RCSI FACULTY OF NURSING & MIDWIFERY

Review of the Mental Health Commission's Quality Framework (2007)

Evidence Review

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On behalf of

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For

The Mental Health Commission of Ireland

ABBREVIATIONS

A&F	Audit and feedback
ACP	Advance Care Planning
ADHD	Attention Deficit Hyperactivity Disorder
AMHSs	Adult Mental Health Services
AMYOS	Assertive Mobile Youth Outreach Service
Apps	Applications
ASD	Autism Spectrum Disorder
ASCOT-Carer	Adult Social Care Outcomes Toolkit for Carers
AUDIT	Alcohol Use Disorders Identification Test
BA	Behavioural Activation
BAME	Black and Minority Ethnic
BED	Binge-Eating Disorder
BPD	Borderline Personality Disorder
CAMHS	Child and Adolescent Mental Health Services
CareRQoL	Care-Related Quality of Life
CASS	Clinician Associative Stigma Scale
CATI	Computer Assisted Telephone Interviews
CBSST	Cognitive Behavioural Social Skills Training
CBT	Cognitive Behavioural Therapy
CES	Carer Experience Scale
CHIME	Connectedness, hope and optimism, identity, meaning, empowerment
CQC	Care Quality Commission
CRA-S	Community Reinforcement Approach for Seniors
CRC	Collegiate Recovery Communities
CTO	Community Treatment Orders
CTRS	Cognitive Therapy Rating Scale
DoH	Department of Health
DBT-A	Dialectical Behaviour Therapy for Adolescents
DNA	Did Not Attend
DSS	Decision Support Services
EBA	Evidence-Based assessment
EBP	Evidence-Based practice
EBT	Evidence -Based Treatments
ECT	Electro-Convulsive Therapy
EDRQ	Eating Disorder Recovery Questionnaire
EIP	Early Intervention in Psychosis
ENABLE	Educate, Nurture, Advise, Before Life Ends
EViPRG	European Violence in Psychiatry Expert Research Group
HABS-U	Healthcare-workers' Aggressive Behaviour Scale-Users
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
ICMHS	Integrated Community MHS
IMHA	Independent Mental Health Advocacy
IMR	Illness Management and Recovery
IPS	Individual Placement and Support
IPV	Intimate Partner Violence
LGB	Lesbian, Gay and Bisexual
LGBTQ+	Lesbian, gay, bisexual, transgender, transsexual, 2/Two-Spirit, queer, questioning, intersex, asexual, ally
MAP	Managing and Adapting Practice
MET	Motivational Enhancement Therapy

MFQ	Mood and Feelings Questionnaire
MHC	Mental Health Commission
MHS	Mental Health Services
MIO	Mothering from the Inside Out
MMH	Maternal Mental Health
MMHU I-T	Mobile Mental Health Unit
MSHRP	Mount Sinai Human Rights Program
NCA	National Clinical Audit
NGRI	Not Guilty by Reason of Insanity
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OCC	Outpatient Civil Commitment
PDMP	Prescription Drug Monitoring Program
PESTLE	Political, Economic, Sociological, Technological, Legal and Environmental
PSI	Power Safety Identity
PSPs	Peer Support Providers
PPI	Patient and Public involvement
PMHP	Primary Mental Health Professional
QI	Quality improvement
R&D	Research and development
RAS-DS	Recovery Assessment Scale-Domains and Stages
RAS-SF	Recovery Assessment Scale-Short Form
RCPSI	Recovery Coach and Peer Support Initiative
RCSI	Royal College of Surgeons in Ireland
RCT	Randomised Controlled Trial
SAA	School-aged Assessment of Attachment
SAPROF	Structured Assessment of Protective Factors
SARC	Sexual Assault Referral Centre
SCST	Social Cognitive Skills Training
SCQ	Social Communication Questionnaire
SES	Socioeconomic Status
SGM	sexual and gender minorities
SInQUE	Social Inclusion Questionnaire User Experience
SMART	Structured Material for Therapy
SMI	Severe Mental Illness
SPA-5	Subjective Personal Agency Scale
UK	United Kingdom
USA	United States of America
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO-5	World Health Organisation Well-being Index
WTOPPAP	Working Things Out Adolescent Programme and the Parents Plus Adolescent Programme
YMH	Youth Mental Health

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Executive summary

This evidence review includes published research related to mental health services nationally and internationally. The research identifies the changes that have taken place since 2015 in nineteen areas of mental health care. These areas are documented in the text and in tables presented in the Appendices. A PESTLE analysis demonstrates the factors present in the previous quality framework (2007) and comparison is made with the Australian National Recovery Framework (2014). Recommendations arising from the PESTLE analysis and the literature review are presented. The main areas of concern identified by users of mental health services relates to difficulty in accessing services, long waiting times for treatment, lack of understanding of patient and client needs and lack of resources. These findings are consistent throughout the review. What is evident throughout the studies found is the paucity of research relating to the experiences and needs of individual service users, which add to the need and urgency for large scale studies to be undertaken into individuals with mental health illness.

Major change has taken place in mental health services in Ireland. The most striking change occurred in the areas of digital e-technology, child and adult mental health services (CAMHS), forensics and acute care. Cognitive Behavioural Therapy (CBT) and associated therapies have also increased in number. The literature identifies that care of the older person, continuing/long stay care and rehabilitation remain under researched and underfunded.

Digital technology was in its infancy when the previous framework was developed. Technology has expanded to the extent it is now being used across all areas of mental health care in most countries and is likely to develop further in the coming years. This usage is posing difficulties for service users but particularly for professionals who encounter lack of access and difficulty in negotiating digital systems. The need for increased training for staff and more resources to support usage are consistent themes.

Forensic mental health services have developed worldwide and findings indicate that forensic services have difficulty in keeping pace with the increased numbers of adults and youth accessing care and treatment. CAMHS are having difficulty in providing services to children and adolescents in crisis, out-of-hours, schools and communities. Findings recognise the stress professionals endure in delivering services and studies identify the need for training and counselling for professionals and clinicians.

The voice of intellectual disability is now being heard and recognised to an extent. Intellectual disability in persons with a mental health illness is expanding and this is causing real concern for service users, parents and carers in their efforts to seek appropriate services. Their main area of concern relates to difficulty in accessing mental health care and treatment. Research studies related to LGBTQ+ have increased in number during the past 5 years and the main areas of concern for this population are stigma and discrimination. These two areas are also identified in ethnic minority groups and travellers. Overall mental health services are expanding and care and treatments are now mostly delivered in community care settings with moderate to high success in achieving positive outcomes for those individuals accessing services and those delivering services.

1. Introduction

This evidence review presents the mental health peer reviewed research articles accessed to meet the Mental Health Commission (MHC) requirements for the development of a new quality framework. The extensive search includes research pertaining to mental health care and services. This includes frameworks, audits, toolkits, quality, recovery and wellness, legislation, acute adult and continuing long stay care, carers/family and peers, CAMHS, digital e-technology, forensics, medication management, intellectual disability, LGBTQ+, mother and infant, rehabilitation, professionals, psychiatry of later life and therapies including CBT.

1.1 Mental Health Commission mandate

The Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland (RCSI) were asked by the MHC to undertake a review of and update the Quality Framework for Mental Health Services in Ireland dated 2007 (The Quality Framework). The Quality Framework was designed to be used as an indicator of the level of quality of services being provided and is applicable to all mental health services in the public, voluntary and independent sectors. It includes: acute adult mental health care, child and adolescent mental health care, continuing mental health care/long stay, forensic mental health care and mental health care for people with intellectual disability, and psychiatry of later life. The MHC is an independent statutory body established pursuant to Section 32 of the Mental Health Act 2001. The principle functions of The MHC 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 the Act. It is essential that providers of mental health services across Ireland have robust governance structures in place to manage risks, protect residents and provide quality care (Farrelly 2020). Further information on governance of mental health services in Ireland is provided in the Quality and Mental Health Care (national and international context) section in this review.

At voluntary rather than at statutory organisational level, Mental Health Ireland is a not for profit, registered charity company limited by guarantee that in 2016 adopted the code of practise for voluntary organisations for Good Governance of Community, Voluntary and Charitable Organisations in Ireland. This code was replaced by the Charities Regulator Governance Code in 2020 (Mental Health Ireland Health Connections 2021).

1.2 Governance of Mental Health Services

Governance of mental health services varies across countries, states and organisations with limited information available on the processes by which governance is undertaken. The most developed governance structures are found in Ireland, Australia, Britain and Scotland. The national framework for recovery oriented mental health services, endorsed by the Australian Health Ministers' Advisory Council in 2013 (Council of Australian Governments 2012), provides a new policy direction to enhance mental health service delivery that is intended to provide guidance to jurisdictions and service providers on embedding recovery-oriented mental health care. The Australian Commission on Safety and Quality in Health Care (2017) (the Commission) developed the National Model Clinical Governance Framework. Challenges in obtaining research ethics and governance approvals for an Australian national intersector, multisite audit study were identified by (Buck et al. 2020). Further information is provided in the National Model Clinical Governance Framework (Australian Regulatory

Oversight 2015) and in the NSQHS Standards User guide for governing bodies (2019, 2020). The Review of the Clinical Governance of Public Mental Health Services in Western Australia (WA) (2019) strengthened clinical governance by the appointment of a new Chief Medical Officer, Mental Health for the MHC to strengthen its leadership role by contributing to strategic planning and policy development and strengthening consumer and community focused clinical care (Clinical Governance of Public Mental Health Services in WA (2020). The Review of the Clinical Governance of Public Mental Health Services can be viewed at https://ww2.health.wa.gov.au accessed July 9 2021.

In England, The Care Quality Commission (CQC 2009) https://www.cqc.org.uk is the independent regulator of health and adult social care services. Its purpose is to provide people with safe, effective, compassionate, high quality care and to encourage care services to improve. Following the Health and Social Care Act (2012), the National Health Service (NHS) changed its structures and processes to more clearly put patients first, by focusing on improved quality and outcomes. *Monitor* is the sector regulator for health services in England. *Monitor* protects and promotes the interests of patients by ensuring that the whole sector works for their benefit by working closely with the Care Quality Commission (CQC), the quality and safety regulator.

In taking a global view, the health systems governance programme of the World Health Organisation (WHO 2018) supports Member States by strengthening governance at the policy, planning, purchasing and provision levels thus boosting rapid changes in the service delivery culture. This system's function enables it to define, lead and implement policies in health service delivery, health financing and resource generation, while responding to health priorities and reflecting own goals, strategies and values, thus providing effective implementation of primary health care towards universal health coverage, including health security.

Regulatory structures are not uniform across jurisdictions. England, Northern Ireland, and the Netherlands each have one single regulator with responsibility for regulation of health and social care services. The Netherlands has a broad regulatory remit and uses the term "Supervision" which equates to 12 Regulators. Wales has two regulators with responsibility for mental health services. The Mental Welfare Commission for Scotland has oversight responsibilities of some mental health services and a Care Inspectorate which regulates mental health services. The Director of Mental Health and Addiction Services office in New Zealand contains the Chief Statutory Officer under the New Zealand Mental Health Act. The Victoria State Government regulates mental health and all other health and social care services in Victoria, Australia (Victoria State Government 2022) and the Australian Commission on Safety and Quality in Health Care leads and coordinates national improvements in the safety and quality of health care (Wolfe and Wolfe 2019, Victoria State Government 2022).

2. Background

Limited frameworks were found relating to mental health care. Two frameworks of note are analysed and presented in this document, the Irish and Australian frameworks: The MHC Quality Framework (2007) and National Framework for Recovery-Oriented Mental Health Services (2014). Whilst the Irish framework focus is on quality, the Australian framework is focused on recovery-oriented mental health services, which provides a vital new policy direction to enhance and improve mental health services delivery in Australia.

The United States of America was the first country to make use of modern methods in health care development and implementation (Berwick et al. 2004). The United Kingdom, Canada and Australia introduced accreditation through assessment and development systems (Shaw 2001) and continuous quality improvements, standards and evidence based practices (EBP) (Leyland 2002). Quality was explored from national and international perspectives and context. Relevant national reports focused on shaping a healthier future in mental health services (Department of Health (DOH) 1994), quality and fairness (DOH 2001), and a vision for change in mental health policy (MHC 2006). Quality and quality of life in mental health policy and the national health information strategy are identified (Department of Health and Children (2004). The Health Information and Quality Authority (HIQA) set and monitor standards on safety and quality in health care services provided by the Health Service Executive (HSE) (HIQA 2006).

Relevant international papers have focused on improving health care in developing countries and the economics of quality in the UK (Ovretveit, 2002 a,b), new improvement strategies (Berwick 2004), mental health team leadership and quality of life (Corrigan et al. 2000), comparative approaches to quality health care in the USA and Sweden (Ovretveit 2000 a,b), shaping strategic change in large organisations (Pettigrew et al. (1992) and quality improvements (QI) in mental health and mental health policy (WHO 2003, 2005). Focus on safety was explored through building a safer health system (Institute of Medicine 2000), stakeholder views on mental health care (MHC 2005a) and quality assurance indicators in mental health (WHO 1994) which shed light on safety in health care delivery.

Valuing recovery-oriented practice at the interface between mental health services and communities came to the fore in the 1990's (Simpson et al. 2016, Biringer et al. 2017). Implementing recovery-oriented mental health service was a policy priority in many countries (Bauer et al. 2019, Brown 2020). Excess mortality among people with severe mental illness (SMI) was largely attributed to co-morbid physical illness (Brown et al. 2018, Gronholm et al. 2017). Wellness and wellbeing were introduced to the recovery concept in the Australian mental health recovery framework (2014). Recent studies explored wellness from the perspective of employment by focusing on self-reliance, self-confidence, respect and community integration (Drake and Wallach 2020). Legislation has posed difficulties for health planners and service provides relating to community-based mental health services and different views exist on the challenges of implementing legislation. Stigma remained ever pervasive (Park et al. 2015). Access to quality mental health services was viewed as being critical to reforming health care systems yet, governmental investment in mental health services had declined in many countries since the start of the economic recession in 2008 (Docherty and Thornicroft 2015). High-quality research trials were recommended to provide more robust evidence on managing mental health provision (Bucci et al. 2015).

Adult mental health in most European and high-income countries changed conceptually and structurally during the second half of the 20th century. Deinstitutionalisation reduced the number of psychiatric beds and transferred priority to outpatient care and community-based services (Galavan 2017). Mental health services in the community continued to expand to address the issues faced by those with serious mental illnesses, with limited user involvement (Kelly et al. 2019). Service user involvement remained at a tokenistic level (Laitila et al. 2018). Even though mental health services policy stipulated that family carers be involved in care planning (MHC 2006) involvement by persons with psychotic disorders was under-implemented and undervalued in mental health care (Cree et al. 2015, Doody et al. 2017). Mental health services deinstitutionalisation resulted in a higher burden of care for relatives (Rössler and Drake 2017). There were limited interventions targeted at people with serious mental illness (Valentini et al. 2016, Jensen et al. 2017, 2019). The evidence of family involvement in care planning produced conflicting experiences related to different requirements between mental health professionals, families and service users (Doody 2017). Care planning and family focused interventions had not yet reached an operational consensus. Peer support was mentioned in a mainly positive manner but differing expectations of the role had not yet reached a level of consensus (Storm et al. 2020).

The focus of CAMHS in the early 2020's was on exploring areas that are now critical for the mental health of child and adolescents and their services. Early studies recommended the implementation of evidence based school mental health programmes for early school leaver adolescents, under the governance of the Department of Justice and Science and a college health promotion programme was implemented (MHC 2006e). It was also recommended that mental health spending should be shifted from adult to adolescent mental health services, a question that remains pertinent today (Neal 2015). The lived experiences of persons with mental illness were explored in Australia and this had led to a high level of participation and inclusion of people in mental health services (Piccone et al. 2018). Adolescent perceptions of benefit to access and young adults' need for more understanding (Tatlow-Golden 2015, Ebert et al. 2019) were in evidence. To enable understanding a toolkit to enhance caregiver participation in CAMHS was developed (Haine-Schlagel et al. 2016, 2017).

Studies included the social influences on seeking help from mental health services (Rickwood et al. 2015, Rice et al. 2018), use of mental health services by young adults before and during correctional custody (Khan et al. 2016), and the provision of services as a quality indicator for adolescent substance abuse treatment facilities (Ramchand et al. 2015). Research heralded shared decision making in adolescent mental health care (Abrines-Jaume 2016), developing interventions in CAMHS services (Kennedy 2015), resilience as a breakthrough for quality mental health care and experiences (Backer et al. 2015, Indeberg et al. 2019, Ineland et al. 2017) and youth experiences of engaging with an inpatient unit (Stanton et al. 2017). Studies that paved the way for future research included: young children and their parents' perceptions and experiences of child and adolescent mental health services (Sharples et al. 2017), outcomes and economic implications in the treatment of young people with serious mental illness (Brimblecombe et al. 2017), challenges in successful transitions from child to adult mental health services (Cleverley et al. 2016) and treatment outcomes (Edbrooke-Childs et al. 2016, 2017). Studies were presented that explored ethnicity from the lens of association between ethnicity and care pathway through CAMHS in children presenting with emotional problems, the experiences of refugee adolescents seen by school-based mental health services (Fazel et al. 2016) and childhood bullying victimisation associated with the use of mental

health services over five decades. The Special Educational Needs and Disability Code of Practice were viewed as an opportunity for school mental health services (Foreman 2016). Researchers recommended study of non-obsessive-compulsive anxiety disorders in child and adolescent services (Hansen et al. 2016), the provision of early intervention and assessment within the multidisciplinary team for children with autism (Stadnick et al. 2017), the prevalence of adverse childhood experiences on non-suicidal self-injury (Baiden et al. 2017) evidence-based practice in child and adolescent mental health services (Westerlund et al. 2021) and targeted family intervention for adolescents with social, emotional and behavioural difficulties attending CAMHS (Wynne et al. 2016).

Continuing mental health care/long stay changed structurally during the second half of the 20th century due to deinstitutionalisation and transfer of services to outpatient care and community-based services (Galavan 2017, Rössler and Drake 2017) and mental health services in the community continued to expand to address the issues faced by those with serious mental illnesses in long stay care (Kelly et al. 2020). More involvement in decision-making about individual care and treatment was proposed (Laitila et al. 2018), yet families perceived care planning to be uncoordinated (Valentini et al. 2016, Doody et al. 2017, Rössler and Drake 2017) as there were limited interventions targeted at people with mental illness (Jensen et al. 2017).

Digital e-technology and telehealth were introduced in the mid 90's with a small number of cost-effective e-health applications available for treating depression in community and clinical settings (Batterham 2015, Brooks et al. 2017). Advances in children's tele-mental health provided informed direction for child providers using remote technologies as a means to extend practices (Orlowski et al. 2016). Promoting knowledge and skill in tele-mental health was critical to meaningfully overcoming barriers to children's mental healthcare (Myers and Comer 2016). Ethnicity was posing difficulties for immigrant and refugee populations, resulting in adverse mental health outcomes (Sundvall et al. 2015, Salami et al. 2019). Immigrant service providers supported integration and overall well-being, however the mental health needs of young people from refugee backgrounds, their experiences and the barriers they faced in accessing mental health services remained undocumented (Valibhoy et al. 2017). Variation also existed in how individuals with a diagnosis of mental illness experienced discrimination (Clement et al. 2015, Sarkin et al. 2015, Hamilton et al. 2016, Henderson et al. 2020) and ethnicity research indicated mistrust with services (Henderson et al. 2020).

Forensics (FMHS) was identified in the literature as being historically poorly managed, under-resourced and inconsistently delivered (Zhao et al. 2015, Stegbauer et al. 2017, Martyr 2017). Numerous transition difficulties were identified across forensic CAMHS's for young offenders with mental health disorders (Liegghio et al. 2017, Livanou et al. 2017). Individuals with psychosis were over-represented in the criminal justice system and at elevated risk of re-offending. They also suffered from social stigmatisation (Ogloff et al. 2015, Leonard et al. 2016, Stewart et al. 2015, 2017). An association between increased contacts with mental health services and reduced re-offending in those ordered to mental health treatment rather than punitive sanctions was observed (Ogloff et al. 2015, Sedgwick et al. 2016.). Engaging criminogenic interventions in community mental health settings with consumers, providers and administrators was explored (Joa et al. 2017, Wilson et al. 2017). The effect of Community Treatment Orders (CTOs) in persons exhibiting symptoms of First Episode of Psychosis was explored and further research was indicated to identify factors

associated with compulsory treatment and involuntary admissions (Adelugba et al. 2015, O' Donoghue et al. 2016, Joa et al. 2017, Levy et al. 2018).

Medication was poorly documented with little information available about the particular medications that were being prescribed by community mental health services (Daviss et al. 2016, Paton et al. 2019 a, b) or about people with co-occurring substance misuse and psychiatric disorders (Mauro et al. 2016). Increasing efforts to protect children by increasing access to safer medications and evidence-based psychosocial interventions were mooted (Choi et al. 2016, Daviss et al. 2016). Research indicated that many individuals were on higher doses of antipsychotic drug than was required for optimal functioning, yet limited guidelines existed on how to reduce use of the drug (Steingard 2018). Nurse prescribing in Ireland and in the United Kingdom has grown significantly since 2010 (Dobel-Ober and Brimblecombe 2016, Watson 2020).

Difficulties remained in relation to people with intellectual disabilities, immigrants and LGBTQ+ clients of mental health services and those needing psychiatry services in later life. People with intellectual disability experienced higher rates of mental health disorders than the rest of the population and research evidenced multiple barriers preventing access to appropriate services (Bonell 2012, Whittle et al. 2019). Waghorn et al. (2020) explored the importance of evidence-based supported employment for people with psychiatric disabilities in Australia.

In relation to older person care, cultural and governance reforms were introduced following government reports, often as a result of negligence towards older persons. Of particular note was The Oakden Report which drew national attention to the care of older people with complex clinical needs in Australia and that served to point a way forward for older persons' mental health services (McKellar and Hanson 2020). Unmet needs were found in a policy brief evaluating how California's mental health system had served older adults (Kietzman et al. (2018), leading to staff reporting age-relevant data indicators (Frank et al. 2018). In Canada, measures to include older people in policymaking were not well articulated or researched (Restall 2015).

A range of professionals worked in delivering mental health services. The number and type were less than currently in position. The meaning that psychologists gave to their work with clients and their use of personal coping strategies in difficult environments was explored (Gone 2015, Kivisto and Watson 2016, Haines et al. 2018, Sciberras and Pilkington 2018). Clinicians working with people with Borderline Personality Disorder (BPD) often viewed this work as challenging, especially when there was a high risk of suicide or self-harm (Hughes et al. 2017, Ponce et al. 2019). Other studies report a lack of clarity about the role of the mental health social worker within community mental health teams and highlight limited evidence base (Hughes et al. 2017). Mental health nurses needed more support to work towards a greater understanding of compassionate care for clinical practice (Barron et al. 2017). A wide variety of peer worker roles were introduced into mental health services internationally. Engaging peer support was expected to improve service engagement and delivery, however early studies recommended that peer workers should enter into an alliance to address barriers in integration (Crane et al. 2016, Vandewalle et al. 2016). Research was lacking into the mental health support services that were available to persons with a mental health disability across organisational contexts and cultures (Gillard et al. 2015, Good and Hannah 2015, Colucci et al. 2017, Holley, Gillard and Gibson 2015, Healey et al. 2017). Therapy delivery was in its infancy. Studies identified therapies from mainly two perspectives: CBT and EBP. Research papers identified

mothers' and infants' care from the perspectives of barriers to access care, ethnicity, perinatal care, youth pregnancy and perception of care. A persistent theme running through studies relating to mother and infant care was lack of access to mental health services at various points along the journey for both. See Figure 1 to view the mental health service concepts identified in the evidence review.

Figure 1: Review of mental health care concepts

3. Methodology

Cooper's (1989) five stage approach, with revision, guided this integrative review: concept/project formulation, data collection, evaluation of data for suitability, data analysis and interpretation and presentation of results. The project concept formulation is described in the introduction (Cooper 1989).

3.1 Data collection

The search strategy combined two concepts: Mental health services and quality frameworks. These concepts were operationalised broadly to capture as many relevant articles as possible. Nineteen concepts were identified and within each concept between five and ten sub-concepts were introduced. The overall review was limited to articles that were written in English and published between 2009 and 2021 and which had an abstract, the exceptions being grey literature. The majority reviewed were in the bracket (2017-2021). The search was re-run in 2022 to ensure the inclusion of the most recent peer-reviewed literature in this review. Results from all searches were grouped according to the identified concepts and finally consolidated into the review. The searches provided a yield of more than 14,000 papers of which 1,500 were evaluated. Grey literature was used to access mainly reports. Literature accessed and utilised in report are listed in the reference and bibliography sections.

3.2 Search history databases

Library databases that were searched included EBSCO*host*, Pub Med Central, Google Scholar, Medline, CINAHL, PsycInfo, DynaMed, EMBASE, and Health Business Elite. Returns for each term are listed in Table 1.

Table 1: Search strategy

Search term	Results
MH Community Mental Health Services and Governance	5,024
MH Recovery or Mental Health Recovery	3,000
DE Recovery Disorder or TI Recovery or AB Recovery	2,700
Mental health Frameworks or Audits or Toolkits	560
Mental Health Mother or Infant or Perinatal	560
Advanced Nurse Practice or advanced practice or strategy in mental health	1,012
Mental Health in Intellectual Disability	400
Mental Health in LGBTQ+	700
Continuing mental health care	300
Mental health in Rehabilitation	150

3.3 Evaluation of data

Results of the literature search were screened against inclusion and exclusion criteria. Articles were included if they met most, or all, of the following criteria: based on empirical research, contained an abstract, written in English, focused on mental health care and settings, placed emphasis on community mental health care and settings, placed emphasis on service users, carers, professionals and organisations involved in mental health care and included quality and recovery based care.

3.4 Data analysis and interpretation

Papers were reviewed for study design, sample approach and sample size, methodology, aims presented, outcomes, relevance and recommendations. Papers reviewed were deemed to yield a greater level of information than was possible to present in this review.

3.5 Presentation of results

Sample sizes of study populations researched in the papers reviewed ranged from 1 to 34,000 (one outlier of 86,000). The majority of journal articles used either descriptive-correlational designs, qualitative, mixed methods, longitudinal, quasi or true experimental and 30% of papers reviewed used quantitative analysis. Of the papers evaluated, full texts were read for 550 and abstracts read for the remainder. The majority of relevant papers sourced were of Australian, Canadian, US, UK, Irish or European origin.

The Bibliography contains reports from the MHC, HSE, Department of Health and Children, Department of Health, WHO and other relevant organisations. Review of these reports, if appropriate, are presented and referenced in the Bibliography.

Tables I - XIX are presented in Appendix I. All are related to mental health care as identified in this evidence review. Tables provide additional information not presented in the review. Each framework table is composed of: author, date and country, design, sample, methods, aim, findings or outcomes and recommendations. Country of origin was not always available. On average 50% of studies presented in the tables are quantitative and include surveys, audits RCTs, mixed methods, multinational randomised trials, and 50% are qualitative studies.

4. PESTLE analysis of MHC Quality Framework (2007)

4.1 Background to the Quality Framework

The Quality Framework (2007) was comprised of eight themes, 24 standards and 163 criteria. The framework placed the service user at the centre. The themes, standards and criteria contained in the Quality Framework provided clear guidance for service users, their families/chosen advocates, service providers and the public as to what to expect from a mental health service. It also afforded the opportunity for service users to provide feedback on the standards, which should be incorporated into the service planning process. The framework facilitated a mental health service to monitor its own performance against the standards. The Quality Framework also acted as a driver for change in mental health policies, practice and structures at local, regional and national levels. 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)].

The Quality Framework was applicable to all mental health services including CAMHS, adults, older persons, persons with an intellectual disability and a mental illness and forensic services (MHC 2007). The framework applied equally to all services irrespective of whether they were being delivered within the service user's home, community settings both residential and non-residential, or within in-patient facilities. The standards provided a framework for the development of a mental health service.

Whilst the Irish framework focused on quality, the Australian framework titled A National Framework for Recovery-oriented Mental Health Services (2014), focused on recovery-oriented mental health services which provide a vital new policy direction to enhance and improve mental health services delivery in Australia. The framework, similar to the Irish framework, draws on national and international research to provide a national understanding and approach to recovery-oriented mental health practice and service delivery. It complements existing professional standards and competency frameworks at national and state levels. People with a lived experience of mental health issues, their carers and families participated in its development. See Tables XX - XIV in Appendix II for further information.

4.2 https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-tocAnalysis of framework

Political, Environmental, Social, Technology, Legislation and Economic (PESTLE) environmental analysis was deemed to be the most appropriate framework by which to analyse the existing (2007) Quality Framework. This analysis when taken in conjunction with the extensive evidence review and analysis of submissions from interested persons and organisations and interviews with relevant stakeholders will inform the development of the new framework. The six factors underpinning PESTLE includes many factors that are relevant to this analysis while conversely some factors in the Framework (2007) do not fit into PESTLE. Judgement was used to place these factors in the appropriate PESTLE domain. The sub-factors of PESTLE Framework are presented in Table 2 below.

Table 2: Summary PESTLE analysis of Mental Health Commission Quality Framework (2007)

1: Political factors
The Quality Framework (2007) analysis identifies standards relating to service users receiving mental health care and treatment from a community based service that addresses their changing needs, at various stages in the course of illness and recovery processes. This implies that an integrated service serving each catchment or community area exists, that is composed of multidisciplinary teams and has core members drawn from all clinical specialities. Individual care and treatment plans indicate the Quality Improvement (QI) processes in this regard are in place, including a formal complaints procedure. Mental health care and treatment delivered from a community based service addresses prevention, early detection, early intervention and mental health promotion. Adding to these processes therapeutic services and programmes are provided that are based on identified needs and delivered in the most appropriate environment. Information is communicated in an appropriate manner, supported by other forms of communication. A variety of languages are provided. Clinical processes are defined and adhered to. This includes The MHC's rules governing the use of electro-convulsive therapy (ECT), seclusion and mechanical means of bodily restraint and the codes of practice on the use of physical restraint in approved centres and to the admission of children. Care planning standards indicate holistic service delivery, based on assessed need, and approved centres adhere to regulations pertinent to general health. 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 and with input from service users, MDT and family /advocate at appropriate recovery times. Family involvement and boundaries are designated and supported and specific outcome criteria for child services are in place. Parents/guardians are partners in the treatment processes and a mental health service has a policy regarding the implementation of this standard and monitors its performance as part of a QI process. See Appendix II for further information.
2: Environmental factors
Analyses of environmental factors are evident in the standards**.** Approved centres adhere to regulations dealing with food and nutrition and food safety, including nutrition and storage. Service users' dietary needs are assessed and they receive a well-balanced diet that incorporates choice of menu and is available at time intervals appropriate to the service users identified needs. A policy regarding the implementation of this standard with reference to reception, storage, preparation and distribution of food to prevent food borne illnesses as part of a QI process is in place. Mental health services demonstrate 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. The MHC acknowledges that a quality physical environment promotes good health and upholds the security and safety of the service users. Service users receive care and treatment in settings that are safe, and that respect the person's right to dignity and privacy and on their recovery processes. Waste is properly managed to minimise risks. Environmental structures are in place. Approved centres adhere to regulations on food safety, clothing, residents' personal property and possessions, recreational activities, visits, communication, searches, care of the dying, transfer of residents, provision of information to residents, privacy, premises, health and safety, and use of closed circuit television. At organisational level service users receive care and treatment in an

	environment that is clean, tidy, peaceful, safe and well-maintained and where bedrooms, where shared, provide for the privacy and dignity of service users and safety of property See Appendix II for further information.
3: Social factors	
	Standards demonstrate that mental health services acknowledge staff with appropriate skills, expertise and morale as key influencers in the delivery of a quality mental health service. Educational structures in approved centres are guided by the Regulation pertaining to staffing. Family-friendly working arrangements are in place. Equality in recruitment and retention of staff regardless of their gender, marital status, family status, sexual orientation, religion, age, disability, ethnicity and membership of the traveller community or social class are in place. Educational processes include workload management. Multidisciplinary teams include staff with the appropriate skills mix and expertise to address the assessed needs of the population being served within a QI process. Continuous professional development is a key performance indicator that is monitored and recorded and which adheres to Regulations. Service users and advocates are involved in delivering training programmes for staff and non-clinical staff receive training to develop an awareness of mental health understanding of mental ill-health and its impact on the person concerned and his/her family. Lifestyle includes religion and spiritual beliefs. 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. Service users experience receipt of care that respects confidentiality, privacy, autonomy and dignity. See Appendix II for further information.
4: Technological factors	
	Few Technology factors are included in the Framework and it is recognised that telehealth and digital technology was in its infancy in mental health care delivery or services when the 2007 framework was developed. These Standards from PESTLE include: Structural dimensions relating to implementation and training for staff See Appendix II for further information.
5: Legislation factors Mental Health Acts are included. See Appendix II for further information	
	The fundamental principle underpinning mental health service is that the interests of service users are paramount and as such is adhered to. Service users experience care that respects confidentiality, privacy, autonomy and dignity. Mental health services comply with relevant legislation, regulations, professional standards and codes of ethics protecting and respecting the servicer user rights. Discrimination laws are adhered to in respect of Regulations relating to religion, care of the dying, therapeutic services and programmes, provision of information to residents, and privacy and service users experience receive 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, and ethnicity, membership of the travelling community or social class. If making 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. 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. In relation to employment laws mental health services comply with relevant legislation, regulations, professional standards and codes of ethics protecting and respecting their rights. Service users are consulted regarding individual values and beliefs. Providers respond sensitively to the beliefs, value systems and experiences of service user during

service delivery, and provide appropriate privacy to practice cultural, religious and spiritual belief. Mental health laws regarding the MHC's codes of practice regarding admission, transfer and discharge to an approved centre and communication, planning and document are adhered to.

The Mental 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 and to acknowledge values, beliefs and experiences.
The MHC's rules governing the use of ECT, seclusion and mechanical means of bodily restraint and codes 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 are adhered to.

Equality of **s**tatus standard is reflected in equality of status within the relationship, thus enabling users 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 and become empowered regarding self-care and treatment by exercising choice, rights and informed consent. Services are provided that are compatible with legislation in relation to service users consultation, rights, choices or alternative choices, consent.

Equality of services is provided in accessing a service regardless of the service user's gender, marital status, family status, sexual orientation, religion, age, disability, and ethnicity, membership of the traveller community or social class. Members of the general public, primary care services, service users and families/chosen advocates, receive information about services available to them including access. Information on access and equality for minority groups is available in ways that are accessible to people from minority groups including refugees, asylum seekers, homeless persons, travellers, and persons who are deaf.

Health and safety laws are reflected in respecting the right of the person to dignity, bodily integrity, privacy and autonomy, confidentiality, privacy, autonomy and dignity.

Data protection laws are adhered to as part of a QI process. Peer supports and advocacy are available to service users in the recovery process and approved centres adhere to the provision of clear information to residents on advocacy access and services. Service users are active participants in the planning, implementation, evaluation and review of their own care and treatment and mental health services provide a mechanism for obtaining collective feedback from these areas from service users at all levels. EBP evaluation standard ensures that mental health services are delivered in accordance with evidence-based codes of practice, policies and protocols as mental health services should be striving towards evidence-based codes of practice as part of a QI process. See Appendix II for further information.

6: Economic factors

The Quality Framework acts as a driver for change in mental health policies, practice and structures at local, regional and national levels. The Quality Framework has budgetary implication. *QI Processes*: Stakeholders identify a seamless service as an essential component of a quality service and the mental health services has a policy in place regarding the implementation of this standard as part of a QI process.

*Access to Quality Services***:** Mental health services are accessible to the community and available on a 24-hour basis, seven days a week and its location is accessible both geographically and physically and monitors its performance as part of a QI process. Delivering a quality service ensures that staff skills, expertise and morale are key quality influencers and uses proven quality and safety methods and complies with relevant legislation and regulations. Approved centres adhere to all regulation of the Mental Health Act 2001 (Approved Centre) Regulations 2006.

Risk management ensures that a whole system approach to risk in delivering quality care is in place and an effective risk management system is communicated by education and compliance. Staff receives training in quality and safety improvement and access to evidence based resources and the mental health service has a policy regarding the implementation, monitoring and performance of QI initiative for adults and children. The mental health service has a documented QI plan and associated continuous QI programme for service planning and implements the QI plan on an ongoing basis and regularly monitors its performance against it. Services monitor performance in relation to this standard as part of a QI process**.** Implementing QIs through technology is evident through mental health services operational plans that are based on the service plan which establishes timeframes, responsibilities and targets for implementation. The mental health services manages its budget in accordance with nationally accepted accounting practices and allocates a portion of its budget for the provision of staff development and for the participation of service users in the service. See Appendix II for further information.

4.3 Discussion on analysis of the Mental Health Quality Framework (2007)

4.3.1 Political factors

Political factors influenced the framework standards through structural, organisational and community based services including the therapeutic environment. Service planning and service users were presented in clinical processes and corporate governance. Structural factors were often neglected due to lack of funding. Specialist older adult mental health community teams and structures were recommended as the predominant model with separate functional and dementia wards for older adults. This had structural implications in overcoming the challenge of striking a balance between providing a therapeutic environment and minimising risk. Design considerations were recommended and require more attention in a new framework, particularly in relation to later life care (Murray 2019). The complexity of healthcare environments posed challenges to the evaluation of interventions as failure to implement interventions well may have detrimental impacts on the effectiveness of evidence-based practices (Parolini et al. 2019).

Community mental health organisations are critical to sustainable quality care delivery (Horwitz 2019). Despite the compelling logic for integrating care for people with serious mental illness, there is also need for quantitative evidence of results as integrated care can make a significant difference in rates of preventive care, health, and cost-related outcomes for people with serious mental illness and community-based mental health care. Programmes that are informed by therapeutic and case management principles may be most beneficial (O'Donnell et al. 2020). There is a growing interest in sustainability, but its definition and the factors that affect it are not well understood (Holttum 2019).

Healthcare systems devoted significant resources towards collecting data to support care quality and improvement. National clinical audits (NCA) contributed to these objectives by providing public reports of data on healthcare treatment and outcomes, but their potential for QI in particular was not realised fully among healthcare providers and requires more focus in a new framework (McVey et al. 2021). Clinical audits should underpin everything clinicians do to constantly evaluate and improve clinical practice. Errors in practice, suboptimal practice or inefficiencies can occur in any part of the health-care system, despite the training and best intentions of health-care professionals (Skull 2020). When designing health care practices and programmes to be patient and family-centred, parents of children bring valuable viewpoints and experiences to health professionals and promote a patient centred environment. These factors should be included in a new framework (Schnell et al. 2020). Individuals with borderline personality disorder are high users of mental health treatment services. A stepped care approach may help to triage clients and allow access to interventions with minimal client, clinician and system burden, suggesting that specific organisational and individual factors may increase timely and efficient implementation of interventions for people with personality disorders (Pigot et al. 2019). See Appendix II for further information.

4.3.2 Environmental factors

This dimension of the general environment represents the demographic characteristics, norms, customs and values of the population within which the organisation operates. Environmental factors have come to the forefront relatively recently. Growing awareness of the potential impacts of climate change is affecting how companies operate. This has led to many organisations getting more involved in practices such as corporate social responsibility and sustainability (Whittle et al.

2018; Silva et al. 2020). Some environmental factors were mentioned in the existing framework standards but require greater attention in a new framework. Access to services was a consistent theme throughout the framework standards. Access requires significant approaches in a new framework. See Appendix II for further information.

4.3.3 Social factors

PESTLE analysis demonstrates that many of the factors recognised as social are mentioned briefly in the 2007 standards framework. PESTLE analysis also acknowledges that many of the social factors not recognised in PESTLE are new and have come to the fore in mental health services and care since the Quality Framework was developed in 2007. These new social factors relevant to a mental health service are identified from the evidence review developed for the new Framework. Barriers identified from PESTLE include sociodemographic and clinical factors (Silva et al. 2020). Ethical and cultural dimensions are important factors in adult, adolescent and later life mental health care. Inequalities in mental health were documented in the framework using individual social statuses such as socioeconomic status (SES), racial, ethnicity, refugee, underserved and migration status (Goodwin et al. 2018). Whilst many of those concepts were mentioned in the national framework (2007) they were in infancy at the time the framework was published. See Appendix II for further information.

Research indicates that inequalities exist relating to navigating the system, mental health stigma, language barriers and few culturally competent providers. Collaborative efforts across stakeholders are called for to address the mental health needs of racial and ethnic minorities (Torres Stone et al. 2020). The lived experience of individuals with intellectual disability, LGBTQ+, mothers and infants and older persons are briefly presented in the framework. A new framework needs to highlight the importance of being able to access and utilise services in an equitable and efficient manner (Bartram and Stewart 2019, Butz et al. 2019, Drake and Wallach 2020). In mental health services recovery constitutes a guiding principle that is endorsed in professional medical guidelines and has become central to mental health policies across the world and needs inclusion in aspects of care (Gaine et al. 2021, Khan and Tracy 2021). Recovery is mentioned in the framework. More emphasis on the users' right to be involved in key decisions of their care is needed (Brunner and Plotkin Amrami 2019, Hanson et al. 2019, Rioli et al. 2020).

Travellers are a minority ethnic group who experience a high prevalence of mental health problems (Kearns et al. 2019), and a rate of suicide six times higher compared to the general Irish population (Villani and Barry 2021). Refugee and immigrant families face access problems, resettlement stress, distrust of authority and power, stigma of mental illness, and language and cultural barriers which according to Ellis et al. (2020) need to be attended to. The LGBTQ+ communities are often faced with stigma and discrimination. Lesbian, gay and bisexual (LGB) individuals experience higher rates of mental health difficulties in comparison to their heterosexual counterparts (Plöderl and Tremblay, 2015). Such areas are mentioned in the framework but need greater depth. As suicide rates rise in many countries, it is important that community and hospital mental health providers are able to assess for suicide risk among individuals with mental illness (Díaz-Fernández et al. 2020, Ponce et al. 2020). Relevant social factors relate to recovery, lifestyle, health consciousness, wellness, wellbeing, lifestyles and lifestyle attitudes, and although mentioned in the national framework (2007) need to be included in greater depth in a new framework. See Appendix II for further information.

4.3.4 Technology

Technological factors pertain to innovations in technology that may affect the operation of the organisation or service in a positive or negative manner. This refers to technology incentives, the level of innovation, automation, research and development (R&D) activity, technological change and the amount of technological awareness that a society or organisation possesses. These factors may influence decisions to launch or not launch certain products or services. Technology was in its infancy when the Quality Framework (2007) was developed, so it is recognised that telehealth or digital use would not be included in the framework. PESTLE analysis identifies this lack and as a consequence several recommendations for action are presented that are based on PESTLE analysis and the evidence search undertaken for the development of the new Framework. Telehealth is growing in community mental health and growth is expected to continue throughout all services (McClellan et al. 2020). Telehealth-based services were recognised in the framework standards and it is expected that innovations and services will be introduced into the new framework standards in greater depth. There are a number of effective and cost-effective e-health applications available for treating persons with mental health illness in community and clinical settings (Myers and Comer 2016, Rowntree and Feeney 2019, Pithara et al. 2020). Barriers and negative clinician attitudes to telehealth acceptance were identified in the literature and include concerns over telehealth safety, reliability and security. These factors need to be addressed in particular in relation to software and equipment usability and associated costs in new standards (Cliffe et al. 2020). Use of specific telehealth Initiatives, include SMS reminders, social media, smart phone Apps, mobile, computer and internet, video game use, video conferencing and Photo Voice all have a significant role in mental-health tele-health and need to be considered in new standards (Australian Mental Health Framework 2014, Kjelsaas et al. 2019, Anyaegbu 2021). See Appendix II for further information.

Many smartphone applications (apps) for mental health (MHapps) are producing positive results for patients, families and staff indicating that tele-psychiatry is a realistic option for community mental health services and for inclusion in new standards (Zulfic et al. 2020, Mahmoud et al. 2021). An innovative mobile digital care pathway tool is being piloted to facilitate coproduced recovery-focused care planning (Pithara et al. 2020). New digital and technological advances need to be explored with a view to implementing innovative techniques into mental health services. See Appendix II for further information and Recommendations for further information.

4.3.5 Legal factors

PESTLE analysis indicates that relevant mental health acts, immigration laws, employment laws, consumer protection, and health and safety laws were adhered to in the framework standards. Organisations need to know what is and what is not legal in order to deliver services successfully and ethically, and managers need to be aware of any potential changes in legislation and the impact it may have on their organisation and services delivery in the future. Individual right's, will and preferences are important elements influencing mental health care delivery. These concepts were mentioned in the framework standards and require inclusion in a new framework. However, understanding of coercion amongst mental health professionals is underdeveloped, suggesting adoption of the least restrictive principle, by extending non-coercive measures in relevant mental health areas needs consideration (Gooding et al. 2020, Ross 2020).

An underdeveloped area in the framework standards relates to care for people with serious illness who became part of the criminal justice system as this requires mental health professionals to

exercise judgement and adhere to legislation (Morris 2020, Hwang 2020) including community treatment orders (CTO's) (Levy et al. 2018). Transition from institution to community initiative poses difficulties for adult and young people with serious mental disorders (Adily et al. 2020) and professionals working in forensic services need to develop sustainable therapeutic relationships (Mellor 2020). New standards need to adhere to the nation's legal and professional laws to ensure the safety of the patients and persons served, thus avoiding and reducing mental distress and legal costs. See Appendix II and recommendations for further information.

4.3.6 Economic discussion

Economic factor analysis identified that the majority of factors, although important, are not applicable to mental health services to a large extent. Framework standards that are applicable to mental health services identify funding and budgeting as the main economic and mental health drivers for delivery of quality services along with recruitment and training of staff. Quality needs to be included in the new framework from the perspective of audit, assessment and delivery of quality care, implementation and evaluation of the services delivered. A framework to audit nursing care to prevent harms and ensure safety will ensure that assessments of, for example skin integrity, mobility, pain, continence, nutrition and cognition (delirium, depression and dementia) is undertaken (Redley and Baker 2019). Advance care planning (ACP) is fundamental to guiding care at the end of life. An economic framework for understanding and quantifying the economic effects of ACP is recommended (O'Hanlon et al. 2018). The use of clinical performance feedback, known as Audit and Feedback (A&F), to support QI activities is based on the rationale that measurement is necessary to improve quality of care and this area needs to be included in a new framework (Weske et al. 2018, Hackett and Strickland 2019, Skull 2020). The need for appropriate oversight for QI that builds equivalence with research oversight is proposed and recommended (Naughton et al. 2020). Also recommended is an evaluation framework to validate the performance of an auditing tool designed from clinical and non-clinical staff perspectives (Yesmin and Carter 2020). See Appendix II and recommendations for further information.

5. Review of Mental Health Care Concepts

5.1 Legislation

The Quality Framework (2007) 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, 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 MHC [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 (MHC, 2007).

