 7.2, 7.4, 8.2
3.4	The adult education system should offer appropriate and supported access to information, courses, and qualifications to service users, carers and their representatives that would help to enhance and empower people to represent themselves and others.	1, 2, 3, 7	1.5, 2.3, 3.1, 3.3, 3.5, 7.2
3.5	A National Service User Executive should be established to inform the National Mental Health Service Directorate and the Mental Health Commission on issues relating to user involvement and participation in planning, delivering, evaluating and monitoring services including models of best practice; and to develop and implement best practice guidelines between the user and provider interface including capacity development issues.	3, 7, 8	3.4, 3.5, 7.2, 8.1
3.6	Carers should be provided with practical support/ measures such as; inclusion in the care planning process with the agreement of the service user, inclusion in the discharge planning process, timely and appropriate information and education, planned respite care and should have a member of the multidisciplinary team to act as a keyworker/designated point of contact with the team and to ensure these services are provided.	1, 2, 3, 5, 6, 7, 8	1.1, 1.2, 2.2, 3.1, 3.5, 5.1, 6.1, 7.2, 8.1
3.7	The experiences and needs of children of service users should be addressed through integrated action at national, regional and local level in order that such children can benefit from the same life chances as other children.	1, 3, 4, 5, 6	1.5, 3.5, 4.1, 5.1, 6.1
3.8	Mental health services should provide ongoing, timely and appropriate information to service users and carers as an integral part of the overall service they provide.	1, 2, 3, 5, 6, 8	1.1, 1.2, 1.4, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 5.1, 6.1, 8.3
3.9	Information on the processes involved in making complaints or comments on mental health services should be widely available.	1, 2, 3, 6, 8	1.1, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 6.1, 8.3
3.10	Service user involvement should be characterised by a partnership approach which works according to the principles outlined in this chapter and which engages with a wide variety of individuals and organisations in the local community.	1, 2, 3, 5, 6, 7, 8	1.1, 1.2, 1.3, 1.5, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 3.4, 3.5, 5.1, 6.1, 7.2, 7.4, 8.3
4.1	All citizens should be treated equally. Access to employment, housing and education for individuals with mental health problems should be on the same basis as every other citizen.	1, 2, 3	1.5, 2.3, 3.2, 3.3, 3.5
4.2	Evidence-based programmes to tackle stigma should be put in place, based around contact, education and challenge.	1, 2, 3, 7	1.4, 1.5, 2.1, 2.3, 3.5, 7.2
4.3	The flexible provision of educational programmes should be used to encourage young people to remain engaged with the education system and to address the educational needs of adults with mental health problems.	1, 3	1.5, 3.3, 3.5

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
4.4	Measures to protect the income of individuals with mental health problems should be put in place. Health care access schemes should also be reviewed for this group.	1, 3, 5	1.5, 3.5, 5.1
4.5	Mental health services should take account of local deprivation patterns in planning and delivering mental health care.	1, 5, 8	1.2, 1.3, 1.4, 1.5, 5.1, 8.1, 8.2, 8.3
4.6	Evidence-based approaches to training and employment for people with mental health problems should be adopted and such programmes should be put in place by the agencies with responsibility in this area.	1, 2, 3, 7, 8	1.1, 1.4, 1.5, 2.3, 3.3, 3.5, 7.2, 8.1, 8.2
4.7	The provision of social housing is the responsibility of the Local Authority. Mental health services should work in liaison with Local Authorities to ensure housing is provided for people with mental health problems who require it.	1, 2, 3	1.1, 1.2, 1.5, 2.3, 3.5
4.8	Mental health services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard, and mental health services should be resourced to provide services to other ethnic groups, including provision for interpreters.	2, 3, 4, 5, 7	2.1, 2.2, 3.1, 3.2, 3.3, 4.1, 5.1, 7.2
4.9	Community and personal development initiatives which impact positively on mental health status should be supported e.g. housing improvement schemes, local environment planning and the provision of local facilities. This helps build social capital in the community.	1, 3, 5	1.3, 1.5, 3.3, 3.4, 3.5, 5.1
4.10	The National Mental Health Service Directorate should be specifically represented in the institutional arrangements which implement the National Action Plan against Poverty and Social Exclusion, with specific targets to monitor action in achieving greater social inclusion for those with mental health problems.		The outer layer of the framework acknowledges that mental health services cannot be looked at in isolation but are an intrinsic component of society (See S 2.3 Format of the Framework)
5.1	Sufficient benefit has been shown from mental health promotion programmes for them to be incorporated into all levels of mental health and health services as appropriate. Programmes should particularly focus on those interventions known to enhance protective factors and decrease risk factors for developing mental health problems.	1	1.4
5.2	All mental health promotion programmes and initiatives should be evaluated against locally agreed targets and standards.	8	8.1, 8.3
5.3	A framework for inter-departmental cooperation in the development of cross-cutting health and social policy should be put in place. The NAPS framework is a useful example of such an initiative (see Chapter Four).	1, 2, 8	1.2, 1.3, 1.5, 2.3, 8.1, 8.3
5.4	Designated health promotion officers should have special responsibility for mental health promotion working in cooperation with local voluntary and community groups and with formal links to mental health services.	1	1.4
5.5	Training and education programmes should be put in place to develop capacity and expertise at national and local levels for evidence-based prevention of mental disorders and promotion of mental health.	1, 7, 8	1.4, 7.2, 7.3, 7.4, 8.3
7.1	All individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services.	5	5.1