5.2 The Office of the Inspector of Mental Health Services

The Office of the Inspector of mental health services is made up of the Inspector of Mental Health Services and a multi-disciplinary team of Assistant Inspectors with whom the Inspector works to visit every approved centre each year, to ensure that mental health services are providing quality care and treatment in line with the law. An Approved Centre is a hospital or in-patient service that is registered by the MHC. The inspector publishes the findings every year in the MHC's annual report. As required by the Mental Health Act, 2001 the Inspector is a Consultant Psychiatrist. The team includes professionals from the following backgrounds: Clinical Psychology, Nursing, Occupational Therapy, Psychiatry, Service Users and Social Work (MHC, 2007).

5.3 Functions of the Inspector (Section 51 of the 2001 Act)

The functions of the Inspector are to visit and inspect every approved centre in the State at least once in each year and as appropriate to determine: the quality of care and treatment given to persons in receipt of mental health services, the degree and extent of compliance by approved centres and other such deemed necessary. Following the review of mental health services the Inspector will furnish a report in writing to the MHC on the quality of care and treatment given to persons in receipt of mental health services. The Inspector will ascertain, pursuant to any inspections carried out of approved centres or other premises where mental health services are being provided, the degree and extent of compliance by approved centres with any code of practice prepared by the MHC under section 33(3)(e) and such other matters as he or she considers appropriate to report on arising from his or her review (MHC, 2007).

5.4 The Assisted Decision-Making (Capacity) Act 2015

Decision Support Services (DSS) are an essential service for all adults who have difficulties with decision-making capacity. This may include people with an intellectual disability, mental illness or acquired brain injury, as well as people with age-related conditions who may need supports to make decisions. Estimates suggest that there could be as many as 220,000 people living in Ireland who have capacity related difficulties and who may become users of the DSS. Based on the above figure, it is estimated that one in 20 adults could have an active arrangement registered with the DSS, and that one in every two people will interact with the DSS in their lifetime (Flynn 2020). Under the provisions of the 2015 Act, the remit of the MHC was extended to include the establishment of the DSS. The DSS is now one of four functions of the MHC. Although it is not confined to mental health, the DSS has found a natural home in the MHC as it has vital experience of setting up innovative

structures under reforming legislation to deliver on a human rights agenda. The Director of the DSS sits on the Executive of the MHC. The 2015 Act is a significant piece of reforming human rights legislation which provides a modern statutory framework for supported decision-making. The Act reforms Ireland's capacity legislation, which has been in place since the 19th century, by establishing a modern statutory framework to support decision-making by adults who have difficulty in making decisions without help (Saunders, 2020).

The Irish Health Services Accreditation Board was established via Statutory Instrument in 2002 by the Minister for Health and Children to operate acute hospital accreditation programmes and to grant accreditation to hospitals meeting standards set or recognised by the Board. The Health Bill (2006) established HIQA. The functions of HIQA, as stated in the Health Bill 2006, shall not encroach on the statutory functions of the MHC [Health Bill 2006, Head 9(2)]. The 2015 Act repeals the Marriage of Lunatics Act 1811 and the Lunacy Regulation (Ireland) Act 1871. The Assisted Decision-Making (Capacity) Act (2015) abolishes the current wards of court system and replaces it with a modern, person-centred framework to maximise autonomy for people who require support to make decisions about their personal welfare, property and financial affairs. The MHC provides up to date information to the public about the ongoing implementation of the DSS and the 2015 Act. The full commencement of the 2015 Act is essential for Ireland to become compliant with the United Nations Convention on the Rights of Persons with Disabilities, which was ratified by the State in March 2018. Those who work with people who would benefit most from the establishment of the Decision Support Service have also welcomed the new website (Saunders, 2020).

Judgements were made by the European Court of Human Rights (ECtHR) involving persons with Schizophrenia. Wigand et al. (2021) analysed judgements made by the ECtHR involving persons with schizophrenia in 105 judgements originating in 29 countries. Article 5 (Right to liberty and security) of the European Convention on Human Rights was ruled by the ECtHR to have been violated in 46 % of judgements, Article 3 (Prohibition of torture) in 20%, and Article 8 (Right to respect for private and family life) in 19%. These findings demonstrated inadequate access to mental health care, especially in prisons, during police operations, involuntary confinement, detention and ill-treatment and were deemed a risk factor for psychosis. The right to family life and other competing rights such as the rights of others, extradition/expulsion and protection of other persons' human rights against violent behaviour by persons with schizophrenia need consideration. The judgements suggest that even though the ECtHR has a balanced view on involuntary confinement, national legislation and internal hospital guidelines should be written in a manner to help maximise human rights.

5.5 Quality in mental health care and healthcare (National and International Context)

Ireland has adopted a strategic approach to mental health reform that includes a range of coordinated quality and recovery initiatives. This approach provided a foundation for engaging government, health care organisations, the MHC, clinicians, service users and carers in developing quality and outcome measurements. This coordinated model involves a range of interconnected initiatives linked to quality and recovery initiatives over time (MHC, 2007). Several bodies and organisations were developed to support quality and healthcare in Ireland. Quality dimensions have been put on the agenda for health and social services by the Department of Health, including the MHC Judgement Support Framework (MHC 2017 Version 4), the HSE and HIQA.

The HSE (2017) Best Practice Guidance for Mental Health Services supports clinicians in meeting regulatory requirements and continuous QI's and ensures that children and adults in the care of mental health services receive a high quality, safe service that meets their needs (HSE, 2017). This Best Practice Guidance is one composite document that includes: The Mental Health Act (2001) as amended, Statutory Instruments, Rules, Regulations and Codes of Practice, the MHC Quality Framework (2007) and the MHC Judgement Support Framework (2017 Version 4). The Best Practice Guidance document also includes other national legislation, HSE policies and procedures and national and international best practice. The Co-Production in Practice Guidance is a principles based document, developed to support mental health services in the implementation of the National Framework for Recovery in Mental Health (2018-2020), launched in 2017, in Ireland. The Framework aims to strengthen the delivery of a quality person-centred service and to provide mental health services with a practical guide to co-production in practice. The principles within the guidance document are reflective of the current mental health quality and safety agenda, mental health legislation and service user expectations and provides a basis for better governance in planning and managing services, measuring improvement, identifying and addressing gaps, areas of concern or deterioration in the quality and safety of the services provided. HIQA and the MHC "jointly developed these standards to promote improvements in how services conduct reviews of patient safety incidents and intend to set a standard for cohesive, person-centred reviews of incidents" (MHC 2020).

HIQA and the MHC have also developed national standards for adult safeguarding in health and social care services and associated rules (MHC 2020). The MHC assessed a number of areas during 2020/21. These included National Standards for Mental Health Services, codes of practice, rules, guidance documents, toolkits, consultations, e-learning resources, protected disclosures, data activity, mental health tribunals and legislation. In 2022, new guidelines pertaining to physical and mechanical restraints and seclusion in mental health care were developed by the MHC.

5.6 Recovery in mental health care –The national context

The National Framework for Recovery in Mental Health, launched on the 20th November 2017, builds on the committed efforts in recent decades of Irish service users, family members, carers and service providers to develop a more recovery-oriented mental health service that is worthy of those who use and provide that service. The Framework was developed based on current understanding of recovery and how mental health service provision supports recovery and was co-produced. The National Framework for Recovery in Mental Health is for service users, family members and carers, mental health service providers and the voluntary and community sector. It will facilitate the development of programmes on Recovery. Supporting documents relating to the Framework, National Framework for Recovery in Mental Health and measures outlined in the Framework, short version of the Framework, the Family Recovery and Co-Production in Practice Guidance Document (2018-2020), Family Recovery Guidance Document and Recovery Education Guidance Document are available in the National Framework for Recovery in Mental Health website.

5.7 Wellness and well being

Community care is increasingly becoming the mainstay of mental healthcare provision in many countries and patient satisfaction is an important barometer of quality of patient care. Healthy lifestyle interventions including wellness are recommended to reduce smoking, improve nutrition

habits and improve other health behaviours of people living with serious mental illness (de Vos et al. 2017, Bardone-Cone et al. 2018, Baker et al. 2019). One approach to improving the availability of these types of interventions is to utilise the mental health peer workforce. A further wellness strand relates to the need to develop a new treatment paradigm in mental health that emphasises employment. Supported employment is an evidence-based intervention that can help the majority of people with mental health disability to succeed in integrated, competitive employment. Employment engenders self-reliance and leads to self-confidence, the respect of others, personal income and community integration (Drake and Wallach 2020).

The benefits of exercise, music and theatre were explored from several perspectives including the importance of healthcare assistants in delivering exercise programmes in secure mental health units where they are considered integral to exercise promotion as they are considered as being intimately involved in the daily lives of patients (Kinnafick et al. 2018). The role of music was considered to be beneficial in reducing distress in people with mental illness (Fingleton, O'Connor, Stynes 2018). Just one study relating to Patient and Public involvement (PPI) PPI-specific programmes in mental health was found (Frawley et al. 2019). The Irish national mental health service provider commissioned a national training programme to support a PPI initiative across nine regional administrative units in mental health services. Participants believed that such programmes should include understanding about how conflict is resolved, how committees work effectively and how to develop interpersonal and facilitation skills (Frawley et al. 2019).

6. Frameworks, audits, toolkits in mental health

Frameworks were explored in the literature from several perspectives: quality, ethics, clinical and through consolidation of frameworks and audits, and A&F. Healthcare providers explored quality from the lens of e-health. A study undertaken in five English NHS hospitals, explored the perceptions of 54 members of hospital boards and their quality committees on their use of NCA data. Findings indicate that the hospitals' governing bodies perceived that an imbalance existed between the benefits to their institutions from the use of NCA data and the losses recorded. Participants perceived the substantial resources consumed by participating in NCA's resulted in many questioning the audits' legitimacy (McVey et al. 2021). There is also insufficient evidence to measure how national e Health strategies and their implementation are evaluated and monitored, as most approaches aim to measure at the micro level. Tsai and Koch (2019) use the Swedish National eHealth WHO-ITU National eHealth strategy toolkit to build an evaluation and monitoring framework for national eHealth, to identify e Health outcomes and outputs and to combine outcome and output indicators to support comprehensive measurements of e Health in Sweden. In gaining understanding on the perceptions of physicians on audit and data interaction, Kamhawy et al. (2020)(n=15) identify the factors that affect physicians' experiences of receiving and interacting with practice data by designing a framework to examine their academic and administrative structures and by interfacing with performance feedback systems.

6.1 National clinical audits quality integrated ethical frameworks

Naughton et al. (2020) examine international approaches to the ethical oversight and regulation of Quality Improvement (QI) and clinical audit in healthcare systems with data extracted from 19 National guidance documents, using an a priori framework from six countries: Ireland, England, Australia, New Zealand, USA and Canada. Findings demonstrate a need for appropriate oversight and responsive infrastructure for QI that is underpinned by ethical frameworks and research oversight. Results reflect that an accredited quality and patient safety management audit system was being undertaken in hospitals. Tan et al. (2019) (n=163) explore data quality audit of a clinical quality registry of the Australian and New Zealand Hip Fracture Registry and found that regular audits of data abstraction were needed to guarantee the integrity and credibility of registry outputs. Integrity and compliance were also monitored by Weske et al. (2018) in identifying that compliance with obligatory rules and regulations was determined by using the internal audit system.

6.2 Audit and feedback consolidated frameworks

Concerns persist about the reliability of A&F to support QI's successful implementation. A&F should reflect an iterative, self-regulating QI process (Wagner et al. 2017). The Consolidated Framework for Implementation Research (CFIIR) was used by Wagner et al. (2019) with (n=25) individuals, representing 18 primary care teams, in Canada. Results indicate that implementation reflected an incomplete feedback loop, suggesting that the potential mechanism of action of A&F may be deceptively clear but that moving from measurement to action can be complex in practice. To seek further clarity Cooke et al. (2018) (n=6), in an extension of previous work, develop a process for audit and group feedback for physicians and recommend that relationship, question choice, data visualisation, and facilitation, should be considered. The importance of non-specialist physicians in occupational health service delivery remains understudied and their competency requirements poorly understood. Lalloo et al. (2020) (n=200) evaluate the quality of non-specialist occupational health reports

and compare these with specialist reports. Findings demonstrate a consistently high standard of occupational health report quality. In a further UK study on A&F, a cycle of audit and barrier identification, using best practice guidelines called Method for using Audit and Feedback in Participation Implementation was described by Kolehmainen et al. (2020). Visual displays such as charts and tables may significantly moderate the effects of A&F interventions. Lee et al. (2020) (n=44) describe the content of visual displays in feedback interventions by recognising elements that offer empirical, theoretical, and design studies.

6.3 Audit and feedback in primary care settings

A&F in primary care settings remains underdeveloped. Globally, the problem of hidden harms to children of parents who use drugs and alcohol is recognised but is poorly understood in a community setting. In an Irish study, Galligan and Comiskey (2019) estimate the prevalence of children with potential hidden harms using the Framework (Drugs and Alcohol Dependency) Rapid Alcohol Problem Screen tool. Service providers highlight the need to improve interagency and interdisciplinary communication between drug and family services. In a further community audit, identification of hazardous alcohol use was found to be an important step in connecting individuals to treatment and child protective services. The Alcohol Use Disorders Identification Test (AUDIT) is a common screening tool in this setting. In a UK study, Seay and Feely (2020) (n=4009) examine the type and number of factors present in a sample of child protective services-involved parents. Results reflect that the two-factor AUDIT is appropriate for screening parents and should improve early identification and referral to treatment for this group with hazardous alcohol abuse. Yesmin and Carter (2020) designed an evaluation framework to obtain empirical evidence on the effectiveness of automated privacy auditing and for detecting anomalies for dynamic hospital workflows. However, the complexity of healthcare environments poses challenges to the evaluation of interventions as poor implementation can have detrimental impacts on the effectiveness of evidence-based practices. Parolini et al. (2019) described a theory-driven systems approach with advanced implementation frameworks that enables linkages between the implementation outcomes and their links to patient outcomes.

6.4 National clinical audits

Audits examine how clinical care is being provided and whether benchmarks are being met as well as identifying opportunities for improvement. Detection of problems is greatly improved when audits of practice are regularly undertaken and as part of a continuous process of QI (Skull 2020). NCA's are a well-established QI strategy used in healthcare settings. Alvarado et al. (2020), while recognising that significant resources, including clinicians' time are invested in participating in NCAs, acknowledged that the value of resultant feedback in stimulating QI's remains unknown. These researchers explored the reasons behind this variation and the mechanisms of provider interactions with NCA's. Limited evidence also exists regarding the impact of quality dashboards and A&F research on clinical and managerial teams. Randell et al. (2019) (n=54) researched the use of quality dashboards in the NHS and identified the need for staff to choose performance indicators, assess performance, identify causes, communicate from ward to board, and ensure data quality. These concepts have implications for the design of quality dashboards. The rate of audit completion in general surgery has not been investigated. Dunne et al. (2018) (n=39 audits) assess the rates of audit activity and completion and the barriers to successful audit completion in a multi-centre study evaluating current surgical audit practice. Findings show poor compliance and just seven audits completed to re-audit. Audit discharge was explored by Potent et al. (2020) through

identification and comparison with Australian standards of the performance of electronic discharge summaries from three hospital in-patient streams, including mental health. Key areas found for improving completeness of electronic discharge summaries were page length, discharge destination, alerts, patient education and recommendations.

6.5 Toolkits

Patient engagement is a key tenet of patient-centred care and is associated with many positive health outcomes. Keddem et al. (2020), in creating a web-based, interactive patient engagement toolkit to improve patient engagement in primary care in the USA, found that factors for successful implementation and dissemination include implementer engagement, organisational support and strong collaborators. Future toolkits need to highlight the type of facilitators necessary for successful implementation of toolkit content. The role of patients and families has evolved from being viewed as entities being told what to do, to consumers of health services, to being central to health system design and clinical decision-making. Schnell et al. (2020) applied the Patient Engagement in Redesigning Care Toolkit model. Results evidenced that engaging families at various levels of programme design and function produce patient-centred, value-based environments. Incorporating patient perspectives into clinical studies is important to the development of high-quality, safe, and effective fit-for-patient medicines, yet no accepted methodology to help design more patient-centred studies has been established systematically.

Elmer et al. (2020) discussed the Patient Experience Initiative designed to create tools to include the patient perspective into the design and implementation of clinical studies and indicates the importance of Toolkits to engage patients early in protocol development and to assess patient experiences during clinical studies. Value-based health care is accompanied by ambiguity concerning the meaning of the concept. In a study undertaken in the Netherlands, Steinmann et al. (2020) (n=23) builds on discourse analysis to map the ambiguity surrounding VBHC. The study reveals that VBHC's conceptual ambiguity arises mainly from differing and often deeply rooted presuppositions which frame different perceptions on ‘Value’ in health care and that recognition is needed when studying, implementing and evaluating VBHC.

6.5.1 Toolkit Implementation

Greater specification of implementation strategies is a challenge as there is little guidance for identifying the use of multiple strategies involved in complex interventions. The Cardiovascular Toolkit project is designed to reduce cardiovascular risk and is mapped and implemented across four phases: pre-conditions, pre-implementation, implementation, and maintenance and evolution. Mapping reveals patterns in the timing of implementation strategies. Huynh et al. (2018) recommend strategies that are developed within complex multi-level interventions, in support of rigorous evaluation and sound implementation research. A toolkit to facilitate implementation can increase the use of evidence-based interventions. Most available toolkits provide resources about the intervention but lack guidance for adaptation to different contexts or strategies to support implementation (Thoele et al. 2020). To address this implementation problem Thoele et al. (2020) developed and used a toolkit to guide the implementation of an evidence-based intervention. The aim was to identify and intervene for people with risky substance use with data obtained from investigators and site coordinators, from 14 acute care hospitals. The final toolkit included 54

different tools that may be used to create resources for the implementation of other evidence-based interventions, in varied settings, and mental health conditions.

To incorporate the effects experienced by carers providing informal care to family members, carer-related preference-based measures are developed for use in economic evaluation, which include the Adult Social Care Outcomes Toolkit for Carers (ASCOT-Carer), Carer Experience Scale (CES), and Care-Related Quality of Life (CareRQoL). Engel et al. (2020) (n=351) investigated the extent to which these three instruments measure complementary or overlapping constructs using survey data received from carers residing in Australia. Although some overlap was observed, the 3 carer-related preference-based measures appeared to tap into different constructs of carer-related quality of life and caring experiences and cannot be used interchangeably. It is expected that the Toolkit being developed for a new Quality Framework for the delivery of mental health services in Ireland will add to the existing body of knowledge in this area.

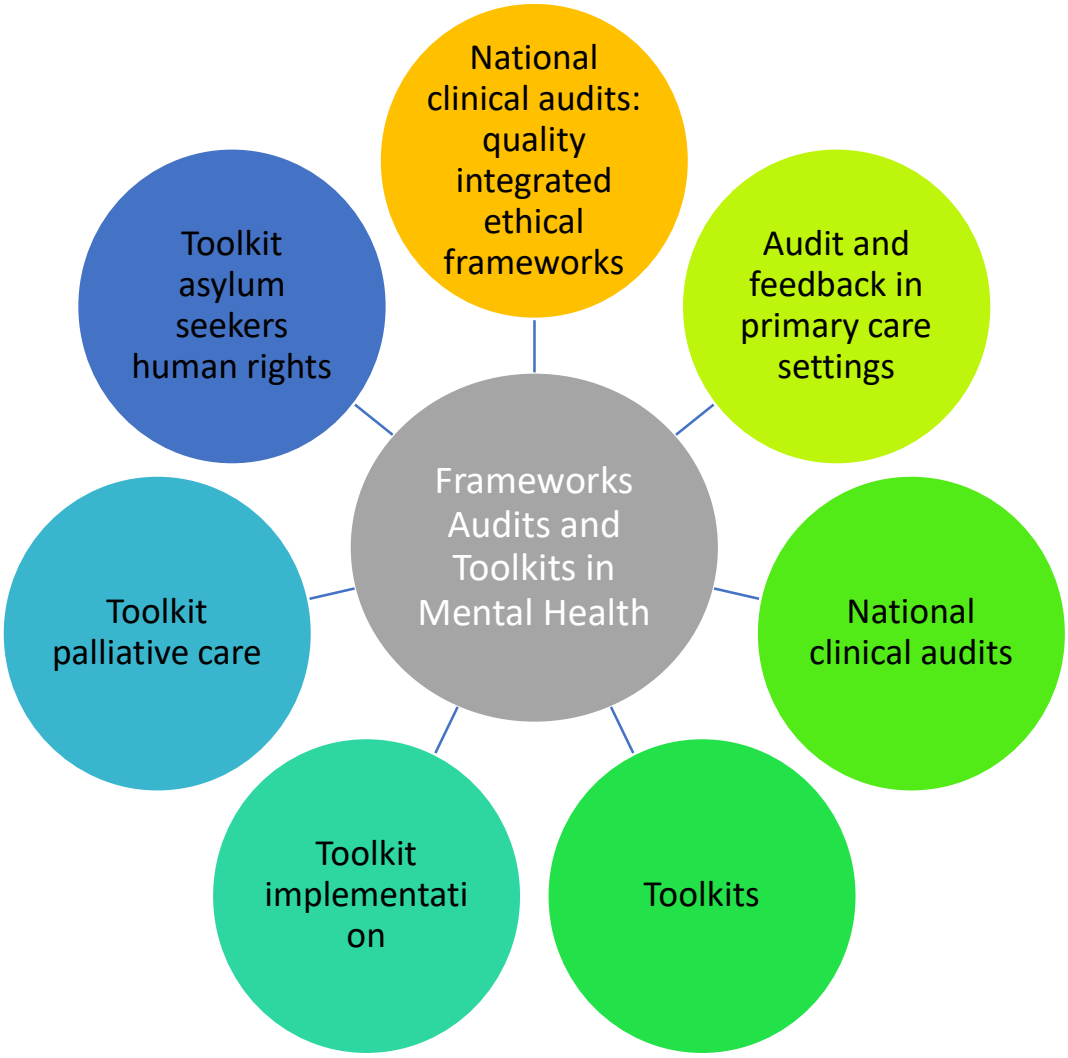
6.5.2 Toolkit Palliative Care

Few community cancer centres offer early palliative care for patients with newly diagnosed advanced cancer and their family caregivers. Zubkoff et al. (2018) (n=4) implement an early concurrent palliative care Toolkit model: ENABLE (Educate, Nurture, Advise and Before Life Ends) in four centres to assist the centres in integrating early palliative care for those patients. The model is guided by the RE-AIM Framework (Reach, Effectiveness-Adoption, Implementation and Maintenance) and instrument-development that is based on the literature, expert and site stakeholder review and feedback, and pilot testing during site visits. Four instruments developed to measure ENABLE implementation will be integrated into a comprehensive "toolkit" to meet the study aims and to support the transfer of best practices. Toolkit development poses challenges that need to be addressed if being used in the field of assessment. Education leaders in hospice and palliative medicine developed the Hospice and Palliative Medicine Toolkit of Assessment Methods and propose strategies to strengthen and standardise future assessment. It is expected that implementation in this setting will provide the highest quality patient and family-centred care in serious illness and which also may be appropriate for use in other settings, for example in mental health care (Morrison et al. 2020).

6.5.3 Toolkit Asylum Seekers Human Rights

Forced migration has reached a peak worldwide and healthcare professionals are increasingly volunteering with medical human rights programmes. The Mount Sinai Human Rights Program (MSHRP) provides pro bono forensic medical, gynaecological and psychological evaluations to document evidence of human rights abuses experienced by asylum seekers. MSHRP refined its workflow and processes to facilitate the coordination of 305 forensic asylum evaluations and 117 continuity care referrals (2015-2018). This resulted in a toolkit that includes data management tools, changes to asylum clinics and service delivery thus meeting the demand for forensic medical evaluations of asylum seekers and appropriate continuity of care (Ruchman et al. 2020). See Figure 2 and Tables: I, II and III in Appendix I for further details on these areas. Recommendations are also suggested.

Figure 2: Frameworks, audits, and toolkits in mental health



6.6 Quality in mental health care

Mental health services prevent and treat mental disorders and in this way maintain, improve, and restore the mental health of the population. There are a number of different approaches to QI, but one leading models was critiqued, 'lean thinking' (also known as 'lean methodology' or simply 'lean') and exploration of its application in mental healthcare (Boland 2019).

QI approaches are firmly established in mental health services in the UK's National Health Service. A QI initiative to examine challenges in the delivery and effectiveness of evidence based treatments (EBT) to World Trade Centre responders who had received care through a Centre of Excellence, was discussed by Bellehsen et al. (2019). Methodology for evaluating and improving the quality of mental health services and the related qualitative and quantitative indicators were identified by Samartzis and Talias (2019). It is acknowledged that existing definitions and measurement approaches to quality of health care often fail to address the complexities involved in understanding quality (Agarwal et al. 2019a,b), mainly due to the perceptions of quality, rather than to clinical indicators of quality, as quality cannot be understood outside social norms, relationships, trust and values (Hanefeld et al. 2017). Care coordination is identified as the integration of care across different providers and treatment settings. Gaebel et al. (2020) focused on care coordination in an update of a previous European Psychiatric Association guidance on the quality of mental health service's in which fifteen recommendations for practice are provided.

Health professionals perceive the quality of care they deliver as high and that good relationships existed with families (Moen et al. 2021), however it was also recognised that the quality of care and subsequent outcomes remained suboptimal for those suffering from mental health illnesses. Increased access to mental health care is associated with improved outcomes, including decreased suicidal behaviour (Pyne et al. 2020). The quality gap in mental health service was perceived to exist in Australia where mental health systems sought to address this gap through focussing on service reform and quality under standard clinical practice guidelines (Jorm et al. 2015). Definitions of care quality that incorporated data from Service Provision Assessment surveys identified that results offered valuable insights to strengthen the existing body of knowledge on quality of care (Moucheraud and McBride 2020).

In conclusion, findings show that quality was a widely discussed concept found in the research papers evaluated. Papers focused on access, measuring quality from a conceptual view, QI's initiatives, monitoring community health workforce domains and performance, professionals' perceived quality of care, family involvement and sense of coherence and quality gaps. Identification of access and negotiation were the most widely discussed stages in terms of barriers to care with the least discussed stage being negotiation. See Table IV in Appendix I for further details on these areas. Recommendations are suggested.

7. Recovery in mental health

The meaning of Recovery remains unclear and ambiguous (Australian Mental Health Recovery Framework 2014, Pincus et al. 2016, Giusti et al. 2019, Egeland 2021). In mental health services recovery constitutes a guiding principle that has become central to mental health policies. In its concept state *Recovery* can be a challenge for clinicians to successfully embed into professionally directed treatment (Khan and Tracy 2021). Embedding the principles of recovery-oriented practice into care will be supported by providing recovery education and training for staff and by the promotion of active service user engagement (Nardella et al. 2021). An Irish study proposes coaching as a mechanism or strategy to make the philosophy of recovery a reality in mental health practice (Mc Sharry and O' Grady 2021). However, attempts to identify pathways to health improvement in a community-led empowerment initiative, engaged in the Big Local programme in England, indicates that there is no clear single pathway leading to mental health improvement (McGowan et al. 2019). Care Planning addresses concerns about safety and fragmented community mental health care. These concerns led to the development of the care programme approach in the UK that requires service users to have a care coordinator, written care plan and regular reviews and education and training for staff that is designed to enable personalised, recovery-focused care (Simpson et al. 2016). For mental health practice to become more recovery-oriented, consensus on what constitutes well-functioning recovery must be reached by patients, practitioners and researchers alike (Bitter et al. 2019).

7.1 Recovery models and outcome measures in recovery

Empirical research on the outcomes and psychological mechanisms of Recovery remains underdeveloped. The recovery model in mental health care emphasises users' right to be involved in key decisions on their care, including choice of one's primary mental health professional (PMHP) and being able to change a PMHP if desired (Rioli et al. 2020). The Partners in Recovery Australian programme identifies how changes in unmet needs influence recovery (Hancock et al. 2018) and Open Dialogue, an innovative approach to mental health care with in-patient young adults in Australia emphasises family involvement, flexibility, interdisciplinary and collaboration. Yet even though staff members were supportive of Open Dialogue, the focus on economic efficiencies hindered progress (Dawson et al. 2021).

In recent years, mental health services and programmes throughout Australia have adopted different conceptual models for helping staff to understand personal recovery processes and how they might enable and support personal recovery. While this national framework is not seeking to standardise the use of particular models, they highlight four processes involved with personal recovery as finding and maintaining hope, re-establishment of positive identity, building a meaningful life and taking responsibility and control (Australian Mental Health Recovery Framework 2014).

Recovery outcomes were explored from the perspectives of CAMHS, children, ethnic minorities and persons with enduring mental illness. Few studies reported recovery outcome metrics for CAMHS. A UK study, investigated reliable change and recovery rates for treatment as usual, provided by one community CAMHS and found that half of young people reliably improved on at least one routine outcome measure (Gibbons et al. 2019). Findings from a study of a measure of recovery: Hope, Agency and Opportunity indicate that cultural behaviours had greatest impact on recovery (Bowen et al. 2020). A US study examining social factors including limited literacy found that even though

literacy was not a predictor of recovery, further research should examine the relationship between social supports and literacy (Garverich et al. 2021). In assessing ethnic minorities, the CHIME Framework (connectedness, hope and optimism, identity, meaning, empowerment), as a recovery-oriented intervention, demonstrates that the stigma surrounding mental illness is a key challenge to the recovery experience and that providing culturally appropriate services could be viewed as a human right issue for minority groups (Sofouli 2021).

Findings from a US study, undertaken with participants with a diagnosis of a psychotic or mood disorder, indicate that recovery may be influenced not only by symptoms, but by social and environmental circumstances (Compton et al. 2020). Studies exploring personal recovery processes on well-being among individuals with schizophrenia spectrum disorders, found that recovery is a multidimensional concept that includes symptomatic, functional, social and personal recovery (Chan et al. (2018). A study undertaken in Holland, with people with a psychotic illness indicates the psychosocial, social and biological determinants of personal recovery (Van Aken et al. 2021). In a specific situation, sociocultural milieu may promote recovery from anorexia nervosa amongst young women as this condition increases social withdrawal and recovery and leads to re-engagement with resultant meaningful relationships (Allison et al. 2021).

7.2 Recovery and quality of life

Recovery and quality of life is explored from several perspectives including disclosure. Disclosure impacts on quality of life and recovery disclosure, especially with family, may improve quality of life and recovery of people with mental illness (Mayer et al. 2021). Findings indicate that the relationship between functional recovery and quality of life treatment outcomes in patients affected by schizophrenia increases as functional recovery levels increase and that offering empowerment-oriented care services may be more effective than global function improvement in recovery for this group (Ertekin Pinar and Sabanciogullari 2020). A Norwegian study indicates that nursing practices may improve functional recovery levels and 'hope for recovery' by focusing on patient needs and on their coping and empowerment skills in addition to providing practical assistance (Biringer et al. 2017). Other studies found that depressive symptoms and personal functioning negatively or positively affect the subjective quality of life of patients with serious mental illness and in rehabilitation (Dürr and Lunde 2020, Beentjes et al. 2021, Zhang et al. 2021). Piat et al. (2021) used the best-fit framework synthesis method to explore recovery orientation.

7.3 Family and community initiatives

Family centred conversations focussing on how family members can be supportive to each other were explored in a family nursing intervention, with young people in Norway. Findings indicate that health care professionals can play an important role in facilitating a safe environment by talking openly about the experience of living with, and managing, mental health illness (Aass et al. 2020). A study exploring the interrelationship between mental well-being and mental distress in young people found that a relationship existed and also that recovery-oriented practice takes place in organisational environments that influence an individual's recovery (Bauer et al. 2019). To meet the needs of families involved with child protective services due to substance abuse, a model developed in the USA highlights elements of family-focused practice that allows children to remain safely at home with parents who are in treatment (Hanson et al. 2019). At the other end of the spectrum the psychiatric problems and their associated mental health utilisation by students in recovery from addic-

tion in collegiate recovery communities (CRCs), in the USA, suggests that a significant number of students in CRCs had additional psychiatric problems that required professional mental health services (Giggie et al. 2021).

7.4 Recovery health life style interventions

Research shows that studies explore recovery interventions from the perspectives of lifestyle, physical and psychosocial outcomes, substance use disorder and eating disorder. Individuals with severe and persistent mental illness encounter both poorer physical health and psychosocial well-being in comparison to the general population. In examining the effects of interventions for physical exercise, nutrition and psychosocial outcomes in obtaining community mental health services, clients were found to have decreased anxiety and depressive symptoms and positive outcomes (Mechling and Arms 2019). Involvement in a Participatory Video project indicated that this intervention fostered recovery (Whitley et al. 2021). In a different context, Martin-Fernandez et al. (2022) discuss the current therapeutic work relating to alcohol abuse as being focused on relapse prevention or avoidance and the control of its determinants. They advise that since only a small portion of patients can access alcohol addiction treatment, it is crucial to find a way to offer new support towards reductions or cessations. The harm reduction (HR) approach and mental health recovery perspective offers another way to support the patient with alcohol addiction. Vitae is a HR programme that is based on the principle of psychosocial recovery for people with alcohol use disorders. From a publication perspective, specific recovery-related issues included a significant recovery research portfolio and use of mixed-methods rather than solely qualitative studies (Slade 2021).

In conclusion, recovery models seek to operationalise recovery by improving mental health in people with severe and enduring conditions. Empirical research on the outcomes and psychological mechanisms of recovery remain underdeveloped. Recovery outcomes were explored from the perspectives of CAMHS, children, ethnic minorities and persons with enduring mental illness. Few studies have reported recovery outcome metrics for CAMHS. Recovery and quality of life is explored from the perspective of functional recovery, expectation and hopes, and relationships and disclosure. Research shows that studies explore recovery interventions from several perspectives including lifestyle, psychosocial outcomes, substance use and eating disorders. Findings also indicate that health care professionals play a key role in facilitating a safe environment for those recovering from mental illness by talking openly about the experience of living with, and managing, mental health illness. See Table V in Appendix I for information relating to recovery in mental health care. Recommendations are suggested.

8. Wellness and wellbeing

Recovery, wellness and wellbeing are interwoven within studies but particularly within the Australian Mental Health Framework (2014). Wellness and wellbeing is presented in the literature from the perspectives of wellness, integrated community mental health services (ICMHS), patient satisfaction, patient wellbeing, wellbeing index, lifestyle social interventions, peer delivered and national training programmes and PPI. The key factors associated with patient satisfaction with community mental health services in England, that are based on the Care Quality Commission (CQC), reveal the need for service integration. Findings show that patients experiencing financial, accommodation, or physical health needs are not satisfied with services offered (Stamboglis and Jacobs 2020). Community MHSs incorporate family, community, professionals and social dimensions, yet little research on this area exists (Browne and Hurley 2018). The experiences of clients, family and staff (n=37) about the community life of people post-ICMHS suggest that the service could have positive clinical and social outcomes, but the results are inconclusive (Chiang et al. 2020). Stamboglis and Jacobs (2020) suggest that service users provide insights and clearer directions for research and practice development that include "timely support," "family presence," "better family relationships," "expanding social networks," "letting go" and "better self-efficacy and self-care".

The concept of psychological resilience refers to the ability to 'bounce back' after adversity. Brunner and Plotkin Amrami (2019) interweave four strands of explanation—political, scientific, technological, and cultural -to account for the success of resilience thinking that they recognise as being connected to wellness. Routines and rituals support habitual wellness. The Five-item World Health Organisation Well-Being Index (WHO-5) was used in an outpatient community mental health service to measure generic well-being and to examine the psychometric properties of the WHO-5 with (*n* = 191) adults. Patients with schizophrenia diagnoses reported higher wellbeing scores and patients with depression and personality disorders reported lower wellbeing scores, supporting the unidimensional structure of the questionnaire (Lara-Cabrera et al. 2020).

8.1 Lifestyle social interventions: peer delivered

Two studies were found identifying peer delivered intervention and employment. Kelly et al. (2020) (n=43) in an Australian study, evaluate the feasibility of peer-workers facilitating the delivery of an 8-session telephone delivered healthy lifestyle coaching intervention within community based mental health settings. Results show promise regarding the feasibility of peer-workers delivering better health choices. Employment is critically important in mental health care. Brucker and Doty (2019) measure agency staff attitudes about employment for persons with serious mental illness (n=2,218) in four community mental health centres, in the US. Findings showed that staff views on the benefits of work, the ability of clients to handle the demands of the worker role and client motivation to work were mixed.

8.2 Exercise, music and theatre

A secure mental health setting can exacerbate barriers to exercise, and facilitate physical inactivity and sedentary behaviour. Kinnafick et al. (2018) (n=11) explore healthcare assistants' perceptions of exercise and their attitudes to exercise promotion for adult patients in a large UK-based secure mental health hospital. Findings indicate that with education and organisational support healthcare assistants are well placed to identify individual needs for exercise promotion, thus leading to

successful person-sensitive interventions. Many mental health services users engage in potentially therapeutic amateur music practice, though the role of this in the maintenance of mental health is largely unexplored. Fingleton, O'Connor, Stynes (2018) (n=6) explore the application of psychoanalytic ideas to music-playing and provide suggestions for how this activity could sublimate distress. McCaffrey (2017, 2020) evaluate music therapy and explore the role and impact of group song writing with multiple stakeholders. Many mental health services have adopted a recovery-oriented rhetoric that acknowledges that those who use mental health services have acquired valuable expertise that should be used to inform health provision. McCaffrey (2018) (n=6) explores the lived experience of adult service users who have attended music therapy. Findings suggest that relating to meaningful occupation, challenge, reciprocity and frustration broaden understanding of what music therapy can offer to service users in statutory mental health services in Ireland.

8.3 National training programme

Little is known about PPI-specific programmes in mental health. The Irish national mental health service provider commissioned a national training programme to support a PPI initiative across nine regional administrative units in mental health services. Participants identify training topics of greatest importance to them and report on what they learnt and what helped their learning. Frawley et al. (2019) (n=54), in evaluating the PPI training programme, identify that participants believed that such training programmes, involving both professional and non-professional participants, require all participants to work together to achieve desired outcomes, in particular at the commissioning and design stages.

In conclusion, many mental health services have adopted a recovery-oriented rhetoric that acknowledges that those who use mental health services have acquired valuable expertise that should be used to inform health provision and promote recovery. Findings suggest that music has a part in recovery and that relating to meaningful occupation, challenge, reciprocity and frustration broadens the recovery armoury of mental health service users. See Table XIX in Appendix I for further details on these areas. Recommendations are suggested.

Figure 3: Quality in mental health care

8.4 Acute adult mental health care

Several researchers have identified access to mental health services and associated barriers (Bucci et al. 2015, Docherty and Thornicroft 2015**,** Vandewalle et al. 2016, Bartram and Stewart 2019, Butz et al. 2019, Whittle et al. 2019, Silva et al. 2020). Whilst access and barriers are mentioned in many studies, a few mention these areas specifically. Studies explored the sociodemographic and clinical factors associated with use and barriers to treatment, interventions and research studies. A Portuguese study found that the majority of participants with mental health illness accessing care were not treated and that treatment was more common among participants with mood disorders and disability and less common among single participants, those with basic/secondary education and among those accessing a first appointment (Butz et al. 2019, Silva et al. 2020). Income-based inequities in access to psychotherapy were found in Canadian and Australian mental health services studies, indicating that utilisation of psychologist services was more concentrated at higher income levels and unmet needs were inequitably delivered in both countries (Bartram and Stewart 2019).

Studies associated with severe mental illness (SMI), psychosis and first episode were identified from the search. Studies considered psychosis, schizophrenia, bi-polar and suicide. Psychotic symptoms are prevalent in clinical settings and in the general population (Berti et al. 2018, Chan et al. 2018, Góngora-Alonso et al. 2020). A study undertaken in Ireland (n=139) explored the frequency of self-reported psychotic symptoms among 2,542 outpatients at their first visit for mental health services. Findings from this study indicate that the difference between psychotic and non-psychotic psychopathologies is a function of the presence, frequency, and severity of psychotic symptoms (Ju et al. 2021). The Early Intervention in Psychosis (EIP) programme engaged patients in early assessment and phase-specific interventions Lalevic et al. (2019) found that patients experiencing their first episode of psychosis can successfully be treated in the community with appropriate professional and family support.

Individuals affected by psychotic disorders frequently disengage from mental health services and without a universal definition it is difficult to compare rates and factors leading to disengagement across studies (Reynolds et al. 2019). The Recovery Knowledge Inventory used in a Norwegian study revealed relatively low orientation towards recovery in areas which clinicians perceived as essential for recovering from mental illnesses (Egeland et al. 2021), yet the recovery process was found by individuals to be helpful when feeling overwhelmed by symptoms (Serrano-Ripoli et al. 2021). The perceptions of recovery, identity, and wellbeing among people with SMI attending recovery-oriented support groups was found to enhance personal recovery (Cruwys et al. 2020, Pelletier et al. 2020) and the Latent Change Score approach indicates that the initial levels and changes in personal recovery and sense of coherence were positively related to each other (Chiba et al. 2021).

Agitation among patients is a common and distressing behaviour across a variety of health care settings. Agitation is explored in the literature from a management and psychological distress perspective. Unless recognised early and effectively managed it can lead to aggression and personal injury. The experiences of mental health nurses (n=20) in recognising and managing agitation in an inpatient mental health setting are described as combining clinical knowledge, assessment protocols and training with information from patients allowing individualised assessment of agitation (Tucker at al. 2020). The Langner Symptom Survey examined differences in self-reported psychological distress in two samples of adults taken in 2005 and 2018 and found that more respondents from the 2018 sample reported current counselling compared to the 2005 sample and were almost twice as likely to be

classified as distressed and in need for treatment than their 2005 counterparts (Haeberlein et al. 2020).

8.5 Anxiety disorder and depression

Anxiety and depression are considered from the perspectives of recovery assessment, behavioural support, and treatment (Lewis et al. 2019). Findings from an Australian study (n=295) exploring the suitability of The Recovery Assessment Scale-Domains and Stages (RAS-DS) tool found that recovery is pertinent to individuals and that the short-form (RAS-SF) offers opportunity for routine measurement of recovery in populations with anxiety (De Silva et al. 2021). https://web-a-ebscohost-com.proxy.library.rcsi.ie/ehost/viewarticle/render?data=dGJyMPPp44rp2/dV0+njisfk5Ie46bNJrqe0TrCk63nn5Kx95uXxjL6orUqupbBIsKeeUbiosFKwq55Zy5zyit/k8Xnh6ueH7N/iVbCmtUu3qLZOtKmki+fau3mup+J54dviRePb4nmrquB54qO2e7apq020299+sq3ieuSqtljx2/GL5+XsheXoskiuraSE3+TlVePkpHzgs+6L996kjN/du1nMnN+Gu6iuSq6jsEiurLZFrqavPuTl8IXf6rt+8+LqjOPu8gAA&vid=9&sid=a01daced-eeda-4bad-8c83-56eaf47dbf48@sessionmgr4007Behavioural activation (BA) is a well-supported treatment approach for depression. The effectiveness of nine sessions of BA as a treatment for major depressive disorder in a community mental health clinic setting with (n=80) indicates that the measures of BA mechanisms improved over time and changes were associated with change in depressive symptoms (Crits-Christoph et al. 2021).

The incidence, recurrence and comorbidity of anxiety disorders in four major developmental stages were explored by (Essau et al. 2018). Gibbons et al. (2019) (n=237) examine the predictors of treatment attendance in cognitive therapies for major depressive disorder and found that 27% of patients discontinued treatment after a single treatment session. They advise that techniques to improve engagement in therapies and matching patients to treatment based on predictors may be effective ways to optimise treatment engagement. A study undertaken by Lewis et al. (2018) (n=165) found that community mental health therapists often endorse an eclectic orientation that reveals distinct patterns of practice that do not align with traditional evidence-based practice approaches. The need for future research to explore how these patterns of practice relate to client outcomes and training was recommended.

8.6 Suicide and suicide prevention

Studies explore suicide from the perspective of risk, lack of treatment, lack of compliance, availability and service improvements. As suicide rates rise in many countries, it is important that community mental providers are able to assess for suicide risk among individuals with mental illness. Ponce et al. (2020) analyse a performance improvement process related to suicide assessment, carried out in the United States, using critical incident data and multidisciplinary stakeholder input. They advise that future work should integrate skills-based assessment. Lack of treatment compliance in patients with schizophrenia is a risk factor that leads to illness-relapse, hospitalisation and potentially strengthens suicidal behaviour. Díaz-Fernández et al. (2020) (n=344) assess suicidal behaviour in community patients with Schizophrenia and the impact of antipsychotics administration in comparison to previous standard treatment. Findings indicate that a combination of intensive case-managed and antipsychotic treatment helps to reduce suicidal behaviour compared to standard treatment in this group.

Suicide mortality is researched from the perspective of closure of community mental health centres, suicide prevention frameworks, service capacity improvements and hospital care. Hung et al. (2020) in examining the number of community mental health centres (CMHCs) per capita and suicide mortality, recommended that state governments should redress the declining number of CMHCs and the services these facilities provide, which may be an important component of suicide prevention efforts. The impact of strengthening mental health services to prevent suicidal behaviour is underdeveloped. Successive suicide prevention frameworks and action plans have called for improvements to mental health services and enhancement of workforce capacity. There is debate regarding the priorities for resource allocation and the optimal combination of mental health services to best prevent suicide (Hung et al. 2020, Ponce et al. 2020). An Australian study exploring the potential impact of increasing service capacity improvements on the incidence of suicidal behaviour suggests that more than one-quarter of suicides and attempted suicides in this population could potentially be averted with a combination of increases to hospital staffing and non-acute mental health care (Atkinson et al. 2019). Kapur et al. (2016) investigate the timing of suicide in high-risk mental health patients in the United Kingdom by comparing the incidence of suicide at the weekend versus during the week. Findings do not support the claim that safety in mental health services is compromised at weekends. Zhao et al. (2015) and La Guardia et al. (2019) recommend future research studies into why few suicide attempters are provided with mental health service care following receipt of treatment in the general hospital emergency department, as access to mental health care is regarded as a central suicide prevention strategy.

A study focusing on psychiatric hospitalisation indicates that among suicide decedents in the population, 4 % were inpatients at the time of death and that in the year before death 26% had contact with in-patient and out-patient services indicating that contact with services prior to suicide was found to be common (Walby et al. 2018). Preliminary research has suggested that mental health clinicians who work with people with SMI may experience associative stigma. A study by Yanos et al. (2020) (n=68) indicates that associative stigma may have negative consequences and may be an appropriate target for interventions designed to reduce burnout among mental health providers.

8.7 Diagnoses with bipolar disorder

Research into bipolar disorder has primarily focused upon clinical recovery, i.e. symptom reduction, and overlooked person recovery outcomes emphasised by service users. A UK study (n=27) explored the psychological factors that underpin clinical recovery and personal recovery and found that understanding the psychological factors driving recovery in bipolar disorder is essential in ensuring recovery focused therapeutic approaches (Mezes et al. 2021). Enrique et al. (2020) present an internet-delivered self-management programme offering therapeutic approaches for bipolar disorder in mental health services in Ireland and report positive outcomes. A UK study (n=1,364) exploring the factors associated with the delay before diagnosis of bipolar disorder and the onset of treatment in secondary mental healthcare demonstrated that compulsory hospital admission is associated with a significant reduction in both diagnostic and treatment delay. Also, prior diagnosis of schizophrenia and psychotic depression are associated with reduced treatment delay, highlighting a need for further study on strategies to offer appropriate clinical treatment sooner (Patel et al. 2015).