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
7.2	Further research and information on the prevalence of mental health problems in primary care and the range of interventions provided in primary care is needed to effectively plan primary care services and the interface between primary care and specialist mental health services.	8	8.1
7.4	Appropriately trained staff should be available at the primary care level to provide programmes to prevent mental health problems and promote wellbeing.	1, 7	1.2, 1.4, 7.1, 7.2
7.5	It is recommended that the consultation/liaison model should be adopted to ensure formal links between CMHTs and primary care.	1	1.2, 1.3, 1.4
7.6	Mental health professionals should be available in the primary care setting, either within community care, the primary care team or the primary care network.	1, 3	1.2, 1.3, 3.5, 5.1
7.7	Local multidisciplinary CMHTs should provide a single point of access for primary care for advice, routine and crisis referral to all mental health services (community and hospital based).	1, 5	1.2, 1.3, 5.1
7.8	Protocols and policies should be agreed locally by primary care teams and community mental health teams - particularly around discharge planning. There should be continuous communication and feedback between primary care and the CMHT.	1, 8	1.2, 1.3, 1.5, 8.1
7.9	A wide range of incentive schemes should be introduced to ensure mental health treatment and care can be provided in primary care.	5	5.1
7.10	Physical infrastructure that meets modern quality standards should provide sufficient space to enable primary care and CMHTs to provide high quality care.	4	4.1
7.11	The education and training of GPs in mental health should be reviewed. GPs should receive mental health training that is appropriate to the provision of mental health services described in this policy (i.e. community-based mental health services). Service users should be involved in the provision of education on mental health.	7	7.2
9.1	To provide an effective community-based service, CMHTs should offer multidisciplinary home-based treatment and assertive outreach, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families. Each multidisciplinary team should include the core skills of psychiatry, nursing, social work, clinical psychology, occupational therapy. The composition and skill mix of each CMHT should be appropriate to the needs and social circumstances of its sector population.	1, 3, 5, 7	1.1, 1.3, 1.5, 3.5, 5.1, 7.1
9.2	The cornerstone of mental health service delivery should be an enhanced multidisciplinary Community Mental Health Team (CMHT), which incorporates a shared governance model, and delivers best-practice community-based care to serve the needs of children, adults and older people.	1, 8	1.3, 1.5, 8.1
9.3	Links between CMHTs primary care services, voluntary groups and local community resources relevant to the service user's recovery should be established and formalised.	1, 2, 3, 8	1.3, 1.5, 2.3, 3.5, 8.1
9.4	All CMHTs should have direct access to medical and radiological services as part of the comprehensive assessment of specific presentations.	1	1.3

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
9.5	Evaluation of the activities of the CMHT in terms of meaningful performance indicators should take place on an annual basis and incorporate service user feedback.	3, 8	3.4, 3.5, 8.3
9.6	Research should be undertaken to establish how many services currently have effective CMHTs and to identify the factors that facilitate and impede effective team functioning and the resources required to support the effective functioning of CMHTs.	7	7.4
10.1	The need to prioritise the full range of mental health care, from primary care to specialist mental health services for children and adolescents is endorsed in this policy.	1	1.1, 1.2, 1.3, 1.4, 1.5
10.2	Child and adolescent mental health services should provide mental health services to all aged 0-18 years. Transitional arrangements to facilitate the expansion of current service provision should be planned by the proposed National Mental Health Service Directorate and the local CMHTs.	1, 8	1.2, 1.5, 8.3
10.3	It is recommended that service users and their families and carers be offered opportunities to give feedback on their experience and to influence developments within these services.	1, 2, 3, 6, 7, 8	1.1, 1.2, 2.2, 3.1, 3.2, 3.4, 3.5, 6.1, 7.2, 7.4, 8.3
10.4	Programmes addressing mental health promotion and primary prevention early in life should be targeted at child populations at risk.	8	8.3
10.5	For those children in school settings it is recommended that the SPHE be extended to include the senior cycle and that evidence-based mental health promotion programmes be implemented in primary and secondary schools.	1	1.4
10.6	Provision of programmes for adolescents who leave school prematurely should be the responsibility of the Department of Education and Science.	1	1.5 The outer layer of the framework acknowledges that mental health services cannot be looked at in isolation but are an intrinsic component of society (See S 2.3 Format of the Framework)
10.7	Two child and adolescent CMHTs should be appointed to each sector (population: 100,000). One child and adolescent CMHT should also be provided in each catchment area (300,000 population) to provide liaison cover.	1, 8	1.1, 1.3, 1.5, 8.1
10.8	These child and adolescent CMHTs should develop clear links with primary and community care services and identify and prioritise the mental health needs of children in each catchment area.	1, 2	1.5, 2.3
10.9	Urgent attention should be given to the completion of the planned four 20-bed units in Cork, Limerick, Galway and Dublin, and multidisciplinary teams should be provided for these units.	8, 1	8.3, 1.5, 1.3
10.10	Early intervention and assessment services for children with autism should include comprehensive multidisciplinary and paediatric assessment and mental health consultation with the local community mental health team, where necessary.	1	1.5
11.1	Education and promotion of positive mental health should be encouraged within the general community. These initiatives should have clearly specified goals and objectives and should be evaluated regularly.	1	1.4
11.2	A Health Promoting College Network should be developed and implemented.	1	1.4

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
11.3	CMHTs should provide support and consultation to primary care providers in the management and referral of individuals with mental health problems.	1	1.3, 1.5
11.4	The proposed general adult mental health service should be delivered through the core entity of one Community Mental Health Team (CMHT) for sector populations of approximately 50,000. Each team should have two consultant psychiatrists.	1	1.3, 1.5
11.5	It is recommended that a shared governance model, incorporating clinical team leader, team coordinator and practice manage be established to ensure the provision of best-practice integrated care, and evaluation of services provided.	1, 8	1.1, 1.2, 1.3, 8.3
11.6	CMHTs should be located in Community Mental Health Centres with consideration for easy access for service users. High quality day hospitals and acute in-patient care facilities should also be provided.	1, 5	1.3, 1.5, 5.1
11.7	CMHTs should evolve a clear care plan with each service user and, where appropriate, this should be discussed with carers.	1, 3, 6, 8	1.1, 1.2, 1.3, 3.2, 3.4, 6.1, 8.3
11.8	Each team should include a range of psychological therapy expertise to offer individual and group psychotherapies in line with best practice.	1, 3	1.3, 1.5, 3.5
11.9	Service users and providers should collaborate to draw up clear guidelines on the psychological needs of users and the range of community resources and supports available to them locally.	1, 3, 8	1.1, 1.3, 1.5, 3.4, 3.5, 8.3
11.10.	Home-based treatment teams should be identified within each CMHT and provide prompt services to known and new service users as appropriate. This sub-team should have a gate-keeping role in respect of all hospital admissions.	1, 3	1.2, 1.3, 1.4, 1.5, 3.5
11.11	Arrangements should be evolved and agreed within each CMHT for the provision of 24/7 multidisciplinary crisis intervention. Each catchment area should have the facility of a crisis house to offer temporary low support accommodation if appropriate.	1, 5	1.3, 5.1
11.12	In addition to the existing Early Intervention Services (EIS) pilot project currently underway in the HSE, a second EIS pilot project should be undertaken with a population characterised by a different socio-demographic profile, with a view to establishing the efficacy of EIS for the Irish mental health service.	1	1.4
11.13	Each 50 bed acute psychiatric unit should include a close observation unit of six beds.	8	8.1
11.14	Each of the four HSE regions should provide a 30-bed ICRU unit - with two sub-units of 15 beds each - to a total of 120 places nationally, staffed with multidisciplinary teams with appropriate training.	8	8.1
11.15	Each of the four HSE regions should provide two high support intensive care residences of ten places each.	8	8.1
12.1	A strong commitment to the principle of "Recovery" should underpin the work of the rehabilitation CMHT - the belief that it is possible for all service users to achieve control over their lives, to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation.	2, 3	2.3, 3.5
12.2	Some 39 rehabilitation and recovery CMHTs should be established nationally, with assigned sector populations of 100,000. Assertive outreach teams providing community-based interventions should be the principal modality through which these teams work.	1, 5	1.3, 1.4, 1.5, 5.1

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
12.3	The physical infrastructure required to deliver a comprehensive service should be provided in each sector. Rehabilitation and recovery CMHTs should have responsibility for those physical resources appropriate to the needs of their service users, such as community residences.	1, 5	1.3, 1.5, 5.1
12.4	Opportunities for independent housing should be provided by appropriate authorities with flexible tenancy agreements being drawn up in accordance with each service user's needs. Arrangements that best enable service users to move from high support to low support and independent accommodation need to be considered.	1, 3, 4	1.2, 1.3, 1.5, 3.5, 4.1
12.5	Rehabilitation and recovery mental health services should develop local connections through linking with local statutory and voluntary service providers and support networks for people with a mental illness is required to support community integration.	1, 2, 3	1.3, 1.4, 1.5, 2.3, 3.5
12.6	All current staff within the mental health system who are appointed to rehabilitation and recovery services should receive training in recovery-oriented competencies and principles.	3, 7	3.5, 7.2
12.7	The development of formal coordination structures between health services and employment agencies should be a priority if the delivery of seamless services is to be facilitated.	1, 3	1.2, 1.5, 3.5
12.8	To facilitate the service user in re-establishing meaningful employment, development of accessible mainstream training support services and coordination between rehabilitation services and training and vocational agencies is required.	1, 2, 3	1.3, 1.5, 2.3, 3.5
12.9	Evaluation of services to the severe and enduring service user group should incorporate quality-of-life measures and assess the benefit and value of these services directly to service users and their families.	7, 8	7.4, 8.3
13.1	Any person, aged 65 years or over, with primary mental health disorders or with secondary behavioural and affective problems arising from experience of dementia, has the right to be cared for by mental health services for older people (MHSOP).	1	1.3, 1.5
13.2	Mental health promotion among older adults should preserve a respect for the potential in older people to grow and flourish in later life and to counter negative myths of ageing that can become self-fulfilling prophecies.	1, 2, 3, 5	1.4, 2.1, 2.3, 3.5, 5.1
13.3	Health promotion programmes and initiatives found to be beneficial to older adults should be implemented.	1	1.4
13.4	Primary health care teams should play a major role in assessment and screening for mental illness in older people and should work in a coordinated and integrated manner with the specialist teams to provide high quality care, particularly care that is home-based.	1, 3	1.2, 1.3, 1.5, 3.5
13.5	A total of 39 MHSOP multidisciplinary teams should be established nationally, one per 100,000 population, providing domiciliary and community-based care.	1, 5	1.1, 1.3, 1.5, 5.1
13.6	Priority should be given to establishing comprehensive specialist MHSOP where none currently exist.	1, 5	1.1, 5.1
13.7	Physical resources essential to service delivery, acute beds and continuing care, service headquarters, community-based and day facilities should be provided for MHSOP within each sector.	1, 5, 8	1.3, 5.1, 8.3

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
13.8	There should be eight acute assessment and treatment beds in each regional acute psychiatric unit for MHSOP.	1	1.3
13.9	There should be one central day hospital per mental health catchment area (300,000 population) providing 25 places, and a number of travelling day hospitals in each mental health catchment area.	5	5.1
13.10	There should be an appropriate provision of day centres in each mental health catchment area, but their provision should not be the responsibility of the MHSOP.	1, 5	1.3, 5.1
13.11	There should be appropriate recognition and linkage with voluntary agencies in the field.	1, 2, 3	1.3, 1.5, 2.1, 2.3, 3.3
13.12	Carers and families should receive appropriate recognition and support including education, respite, and crisis response when required.	1, 6	1.1, 1.2, 6.1
13.13	Older people with mental health problems should have access to nursing homes on the same basis as the rest of the population.	5	5.1
13.14	There should be 30 continuing care places for older people with mental disorders in each mental health catchment area.	8	8.3
14.1	The process of service delivery of mental health services to people with intellectual disability should be similar to that for every other citizen.	5	5.1
14.2	Detailed information on the mental health of people with intellectual disability should be collected by the NIDD. This should be based on a standardised measure. Data should also be gathered by mental health services for those with intellectual disability as part of national mental health information gathering.	7, 8	7.4, 8.2
14.3	A national prevalence study of mental health problems including challenging behaviour in the Irish population with intellectual disability should be carried out to assist in service planning.	7, 8	7.4, 8.2
14.4	The promotion and maintenance of mental well-being should be an integral part of service provision within intellectual disability services.	1	1.4
14.5	All people with an intellectual disability should be registered with a GP and both intellectual disability services and MHID teams should liaise with GPs regarding mental health care.	1	1.1, 1.2, 1.3
14.6	Mental health services for people with intellectual disability should be provided by a specialist mental health of intellectual disability (MHID) team that is catchment area-based. These services should be distinct and separate from, but closely linked to, the multidisciplinary teams in intellectual disability services who provide a health and social care service for people with intellectual disability.	1	1.1, 1.3, 1.5
14.7	The multidisciplinary MHID teams should be provided on the basis of two per 300,000 population for adults with intellectual disability.	8	8.1, 8.2
14.8	One MHID team per 300,000 population should be provided for children and adolescents with intellectual disability.	8	8.1, 8.2
14.9	A spectrum of facilities should be in place to provide a flexible continuum of care based on need. This should include day hospital places, respite places, and acute, assessment and rehabilitation beds/places. A range of interventions and therapies should be available within these settings.	1, 3	1.1, 1.3, 1.5, 3.5