8.8 Schizophrenia EBP measurement tools

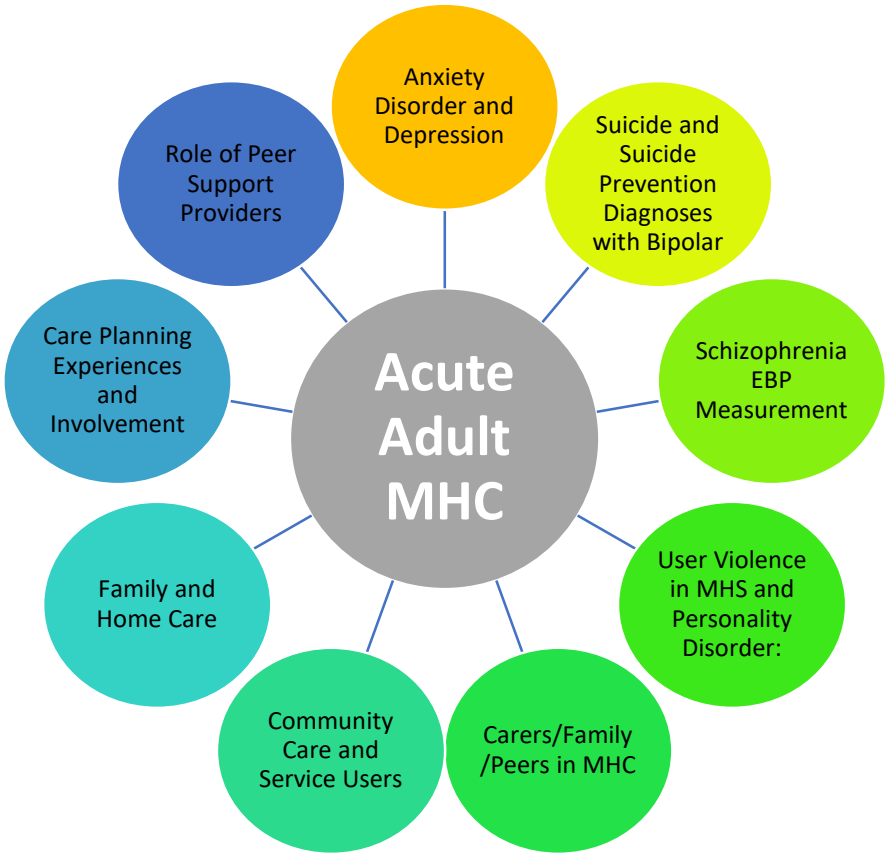
Methods to identify and harness individual cognitive strengths while addressing relative weaknesses have the potential to complement recovery services for first-episode psychosis, but systematic implementation is needed. To explore this further, Saperstein et al. (2020) develop a cognitive health toolkit with trained teams from OnTrackNY and examine toolkit feasibility and clinical utility during the first year of roll-out. Preliminary feasibility data is encouraging but barriers to assessment need to be identified and addressed. Research demonstrates that Schizophrenia and SMI is measured by several EBP tools: Social Inclusion Questionnaire User Experience (SInQUE), Assertive Community Treatment (ACT), Flexible Assertive Community Treatment (FACT) and Subjective Personal Agency scale (SPA-5). Individuals with severe mental health problems are at risk of social exclusion, which may complicate their recovery. Mental health and social care staff have, until now, had no valid or reliable way of assessing their clients' social inclusion. Mezes et al. (2021) (n=192) assess The SInQUE to address this gap and indicate the SinQue for use by mental health staff. Assertive Community Treatment (ACT) is an established evidenced based practice tool that provides intensive community treatment for individuals with severe mental illness with recurrent hospitalisations and/or homelessness. Results from a study undertaken in China (n=60) demonstrated that culturally adapted ACT is both feasible and effective for patients attending outpatients with schizophrenia (Luo et al. 2019). Replication studies with larger samples and longer duration of follow up are recommended (Luo et al. 2019, Moser and Monroe-DeVita 2019, Odden et al. 2019, Spivak et al. 2019, Svensson et al. 2018, Bendayan et al. 2021).

Findings from recent studies (2018-2020) reveal challenges with implementation centred on basic implementation activities. Thorning et al. (2020) advise that implementation of ACT can be accomplished by employing a rigorous framework and infrastructure. Flexible assertive community treatment (FACT) is a community-based treatment model for patients with SMI that has been widely implemented despite little evidence for its effectiveness. Nielsen et al. (2021) (n=2,034) evaluate the effect of FACT on mental health care outcomes compared with treatment from standard community mental health teams (CMHTs) or assertive community treatment (ACT) teams, in Denmark. Results suggest that FACT can provide a more intensive approach in terms of increased outpatient contacts than CMHT care or ACT but recommend further FACT evaluation through RCT's that includes a cost-effectiveness component before wider implementation. Yamaguchi et al. (2020) develop a five-item SPA-5 that can be completed by people with serious mental illness and indicate that further studies are needed to confirm the results outside Japan. A unique mode of delivery was presented in rural Greece. Peritogiannis et al. (2020) (n=76) analyse hospital admissions and length of hospital stay in patients with schizophrenia and related disorders, who are engaged to treatment with a Mobile Mental Health Unit (MMHU I-T) and found a significant decrease in the number of voluntary and involuntary hospitalisations on days of hospital stay after treatment engagement with MMHU I-T, but recommend future research to address the cost-effectiveness of such an interventions.

8.9 User violence in mental health services MHS personality disorder

Ruiz-Hernández et al. (2019) with mental health professionals (n=359) adapted the Healthcare-workers' Aggressive Behavior Scale-Users (HABS-U). The study undertaken in Murcia, Spain established the frequency of exposure to hostile indicators and also determined which professional group were most exposed. Findings indicate that non-medical and nursing were most exposed, as well as patients attending Brief Psychiatric Inpatient and Medium-Stay Inpatient Services. The adaptation of the scale may be useful to detect user violence, as well as to evaluate the efficacy of intervention programmes. Individuals with personality disorders, particularly borderline personality disorder, are high users of mental health treatment services. Emergency service responses often focus on crisis management, and there are limited opportunities to provide appropriate longer term evidence-based treatment. Many individuals with personality disorders find themselves in a revolving cycle between emergency departments and waiting for community treatment. A stepped care approach may help to triage clients and allow access to interventions with minimal client, clinician and system burden (Pigot et al. 2019). The community-based mental health care programme GBV is based on the British Community Mental Health Teams and the Dutch Flexible Assertive Community Treatment model. Mueller-Stierlin et al. (2020) evaluate the assessment process and analyse the effectiveness and cost of GBV compared to treatment as usual. The study's results are expected to provide information on whether the community-based mental health care programme GBV contributes to improving mental health care provision in Germany**.**

Figure 4: Acute Adult Mental Health Care



In conclusion, individuals affected by psychotic disorders frequently disengage from mental health services. Without a universal definition of psychosis it is difficult to compare rates and factors leading to disengagement, or on the impact of strengthening mental health services to prevent suicidal individuals with mental illness. Research into bipolar disorder has primarily focused upon clinical recovery symptoms and overlooked person recovery outcomes that are emphasised by individuals with this disorder. Also, findings indicate that prior diagnosis of schizophrenia and psychotic depression are associated with reduced treatment delay, highlighting a need to offer appropriate clinical treatment sooner. See Figure 4 above for summary of acute adult mental health care and Appendix I for further information on the areas presented in this section. Recommendations are suggested.

9. Carers, family, peers in mental health care

Carers, families and peers are pivotal to the delivery of care to family members. Studies focus on the experience of the community life of mental health clients receiving ICMHSs. Findings indicate that timely support, family presence and people who had previously received the services of ICMHS, expanded their social networks in the community and had better family relationships (Chiang et al. 2020). There is increasing cross-disciplinary research on the relationship between individuals' social, cultural and community engagement (SCCE) and mental health. A cross-disciplinary research agenda on SCCE and mental health (n=1,000) identified mode, process, engagement impact and infrastructure as core themes required to facilitate engagement (Fancourt et al. 2020).

9.1 Community care and service users

Community care is increasingly the mainstay of mental healthcare provision in many countries. In six of the eight papers that discussed community care, patient satisfaction and safety issues were mentioned as being important barometers of quality of patient care. The Care Quality Commission (CQC) survey, used in the United Kingdom, identified older age, being employed, a safe environment and being able to work as indicating higher satisfaction (Stamboglis and Jacobs 2020). Little is known about service user and carer perspectives on safety issues yet, they are important in preventing and reducing harm. The Yorkshire Contributory Factors Framework—Mental Health (YCFF-MH) explored these perspectives and found the need for a safety culture that promotes safety and well-being and a social environment that is able to identify threatened violence (Berzins et al. 2020). The Power Safety Identity (PSI) model highlights the importance of services being more focused on care rather than control (Bacha et al. 2020). Dissatisfaction occurring in patients with unmet needs is higher if they are not being involved in decisions concerning their care, or if they are not hospitalised: a decision-making right emphasised by Rioli et al. (2020).

The recovery model in mental health care emphasises users' right to be involved in key decisions of their care. Conversely, not all mental health workers experiences are positive. Many carers report feeling unrecognised by professional healthcare teams. A study undertaken in Norway (n=453) identified that carers who are mental health professionals are often not recognised for their professional knowledge and face similar communication barriers as other carers (Stain et al. 2020). A similar study undertaken in Finland recognised that user involvement meant that people using mental health services felt respected, listened to and able to co-operate with professionals, leading to a sense of achievement (Laitila et al. 2018). Findings from a similar study exploring the satisfaction of adult patients in Canada, in units staffed by multidisciplinary professionals (n=325), and using the 3-factor conceptual framework, identified higher levels of satisfaction among patients who received good continuity of care and well-managed, frequent services in relation to their needs (Fortin et al. 2018).

9.2 Family and home care

Family involvement for persons with psychotic disorders is under implemented in mental health care, despite its firm scientific basis (Boland 2019, Rioli et al. 2020). Studies identified family involvement by using national guidelines, psycho-education and exploration of ethical issues related to family care. National Guidelines in Norway include interventions that provide a basic level of family involvement and training and guidance for health care personnel and a family coordinator (Allchin et al. 2020, Hestmark et al. 2020). The increase in the number of homebound individuals is

causing health-care professionals to expand in-home health services such as psychotherapy. Delivering psychotherapy in clients' homes presents many advantages to these homebound individuals. Ethical issues identified in this environment relate to boundaries, confidentiality and privacy, competency, insurance coverage, and autonomy issues. It was recommended that therapists should adhere to their professional body guidelines (Boland 2018). A further area requiring attention relates to stress and stigma on family caregivers. Bonsu et al. (2020) found that caregiver stress (n=280) negatively influenced caregiver wellbeing. Social interventions targeted at people with severe mental illness (SMI) often include volunteers. However, in this underdeveloped area, the families often doubted their personal judgement and relied on mental health workers to act as a safety net. The volunteer involvement was found to be meaningful but also challenging (Jensen et al. 2017).

9.3 Care planning experiences and involvement

Results evidenced that families perceived care planning to be uncoordinated and that their lived experiences were not always appreciated. Carers report feeling marginalised and distanced from services by not been listened to and concerns not being recognised (Doody et al. 2017). Evidence suggests that interventions for carers have a beneficial impact on their psychological health (Cree et al. 2015, Fortin et al. 2018, Laitila et al. 2018). Relatives' experiences with severely mentally ill patients, in integrated mental health services, suggest that the services offered significant relief and substantial support in daily life through having a reduced burden of carer responsibility (Valentini et al. 2016). In contrast, carers identified major carer needs (Susanti et al. 2018). There is limited implementation knowledge on family-focused interventions. The Consolidated Framework for Implementation Research combines known elements from research into five domains of influence. One of these interventions is the "Let's Talk about Children" programme (Let's Talk), however, a study conducted with service managers indicates that greater understand of the dynamics of parent and practitioner readiness for delivering ‘Let's Talk’ is needed with this population (Susanti et al. 2018).

9.4 Role of peer support providers

Seven studies were found identifying the role of peer support providers (PSPs). PSPs define peer support as a distinct occupation in the context of traditional mental health services. The role was found to be positive overall with good practice and supporting role integration. Barriers also exist that mainly relate to role identity, overlapping of roles with other professionals, protective practices and recruitment issues and ‘shared identities’ (Crane et al. 2016, Jones et al. 2019). Good practice in the structural issues of recruitment and training exist, but differences in expectations of the peer worker role in different organisational cultures were found, often eroding the distinctiveness of the role and indicating that protective practices exists that minimise risk to peer worker well-being and that restrict the sharing of lived experience (Gillard et al. 2015). Alternatively, analysis revealed potential new understandings of risk management based on the distinctive, experiential knowledge that peer workers bring to the role (Mancini 2018). Inter-professional team meetings and sharing lived experiences suggest that PSPs can uniquely contribute to the coordination of physical health and mental health services for individuals with serious mental illness (Storm et al. 2020). A community based mental health team, based in Australia, identify peer support workers' ability to navigate a legitimate place within care teams and promote integration in inter-professional teams as important factors (Ehrlich et al. 2020). Findings from an RCT (n=590) indicate that people offered a

peer worker discharge intervention in addition to usual follow-up care in the community were less likely to be readmitted in the 12 months post discharge than people receiving usual care alone (Gillard et al. 2015).

In conclusion, studies identified that people using mental health services felt respected, listened to and able to co-operate with professionals, leading to a sense of achievement. Studies also recognised higher levels of satisfaction among patients who received good continuity of care and well-managed, frequent services in relation to their needs. Carers reported feeling marginalised and distanced from services by not being listened to and their concerns not being recognised in units staffed by multidisciplinary professionals, often where different organisational cultures existed. Peer workers perceived their role as being mainly positive but that protective practices existed that eroded the distinctiveness of the role and peer worker well-being.

See Appendix I and recommendations for further information on the areas presented in this section.

10. Child and adolescent mental health services

Descriptions of what constituted 'child and adolescence' research varied across studies, yet despite variability shared common features were found. Studies include exploration of the future of mental health services and of child and youth mental health and are of medium to high quality. High quality surveys were found in relation to clinical staging, predictors of re-assessing community-based care, depressive symptoms change after contact with services, potentially trauma-related diagnoses, non-suicidal self-injury, and evidence based assessment and ethnicity and care pathway. Studies relating to young men's and children's access to community based mental health care highlight a number of barriers and facilitators and report outcomes that include low rates of help-seeking, high rates of suicide and other adverse outcomes for young men. Adolescence and emerging adulthood corresponds to a period of disconnection from healthcare services for young men. Papers report on the importance of enhanced primary care early intervention centres that support identification of barriers to access and the difficulty encountered by young men in overcoming male role expectations, talk therapy as an unknown territory and difficulties encountered in navigating the system and intake processes.

10.1 Future of mental health services for children

The future of mental health services for children and young people was identified in four studies. There is increasing recognition of unmet needs (Corscadden et al. 2019). Demand to access care is increasing (Cotgrove 2018). Prioritising the use of scarce resources where they are needed most, will reduce unnecessary attendances at emergency departments (Kirkland et al. 2018). A collaborative partnership between service users and carers that led to improving integrated mental health services for young people and families demonstrated that sharing lived experiences had a positive impact on recovery. Less clear is the role of young people in peer support roles, especially within child and youth mental health (YMH) settings. One such peer workforce, operating in Australia, identified positive outcomes by co-designing services for young people with young people (Hoyland et al. 2018).

10.2 Transition from youth and adolescent mental health services

A significant number of youths need to transition from CAMHS to adult mental health services (AMHSs). Twelve studies found explored the transition process, which was deemed to be unclear. Transition is often experienced poorly by youth because as services have an upper age limit of 18-years of age, youths requiring ongoing mental services must "transition" to adult-oriented general practitioner care and may face a difficult transition period. In Ireland 5,000 adolescents transition at age 18 and of those 600 commence further education (HSE 2017b). Understanding the key elements of a successful transition and the indicators being used to measure transition care processes is needed (Hill et al. 2019). Cohen et al. (2020) in examining service continuation among those aging out of child system services found that most with predictors of a serious primary mental health diagnosis such as schizophrenia, bipolar and major depressive disorders were a risk to self and others. They did not enrol in adult services, suggesting that historical policies and practices may contribute to service disconnection. A Canadian study undertaken by Schraeder et al. (2021) (n=2,822) found that 20-26% received services from a community-based Child and YMH agency. Evans and Huws-Thomas (2020) (n=66) identify that General Practitioners represent the most frequent health care practitioner to refer to CAMHS services. Self-harm, suicidal intent, thoughts or overdose represented the highest percentage of referrals. An extended inpatient treatment facility

for adolescents with severe and complex mental illness in Australia involved service users, young people, their families and their carers as co-creators in the development of new mental health services, leading to positive outcomes (Piccone et al. 2018).

Persons identified in early childhood as having autism often have co-occurring health problems that extend into adolescence. Powell et al. (2021) suggest that a minority of these persons receive recommended guidance from their primary care providers starting at age 12 years to ensure a planned transition from paediatric to adult health care. Researchers analysed preliminary data from a follow-up survey of parents and guardians of adolescents aged 12-16 years who had previously participated in the Study to Explore Early Development. Findings indicated that few adolescents received the recommended transition guidance. Recommendations for improved provider training and coordination of programmes to meet their needs can improve adherence to recommended guidance for transitioning from paediatric to adult health care.

Psychiatric disorders in young people may lead to persistent disability and even premature death. Lorfino et al. (2019) in an Australian study (n=2,254) recommend clinical staging as an adjunct to diagnosis in the transition from earlier to later stages of anxiety, mood, psychotic, or comorbid disorders. However, the longer-term utility of this system has not been established. In contrast, positive outcomes are possible when dedicated support is provided. McCay et al. (2020) examine the degree to which youth identified as ready for discharge from three Canadian Early Psychosis Intervention (EPI) programmes. Participants demonstrated lower levels of symptoms, greater quality of life, greater self-esteem and greater levels of functioning, following EPI treatment when compared to similar youth described in the literature. This suggests that study participants had achieved optimal outcomes following EPI treatment. Green et al. (2019) (n=288) analyse an Australian sub-acute YMH residential service model and found that the Youth Prevention and Recovery Care (Y-PARC) model provides care to those transitioning out of hospital inpatient units. Findings demonstrate that admissions to Accident and Emergency and the use of the criminal justice system decreased, with improved outcomes and cost differences in the short-term. Stanton et al. (2017) (n=48) explore youth experiences of engaging with an inpatient unit and found managing risk was the main issue identified by clinicians. Participants wanted more communication and collaboration.

Kapp et al. (2017) (n=663) explore the factors that influence perceived quality, from the perspective of patients and parents attending or having attended (drop-out) outpatient units, within CAMHS. Findings indicate that clinicians need to provide care that is based on the needs and expectations of patients and parents. Repeat visits to emergency departments for psychiatric care reflect poor continuity of care and impose a high financial cost. A study undertaken by Singh et al. (2019) identified 34,000 fewer repeat psychiatric-related emergency department visits. In a systematic review of 'the impact of paediatric mental health care provided in outpatient, primary care, community and school settings on emergency department use' Kirkland et al. (2018) found limited evidence to suggest that the provision of services in the community impacted on the use of emergency departments.

10.3 Developments and transformations in psychotic disorders

Studies describe the importance of developing mental health innovations for CAMHS. Provision of transformations in mental health care is a consistent theme across studies. There is evidence that

several countries are now engaged in transformation of youth mental health services and in evaluation of new initiatives, but under provision of services remain (Beatty et al. 2019, Schraeder et al. 2021). Recent development in youth mental health, that incorporates all levels of severity of mental disorders, is encouraged by progress in the field of early intervention in psychotic disorders, across four countries (Australia, Ireland, the UK and Canada) (Schraeder et al. 2021).

The National Clinical Audit of Psychosis – Early Intervention in Psychosis (2019-2020) England Report provides national and organisation level findings on the treatment of people by EIP teams in England. Data were collected as part of the National Clinical Audit of Psychosis (NCAP). EIP services are specialised services providing prompt assessment and evidence-based treatments to people with first episode psychosis (FEP) (HQIP 2019-2020). The Early Intervention for Psychosis in Ireland: Are We There Yet Report was published by Power in 2019. Power states that **e**arly intervention in psychosis services are now a priority for Ireland's HSE and that A Model of Care for EIP services was completed after wide consultation. This Model of Care outlines the rationale, configuration, resources, governance, and quality assurance required to operate EIP services. Two models are recommended, one termed the Hub and Spoke service being used for rural and smaller urban areas and the other a Stand-Alone service model for large urban and metropolitan areas. It is expected that those Models of Care will bring better outcomes, service satisfaction and cost savings to people being treated by Early Intervention in Psychosis services.

The clinical onset of BPD usually occurs in young people (aged 12-25 years) and commonly leads to difficulty achieving and maintaining education and/or employment. While current psychosocial interventions lead to improvements in psychopathology, they have little effect upon functioning. Chanen et al. (2020) discuss the Individual Placement and Support (IPS) Model that is client-driven and assists individuals with SMI to engage with education and/or employment appropriate to their personal goals, with ongoing support to maintain this engagement. IPS is a targeted functional intervention, which has proven effective in improving vocational outcomes for adults and young people with psychotic disorders. Olson et al. (2020) present results from a process evaluation of the National Training and Technical Assistance Centre for Child, Youth, and Family Mental Health conducted to support the Centre's QI and technical assistance. Results indicate that the overall level of satisfaction with technical assistance was high and content was generally aligned with need.

Australia developed a model comprised of a distinct front-line youth mental service: Headspace, which was initially stimulated by success in early intervention in psychosis in Ireland. Headspace has been driven primarily through advocacy and philanthropy resulting in front-line services called *Jigsaw* which are being implemented across different jurisdictions. Beatty et al. (2019) examine the clinical profiles of young people referred between mental health services and Jigsaw in Galway, Ireland over a 5-year period. Findings indicate that a recent act of self-harm was more prevalent in individuals referred from Jigsaw to adult mental health services. Common barriers to help-seeking are lack of awareness of appropriate services and low mental health literacy. The Headspace awareness campaigns are designed to address these factors. An Australian study undertaken by Perera et al. (2020) (n=4,707) explored whether distance from a Headspace centre affects community awareness of Headspace and found that awareness of Headspace and its services was significantly greater among those living in Headspace areas than among those living further away. Given early onset of mental disorders and the inadequate access to appropriate services a

meaningful service transformation, based on globally recognised principles, is welcomed (Cotgrove 2018).

The transformation of youth mental health services in Western Canada is progressive. Malla et al. (2019) explored The Transformation Model: a value based services for youth with mental health and substance abuse problems that was designed to form the basis for scaling up youth services in Canada and elsewhere. Transformation is focused on the five key objectives of the pan-Canadian ACCESS Open Minds network (ACCESS OM), namely early identification, rapid access, appropriate care, continuity of care, and youth and family engagement (Reaume-Zimmer et al. 2019). Restructuring processes and challenges in delivering services and care needs are based on the objectives of ACCESS OM (Abba-Aji et al. (2019) and delivered through teams' service networks, restructuring, and partnerships.

10.4 Future of crisis mental health care emergency

Three studies support improving the youth mental health (YMH) system. There is an international movement toward developing community-based service hubs that provides collaborative care to youth. The YouthCan IMPACT integrated youth services project demonstrates the need for key stakeholder group and individual involvement in its development, execution and implementation (Henderson et al. 2020). Many mental health services remain hospital-centric, often without adequate outreach services. On the basis of outcome evidence there is need to shift the balance of mental health services from hospital-centred with community outreach, when convenient for staff, to community-centred and mobile, with in-reach to hospital only when necessary (Rosen et al. 2020). These authors propose a framework that advocates health ecosystems as a community-centric mental health approach to mental healthcare and training. A substantial number of children experience persistent or recurrent problems and may need more than one episode of care. Yet, there is a paucity of research on recurrent service use. In examining the predictors of re-accessing community-based care, Sarmiento and Reid (2020) establish that just 30% of children (n=1,802) who had an episode of care re-accessed services again within 4 years. A better understanding of the factors that influence recurrent service use may facilitate this process for families.

10.5 Interventions in CAMHS

Much is known about the value of early intervention and effective community interventions (Cotgrove 2018). CBT is used for anxiety and depression in the treatment of mental health illness in adolescents. Lorentzen et al. (2020) investigated the effectiveness of CBT with adolescents (n=163) in Norway, using the Structured Material for Therapy (SMART). Findings show that SMART may be considered as a first step in a stepped care model for anxiety and/or depression treatment in CAMHS. In a further extension to adolescent innovations in practice the use of Dialectical Behaviour Therapy for Adolescents (DBT-A) is an intervention with a growing evidence base for treating adolescents with emotional and behavioural dysregulation. In an Irish study, Flynn et al. (2019) with (n=54 clinicians and adolescents) indicates that DBT-A can be successfully implemented in CAMHS settings and is able to yield positive outcomes for adolescents.

Sensory modulation is used to develop self-regulation and enable occupational participation but little is known about the use of sensory modulation within community settings. An Australian study by Williamson and Ennals (2020) reveals that young people and their families' value the positive

experiences of sensory modulation through the processes of co-creation in young peoples' activities of daily living. The impact of activity-based group work, adventure therapy group practice, on youth in a community-based mental health setting, explored by Vankanegan et al (2019), demonstrates positive outcomes. Assertive community treatments (ACT), an established treatment for adults, has an emerging evidence base for improving outcomes in youth and Daubney et al. (2021), using The Assertive Mobile Youth Outreach Service (AMYOS) of Children's Health Queensland, Australia report positive outcomes also.

10.6 Depression, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder

Studies were found that relate to depression, Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) in adolescents. Midgley et al. (2017) found that adolescents (n=77) with moderate to severe depression identify bewilderment, depression and self- blame as impacting on how they seek help and engage in treatment. In contrast, a study undertaken in the United Kingdom by Neufeld et al. (2017) (n=1,238) using the Mood and Feelings Questionnaire [MFQ], to assess the extent to which depressive symptoms in adolescents change after contact with mental health services, found positive outcomes.

ADHD is a lifelong disorder, which if undiagnosed or untreated can lead to significant impairment resulting in a high economic cost for society. Hughes et al. (2017) review clinical guidelines from Canada, North America, Europe and the UK for the diagnosis and management of ADHD for adolescents previously diagnosed in CAMHS, on transition to adult services. They sought to apply the available guidelines to an Irish context and recommended that clinical guidelines in this context should incorporate a biopsychosocial approach. Barnes (2020) investigates adherence to the National Institute for Health and Care Excellence (NICE) guideline for diagnosing ADHD. Findings acknowledge that the gold standard practice for diagnosing ADHD in CAMHS should be the adoption of clear, protocol-driven pathways to support access and treatment.

Children with ASD exhibit high rates of challenging behaviours that impair functioning and represent the primary presenting problem in mental health services (Stadnick et al. 2017, Barnes 2020, Hoch et al. 2020). Obtaining symptom reports from multiple informants is critical for treatment planning. Stadnick et al. (2017) evaluate caregiver-teacher concordance of ratings of the intensity of challenging behaviours in children (n=141) with ASD and advocates for increased attention to the range of psychiatric problems children with ASD present with, thus providing individual treatment.

Hoch et al. (2020) compare exposure to potentially traumatic events and trauma-related diagnoses between children (n=7,695) with ASD, developmental disabilities and with other mental health diagnosis (e.g. depression) and find that diagnosis, negative life events and children's locations predict trauma reports and trauma diagnoses. Diagnosis involves screening. The Social Communication Questionnaire (SCQ) is a widely used screening measure for the assessment of ASD. Its sensitivity and specificity when used with older children in the context of community CAMHS is unclear. Hollocks et al. (2019) undertook screening with young people (n=77) with suspected ASD using parent and teacher-reported SCQ's and found that SCQ scores did not significantly predict the outcome of the diagnostic assessment, suggesting that the SCQ is not an effective screening tool when used in this context.

Suen et al. (2021) compare the perspectives of caregivers of children with autism receiving care at the Neurobehavioral Healthy Outcomes Medical Excellence (HOME) Programme developed in the University of Utah, Department of Psychiatry. This is an interdisciplinary clinic for patients with autism and other developmental disabilities with those responding to the 2016 National Survey of Children's Health (NSCH). Compared with the NSCH cohort (n=1,151), children enrolled in HOME (n =129) had severe autism and co-occurring intellectual disability. Caregivers perceived that children receiving care within HOME more often received family-centred, coordinated care compared with a national sample of children with autism, suggesting that an interdisciplinary clinic model may best serve children with autism with high severity symptoms and co-occurring conditions.

10.7 Students with Autism spectrum disorder

There is a growing need to provide appropriate services to help students with ASD transition to employment. Wong et al. (2021) investigate what aspects of support should be prioritised when preparing youth with ASD for employment. The findings indicate two pathways for youth with ASD. For youth with higher daily functioning skills academic performance mediated the relationship between parent participation and employment. For youth with lower daily functioning skills, school-based transition supports was the key mediator.

Cvejic et al. (2018) summarise the impact and experience of transition to adult mental health care for people with intellectual disability and those who support them. Several opportunities for improvement are identified in policy, service structure and organisation, research and workforce capacity. They suggest that enhancements in these areas will lead to improved outcomes for young people with intellectual disability transitioning from child-to adult-oriented mental health care. Merrick et al. (2020) examine the predictors of transfer to adult mental health services and explore experiences of transition in (n=118) young people with ASD and additional mental health problems, in the UK. These adolescents were followed up every 12 months over 3 years after discharge from CAMHS. Findings show that although some adolescents were able to successfully manage their mental health following discharge, others reported levels of unmet need and negative experiences of transition.

10.8 Children with neurological disorder

Brandt et al. (2021) aimed to establish rates and gender patterns of 25 comorbidities in 1,912 children (72% male) with a neurological disorder and a comparison group (n=40,718, 45% male) from a large clinical records data-set in child mental health services in the United Kingdom with clinician-recorded data on neurological and psychological conditions. Obsessive compulsive disorder, oppositional defiant/conduct disorder, ASD disorders and intellectual disabilities were found more often in both boys and girls with neurological disorders than in the comparison group.

Comer-HaGans et al. (2020) conduct data analysis from caregivers completing the 2011–2012 National Survey of Children's Health, in the USA by restricting the sample to parents of youth between 3–17 years (n =81,510). Results demonstrated that compared with youth without intellectual disability, youth ages 3–17 with intellectual disability had a significantly higher prevalence of mental health and neurodevelopmental conditions and mental health care use. These

findings indicate that youth with intellectual disability are at greater risk of having coexisting mental health and neurodevelopmental conditions than youth without ID and are more likely to receive treatment.

Bird et al. (2021) explored paranoia in (n=301) (11-17 years old adolescents) attending Canadian CAHMS services. Results indicate that most of the adolescents had affective disorders (*n*=195), self-harm/suicidality (*n* = 82), or neurodevelopmental conditions (*n*=125). Few had suspected psychosis (*n*=7). Rates of paranoia were double compared with previous reports from the general population. Paranoia is relatively common and persistent across a range of clinical presentations in youth and when occurring alongside emotional problems, important peer interactions may be adversely affected. Wider consideration of paranoia in adolescent patients is needed. Suesse et al. (2021) investigate factors associated with frequent (admissions), high (total length of stay) or heavy (frequent and high) in-hospital use, and with ongoing increased hospital use for mental health conditions. Findings indicate that ongoing high use was associated with admissions for schizophrenia and a history of self-harm. Interventions targeted at younger people hospitalised with schizophrenia, a history of depression or self-harm, particularly with evidence of social and or health disadvantage, should be considered to improve long-term patient and health system outcomes (Ailey et al. 2019, Suesse et al. 2021).

10.9 Suicidal self-harm

Three studies relating to non-suicidal self-injury were found. Baiden et al. (2017) explore the prevalence of adverse childhood experiences (n=2,038) on non-suicidal self-injury and found that 29% engaged in non-suicidal self-injury, indicating that the assessment procedures for indicators of mental health should take into account non-suicidal self-injury. Gray et al. (2019) (n=88) presented the Research Network (WARRN) which is a formulation-based technique for the assessment and management of serious risk (e.g. violence to others, suicide, etc.) and which is used across most CAMHS in Wales. Findings show that the increased safety of service users and the general public led to a belief that WARRN had saved lives. An under researched study area relates to violence by adolescents which makes these young people vulnerable. The use of a co-design workshop to develop a family focused model of care was explored by Kehoe et al. (2020). Findings indicate that this approach is a critical element in addressing adolescent violence in the home.

10.10 Interventions and outcome measures

Six studies relating to Evidence Based Assessments (EBAs) and EBPs were found. Disparity exists between policy recommendations and the use of outcome measures in clinical practice (Sharples et al. 2017, Cotgrove 2018, Dickson 2020). Research has moved toward understanding the dissemination and implementation of EBPs. Therapist knowledge and attitudes play a fundamental role in EBP adoption however, studies have produced mixed findings. The extent to which knowledge and attitudes and youth characteristics predict specific practices derived from the evidence-base was explored by Okamura et al. (2019) (n=46). Results suggest that specific EBP knowledge predicts specific practices, highlighting the need for more specificity when examining predictors of EBP use. Mersky et al. (2020) advise that researchers need to access multiple EBTs while navigating implementation barriers between children's mental health research, services, and policy. Despite progress in research on EBTs for youth psycho-pathology, many youths with mental health needs did not receive services. Wise Interventions are single-component, social-psychological

interventions that have improved health and interpersonal youth outcomes, yet their potential to reduce youth psychopathology has not been systematically explored (Schleider et al. 2020).

10.11 Evidence-based assessment in CAMHS

EBA plays a critical role in the delivery of effective treatments yet little is known about the assessment practices of mental health clinicians who treat youths and the factors that support EBA. Cho et al. (2021) in exploring clinician use of EBA (n=2,575), found that frequent pre-treatment, ongoing, and post-treatment assessments are being used but a lack of practical assessment tools appear to be a barrier to its use. The implementation of EBPs in community mental health settings for youths (n=101) was explored by Wright et al. (2019), by using therapist-reported caregiver attendance in treatment sessions as a quality indicator. Patterns appear to be consistent with empirically informed practice parameters. Implementation is a process of recognising and adapting to both predictable and unpredictable barriers. Lehane et al. (2018), taking an expert view in an Irish study, explore the evidence-based practice education required for healthcare professions. Horwitz et al. (2019) (n=89) identify clinician characteristics related to sustained use in EBP by using the Managing and Adapting Practice (MAP). Eighty per cent reported continued use of MAP. Other studies explore intervention. Cheron et al. (2019) explore a progress monitoring data system, Mersky et al. (2020) describe two projects aimed at increasing access to EBTs and McLennan (2020) queries if Canadian children and their families are receiving effective mental health interventions.

10.12 Family Intervention in CAMHS

Four studies found relate to family and YMH interventions and three studies to youth and caregivers perceptions of their experiences, with evaluation being a consistent theme across the studies. Family intervention is targeted mainly at adolescents with social, emotional and behavioural difficulties, attending CAMHS. Wynne et al. (2016) with (n=93 adolescents) attending CAMHS in Ireland, evaluate implementation of the Working Things Out adolescent programme and the Parents Plus Adolescent Programme (WTOPPAP). Findings demonstrate that the WTOPPAP may be an effective intervention for adolescents with social, emotional and behavioural difficulties. Mendenhall et al. (2019) explore the implementation of the Strengths Model for Youth, a quality of life recovery oriented case management model, at a community mental health centre. Results show that the model has positive impacts on case managers' feelings of compassion, satisfaction and compassion fatigue. However, implementing and evaluating EBP programmes in CAMHS requires further process improvements to achieve positive outcomes (Deighton et al. 2016). Guinaudie et al. (2020) use ACCESS Open Minds (ACCESS OM) to implement and evaluate shared decision making (SDM) practices within YMH settings across Canada. Through the integration of SDM practices, ACCESS OM has formulated valuable insights that can be applied to other health problems and settings.

10.13 Child and family centred care

Children and young people in the care system experience high levels of mental health difficulties, yet their views on these difficulties and of mental health services have rarely been explored (Frauenholtz and Mendenhall 2020). A study undertaken by Tatlow Golden (2015) in Ireland, with eight young adults with experience of the care system, explored their mental health challenges and service experiences. Findings illuminate young adults' views of their emotional well-being while in care, and the double stigma of being in care and having mental health difficulties. Frauenholtz and Mendenhall (2020) assess the perceptions of eight youth and caregiving families participating in

a community-based mental health system of care. Satisfaction and appreciation with the care they received and empowering communication were deemed as being important to their mental health. A large study accessing youth-targeted mental health services for a first episode of care was undertaken in Australia by Rickwood et al. (2015) with (n=30,839 young people) who access in-person services and (n=7,155 clients) of the online service. Results show a major developmental shift in help-seeking influence across the age range and a striking difference between the online and in-person service modalities.

10.14 Family therapists

Seven studies describe the importance of family therapists to the lives of family and children. Family therapists understand that children presenting for treatment are often bearers of symptoms that signal relational problems within the family system. Family therapists typically consider those relational problems as their base line for therapy. Kozlowska and Elliott (2017) use The School-Aged Assessment of Attachment (SAA) to assess the attachment strategies of the siblings of children presenting for psychiatric evaluation. Findings show that siblings presenting to mental health services are significantly affected by family relational stress. Stapley et al. (2017) create a typology of parents' experiences beginning with their teenage child's referral to CAMHS in the UK (n=85) and recommend that clinicians working in CAMHS need to adapt their ways of working to best support these families. Lived experience explored in a partnership approach, undertaken in Australia, has led to a high level of participation and inclusion of people with a lived experience of mental health services (Piccone et al. 2018).

Child development and children's mental health services are currently not an integrated service in some countries. Children with social-emotional, behavioural and developmental issues present to both services. Clinicians in Zero to Four, Child and Youth Mental Health, and the Child Development Service in Brisbane work more closely when families require the involvement of both services (Hodges and Olsen Leach 2018). Balancing both developmental and mental health is important to fully meet the needs of children and families. Another area of concern is Childhood Bullying. Evans-Lacko et al. (2017) (n=9,242) examine the impact of bullying victimisation on mental health service use from childhood to midlife. Compared with participants who were not bullied in childhood, those who were frequently bullied were more likely to use mental health services in childhood and adolescence and also in midlife. Natural mentoring relationships are thought to foster positive youth development and buffer against the risks associated with the difficult years of adolescence. Van Dam et al. (2018) examine the relationship between natural mentoring and youth outcomes and identified that the largest effect sizes were found for social-emotional development and academic and vocational functioning. Alleyne (2020) explored roadblocks encountered by children and their parents in providing school-based mental health service.

10.15 Medication and ADHD

Al-Khudairi et al. (2019) examine the frequency and dose of antipsychotic medication use and whether ADHD disorder medication is associated with a reduced use of psychotropic medication in adults with intellectual disability and ADHD disorder, attending a specialist community intellectual disability service. The study found a high incidence of autism in people with intellectual disability and ADHD. Findings from this study indicate that 64% of people with ADHD and intellectual disability taking ADHD medication, were on antipsychotic medications compared to 93% of people with ADHD and intellectual disability without ADHD medications. Due to the limited research found

in this area further research is needed including randomised controlled trials to determine whether the use of ADHD medication reduces the use of antipsychotic medication in people with intellectual disability and ADHD.

10.16 Homelessness and migrants

Children present to mental health services in different ways. Informal homelessness or, as CentrePoint UK describe, 'the hidden homeless' include young people who may sleep on their friends' or extended family's couches or floor. They estimate that 103,000 people aged 16-24 in the United Kingdom presented to their Local Authority in 2017-2018 as being or at risk of being homeless. Adolescents need to be identified as surfers by clinicians so that support may be offered and to receive community-based support when planning for discharge from hospital (Quintyne and Harpin 2020). Park et al. (2020) explore mental health professionals' perceptions about barriers and facilitators to engaging underserved populations. Their findings reveal that many professionals endorse barriers to engaging ethnic minorities and families receiving social services.

YMH services are underutilised, particularly for migrant youth (Colucci et al. 2017). Nadeau et al. (2017) explore how migrant families (n=15) with a psychiatric diagnosis, understood quality of care, including factors improving access to care. They found that continuity of care and inclusion of family intervention collaborative decision-making pathways to care were deemed necessary. Khan et al. (2016) explore young people (n=13,919) incarcerated in correctional centres, in Canada, and found that 42% had a mental health-related visit during incarceration and had high use of psychiatric services before entering custody among individuals with schizophrenia.

10.17 Access to University, Schools

Demands for mental health services in post-secondary institutions are increasing. Vallianatos et al. (2019) describe key features of a response to these needs: ACCESS Open Minds University of Alberta (ACCESS OM UA) is focused on improving mental health services for first-year students through transformation activities that include timely connections to follow-up care and engagement of students and families/carers. Most people now understand that school mental health professionals play a role from mental wellness to crisis intervention. Desrochers (2019) outlines the extent of student needs being addressed by these professionals and on the increasing need for schools to work more effectively with specialist mental health providers. Mental health leads from 255 schools with mental health professionals and other key stakeholders took part in workshops across the UK. Cotrina et al. (2019) report the results of this evaluation including evidence of improved interagency working between stakeholders. More controlled research is needed to consider generalisability and scalability. Scanlan et al. (2022) explore outcomes associated with students' involvement in co-designed and co-delivered recovery-oriented practice workshops in Australia and found positive engagement.

10.18 Youth and adolescent migrants school based mental services

Colucci et al. (2017) discuss mental health services among children and young people from refugee backgrounds by comparing the perspectives of professionals and service users to identify similarities and differences. Little is known about how undocumented immigrants navigate healthcare utilisation issues apart from access. Cha et al. (2019) examine undocumented immigrants (n=30 college students) at the University of California who have access to healthcare and how immigration

status hinders mental health services utilisation. Students expressed low perceived need because they normalised mental strain and stigma as a natural product of their unstable immigration status.

To understand how immigration status hinders mental health utilisation Guinaudie et al. (2020) argue that undocumented immigration status negatively affects students' ability to assess their own mental health and need for services. While the mental health needs of refugee adolescents and the barriers they face are documented their contact and experiences with clinicians in mental health services are limited. Valibhoy et al. (2017) examine adolescents (n=16) born in 9 different countries and living in Australia, for five years, who had expressed their need for ease of access to services, greater acceptability and sensitivity to their cultural needs. Adults from black and minority ethnic (BAME) backgrounds are less likely to access mental health services through voluntary care pathways and are more likely to access through compulsory ones. Edbrooke-Childs et al. (2016) explore the association between ethnicity and care pathway through CAMHS in children presenting with emotional problems in children (n=11,592) from 26 CAMHS. Similar to adults, children from BAME groups may be more likely to access CAMHS through compulsory rather than voluntary care pathways.

10.19 Telehealth in child mental health services

Benefits to the use of telehealth in child mental health services are identified as accessibility, convenience and appeal and as a preventative/psycho educational tool rather than a replacement for face-to-face therapy (Cliffe et al. 2020). Promoting knowledge and skill in tele-mental health is critical to meaningfully overcoming traditional geographic barriers to children's mental healthcare (Myers and Comer 2016, Rice et al. 2018). Technology can increase CAMHS capacity by supporting and delivering interventions, yet it has not been widely adopted by CAMHS professionals. Uptake can either be facilitated or obstructed by professionals' attitudes, which remain largely unknown (Cliffe et al. 2020, McClellan et al. 2020). Child mental health professionals (n=154) in the UK perceive themselves as being competent at using technology and that e-technology was helpful in their clinical work. Conversely, some professionals had difficulty accessing online, were unsure what resources were available and whether technology is safe, private or reliable. Limited financial and infrastructural resourcing are factors that may account for the slow uptake of technology within CAMHS (Orlowski et al. 2016, Cliffe et al. 2020). Gaming is a growing area, including increasing interest in the use of gaming clinically. There are conflicting reports on its harms and benefits. An Irish survey indicated that younger patients were more likely to own a smartphone and those who played videogames were younger than those who do not, suggesting that an opportunity exists for mental health professionals to deliver interventions through smartphone and video games (Rowntree and Feeney 2019).

10.20 High risk male offenders

Provision of specialised community mental health services for higher-risk male offenders with a mental disorder may reduce recidivism in the short and longer term (Stewart et al 2017). Young offenders with mental health disorder also face difficulties in transition from child and adolescent services to adult mental health services (Livanou et al. 2017). Livanou et al. (2017) present an overview of transitions across forensic child and adolescent mental health services, in England and Wales, by delineating the national secure services system for young people in contact with the youth justice system. Findings indicate that young offenders experience a broad range of difficulties

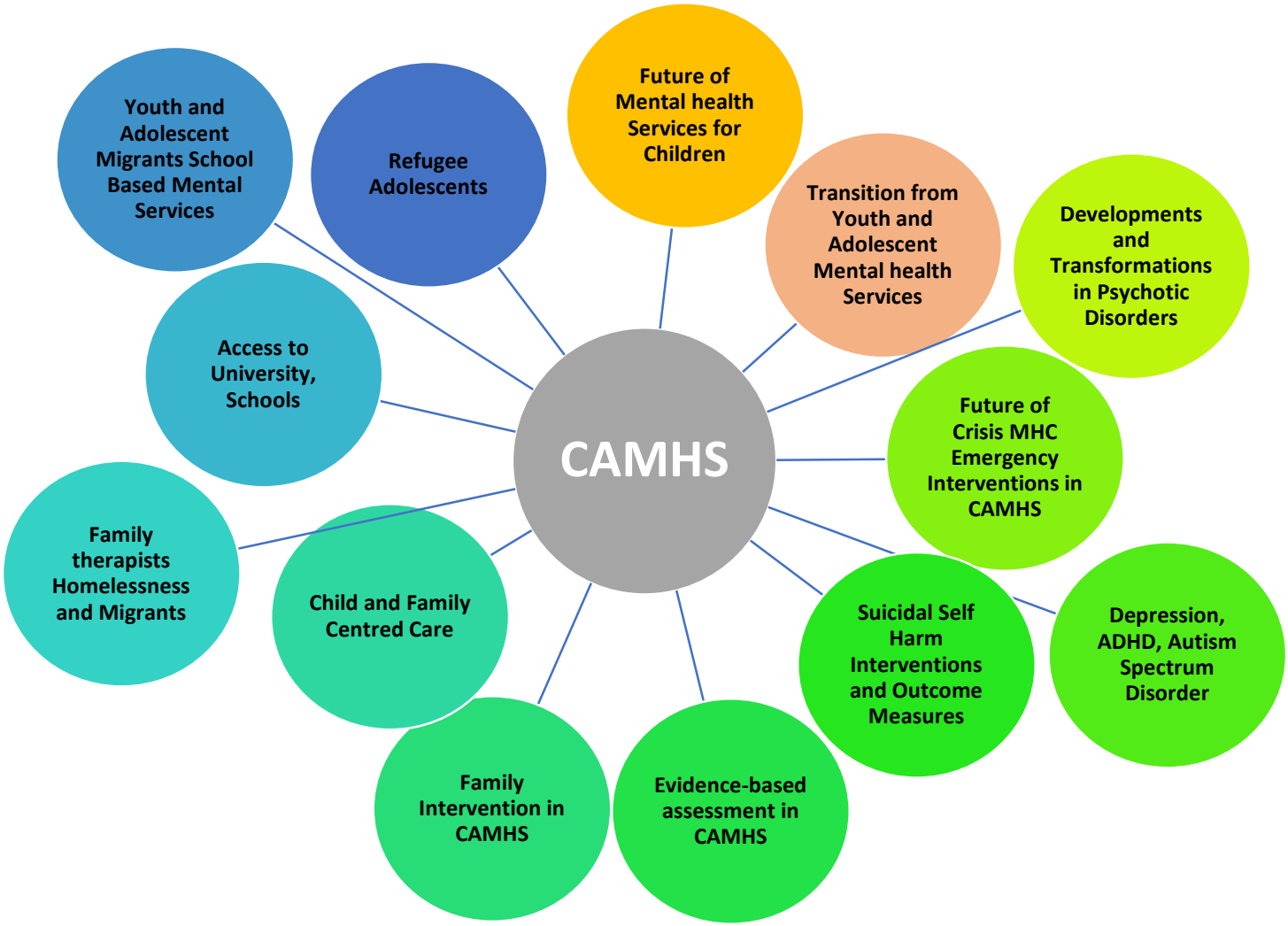
including multiple interfaces with the legal system. Key workers in forensic services are advised to facilitate the transition process by developing sustainable relationships with the young person and creating a safe clinical environment.

10.21 Police encounters with children and youth accessing mental health services

Two studies explore reasons for police encounters and risk of re-offending. Within the Canadian context, a study undertaken by Liegghio et al. (2017), with children and youth (n=1,449) who had police involvement at the time of accessing mental health services, indicates that over a five year period the average number of young people with police involvement was one in six. Analysis revealed that support in the home for a distressed child and concerns about a child's conduct and behaviours in the community were the main reasons for police involvement, indicating the need for community social work practice involvement.

In conclusion, descriptions of what 'child and adolescence' research means varied across studies, yet despite variability shared common features were found. Studies include exploration of the future of mental health services and of child and youth mental health. Papers were found on services, transition from child to adult services, recent developments, crisis mental care in emergency, recurrent use of services, transferral, interventions, EBP, and mental health illnesses including frequently found conditions such as psychosis, schizophrenia, suicide and violence. Studies also related to homelessness, ethnic minorities and school children with mental health illness. Adolescence and emerging adulthood corresponds to a period of disconnection from healthcare services for young men. The importance of enhanced primary care early intervention centres that support identification of barriers to access and the difficulty encountered by young men and support with difficulties encountered in navigating the system are highlighted as areas for further research. A substantial number of children experience persistent or recurrent problems and may need more than one episode of care. Yet, there is a paucity of research on recurrent service use. Children and young people in the care system experience high levels of mental health difficulties, yet their views on these difficulties and of mental health services have rarely been explored. See Figure 5 for summary of child and adolescent mental health services. See Appendix I for more information on the subjects discussed in this section. Recommendations are suggested.

Figure 5: Child and adolescent mental health services



11. Continuing mental health care / long stay

There are predictable declines associated with the aging process. Older persons with cognitive or health declines experience increasing vulnerability to others' predatory behaviours, including family and neighbours. Speck and Baker (2021) demonstrate a classification system designed to document cognitive and health decline patterns over time with Legal Nurse Consultants: using caregiver reports or medical/social records. When detected, the increased risk for the older person is an opportunity to determine the level of decline and identify interventions to mitigate maltreatment risk. Huang (2021) attempts to reduce long stays (defined as >30 days) by identifying the causes and preventing such situations. Findings show that by focusing on the causes of long stay it is possible to reduce the length of stay of patients using an aggressive management strategy. Turcotte et al. (2019) identify patient attributes associated with a prolonged length of stay in complex continuing care hospitals. This study identified care variables that are predictors of prolonged length of stay and that provide information for care planners and health system administrators working to improve patient flow in this context and which includes planning. Allison et al. (2018) discuss the implications for mental health service planning including the avoidance of long stay care.

The Australasian College for Emergency Medicine (ACEM) study of 72 hospitals in Australian and New Zealand revealed that people with severe mental illness often face long stays in emergency departments while waiting for a hospital psychiatric bed. For older people, a long stay in the emergency department (ED) may reflect the complexity of their presentation, or deficiencies in systems that manage these complexities. In an Australian study, Sweeny et al. (2020) identify predictors of a long ED length of stay for patients ≥65 years old (n=16,791). Findings demonstrate that increasing age was associated with an increasing ED length of stay. Increasing age was also associated with malnutrition. Kao (2021) explores the nutritional care of older adult residents living in long-term care facilities and recommends monitoring their nutritional status and developing appropriate nutritional care plans as this initiative can help prevent development of disabilities in older adult residents, and reduce long-term healthcare expenditures. Woodward et al. (2020) determine the incidence and the characteristics of patients who developed hospital-acquired malnutrition (HAM) across five Australian public hospitals (n=17,717) and found that the incidence of HAM was significantly associated with long LOS, transferring between hospitals, developing a cognitive impairment and a pressure injury or fall during admission.

Recovery models seek to operationalise recovery by improving mental health in people with severe and enduring conditions. Residential In-Reach services were implemented in Australia, to treat residential aged care residents for acute conditions in their place of residence, to avoid preventable hospital presentation. Kwa et al. (2021) compare acute healthcare resource utilisation by residential aged care residents under two models of care and observed that in the 12 months following implementation of the new model of care an increase in Residential-in-Reach activity and a decrease in emergency department presentations was found. Embedding the principles of recovery-oriented practice into care by providing recovery education and training for staff promotes active service users engagement (Nardella et al. 2021), and makes the philosophy of recovery a reality in mental health practice (Mc Sharry and O' Grady 2021).

It is not known if acute hospital care comprehensively address interrelated factors that contribute to preventable harms that are common in older hospitalised patients. Redley and Baker (2019) (n=400) test the mnemonic *Have you SCAND MMe Please?* in four hospital in Australia to audit nursing care in preventing harm to older inpatients. The framework provides a model for harm prevention to improve quality of care, cost effectiveness and safety for older hospitalised patients. Miller et al. (2018), in the United States, develop an integrated framework to track care that was expected to improve efficiencies.
ACP is fundamental to guiding medical care. O'Hanlon et al. (2018) develop an Economic Framework for quantifying the economic effects of ACP and indicate that ACP can lead to more efficient allocation of resources by aligning care to patient preferences. There has been considerable interest in using the ASCOT toolkit, developed in England, to measure quality-of-life outcomes of long-term care (LTC-QoL) (Trukeschitz et al. 2020). Further research on the reliability, effectiveness and feasibility of using the tool in different care settings and in different countries was recommended.

Older persons also suffer stigma. Findings from a Korean national survey (n=3,055) found that utilisation of services by the elderly was more strongly affected by perceived stigma than by younger groups, indicating the need to improve access to mental health care among elderly people (Park et al. 2015).

Medication management poses difficulties for older persons. Silverstone-Simard et al. (2021) examine the association of medication use and other clinical factors associated with the amount of time until a patient is considered dischargeable from an inpatient unit. The study was undertaken with patients (n=200) with dementia and agitation, hospitalised at a Canadian hospital. Olanzapine, benzodiazepine, and PRN benzodiazepine use were associated with longer time until patients with dementia and agitation were considered ready for discharge. This raises the question as to whether the risks of these medications outweigh the benefits in a hospital setting. Winter et al. (2019) evaluate trends in reporting diagnoses of long-stay residents on antipsychotics reporting of schizophrenia, Tourette's, and Huntington's and identify that the increased reporting of these diagnoses appears to be new and concentrated in residents on antipsychotics.

Long stay individuals are also involved in forensic mental health services including long stay hospitalisation. Senn et al. (2020) compare the characteristics of long-stay patients in England (n=401) and in the Netherlands (n=102) in an attempt to draw conclusions on the degree to which the Dutch service model might be relevant to England. Findings indicate that compared to their English counterparts, the long-stay Dutch patients were less likely to be diagnosed with schizophrenia, but more likely to have personality disorder and have committed sex offences. The English group were younger at first conviction and at first custodial sentence.

Di Lorenzo et al. (2020) evaluate the longest hospitalisations in an acute psychiatric ward to identify the factors that contribute to long-stay. Findings indicate that clinical illness severity and the need for complex therapeutic and rehabilitative treatments was associated with prolonged psychiatric hospitalisations. Holley et al. (2020) explore how long stay patients experience secure care and the factors that they felt influenced long stay. They identify that planning care for long stay patients in secure psychiatric settings should take account of the differing stances patients adopt towards engagement and progression.

There is little information available about the daily experiences of nurses working in forensic nursing. Dutta et al. (2016) explore the roles and relationships of forensic psychiatric nurses with long-stay patients, in a high secure hospital, in England. Nurses interviewed were committed professionals. The study presents a number of pertinent issues regarding long-stay patients that provide a basis for further research and inform policy, educational reforms, and clinical practice.

In conclusion, research studies on continuing mental health and long stay patients are scarce and few large scale studies were found. There are predictable declines associated with the aging process that leaves older persons with cognitive or health declines and vulnerable to others' predatory behaviours and abuse, including from family and neighbours. It is not known if acute hospital care comprehensively addresses interrelated factors that contribute to preventable harms common in older hospitalised patients, as research in this area is also limited. Medication management poses difficulties for older persons often resulting in confusion, falls and limited nutritional intake. Long stay individuals are also involved in forensic mental health services including long stay hospitalisation. These areas require further research. Recommendations are suggested.

12. Digital e-Technology in Mental Health Services

A large number of studies address technology use. Most countries are undergoing a technological revolution, including meeting health needs through technology. Government policy is shifting towards a "digital by default" position in many countries (Tobitt and Percival 2019, HSE 2020). Telehealth-based services in community mental health settings are on the rise and growth is expected to continue (McClellan et al. 2020). Within the Australian context barriers to usage include clinician reluctance, lack of consumer awareness, structural barriers such as funding and gaps in the translational evidence base (Batterham et al. 2015, McClellan et al. 2020).

Implementation strategies are needed to promote tele health benefits. Benefits include economic gains, reductions in disease burden and greater availability of interventions for prevention and treatment of mental ill-health. Increasing knowledge about the effectiveness of telehealth and providing clinicians with safe opportunities to gain comfort and competency with the technology is needed. Favourable opinions of telehealth are reported (McClellan et al. 2020). High levels of patient engagement compared to in-person service attendance was found. Positive outcomes are reported including an increase in the number of patients served, efficiency in service delivery, positive feedback from patients, families and staff members indicating that tele psychiatry is a realistic option for community mental health services. Further research was indicated in relation to tele psychiatry planning and implementation (Zulfic et al. 2020, Mahmoud et al. 2021).

12.1 Use of Specific Telehealth Initiatives

Twelve studies address the use of specific Telehealth Initiatives, including SMS reminders, social media platforms, smart phone apps, mobile, computer, internet, video game use, video conferencing and Photovoice as contributing to telehealth. The use of diverse initiatives highlights the increasing importance of telehealth usage in mental health, including for child and adolescents (Comer and Myers 2016, Bonfils et al. 2018, Pithara et al. 2020). SMS reminders to attend appointments are increasingly being used, yet its efficacy remains unclear. Increased rates of non-attendance/did not attend (DNA) to healthcare appointments remain a problem. A study undertaken in a community mental health care team in the United Kingdom identified negative barriers as increased costs and wasted clinician time. However, this study also found that the average DNA was reduced from 5% -12%, indicting that SMS reminders could provide an inexpensive way of achieving reductions in DNA. Further research with a larger and randomised sample size was indicated (Anyaegbu 2021).

Online social networking is ever present, but research regarding its relationship to wellbeing has yielded contradictory results. Seven aspects of 3,674 Facebook posts identified that Facebook has the potential to forge social connections for those who are socially isolated, but its use was neither helpful nor harmful. Given the prevalence of social networking, a clearer understanding of its impact on wellbeing is needed for mental health providers (Kjelsaas et al. 2019). Many smartphone applications for mental health (MHapps) are available to the public. The efficacy of three publicly available MHapps (n=226) to a waitlist control condition was examined in a RCT that tracked cognitive behaviour, toolkit App and CBT strategy. Results indicate that increasing coping self-efficacy, rather than emotional self-awareness or mental health literacy, was the underlying process contributing to effects on mental health for all three MHapps (Bakker et al. 2018).

Mobile, Computer and Internet use in Rehabilitation in Psychosis is being used. Findings from a UK survey to gauge levels of engagement with mobile phones (Internet-enabled or cell phone), computers and the Internet in community mental health rehabilitation found levels of engagement in patients with Psychosis as being substantially less than those recorded in the general population (Briand et al. 2018). Ensuring equal access to online opportunities, including healthcare innovations and implementation was recommended (Tobitt and Percival 2019). To help meet this aim an innovative mobile digital Care Pathway Tool, that used principles of co-production was piloted by Pithara et al. (2020) (n=20) to identify factors influencing its implementation. The tool was thought to facilitate co-produced recovery-focused care planning. However issues needing further research were identified as Internet connectivity and organisation resources such as information technology and intervention engagement.

Video and Phone Conferencing-mediated psychological therapy for adult clients with intellectual disability is being explored in order to change how psychological assessments and interventions are delivered. Clients referred for psychological therapy at an adult intellectual disabilities' community health service, in England, were deemed suitable for phone therapy. All clients were assessed using the Red/Amber/Green (RAG) system by a consultant clinical psychologist for risk and potential suitability given their ability and needs. It is hoped the data will be used to help inform practice or policy when using such systems (Tobitt and Percival 2019). Chivilgina et al. (2021) explore digital technologies for patients with schizophrenia.

12.2 Smartphone and video gaming use

This is a growing area, including increasing interest in the use of gaming clinically. An Irish survey indicates that an opportunity exists for mental health professionals to deliver interventions through smartphone and video games (Rowntree and Feeney 2019). Telehealth is also being used to build wellness behaviour and make lifestyle changes (Bakker et al. 2018). The use of telephone-based behavioural change to support services among clients (n=375) indicates that television was the most common source of awareness. Telephone services strategies to optimise reach were recommended (Fehily et al. 2020).

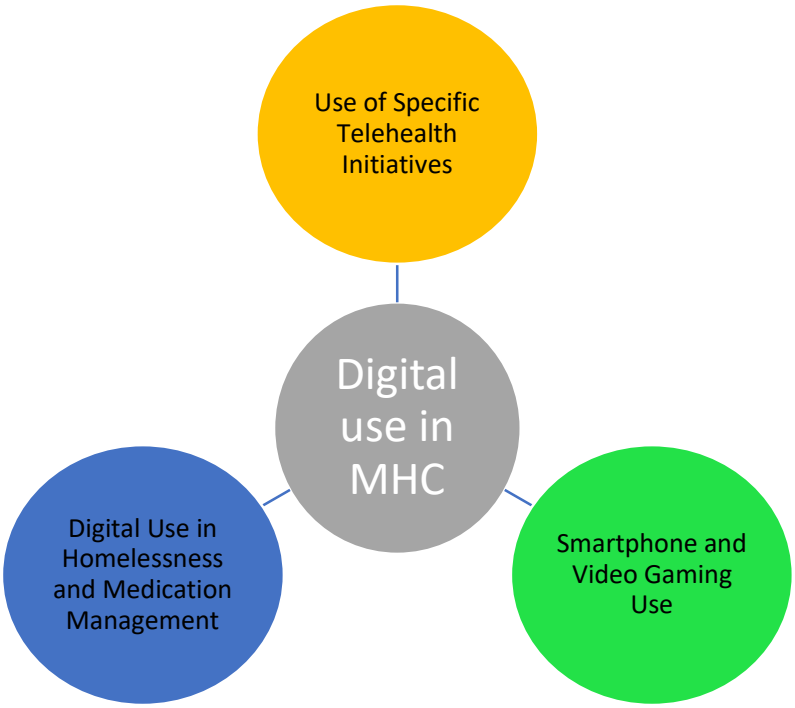
12.3 Digital use in homelessness and medication management

Watson et al. (2020) in exploring medication-taking behaviours and factors influencing adherence in patients with mental illness and recent homelessness found external supports and individual medication management strategies important in supporting medication adherence. Perceived need for mobile technology, in addition to existing supports for adherence, was low. The Recovery Coach and Peer Support Initiative (RCPSI), undertaken in Indiana, focused on peer recovery coaches engaging with opioid overdose patients in emergency department settings. The initiative promoted entry into recovery services with the support of representatives of eleven local health service vendors. Teleconference meetings served as the main component of an informal learning collaborative (Staton et al. 2021).

In conclusion, tele health is now reaching mental health clients with positive examples of usage in community mental health services and with usage of smart phones and apps. Negative clinician attitudes toward telehealth are identified as a key barrier to overall telehealth acceptance and implementation. Concerns about software and equipment usability and whether telehealth-delivered services are equivalent to face-to-face treatment were the main areas of concern

expressed by clinicians. The effectiveness of telehealth and providing clinicians with safe opportunities to gain competency with the technology are needed. Use of Tele psychiatry is in its infancy, yet a growing need is recognised across community mental health care organisations in many countries. See Figure 6 for summary of digital use in mental health care. See Appendix I for further information on the areas presented in this section. Recommendations are suggested.

Figure 6: Digital use in mental health care



13. Ethnicity

Access and utilisation of mental health services for immigrants and refugees were the main areas related to ethnicity found in the evidence review. Five studies discussed immigrant and refugee population's experiences and life stressors as a result of difficult migration journeys and challenges in leaving one country and adapting to another country and to service providers (Ellis et al. 2020). These life stressors resulted in adverse mental health outcomes and inadequate support-enhancing resources. Asylum seekers and refugees face barriers in accessing and negotiating mental health services, education and training. A study undertaken with nine Canadian immigrant serving agencies (n=53) reported on the complexity of access, language barriers, cultural interpretations of mental health and stigma around mental illness (Salami et al. 2019). Improving mental health service delivery to immigrants, developing community-based services, training immigrant service providers, enhancing collaboration across sectors and appointing more interpreters were recommended.

In relation to the barriers faced by young refugees, the Candidacy Framework (CF) (n=23), identifies the need for a holistic approach to overcoming barriers (van der Boor and White 2020). Resettlement stress, distrust of authority and power, stigma of mental illness, language and cultural barriers were found (Ellis et al. 2020). Young refugees from similar backgrounds face similar barriers as adults do. An Australian study found that young people (n=16) placed most emphasis on interpersonal relationships, traumatic experiences they had encountered and the practitioner's sensitivity to their cultural background. These findings indicate the need for practitioners to adopt a contextualised approach to cultural sensitivity (Valibhoy et al. 2017). A comparative study, undertaken in the UK, found that black and mixed-race young people (n=14,588) were more than twice as likely to be referred through social care and youth justice than through primary care compared to young white British people accessing youth mental health services. Understanding the reasons for these differences is critical to reducing inequalities and improving pathways to mental health care access for this population (Edbrooke-Childs and Patalay 2019).

13.1 Coercion, discrimination, rights, will and preferences

Few research studies are aimed at reducing coercive rights and the laws that govern such rights. Initiatives aimed at preventing and reducing 'coercive practices' in mental health and community settings identify opportunities to promote individuals' rights, will and preferences. Efforts to prevent and reduce coercion appear to be effective. However, no jurisdiction appears to have combined the full suite of laws, policies and practices which are available, and which taken together might further the goal of eliminating coercion (Gooding et al. 2020). Considerable variation exists in how individuals with a diagnosis of mental illness experience discrimination. Findings from a study exploring discrimination experiences of people (n=3,579) using mental health services in England suggest that discrimination is not related to specific diagnosis but rather is associated with mental health problems generally (Hamilton et al. 2016). Discrimination experienced by adults (n=202) receiving care from community mental health teams was associated with low engagement with services. Least restrictive practice is a key principle of mental health legislation as this seeks to minimise coercion and maximise the human rights of mental health services (Gooding et al. 2020).

There is conflicting and equivocal evidence for the efficacy of compulsory community treatment. Although people from indigenous or culturally and linguistically diverse backgrounds are over-represented in compulsory admissions to hospitals, little is known about whether this also applies to

compulsory community treatment, which also includes forensic orders. Using databases from Queensland (n =14,864), Kisely et al. (2020), investigated whether people from these backgrounds were more likely to be on compulsory treatment and if so the impact on health service use over the following 12 months. Findings indicate that in common with other coercive treatments people from culturally and linguistically diverse backgrounds were more likely to be placed on compulsory community treatment, although the evidence for effectiveness remains inconclusive.

13.2 Stigma

Stigma was a consistent theme across mental health studies. Individuals struggling with SMI may experience stigma along multiple dimensions. These dimensions include experiences of discrimination by others, unwillingness to disclose information about their mental health and their internalisation or rejection of the negative and positive aspects of having mental health problems (Park et al 2015, Hofmann et al. 2020). Diagnoses and self-reported stigma among people receiving mental health services in California were explored by Sarkin et al. (2015). Results show that although people (n=1,237) with mood disorders reported more discomfort with disclosing mental illness than people with schizophrenia yet, they did not report experiencing more discrimination than people with schizophrenia, suggesting that the multidimensional experiences of stigma differ as a function of age, gender, and diagnosis. A study exploring https://web-b-ebscohost-com.proxy.library.rcsi.ie/ehost/viewarticle/render?data=dGJyMPPp44rp2/dV0+njisfk5Ie46bNJrqe0TrCk63nn5Kx95uXxjL6orUmvpbBIsKeeTrirrlKwqJ5Zy5zyit/k8Xnh6ueH7N/iVauos1Cwp7BOt66ki+fau1Hgr6994Ku3Rd+v33urqrdO4KO2Ua+rq1C227VOta+xUbCstFju2uFF9KPxffHp63/wpq8+6tfsf7vb7D7i2Lt769vihaTq33+7t8w+3+S7SrOqrk6ypq8+5OXwhd/qu37z4uqM4+7y&vid=48&sid=9b91eb59-a9ac-496b-8915-88e767939266@pdc-v-sessmgr01perceptions of shame in second generation Mexican American people suggests that discomfort with emotional topics, family norms, and confidentiality concerns were major obstacles to engagement with mental health services, indicating the need for improving engagement with mental health services (Hofmann et al. 2020). Cultural adaptations and the potential efficacy gains of cultural adaptations to service delivery were found to be helpful (Healey et al. 2017).

Stigma of mental ill-health and attitudes towards help-seeking are recognised barriers to seeking professional help. A study undertaken in two localities in Britain, by Kearns et al. (2019) explored if the introduction of community-based mental health services to a geographic area impacts mental health stigma and attitudes towards local residents (n=1,074) seeking professional help. Findings indicate that the presence of local, accessible mental health services positively impacted help-seeking behaviour by reducing stigma and changing norms and attitudes around professional help-seeking.

Racial ethnic differences of persons receiving mental health services exist. Inequalities in mental health are documented using individual social statuses such as SES, ethnicity and migration status (Goodwin et al. 2018). A mental health needs assessment was undertaken by Torres Stone et al. (2020) with sixty-one residents and/or consumers of mental health services, in New England, USA. Findings show that systems-related and psycho-social barriers to seeking services included difficulty in navigating the system, mental health stigma, language barriers and few culturally competent providers. Collaborative efforts across stakeholders were called for to address the mental health needs of racial and ethnic minorities (Torres Stone et al. 2020). Associative stigma amongst mental

health providers may also exist. Yanos et al. (2020) use the Clinician Associative Stigma Scale (CASS)(2017) to explore the associations with measures of burnout, job satisfaction and turnover intention in service providers (n=68) in a community mental health centre, in the USA. Findings suggest that CASS significantly predicted burnout and job satisfaction, indicating that associative stigma may have negative consequences for mental health services providers.

13.3 Racial and ethnic differences in mental health associated medical conditions

Just four relevant papers were found that associated mental health illness and medical conditions. This included pregnant women who had reported prenatal depressive symptoms by race or ethnicity. A study undertaken in Florida, among pregnant women (n=81,910), using data from the Florida Healthy prenatal screening programme found that pregnant Hispanic women, reporting prenatal depressive symptoms, were least likely to use mental health services. Findings have significant public health implications that identify the need for targeted intervention for pregnant women with prenatal depressive symptoms (Chang et al. 2016).

In a different context, a study undertaken in Germany, by Morawa and Erim (2020) with ethnic adult cancer survivors (CS) of different ethnic origins, who also experienced depression (n=255), indicates no substantial differences between migrants and native cancer survivors, thought to be due to migrants´ good language proficiency and German citizenship or unlimited residence permit. Culturally and linguistically diverse mental health communities found that co-design improved best practice methods for service design and service improvement (O Brien et al. 2021).

Even though asylum seekers are considered vulnerable to mental ill-health, knowledge of their suicidal behaviour is limited. Sundvall et al. (2015) in seeking to understand the factors that influence the clinical assessment of asylum seekers who have attempted suicide compared to matched non-asylum Swedish suicide attempters (n=88) found that asylum seekers were more traumatised, received different diagnoses than the control group and were referred to less specialised follow-up after treatment, indicating unequal access to care.

13.4 Ethnic minorities, underserved and minority indigenous persons and Travellers

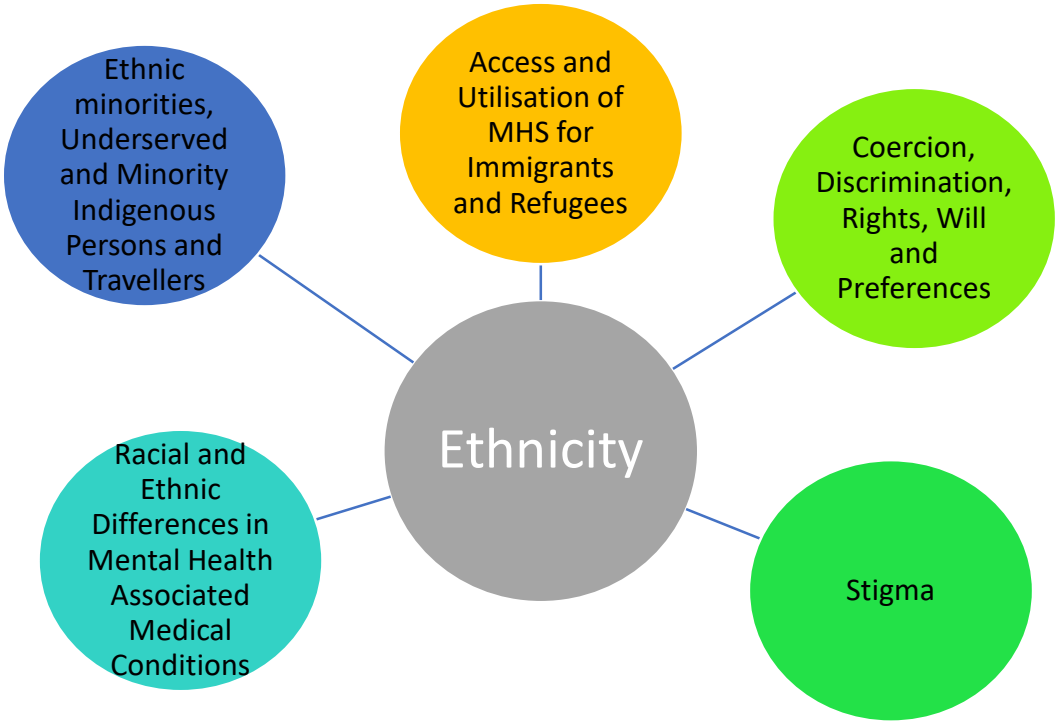
Individuals who are homeless or in vulnerable housing situations are at an increased risk for mental illness, other morbidities and premature death. Standard person case management, assertive community treatment and interventions provided at a critical time improved healthcare navigation (Ponka et al. 2020). These interventions were found to improve health and social outcomes and to be cost-effective (Ponka et al. 2020). Interventions for homeless youth suffering from first episode psychosis and comorbid substance use disorder remain under researched. A Canadian Assertive community intervention team offering outreach interventions and integrated care for this group is associated with earlier housing stability and reduced hospitalisation (Doré-Gauthier et al. 2019). Culturally appropriate mental health services are essential for indigenous people who suffer the greatest mental health disparities of any ethnic group. Yet, few mental health professionals receive training to work with this population (Lewis et al. 2018, 2019). These researchers recommend that training sessions for professionals and organisations needs to include information that is grounded in cultural competency and cultural humility and that aims to increase knowledge, awareness, and skills (Lewis et al. 2018, 2019).

The management and delivery of short term mental health services to underserviced and hard to reach individuals has also been explored. A study that places emphasis on coordination between health professionals involved in the Psychological Support Services programme in Sydney Primary Care Network and a centrally coordinated referral process were successful in supporting clients to ensure they did not fall through the gaps (Makam and Cheung 2018). Chu et al. (2020) explore shelter utilisation of *Housing First* across five Canadian cities. They identified individual participant characteristics that are associated with different shelter use patterns. This knowledge may help to inform service planning and contribute to modelling efforts for homelessness. Another group needing services is the immigrant community based outreach and treatment for underserved older adults with clinical worry. A study undertaken In Texas by Stanley et al. (2018), to determine whether an intervention termed Calmer Life improved worry and anxiety disorder-related symptoms for such older adults found improvements at 6 and 9 months, indicating its usefulness for low-income older adults with identified worry or anxiety.

Travellers are a minority ethnic group who experience a high prevalence of mental health problems and a rate of suicide six times higher compared to the general Irish population (Villani and Barry 2021). Adult Travellers' perceptions of mental health and relevant factors required for promoting positive mental health were explored. Findings indicate that Travellers conceptualise mental health mostly in negative terms and show a lack of awareness of the concept of positive mental health. Cultural identity and social-emotional skills emerged as key factors in promoting positive mental health among Travellers (Villani and Barry 2021).

In conclusion, stigma was a consistent theme across studies. *A*ccess and utilisation of mental health services for immigrants and refugees were the main areas found in the evidence review. Studies identified immigrant and refugee population's experiences and life stressors due to difficult migration journeys and adaptation challenges. Studies also related to ethnic minorities, underserved and minority indigenous persons and to Travellers, interventions, supports and coordinated services. Culturally appropriate mental health services are essential for ethnic minorities and Travellers yet, few mental health professionals receive training to work with these populations. See Figure 7 for summary of Ethnicity and Recommendations for more detail.

Figure 7: Ethnicity



14. Forensic mental health care

Excellence in forensic and other mental health services can be recognised by the necessary abilities to conduct RCTs and rigorous quantitative research to continuously improve outcomes from treatment (Kennedy et al. 2019).

Kennedy et al. (2021) seek to accelerate transformation in forensic psychiatry following Covid-19 in the Republic of Ireland. They highlight how urgent and clinically led responses had underlined redundancies and confusions in the governance of mental health services and a vacuum in policy making. These authors make a number of recommendations to improve forensic mental health services. They recommend a greater emphasis on services for patients with schizophrenia and other severe, enduring mental disorders that aim at reducing standardised mortality ratios, managing risk of violence and improving outcomes such as symptomatic remission, functional recovery and forensic recovery of autonomy. They also seek more use of information technology at service level and at national level to use Scandinavian-style population-based data linkage research that should become legally sanctioned and necessary. A further recommendation is that a national research and development centre for medical excellence in forensic psychiatry be established as a matter of urgency. This new centre needs to be complimentary to and different from quality management.

14.1 Effects of Community Treatment Orders- First episode of psychosis

When patients are judged to legally lack the capacity to consent to care, treatment can be mandated through Community Treatment Orders (CTO's). Seven studies relating to CTOs were found. CTO's are a controversial practice as they extend the practice of involuntary treatment into the community. Levy (2018) explores the effects of CTOs in persons (n=38) exhibiting symptoms of First Episode of Psychosis and who were legally deemed unable to consent to care during their follow-up. Findings indicate that after receiving the CTO patients received treatment and had significant improvements reported in clinical and functional outcomes.

O' Donoghue et al. (2016) undertook a study in New Zealand to determine whether there was a difference in the rate of CTOs and revocation (readmission) orders following the implementation of a recovery-orientated model. Findings indicate that prior to the re-configuration there were 893 individuals subject to a CTO and 136 of these individuals had a revocation of their CTO. Limited evidence is available regarding the effect of CTOs on mortality and readmission to psychiatric hospital.

Outpatient civil commitment (OCC), termed CTOs in European and Commonwealth nations, requires the provision of needed-treatment to protect individuals against imminent threats to health and safety. Segal (2020) evaluates consistency in OCC-outcomes. Findings indicate that OCC was based on mental health system characteristics, measurement and design principles thus indicating beneficial associations between OCC and direct measures of imminent harm and reductions in threats to health and safety. Segal finds support for OCC as a less restrictive alternative to inpatient care. Dawson et al. (2021), in an Australian study, examine how the concepts of risk and risk management impact care planning from the perspectives of individuals on CTOs, their families, and clinicians. Findings show that care planning occurred within a culture of practice dominated by risk that was understood differently by each participant group. They further recommend that practice needs to broaden to include understanding of the personal and social adversities individual's face that permits them to change their focus from clinical recovery to recovering socially (Dawson et al.

2021). Ross (2020), in an Australian study, explores coercive practice, with a focus on seclusion from a whole-of-mental-health-system perspective as distinct from the behaviour of individual service users. Findings indicate that exemplars can strengthen the utility of the least restrictive principle by focusing on systemic changes and community level alternatives to hospitalisation, coercion and seclusion.

Clinical outcomes between patients placed on CTOs were compared to a control group of patients discharged to voluntary community mental healthcare, in the UK, using the Clinical Record Interactive Search (CRIS) system. Findings from this study by Barkhuizen et al. (2020) demonstrate that 830 participants were discharged on a CTO and 3,659 control participants were discharged without a CTO. Those on CTOs were readmitted sooner, spend more time in hospital and had a lower mortality rate. The potentially disproportionate role of misdemeanour arrests on competency services was explored by Gardner et al. (2020). A review of court-ordered competence evaluation reports in Virginia, USA, comparing defendants facing only misdemeanour charges to defendants facing felony charges (n=1,126) identify that defendant's facing only misdemeanours were more often thought to be incompetent to stand trial than were defendants facing only felony charges, perhaps due to the greater prevalence of psychotic symptoms. This finding suggests that incompetence opinions were primarily explained by the presence of psychotic symptoms (Gardner et al. 2020).

14.2 Disengaging with Psychosis

Individuals with psychosis are over-represented in the criminal justice system and as a group are at elevated risk of re-offending. Studies have observed an association between increased contacts with mental health services and reduced risk of re-offending in those who are ordered to mental health treatment, rather than punitive sanctions. The effect of disengagement from mental health treatment on probability of re-offence was explored in a study undertaken in Australia, by Hwang et al. (2020) (n=4,960) with offenders, with psychosis who had received non-custodial sentences and had engaged with community-based mental health treatment. A threefold increase was observed in the risk of re-offending for those who disengaged from treatment compared to those who did not, indicating the need for continued engagement with mental health services following release for offenders with psychosis. Independent Mental Health Advocacy (IMHA) has been proposed as a way of maintaining peoples' rights in involuntary settings, but little is known about the challenges and opportunities associated with this provision to those on compulsory treatment orders in the community (Weller et al. 2019).

In Australia, an IMHA service is available to people who are at risk of or subject to compulsory treatment, including those who are subject to CTOs. The IMHA service provides independent non-legal advocacy to those in the community. Findings indicate that while advocacy was well received by consumers, tensions specific to the community setting were influenced by the attitudes of clinicians to need, risk and recovery as opposed to a coherent understanding of consumer preference and choice (Weller et al. 2019). Results from a study undertaken by Wilson et al. (2017), (n=46), relating to the facilitators and barriers associated with engaging criminogenic interventions in community mental health settings suggest that participants supported the provision of criminogenic interventions to justice involved persons with serious mental illness in this setting. Key issues to consider when engaging criminogenic interventions include identifying sustainable funding

sources, providing training for staff and tailoring the delivery and pace of the content to the particular treatment needs of participants (Wilson et al. 2017).

14.3 Involuntary certification

A number of retrieval studies relate to certification, high risk offenders, aggression and police encounters. Involuntary certification in a secure forensic centre may occur if a person is mentally ill, incapable of making treatment decision and likely to cause harm to self or others. A Canadian study with (n= 112) certified patients treated during hospital admissions found that fifty patients required more than one certification. Among those certified, schizophrenia and related psychosis, substance use disorder and antisocial personality disorder were the most common discharge diagnoses, and antipsychotics the most frequent discharge medications (Adelugba et al. 2015). The role of compulsory treatment of serious mental disorders has been the topic of public debate in some countries (Weller et al. 2019), yet, little is known about the attitudes of the general public towards involuntary admission and compulsory treatment of people with serious mental disorders. Public attitude was explored in a sample of 2,001 persons in Norway, by Joa et al. (2017) using Computer Assisted Telephone Interviews (CATI). Findings demonstrate that the adult population largely supported current legislation and practices regarding involuntary admission and compulsory treatment in the mental health services.

14.4 Transition from Institution to Community

Transition poses difficulties for offenders with serious mental disorders. The Community Mental Health Initiative assists offenders with serious mental disorders in their transition from institutions to the community (Hwang et al. (2020). The initiative incorporates different styles of service that may produce different intervention outcomes. Research indicates that men receiving only community mental health services had a significantly lower risk of returning to custody and of recidivism than men receiving discharge planning alone or no community mental health services at all (Stewart et al. 2017). Research has suggested that increased length of mandated community treatment for individuals with a serious mental disorder leads to better outcomes, but few studies report whether these outcomes are maintained after treatment ends. McDermott et al. (2020) evaluate the impact of court-mandated treatment on outcomes for individuals found not guilty by reason of insanity (NGRI) and released to the community. Findings show that 44% of individuals released to the community without court-mandated supervision were arrested for another offense in the study period, compared with 8% released under the supervision of the conditional release programme. In contrast, those who were restored to sanity and ultimately released unconditionally had higher arrest rates (25%). This study suggests that court oversight on an ongoing basis may be necessary to help justice-involved individuals with a serious mental disorder avoid the criminal justice system and remain engaged in community treatment.

Provision of specialised community mental health services for higher-risk male offenders with a mental disorder may reduce recidivism in the short and longer term (Stewart et al 2017). Young offenders with mental health disorder also face difficulties in transition from child and adolescent services to adult mental health services. Key workers in forensic services are advised to facilitate the transition process by developing sustainable relationships with the young person and creating a safe clinical environment (Livanou et al. 2017).

Psychosis is a known risk factor for offending behaviour, but little is known about the association between early contact with mental health services and reoffending after an index offense in individuals with psychosis. This association was examined in Australia by Adily et al. (2020) with a sample of 7,030 offenders. Findings show that the risk of reoffending was significantly lower in those with clinical contact when compared to offenders without clinical contact. Early and frequent clinical contact with mental health services after an index offense was recommended.

14.5 Clinical judgement pathways and aggression

The Auckland Regional Forensic Psychiatry Services introduced structured clinical judgment instruments, developed in Ireland (DUNDRUM-3 and DUNDRUM-4) to assist staff in decision-making regarding service users' clinical pathways. Wharewera-Mika et al. (2020) explored and confirmed the usefulness of the clinical judgement instrument measures in enhancing the overall quality of clinical decision-making. This study recommended the inclusion of an additional 'pillar' focused on cultural identity and spirituality, and to involve cultural expertise at the point of structured clinical judgement when using the measures, thus broadening the use of the instrument for ethnic minorities in other countries.

There is little evidence to demonstrate that neurobiological methods, or other methods independent of clinical judgment, have been investigated to assist decision making in forensic mental health services. Sedgwick et al. (2016) (n=50), indicate that poor performance on tests of cognitive control and social cognition predict inpatient violence while a neuro-physiological measure of impulsiveness shows utility in predicting reoffending. Patient aggression found in in-patient mental health services is more likely when dynamic risk factors escalate. Greer et al. (2020) (n=25), identify a number of dynamic risk factors associated with inpatient aggression with an overlay between forensic and non-forensic services. It was found that individual cognitive, affective, behavioural, and situational factors may be amenable to rehabilitative support.

There is a lack of evidence from the perspectives of patients and service users in understanding a patient's point of view in critical episodes and for deescalating relational tension. The first access to a mental health service is often marked by aggressive behaviours and anger. Listening techniques and ways of personalising the relationship permit the patient to invest in a relationship of trust (Faccio et al. 2021). In investigating male offenders who had contact with forensic mental health services in Australia (n=130), Ogloff et al. (2015) found the majority had co-occurring mental and substance use disorders. A significant minority met the criteria for antisocial personality disorder indicating that those who work with people with psychiatric disabilities and co-occurring substance use disorders need to ensure that the substance disorders are addressed to help ensure recovery from mental illness and to reduce the likelihood of offending. Peer-review networks aims to help services improve the quality of care offered. A peer-review quality network for low-secure mental health services examined the impact of network membership on outcomes of care in (n=38 low secure units) and found no evidence that participation in a peer-review network led to marked changes in the quality of the physical environment of secure units at 12 months (Aimola et al. 2018).

14.6 Aggressive behaviour

The European Violence in Psychiatry Expert Research Group (EViPRG), led by Cowman et al. (2017) aimed to incorporate an EU and multidisciplinary response in the determination of violence management practices and related research and education priorities. This research took place

across 17 European countries via e Delphi with (n=2,809) respondents in Round 1 and (n=999) in Round two, the majority of whom worked clinically in acute psychiatry and the remainder in mental health areas. Results show that 20% of respondents had not received training on violence management, indicating that strategies are needed to prevent aggressive patients from harming themselves, other patients or staff. Violence risk assessment and management should be guided by validated instruments covering both risk and protective factors. The Structured Assessment of Protective Factors (SAPROF) administered to patients (n=261) in the UK indicates that adoption of the SAPROF has the potential to improve awareness of protective factors and enhance therapeutic engagement (Haines et al. 2018).

14.7 Sexual Assault Violence

Sexual assault violence was explored in two studies. The NHS England commissioning guidance for Sexual Assault Referral Centre (SARC) calls for clear pathways between SARCs and other mental health services including: CMHTs; CAMHS or crisis teams (CTs). A survey undertaken in the UK found that few mental health services had formally negotiated pathways with SARCs. Improving relationships between SARCs and mental health services was recommended (Brooker et al. 2019). Intimate Partner Violence (IPV) committed by individuals with severe mental illness (SMI) was evaluated in the context of identifying rates of IPV in the first year post-discharge from psychiatric hospital. Findings show that one in five patients committed at least one act of IPV in the first year and that the risk of IPV was highest immediately post-discharge and decreased over time, with the sharpest decline after 20 weeks, suggesting that coordinated risk management efforts should focus on the time immediately following hospital discharge (Kivisto and Watson 2016).

14.8 Schizophrenia

Six studies examined mental health illness post-discharge. The effects of public attention to schizophrenia on the use of mental health services in patients with schizophrenia was explored in Korea, by using big data analysis. Data on the frequency of internet searches for the condition and the patterns of mental health service utilisation by patients with schizophrenia spectrum disorders was obtained by Hyun et al. (2020). Findings suggest that public attention, awareness, knowledge and perceptions of schizophrenia could negatively affect illness behaviour in patients with the illness.

The level of contact by adults released from prison in Queensland after acute care self-harm was explored. Findings indicate that out of 217 discharges, 55% received mental health care within seven days of discharge, highlighting the need to improve the integration of community mental health care for people with a recent history of incarceration, who present to acute care following self-harm (Young et al. 2020). The use of restrictive practices on males released from prison and entering acute mental health services remains under researched. Quinn et al. (2019) found that those admitted from prison were no more likely to experience restrictive practices than other mental health services users. However, they were more likely to have a co-existing diagnosis of alcohol/substance use or personality disorder, in addition to a primary diagnosis of psychotic illness. This finding suggests that proportionate use of restrictive practices is potentially indicative of the clinical use of effective alternative management strategies. In the UK and Ireland, the mental health of people in prison has received increasing attention with developments and improvements seen in commissioning, provision and quality (Weller et al. 2019, Young et al. 2020). The Quality Network for Prison mental health services initiative explored whether any changes were observed in

the compliance of quality standards. Improvements in five of the nine standard domains tested were found but a longer period of review to fully assess the impact of such programmes within prison mental health services was recommended (Georgiou and Townsend 2019).

14.9 Street triage collaboration between mental health workers and police

Street Triage is a collaborative service between mental health workers and police that aimed to improve the emergency response to individuals experiencing crisis. The design and potential impact of factors hindering or facilitating implementation of the services were explored in two UK locations (n=14) using operating models that included a joint response vehicle or a mental health worker in a police control room. The ability to make referrals to MHS was perceived as a successful outcome however there was evidence to suggest that Street Triage may increase pressure on already stretched mental health and police services (Horspool et al. 2016). A collaborative partnership approach that can advocate for service users in police and mental health services was recommended. Partnerships with community service user organisations were found to be the most empowering model of collaboration through effectively advocating for change (Chambers 2021).

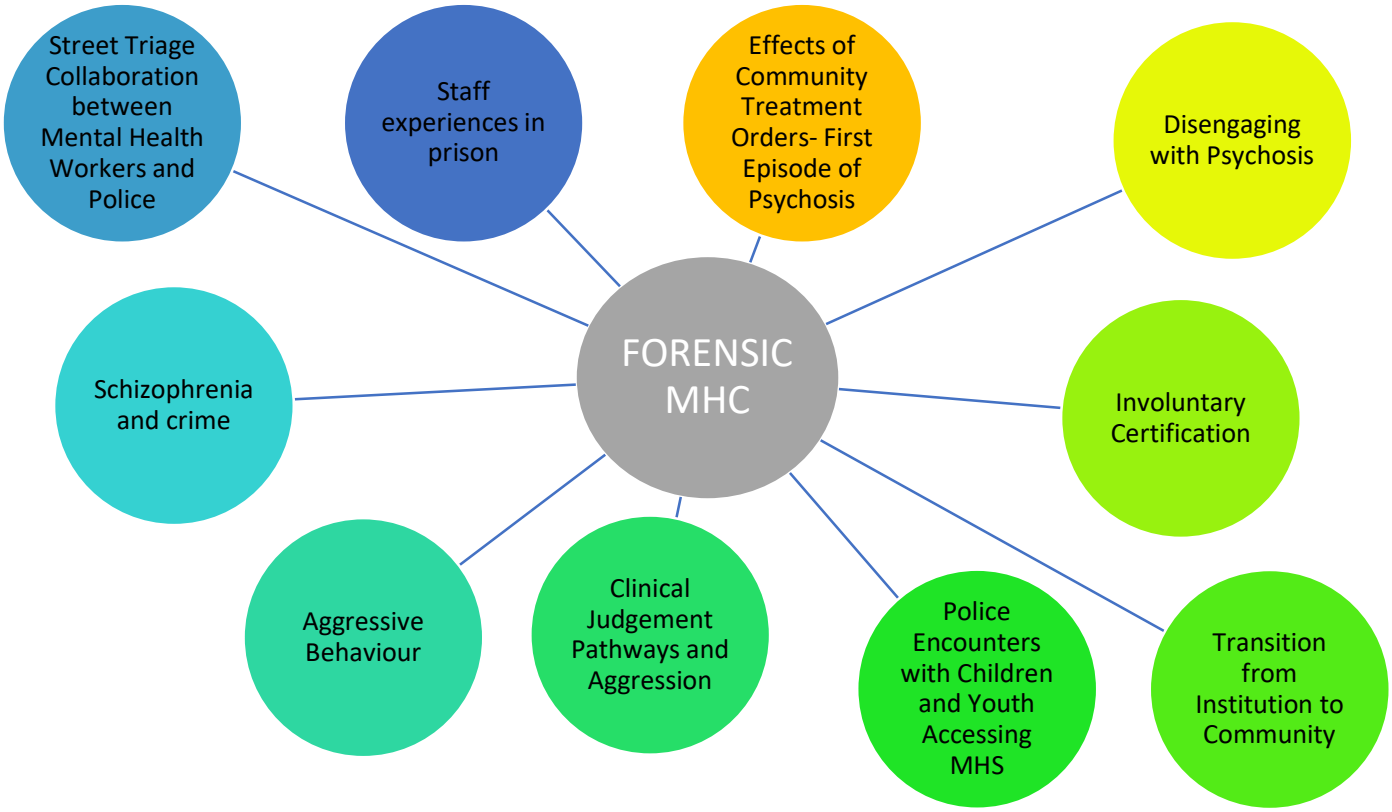
14.10 Staff experiences in prison

Six studies explore the experience of staff working in Forensic Mental Health facilities. Forensic Mental Health (FMH) services represent a complex service area with competing legal, political and health care demands. In many cases, FMH services are the first contact some individuals have with mental health services (Martyr 2017, Forrester et al. 2018). Staff working within these services must navigate the competing demands of care and control. They have an important influence on how FMH services function and on the quality of care that is provided. Mellor (2020), explored how power, control and risk management influenced staff experiences of the therapeutic relationship existing in inpatient FMH services in the UK (n=12). Findings highlight the dynamic process in which staff hold dual-roles between care and control and the importance of staff team cohesion and safety. Forrester et al. (2018), explore human rights abuse in a documentary review exploring contact with mental health services in England and Wales and found increases in self-harm, self-inflicted deaths and violence as areas of controversy. These findings indicate that introducing comprehensive mental health models throughout prisons would provide new services and a rights-based framework for the socially disadvantaged. Findings from a study exploring the communication processes needed when individuals in mental health crisis are taken to the emergency department show differing perceptions relating to privacy concerns (Hickey et al. 2020). Police believed that communication needed to be improved particularly as to the disposition of the individuals they bring to the ED, whereas ED staff believed they communicated well with police, indicating the need for improvement in communication between both groups (Hammervold 2020, Hickey et al. 2020).