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
14.10	In order to ensure close integration, referral policies should reflect the needs of individuals with intellectual disability living at home with their family, GPs, the generic intellectual disability service providers, the MHID team and other mental health teams such as adult and child and adolescent mental health teams.	1	1.2
14.11	A national forensic unit should be provided for specialist residential care for low mild, and moderate range of intellectual disability. This unit should have ten beds and be staffed by a multidisciplinary MHID team.	8	8.1, 8.2
15.1.1	Every person with serious mental health problems coming into contact with the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done. Where mental health services are delivered in the context of prison, they should be person-centred, recovery oriented and based on evolved and integrated care plans.	1, 2, 3, 5	1.1, 2.1, 3.5, 5.1
15.1.2	FMHS should be expanded and reconfigured so as to provide court diversion services and legislation should be devised to allow this to take place.	8	8.1
15.1.3	Four additional multidisciplinary, community-based forensic mental health teams should be provided nationally on the basis of one per HSE region.	8	8.1
15.1.4	The CMH should be replaced or remodelled to allow it to provide care and treatment in a modern, up-to-date humane setting, and the capacity of the CMH should be maximised.	8	8.1
15.1.5	Prison health services should be integrated and coordinated with social work, psychology and addiction services to ensure provision of integrated and effective care. Efforts should be made to improve relationships and liaison between FMHS and other specialist community mental health services.	1, 3	1.1, 1.2, 1.3, 1.5, 3.5
15.1.6	A dedicated residential 10-bed facility with a fully resourced child and adolescent mental health team should be provided with a national remit. An additional community-based, child and adolescent forensic mental health team should also be provided.	8	8.1
15.1.7	A 10-bed residential unit, with a fully resourced multidisciplinary mental health team should be provided for care of intellectually disabled persons who become severely disturbed in the context of the criminal justice system.	8	8.1
15.1.8	Education and training in the principles and practices of FMH should be established and extended to appropriate staff, including An Garda Síochana.	7	7.2
15.1.9	A senior garda should be identified and trained in each Garda division to act as resource and liaison mental health officer.	7, 8	7.3, 8.3
15.2.1	A data base should be established to refine the dimension and characteristics of homelessness and analyse how services are currently dealing with it.	7, 8	7.4, 8.2
15.2.2	In the light of this information, scientifically acquired and analysed, make recommendations as to requirements and implement them.	8	8.1
15.2.3	The Action Plan on Homelessness (162) should be fully implemented and the statutory responsibility of housing authorities in this area should be reinforced.	8	8.1 The outer layer of the framework acknowledges that mental health services cannot be looked at in isolation but are an intrinsic component of society (See S 2.3 Format of the Framework)

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
15.2.4	A range of suitable, affordable housing options should be available to prevent the mentally ill becoming homeless.	1	1.2, 1.5
15.2.5	The CMHT team with responsibility and accountability for the homeless population in each catchment area should be clearly identified. Ideally this CMHT should be equipped to offer assertive outreach. Two multidisciplinary, community-based teams should be provided, one in North Dublin and one in South Dublin, to provide a mental health service to the homeless population.	5	5.0.1
15.2.6	Community mental health teams should adopt practices to help prevent service users becoming homeless, such as guidelines for the discharge of people from psychiatric in-patient care and an assessment of housing need/living circumstances for all people referred to mental health services.	1	1.1, 1.2, 1.3
15.2.7	Integration and coordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged.	1, 2	1.2, 1.3, 1.5, 2.3
15.3.1	Mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems.	1	1.2
15.3.2	General adult CMHTs should generally cater for adults who meet these criteria, particularly when the primary problem is a mental health problem.	1	1.2
15.3.3	The post of National Policy Coordinator should be established to deliver national objectives and standards pertaining to primary care and community interventions for drug and alcohol abuse and their linkage to mental health services.	8	8.3
15.3.4	Specialist adult teams should be developed in each catchment area of 300,000 to manage complex, severe substance abuse and mental disorder.	1, 5	1.3, 1.5, 5.1
15.3.5	These specialist teams should establish clear linkages with local community mental health services and clarify pathways in and out of their services to service users and referring adult CMHTs.	1, 3	1.2, 1.5, 3.5
15.3.6	Two additional adolescent multidisciplinary teams should be established outside Dublin to provide expertise to care for adolescents and co-morbid addiction and mental health problems. This provision should be reviewed after five years.	1, 5	1.5, 5.1
15.4.1	Health promotion initiatives that support greater community and family awareness of eating disorders should be supported and encouraged.	1	1.4
15.4.2	The activities of voluntary agencies in promoting awareness and responses to eating disorders should be supported.	2	2.3
15.4.3	Special emphasis should be placed on including training modules on eating disorders in the undergraduate and postgraduate training of health professionals.	7	7.2
15.4.4	Eating disorders in children and adolescents should be managed by the child and adolescent CMHTs on a community basis, using beds in one of the five in-patient child and adolescent units if required.	1, 5	1.5, 5.1
15.4.5	There should also be a full multidisciplinary team in a National Centre for Eating Disorders, to be located in one of the national children's hospitals, for complex cases that cannot be managed by local child and adolescent CMHTs.	1, 7	1.1, 1.5, 7.1