In conclusion, FMHSs are growing and provide an important access route to more intensive and sustained pathways through the care and treatments they provide. FMH services represent a complex service area with competing legal, political and health care demands. Incarcerated individuals are a vulnerable population often presenting to mental health services with high rates of mental disorders, substance use abuse and other chronic medical co-morbidities. They also suffer from social stigmatisation. Excellence in forensic and other mental health services can be recognised by the abilities necessary to conduct RCTs and rigorous quantitative research to continuously

improve outcomes from treatment. See Figure 8 for summary on forensic mental health care. Recommendations are suggested.

Figure 8: Forensic mental health care



15. Medication management in mental health

Twelve studies were found that explored prescribing pattern in mental health care. Rowntree et al. (2020), used Business Intelligence software to review the most commonly prescribed psychiatric medication in Ireland. During the study period, Olanzapine was the most commonly prescribed drug, and its use declined by one-quarter over the study period. The monitoring of prescribing has taken place through a Prescription Drug Monitoring Program (PDMP) used to control prescription drug abuse through flags found on PDMP reports (Hunt et al. 2019). Johnson et al. (2019) discuss a quality initiative used to increase the proportion of patients with no identified psychotropic drug discrepancies. This quality initiative led to improved prescribing accuracy and avoidable drug-related harms to patients (Johnson et al 2019). A study exploring the association between medication adherence and disease stability in patients (n=145,860) with mental illness, in Asian communities, found that medication adherence was positively associated with disease stability, however large variations in the rate of medication adherence and disease stability among services could reflect management differences at this level (Li et al. 2020).

Yet, clinician's confidence and readiness remains unclear. A key limitation to medicines utilisation is clinicians' reluctance to include medication-assisted treatment in their routine practice (Iheanacho et al. 2020). Despite the availability, safety and effectiveness of medication-assisted treatment for substance use disorders utilisation remains suboptimal. As patients with severe mental illness often lack care coordination the presence of siloed care across separate health care systems can negatively impact quality and safety of patient care. Group Concept Mapping provides a strategic process to allow future shared decision-making and enhanced collaboration among stakeholders to take place (Hager et al. 2019).

Nurse prescribing in Ireland and the United Kingdom is well established. The nurse prescribing programme commenced in the School of Nursing and Midwifery, RCSI in 2005/2006 and by December 2020, 1,026 nurses and midwives, including nurses registered in mental health, had successfully completed the programme, in RCSI and with other providers across the State (School of Nursing and Midwifery, RCSI 2021). The Certificate in Nurse and Midwife Prescribing is funded by the HSE. The areas in which mental health nurses in Ireland are registered to prescribe are in the mental health sub-specialisms of acute care, addiction, CAMHS, CBT, community, home care, home-based crisis team, intellectual disability, liaison, primary care, prison in-reach liaison, mental health promotion, psychiatry of old age, suicide crisis assessment (SCAN), perinatal and homelessness.

15.1 Antipsychotic medications

Seven studies explored antipsychotic medications (Daviss et al 2016, Alexander and Lynne 2020). Psychotropic prescribing takes place in mental health services and in primary care in Ireland and the UK. People prescribed antipsychotic medication, at risk of developing metabolic syndrome, are on higher doses of antipsychotic drugs than is required for optimal functioning, yet only limited guidelines for reduction exist (Hackett and Fitzgerald 2020). However, individuals offered the opportunity to gradually reduce their doses of antipsychotic drug, in collaboration with the treating psychiatrist, found that at 5 years, there were no significant differences in two outcomes measures: rate of hospitalisation and employment status (Steingard 2018). A QI project aiming to bolster anticholinergic medication (ACM) de-prescription, undertaken with clinically appropriate patients with schizophrenia and other psychiatric disorders, showed that de-prescription of ACM in this setting can occur with prescriber education and support (Gannon et al. 2020). Two studies explored

concurrent agonist treatment. The relationship between concurrent physician-based mental health services and acute health service use for individuals (n=774) with mental health disorders, enrolled in Opioid Agonist Treatment in Canada, was explored. Findings show that improved clinical outcomes for complex patients was associated with enhanced use of acute care services (Morin et al. 2020). One class of drugs reported to be increasingly involved in overdose fatalities is benzodiazepines (Jessell et al. 2020). A study exploring the prevalence rates of prescribing benzodiazepines with people (n=48,679) with and without co-occurring substance abuse disorders (SUD), in community mental health settings, found that 35 % had a co-occurring SUD and 32% had an anxiety, a practice that according to Jessell et al. (2020) poses risks for dependence and overdose.

15.2 Substance Use Disorders-Inpatient Care

There is a high prevalence of co-occurring disorders in mental health and addiction, but the services available to prevent and treat them are often fragmented. Five studies were found that explored co-occurring disorders in mental health. Substance use is frequently co-morbid with anxiety and depressive disorders and is also associated with poor treatment outcomes (Mauro et al. 2016). Findings from a US study exploring coordination of patients (n=14,037) with co-occurring disorders, indicated that half of substance abuse disorder treatment facilities were in classes with co-located mental health services and only a quarter provided comprehensive co-occurring disorders services (Mauro et al. 2016). Cross-training activities have been used to help minimise breaks in service continuity and assess to what extent positional clarification (a specific type of cross-training activity) can help bridge fragmented services for co-occurring disorders through promoting professionals' interactions (Perreault et al. 2020).

Two papers identified anxiety and drug overdose. A UK study demonstrates that 14% of patients (n=3,795) admitted to inpatient psychiatric wards with an anxiety or depressive disorder had a secondary diagnosis of a substance use disorder (Williams et al. 2021). A US study (n=2,686) indicates that patients hospitalised for deliberate drug overdose or suicide and of white race-ethnicity was predictive of mental health assessment and admission to an inpatient psychiatric facility (Charron et al. 2019). The Addiction Recovery Coaching (ARC) programme, along with mental health nursing interventions to support recovery from substance use disorder, demonstrates improvements in patient-reported outcome measures, reductions in symptoms of depression and anxiety and positive social contacts between participants (Rutherford and McGowan 2021).

15.3 Pharmacological management of acute behavioural disturbance

Three studies were found that explored the pharmacological management of acute behavioural disturbance. A QI programme addressed prescribing practice for acutely disturbed behaviour in the UK on 2,172 episodes of acutely disturbed behaviour. Results show that a benzodiazepine alone was administered in 60% of episodes and in 39% of episodes where parenteral rapid tranquillisation medicine was used it was found that parenteral medication may fail to achieve a calming effect in the acutely disturbed patient (Paton et al. 2019). Findings on the effectiveness of long-acting injectable antipsychotics compared to oral medications in individuals with a diagnosis of schizophrenia spectrum disorder indicate that long-acting injectable antipsychotics reduced hospitalisation rates and emergency visits thus contributing to their use as a cost-effective treatment in the management of this group of patients (Latorre et al. 2020).

15.4 Alcohol abuse and self-harm and suicide

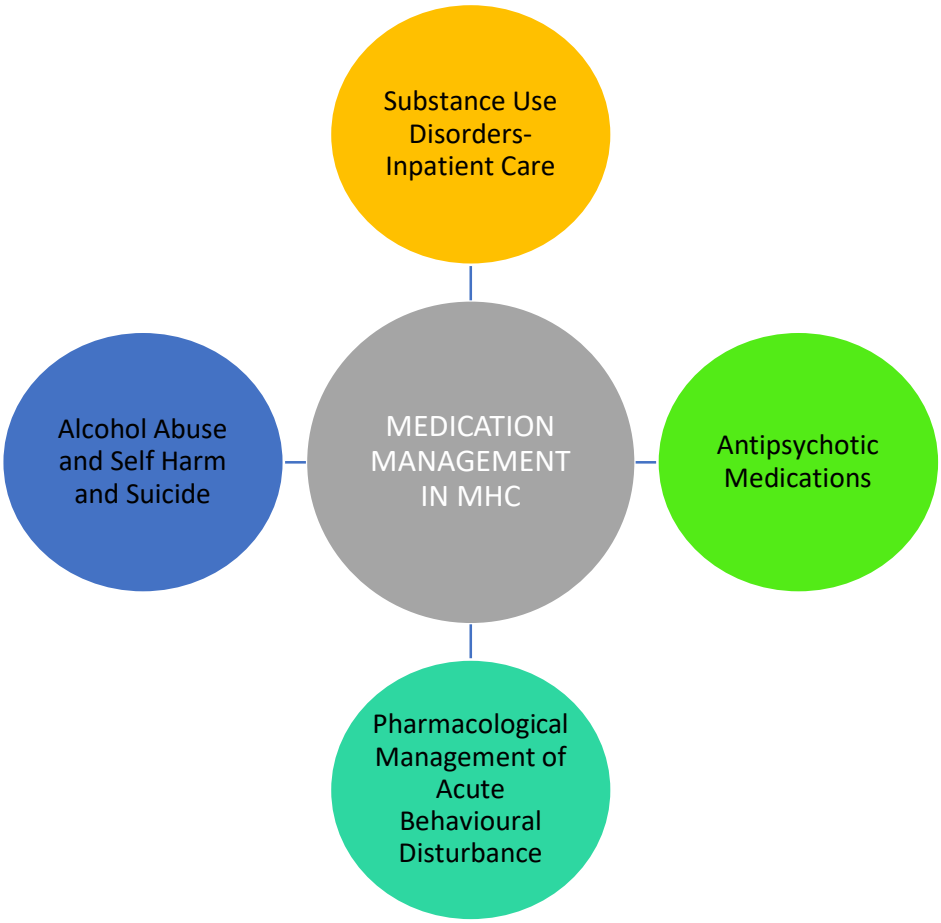
Differences also occur in persons engaging in mental health services and abusing alcohol. Of 339 individuals presenting with an episode of self-harm to Emergency Departments in New Zealand, 15% harmed themselves again within one year and for one in six of these 50 people, the repeat episode was fatal. Having alcohol in the blood and already being engaged with mental health services at the time of the index episode may predict the occurrence of a further self-harm episode, indicating that clinicians may need to be vigilant when following up individuals who had been drinking alcohol at the time of an initial self-harm presentation (Ames 2017). Suicide is a major concern for professionals, including mental health nurses, because of its clear correlation with mental illness. In New Zealand, coroners investigate all deaths that appear to be a result of suicide, and provide reports to mental health services. Coroners recommend that these services should implement suicide-prevention strategies that would facilitate improved communication, risk containment, service delivery and family involvement (Manuel et al. 2018).

Møllerhøj et al.(2020) illuminate drug alcohol use and user experiences of schizophrenia, reasons for receiving antipsychotic medication, and encounters with mental health services (n=24), in Scandinavia. Participants describe challenges in everyday functioning. Conversely, they rate their current mental and physical well-being as high and seem satisfied with their progress, indicating personal recovery. Participants emphasised the importance of trustful relations with healthcare professionals, and with their antipsychotic medication formulation provided 3-monthly.

Williams et al. (2021) examine the quality of care received by patients (n=3,795) admitted to inpatient psychiatric wards in England with an anxiety or depressive disorder and compare subgroups with or without a comorbid substance use disorder. In all, 543 (14%) patients had a secondary diagnosis of a substance use disorder. Findings evidenced poor quality of care for inpatients with anxiety and depressive disorders and with comorbid substance use disorders, highlighting the need for more support for these patients.

In conclusion, co-occurring disorders in mental health and addiction present a high prevalence, but services available to prevent and treat them are often fragmented. Substance use is frequently comorbid with anxiety and depressive disorders and is also associated with poor treatment outcomes. Having alcohol in the blood and already being engaged with mental health services at the time of the index episode may predict the occurrence of a further self-harm episode, indicating that clinicians need to be vigilant when following up individuals who had been drinking alcohol at the time of an initial self-harm presentation. See Figure 9 for summary of medication management in mental health care, Appendix I and recommendations.

Figure 9: Medication management in mental health care



16. Mental health care for people with intellectual disability

Research studies are expanding in the area of people with intellectual disability. The need for support in the community is a consistent theme across studies. People with intellectual disability experience higher rates of mental health disorders than the rest of the population, and expert opinion holds that multiple barriers prevent people with intellectual disability from accessing appropriate services (Weise et al. 2021). Whittle et al. (2018) identify barriers and enablers across key dimensions of access: utilisation of services, service availability, relevance, effectiveness and access and equity. These dimensions provide insight into the ways service users, carers and service providers navigate an often hostile system. Weise at al. (2021) explore delivery of mental health services to people with intellectual disability. Key findings suggest the need for specialised intellectual disability services, clear policy and governance and including people with intellectual disability in the design and delivery of services. They also identify the importance of holistic and collaborative services, an equipped workforce, quality assessment and treatment and ongoing research. Painter et al. (2018) propose a set of needs-led mental health clusters to accommodate people accessing intellectual disability services, in the United Kingdom. Lewis et al. (2020) utilise 10 years of data from 6,260 persons in Australia who had received disability services and specific mental health services by quantifying the relationship between disability services use and service use by adults with intellectual disability and co-existing mental illness. Findings demonstrate that the receipt of disability services was associated with greater odds of accessing community mental health services but not psychiatric hospital admissions in this group.

16.1 Intellectual Disability with Autism

Gilmore et al. (2021) compare the prevalence of physical and mental health conditions among autistic older adults with intellectual disability (n =2054) to autistic older adults without intellectual disability (n=2,631). Findings highlight that autistic older adults with intellectual disability were more likely to have medical illnesses and schizophrenia/psychotic disorders whilst autistic older adults without intellectual disability were more likely to have medical illnesses and suicidal ideation or intentional self-injury. These findings highlight the importance of developing tailored health management strategies for the autistic older adults with and without intellectual disability.

People with an autism spectrum disorder and/or an intellectual disability are often unable to communicate pertinent information when admitted to hospital, and nurses rely on family members or carers to obtain information. Schopf et al. (2020) assessed completeness of assessment information between the psychiatric ED and the inpatient unit. Findings suggest that in the psychiatric ED, nurse specialists were able to obtain more information from family/caregivers compared with the inpatient unit suggesting that when the patient's family members or carers are present a more complete assessment will support an easier admission process and transition to the inpatient unit.

Helverschou et al. (2021) describe the development of a professional network and a standardised protocol for clinical assessment in clinical centres for autistic individuals with intellectual disability, in Norway. Findings indicate that the network and protocol may improve professional competence and facilitate specialised services for this group. Stadnick et al. (2020) examine mental health service patterns of 2,537 youth with autism spectrum disorder compared with 2,537 matched peers receiving care in Los Angeles. Findings revealed significant differences between youth with and without autism spectrum disorder in the amount, length, service type, and evidence-based practice

delivered. Results provide direction in targeting implementation efforts for this group. Oakley et al. (2021) measure the subjective quality of life in 573 individuals (aged 6-30) including those with autism spectrum disorder (n=344), using the World Health Organisation Quality of Life–Brief and the Child Health and Illness instruments. Findings suggest that support and services for improving mental health, especially depression symptoms, may also improve broader outcomes for autistic people.

A large majority of UN member states ratified the Convention on the Rights of Persons with Disabilities (UNCRPD), a ground breaking instrument for various changes in the area of mental health services. The likely impact of the Convention on disability on mental health services was explored by Jahn et al. (2018). In presenting an overview of implementation and likely effects on mental health services, they identify difficulties and barriers that could be responsible for the long process of implementation of the UNCRPD, and advised that national law and health legislation must be developed to create an obligatory context for inclusive services required for persons with mental health illnesses. Community-based care must be prioritised to allow participation and inclusion. Perera and Courtenay (2018) advise that the mental health and social care needs of people with intellectual disabilities is well-established in the UK, with the support of legislation, often with specialist mental health and social care teams, and with dedicated professionals. Challenges in providing future mental health services for children and adults with intellectual disabilities include enhancing community support and reduced in-patient care, alongside recruitment and training of the workforce (Casanova Dias 2020).

In Australia, Dew et al. (2018) assess the current representation of people with intellectual disability and recommend strategies to enhance the inclusion of intellectual disability in mental health policy in their analysis of nine pieces of Australian mental health legislation and 37 mental health policy documents. Fifteen of the 37 documents mention intellectual disability with limited attention to the specific mental health needs of people with intellectual disability and mental illness. An inclusive approach to the development and implementation of intellectual disability mental health policy was recommended to meet the mental health needs of this group.

16.2 Integrated Psychological Therapy

Barlati et al. (2018) review the feasibility of implementing Integrated Psychological Therapy (IPT) for enhancement of clinical, cognitive and psychosocial functioning in everyday clinical practice, in an Italian mental health service, among patients with schizophrenia. IPT was accepted by the patients and findings have shown promising improvement in clinical, cognitive and psychosocial functioning, persisting over time. Mucci et al. (2021) in an Italian study (n=921) assess whether baseline illness-related variables, personal resources, and context-related factors are associated with work skills, interpersonal relationships, and everyday life skills at 4-year follow-up. Findings suggest that social and non-social cognition and baseline everyday life skills support the adoption of cognitive training programmes, combined with tailored psychosocial interventions that are aimed to promote independent living in routine mental health care. Porcelan et al. (2019) suggest that level of intelligence is not the sole indicator of the appropriateness of psychotherapy and that the full range of mental health services are needed to improve the quality of life for patients with intellectual disability.

Family caregivers often coordinate the care of individuals with Intellectual/Developmental Disability (IDD). Holingue et al. (2020) examine family caregiver' experience by using data from a national tertiary crisis intervention model designed for this group. Caregivers (n =488) completed the Family Experiences Interview Schedule. Less than half of families reported satisfaction with the mental health services received and experiences were worse for caregiving fathers and those individuals with intellectual disability with co-occurring chronic medical conditions. McKenzie et al. (2019) explore the views of staff members (n=16) and service users (n=8) in Scotland regarding the identification and support needs of homeless people with intellectual disability and the role of an intellectual disability screening questionnaire to help improve service provision. The results identify the complex support needs likely to be experienced by many homeless people with ID, the screening tool as having a number of benefits to inform and shape policy and service development and staff members identified need for training in this area.

16.3 Professionals in Intellectual Disability Care

Davies et al. (2019) describe the characteristics and clinical capacity of Australian and New Zealand psychiatrists working in intellectual and developmental disability mental health (IDDMH). Consultant psychiatrists had worked in the area for a median of 11 years and over half (53%) reported expertise in the area, indicating considerable experience in IDDMH. However, it was noted that their work in IDDMH represented a relatively small proportion of their overall work hours, and a minority of respondents were responsible for a large proportion of clinical work. Recommendations highlight the need to explore ways to broaden capacity to meet the needs of people with IDD.

Rauf et al. (2021) examine if COVID-19 restrictions were associated with a change in the number of total consultations carried out by psychiatrists and prescription of psychotropic medication in people with intellectual disability and/or autism spectrum disorder, within a community intellectual disability service in the UK. Findings indicate that during the lockdown period, total consultations increased by 19 per week and medication interventions increased by two per week. Hypnotics and benzodiazepines were the most commonly prescribed psychotropic medications during the lockdown period.

Whitehead et al. (2020) examine a new community-based, clinical mental health service delivered through a multi-professional approach, for young people (12−25 years), with co-occurring ID and mental illness. This study provides preliminary support for the efficacy of the new programme and suggests that future specialist dual disability services look to a family-focused, multidisciplinary approach that includes assessment, treatment, and management, as an effective treatment model. Kaushal et al. (2018) investigate the knowledge and skills of psychiatrists in managing patients with intellectual disability and comorbid mental health disorders and to establish the local implementation of the Green Light Toolkit in the UK. The Green Light Toolkit includes an online audit framework and toolkit that allows benchmarking of services to make informed decisions about where improvements can be made. Participant psychiatrists express the view that inpatient care should be provided in dedicated units for people with intellectual disability, rather than in general adult inpatient wards while expressing concern that mainstream services had failed to meet the mental health needs of this patient group, thus leading to increased patient vulnerability.

Man et al. (2018) investigate the assessment practices of Australian psychologists (n=102) working with adults with ID and explored barriers to best practice implementation. Psychologists report

many assessment practices that were in line with current national and international guidelines. They also reported a number of barriers to implementing best practice recommendations. Findings from this study have implications for best practice guidelines and policies in how mental health services for individuals with intellectual disability and their families are delivered. Weise et al. (2018) explore the attitudes, confidence and training needs of Australian mental health professionals (n=566) working in the area of intellectual disability mental health. Participants agree that people with intellectual disability have the right to receive good mental health care and they viewed treating this group as part of their role, but given the resources available it was not always possible to provide the comprehensive care they wanted to provide. Further efforts are needed to facilitate the engagement and capacity of mental health professionals in this area and a study by Dagnan et al. (2018) identify positive change following a training programme for general trained therapists who may work with people with intellectual disabilities.

Research on nurse-patient relationships with patients with schizophrenia is sparse. Panozzo and Harris (2021) pilot a survey to explore therapeutic relationships with the schizophrenia population (n= 51 psychiatric nurses). A positive association was found between professional certification and work satisfaction on the nurse-patient relationship. Further exploration of this association was recommended. Savarimuthu (2020) discuss how positive behaviour support (PBS) has become the preferred intervention in the management of challenging behaviour in learning disability and mental health services, and of the absence of literature on nurses' views and experience of PBS and of their role in supporting people with learning disabilities to be able to live in their own homes (Read 2000).

16.4 Prescribing in Intellectual Disability

The clinical and demographic variation in the prevalence of substance use among the general psychiatric population is explored (Strassnig et al. 2020, Andersson et al. 2021, Paton et al. 2021, Zarzar et al. 2021). Koch et al. (2021) assess the prevalence rates of psychotropic medication (PM) treatment in adults with Intellectual Disability, in Germany. Antipsychotics were the most frequent PM used in 44% and polypharmacy and off-label use were common. Recommendations are made for the need to improve PM treatment regarding amount, indication and consideration of non-psychopharmacological treatment options.

A clinical audit of prescribing practice in the context of a QI programme for people with intellectual disability uses practice standards for audit derived from relevant, evidence-based guidelines, including NICE. Paton et al. (2016) (n=54) in a UK study undertook a clinical audit of prescribing practices by collecting information on prescribing from a sample of 5,654 people with Intellectual disability and mental illness. Findings show that almost two-thirds were prescribed antipsychotic medication, of whom half were on the schizophrenia spectrum or had an affective disorder diagnosis, while a further third exhibited behaviours recognised by NICE as potentially legitimate targets for treatment, such as violence, aggression or self-injury. Data from mental health services suggest that antipsychotic medications were not widely used outside of licence and/or evidence-based indications in people with intellectual disability.

Salavert et al. (2018) examine the prevalence of substance use disorders (SUD) in a sample of patients with intellectual disability admitted to a brief hospitalisation psychiatric unit. The main SUD was cannabis use disorder in a quarter of admissions followed by alcohol use disorder in a fifth and cocaine use disorder in 14%. The use of more than one substance was the most frequent pattern.

Cannabis use disorder and cocaine use disorder were overrepresented in the group with mild intellectual disability. A greater number of psychiatric admissions were observed for the group with SUD. Further efforts are needed to focus on specific therapeutic approaches. Studies provides further knowledge about patients at risk for co-morbid substance abuse and poor treatment outcomes. Further efforts are needed to prevent emerging substance abuse and improve outcomes.

16.5 Offenders with an Intellectual Disability: Forensics

Offenders pose a challenge to Intellectual Disability Service providers. No previous study has been carried out to measure offending behaviour amongst persons with an intellectual disability attending mental health services in Ireland. The Forensic Intellectual Disability Working Group of the Irish College of Psychiatrists was established to address this issue by establishing the level of need for a Forensic Intellectual Disability Service and to develop a college position paper. A survey undertaken by Leonard et al. (2016) (n=431 service users) targeted the lead clinicians of all Intellectual Disability Psychiatry, General Adult Psychiatry and Forensic Psychiatry Services in the Republic of Ireland. Findings show that those engaging in offending behaviour were predominantly young males. Assault was the most common offence type. A significant number of serious offences such as unlawful killing, sexual assault and arson were reported. A Consultant Forensic Psychiatrist with special interest in intellectual disability was appointed to lead services in Ireland.

Chester et al. (2019) sought the perspectives of patients and family/carers on the outcomes important to them. This study was the first to investigate the outcomes of relevance to patients with an intellectual disability, and their families. These views have been incorporated into an outcomes framework that will form the foundation of future prospective outcome studies. The Screener for Intelligence and Learning Disability (SCIL) is designed to screen for intellectual disability in forensic populations. Esch et al. (2020) advised that this assessment method is only validated in "detention fit prisoners" with low need of care. These researchers investigated the psychometric properties of the SCIL in mentally ill detainees with high care needs and find that the SCIL gives a quick and accurate indication of whether a person is at risk for intellectual disabilities and may be applied in mentally ill detainees. Samele et al. (2021) examine psychiatric and developmental morbidity amongst police detainees, and established differences in need between morbidity categories in (n=134) entering police custody in one London police station, over a 2-week period. Findings confirm high rates of mental health problems amongst police detainees and also demonstrated their high risk of suicide and high levels of unmet need, especially for accommodation. This study identified the need to provide mental health services in police stations and to resolve detainee issues early in the criminal justice system.

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16.6 Restrictive Practices

The reduction of restrictive practice has gained momentum. There remains confusion as to the definition of ‘restrictive practices’ across all sectors of health care, including the difference between ‘restrictive practices’ (such as attitudes of control, limit setting and unnecessary ward rules) and ‘restrictive interventions’ (including physical, chemical or mechanical restraint). A study was undertaken by the MHC that provides new guidelines on the use of restrictive practices in approved centres in Ireland, that includes seclusion, mechanical restraints and physical restraints (Larkin 2022). Bynoe et al. (2021) explore strategies to minimise restrictive practice and subsequent acts of

challenging behaviour. Findings highlight the relevance of restrictive practice to children's nursing that may result in challenging behaviour, or even restrictive interventions. People with intellectual disabilities, from different ethnic groups accessing mental health services have been found to be different between ethnic groups (Maestri- Banks 2020).

In conclusion, services for people with intellectual disabilities have evolved from hospital-based care to more community provision, often due to changes in social policy or following a scandal in provision, but often vary in composition and structure. Research studies are increasing in all areas of intellectual disability and these are presented in this section. Few studies explored the experiences of people with intellectual disability or the experiences and supports needed by family and carers to care for the child or adult with intellectual disability in their own homes. Further research is needed in these areas. See Figure 10 and Appendix I for further information. Recommendations are suggested.

Figure 10: Mental health care for people with intellectual disability

17. LGBTQ+ https://web-b-ebscohost-com.proxy.library.rcsi.ie/ehost/results?vid=42&sid=9b91eb59-a9ac-496b-8915-88e767939266@pdc-v-sessmgr01&bquery=(MH+"Mental+Health+Services")+OR+(MH+"Mental+Health+Services+")+OR+(+DE+"Mental+Health+Services"+OR+DE+"Community+Mental+Health+Services"+)+OR+(+TI+"mental+health+services"+OR+AB+"mental+health+services"+OR+TI+"psychiatric+health+services"+OR+AB+"psychiatric+health+services"+)&bdata=JmRiPWNtZWRtJmRiPXJ6aCZkYj1wc3loJnR5cGU9MSZzZWFyY2hNb2RlPVN0YW5kYXJkJnNpdGU9ZWhvc3QtbGl2ZQ==

Significant mental health disparities exist between LGBGTQ+ young people and their cisgender and heterosexual peers, yet they do not have equitable access to mental health services (Ferlatte et al. 2019, Glick et al. 2020, Delaney and McCann 2021). Limited research has explored the barriers, which exist for LGBTQ+ young people in accessing services, particularly from their perspectives. Higgins et al. (2021) explore the barriers to access in the Republic of Ireland by using online survey design (n=1,064). Findings show that barriers to accessing services are interlinked across three levels: individual, sociocultural, and mental health system. Recommendations from this research highlight the need for cultural competency training for practitioners that address issues and concerns pertinent to LGBTQ + young people and to ensure care and support that is responsive and sensitive to the needs of these groups.

Waryold and Kornahrens (2020) provide interventions to diminish barriers to care and foster provider preparedness for the care of LGBTQ+ individuals. Smith and Wright (2021) report that numbers of older LGBTQI+ people are increasing worldwide and most want to remain in their own homes as they age. They examine (n=69) older (over 60 years) LGBTQI+ people's perceptions and experiences of using formal home care services in the community. Their concerns centred on fear and discrimination. Recommendations include the need for sensitivity training in the needs of older LGBTQI+ people by home care service providers and the need for further research to gain further understanding of their needs and preferences. Hughes (2018) explores the health and well- being of LGBTQ+ people aged 50 years and over (n=312) in New South Wales. Findings show mental health as being lower among carers and those not in a relationship, while psychological distress was greater among those living alone and those experiencing higher rates of loneliness.

Higgins and Hynes (2019) discuss end-of-life needs of people who identify as LGBTQ+ and are at risk of receiving suboptimal care, irrespective of whether they are being cared for at home or in a nursing home, hospital, or hospice. They advise that even though little research on the needs of LGBTQ+ people at the end of life exists this study explores some of the concerns that practitioners should consider during their interactions.

Ferlatte et al. (2019) explore the barriers among sexual and gender minorities (SGM) (n=2,778) who screened positive for depression and risk of suicide. Data from an online survey of SGM (n =2,778) found that 37 % of respondents met criteria for depression and 74% screened for being at risk of suicide. Findings indicate barriers as inability to pay, insufficient insurance, a preference for 'waiting' for the problems to go away and feeling embarrassed and ashamed about mental health challenges.

In exploring a specific medical condition, the adequacy of mental health services for HIV Positive patients with depression is unclear. Major depression can profoundly impact clinical and quality-of life outcomes of people living with HIV. Choi et al. (2016) describe the prevalence of antidepressant use and mental health care for HIV-positive patients (n=990) with depression, in Canada. Results indicate gaps in delivering publicly funded mental health services to depressed HIV positive patients and unequal access to these services, particularly among vulnerable groups. More effective mental health policies and better access to mental health services were recommended suggesting policy and practices implications of these findings, a finding also supported by Cochran et al. (2017) and Ferlatte et al. (2019).

17.1 Providing care to LGBTQ+ Clients

Aisner et al. (2020) initiate discussion on how nurse practitioners, primary care and family practice providers can provide inclusive, unbiased, evidence based, quality care to the LGBTQ+ community. They highlight the need for education and training to help overcome barriers to care delivery. This is supported by Kamen et al. (2019) (n=273) in reporting challenges accessing competent cancer treatment for this population. Casey et al. (2019) explore poor health outcomes in a study to examine reported experiences of discrimination against LGBTQ+ adults (n=489) in the United States. Evidence indicates that discrimination was widely experienced by LGBTQ+ adults across health care and other domains, especially among racial/ethnic minorities. Further efforts relating to policy are needed to reduce these negative experiences and resultant health impact on sexual and/or gender minority adults and those who experience discrimination. Golub et al. (2020) report that young people of colour had high HIV incidence rates and suffered health inequities, with regard to daily oral pre-exposure prophylaxis. Their study undertaken in the USA aimed to understand concerns, priorities, and preferences around biomedical HIV prevention treatments among LGBTQ+ youth (n=93). Findings indicate the need to educate young people about biomedical prevention including side effects, drug interactions, dosing/usage and ensuring that prevention products are accessible to them.

17.2 Transgender people's experiences of mental health services

Research has indicated that lesbian, gay, bi-sexual, trans and queer/questioning + (LGBTQ+) adolescents have disproportionately high rates of substance use compared to heterosexual peers. The transgender community have been identified as an underserved, under-researched community in Ireland and abroad (Plöderl and Tremblay, 2015, McNamara and Wilson, 2020). While there has been a surge in research carried out with the community in recent years, little is known about the personal experiences of Irish transgender people when using mental health services. Delaney and McCann (2021) advise that nurse managers have a central role in supporting a transgender-positive organisational approach to care by ensuring policies, care practices and a supportive environment in a respectful and inclusive manner.

A small study (n=4) exploring the personal experiences of those identifying as transgender and having experienced access difficulties found lack of information and non-affirmative experiences as contributing to poor clinician–patient relationships thus impacting attrition. The lesbian, gay, bisexual and transgender (LGBTQ+) communities are a minority population that have higher rates of mental disorder than the general population counterparts (Plöderl and Tremblay, 2015). Youth

mental health is also impacted. Research examining multiple levels of influence was developed with youth input within the community and schools in Minnesota. Eisenberg et al. (2020) tested the hypotheses that LGBTQ+ students (n=2,454) attending high schools and living in communities with more LGBTQ+ supportive environments had lower odds of substance use behaviours (cigarette smoking, alcohol use, marijuana use, prescription drug misuse) than their peers in less supportive LGBTQ+ environments. Findings indicate that LGBTQ+ adolescents who lived in areas with more community support had lower odds of frequent substance use, indicating the importance of strengthening LGBTQ+ adolescent's community resources.

17.3 Lesbian, gay and bisexual experience

LGB individuals experience homophobia and stigmatisation within society (Plöderl and Tremblay, 2015). In response to this historical stigmatisation a number of policies and guidelines were created to develop ethical practice while working with this minority group (Plöderl and Tremblay, 2015). McNamara and Wilson (2020) capture the experiences of LGBTQ+ individuals within mental health services and examine if guidelines are being adhered to. Their meta-narrative synthesis of 13 empirical papers, published between 1999 and 2019, was the first systematic review to look at the experiences of clients who had attended mental health services. Findings indicate both negative and positive experiences of service users. The research discusses major themes, implications for practice and directions for future research.

17.4 Suicide Risk

Green et al. (2021) examine the relationship between sexual orientation acceptance from others and suicide attempts among LGBTQ+ youth in a survey of LGBTQ+ youth across the United States. Results show that all forms of peer and adult acceptance were associated with reduced reports of a past-year suicide attempt, with the strongest associations found for acceptance from parents and straight/heterosexual friends. Also, youth with high levels of acceptance from peers had significantly lower odds of reporting a past-year suicide attempt, suggesting unique associations with suicide risk for both peer and adult acceptance. McDermott et al. (2018) reveal that young people who identify as lesbian, gay, bisexual, and queer transgender have elevated rates of suicidality, yet few studies have explored help-seeking and suicidality. They report on a UK mixed-method study (n=789). Results indicate that participants only asked for help when they reached a crisis point because they were normalising their emotional distress. Those who self-harmed, had attempted or planned suicide were most likely to seek help. In 2022, The Department of Health and Aged Care in Australian introduced guidelines to prevent suicide stating that almost half of all Australian adults will face mental ill-health during their lives and that suicide was the main cause of death for Australians aged 15 to 49 years in 2019 (Australian Government 2022).

17.5 Interventions

Hall et al. (2019) examine the feasibility of an intervention called Being Out With Strength (BOWS), which is an 8-session, small-group, CBT-based intervention to reduce depression among LGBTQ+ young people (n=79). Findings reveal a demand for BOWS by LGBTQ+ individuals that is likely to be accepted by the population. Cochran et al. (2017) investigate differences associated with mental health morbidity, functional limitations or disability, and mental health service use among adults interviewed in the National Health Interview Survey. Respondents were 68,816 adults, including 1,664 LGBTQ+ individuals. Findings show that LGBTQ+ adults, as compared to heterosexual adults, demonstrate higher prevalence of mental health morbidity and functional

limitations. Overall LGBTQ+ adults were more likely to use services, with the source of functional limitations moderating these effects among men. This study presents a unique set of concerns within the integrated care setting.

17.6 College Students Use of MHSs: Education

Policies are explored by Garg et al (2021) in their review of policy differences, including laws and education standards that are relevant to students who identify as LGBTQ+. They compare required topics, parental/guardian permission, LGBTQ+ inclusion and normative language requirements in school-based sex education for youth in the USA. Their findings indicate a lack of and the presence of discrimination in school-based sex education policies particularly those related to LGBTQ+ topics. Glick et al. (2020) report that studies in medicine and nursing had led to increased curricular attention to LGBTQ+ health topics yet similar physical therapy education research has not been published. Their survey undertaken with US accredited physical therapist education programme directors had a response rate of 31%. Findings indicate that resources to educate faculty and students on LGBTQ+ health topics are available and that those topics may be introduced into existing curricula.

In a similar vein, Úbeda-Colomer et al. (2020) develop the Barriers to Physical Activity and Sport Questionnaire for BPASQ-LGBTQ+ (n=709) which measures barriers using a socio-ecological model. They find that the instrument is useful for developing interventions to encourage physically active lifestyles among LGBTQ+ people. Kuzma et al. (2019) develop a pilot educational project to provide advanced practice nursing (APRN) students (n=99) in the USA to care for LGBTQ+ patients with cultural humility and to set the standard for LGBTQ+ health content and application for APRN students. Use of mental health services among college students (n=25,844), by sexual orientation was explored by Baams et al. (2018). Differences between LGBTQ+ students and heterosexual students are examined in terms of the counselling and mental health services received. Compared with their heterosexual counterparts, gay males and lesbian/gay and bisexual females reported receiving more counselling from counsellors, therapists, psychologists, and/or social workers, or with mental health services. Bisexual males and LGBTQ+ females were less likely to seek help from a parent or family member. Findings suggest that certain groups of LGBTQ+ students did not find support with their clergy and family, which may indicate a lack of understanding or acceptance of LGBQ+ issues (Baams et al. 2018)

People with severe mental illness (SMI) have sexual health needs but there is little evidence to inform effective interventions to address them. The RESPECT study compared sexual health promotion interventions in the UK (Hughes et al. 2020) with a fully powered RCT to establish the effectiveness of the intervention in the adoption of safer sex. The frequency in which HIV and AIDS and mental health problems coexist and the complex relationship between them highlight the need for effective care models combining both services. Chuah et al. (2017) (n=45) found that Integration based on a collaborative network of mental health services may serve those with multiple co-morbidities but that fragmented and poorly coordinated care can pose barriers. This review identified diversity in integration models combining HIV and mental health services when implemented within appropriate contexts.

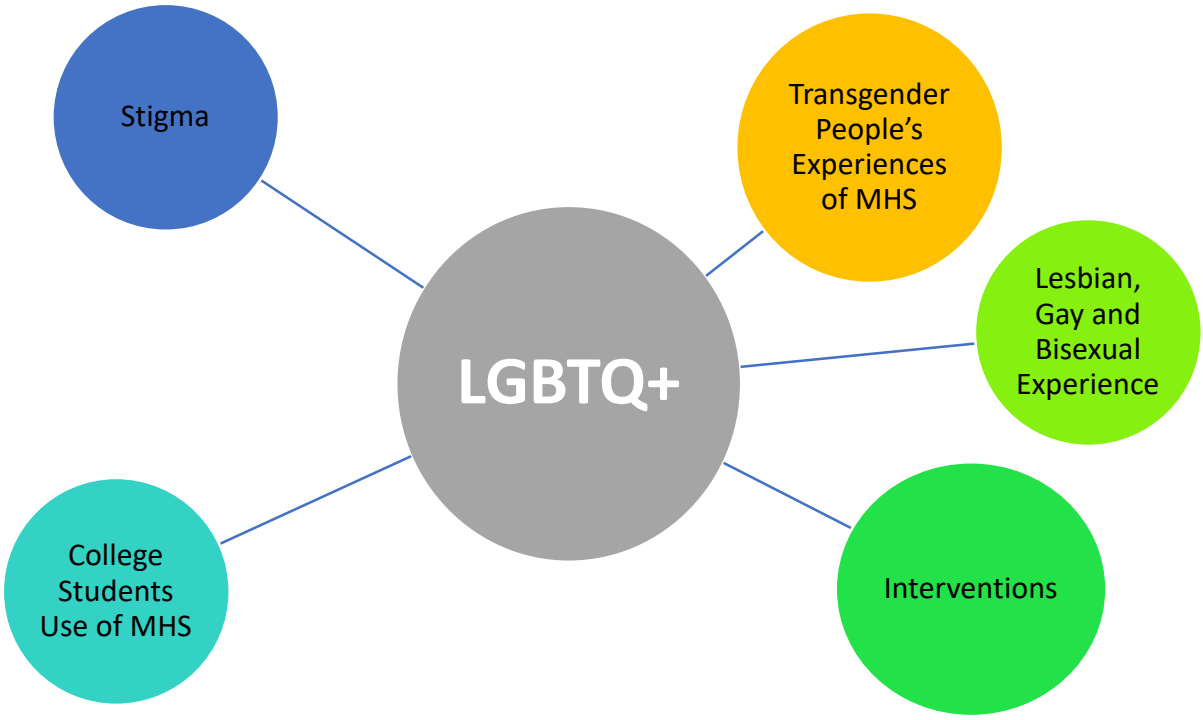
17.7 Stigma

The LGBTQ+ communities are often faced with stigma and discrimination within mental health services according to Plöderl and Tremblay (2015) who identify that their experiences of mental health services had reinforced stigma and lacked understanding of their specific needs. Their needs can be addressed by mental health services that challenge heteronormative assumptions and promote self-acceptance and equity (Eisenberg et al. 2020, McNamara and Wilson 2020). According to Rees et al. (2020) the existing heteronormative culture in mental health nursing practice needs to be challenged and practice needs to demonstrate self-awareness of personal and societal LGBTQ+ biases, prejudices, and stigma and to increase knowledge of LGBTQ+ health care and psychosocial issues. Practice also needs to reflect LGBTQ+ clinical skills that are grounded in professional ethics, guidelines, and standards of care. To this aim, Rees et al. (2020) (n=14) identify the mental health needs of the LGBTQ+ communities and their experiences of accessing mental health care. They identified a need for mental health care that promotes equity, inclusion and respect for diversity and Eisenberg (2020) recommends services that promote health equity and self-acceptance.

Stigma remains a significant challenge for individuals living with HIV disease that can adversely affect overall mental well-being. Faber et al. (2014) explore changes in perceived stigma in adults (n=48) living with HIV disease following their participation in a mental health services programme that was integrated with community-based HIV primary care. Study results show reductions in perceived HIV stigma over time for distancing, blaming, and discrimination dimensions of stigma, suggesting that participation in HIV mental health services may have a favourable impact on perceived HIV stigma.

In conclusion, the LGBTQ+ communities while not a homogenous group face unique challenges when dealing with their mental health needs. Staff who care for these communities are encouraged to engage in appropriate training as responsive service strategies are needed to develop confident, competent and knowledgeable staff. Services that promote health equity and self-acceptance are important to these groups who tend to ask for help when they reach a crisis point. This is thought to be because they normalise their emotional distress. Studies show that those who self-harmed, had attempted or planned suicide were most likely to seek help. See Figure 11 and Appendix I. Recommendations are suggested.

Figure 11: LGBTQ+



18. Mental health care in rehabilitation

Several studies identified rehabilitative mental health care as being relevant to recovery. Deinstitutionalisation has reduced the number of psychiatric beds by transferring priority to outpatient care and community-based services. Such change resulted in the development of rehabilitative mental health care (Rössler and Drake 2017). The efficacy of mental health rehabilitation remains under researched, despite the need for evidence-based approaches in the area. Tsoutsoulis et al. (2020) evaluate the impact of inpatient mental health rehabilitation using psychiatric metrics, with (n =252) individuals, in a non-acute inpatient mental health rehabilitation unit. Findings indicate that those experiencing a readmission significantly decreased following inpatient care except in those with comorbid bipolar or personality disorders and substance use.

Community mental health rehabilitation teams play a major role in supporting people with complex mental health needs who progress from inpatient to a community setting and from more to less supported accommodation. Outcomes for service users (n=193) of a community rehabilitation team support accommodation services offer time-limited support, but most service users did not progress successfully to more independent accommodation within 4 years. Successful move-on requires investment in improving functioning and physical health (Chan et al. 2021).

Rasmus et al. (2021) examine health-related behaviour, optimism, belief about abilities to cope with difficult situations and social exclusion among patients (n=52) aged 18-43 years, with chronic mental health issues, in a 6 month psychosocial rehabilitation programme in a community mental health setting in Poland. Findings indicate that such programmes may deal with interpersonal and intrapersonal problems and improve health behaviour. The findings recommend further evaluative research of other programmes in different settings. Taking a social approach, Maxwell et al. (2019)

evaluate the effectiveness of rehabilitation for improving psychosocial function in patients with schizophrenia and found that from admission to discharge the rehabilitation group made significant gains in psychosocial function and in improving daily living skills. Improvements were clinically significant in one-quarter to one-third of individuals but the authors caution that the durability of any gains remained less clear.

18.1 Globalisation in rehabilitation

Globalisation will continue to influence the risk of developing disease into the future hence there is a need to examine how global health is approached in rehabilitation curricula. How students learn about these various dynamics will impact on their ability to practice in this environment and best meet the needs of the patients they care for. There is insufficient evidence to measure how national eHealth strategies and their implementation are evaluated and monitored, as most approaches aim to measure at the micro level. van der Meer and Wunderink (2019) suggest that despite the notion of community integration for all, people with severe mental illness have continued to require high levels of support, in inpatient settings and in the community. They recognise that the attitudes, knowledge and skills of the staff providing their care are crucial to their recovery. Rehabilitation programmes provide a framework to guide practitioners and help them organise and focus their recovery-oriented approach (Alias et al. 2020).