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
15.4.6	There should be four specialist multidisciplinary teams providing specialist in-patient, outpatient and outreach services for eating disorders; one team per HSE region. These teams should link closely with local adult CMHTs to ensure continuity of care.	1, 8	1.2, 1.3, 1.5, 8.3
15.4.7	Each team should manage an eating disorder sub-unit in a regional general hospital mental health unit. These sub-units should have six beds each, thereby contributing 24 public ED beds nationally.	8	8.3
15.4.8	The four specialised multidisciplinary adult teams, and the national team for children and adolescents, should provide community-based consultation, advice and support to all agencies in their area.	1, 2, 3	1.2, 1.4, 1.5, 2.3, 3.5
15.5.1	The existing provision of nine LMHS teams nationally should be increased to thirteen.	5, 8	5.1, 8.3
15.5.2	Complete multidisciplinary LMHS should be established in the three national children's hospitals.	5, 8	5.1, 8.3
15.5.3	Liaison child and adolescent mental health services should be provided by a designated child and adolescent CMHT, one per 300,000 population (see Chapter 10)	8	8.3
15.5.4	One additional adult psychiatrist and senior nurse with perinatal expertise should be appointed to act as a resource nationally in the provision of care to women with severe perinatal mental health problems.	5	5.1
15.6.1	Two specialist neuropsychiatry multidisciplinary teams should be established in the major neuroscience centres in Dublin and Cork.	8	8.3
15.6.2	As a national resource, a special neuropsychiatric in-patient unit with six to ten beds should be established.	8	8.3
15.6.3	Facilities for video-conferencing and telemedicine should be considered to extend the expertise located in these units nationally, and to enable them to become a consultation and training resource.	7	7.3
15.7.1	There should be agreed protocols and guidelines for engaging with those assessed to be at high risk of suicidal behaviour, and for engaging with those who are particularly vulnerable in the wake of a suicide, within mental health care settings.	1	1.1, 1.2, 1.3, 1.4
15.7.2	Particular care should be given to service users of mental health services who have been identified as being at high risk of suicidal behaviour e.g. those with severe psychosis, affective disorders, and individuals in the immediate aftermath of discharge from in-patient settings.	1	1.1, 1.2, 1.3, 1.4
15.7.3	Integration and coordination of statutory, research, voluntary, and community activities is essential to ensure effective implementation of suicide prevention initiatives in the wider community. In this regard the National Office for Suicide Prevention should be supported and developed.	1, 2, 8	1.4, 2.3, 8.1
15.7.4	The strategies recommended in Reach Out to prevent suicide and to improve mental health provision for people engaging in suicidal behaviour should be adopted and implemented nationally.	1, 2	1.4, 1.5, 2.1
15.8.1	The needs of people with mental health problems arising from or co-morbid with borderline personality disorder should be recognised as a legitimate responsibility of the mental health service, and evidence-based interventions provided on a catchment area basis.	1, 8	1.2, 1.3, 1.5, 8.1, 8.3
15.8.2	Specialised therapeutic expertise should be developed in each catchment area to deal with severe and complex clinical problems that exceed the available resources of generic CMHTs.	1	1.2, 1.3, 1.5

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
16.1	Mental Health Catchment Areas should be established with populations of between 250,000 and 400,000 with realigned catchment boundaries to take into account current social and demographic realities. These catchment areas should be coterminous with local health office areas and the new regional health areas. They should take into account the location of acute psychiatric in-patient units in general hospitals.	1	1.3
16.2	Substantial upgrading of information technology systems should occur to enable the planning, implementation and evaluation of service activity.	8	8.2
16.3	A National Mental Health Service Directorate should be established, which includes senior professional managers, senior clinicians and a service user. The new National Mental Health Service Directorate should act as an advisory group and be closely linked with the management of the Primary and Continuing Care Division of the Health Service Executive.	8	8.1, 8.2, 8.3
16.4	Multidisciplinary Mental Health Catchment Area Management Teams should be established. These teams should include both professional managers and clinical professionals along with a trained service user and should be accountable to the National Care Group Manager and the National Mental Health Service Directorate.	8	8.1, 8.2, 8.3
16.5	Community Mental Health Teams should self-manage through the provision of a team coordinator, team leader and team practice manager.	8	8.3
16.6	Community Mental Health Teams should be responsible for developing costed service plans and should be accountable for their implementation.	8	8.3
16.7	A management and organisation structure of National Mental Health Service Directorate, a multidisciplinary Mental Health Catchment Area Management Team and local, self-managing CMHTs, should be put in place.	8	8.3
16.8	Mental Health Catchment Area Management Teams should facilitate the full integration of mental health services with other community care area programmes. This should include the maximum involvement with self-help and voluntary groups together with relevant local authority services.	1, 5, 6	1.3, 1.4, 1.5, 5.1, 6.1
16.9	Community Mental Health Teams and Primary Care Teams should put in place standing committees to facilitate better integration of the services and guide models of shared care.	1, 3	1.2, 1.3, 1.5, 3.5
17.1	Substantial extra funding is required to finance this policy. A programme of capital and non-capital investment in mental health services as recommended, adjusted in line with inflation, should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services.	8	8..3
17.2	Capital and human resources should be remodelled within re-organised catchment-based services to ensure equity and priority in service developments.	8	8.3
17.3	Other agencies must take up their responsibilities in full so mental health services can use their funding for mental health responsibilities. Mental health services should not provide the broad range of services which are more appropriately provided elsewhere.		The outer layer of the framework acknowledges that mental health services cannot be looked at in isolation but are an intrinsic component of society (See S 2.3 Format of the Framework)
17.4	Approximately 1,800 additional posts are required to implement this policy. This significant non-capital investment will result in mental health receiving approximately 8.24% of current, non-capital health funding, based on 2005 figures.	7	7.1