This philosophy is taken a step further by Parker et al. (2018, 2019) in exploring residents (n=24) understanding and expectations of three recovery-oriented, community-based residential mental-health rehabilitation units. Most residents (87%), had a primary diagnosis of schizophrenia or a related psychotic disorder. The most common reason given for engagement was housing insecurity or homelessness rather than the opportunity for rehabilitation engagement. Receiving rehabilitation support may not be the key driver of their attendance, a finding that has implications for promoting engagement with rehabilitation services. In a follow on study, Parker et al. (2019) undertook a review to identify studies describing Community Rehabilitation Units in Australia, and developed a typology of two service types of community rehabilitation units. There is evidence to suggest that clients valued the support provided by these units, however more robust quantitative methods were suggested.

Following on from previous studies, Craig (2019) discusses how the social model is now understood in rehabilitation. Parker et al. (2020) examine factors predicting improvement in outcomes among (n=501) community care unit consumers (CCU), in Queensland, Australia. The primary outcome from this study was a greater positively regarding their mental health and social functioning. In a follow–on study, the Health of the Nation Outcome Scale was used by Parker et al. (2021). Results show significant improvements in mental health and social functioning and reductions in psychiatry-related bed-days, emergency department (ED) presentations and involuntary treatment. The CCU care was followed by reliable improvements in relevant outcomes for many consumers.

In a different context Abbasi and Muhammad (2022) explore resilience and rate of recovery among addicts and identify the moderating role of social skills. Rehabilitation follows the bio-psychosocial model but also recognises the vital role played by social interventions in improving the functional outcomes needed by users of the service. These include access to housing, occupation and the support of family and friends. In the opinion of Craig (2019) rehabilitation is framed within a model of personal recovery in which the target of intervention is to help the individual find a meaning and

hope to life. Simning et al. (2021) examine whether lower reported well-being prior to receiving rehabilitation services was associated with increased odds of worsening anxiety and depressive symptoms, reduced self-care and household activities following rehabilitation. Findings suggest that older adults with the lowest levels of well-being may have worsening depressive symptoms and impairment in self-care activities following rehabilitation services.

18.2 Rehabilitation in skilled nursing facilities (SNFs)

SNF care is under scrutiny to deliver high-quality care and superior outcomes. Gustavason et al. (2020) evaluate the STRONGER programme IntenSive Therapeutic Rehabilitation for Older Skilled NursinG HomE Residents that is focused on high-intensity functional resistance training in a SNF. The programme was found to be safe and feasible as results improved function and satisfaction.

Taking a global health focus on rehabilitation, Alias et al. (2020) explore how Canadian occupational and physical therapy educators (n=12) understand global health within their academic and clinical practices by using a framework termed "*clinical toolbox*" to broaden clinical training. The Social Skills Deficit Vulnerability Model predicts that people with inadequate social skills are at risk for a range of psychosocial problems, especially when confronted with stress. These psychosocial constructs tested by Segrin (2019) by online survey, indicates that adults (n=775) with mental health illness require continued community-based care such as psychosocial rehabilitation, day centres and group homes to support their recovery and re-integration into their communities. Krompa et al. (2022) explore the effectiveness of community mental health teams and identified the size of the team, leadership, and team cohesion as being contributory factors in its effectiveness. Limited research exists on community mental health services that incorporate family, community and social dimensions. The experiences of clients, family and staff (n=37) on the community life of people post ICMHS suggest the service could have positive clinical and social outcomes, but the results were inconclusive (Chiang et al. 2020, Kelly et al. 2020). Stamboglis and Jacobs (2020) suggest that service users provide insights and clearer directions for research and practice development.

18.3 Rehabilitation for older persons

National surveys report that inpatient rehabilitation for older people is a core function but there are large differences in key performance measures. To explore these variations a study by Young et al. (2020) indicates that Community hospital ward efficiency is comparable with the NHS acute hospital sector. This study suggests that significant community hospital ward savings may be realised by improving performance factors that might be augmented and modified further by economies of scale. In the British context, NHS community hospitals are small hospitals providing local inpatient and outpatient services.

The Illness Management and Recovery (IMR) Model is a rehabilitation programme that helps people with SMI to achieve clinical and personal recovery. Most service users' rated personal recovery as important, regardless of their symptoms and functioning (Skar-Fröding et al. 2021). However, a study undertaken in Denmark where participants with schizophrenia or bipolar disorders received group-based illness interventions, suggests that the impact of the Model on functioning remained unclear (Jensen et al. 2019). Interventions used in a Korean study revealed that independence leading to self-actualisation, psychological integration and social support fosters a sense of achievement and belonging (Jun and Choi 2020). Psychological empowerment: a multidimensional

construct comprised of emotional, cognitive, behavioural and relational domains was found to support measures of quality of life, self-reported health, and depression (Peterson et al. 2021).

18.4 Mental health care in substance use and eating disorders

There is limited evidence of the effectiveness of pharmacological and psychosocial treatment approaches in substance use and eating disorders. The Addiction Recovery Coaching (ARC) programme which uses exercise in conjunction with dedicated mental health nursing interventions, indicates reductions in symptoms of depression, anxiety and positive social contacts (Jun and Choi 2020). This finding supports the addition of ongoing mental health interventions exercise programmes (Rutherford and Mc Gowan, 2021).

Eating disorder is recognised as a debilitating condition often with a long recovery timeline for individuals with anorexia nervosa and bulimia nervosa (Slof-Op't Landt et al. 2019, Bachner-Melman et al. 2021). There is no standardised measurement of recovery from an eating disorder (Bardone-Cone et al. 2018). However, a study undertaken in Israel identified The Eating Disorder Recovery Questionnaire (EDRQ) as a valid, reliable measure of eating disorder recovery and recommends its incorporation into Recovery programmes (Bachner-Melman et al. 2021).

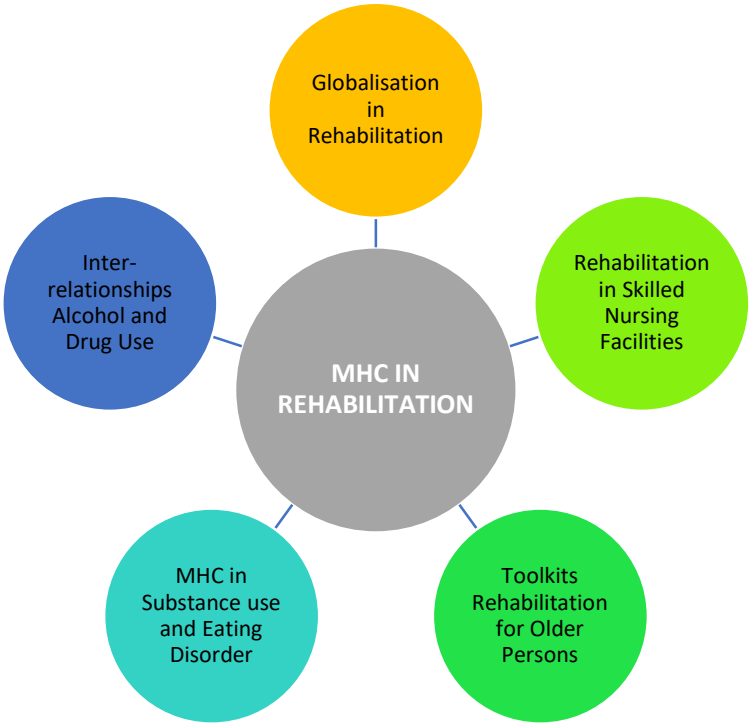
A recent area of research relates to ADHD and eating disorder. A study indicates that the Bulimia Nervosa eating disorder and ADHD are linked together (Svedlund et al. 2021). This link, although not entirely clear, has clinical implications with possible value for individuals with the Bulimia Nervosa eating disorder (Svedlund et al. 2021). A recent approach to eating disorders found that moving away from framings of recovery as an individual achievement to theorising it as a supportive eating disorder recovery can introduce new understandings of recoveries as being co-produced (LaMarre and Rice 2021).

18.5 Inter-relationships alcohol and drug use

Two rehabilitation studies were found that focused on the inter-relationship among alcohol and drug use variables. The first study relates to alcohol and drug use among US people needing mental health services. Results demonstrate that pain reliever, tranquiliser, stimulant and illicit drug and alcohol use revealed positive associations between alcohol and drug use (Wang et al. 2019). The second study (n=693), undertaken in Denmark, Germany and the USA examined whether adding the Community Reinforcement Approach for Seniors (CRA-S) to Motivational Enhancement Therapy (MET) increased the probability of treatment success in older people with alcohol use disorder. Findings from this intervention indicate that this combination did not improve drinking outcome (Andersen et al. 2020).

In conclusion, globalisation continues to influence the risk factors for disease and disability and influences the type of services accessible and the financing and management of such services. Education will shape global health in the area of rehabilitation in the future. The science of psychiatric rehabilitation has advanced, but residential instability, homelessness, forensic involvement, substance abuse and development of new interventions contribute to the rehabilitation challenges for long-term patients. Further research is indicated in the area of rehabilitation. See Figure 12 for overview of the contents discussed.

Figure 12: Mental health care in rehabilitation



19. Mental health care for mother and infant

Studies relating to mother and infant focused on the lack of access to mental health services during the perinatal period. This was viewed as a significant public health concern. Barriers to accessing services may occur at multiple points in the care pathways. Previous reviews have not investigated multilevel system barriers or how they might interact to prevent women from accessing services. To improve multilevel access strategies, Sambrook et al. (2019) address individual, organisational, sociocultural and structural-level barriers at different stages of the care pathway and found that perinatal mental health concerns may go undetected and untreated. A Canadian study (n=16) explored the factors women perceive as preventing or facilitating access to mental health care in the perinatal period. Findings indicate that mothers' concerns were centred on cultural values, access knowledge, relationships, flexibility and system gaps. Discharge from midwifery care at six weeks postpartum was also found to impede access (Viveiros et al. 2018). Perinatal depression and, or anxiety disorders are undertreated pregnancy complications (Sambrook et al. 2019), due partly to low rates of engagement by women. An Australian study (n=218) found that referral was identified as a barrier. Ayres et al. (2019) recommend improving perinatal engagement by actively engaging women in the process and by educating health care professionals about their positive influence on women's engagement.

There is limited research on mothers' perspectives of perinatal mental health services and most research focuses on mother and baby units (MBUs). Powell et al. (2020) (n=139) explore women's views of their experiences of generic wards, MBUs and crisis resolution teams, across 42 mental health trusts. They found that mothers reported the benefits of positive, non-coercive relationships with family and staff for their recovery. In a study undertaken by Bell at al. (2016) with women (n=30) presenting with heightened symptoms of depression in the postpartum period the need for improved access and proximity to services was identified. Quality of recovery after caesarean section surgery is an essential measure of early postoperative patient health status. Quality of Recovery after CS surgery with the drug dexamethasone, and neonate outcome assessment after caesarean section surgery was evaluated. Findings indicate that caesarean section surgery Dexamethasone had a positive effect on early postoperative recovery of patients, with a delay in regression of spinal block and without any significant adverse effects on neonatal outcomes (Patnaik et al. 2021).

19.1 Barriers to accessing midwifery care in ethnicity

Barriers to accessing mental health care during pregnancy and the perinatal period appear to be greater for women from ethnic minority groups, however there is no reliable large-scale data about their actual use of mental health services (Jankovic et al. 2020). The antenatal period provides an opportunity to ensure timely access to secondary mental health services. Access to secondary services for New Zealand women during pregnancy, and for up to 1 year post-delivery, was explored by Filoche et al. (2016). Findings indicate that 27 in 1000 pregnancies were associated with access to secondary mental health services and ethnicity, young age, smoking, eating disorder, alcohol and substance use during pregnancy were identified as risk factors (Eddy et al. 2017). Access rates to secondary mental health services, including involuntary admissions to psychiatric inpatient care and patterns of engagement for ethnic minority women in the UK were explored. Findings show that out of 615,092 women who gave birth 3.5% started a contact with mental health services during the perinatal period (Jankovic et al. 2020).

Depression in pregnant women from ethnic groups was reported in a study undertaken in the USA. (n= 81,910). Results identify the need for significant public health targeted interventions for pregnant women with prenatal depressive symptoms (Chang et al 2016). South African mothers used a Right to Mental Health Framework to investigate barriers to accessing perinatal mental health care (n=14). Findings indicate that physical health was prioritised over mental health at the clinic level, with inadequate numbers of antenatal and mental health providers being available to provide essential perinatal mental health services (Brown et al. 2018). A UK study (n=2,260) explored the association between social ethnic networks and service provision. An increase in perceived inadequate support in women's close networks was associated with increased use of mental health services (Kapadia et al. 2018). A study of socioeconomically disadvantaged areas in New York found that mental health care remained largely inaccessible for ethnic non-native speaking mothers living in poverty (McDonald and Acri 2018).

Suicide is the leading cause of maternal death in New Zealand, particularly amongst Māori and Pacific residents and in order to determine the mental health status of both groups of pregnant women Holden et al. (2020) explore current maternal mental health (MMH) screening practices, maternity carers and mothers. Findings indicate that MMH screening was ad hoc, indicating that services need to be targeted at patient, provider, and systems levels.

Jimenez et al. (2017) examine whether children (31,272) seeking post-mild traumatic brain injury (mTBI) mental health care had previous mental health diagnoses or a new onset of such disorders, and if different by race or ethnicity. Findings show that mTBI was associated with increased utilisation of mental health services but most of these services were received by children with previous mental health disorders. Findings indicate the importance of providing individualised, culturally, and linguistically competent care to improve outcomes after mTBI for all children.

19.2 Integrated perinatal and infant mental health services

Perinatal mental disorders (PMDs) are the most common complication of pregnancy and the first postpartum year. Bergar et al. (2017) in examining PMD prevalence and use of mental-health services by perinatal women, in Switzerland, found that women with PMD used mental health services mainly in non-obstetric outpatient settings, predominantly for medication prescription. Findings from this study indicate that Primary care providers and mental health specialists contributed equally to consultation treatments. Lee and Newman (2018) advocate for a coordinated and integrated approach with focus on early intervention to deliver perinatal and infant mental health services. The significance of perinatal mental disorder for maternal wellbeing and its impact on infant development was explored through a model of care, in a hospital unit in Australia, that had been established as a residential therapeutic unit offering short-term treatment (Lee and Newman 2018). Maternal depression is a chronic set of disorders associated with significant burden to caregivers, children and families. Acri et al. (2018) with (n=320) children and their caregivers examine the relationships between caregiver depression and perceived barriers to treatment and found that caregiver depression was associated with adversities to the child, caregiver and family.

19.3 Interventions

Poor mental health in the perinatal period can impact negatively on women, their infants and families (Schmied et al. 2016). An Australian study identify high postnatal use of child and

family health nurses and general practitioners (n=106). Findings also indicate limited use of specialist mental health services by women identified with moderate to high risk of mental health problems, in the period from pregnancy to 12 months after birth (Schmied et al. 2016). Mental illness in a parent or child often exacerbates the challenges of managing psychological distress. Suchman et al. (2016) piloted Mothering from the Inside Out (MIO) with mothers (n=17) receiving services at a community-based mental health clinic and found MIO was feasible and acceptable when delivered in this setting. However, no improvement in mother–child interaction quality was found and low-income women experienced disproportionately high rates of adverse maternal mental health outcomes, such as pregnancy-related depression and less access to behavioural health support. Warm Connections, is a parenting education intervention that may reduce distress and increase parenting efficacy among low-income mothers (Klawetter et al. 2020).

Pregnancy in youth and young adults is considered high risk from a number of different standpoints. Norris et al. (2016) describe demographic characteristics associated with Canadian pregnant and postpartum youth and young adults (n=28) attending a youth outreach clinic. Findings indicate that outreach mental health clinics resulted in fewer missed appointments, thus improving access, outcomes and barriers to receiving care.

Adams and Jahoda (2019) explore mothers' experiences of seeking mental health support for their child or adolescent with severe or profound intellectual disabilities. Mothers reported that their child faced discrimination when accessing services and they perceived that professionals often lacked the knowledge and skills to work with people with severe disability. This small study highlighted the need for more appropriate mental health support for individuals with severe and intellectual disabilities. Findings suggest further research is needed in relation to adapting psychological therapies for this population.

In conclusion, limited studies were found relating to mental health in mothers. The main focus for mothers was on the lack of access to mental health services during the perinatal period, an area that is viewed as a significant public health concern. Barriers to accessing services may occur at multiple points in the care pathways, indicating the need for further comprehensive research. There is limited research on mothers' perspectives of perinatal mental health services and most research focuses on mother and baby units (MBUs). Research findings indicate the need for significant public health targeted intervention for pregnant women with prenatal depressive symptoms. See Appendix I for further information on mother and infant mental health care. Recommendations are suggested.

20. Professionals in mental health care

Professionalism was a consistent theme across studies. Professionalism, as a concept relates to the professionals who deliver the service and is generally framed in terms of operational excellence and quality of care. Aylott et al. (2020) sought to determine the lived experience of patients, carers and healthcare professionals and indicated that more research was needed in the area of mental health care delivery. The studies presented here relate to professionals working in mental health services. These studies include presenting the importance of psychologists' experiences and challenges, compassion and engagement demonstrated by community mental health nurses, social workers in multidisciplinary community teams, social care professionals, rehabilitative mental health and trauma care. Inter-professional education enhances the capacity of mental health systems to provide recovery-oriented, evidence-based care to individuals living with mental illness.

Compassion was at the core of all healthcare professionals' practice (Ponce et al. 2019). Barron et al. (2017) described perspectives of compassion, illuminating its complexity and impact on emotional responses and relationships with self, patients, colleagues and the organisation. Participants identified difficulties engaging with compassionate practice and their need for support in gaining a greater understanding of compassionate care for clinical practice and also for self-compassion. There exists a need for the continuous development of new, collaborative ways of working between professionals at their different stages of interaction with their "shared clients" (van Dijk et al. 2021). Engagement challenges with youths in mental health community settings often resulted in reduced benefits relative to outcomes.

Therapists identified two types of engagement challenges—Limited Client Engagement and Expressed Client Concerns. Findings suggest that therapists (n=103) may benefit from learning strategies to address these two distinct types of engagement challenges encountered in implementation of EBP (Hakim et al. 2019). Burnout among community mental health professionals has been associated with ill health. However it was also indicated that knowledge and confidence in delivering EBP and their positive perceptions of EBP were found to be protective against emotional exhaustion, but these perceptions did not buffer the risks associated with heavy workloads (Kim et al. 2018).

20.1 Professional clinician experiences and challenges

Implications for registered psychologists working in the public mental health services were explored in three research studies that identified the meaning psychologists gave to their work, coping strategies used, role as educators and experience of working in teams. Personal coping strategies were used to survive in this demanding work place (Hughes et al. 2017, Sciberras and Pilkington 2018). Coping strategies were also identified when working with people with bi-polar disorder. This work was often viewed as challenging by professionals, especially when there was a high risk of suicide or self-harm. Insights into the lived experiences of clinicians emphasise the stressful nature of the role and the need for coping strategies. Therapists identify two types of engagement challenges—Limited Client Engagement and Expressed Client Concerns. Findings suggest that therapists (n=103) may benefit from learning strategies to address these two distinct types of engagement challenges encountered in the implementation of EBP with people with bi-polar disorder (Hakim et al. 2019). Challenges also occur with therapists when delivering EBP in children's mental health. Burnout among community mental health therapists' has been associated with poorer therapist health. Therapists' knowledge and confidence in delivering EBP and their positive

perceptions of EBP were found to be protective against emotional exhaustion, but these perceptions did not buffer the risks associated with heavy workloads (Kim et al. 2018).

Findings from a small study undertaken in the UK, by Hughes et al. (2017) point to the importance of counselling psychologists in helping clinicians working within multidisciplinary teams to develop a deeper understanding of their responses, through training and supervision, which could in turn enhance the care provided. Examples of psychologists as educators of other professionals in implementing evidence-based practices, collaborating with people in recovery, enhancing cultural competence, and reducing mental health disparities were identified by Ponce et al (2019). They found their client work as being a source of satisfaction but equally as a source of stress where the quality of their work experience was shaped by the larger context of their work setting. Negative emotions arising from the system were perceived to be more distressing than those arising from client work. This negativity was due mainly to powerlessness, lack of control and divergent values which contributed to distress and reduced job engagement. Effective mental health care is dependent on engaging service users, but some individuals do not attend appointments, and may even stop engaging with services, requiring innovative engagement strategies (Henderson et al. 2020).

Aspects of the social workers' role were summarised as: compassionate care, person centred approaches to practice, holistic involvement, and the wide scope of support provided to clients (Boland et al. 2019, Henderson et al. 2020, van Dijk et al. 2021). Mental health professionals used varied engagement approaches to fit with the changeable and unique needs of service users, yet little is known about the engagement experiences of staff working in early intervention settings, indicating a need to further understand staff experiences of engagement in this setting (Henderson et al. 2020, van Dijk et al. 2021). Boland et al. (2019) identified few differences between service users' experiences of mental health social workers compared with other mental health staff, highlighting the need for further research to improve understanding of the mental health social worker role and how it is experienced by the service user.

Compassion needs to be at the core of all healthcare professionals' practice. Four studies relating to compassion, engagement and the boundary spanning role of community mental health nurses were found, indicating the positive contribution made by nurses in delivering compassionate care. van Veen et al. (2020) explore the working alliances possible between patient and community mental health nurse during Interpersonal engagement and Henderson et al. (2020) indicate that staff demonstrate the qualities of persistence and adaptability when engaging successfully with stakeholders. Findings also suggest that engagement needs to become a core aspect of nurse education and training. The study recommends that registered mental health nurses and other health and social care professionals would benefit from systematic guidance regarding engagement strategies. The application of a community mental health nursing (CMHN) model, using a standard nursing care and cognitive behavioural therapy intervention, relating to life skills and work productivity, was implemented by Kellett et al. (2020) with adult people with schizophrenia (n=193). The findings indicates that there was a significant positive difference before and after implementation of the intervention, indicating that the CMHN intervention models could be a skill to strengthen the ability of those persons to live in the community.

Organisational change poses difficulties for staff working in Community Mental Health Teams (n=20). Healthcare professionals' and service users' experiences of inter-sectoral care occurring between hospital and community mental healthcare indicates the need for better management practice and support, training and supervision of staff, as the foundations of safe practice (Lines 2020). Other research found related to community pharmacies and to additional specialist consultation (Jørgensen et al. 2020). Community pharmacies are accessible health care destinations that effectively provide a range of public health services. The opinions of consumer (n=537) of mental health promotion and the perceived role of pharmacy staff in this area was explored. Findings indicate that the pharmacy was viewed as a suitable environment for health promotion, highlighting an opportunity for pharmacists to engage with consumers about their mental health (Bush 2020, Hall et al. 2021).

Fehily et al. (2020) suggest offering additional consultation with a specialist. The effectiveness of offering clients an additional consultation with a specialist clinician embedded within a community mental health services was explored in Australia (n=811). Results indicate that clients were satisfied with the preventive care interventions offered. This study also provide an economic evaluation of the specialist clinician model being delivered by an occupational therapist. The evaluation indicates that this model of care was low- per- client- cost whilst increasing key preventive care delivery outcomes, and was positive towards the role of the occupational therapist (Fehily et al. 2020). A UK study explored care coordinators' views about their ability to monitor physical health in clients with SMI (specifically, psychosis). Findings show the need for care coordinators and other professionals to address barriers to the provision and promotion of physical health interventions to this population (Hanley 2017, Gronholm et al. 2017).

An unexplained area relates to the struggle adults with autism and mental health problems face. The perspectives of clinicians, staff and autistic adults on improving community mental health services for autistic adults were explored by Maddox et al. (2020) with autistic adults, clinicians and leaders in the USA. Findings point to the need for greater efforts in training clinicians to work more effectively with autistic adults and to increase coordination between the mental health and developmental disabilities systems.

Turnover is a critical problem for community mental health providers, and supervisors may play an important role in mitigating turnover. Increased supervisory support is associated with lower turnover intention suggesting that supervisory support is an important role for direct supervisors (Fukui et al. 2019)(n=186). A large US study (n=15,520) examined inpatient psychiatric discharges. Findings show that patients who had a scheduled outpatient appointment were significantly more likely to attend an outpatient mental health services within 7 and 30 days compared to patients who did not have an outpatient appointment, indicating that scheduling is an effective and low-resource discharge planning practice (Smith et al. 2020).

20.2 Trauma Informed Care

Trauma informed care is an approach to the delivery of mental health care that requires sensitivity to the effects of trauma on the lives of people accessing services. The potential for implementation of Trauma Informed Care into mental health services was explored in an Australian study (n=73) from the perspectives of clinicians and senior managers. Findings indicate that managers seek leadership, resources, accessible training and clarification of the concept and actions of Trauma

Informed Care (Gammage and Foster 2017). These findings have implications for any service, team or individual seeking to implement Trauma Informed Care within mental health settings (Isobel et al. 2021).

In conclusion, compassionate patient engagement needs to be a core aspect of clinician education and training. Registered professionals and supporting care staff would benefit from systematic guidance regarding engagement strategies in their approaches to patients with mental health illness. See Figure 13 and Appendix I for further information. Recommendations are suggested.

Figure 13: **Professionals in mental health care**

21. Psychiatry in later life

Organisational culture reform for older persons, aged 65 and older is being considered in many countries, including Ireland. Reform for South Australian older persons' mental health services is values based and is built around a central philosophy of compassionate relationship-centred care, that supports psychological safety and transparent accountability (McKellar and Hanson 2020). In the UK, The Royal College of Psychiatrists' Faculty of the Psychiatry of Old Age report is firmly in favour of specialist older adult mental health wards as the predominant model (Murray 2019). Yeo et al. (2020) recommend that greater efforts are needed to develop gender-tailored community interventions for older adults thus maximising its benefits (Yeo et al. 2020).
Previous studies have shown increased rates of death and dementia in older people with specific serious mental illnesses such as bipolar disorder or depression (Paul et al. 2019, Daley et al. 2020). A large UK study found that older adults referred to a secondary care psychiatric service demonstrated higher rates of dementia and death than those reported for the general population and also that survival was reduced in patients referred to liaison psychiatry services (Kershenbaum et al. 2020).

21.1 Caregivers interventions

Caregivers are essential to service delivery in all settings. This is evident from studies that identify caregiver role as supporting interaction and interventions that are designed for older persons. An intervention programme assessing caregiver strain, positive aspects of care and physical and mental health demonstrated improvement in caregiver's mental health, increased satisfaction with care, and less caregiver strain (Paul et al. 2019). A study undertaken in the UK, by Daley et al. (2020), evaluates the feasibility of multi professional staff–led recovery intervention targeting older person mental health services. Significant change towards improvement in four of the six interventions, relating to recovery, were identified, but further development of the two remaining interventions associated with quality were advised. Further studies indicate that implementing research priorities for recovery oriented interventions, led by staff, point to the need to include the views of service users, carers and clinical staff to produce meaningful results (Emrich-Mills et al. 2019, Morres et al. 2019). Research identified by people using, or working in services for dementia and older adult mental adult, identify four hundred and eighteen research ideas. The top 10 topics were identified as surrounding care, psychosocial support and mental health in dementia, demonstrating the possibility of including key adult stakeholders in research priority setting at local level (Emrich-Mills et al. 2019). An area rarely researched relates to Spirituality-related needs, preferences, and the experiences of individuals and families receiving mental health services. Findings highlight the importance of providing spiritually integrated services to individuals who value spiritual practices or participate in faith communities helpful (Yamada et al. 2020).

21.2 Attitudes and perceptions toward seeking mental health services

Little is known about the factors associated with older adults' attitudes towards accessing mental health services. Contextual and personal predictors were explored in a study undertaken in Germany that identified higher perceived social supports as being associated with more positive attitudes towards seeking mental health services (Kietzman et al. 2018). Support for older adult delivery system of care in California indicates the presence of unmet needs among older adults with mental illness. Enhancing and standardising outreach care was recommended (Frank et al. 2018). A study undertaken in Spain identified the GRADIOR computer-based cognitive rehabilitation

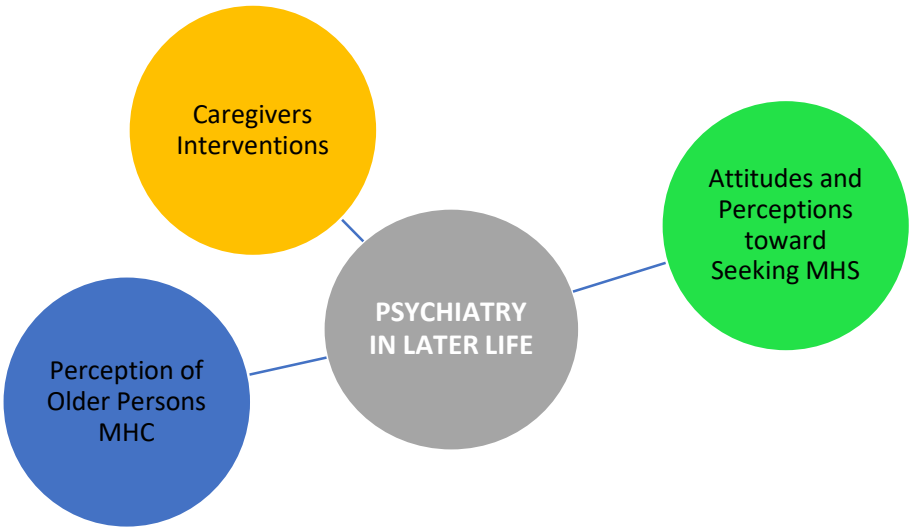
programme, consisting of a series of exercise modalities with difficulty levels as meeting the needs of older people with dementia (Franco-Martín et al. 2020).

22.3 Perception of older persons mental health care

Access is investigated in Australia, by using a Decision Framework to recognise psychological problems. Findings indicate that although older adults had a good understanding of the role of mental health disciplines they may have difficulty in recognising anxiety and milder levels of mental health concerns: these barriers need to be considered by professional's working with older adults (Knight and Winterbotham 2020). Other barriers are provided in an overview of existing psychogeriatric services undertaken in Albania, Bulgaria, Greece, and North Macedonia where variation regarding service availability, inpatient treatment and psychological distress were found to exist (Alexopoulos et al. 2020). The Net Promoter Score intervention used as a service improvement tool and outcome measure was found to be negatively related to age (Wilberforce et al. 2019). Screening interventions for early detection and proper management of mental illness can help to prevent severe deterioration in a persons' condition. A comprehensive screening questionnaire: BS4MI-elderly, for common mental illnesses of the elderly, could be a useful instrument for screening the elderly, thus enhancing their satisfaction with mental health services (Yun et al. 2020).

In conclusion, studies describe the importance of care givers and carers in older person care. Six of the ten papers that discussed older persons' perceptions of care made specific reference to barriers to care and to services. Older adults are recognised as a group with poor access to mental health services, particularly those living in rural areas. Community engagement is critical for healthy aging. What is less understood is the role gender plays in older adults. Perceptions of older persons with mental health services remain under researched, with just six studies found. See Figure 14 and Appendix I for further information

Figure 14: Psychiatry in later life



22. Therapies in mental health care

22.1 Cognitive-Behavioural Therapy

Twenty one studies were found relating to therapies delivered to individual with mental health illness. CBT is a first-line treatment for anxiety disorders, particularly when it involves gradual confrontation with feared stimuli (i.e., exposure), however, delivery of CBT for anxiety disorders in community clinics is lacking (Wolitzky-Taylor et al. 2018). Wolitzky-Taylor et al. (2019) assess perceptions of the barriers to delivering (or receiving) CBT for anxiety disorders, in a study undertaken in California. Results demonstrate that providers and administrators indicated a lack of training and competency as the primary barriers and patients reported that their own symptoms impacted on the treatment they were receiving. Further research was indicated. The gold standard measure for CBT fidelity is the Cognitive Therapy Rating Scale (CTRS). Despite its widespread use in research and training programmes, the CTRS structure had not been examined by mental health clinicians with adults and child clients in community mental care. Affrunti et al. (2019) address this gap by scoring clinicians (n=355) providing CBT sessions (n=1,298) by using the CTRS. Findings suggest that the CTRS is a reliable measure of CBT in community mental health settings but that its structure may depend on the clinical population measured.

Xanidis and Gumley (2020) explore the views and experiences of mental health professionals regarding the implementation of CBTp. CBTp for psychosis training usually occurs when the client's case manager meets with them in the community and provides support around their social and functional needs. Findings indicate barriers and facilitators to CBTp implementation including difficulties in coherence among stakeholders regarding the purpose and value of CBTp.

22.2 Cognitive Behavioural Therapy: anxiety

Despite the effectiveness of exposure-based CBT for anxiety disorders, few individuals in need receive this treatment, particularly in community mental health settings, that are serving low-income adults, with anxiety. Wolitzky-Taylor et al. (2018) found that barriers include the need for enhanced therapist training and competency and logistical and funding issues. Further research to address these barriers was recommended. Co-morbidity among the patients with anxiety disorders was common and may negatively impact treatment outcome. Potentially, trans-diagnostic cognitive-behavioural treatments deal more effectively with comorbidity than standard CBT therapies. Reinholt et al. (2017) tested the effectiveness of The Unified Protocol as applied to patients (n=47) having a principal diagnosis of anxiety. The Unified Protocol is a CBT treatment that may be used to treat common mental disorders like anxiety and depression. Pre-post-treatment effects were examined for people receiving the Unified Protocol treatment in an outpatient setting. Findings indicate that patients with comorbid depression benefit more from treatment than patients without co-morbid depression, indicating that the Unified Protocol can be successfully applied to a mental health service group setting.

22.3 Cognitive Behavioural Therapy: Autism

CBT can improve anxiety and depression in autistic adults, but few autistic adults receive this treatment. Maddox et al. (2019) examine factors that may influence clinicians (n=100) use of CBT with autistic adults and found that clinicians reported stronger intentions, more favourable attitudes and higher self-efficacy to start CBT with non-autistic adults than with autistic adults and that the only significant predictor of intentions to begin CBT with clients with anxiety or depression was

clinicians' attitudes. More favourable attitudes predicted stronger intentions. These findings suggest that tailored implementation strategies are needed to increase clinicians' adoption of CBT for autistic adults.

22.4 Cognitive Behavioural Therapy: Psychosis

CBT for schizophrenia spectrum disorders is an evidence-based treatment yet in many countries individuals with a primary psychotic disorder are unable to access this treatment. Kopelovich et al. (2019) identify that Stepped Care interventions have shown promise as an applied treatment delivery model in other settings, and for other psychotherapeutic interventions. They establish, in a study undertaken in the USA, how the Stepped Care Model can be applied to CBT for psychosis in community mental health settings by increasing access to the intervention through involving the multidisciplinary team. A similar therapy is Cognitive Therapy. The association between adherence and competence in cognitive therapy techniques with people (n=97) receiving cognitive therapy for major depressive disorder, in a community mental health setting, indicates support for the hypothesis that use of cognitive therapy techniques was associated with change in the persons compensatory skills (Barlati et al. 2018, Crits-Christoph et al. 2020).

22.5 Evidence- based treatments

Reding et al. (2018) examine the perspectives of service providers (n=133) placed on a rapid path to mandated evidence-based treatment delivery by using an inductive coding process, to capture themes obtained from feedback. The majority of provider comments were negative. Results illustrated the intended and unintended consequences of large-scale implementation efforts on community services when implementing evidence-based treatment, including the amount of time taken to implement and a lack of staff training to undertake the process. Lucid et al. (2018) examined supervisor and clinical and organisational factors that are associated with the intensity of EBT. Results suggest that an implementation climate that supports EBT may be the most critical factor for improving intensity of EBT coverage. Greater coverage by organisations to encourage usage by supervisors was recommended.

A similar therapy is Dialectical Behavioural Therapy (DBT). Dialectical Behavioural Therapy (DBT) is a comprehensive cognitive behavioural treatment that treats people who see little improvement in their condition when other therapy models are being used. This treatment focuses on problem solving and acceptance-based strategies and operates within a framework of dialectical methods (Blood et al. 2020). While there is evidence to support the use of group DBT in the treatment of binge eating disorder (BED), few studies have reported on its effectiveness when delivered in routine clinical practice. Blood et al. (2020) with adults (n=56), explore the effectiveness of Group DBT for BED when delivered in a community eating disorder service. Results indicate that Group DBT is an acceptable and effective treatment for adults with BED when delivered in this setting.

22.6 Psychodynamic psychotherapy for challenging behaviours in schizophrenia

Saha et al. (2019), in an Australian study, outlined the use of psychodynamic psychotherapy as an adjunct to treatment as usual for addressing challenging behaviours in a patient with schizophrenia, under the care of a community mental health team (CMHT), in the context of being administered depot medication under a CTO, and where conventional methods had failed. With treatment this individual demonstrated improved compliance and overall engagement and consequent to regularly

receiving medication her mental state improved and hospitalisations decreased. Further research is needed to explore the full range of this therapy use with a larger study.

22.7 Social cognitive skills training

Social Cognitive Skills Training (SCST) with schizophrenia is explored. Despite a growing emphasis on community care in mental health services the synergistic effects of social cognitive intervention strategies on routine community mental health services are not well documented. A study undertaken by Lim et al. (2020) with individuals (n=47) with schizophrenia adapted a group-based SCST programme among community-dwelling individuals. Findings suggest that the adapted version of the SCST programme was feasible for implementation and demonstrated promise for enhancing social cognition and functioning in outpatient settings. Social skills were also researched by Karaman et al. (2020) in their exploration of the effect of Psychosocial Skills Training (PSST) on the social functioning of patients (n=22) with schizophrenia, who received occupational therapy in a community setting. Findings indicate that the addition of Psychosocial Skills Training to routine service seemed to help in relieving clinical symptoms.

22.8 Increasing access to psychological treatments: Intervention model

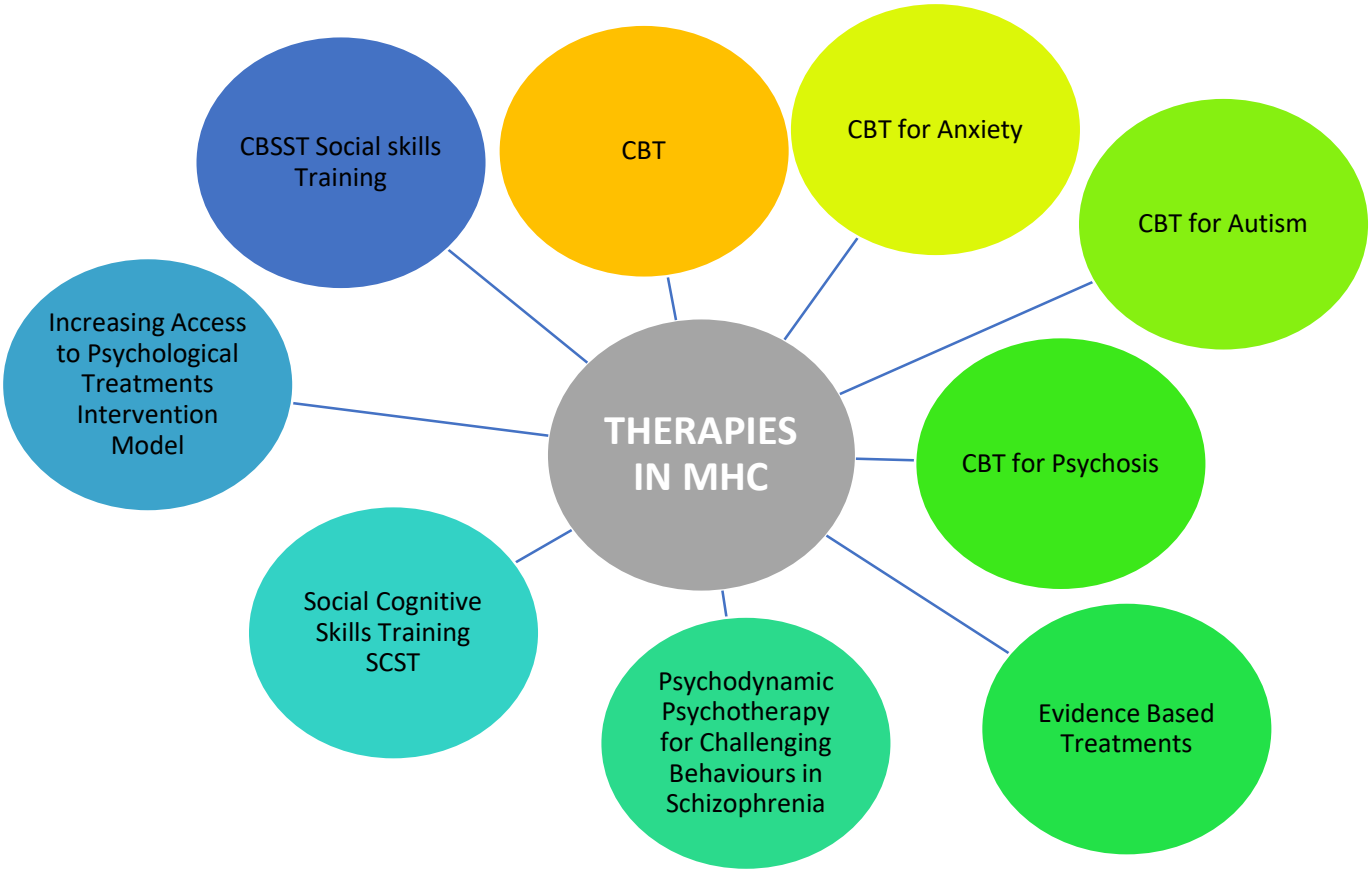
In the UK, a national programme titled 'Improving Access to Psychological Treatments' has significantly increased supply and assessed effectiveness, but paid less attention to uptake and equity. Two large-scale ‘community workshop’ intervention models were developed by Brown (2018) to improve uptake and equity for common mental health problems. The key component of the model is a ‘group-sensitive engagement’ ethos. Findings indicate that the model of community workshops with its ‘group-sensitive engagement’ ethos, to which adults can self-refer, may be very relevant in providing access. Bartram and Stewart (2019) compare income-based inequities in access to psychotherapy and other mental health services in Canada and Australia and found sharply contrasting responses to high rates of unmet need. The results indicate that utilisation of psychologist services was more concentrated at higher income levels.

22.9 CBSST social skills training

A study undertaken by Sommerfeld et al. (2019) examined stakeholder perceptions of the 'fit' between cognitive-behavioural social skills training (CBSST) and assertive community treatment (ACT) when implementing CBSST into existing community-based ACT teams. They also sought to identify perceived client and provider benefits for integrating CBSST into ACT. Results were positive. Assertive community treatment (ACT) is a form of community-based mental health care for individuals experiencing serious mental illness that interferes with their ability to live in the community. Kellett et al. (2020) in a sample of carer providers (n=58), undertook 5-sessions of cognitive analytic consultation and found that this form of collaboration was a suitable method of consultation for care providers, attempting to work effectively together in community mental health teams. Testing in a clinical trial was indicated. Whilst the evidence for the efficacy of treatment interventions for individuals with dual diagnosis has been developing in recent decades, little is known about individual perceptions and the personal benefits of attending integrated treatment programmes within this population group. Chilton et al. (2019) (n=15) investigated the experiences of individuals with a range of complex mental health and co-existing substance misuse problems who took part in a psycho-educational group (PEG) programme. Findings identify the complexity of the therapeutic process and support the use of integrated treatment programmes in this population.

In conclusion, twenty one studies were found relating to therapies delivered to people with mental health illness. CBT is a first-line treatment for anxiety disorders, particularly when it involves gradual confrontation with feared stimuli, for example exposure, however studies identify that delivery of CBT for anxiety disorders in community clinics is lacking. The efficacy of treatment interventions for people with dual diagnosis indicates the use of psychodynamic psychotherapy as an adjunct to treatment as usual for addressing challenging behaviours in patients with schizophrenia under the care of a community mental health team. See Figure 15 and Appendix I for Therapies (CBT) in mental health care. Recommendations are suggested.

Figure 15: Therapies in mental health care



23. Discussion

This evidence presented in this evidence review demonstrates variable quality. Overall the quality of outcomes and discussion were of medium to high quality. The Grey literature was also explored mainly to access reports. Few research methodologies had the degree of control needed to rule out other explanations, although RCTs and large sample studies demonstrated excellent research methods and findings, that are capable of transferability and replicability for use in other contexts and environments. Evidence demonstrates benefit in consideration of selected outcome measures in mental health care services. Recommendations presented in this review reflect study findings. What is evident throughout the studies found is the paucity of research relating to the experiences, outcomes and needs of individual service users which add to the need and urgency for large scale studies to be undertaken into individuals with mental health illness. As the purpose of this evidence review is to explore research relating to mental health services in the development of a new quality framework, frameworks, audits and toolkits are introduced first. Frameworks are explored from the perspectives of quality, ethics, clinical and through consolidation with audits and toolkits.

Clinical audits evaluate and improve day to-day clinical practice as errors in practice, suboptimal practice or inefficiencies can occur in any part of health-care systems (Skull 2020). Clinical audits examine how clinical care is provided, aid the detection of problems, identify areas for improvement and provide information on trends and patters. Studies demonstrated variable quality of evidence relating to frameworks and audits and in many studies those areas were integrated. One such area relates to national clinical audits that provides public reports of data on healthcare treatment and outcomes. However, their potential for quality improvement is not yet fully realised among healthcare providers. While the utility of clinical audits is well documented, questions have been raised in relation to reconciling/balancing the benefit of the audit and the burden of participation in terms of resources and costs (Kamhawy et al. 2020). The development and maintenance of a transparent audit trail is also cause for concern in audit cycle for the reasons mentioned above (Hackett and Strickland 2019). These were consistent themes in many studies concerning the use of audits that may indicate user hesitancy. Findings are also consistent in demonstrating the need for oversight and responsive infrastructure for Quality Improvement (QI) that is underpinned by ethical frameworks and research oversight (Weske et al. 2018, Tan et al. 2019, Naughton et al. 2020). Audit and framework is being used to support QI successful implementation and reflects a self-regulating process that uses a consolidated framework. However, findings reflect an incomplete feedback loop during implementation (Wagner et al. 2019), that may be minimised by best practice guidelines (Kolehmainen et al. 2020, Seay and Feely 2020). Toolkits are found that identify quality from outcomes and patient engagement perspectives and in some cases to enable individuals to evaluate their own practice and consider relevant measurable outcomes from practice (Snaith et al. 2018).

23.1 Quality

The mechanisms for improving quality in mental healthcare are underpinned by legislation, government policies, professional standards, peer reviews, and consumer involvement. It was only in recent years that countries extended their quality focus to assessment, measurement and improvement combined with research initiatives, EBP and professional engagement (Agarwal et al. 2019, Bellehsen et al. 2019, Boland 2019). Quality measures which are underpinned by evidence-based practice is a well supported them in the literature.

The more robust evidence links QI approaches in healthcare to application in the provision of mental healthcare, particularly with reference to the use of data, evidence and metrics. Measuring and monitoring indicators and the quantification of quality through them are the basis for evidence-based health policy that ultimately leads to quality services. Both Ireland and Australia adopted a strategic approach to mental health reform that co-ordinates quality and recovery initiatives. This approach provides a foundation for engaging mental health stakeholders in developing quality and outcome measurements.

Patient safety is dominant throughout the literature. Patient safety is a priority for patients, staff and the health care systems. In Ireland, the Patient Safety Strategy (HSE 2019) was developed by patients and staff, working together to identify and implement improvements in healthcare provision. The Strategy recognises that patients and those who use mental health and disability services are often best placed to inform and support safety improvement, and places a significant emphasis on patients being central to the planning and the implementation of the Strategy. As part of its commitment to care, compassion, trust and learning the HSE has introduced a facilitator development programme to enable cultures of person-centeredness for persons who both use and provide services throughout the Irish healthcare system. The programme further supports sustainable capacity by imbedding cultures of person-centeredness within services systematically and incrementally (HSE 2017d).

23.2 Recovery

The meaning of recovery remains unclear and ambiguous particularly when recovery models seek to operationalise recovery, gain understanding of perceptions and validate changes in personal recovery (Bitter et al. 2019, McCaffrey et al. 2020). The Irish national framework for recovery in mental health builds on the committed efforts of Irish service users, family members, carers and service providers to develop a more recovery-oriented mental health service (HSE 2017). Australia has also incorporated wellness into its recovery framework. The literature describing the person's recovery process and their relationship with the clinical services they received added to the dialogue around recovery in different cultures, which was often seen as challenging (Cruwys et al. 2020). Also challenging was the lack of consistency in measurement which likely contributes to the broad range of findings regarding clinical recovery in mental health (Pelletier et al. 2020). Clinicians face challenges in translating embedded recovery concepts into professional practice that often results in delivery of sub-optimal care (Khan and Tracy 2021).

Few rigorous designs analysing recovery models and empirical research on the outcomes and psychological mechanisms of recovery are found. Consistency in the measurement of recovery models in mental health care emphasises service users' right to be involved in key decisions regarding their care, including their choice of a primary mental health professional (Rioli et al. 2020). Few studies reported recovery outcome metrics for CAMHS (Gibbons et al. 2019). Consistency in the discussion of how recovery is perceived among ethnic minorities includes studies on how stigma surrounding mental illness is a key challenge to the recovery experience (Mistler et al. 2021). Wellness and wellbeing has entered the lexicon of recovery in several ways. This includes the concept of psychological resilience, referring to ability to 'bounce back' after adversity (Brunner and Plotkin Amrami 2019), and routines and rituals that support habitual wellness (Lara-Cabrera et al. 2020). A new treatment paradigm in mental health emphasises employment by engendering self-reliance and self-confidence on the road to recovery (Drake and Wallach 2020). The perceptions of

recovery, identity, and wellbeing among people with acute, SMI are enhanced by attending recovery–oriented support groups (Cruwys et al. 2020, Pelletier et al. 2020).

23.3 Acute adult mental health care

Descriptions about what constituted 'access and barriers' to adult mental health care varied across studies. Despite the variability some common features are shared, including access, availability, relevance, effectiveness, equity and utilisation of services (Butz et al. 2019). The treatment gap for mental health disorders remains a challenge worldwide. Identifying reasons for non-treatment may contribute to reducing this gap (Silva et al. 2020). Studies associated with SMI, psychosis and first episode are identified and include schizophrenia, bi-polar and suicide (Chan et al. 2018). Studies identify that individuals affected by psychotic disorders frequently disengage from mental health services (Reynolds et al. 2019), including disengagement from treatments. In examining the predictors of treatment attendance in cognitive therapies for major depressive disorders, techniques to improve engagement in therapies were advised (Gibbons et al. 2019). Suicide and suicide prevention was explored from the perspective of risk, lack of treatment, lack of compliance, availability, service improvements and the importance of assessments for suicide risk among people with mental illness (Ponce et al. 2020).

Several measurement and assessment tools were found that relate to mental health. These include the RAS-DS tool for anxiety and depression (De Silva et al. 2021), and an internet-delivered self-management programme offering therapeutic approaches for bipolar disorder in Ireland that reports positive outcomes (Enrique et al. 2020). Other measurement tools were found including Schizophrenia EBP Measurement Tools to identify and harness individual cognitive strengths (Saperstein et al. 2020), the SInQUE for use by mental health staff (Mezes et al. 2021) and the SPA-5 scale that can be completed by people with serious mental illness (Yamaguchi et al. 2020). To establish the frequency of exposure to hostile indicators mental health professionals adapted the Healthcare-workers' Aggressive Behavior Scale-Users (HABS-U) (Ruiz-Hernández et al. 2019). Further research was indicated to determine the feasibility of measurement tools in other contexts.

23.4 Carers and family

Carers, family and the individual's peers were identified from the perspectives of community integrated care, family and home care, experiences with services and family focused interventions. Community care, patient satisfaction, wellbeing and safety issues (Berzins et al. 2020) were mentioned as being important barometers of the quality of patient care delivered (Stamboglis and Jacobs 2020). Dissatisfaction occurring in patients with unmet needs was found particularly if they were not involved in decisions concerning their care and their decision-making right was not acknowledged (Arya 2020, Rioli et al. 2020), indicating the need to develop better communication and shared decision-making methods (Stain et al. 2020). Families may have difficulty in their experiences of involvement in care planning (MHC 2007). The evidence of family involvement in care planning has produced conflicting experiences related to different requirements between mental health professionals, families and service users in respect of coordination of services (Doody et al. 2017). Caring for a person with a mental illness requires a high level of commitment from families to support their relative's recovery (Valentini et al. 2016, Fortin et al. 2019). The need for formal recognition of carers' experiences of involvement in care planning, policy and practice was indicated.

23.5 CAMHS

The highest number of studies found relate to CAMHS. Studies identified diagnosis, predictors in accessing care and if depressive symptoms change after care. In exploring clinical staging as an adjunct to diagnosis, to address emerging psychiatric disorders, findings demonstrated that differential rates of progression from earlier to later stages of anxiety, mood, psychotic, or comorbid disorders were observed. Stage-specific clinical interventions were being used, however, longer-term utility of this form of staging has not been established (Iorfino et al. 2019).

Children experiencing recurrent problems may need more than one episode of care, yet, there is a paucity of research on recurrent service use (Sarmiento and Reed 2020). Childhood trauma was explored in three large studies. An important study, undertaken in Ireland, explored the experiences of adolescents attending secondary mental health services and referred to Jigsaw Galway (Beatty et al. 2018). A large study comparing exposure to potentially traumatic events in children with a mental health diagnosis of Autism indicated that the diagnosis was dependent on environmental factors (Hoch et al. 2020). A study (n=2,038) exploring adverse childhood experiences on non-suicidal self-injury indicated that one third had engaged in non-suicidal self-injury leading researchers to advise that assessment procedures for indicators of mental health should take into account non-suicidal self-injury (Baiden et al. 2017).

The majority of studies relating to child and adolescent care used qualitative methods with sample size ranging from 8 to 50. Overall evidence quality was variable. The more robust qualitative evidence linked collaborative and partnership approaches to co-designing services by placing service users centre and foremost and identifying peer support roles as delivering improved service and outcomes (Hoyland et al. 2018, Piccone et al. 2018). This approach aligns with recovery-oriented care (Green et al. 2020) and with the principles guiding service transformation and objectives (Malla et al. 2019). The use of CBT and EBP for anxiety and depression and the effectiveness of the SMART model as a first step in a stepped care model were explored by Lorentzen and Handegård et al. (2020) and by Lorentzen and Fagermo et al. (2020). O'Connor et al. (2019) explored the prevalence and patterns of diagnostic adjustments in an electronic mental health care register. Several studies related to youth transition from CAMHS to adult mental health services among those aging out of child system services, at age 18. However, studies also demonstrated that most adolescents with predictors of a serious primary mental health diagnosis and at risk to self and others did not enrol in adult services. This area is recognised as being in need of research in view of this finding (Cohen et al. 2020).

The NICE guidelines indicated that the gold standard practice for diagnosing ADHD should be the adoption of clear, protocol-driven pathways (Barnes 2020). Evidence Based Assessment pre, ongoing and post-treatment (Cho et al. 2020) were recommended as a quality indicator in the community implementation of EBPs (Wright et al. 2019) and to document rates of sustained use with clinicians of an evidence-based practice following training (Horwitz et al. 2019). Evidence for use of EBA varied across studies with findings being broadly positive indicating that use of more practical measures and greater clinician training may improve the integration of standardised measures into routine practice (Mersky et al. 2020).

Research relating to refugees, the undocumented, migrants and Travellers is explored from their education, social and mental health perspectives, and the barriers associated with accessing mental

health services for these groups are well documented in many studies (Quintyne and Harpin 2020). Other studies explored if transitions in and out of homelessness related to mental health episodes (Moschion and van Ours 2021), homelessness and polysubstance use and how transition in these circumstances affected recovery and treatment (Nicholls and Urada 2021). Studies also explore medication adherence in patients with mental illness and recent homelessness and their use of mobile technology (Watson et al. 2020). Also explored were the use of co-design methods with culturally and linguistically diverse communities in order to improve mental health services (O'Brien et al. 2021). Considerable variation exists in how individuals with a diagnosis of mental illness experience discrimination. Findings suggested that discrimination is not related to specific diagnoses but rather is associated with mental health problems generally (Kessler et al. 2015, Hamilton et al. 2016, Gooding et al. 2020).

23.6 Continuing mental health care including long stay

This area is explored from the perspective of recovery as a guiding principle that has become central to improving mental health policy in people with severe and enduring conditions (Khan and Tracy (2021). Residential In-Reach services that treat residential aged care residents for acute conditions in their place of residence, to avoid preventable hospital presentation, is a relatively new initiative with good outcomes reported (Kwa et al. 2020). Embedding the principles of recovery-oriented practice into care by providing recovery education, training and coaching for staff promoted active service users engagement (Kessing 2021, Nardella et al. 2021) and made recovery a reality for people experiencing continuing mental health care including long stay (Mc Sharry and O' Grady 2021).

23.7 Digital e- Technology Use

The use of Tele psychiatry is in its infancy, yet a growing need is recognised across community mental health care organisations in many countries. High levels of patient engagement have been reported with tele psychiatry when compared with in-person service attendance, particularly in relation to increased patient numbers, efficiency of service delivery and overall positive feedback from patients, families, and staff members. These findings support the use of tele psychiatry as a realistic option for the delivery of community mental health services. Further research was indicated in relation to the planning and implementation of Tele Psychiatry (Zulfic et al. 2020, Mahmoud et al. 2021).

Studies identified benefits to its use in all services including CAMHS as accessibility, convenience and appeal and as an educational tool rather than a replacement for face-to-face therapy (Cliffe et al 2020). Yet, the use of technology interventions remain inconsistent and challenging for professionals in most CAMHS and even though technology supports and delivers interventions it has not been widely adopted by CAMHS professionals (Cliffe et al. 2020, McClellan et al. 2020). Technology use was identified in medium sized sample studies as being effective and stimulating, yet challenging for users and particularly so for clinicians. Studies highlighted the use of diverse initiatives indicating the increasing importance of telehealth usage in community mental health, rehabilitation, psychosis and older age care. As television was found to be the most common source of mental health awareness the optimisation of the reach of this medium/communicational channel should not be underestimated (Fehily et al. 2020).

23.8 Ethnicity

A large number of studies related to mental health services for immigrants and refugees, racial and ethnic differences and to providing services to underserviced and hard to reach individuals. Evidence demonstrated that access to, and negotiation with services was widely discussed. Most research findings depicted the experiences of refugees arriving in Australia, Canada, UK and USA. Several large scale surveys focused on refugees but the majority were qualitative studies with relatively small sample sizes. Results from a large survey exploring entry to services with a focus on ethnicity indicated that black and mixed-race young people were mainly referred through social care and youth justice rather than through primary care (Edbrooke-Childs and Patalay 2019). Large study findings demonstrated that people from indigenous or culturally and linguistically diverse backgrounds were over-represented in compulsory admissions to hospital (Kisely et al. 2020). Stigma was a consistent theme across studies and a cause for concern with group members mentioned here. Individuals struggling with serious mental illness (SMI) may experience stigma due mainly to discrimination by others and their own unwillingness to disclose information about their mental health problems (Salami et al. 2019, Ellis et al. 2020, Hofmann et al. 2020). Studies also related to ethnic minorities, underserved and minority indigenous persons and to Travellers (Edbrooke-Childs and Patalay 2019). Travellers experience a high prevalence of mental health problems. Findings from an Irish study indicated that cultural identity and social-emotional skills were key factors in promoting positive mental health among Travellers (Villani and Barry 2021).

23.9 Forensic Medicine

The majority of large scale studies in forensic medicine originated in Australia, New Zealand, US and the United Kingdom and focused on out-patient, in-patient, community and prison and police services. Even though aggregated OCC studies reported inconsistent outcomes, beneficial associations between OCC and direct measures of imminent harm indicated reductions in threats to health and safety and support for OCC as a less restrictive alternative to inpatient care (Segal 2020). Several studies related to individuals with psychosis, a group that are over-represented in the criminal justice system and at elevated risk of re-offending (Ross 2020).

Other studies explored the causes and consequences of delayed diagnosis of autism spectrum disorder in forensic practice (Smith 2021) and crime and victimisation among people with an intellectual disability with and without comorbid mental illness (Thomas et al. 2019). Screening for intellectual disability in mentally disturbed detainees was assessed using the psychometric properties of the Screener for Intelligence and Learning Disability (SCIL) (van Esch, de Vries, and Masthoff 2020). Four large scale studies observed an association between increased contact with mental health services and reduced risk of re-offending in those who were ordered to mental health treatment, rather than punitive sanctions, in patients with psychosis (Levy 2018, Hwang et al. 2020). However, findings suggested that court oversight on an ongoing basis may be necessary to help individuals with a serious mental disorder avoid the criminal justice system and remain engaged in community treatment (McDermott et al. 2020). The first access to a mental health services is often marked by aggressive behaviours, anger and a lack of evidence from the perspectives of patients and service users in understanding a patient's point of view in a critical episode (Faccio et al. 2020).

23.10 Medication management

Very little research evidence was available about the particular medications that are being prescribed by community mental health services particularly. Evidence-based models were consistently being used to measure prescribing patterns. Substance use is frequently comorbid with anxiety and depressive disorders and associated with poor treatment outcomes. Co-occurring disorders in mental health and addiction present a high prevalence, but services available to prevent and treat them are often fragmented. A recent model of cross-training activities was used to minimise breaks in service continuity by promoting interactions to help professionals better orientate and treat their client with quality care (Perreault et al. 2020). A parallel QI study to bolster anticholinergic medication de-prescription was undertaken with clinically appropriate patients with schizophrenia and other psychiatric disorders. Positive results suggested that de-prescription of ACM in this setting can occur with prescriber education and support (Gannon et al. 2020). Studies explored the pharmacological management of acute behavioural disturbance (Paton et al. 2019, Williams et al. 2021) and results indicated that pain reliever use, tranquiliser use, stimulant use and illicit drug and alcohol use revealed positive associations (Wang et al. 2019).

23.11 MHSs for people with intellectual disability

Research studies relating to individuals with intellectual disability are increasing with many published between 2019 and 2021. The lack of support in the community is a consistent theme. Studies identified that people with intellectual disability experience higher rates of mental health disorders than the rest of the population, and also experience multiple barriers in accessing appropriate services (Hellerud 2019, Whittle et al. 2019). A large majority of United Nations (UN) member states ratified the UNCRPD, a ground breaking instrument for various changes in the area of mental health services (Jahn et al. 2017). Irish researchers explored the well-being of staff working in intellectual disability settings in Ireland during a pandemic (McMahon et al. 2020) and mental health services for people with intellectual disability from the perspectives of evidence, barriers and opportunities (Ramsay and Dodd 2018). Other studies included perspectives on integrated mental health care for autism (Stadnick et al. 2020) and parent training for youth with autism in community settings (Straiton et al. 2021). A protocol for implementing the Incredible Years-ASLD® programme with Spanish children with autism and pre-term children with communication and/or socialisation difficulties was developed and delivered promising results (Valencia et al. 2021).

Differences between ethnic groups accessing mental health services were found to be different in people with intellectual disabilities (Maestri- Banks 2020). EBP, clinical audit and quality initiatives, including the NICE guidelines were identified as being utilised in the care of persons with intellectual disability (Paton et al. 2015). Offenders with an intellectual disability pose a challenge to intellectual disability service providers. An Irish survey of all intellectual disability psychiatry services reports a significant number of serious offences referring to psychiatry services (Leonard et al. 2016).

The challenges in providing future mental health services for children and adults with intellectual disabilities includes enhancing community support, reducing in-patient care (Perera and Courtenay 2018), individualised care planning and delivering education and training programmes for health and social care providers (Kalb et al. 2021). Also recommended were strategies to minimise restrictive practice and subsequent acts of challenging behaviour (Bynoe et al. 2021).

23.12 Mental health care in LGBTQ+

Four major studies were found relating to LGBTQ+. Barriers to accessing mental health services from the perspective of young LGBTQ+ people were identified in most studies. McCann and Sharek (2014) surveyed LGBTQ+ peoples experiences of mental health services in Ireland. They identified barriers and opportunities, highlighted service gaps, and identified good practice in addressing the mental health, and well-being of LGBTQ+ people. Findings indicated that 77% had received a psychiatric diagnosis and 43% felt practitioners were unresponsive to their needs. Also, in Ireland, a study indicated that nurse managers were in key positions to advocate for practice and organisational change, thus ensuring that support for, and provision of care was provided in a responsive and sensitive manner that addressed the particular needs of LGBTQ+young people (Higgins et al. 2021). Differences between LGBTQ+ students and heterosexual students in terms of counselling received from mental health services were also identified (Plöderl and Tremblay, 2015, Baams et al. 2018). Studies indicated that student needs can be addressed by mental health services that challenge heteronormative assumptions and promote self-acceptance and equity (Eisenberg et al. 2019, McNamara and Wilson 2020).

23.13 Mental health care for mother and Infant

Research identified a lack of access to mental health services at multiple points in the care pathways for mothers and infants during the perinatal period (Viveiros et al. 2018, Sambrook et al. 2019). Several large scale studies originated in the UK, Canada, New Zealand and Australia and the remainder were mostly small scale qualitative studies. Symon et al. (2018) adapted the Quality Maternal and Newborn Care (QMNC) Framework to evaluate models of antenatal care. There was limited research on mothers' perspectives of perinatal mental health services and most research focused on mother and baby units (MBUs). Mothers reported the benefits of positive, non-coercive relationships with family and staff for their recovery (Powell et al. 2020). Barriers to accessing mental health care during pregnancy and the perinatal period appeared to be greater for ethnic minority women, however, there was no reliable large-scale data about their actual use of such services (Jankovic et al. 2020). Hence research that is targeted at patient, provider, and systems levels was needed (Holden et al. 2020). The significance of perinatal mental disorder for maternal wellbeing and its impact on infant development indicated the need for a coordinated and integrated approach, with focus on early intervention to deliver perinatal and infant mental health services (Lee and Newman 2018).

23.14 Mental health care in rehabilitation

Limited studies were found in the area of rehabilitation. Community mental health rehabilitation teams support people with complex mental health needs who progress from inpatient to community settings by offering time-limited support. Findings indicated that most service users did not progress to more independent accommodation within four years, indicating that improving functioning and physical health may support successful move-on (Chan et al. 2021). One such support relates to rehabilitation in skilled nursing facilities (SNFs) that was found to deliver high-quality care. The STRONGER programme termed IntenSive Therapeutic Rehabilitation for Older Skilled NursinG HomE Residents focused on high-intensity functional resistance training that was found to be safe and feasible in improving function and satisfaction (Gustavason et al. 2020). Sylvain et al. (2018) outlined the development and implementation of a mental health work rehabilitation programme which provided benefits to participants**.** Community mental health services incorporate family,

community and social dimensions, yet little research in this area exists. The experiences of clients, family and staff about the community life of people post ICMHS suggested that the service could have positive clinical and social outcomes, but results were inconclusive (Chiang et al. 2020, Kelly et al. 2020). The IMR Model was used to help people with SMI to achieve clinical and personal recovery (Skar-Fröding et al. 2021).

23.15 Professionals in mental health care services

This review demonstrated studies of medium to high level evidence relating to professionals in all mental health settings delivering care in a professional manner. The implications for registered psychologists and medical doctors working in the public mental health services were explored in studies that identified their coping strategies as being divergent. Their work was viewed by them as a source of personal satisfaction but equally as a source of stress (Hughes et al. 2017, Sciberras and Pilkington 2018). Lack of clarity was evident in studies relating to the role of the social worker within adult community mental health teams and from the perspective of service users. Findings highlighedt the need for further research to improve understanding of the important work undertaken by social works (Boland et al. 2021). Other studies indicated the positive contribution made by all health and social care staff in delivering compassionate care (Barron et al. 2017). The engagement and the boundary spanning roles of community mental health nurses working between hospital and community mental healthcare settings indicated the need for negotiating the foundations of future practice (Jørgensen et al. 2020). The need for intensive training for clinicians to work more effectively with autistic adults was highlighted (Henderson et al. 2020, van Dijk et al. 2021). Findings point to the need for increased coordination between the mental health and developmental disabilities systems (Maddox et al. 2020).

23.16 Psychiatry of later life

Research studies into older age psychiatry focused on hospital care, specialist and community mental health services, mental health illnesses, research and perceptions and experiences. Studies also explored mental health illness and individual perceptions and experiences. Studies highlighted inconclusive evidence as to the success or otherwise of the organisational culture reform for older persons that is taking place in many countries including Ireland. This may change in time as currently reforms are ongoing and results and evaluations are awaited. This cultural change is values based and built around a central philosophy of compassionate care that supports psychological safety and promotes transparent accountability (McKellar and Hanson 2020). Little evidence was found relating to the factors associated with older adults' attitudes towards seeking mental health services. Studies found increased rates of death and dementia in older people with serious mental illnesses, such as bipolar disorder or depression (Paul et al. 2019, Daley et al. 2020). Higher social and physical supports are needed for older persons to remain well and screening interventions may prevent deterioration in their condition (Yun et al. 2020).

23.17 Therapies in mental health care

Studies identify therapies from several dimensions, including CBT, Cognitive Therapy (CT), EBP, DBP, and CBSST. Findings indicated that CBT is a first-line treatment for anxiety disorders however barriers and facilitators to CBTp implementation existed, particularly in community clinics. Lack of training and competency were indicated as primary barriers (Xanidis and Gumley 2019). Studies demonstrated that the gold standard measure for CBT fidelity is the CTRS. However, the scale

structure remains to be examined with community mental health clinicians, where the scale structure may depend on the clinical population being measured (Affrunti et al. 2019).

Tailored implementation strategies were recommended to increase clinicians' adoption of CBT for autistic adults (Maddox et al. 2019). CBT for schizophrenia spectrum disorders is an evidence-based treatment yet, in many countries individuals with a primary psychotic disorder were unable to access this intervention. The Stepped Care Model can be applied to CBT for psychosis in community mental health settings by increasing access to the intervention through involving the multidisciplinary team (Kopelovich et al. 2019). Difficulties with access to EBT treatment existed. An implementation climate that supports EBT may be the most critical factor for improving intensity of EBT coverage (Lucid et al. 2018). There is evidence to support the use of Group Dialectical Behavioural Therapy (DBT) in the treatment of binge-eating disorder (BED) and results indicated that Group DBT is an acceptable and effective treatment for adults with BED when delivered in community mental health settings (Blood et al. 2020). Findings from a psycho-educational group (PEG) programme indicated the complexity of the therapeutic process and highlights understanding of the treatment from the service user perspective. Findings also supported the use of integrated treatment programmes with a dual-diagnosis population, for example individuals with an Intellectual Disability and a mental health diagnosis (Chilton et al. 2020).

24. Conclusion

This evidence review demonstrates variable quality of evidence relating to mental health services. The higher quality research studies present best practice recommendations that contribute weight to the discussion and study. The evidence review contains a discursive analyses of the main areas pertaining to mental health services, service users, supporting families and carers and mental health and social care practitioners providing this care.

Mental health frameworks are explored from the perspective of quality, ethics, clinical and through consolidation processes alongside audits and toolkits. Quality gaps in several countries are addressed through focus on service reforms that use standardised clinical practice guidelines to identify quality and to strengthen the existing body of knowledge on quality of care. Evidence consistently demonstrates that findings from the larger high quality surveys have the potential to increase best practice findings and recommendations. Findings from studies shed new light on the important current material influencing CAMHS's.

The recovery model is explored in the literature through the lens of users, perceptions of recovery and partners in recovery. Studies examine attitudes towards patient recovery and reveal variable responses. Recovery approaches are identified as the overarching framework for improving mental health services for people with severe and enduring conditions that require greater understanding by patients, carers, practitioners and researchers of what constitutes well-functioning recovery

Consistency was found in the measurement of outcomes in relation to carers, family and peers. Findings highlight their pivotal role in delivering care to family members in residential, community, or home environments that is centred on their loved one. However persons with a mental illness and their family need greater research focus. Studies also indicate the need for a safety culture that allows staff and users to raise concerns and be heard and to promote a social environment that is capable of identifying threatened violence.

Technology use was identified in medium sized sample studies as being effective and stimulating, yet challenging for users and particularly so for clinicians. Digital technology is being used across most clinical practices and sites and the literature reveals the ongoing utilisation of a variety of digital supports. Studies address the use of specific telehealth initiatives.

A large number of studies relate to forensic mental health (FMH) including CTOs, disengaging with psychosis, involuntary certification and transition from institution to community initiatives. Other studies relate to police encounters with children and youth, clinical judgement pathways and risk factors predicting aggression. Large scale studies undertaken with people with acute psychosis or offenders demonstrate an association between increased contacts with mental health services and reduced risk of re-offending in those who are ordered to mental health treatment, rather than punitive sanctions.

Studies identify that people with intellectual disability experience higher rates of mental health disorders than the rest of the population and report the need for individuals, carers and their families to navigate an often hostile system in relation to their rights and legislation.

There is limited research on mothers' perspectives of perinatal mental health services and most research focuses on mother and baby units (MBUs). Mothers report the benefits of positive, non-coercive relationships with family and staff for their recovery (Powell et al. 2020).

The LGBTQ+ communities are often faced with stigma and discrimination with access to, and within mental health services. People within the LGBTQ+ communities have identified their experiences as reinforcing stigma and of a lack of understanding of their specific needs. The stronger evidence from published research contributes greater weight to the discussion and best practice outcomes. Stigma and discrimination are also experienced by ethnic minorities, a relatively new area to research within the mental health literature.

This review demonstrates a high number of studies of medium to high level evidence relating to professional clinicians working in all settings, with people experiencing a wide variety of mental health illness and delivering care in a professional manner. Use of CBT and other forms of the expanding number of cognitive behavioural therapies is evident in the literature.

Evidence across the trajectory of older person care in acute and continuing care and psychiatry in later life demonstrates that higher perceived social supports are associated with more positive attitudes towards seeking mental health services, and to recovery. Conversely, screening interventions for early detection and proper management of mental illness prevents severe deterioration in older persons' condition and enhances satisfaction with mental health services.

25. Recommendations

25.1 Recommendations from PESTLE Analysis

The following recommendations were obtained from the PESTLE analysis. Mental health services may choose to explore these further. They are presented here as possible suggestions.

1: Political Factors

- Ward design for people with dementia should include consideration for ward layout, reception and socialising areas, communal eating, and outdoor space.
- Appropriate care for people with dementia requires a clinic room with appropriate equipment for making observations, phlebotomy, and taking electrocardiogram readings.
- Service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences.
- Cultural norms relating to ethnicity, immigrants, refugees, hard to reach and Travellers are understood and addressed.
- Refugee children require therapeutic relationship-especially the qualities of trust, understanding, respect and a caring connection.
- Promotion initiatives for Travellers focus on reducing discrimination, enhancing social and emotional wellbeing and self-esteem, improving living conditions, reducing mental health stigma, promotion of Traveller culture and positive self-identity.
- The health and wellbeing and recovery of ethnic minorities, immigrants and Travellers are addressed.

2: Environmental Factors

- Awareness of attitudinal barriers to access that are more likely among poorly educated persons with mental illness.
- Advocate for access and availability information to services for people with intellectual disability.
- Educate service users and carers of relevance, effectiveness and equity of mental health services.
- The nutritional needs of service users, ethnic minorities, refugees and homeless are recognised and delivered.

3: Social Factors

- Recovery needs are introduced in all mental health service programmes.
- Recovery principles include service user lived experience.
- Recovery-orientated services require organisational commitment.
- Consensus on what constitutes well-functioning recovery is reached by patients, practitioners and researchers alike.
- Mental health promotion is available for all age groups to enhance protective factors and decrease risk factors for developing mental health problems.
- Mental health practitioners and other key stakeholders are aware of the distinct cultural components that influence the recovery process so as to promote the development of culturally sensitive, accessible and effective recovery-oriented interventions.
- Children and adults with intellectual disabilities have enhanced community support and reduced in-patient care alongside recruitment and training of the workforce.
- Collaborative efforts across stakeholders address the mental health needs of racial and ethnic minorities in a local community.
- Spirituality relating to ethnic, immigrants, non-faith based and refugees are addressed.

- Ethical values of the person to dignity and autonomy, values and beliefs and appropriate privacy to practice cultural, religious and spiritual beliefs is evident.
- Access to advocates is available.
- Service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences.
- The cultural norms relating to ethnic, immigrants, refugees, hard to reach and Travellers are understood and addressed.
- Refugee children are able to develop therapeutic relationships especially the qualities of trust, understanding, respect and a caring connection.
- **P**romotion initiatives for Travellers focus on reducing discrimination, enhancing social and emotional wellbeing and self-esteem, improving living conditions, reducing mental health stigma and promotion of Traveller culture and positive self-identity.
- The health and wellbeing and recovery of ethnic minorities, immigrants and Travellers are addressed.
- Crime levels amongst ethnic minorities and refugees are addressed.

4: Technology Factors

- New technologies, user friendly mental health information systems and digital means of communication for service users and other stakeholders are in place.
- The National Mental Health Minimum Data subset is updated.
- Technological and interpretation awareness and where necessary service users are provided with access to interpretation services, including a sign language translator.
- Internet infrastructure and access to new technology and level of innovation structures are developed further to take into account new forms of web-based and information processes.
- Mental health service consultation process with stakeholder is in place.
- Training and/or workshops on use of technology in mental health emphasises its safety and security.
- Adequate funding of e-mental health services are in place.
- Clinicians are informed about designated e-technology resources.

5: Legal Factors

- Equality services for ethnic minorities, migrants and Travellers are in place.
- Prescribing accuracy to reduce avoidable drug-related harms to patients is promoted.
- Least restrictive principle is in place to extend non-coercive measures.
- Incarcerated patients are treated in a less punitive manner.
- Key workers in forensic services facilitate the transition process by developing sustainable relationships with the young person and creating a safe clinical environment.
- Coroners recommend that the mental health service implements suicide-prevention strategies that facilitate improved communication, risk containment, service delivery and family involvement.
- In relation to suicide, Coroners, mental health services and professional staff consider the latest clinical evidence for suicide prevention.
- Mental health services provide interventions for which there is evidence, including facilitating family participation and providing access to psychotherapies.

6: Economic Factors

- Budgets are allocated for new technology and enhancement of quality initiatives.
- Digital ehealth from a quality perspective is promoted.
- Internet infrastructure, access to new technology and innovation structures are in place.

25.2 Recommendations from evidence review

The following recommendations were obtained from the evidence review analyses. Mental health services may choose to explore these further. They are presented here as possible suggestions.

1: Recovery Care Planning

- Care Planning requires service users to have a care coordinator, written care plan and regular reviews and education and training for staff that is designed to enable personalised, recovery-focused care (Simpson et al. 2016).

2: Recovery Ethnic Minorities

- A key challenge to the recovery experience of ethnic minorities is stigma. Providing culturally appropriate services could be viewed as a human right issue for minority groups (Sofouli 2021).
- A significant recovery research portfolio and use of mixed-methods rather than solely qualitative studies are indicated to provide more robust findings relating to recovery (Slade 2021).
- Researcher recruitment strategies need to include service users as they are not always given the choice to participate in research (Bucci et al. 2015).
- The Eating Disorder Recovery Questionnaire (EDRQ) if incorporated into recovery programmes is a valid, reliable measure of eating disorder recovery (Bachner-Melman et al. 2021).

3: Recovery Wellness and Wellbeing

- Having more community-based mental health services to support the recovery of adults with psychiatric disabilities improves their quality of life within their communities (Ramafikeng et al. 2020).
- With education and organisational support healthcare assistants, working in high secure mental health hospitals, are well placed to identify individual needs for exercise promotion thus leading to successful person-sensitive interventions (Kinnafick et al. 2018).
- Participants believed that PPI training programmes, involving both professional and non-professional participants, required all participants to work together to achieve desired outcomes, in particular at the commissioning and design stages (Frawley et al. 2019).

4: Frameworks

- Regular audits of data abstraction are needed to guarantee the integrity and credibility of registry outputs (Tan et al. (2019).
- Using the internal audit system will increase compliance with obligatory rules and regulations (Weske et al. 2018).
- ACP is fundamental to guiding medical care and for quantifying the economic effects of ACP. This leads to more efficient allocation of resources by aligning care to patient preferences (O'Hanlon et al. 2018).
- Improved interagency and interdisciplinary communication between drug and family services for children with potential hidden harms are recommended (Galligan and Comiskey 2019).
- Awareness that the effectiveness of implementation actions depends not only on the actions themselves, but also on the pre-existing motivation to comply (Weske et al. 2018).

5: Audits

- Creating a web-based, interactive patient engagement toolkit to improve patient engagement requires organisational support and strong collaborators (Keddem et al. (2020).
- Incorporating patient perspectives into clinical studies is important to the development of high-quality, safe, and effective fit-for-patient audits (Schnell et al. 2020).

- Staff need to choose performance indicators, assess performance, identify causes, communicate from ward to board and ensure data quality when using quality dashboards (Randell et al. 2019).

6: Toolkits

- Awareness that the MSHRP Toolkit is indicated. The Toolkit includes data management tools, changes to asylum clinics and service delivery to meet the demand for forensic medical evaluations of asylum seekers and appropriate continuity of care (Ruchman et al. 2020).

7: Acute Adult Mental Health Care

- Techniques to improve engagement in therapies and matching patients to treatment based on predictors may be effective ways to optimise treatment engagement, as some patients discontinue treatment after a single treatment session (Gibbons et al. 2019).
- Having awareness that prior diagnosis of schizophrenia and psychotic depression are associated with reduced treatment delay. Research studies highlight a need for further study on strategies to offer appropriate clinical treatment sooner (Patel et al. 2015).

8: Carers/Family/Peers

- Ethical issues relating to boundaries, confidentiality and privacy, competency, insurance coverage, and autonomy may arise in delivering psychotherapy to clients: therapists are advised to adhere to their professional body guidelines (Boland 2019).

9: Child and Adolescents (CAMHS)

- There is need to shift the balance of mental health services from hospital-centred with community outreach to community and home care. A framework that advocates health ecosystems as a community-centric mental health approach to mental healthcare and training is recommended (Rosen et al. 2020).
- SMART may be considered as a first step in a stepped care model for anxiety and/or depression treatment in CAMHS (Lorentzen et al. 2020).
- Adherence to the NICE guidelines demonstrate the gold standard practice for diagnosing ADHD in CAMHS. Adoption of clear, protocol-driven pathways to support access and treatment is needed (Barnes 2020).
- Assessment procedures for indicators of mental health should take into account non-suicidal self-injury (Baiden et al. 2017).
- Adolescents with social, emotional and behavioural difficulties attending CAMHS in Ireland value Implementation of the WTOPPAP programme (Wynne et al. 2016).
- Implementing and evaluating EBP programmes in CAMHS requires further process improvements to achieve positive outcomes (Mendenhall et al. 2019).
- Adolescents need to be identified as surfers by clinicians so that support may be offered and they receive community-based support when planning for discharge from hospital (Quintyne and Harpin 2020).

10: Digital Tele-Mental Health Services

- Implementation strategies are needed to promote tele health benefits. Strategies include economic gains and provision of more interventions for prevention and treatment of mental ill-health that are complementary to existing mental health evidence-based services (Batterham et al. 2015).
- Clinicians need to be provided with safe opportunities to gain comfort and competency with existing and new technology (McClellan et al. 2020).
- Further research is needed in relation to Tele Psychiatry planning and implementation (Zulfic et al. 2020, Mahmoud et al. 2021).
- Further research with a larger and randomised sample size is indicated for use of SMS Reminders for DNA alerts (Anyaegbu 2021).
- Telephone services strategies to optimise reach in remote areas are recommended (Fehily et al. 2020).

11: Ethnicity in Mental Health Care (Immigrant and Refugee and Underserved Populations)

- Improving mental health service delivery to immigrants, developing community-based services, training immigrant service providers, enhancing collaboration across sectors and appointing more interpreters are recommended (Salami et al. 2019).
- Adopting a contextualised approach to cultural sensitivity by practitioners is recommended as young immigrant people place emphasis on interpersonal relationships and on the traumatic experiences they encountered (Valibhoy et al. 2017).
- Systems-related and psycho-social barriers to seeking services by ethnic groups indicated the need for collaborative efforts across stakeholders to address the mental health needs of racial and ethnic minorities (Torres Stone et al. 2020).
- Training sessions for professionals and organisations, related to indigenous groups, need to include information that is grounded in cultural competency and cultural humility and should aim to increase knowledge, awareness, and skills (Lewis et al. 2018).
- Recognition by stakeholders of cultural identity and social-emotional skills as being key factors in promoting positive mental health among Irish Travellers is indicated (Valibhoy et al. 2017).

12: Forensic Mental Health Care

- When engaging criminogenic interventions there is need to identify sustainable funding sources, provide training for staff and tailor the delivery and pace of the content to the particular treatment needs of participants (Wilson et al. 2017).
- Key workers in forensic services are advised to facilitate the youth transition process by developing sustainable relationships with the young person and creating a safe clinical environment (Livanou et al. 2017).
- Early and frequent clinical contact with mental health services after an offense is recommended (Adily et al. 2020).

13: Medication Management

- Clinicians need to be vigilant when following up individuals who had been drinking alcohol at the time of an initial self-harm presentation to ED as having alcohol in the blood and being engaged with mental health services may predict the occurrence of a further self-harm episode (Ames 2017).
- Coroners recommend that mental health services should implement suicide-prevention strategies that would facilitate improved communication, risk containment, service delivery and family involvement (Manuel et al. 2018).

14: Mental Health Care for Intellectual Disability

- Providing future mental health services for children and adults with intellectual disabilities includes the provision of community support, specialist mental health and social care teams, dedicated professionals and reduced in-patient care alongside recruitment and training of the workforce (Perera and Courtenay 2018).

15: Mental Health Care for LGBTQ+ People

- Cultural competency training for practitioners that address issues and concerns pertinent to LGBTQ+ young people and to ensure care and support that is responsive and sensitive to the needs of these groups is needed (Higgins et al. 2021).
- Providing more effective mental health policies and better access to mental health services for LGBTQ+ persons includes policy and practices updates (Choi et al. 2016, Cochran et al. 2017, Ferlatte et al. 2019, Higgins et al. 2021).
- Appropriate and responsive service strategies are needed to enable the development of confident, competent and knowledgeable staff when providing care to LGBTQ+ persons (Delaney and McCann 2021).
- LGBTQ+ adolescents with community support had lower odds of frequent substance use, indicating the importance of strengthening LGBTQ+ adolescent community resources (Eisenberg et al. 2020).

- Mental health services reinforce stigma and lack understanding of the specific needs of LGBTQ+ communities that can be addressed by challenging heteronormative assumptions (Eisenberg et al. 2020, McNamara and Wilson 2020).
- Mental health services need to promote the principles of equity, inclusion and respect for diversity that includes health equity and self-acceptance in LGBTQ+ communities (Eisenberg et al. 2020).

16: Mental Health Care for Mother and Infant

- Perinatal engagement in women with post-natal depression will be improved by actively engaging women in the process and by educating health care professionals about their influence on women's engagement (Ayres et al. 2019).
- Mild traumatic brain injury (mTBI), or concussion, is the most common type of traumatic brain injury. Symptoms include headaches, fatigue, depression, anxiety and irritability and impaired cognitive function. Symptoms occur within 3 months post-injury, with the exception of a small number who are said to experience persistent post-concussion syndrome. mTBI is associated with increased mental health service usage (Sylvain et al. 2019).

17: Professionals in Mental Health Care

- Registered mental health nurses and other professionals would benefit from systematic guidance regarding engagement strategies and for the continuous development of new, collaborative ways of working between professionals at their different stages of interaction with their "shared clients" (van Dijk et al. 2021).
- Findings point to the need for greater efforts in training clinicians to work more effectively with autistic adults and to increase coordination between the mental health and developmental disabilities systems (Maddox et al. 2020).

18: Psychiatry of Later Life

- Staff should include the views of service users, carers and clinical staff when implementing research priorities for recovery oriented intervention's for older persons, thus achieving more meaningful results (Emrich-Mills et al. 2019, Morres et al. 2019).
- Enhancing and standardising outreach care for older persons with unmet needs are recommended (Frank et al. 2018).
- BS4MI-elderly, for common mental illnesses of the elderly, could be a useful instrument for screening the elderly, thus enhancing their satisfaction with mental health services (Yun et al. 2020).

19: Therapies in Mental Health

- Further research is indicated in relation to the perceptions of the barriers to delivering, or receiving CBT for anxiety disorders. Providers and administrators indicate lack of training and competency as primary barriers (Wolitzky-Taylor et al. 2018, 2019).
- An implementation climate that supports EBT is recommended for improving intensity of EBT coverage by organisations and to encourage usage by supervisors (Lucid et al. 2018)
- Group DBT is an acceptable and effective treatment for adults with binge-eating disorder (BED) when delivered in a community eating disorder service (Blood et al. 2020).
- Psychiatric rehabilitation along with Psychosocial Skills Training to routine service, delivered in community mental health clinics, has a positive effect on the social functioning and clinical symptoms of patients with schizophrenia (Karaman et al. 2020).

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To: INFO-WHOQR@LISTSERV.WHO.INT
Subject: WHO Resources and links for WHO guidance on community mental health services

WHO Guidance documents and to resources related to the launch event itself (2021): permission from WHO to share with networks and contacts:

- WHO Guidance and Technical Packages -

- WHO Press release in ENGLISH - SPANISH - RUSSIAN
- WHO Feature story- Community-based mental health services using a rights-based approach
- Telegraph Article - Seclusion, restraint and coercion: abuse 'far too common' in mental health services across the world
- Video poem: The Power of Purpose - Community-based mental health care: the Power of Purpose
- YouTube livestream of the WHO Launch event

WHO QualityRights and the work of the PLR unit:

- WHO QualityRights initiative overview
- WHO QualityRights country implementation portal
- Promoting rights-based policy & law for mental health
- Transforming services and promoting human rights in mental health and related areas
- WHO MiNDbank policy and law database

28. Acknowledgements

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29. Appendix I: MHC tables

MENTAL HEALTH FRAMEWORK TABLES NO 1

Table I Framework (Audit and Feedback)

Authors/Date Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Alias et al. (2020) Canada	Framework development	n=12. University-level occupational and physical therapy educators.	Critical Clinical Toolbox development in rehabilitation.	To explore how global health (GH) is understood within academic and clinical practices.	GH seen as a framework to broaden student clinical training via structural competency, cultural and global citizenship.	The need to clarify the parameters of global health and how it complements clinical training within rehabilitation programmes recommended.
Kamhawy et al. (2020) Saudi Arabia	Qualitative Framework Engagement Model	n=15 Physicians	Interview guide to study physician perspectives on A&F Engagement Model based on quality of existing data system.	To identify the factors that affect physicians' experiences of receiving practice data and develop a model to interact with data.	Attributes identified as enabling or not for participant improvement. The final proposed model identifies different zones of engagement.	Model provides a framework to examine physician academic and administrative structures and how they might interface with performance feedback systems with clinicians.
Redley and Baker (2019) Australia	Clinical Care Framework	n=400 Older inpatients in four acute Australian hospitals	Clinical care Framework and Audit of older persons mnemonic 'Have you SCAND Mme'	To identify if a framework to audit nursing care prevents harms common to older inpatients	Mnemonic represents 8 harm factors. Assessments of skin integrity, mobility and pain, gaps in assessment of continence, nutrition are most common.	Provides a harm prevention model to assist nurses to implement comprehensive harm prevention to improve quality of care and safety for older hospitalised patients.
Tan (2019) Australia and New Zealand	Clinical Audit	Qualitative n=163 randomly selected patient records from three hospitals.	Clinical Framework and Case Study of the Australian and New Zealand Hip Fracture Register.	To explore data quality audit of a clinical quality registry in a generic framework.	This study compares the replicated data set to the registry data set.	Findings indicate that regular audits of data abstraction improve data quality, data validity, reliability, integrity and credibility of registry outputs.
Wagner et al. (2019) Canada	Audit and Feedback (A&F) to support QI	n=25 representing 18 primary care teams, in Ontario, Canada.	Clinical performance feedback to support quality improvement (QI) activities in Audit and feedback. Consolidated Frame	To code Transcripts, A&F to reflect an iterative, self-regulating QI process. Based on sound measurement to	Barriers found: frequency of feedback, data validity, design of feedback report, participation and teams implementation of A&F Desired QI activities not found despite investment.	Long periods of time needed to develop capacity for QI. More evaluations may reveal shifts in implementation. Potential A&F mechanism from measurement to action can be complex.

			work for Quality Research in A&F.	improve quality of care.		
Weske et al. (2018) Holland	Qualitative Framework	Internal audits n= 16 Semi structured interviews with internal auditors (n = 23) and ward leaders n=14.	Using the internal audit system (the 'tracer system') of a large Dutch academic hospital. Audit reports analysed.	To explore if implementation actions are linked to compliance by increasing compliance with obligatory rules and regulations.	The effectiveness of implementation actions depends not only on the actions themselves, but also on the pre-existing motivation to comply.	Further research is indicated for different contexts and environments.