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
17.5	Recognition must be given to the need for extra funding for areas that exhibit social and economic disadvantage with associated high prevalence of mental ill health.	5	5.1
17.6	Resources, both capital and revenue, in the current mental health service must be retained within mental health.	8	8.1
17.7	The full economic value of psychiatric hospital buildings and lands should be professionally assessed and realised.	8	8.1
17.8	Provision of community mental health centres as service bases for multidisciplinary community mental health teams should be given priority.	1, 2, 3, 5	1.2, 1.3, 1.5, 2.3, 3.5, 5.1
17.9	The comprehensive and extensive nature of the reorganisation and financing of mental health services recommended in this policy can only be implemented in a complete and phased way over a period of seven to ten years.		All standards
18.1	Education & Training (E&T) should be directed towards improving services as a primary goal and must have the welfare of service users as its ultimate objective.	2, 3, 7	2.1, 2.2, 2.3, 3.5, 7.2
18.2	Training programmes should emphasise the acquisition of skills that are clinically meaningful, should train personnel for leadership and innovative roles, and should foster an attitude of critical enquiry and self-scrutiny in relation to service delivery.	7	7.2
18.3	There should be centralisation of the planning and funding of education and training for mental health professionals in new structures to be established by the HSE in close association with the National Directorate of Mental Health Services. This centralised E&T authority should be constituted to represent stakeholder and service user interest and E&T bodies representing all disciplines.	7	7.2, 7.3
18.4	The HSE should commit itself to adequate, rational and consistent funding of E&T. However the accreditation of courses should remain the responsibility of the respective professional bodies.	7	7.2
18.5	Funding of HSE sponsored training courses should be established on a secure basis to allow for expansion and development of these courses and to ensure manpower requirements in mental health services can be met in coming years.	7	7.2
18.6	A multi-profession manpower plan should be put in place, linked to projected service plans. This plan should look at the skill mix of teams and geographically, taking into account the service models recommended in this report and should be prepared by the National Mental Health Service Directorate working closely with the Health Service Executive, the Department of Health and Children and service providers. This should include consideration of a re-allocation of resources working group to ensure equitable distribution of manpower resources across the four regions.	7	7.1
18.7	Family friendly staff policies and flexible rostering with provision of suitable child care facilities is an important issue for the recruitment and retention of staff, as is help with housing, particularly for foreign nationals.	7	7.1
18.8	A flexible retirement package should be considered to make the best use of valuable experienced staff. This would enable staff nearing retirement to move into part-time work without reducing pension benefit or to retire while carrying on with full or part-time work. Staff earlier on in their career should be able to take a career break and still contribute to their pension benefits.	7	7.1

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
18.9	Future manpower requirements must be driven by service requirements rather than historical factors and should not be wedded to the perceived needs of any single discipline.	1, 3, 7	1.1, 1.2, 1.3, 1.5, 3.5, 7.1
18.10	Within the context of overall service changes, many currently employed staff will need to redefine their role in the light of the development of new community-based teams focusing on early intervention, assertive outreach, crisis resolution and home treatment. Appropriate training should be available for affected staff.	3, 7	3.5, 7.1, 7.2, 7.3
18.11	A personal training and development plan or equivalent should be introduced for all grades of staff in the mental health services. This should help managers set priorities for the use of resources in order to meet common needs more efficiently, organise staff release and target and schedule in-house education and training. In this regard it is also important to make available clear information about routes to employment training and career progression within the mental health service.	7	7.1, 7.2, 7.3
18.12	The quality and scope of undergraduate medical education programmes should be reviewed and the recommendations of the Fottrell report to increase intake should be adopted.	7	7.1
18.13	Current steps to revise post graduate training in psychiatry should be undertaken with a view to increasing the number of graduates in this speciality and equipping them with the range of skills required within the proposed restructured mental health service.	7	7.1, 7.2, 7.3
18.14	The GP training body and the psychiatry training bodies should jointly review all issues in relation to mental health training for GPs.	7	7.1, 7.2, 7.3
18.8	A flexible retirement package should be considered to make the best use of valuable experienced staff. This would enable staff nearing retirement to move into part-time work without reducing pension benefit or to retire while carrying on with full or part-time work. Staff earlier on in their career should be able to take a career break and still contribute to their pension benefits.	7	7.1
18.9	Future manpower requirements must be driven by service requirements rather than historical factors and should not be wedded to the perceived needs of any single discipline.	1, 3, 7	1.1, 1.2, 1.3, 1.5, 3.5, 7.1
18.10.	Within the context of overall service changes, many currently employed staff will need to redefine their role in the light of the development of new community-based teams focusing on early intervention, assertive outreach, crisis resolution and home treatment. Appropriate training should be available for affected staff.	3, 7	3.5, 7.1, 7.2, 7.3
18.11	A personal training and development plan or equivalent should be introduced for all grades of staff in the mental health services. This should help managers set priorities for the use of resources in order to meet common needs more efficiently, organise staff release and target and schedule in-house education and training. In this regard it is also important to make available clear information about routes to employment training and career progression within the mental health service.	7	7.1, 7.2, 7.3
18.12	The quality and scope of undergraduate medical education programmes should be reviewed and the recommendations of the Fottrell report to increase intake should be adopted.	7	7.1
18.13	Current steps to revise post graduate training in psychiatry should be undertaken with a view to increasing the number of graduates in this speciality and equipping them with the range of skills required within the proposed restructured mental health service.	7	7.1, 7.2, 7.3

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
18.14	The GP training body and the psychiatry training bodies should jointly review all issues in relation to mental health training for GPs.	7	7.1, 7.2, 7.3
18.15	A common foundation core programme for all student nurses, followed by specialist training up to the point of registration as a psychiatric, intellectual disability or general nurse should be given serious consideration. In the interim, shortened training should be available for all qualified nurses wishing to register in any of the other nursing disciplines.	7	7.1, 7.2
18.16	The recommendations of the Nursing and Midwifery Resource, July 2002 Final Report of the Steering Group "Towards Workforce Planning" should be implemented in full and further developed on a multidisciplinary basis.	7	7.1, 7.2
18.17	The number of psychiatric nurses in training should be kept under constant review to allow scope for the future development of general adult, child and adolescent and other specialist mental health services and primary care teams.		
18.18	The sponsorship scheme for experienced care assistants to train as nurses should be maintained and extended to ensure appropriate, mature applicants are attracted into the psychiatric nursing profession.	7	7.1
18.19	There is no official requirement to involve service users and carers in the education and training of psychiatric nurses. It is recommended that service users and carers should be consulted and involved in the development of educational programmes.	2, 3, 6, 7, 8	2.3, 3.2, 3.4, 3.5, 6.1, 7.2, 8.3
18.20.	Specialist and advanced nurse practitioner roles for nurses in intellectual disability should be developed in response to identified needs of people using the service.	7	7.1
18.21	A mental health training module should be mandatory and standardised in social work training to ensure all staff especially those without practice experience have a basic understanding of mental health issues and mental health services.	7	7.1-3
18.22	A significant increase in the number of funded postgraduate training places for clinical psychology is needed urgently to fill the current shortfall and meet projected manpower requirements. Additional appointments at senior grade should be established to facilitate supervised clinical placements for those in training. The use of the Assistant Psychologist grade as a career step should also be considered.	7	7.1
18.23	In order to increase the attractiveness of mental health social work and occupational therapy posts, existing deficiencies in terms of professional and geographical isolation, lack of supervision and poor facilities should be addressed.	2, 7	2.3, 7.1
18.24	It is recommended that the position of mental health support worker be established in the mental health system to support service users in achieving independent living and integration in their local community.	7	7.1, 7.2
18.25	Advocacy training programmes should be encouraged and appropriately financed.	2, 3, 6, 7	2.1, 2.2, 3.3, 3.4, 3.5, 6.1, 7.2
18.26	A National Manpower Planning Group should be established to make recommendations regarding the education, training and workforce issues arising from this report, with reference to clinical psychology, counselling psychology and psychotherapy.	7	7.1, 7.2, 7.3

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
18.27	A variety of programmes should be in place for the workplace such as induction programmes, health and safety programmes (for example, cardio-pulmonary resuscitation) and training in conducting staff appraisals.	7	7.2, 7.3
18.28	The establishment of structured, accredited training courses and other measures to support and encourage volunteering in the mental health service should be considered within the broad context of education and training.	7	7.2
19.1	Service users and carers should have ready access to a wide variety of information. This information should be general (e.g. on mental health services in their area) and individualised (e.g. information on their medication).	1, 2, 3, 5, 6	1.1, 1.3, 1.4, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 5.1, 6.1
19.2	The HIQA should put mechanisms in place to carry out systematic evaluations on all forms of interventions in mental health and this information should be widely disseminated.	7, 8	7.4, 8.2
19.3	Measures should be put in place to collect data on community-based mental health services.	8	8.2
19.4	In accordance with the recommendation in the National Health Information Strategy, an electronic patient record (EPR) should be introduced with a unique identifier for every individual in the state.	8	8.2
19.5	A national mental health minimum data set should be prepared, in consultation with relevant stakeholders.	8	8.2
19.6	Mental health services should implement mental health information systems locally that can provide the national minimum mental health data set to a central mental health information system.	8	8.2
19.7	A national morbidity survey should be carried out to determine the prevalence of mental health problems in the population.	7	7.4
19.8	Research should focus on mental health services - outcomes, policy and service, and economics - creating an evidence base for mental health care.	7, 8	7.4, 8.1, 8.2
19.9	The recommendations of the Health Research Strategy should be fully implemented as the first step in creating a health research infrastructure in mental health services.		
19.10	A national mental health services research strategy should be prepared.	8	8.1
19.11	Dedicated funding should be provided by the Government for mental health service research.	7, 8	7.3, 8.1, 8.2, 8.3 The outer layer of the framework acknowledges that mental health services cannot be looked at in isolation but are an intrinsic component of society (See S 2.3 Format of the Framework).
19.12	People with experience of mental health difficulties should be involved at every stage of the research process including the development of research agendas, commissioning, overseeing, conducting and evaluating research as well as supporting the use of the emerging evidence base in policy and practice.	2, 3, 8	2.3, 3.4, 3.5, 8.2, 8.3
19.13	Mental health research should be part of the training of all mental health professionals and mental health services should be structured to support the ongoing development of these skills.	7	7.2, 7.3, 7.4

A Vision for Change Report of the Expert Group on Mental Health Policy		Quality Framework	
Number	**Recommendation**	**Theme**	**Standard**
20.1	It will be the responsibility of the HSE to ensure the implementation of this mental health policy. The key recommendations of the policy must be seen as inter-related and interdependent and should be implemented as a complete plan.	8	8.3
20.2	The National Mental Health Service Directorate, in conjunction with the HSE, should put in place advisory, facilitatory and support capacity to assist the change process.	8	8.3
20.3	The first steps that should be taken to implement this policy include the management and organisational changes recommended in Chapter 16 and the provision of training and resources for change.	8, 7	8.3, 7.2, 7.3, 7.4
20.4	Mental hospitals must be closed in order to free up resources to provide community-based, multidisciplinary team-delivered mental health care for all. A plan to achieve this should be put in place for each mental hospital.	1	1.3
20.5	An independent monitoring group should be appointed by the Minister for Health and Children to oversee the implementation of this mental health policy.		The outer layer of the framework acknowledges that mental health services cannot be looked at in isolation but are an intrinsic component of society (See S 2.3 Format of the Framework.

Appendix D

Relevant Acts and related Documents

The following is a non exhaustive list of legislation, regulations, professional standards, codes of ethics and related documents relevant to protecting and respecting the rights of the service user:

- European Convention on Human Rights Act 2003
- UN Principles for the protection of persons with mental illness, and the improvement of mental health care (MI, 1991)
- Mental Health Act 2001
- Mental Health Act 2001 (Approved Centres) Regulations 2006
- Equal Status Acts 2000 to 2004
- Mental Health Commission Rules R-S59(2)/01/2006 – Rules governing the use of ECT
- Mental Health Commission Rules R- S69(2)/02/2006 – Rules governing the use of Seclusion and Mechanical means of bodily Restraint
- Mental Health Commission - Code of Practice COP-S33(3)/01/2006 - Code of Practice relating to admission of children under the Mental Health Act 2001
- Mental Health Commission Code of Practice COP-S33(3)/02/2006 – Code of Practice on the use of physical restraint in approved centres
- A Guide to Ethical Conduct and Behaviour (Medical Council, 2004)
- Code of Professional Ethics (Psychological Society of Ireland, 2003)
- Code of Ethics and Professional Conduct for Occupational Therapists (Association of Occupational Therapists Ireland, 2002)
- IASW Code of Ethics (Irish Association of Social Workers, 2006)
- Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais, 2000)
- Vulnerable Adults and the Law (The Law Reform Commission, 2006)
- Mental Illness: The Neglected Quarter (Amnesty International, 2003)

Appendix E

Reasons for lack of attention to the economics of quality

Reasons	Explanation
Blindness	To see poor quality a person must be able to see the possibility of things being done the right way or of no error. People grow accustomed to waste and errors and no longer notice.
Responsibility	Healthcare professionals are more interested in clinical quality and outcomes than in saving resources. They do not see reducing costs and saving money as their responsibility, or something that their time is best used for.
Incentives	Healthcare professionals do not believe that they will be allowed to keep any savings which they make. They see themselves as spending time on "non-clinical" matters for no benefit to themselves or their patients.
Negative perceptions about quality methods	Many healthcare professionals are sceptical or negative towards organisational quality initiatives which they perceive as adding bureaucracy, and taking resources from patient care. Many do not see quality methods as being effective.
Knowledge and skill	Healthcare professionals and managers do not know that carefully managed quality improvement can result in better service quality and cost reduction, and have no experience managing projects to achieve this. They are not educated about the subject, trained in how to reduce waste, or in how to select and manage quality projects for results.
Fear	In public services managers are afraid to talk about reducing costs when trying to get a quality programme accepted by personnel. They fear that personnel will see job losses and efficiency savings as the main motive.
Research and local application	Which quality initiatives result in the most quality improvement and which are most cost effective? Large amounts of time and money are spent on different quality activities, but little is known about their effectiveness, comparative effectiveness or cost effectiveness. It is also difficult to translate to the local situation. There is need for more evidence, more skills to assess and apply to the local situation, and more economic research into quality activities.

(Source: Øvretveit 2000)

Appendix F

Phases of Continuous Quality Improvement (CQI)

Harrigan (2000) identified four phases in the process for CQI within a health service system as follows:

(a) Awareness

(b) Planning

(c) Deployment

(d) Full integration

(a) The first stage in the process, awareness, includes three challenges:

1. movement from the acceptance of the status quo to an acknowledgement that there is a difference between how the service is performing and how it could be performing.
2. the service realises that the definition of quality has changed and places more emphasis on the service user.
3. the emphasis on the independence of the health service provider changes to an emphasis on the interdependence on all persons involved in providing quality of care, including the service user.

CQI demands major changes in management philosophy and behaviour. It is crucial that before implementation begins the mental health service leaders such as senior management teams and senior mental health professionals fully understand the requirement for organisational focus, energy and resources.

(b) Planning involves a number of steps:

1. Development of a general CQI plan
   - i. goals for implementation
   - ii. define critical success factors
   - iii. identify actions required
2. Establish structures to support the plan
   - i. Creation of a high-level action team to guide implementation. This may be an existing committee or a new group. The size and nature of the mental health service will determine the composition of the team.
   - ii. The high level action team identifies important issues to be resolved by initial project teams.
   - iii. Facilitators to support the implementation of the quality framework for mental health services are selected and trained.
   - iv. Communication systems which include effective feedback are developed.

(c) Deployment involves dissemination across the mental health services by including the daily management of CQI as an integral part of all stakeholders work to provide the best possible quality of care, building on initial results and continuing training in quality methods. Deployment involves the following:

1. Communication and celebration: Changes should be communicated and results celebrated.
2. Benchmarking: the mental health service benchmarks its own performance against best practice from other services. This will facilitate the refinement and development of new standards of performance and continuous quality improvement will begin.
3. Service user participation: The mental health service continues to involve service users in mental health service changes.

(d) Full integration is achieved when internal structures and processes within the mental health service are in alignment with the continuous quality improvement approach. Service users are involved from the outset.

1. Participative management styles are the norm with quality values part of management on a day to day basis.
2. The quality framework implementation plan is modified to achieve goals.
3. Progress is evaluated with evidence of improvement in performance of the whole system of mental health care delivery.

According to Harrigan (2000) it takes a minimum of five years for continuous quality improvement to be integrated. (CQI Implementation Phases table below).

Movement from one phase to another is not a linear approach. For example some of the steps outlined below in phase 2 may be taken in phase 1.

CQI Implementation Phases			
Phase 1	**Phase 2**	**Phase 3**	**Phase 4**
Building Awareness	Planning	Deployment	Full Integration
Time: 6 months	18 months	36 months	60 months
Educate senior managers and key mental healthcare professionals	Develop implementation plan	Refine plan	implement system changes
Obtain commitment to the quality framework for mental health services.	Build structure to support CQI	Communicate and celebrate initial results	Maintain momentum
Determine organisational readiness for change	Train and prepare facilitators	Continue training programme	Evaluate progress
Clarify strengths and identify opportunities for improvement	Select and launch initial projects	Roll out across the mental health services	Make CQI the management approach
Identify and understand service user expectations (Mental Health Commission, 2005a)	Build commitment to the quality framework for mental health services through leadership and communication	Establish benchmarks for the standards	Involve service users in all processes from the beginning
Formulate communication plan		Seek feedback from service users and providers	Improve processes continuously
		Record organisational processes	

Source (adapted from Harrigan 2000, p119)

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