Table II Audit (Audit and Feedback and Toolkit)

Authors/Date Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Alvarado et al. (2020) England	National Clinic Audit Evaluation (NCA).	n=54 Convenience sample interviews with doctors, nurses, audit clerks in NCAs across 5 providers	Realist evaluation to interrogate how context shapes the mechanisms through which NCAs work (or not) to stimulate quality improvement.	To explore the reasons behind provider health care variations.	Findings summarised as Context+Mechanism = Out come configurations. Five mechanisms explained provider interactions: reputation, professionalism, competition, incentives, and professional development.	Local databases staff able to access data. Customised feedback ensured accuracy due to skills and experience of staff. Mechanisms underpin providers' interactions with NCA feedback.
Cooke et al. (2018) Canada	Mixed methods	n=6 A&F projects.	A comparative case analysis to under-stand why some groups were more in-teractive than others.	To explore if A&F interventions may be strengthened using social interaction to help physicians move from reactions to planning change.	Extends previous work where the Calgary office of the Alberta Physician Learning Program (CPLP) developed a process for A&F audit group feedback for physicians.	Recommendation that relationship, question choice, data visualisation, and facilitation are considered for design and implementation of audit and group feedback.
Dunne et al. (2018) United Kingdom	Qualitative Audit	n=39 audits Multi-centre study evaluating surgical audit practice in general surgery identified & reviewed.	Standardised audit proforma designed. Data held in audit department. Audit teams failing to complete the full audit cycle explained why.	To assess the rates of audit activity and completion and explore barriers to successful audit Completion.	A total of 39 audits were registered across 3 surgical directorates. 15 out of 39 audits completed at least 1 audit cycle, with 4 deemed of no value to re-audit. 7 audits were completed to re-audit.	Achieving a publication or a presentation was the most cited reason for not completing the audit loop. Two of six Trusts refused to participate and 1 failed to initiate the project.
Gustavason (2020) Scandinavia	EBP	Physical therapists Physical Rehabilitation in skilled nursing facilities (SNFs).	Uses i-STRONGER program (IntenSive Therapeutic Rehabilitation for Older Skilled NursinG HomE Residents). PT administered Short Physical Performance Battery. Adopt, implement and,	To evaluate implementation issues including safety such as gait speed, feasibility and to provide information on effectiveness of rehabilitation focused on high-intensity functional resistance	No treatment-specific adverse events were reported. Treatment fidelity was high at >99%, whereas documentation varied from 21% to 50%. Patients exhibited a 0.13 m/s greater change in gait speed than in the usual care group. SNF length of stay was 3.5 days	High-intensity resistance training in this group safe in SNFs, supporting the need to change the intensity of rehabilitation to promote greater value within post-acute care. Study translates evidence into practice. As patient satisfaction was greater, refusals to participate in

			maintain used to evaluate implementation.	training in an SNF with older persons.	shorter for i-STRONGER patients.	therapy sessions trended downward.
Kwa et al. (2021) Australia	Audit	Retrospective audit comparing Residential In-Reach (RIR) activity, hospital presentations, and costs from 2 x 12-month periods, prior to and post-implementation.	Data were expressed as a proportion of the total number of RAC beds in the hospital RIR catchment.	To undertake retrospective audit comparing RIR activity, hospital presentations, and associated costs from 2 to 12-month periods, prior to and post implementation.	RIR episodes of care increased from 589 to 985. ED visits fell from 1616 to 1478. Fewer unplanned ED visits by RIR patients and fewer 28-day ED visits. Under the new model of care ED costs and inpatient admission costs were each lower in the second period.	In the 12 months following implementation of the new model of care, an increase in RIR activity, and a decrease in ED presentations were observed. Further research is necessary to validate these retrospective findings and better evaluate clinical outcomes and consumer satisfaction of the service.
Lalloo et al. (2020) Ireland	Quantitative Audit	n= 200. Non-specialist (NS) & specialist (S) Occupational Health Reports from Irish OH service.	Retrospective peer review audit Assessment form based on modified Sheffield Assessment Instrument for Letters SAIL(OH)1.	To evaluate the quality of non-specialist OH reports and compare with specialist reports.	Of the 200 peer reviewed OH reports, 159 (80%) were from NS. 87% of NS were 'above expected'. NS reports highlight legal and ethical issues more and adhered better to legal, contractual, ethical & to boundaries. Specialist addressed manager's questions better, in their structure and significance.	Findings demonstrate a high standard of OH report quality in this sample of non-specialist OPs that is consistent across all key OH report components. Some development areas identified to inform education/training tailored to this physician group and to assist in competency standard-setting.
McVey et al. (2021) United Kingdom	Qualitative National Clinical Audit (NCA)	n=54 Interviews with staff in different clinical and management settings in five English NHS hospitals about	National Clinical Audits by healthcare providers	To explore if outcomes from NCA's provide public reports of data on healthcare treatment and outcomes and if their potential for quality improvement is realised from the	Members and officers of hospitals' governing bodies perceived an imbalance between the benefits to their institutions from NCA's and the resources consumed by taking part, questioning the audits' legitimacy, which limits	Improvement measures include audit suppliers moving from emphasis on cumulative, retrospective reports to real-time, clearly presenting the "headline" outcomes important to institutional bodies and staff. Further development of interactive digital technologies

		their on use of NCA data.		perspective of hospital boards and quality committees.	scope for improvements based on data proposed by clinical teams.	to help staff explore and report audit data in meaningful ways needed.
Potent et al. (2020) Australia	Qualitative Audit	n=120 Audit of electronic discharge summaries (EDSs) from a tertiary hospital. Stratified to surgical, medical and mental health teams.	Retrospective Study. Auditors evaluated each EDS using an adaptation of the Australian Commission on Safety and Quality in Health Care's EDS toolkit.	To identify, compare and stratify the performance of EDSs from three hospital in-patient streams with Australian standards and stratified to 3 core clinical in-patient streams.	EDS's from all in-patient streams were lengthy and most did not include information regarding discharge destination, patient education or recommendations. General Medicine EDS's were most timely, averaging within 1 day of discharge.	Key areas of improvement remain for improving the timeliness, brevity and completeness of EDSs. Key areas identified improvements include page length, discharge destination, alerts and patient education.
Seay and Feely (2020) United Kingdom	Audit	n = 4009 Confirmatory factor analysis (CFA) Compares the one-, two-, and three-factor structures of the AUDIT in a sub sample of CPS-involved parents (n=1950) who endorsed alcohol use.	The Alcohol Use Disorders Identification Test (AUDIT) Screening Tool Factor structure of AUDIT for CPS-involved parents. Data from Waves I and II of National Survey of Child and Adolescent Well-Being II was used.	To examine the type and number of factors present in a sample of parents involved with Confirmatory factor analysis.	The 2-factor & 3-factor fit better than the single factor model In the 3-factor model. Two of the factors had a correlation of 0.99. Sub-sample results were similar.	The 2-factor AUDIT is appropriate for screening CPS-involved parents. Screening with the AUDIT should improve early identification and referral to treatment for CPS-involved parents with hazardous alcohol.

Table III Toolkits

Authors/Date Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Elmer et al. (2020) Country not provided (NP)	Mixed Methods	TransCelerate Biopharma Inc. Incorporated patient perspectives into clinical studies.	Patient Experience (PE) Initiative. Patient Protocol Engagement Toolkit (P-PET). Study Participant Feedback (SPFQ) Questionnaire	To create tools to include patient perspective into design and implementation of clinical studies	Descriptions/drafts of tools were shared with patients, clinical site advisory groups.	Final versions of P-PET & SPFQ released to the public. Need to incorporate patient perspectives into clinical studies for development of high-quality, safe, effective fit-for-patient medicines.
Engel et al. (2020) Australia	Survey data	n=351. To incorporate the effects experienced by carers providing informal care to family members, carer-related preference-based.	The Adult Social Care Outcomes Toolkit for Carers (ASCOT-Carer), Carer Experience Scale (CES), and Care-Related Quality of Life (CareRQoL) used. Survey data from carers used.	To investigate the extent to which these instruments measure complementary or overlapping constructs.	Data yielded a 5-factor model describing general quality of life outside caring, problems and fulfilment to/from caring, social support with caring, and relationship with the care recipient.	Some overlap was observed. The 3 carer-related preference-based measures seem to tap into different constructs of carer-related quality of life and caring experiences and cannot be used interchangeably. Further research was indicated.
Huynh et al. (2018) USA	Complex EBP interventions	N= 4 phases: Pre-conditions, Pre-implementation Maintenance, Evolution.	CV Toolkit project Enhanced version of Replicating Effective Programs (REP). CV Toolkit mapped and implemented women's usage.	To identify the use of multiple strategies involved in complex cardiovascular interventions in reducing risk.	The CV Toolkit is mapped and implemented across the four phases. Mapping revealed patterns in the timing of implementation strategies.	Multi-strategy frameworks and mapping of implementation strategies within complex, multi-level interventions is needed to support rigorous evaluation and sound implementation research.
Keddem et al. (2020) USA	Mixed Methods	Convenience sample Patient engagement.	Web-based, interactive patient engagement toolkit developed.	To improve patient engagement in primary care across the US Veterans Health Administration (VHA).	Successful implementation and dissemination factors found: Implementer en-gagement, organisational support, collaborators. Bar-riers: short staffing, time, poor buy-in and leadership.	Future toolkits need to highlight the type of facilitators necessary for successful implementation of toolkit content and to tailor interventions to local context to overcome barriers.

Morrison et al. (2021) USA	Qualitative	Education leaders in Hospice and Palliative Medicine (HPM).	A Toolkit to define current HPM assessment methods and to standardise future assessment.	To develop the HPM Toolkit of Assessment Methods.	The process of consensus, gaps in areas of assessment and addressing gaps with new or adapted tools, and limitations in tracking, accessibility and dissemination were found.	It is expected that implementation in this setting will provide the highest quality patient and family-centred care in serious illness.
Ruchman et al. (2020) USA	Mixed methods	n= 305 Mount Sinai Human Rights Program (MSHRP) refined its workflow and processes to facilitate the coordination of evaluations.	Use of Data management tools. To facilitate 305 forensic asylum evaluations and 117 continuity care referrals (2015-2018).	To refine workflow and processes to facilitate the coordination of forensic asylum evaluations and continuity care referrals.	Resulted in a toolkit that included data management tools, changes to asylum clinics and service delivery, meeting the demand for forensic medical evaluations of asylum seekers and ongoing care.	The MSHRP programme provides pro bono forensic medical, gynaecological, and psychological evaluations to document evidence of human rights abuses experienced by asylum seekers. This study may be replicated in other jurisdictions.
Saperstein et al. (2020) USA	Survey	n=933. Data analysis from 18 OnTrackNY teams and examination of toolkit feasibility and clinical utility in year 1 Of roll-out.	Toolkit includes a clinician manual, assessment and decision-making tools, and a menu of cognitive health service options.	To develop a cognitive health toolkit to identify and harness individual cognitive strengths to complement recovery services for first-episode.	Data analysis resulted in the provision of specific services, including psychoeducation, compensatory skills training restorative cognitive training as needed.	Preliminary feasibility data are encouraging but barriers to assessment need to be identified and addressed.
Schnell et al. (2020) NP	Mixed methods	Convenience sample. Engaging families in programme design and function. Complex care programmes.	Care Toolkit (PERCT) Children and Medical Complexity.	To engage families at various levels of programme design and function by applying the Patient Engagement in Redesigning Care Toolkit (PERCT).	Findings indicate that treating patients and families as equal stakeholders necessary to succeed in patient-centred, value-based environments.	Parents of children with medical complexity (CMC) bring valuable viewpoints and experiences to health professionals.
Snaith et al. (2018)	Toolkit and Evaluation	n=1	Toolkit Evaluation of a nurse consultant impact toolkit.	To evaluate the feasibility of transferring a nursing	The tool was validated at a national meeting of consultant radiographers.	Nurses evaluated their own practice and considered relevant measurable outcomes.

UK		One-day structured workshop.	Tested in context of consultant radiographic practice.	'toolkit' to another health profession.	Broad agreement that tools could be used by radiographers following amendments.	Positive outcomes for both professions were recognised.
Steinmann et al. (2020) Netherlands	Qualitative. Literature Review	Documentary analysis n = 22 and interviews n=23 Individuals, organisations, national stakeholders	Patient Empowerment discourse. Values based health care (VBHC) Framework to strengthen medical decisions.	To build on discourse analysis to map the ambiguity surrounding VBHC.	Four discourses found: Patient Empowerment, Governance, Professionalism and Critique. Moves VBHC from an abstract concept to practice and administration.	VBHC's conceptual ambiguity arises from presuppositions that frame perceptions on value in health care. Recognising this is a vital concern when studying, implementing and evaluating VBHC.
THÖLE et al. (2020) Utrecht	Qualitative	n=14 acute hospitals. Data obtained from investigators and site coordinators.	Interventions guided the implementation of an evidence-based Toolkit.	To identify and intervene for people with risky substance use by developing a toolkit.	Final toolkit has 54 tools: define the intervention, engage stakeholders, assess readiness, plan, implement, train and evaluate nurses, implement/effectiveness and create policies.	The approach used to develop this implementation toolkit may be used to create resources for the implementation of other evidence-based interventions in varied settings and mental health conditions.
Trukeschitz et al. (2020) Germany and Austria	Mixed Methods	n=633 The ASCOT Toolkit is adapted for German and Austrian service users.	Adult Social Care Outcomes Toolkit (AS COT) adapted by testing associations from the original English ASCOT service user tool	To measure quality-of-life outcomes of long-term care (LTC-QoL) service provision in national and cross-national studies using the ASCOT Toolkit.	Evidence emerged for a valid cross-cultural adaptation of the German version of ASCOT for service users.	Further research on the reliability and feasibility in different care settings and in different countries is encouraged.
Young et al. (2020 a) United Kingdom	Mixed methods	Impact of wards on secondary care and association between short term and secondary care utilisation.	National data, postal survey, case studies and toolkit used to measure performance relativity, make-up and web-based interactive toolkit.	To investigate variations in key performance measures in community hospital ward performance.	Results indicate that Community hospital ward efficiency is comparable with the NHS acute hospital sector.	Findings suggest future community hospital ward savings may be realised by improving modifiable performance factors and economies of scale.

Table IV Quality in mental health services

Authors/Date Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Agarwal et al. (2019) USA	Conceptual Framework	Review of peer-reviewed articles, reports, and global data collection tools	A conceptual framework for measuring community health workforce (CWH) performance within primary health care systems.	To identify key measurement domains in monitoring community health workforce (CHW) performance	Domains identified (No 21): measurement of incentives for CHWs: incl. supervision and performance appraisal, data use, reporting, quality & experiences of services. Forty-six indicators were agreed upon to measure the sub-domains.	Better data collection approaches at community level needed to strengthen management of CHW programmes and community health systems. Adoption of the proposed framework and indicators by programme directors needed to improve use
Bellehsen et al. (2019) USA	QI initiative EBT Interventions EBT	Analysis of QI data from the Northwell Clinical Center of Excellence (CCE) and annual WTCHP monitoring data for all responders of mental health treatment.	A QI assessment of the Delivery of Mental Health Services among World Trade Centres (WTC) Responders Treated in the Community to characterise the delivery of EBT for mental health problems.	This quality improvement (QI) initiative examines the delivery and effectiveness of WTCHP MHS's for World Trade Centre (WTC) responders who received care.	The study found that 50% with a WTC-certified diagnosis utilised treatment, mainly focusing on WTC-related conditions. Significant disagreement between provider-reported EBT use and independently-evaluated delivery of EBT delivery was associated with a small decrease in Post-traumatic Stress Disorder (PTSD) symptoms.	Providers are engaged in the process of data collection, but there were challenges with adherence to outcome monitoring and goal setting. Data from this report can inform continued QI efforts in the WTCHP, as well as the implementation and evaluation of EBT.
Gaebel et al. (2020) Germany	Systematic meta-review Quality of Life	Focus on Care coordination of a previous European Psychiatric Association (EPA) guidance on the quality of mental health services.	EPA guidance on the quality of mental health services: A systematic meta-review and update of recommendations focusing on care coordination.	To explore EPA recommendations focusing on care coordination.	Twenty three relevant documents covered a wide range of integrated care, home treatment transition from inpatient to outpatient care, integrating technology, QI, economic evaluation and 15 recommendations for care coordination.	Some concepts of care coordination improved the effectiveness and efficiency of MHS's and outcomes on patient level. Further evidence is needed to better understand the advantages and disadvantages of different care coordination models.

Hanefeld et al. (2017) UK Bulletin of WHO	Qualitative	Literature Review	Understanding and measuring quality of care: dealing with complexity.	To reflect on the nature of quality, how perceptions of quality influence health systems and what such perceptions indicate about measurement of quality within health systems.	Six specific challenges: incl. conceptualisation, quality, measurement, utilisation and concepts shaped through experience. Responsiveness as a key attribute and the role of quality as a social construct and implications for measurement indicated.	Need to improve all areas found: technical quality, acceptability, trust, and measurement. Improved understanding of the quality attributes in health systems interrelationships and quality of care cannot be understood outside social norms, relationships, trust and values.
Moen et al. (2021) USA	Qualitative	Literature Review Perception of quality care between health care professionals' and family involvement n=3,250	A Relationship study exploring quality of care, family involvement and coherence in Community Mental Health Services.	To investigate the relationship between health care professionals' perception of the quality of care and attitudes of family involvement	Positive involvement by professionals and families was perceived and a sense of coherence in community mental health services with professionals identified.	The health professionals perceived quality as high and did not perceive the families as a burden.
Moucheraud and McBride (2020) Africa	Systematic Review	Data from Service Provision Assessment (SPA) surveys abstracts n=34 publications.	The 34 articles used SPA data from 14 surveys in nine countries (all in sub-Saharan Africa plus Haiti).	To compare definitions of care quality across research articles.	One-third included no theoretical or conceptual framework for care quality. Few articles included outcomes as a quality construct and structure varied.	There is a lack of a common framework for measuring and reporting quality. A common framework and approach would strengthen the available knowledge on quality of care.

Table V Recovery in mental health care

Authors/Date Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Aass et al. (2020) Canada	Qualitative Study .	Family centred conversations (FCC)	FCSC Is based on the Calgary Family Assessment and Intervention Models and the Illness Beliefs Model.	To evaluate the usefulness of FCSC's in (FCSC), a family nursing intervention.	The study identified two major categories "Facilitating the sharing of reflections about everyday life" and "Possibility of change in everyday life,"	FCSC is focused on how family members can be supportive to each other. Health care professionals can play a role in the process of recovery.
Bauer et al. (2019) England and Wales.	Qualitative Intervention	Semi-structured interviews and a focus group workshop with managers of five initiatives in England that implemented recovery-oriented practice.	Cross-sector initiatives shared a range of characteristics that created favourable conditions using social value and process rather than performance.	To understand the organisational characteristics of initiatives that implement recovery-oriented practice at the interface between mental health services and communities.	The study found supporting recovery as: participation, shared decision-making, flat hierarchies, networking and (social) marketing, risk-taking, valuing and supporting members of their organisations and value-driven leadership.	Recovery-oriented practice takes place in certain organisational environments that influence an individual's recovery, highlighting the need to consider organisational characteristics when evaluating recovery interventions and how people experience recovery.
Compton et al. (2020) Washington, USA	Social Adversity Model	n= 300 participants with a diagnosis of a psychotic or mood disorder.	Social Adversity and Recovery Model	To understand how social adversity impacts recovery and how associations between social adversity and recovery are influenced by symptom severity.	Data on social adversity, recovery measures, and symptom severity identified, indicating how patients with serious mental illnesses experience recovery may be influenced by social and environmental factors.	It is necessary to understand how social adversity impacts recovery and how associations between social adversity and recovery are influenced by symptom severity. This study adds to this debate.
https://web-b-ebscohost-com.proxy.library.rcsi.ie/ehost/viewarticle/render?data=dGJyMPPp44rp2/dV0+njisfk5Ie46bN	Qualitative	n=20 Semi-structured interviews with commissioners, providers and patients' analysed thematically.	Case study of one mental health prescribing service with three nested case studies of social prescribing providers.	To identify the well-being outcomes of a social prescribing model set within a secondary MHS recovery pathway and understand the key characteristics of a social prescribing referral for	The social prescribing model was the supportive discharge pathway which provided opportunities for sustained engagement in community activities, including participation in peer-to-peer support	More in-depth research is required to fully understand when, for whom and in what circumstances social prescribing is effective for patients of secondary mental health services.

Jrqe0TrCk63nn5Kx95uXxjL6orUmvpbBIsKeeS7irt1Kupp5Zy5zyit/k8Xnh6ueH7N/iVauos1Cwp7BOt66ki+fau1Hgr6994Ku3Rd+v33urqrdO4KO2Ua+rq1C227VOta+xUbCstFju2uFF9KPxffHp63/wpq8+6tfsf7vb7D7i2LuK+N6kjN/du1nMnN+Gu6eyT7KmsEi3rqR+7ejrefKz5I3q4vJ99uoA&vid=14&sid=9b91eb59-a9ac-496b-8915-88e767939266@pdc-v-sessmgr01Dayson et al. (2020)				producing these outcomes.	networks and volunteering.	
United Kingdom						
Femdal (2018) Norway	Qualitative	n=10 Qualitative, interpretive. Semi-structured interviews with	Discourse analysis inspired by Foucault was used to analyse the interviews.	To explore how users and professionals construct the place's influence on personal recovery in community	Findings show how place can be constructed as a potential for, and as a barrier against recovery. Constructions matters	To find "the right place" for mental health services was constructed as context-sensitive and complex processes of assessment and co-determination.

		users and professionals.		mental health services.	when choosing a place for the services.	
Fletcher et al. (2019) Victoria, Australia	Surveys (2)	n=190 Nineteen participants, one representing each PARC, completed two surveys Descriptive analyses.	Purpose-designed survey relating to the government guidelines for PARC services. The Quality Indicator for Rehabilitative Care. PARC services have operated from 1-14 years.	To describe and contrast the 19 PARC services operating in Victoria at the time of the study, in terms of structures and function, resources, and content and quality of care.	PARCs are providing recovery-oriented services and offering autonomy and social inclusion, positive consumer experiences, recovery approach to service delivery with an array of group and individual programmes.	Variations exist even though guided by government guidelines according to the Quality Indicator for Rehabilitative Care. It appears services adapt. Further research into implementation processes and their impacts on quality of care is warranted.
Health Service Executive (2020) Ireland	Framework Document	This document is relevant across all services; CAMHS's, Adult, Psychiatry of Later Life, Community and Voluntary sector services with service users and others in their recovery.	The document supports implementation of the National Framework for Recovery in Mental Health (2018-2020) in Ireland by supporting service providers working in co-production with all stakeholders.	The Co-Production in Practice Guidance document is a new initiative developed in Ireland to support mental health services.	Recovery-orientated services promote working in a holistic and respectful manner where all are valued and acknowledged for their unique experiences. The expertise of service users, family members and service providers is accepted and valued to ensure better recovery outcomes.	This document will strengthen the delivery of a quality person-centred service and provide mental health services with a practical guide to co-production in practice (HSE).
Holttum (2019) Uited Kingdom	Qualitative	Literature Review.	Three papers that each spoke to a similar theme, from different angles, and that advance understanding of how social inclusion might be supported to a greater degree in MHS's were analysed.	To examine papers on mental health and social inclusion.	Findings identify blocks to social inclusion from a service user perspective. Some papers point to ways for peer workers and mental health to stand up for people's human rights despite lack of organisational support for such actions.	Papers highlight the ongoing need for better support for social inclusion in MHS across different countries. They also show how such support can be implemented and even made more mainstream. This raises hope for wider progress in MHS's becoming real enablers of social inclusion.

Jørgensen et al. (2020) NP	Qualitative	n=7 Interactive inductive and deductive analysis	An integrative review that achieves specific knowledge of recovery-oriented inter-sectoral care.	To examine the professionals' experience with recovery-oriented inter-sectoral care between mental health hospitals and CMHS's.	Themes identified are 'structurally routine care', 'unequal balance of power between the sectors', 'bureaucracy as a barrier to recovery-oriented inter-sectoral care' and 'flexible mental health''.	The studies included show that recovery-oriented inter-sectoral care is not clearly defined. It is challenging to transfer inter-sectoral care to an organisation with different structural and linguistic barriers.
Kessing (2021) Copenhagen, Denmark	Qualitative	n= 22 Interviews with peer workers (PW) employed in mental health services. .	Analysis presents three categories of peer workers as a representative, interdisciplinary professional and an expert by experience.	To explore the broader context in which the PWs navigate and the concrete outcomes and everyday issues that exist at the individual level.	PWs experience both role ambiguity and goal uncertainty and use substantial discretion in determining the nature, amount and quality of their peer practices.	These categories display PWs different enactments of their lived experiences and reveal ambiguities tied to the lay-expert divide that calls for a heterogeneous understanding of peer work.
Lorien et al. (2020) USA	Qualitative Systematic Review	n=17 Studies of recovery-oriented practice implementation in hospital-based MHS's.	A Systematic review of Literature (2010–2019)	To identify the approaches to, and feasibility of, implementing recovery-oriented practice in hospital-based mental health services.	Studies report on staff training initiatives and user programmes that are facilitated by staff and models of care, resistance to change, staff attitudes to recovery, and consumer involvement in recovery.	It is feasible to implement recovery-oriented practice in hospital-based mental health services. More successful approaches are multimodal, applied over several years and have organizational support.
McCaffrey, et al. (2020) Ireland	Qualitative	n=8 Service users and one staff member Focus groups led by music therapist. Semi-structured interviews.	Interview transcripts were analysed using Thematic Content Analysis Three original songs were composed in three focus groups.	To explore the potential role and impact of group song writing in recovery-oriented mental health services.	Lyrics reflected 3 themes: analysis of interviews revealed four themes "Group song writing breaks down barriers to promote equality, new ideas can expose perceived vulnerabilities" and promote well-being.	Findings suggest that group song writing offers stakeholders a meaningful, reciprocal and equitable space that can foster the concept of co-production that is needed for recovery-oriented working in mental health.
McGowan et al. (2019)	Qualitative	n=48 Community-led	No health	To identify pathways to health improvement	There was no clear single pathway that led	Increasing neighbourhood belonging and community

England		empowerment initiative engaged in the Big Local programme in England.	improvement suggested if no improvement found in key social participation and control factors.	in a community-led empowerment initiative engaged in the Big Local programme in England.	to mental health improve ment. Positive changes in 'neighbourhood belonging' featured in 4/5 health improvement configurations.	empowerment could be a key target for mental health improvement interventions and reduce inequalities, but needs more research to confirm.
Nardella et al. (2021) Australia	Mixed methods study	Convenience. Two groups completed staff training on the concept of recovery-oriented practice and convenience sample.	Surveys and Focus group interviews. Intervention Recovery Knowledge Inventory (RKI) and Recovery Self-Assessment (RSA-Provider) surveys and focus groups.	To evaluate the impact of initiatives on staff knowledge and provision of recovery-oriented care in acute inpatient wards.	Differences between groups found incl. RKI expectations on recovery, self-definition, peers in recovery and life goals and choice and how to embed personal recovery-orientated practice.	There were gaps in the nurses' knowledge and implementation of personal recovery-oriented concepts, highlighting the need for further training and cultural change.
Polcin et al. (2021) California	Qualitative Interviews	n= 373 Residents interviewed on entry into the house, 1-month follow-up, and 6-month follow-up.	Scale (RHES), assessed social environments within one type of recovery home, sober living houses (SLHs) and the social environment, days of substance use, and length of stay.	To assess psychometric properties for the Recovery Home Environment.	RHES unidimensional. Exploratory factor analysis suggested items could be grouped into recovery support (3 items) and recovery skills (5 items). Construct validity of the RHES was supported by other measures tested.	SLHs have been described as "the setting is the service". The RHES represents a new way to measure the recovery environment by focusing on social interactions among residents within SLHs and shared activities in the community.
Skar-Fröding et al. (2021) Norway	Survey	n=321 Cross-sectional study used baseline data from service users with psychosis in 39 clinical units across Norway.	INSPIRE Measure of Staff Support for Personal Recovery examined personal recovery and perceived support provided for recovery. Twenty support-for-recovery items rated on importance and on	To explore the Importance of Personal Recovery and Perceived Recovery Support Among Service Users With Psychosis.	Most rated personal recovery items as important. Perceived support from previous experience with Illness management and recovery; stress coping knowledge; planning for early detection and prevention of relapse	Findings provide empirical evidence that recovery-oriented treatments are relevant for most service users with psychosis with implications for clinical practice. Higher self-reported depressive symptoms, lower score on the Global Assessment of Functioning symptom subscale was associated with less perceived

			the extent of support received.		found.	support indicating more research needed.
Slade (2021) United Kingdom	Mixed Methods	The Recovery Research Team with n-4 large [>UK£2 m]	A highly managed approach to publications from inception to completion.	To provide a personal perspective on the processes involved in managing and sustaining a high-performing mental health recovery research group.	Recovery-related issues demonstrate ability to develop a significant recovery research portfolio Studies relate to recovery, global mental health peer support work and digital interventions.	The positive implications of actively recruiting researchers with mental health lived experience and decision to conduct mixed-methods rather than solely qualitative recommended.
Sofouli (2021) Canada	Intervention	Cnceptualisation of the recovery concept among cultural and ethnic minorities.	Cultural and linguistic factors are explored using the CHIME Framework.	To review the recovery concept among cultural and ethnic minorities by drawing on the CHIME Framework.	The Framework incorporates connectedness, hope and optimism about the future, Identity, meaning in life, empowerment (CHIME) as pertinent to the cultural adaptations of supported housing.	Findings show that the stigma surrounding mental illness is a key challenge to the recovery experience of ethnic minorities and that providing culturally appropriate mental health services could be viewed as a human right issue for minority groups.
Svedlund et al. (2021) NP	Survey Symptoms Scale	n=408. Adults females being treated for bulimic eating disorder.	WHO adult ADHD Self-Report Scale-Screener for comorbid psychiatric symptoms at baseline and 1-year follow-up.	To explore the influence of recovery from eating disorders (ED) at 1-year follow-up on self-reported ADHD symptoms.	ADHD symptoms decreased between baseline and follow-up in recovered patients treated for bulimic ED. And in not recovered patients ADHD symptoms were stable. Decreased depressive symptoms were associated to decreased ADHD symptoms at 1-year follow-up.	Bulimic ED and ADHD are linked together. This link, not completely understood, has clinical implications with possible value for bulimic ED patients with Bulimia Nervosa. More research is indicated.
Tanhan et al. (2020) Turkey	Qualitative Framework	Literature Review Framework Interventions	A Proposed Framework Based on Literature Review of Online	To address biopsychosocial spiritual and economic issues, enhance wellbeing, and	The proposed framework and interventions enhanced wellbeing and decreased	Mental health professionals and authorities can use the proposed framework and interventions to develop

		On-line, phone based and face to face.	Contextual and interventions to Enhance Wellbeing and Address Psychopathology During COVID-19.	empower the mental health profes sion in research and practice.	psychopathological symptoms. MHS's provided these findings to the general public during and after COVID-19.	interventions and research and spiritual and economic issues and enhance wellbeing. This Covid-19 initiative may be utilised in later years also.
Whitley et al. (2021) Canada	Qualitative interviews	n= 20 Three workgroups of people with Severe Mental Illness met per week over a 2-year period to make and disseminate videos about mental illness.	Semi structured interviews undertaken. Intervention with a focus on self-reported impact on recovery.	To elicit the subjective perceptions and experiences of people with Severe Mental Illness (SMI) involved in a Participatory Video project.	Participants made 26 videos and organised 49 community screenings reaching over 1,500 people. Participants reported that regular involvement fostered recovery by skill-acquisition, voice, connectedness a meaningful focus, and personal development.	Regular involvement in a successful Participatory Video program helped foster the recovery of participants with severe mental illness.

Table VI Acute adult mental health care

Authors/Date/ Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Atkinson et al. (2019) . Australia and New Zealand	Mixed methods. A system dynamics model.	The model captured population and behavioural dynamics and MHS referral pathways and was validated using population survey and administrative data, evidence syntheses and an expert stakeholder group.	Optimal combination of (1) secondary (acute) MHS capacity, (2) non-secondary (non-acute) MHS capacity and (3) resources to re-engage those lost to services on the incidence of suicidal behaviour over the period (2018–2028) in Greater Western Sydney (Australia) population catchment.	To investigate the optimal combination of capacity of acute and secondary MHS's and resources to re-engage those lost to services on the incidence of suicidal behaviour.	Findings suggest that 28% of attempted suicide and 29% of suicides could be averted over (2018-2028) based on increases in hospital staffing, with training in trauma-informed care, non-secondary health service capacity, expansion of mental health assessment capacity and re-engagement of at least 45% of individuals lost to services. 15% reduction in psychiatric beds had no substantial impact on the incidence of attempted suicide and suicide over the forecast period.	This study suggests that more than one-quarter of suicides and attempted suicides in the Sydney catchment could potentially be averted with a combination of increases to hospital staffing and non-secondary (non-acute) mental health care. Reductions in tertiary care services (e.g. psychiatric hospital beds) in combination with these increases would not adversely affect subsequent incidence of suicidal behaviour.
Díaz-Fernández et al. (2020). Spain	Longitudinal study	n=344 people with severe mental illness schizophrenia, over a 10 year period Community-based case managed programme.	Previous standard treatment received in mental health units (MHU) compared with current Comprehensive treatment in a community-based, case managed programme.	To assess suicidal behaviour and impact of route of antipsychotics administration in a group of patients with schizophrenia treated in a comprehensive, community-based, case managed programme.	A combination of intensive case-managed and LAIAP treatment helped to improve compliance and to reduce suicidal behaviour compared to standard treatment in patients with severe schizophrenia.	Further research is indicated to explore intensive case-managed and LAIAP treatments.
Haeberlein et al. (2020)	Longitudinal studies	Two samples of well-educated	Psychological distress and need for	To examine differences in self-reported	A larger percentage of respondents from the	The authors ask 'are the findings a reflection of a potential trend'

USA		adults, obtained from two larger studies conducted separately in 2005 and 2008.	treatment was reported by using the Langner Symptom Survey, a psychometrically robust measure of nonspecific distress.	psychological distress and the need for treatment.	2018 sample reported current counselling (12%) compared to the 2005 sample (4%), and they were almost twice as likely to be classified as distressed and in need for treatment than their 2005 counterparts (52% compared to 33% in 2005).	Respondents indicated whether they had never received treatment, previously received treatment, or were currently receiving treatment.
Hung et al. (2020) USA	Survey	Data Bases Retrospective Survey	Data obtained from National Mental Heal th Services Survey (N-MHSS) and the Centre for Disease Control and Prevention (CDC) Wide-Ranging Online Data for Epidemiologic Research (WONDER) (2014-2017).	To examine the number of community mental health centres (CMHCs) per capita and suicide mortality in a retrospective study.	The number of CMHCs decreased by 14% nationally and suicide rates increased. Declines in the number of CMHCs during this period may be associated with approximately 6% of the national increase in suicide, representing 263 additional suicide deaths.	It is recommended that state governments should avoid the declining number of CMHCs and the services these facilities provide, which may be an important component of suicide prevention efforts.
Ju et al. (2021) China	Survey Quantitative	n=2542 Outpatients were recruited at their first visit to the Shanghai Mental Health Centre. Psychotic symptoms over the preceding year were self-reported through the PRIME Screen-Revised	The PRIME Screen-Revised (PS-R) questionnaire. Seven categories of psychotic symptoms were grouped: perplexity and delusional mood; first rank symptoms; overvalued beliefs; suspiciousness/perse cutory ideas, grandiose ideas perceptual	To explore the distribution differences of psychotic symptoms in an outpatient population in terms of frequency, age, gender, and psychotic and non-psychotic disorders.	Of 2,542 outpatients, 1448 (57%) were screened as positive. Frequency of psychotic symptoms declined with age. Younger patients reported more psychotic symptoms than older patients. Suspiciousness and disorganised communication were more common in females than males. Perceptual abnormalities were found	Psychotic symptoms appear to be common in the clinical population and represent nonspecific indicators of psychopathology. The difference between psychotic and non-psychotic psychopathologies is more a function of the presence, frequency, and severity of psychotic symptoms.

		(PS-R) questionnaire.	abnormalities and disorganised communication.		to significantly differ between psychotic and non-psychotic disorders.	
https://web-b-ebscohost-com.proxy.library.rcsi.ie/ehost/viewarticle/render?data=dGJyMPPp44rp2/dV0+njisfk5Ie46bNJrqe0TrCk63nn5Kx95uXxjL6orUmvpbBIsKeeTrirlKwqJ5Zy5zyit/k8Xnh6ueH7N/iVauos1Cwp7BOt66ki+fau1Hgr6994Ku3Rd+v33urqrdO4KO2Ua+rq1C227VOta+xUbCstFju2uFF9KPxffHp63/wpq8+6tfsf7vb7D7i2LuI8e/mPvLX5VW/xKR57LOwSK+vq0+vr65Nq6auUKTc7Yrr1/JV5OvqhPLb9owA&vid=45&sid=9b91eb59-a9ac-496b-8915-88e767939266	Longitudinal study	n=139 Retrospective descriptive study design.	Early intervention in psychosis in the North Lee Mental Health Services programme: A 5-year review.	To describe and review the EIP programme offered by Cork's North Lee Mental Health Services over a 5-year period.	The mean age of onset was 30 years and mean duration of untreated psychosis was 8 months, 66% were single on initial assessment, had history of substance misuse and unemployed. Most engaged with keyworkers and OT. Hospital admission were needed for 12%.	Patients experiencing their first episode of psychosis can successfully be treated in the community with appropriate professional and family support. Deficiencies noted in physical health monitoring as well as in the availability and engagement with family and psychological therapies. Properly resourced early interventions in psychosis needed.

@pdc-v-sessmgr01Lalevic et al. (2019) Ireland						
Lewis et al. (2018) USA	EBP	n=165	Therapists indicate whether they utilise each of 45 unique practice elements from eight evidence-based psychotherapies.	To identify if community mental health therapists endorsed an eclectic orientation, and how therapists utilise elements of evidence-based psychotherapies.	A three-factor model containing distinct patterns of practice that did not align with usual evidence-based practice approaches found planning, practice, monitoring, cognitive, didactic and interpersonal patterns.	Therapists adopted an eclectic approach that brought together elements from theoretically distinct evidence-based psychotherapies. Future research to explore how these patterns of practice relate to client outcomes and training is recommended.
Mezes et al. (2021) USA	Survey	n=192 Five domains are assessed: social integration; productivity; consumption; access to services; and political engagement.	The Social Inclusion Questionnaire User Experience (SInQUE).	To assess The SInQUE.	Mental health and social care staff have, until now, had no valid or reliable way of assessing their clients' social inclusion. The Social Inclusion Questionnaire User Experience nay be recommended.	The component of the SInQUE that assesses current social in-clusion has good psychometric properties and can be recom-mended for use by mental health staff.
Peritogiannis et al. (2020) Greece	Qualitative	n=76.	Data were retrieved retrospectively for patients with schizophrenia and related disorders. Comparison made for the same interval prior and after engagement to treatment with the MMHU I-T.	To assess hospital admissions and length of hospital stay in patients with schizophrenia and related disorders, who are engaged to treatment with a Mobile Mental Health U nit (MMHU I-T).	The average age of patients was 56 years and the mean illness duration was 28 years. The mean follow-up duration was 5.3 years. Decrease in the annual average of the number of voluntary and involuntary hospitalisations and on days of hospital stay after	Treatment of schizophrenia spectrum disorders in rural residents by the MMHUs may contribute to the reduction of patients' admissions and length of hospital stay. Future research is recommended to address the cost-effectiveness of such interventions.

					treatment engagement with the MMHU I-T identified.	
Pigot et al. (2019) Australia	Intervention	Interviews with managers and clinicians engaged in implementation of a Stepped Care approach.	Stepped Care Intervention	To understand the facilitators and barriers to the implementation of a stepped care approach to treating personality disorders that exist.	Participants identified personal attitudes, knowledge and skills as important for successful implementation. Existing positive attitudes and beliefs about treating people with a personality disorder contributed to the clinical champions.	Organizational and individual factors may increase timely and efficient implementation of interventions for people with personality disorders. A stepped care approach may help to triage clients and allow access to interventions with less client, clinician and system burden.
Ponce et al. (2020) USA	Quality	Multidisciplinary stakeholder input in community mental health Centre.	Critical incident data and multidisciplinary stakeholder input to implement a new assessment mechanism and education plan to support staff to address suicide risk.	To describe a performance improvement process related to suicide assessment carried out in a community mental health centre. .	Although the rate of patient death by suicide in this setting is low, managing suicide risk varied widely based on survey responses.	As suicide risk management was based on self-report future work should integrate skills-based assessment. Focusing on provider input and voice in suicide-related efforts in community settings is needed in the future.
Tucker at al. (2020) Western Australia	Qualitative	n=20 Interviews with mental health nurses.	To ensure that practice was In keeping with best practice recommendation in managing agitation an inpatient setting.	To explore the experiences of mental health nurses in recognising and managing agitation in an inpatient mental health setting.	De-escalation strategies were the first choice option for management, though nurses also described using both coercive restraint and medication under certain circumstances.	Nurses combined their clinical knowledge, assessment protocols and training with information from patients to make an individualised assessment of agitation.
Walby et al. (2018) Western European and	Systematic review and meta-analysis.	n= 35 studies. Systematic review and meta-analysis.	Contact with mental health services prior to suicide.	To identify the prevalence of contact with mental health services preceding suicide (2000- 2017).	Among suicide decedents in the population, 4% were inpatients at the time of death. In the year before death, 18% of suicide decedents had	Contact with services prior to suicide was found to be common and contact with inpatient or outpatient mental health services before suicide seems to be increasing.

North American countries		n=20 papers were included in the meta-analysis.			contact with inpatient mental health services, 26% had contact with outpatient mental health services, and 26% had contact with both services. Women had significantly higher levels of contact compared with men.	However, the reviewed studies were mainly conducted in Western European and North American countries, and most studies focused on psychiatric hospitalisation which resulted in limited data on contact with OPD services. Better monitoring and data on suicides that occur during and after treatment warranted.

Table VII Access and Barriers to mental health systems

Authors/date/ Country	Design	Sample	Methods	Research Aim	Research Outcomes	Recommendations
Butz et al. (2019) NP	Process improvement project	Convenience sample QI team in a large children's hospital. Designed interventions	Members from a QI team in a large children's hospital designed interventions to change scheduling practices. Extra interventions included.	To outline the interventions implemented using quality improvement (QI) science to improve access to 1st appointment for those with pain.	Initial changes involved decreased time between calls to families and streamlining notifications among clinicians. Application of QI science improves patient access to mental health care.	Future directions will focus on enhancing the use of the electronic health record, along with pre-visit family engagement. Engaging extra clinicians in managing referrals resulted in stabilising wait times to an average of 63 days to the first appointment.
Silva et al. (2020) Portugal	Survey Data from the 2009 National Mental Health Survey.	Survey Data Base	Logistic regression models analysed the association between sociodemographic and clinical variables with treatment.	To evaluate sociodemographic and clinical factors associated with use and barriers to treatment in Portugal.	Factors found: Treatment with mood disorder, disability, single, basic education, attitudinal and barriers.	Identifies factors associated with non-treatment. Provides evidence to develop future policies and effective interventions.

Table VIII Carers/Family/Peers

Authors/date/ Country	Design	Sample	Methods	Research Aim	Findings/Outcomes	Recommendations
Allchin et al. (2020) USA	Qualitative	(n=16) Semi-structured interviews with 16 service managers and implementation leads, to establish their views on key elements influencing implementation of Let's Talk during a RCT.	Thematic analysis Inductive and deductive approaches. Consolidated Framework for Implementation Research (CFIR) to address the influence of organizational roles in shaping implementation for Let's Talk.	To identify leadership perspectives on key elements influencing the process of implementation of Let's Talk about Children (Let's Talk), a family-focused practice for practitioners working with parents diagnosed with a mental illness.	The findings suggest that specific roles for leadership are vital to implementation within an environment of constant change. More attention is needed to understand the dynamics of parent and practitioner readiness for delivering Let's Talk.	As the first study to document leadership's perspectives of implementing Let's Talk, this paper contributes to the evidence base on their role in implementing family-focused practice models. Different leadership roles need to be engaged to sustain Let's Talk in changing real-world environments. Further research is indicated.
Bacha et al. (2020) United Kingdom	Qualitative	n=8 individuals with experience of the UK mental health system interviewed. Interpretative phenomenological analysis used.	Project was conducted alongside a service user organisation to explore service users' experiences and perceptions of their relationships with mental health Practitioners.	To gain a greater understanding about which relational components can lead to psychological change upon the therapeutic outcomes for people diagnosed with a severe mental illness.	Three superordinate themes emerged from the analysis: trying to survive: am I a person in the system: traumatic experiences within relationships; helpful and transformative relationships. The key transformative components of these relationships were power, safety, and identity.	Mental health services need to be more focused upon care, rather than control. The components of this model are managed by mental health practitioners' and can determine whether these relationships maintain, increase, or alleviate psychological distress.
Berzins et al. (2020) United Kingdom	Qualitative	n=13 service users and n=7 carers in the UK. Qualitative exploration of mental health service user and carer views on	Perceived safety issues identified using framework analysis, guided by the YCFF-MH. Service user development of the Yorkshire Contribu-	To explore what service users of MHS's and their carers consider as safety issues. .	Identified: safety culture, psychological concepts of safety, raising concerns; 'social environment' involved threatened violence, sexual abuse; individual service user. Staff factors; not being listened	Safety issues appear broader than those recorded and reported by health services and inspectorates. Many safety issues have also been identified in other care settings supporting the notion that there are overlaps between service users

		perspectives on safety issues in UK MHS.	tory Factors Framework—Mental Health (YCFF-MH).		to; 'management of staff staffing levels' resulting in poor continuity of care.	and carers' perspectives of safety. Examples of 'active failures' were also described
Fancourt et al. (2020) United Kingdom	Mixed Methods	n=1,000 Engagement with key stakeholders, consultations, integration of findings and prioritisation of key questions.	Established processes and principles for developing research agendas followed, with a six-phase design. Project funded as part of the UK Research and Innovation cross disciplinary mental work programme.	To identify if current research is focusing on the research questions of most immediate urgency, relevance to policy and practice and to co-produce a new cross-disciplinary research agenda on Family Social, cultural and community engagement: SCCE.	Four core themes found: mode, process and impact of engagement and infrastructure needs to facilitate engagement. Many points of agreement on priority questions, but also some specific questions of relevance to different sectors.	This agenda is timely given the extreme pressure on mental health services predicted to follow the current COVID-19 pandemic. It is important to identify how resources from other sectors can be mobilised, and what research questions to support SCCE for mental health into the future.
Hestmark et al. (2020) Norway	Mixed Methods Cluster randomised Trial Questionnaire	n=14 outpatient clusters from community mental health. n=161 patients with psychotic disorders and their closest kin measuring psychosocial health and satisfaction with services.	Seven intervention clusters will receive implementation support for 18 months and control clusters will receive the same support after implementation. Clinicians provide clinical data at inclusion and 12 months & health data from national registries.	To improve MHS and the psychosocial health of persons with psychotic disorders and their relatives, by implementing selected recommendations from the national guidelines in community MH centres and to evaluate this process.	The intervention consists of: A basic level of family involvement and support. Family psychoeducation in single-family groups. Training and guidance of health care personnel. A family coordinator and other implementation measures.	This project may contribute valuable knowledge to the fields of family involvement, MHS research and implementation science. A cost-effectiveness analysis and a political economy analysis will take place. Fidelity will be measured four times in the intervention and two times in the control, and the differences in fidelity changes between both constitute the primary outcomes.
Storm et al. (2020) USA	Qualitative	n=28 semi-structured qualitative interviews with peer support specialists and MHC mental	Data were triangulated to explore peer support specialists and mental health Professionals' perspectives.	To explore the potential of peer support specialists in community mental Health centres as a means to improve coordination of	Five themes found: Advocacy in inter professional meetings, clinical teams, advisory councils, sharing lived experiences and connecting with available	This study suggests that peer support specialists can uniquely contribute to the coordination of physical health and mental health services for individuals with serious mental illness.

	professionals in CMHC with people with SMI.	physical health and mental health services for people with a SMI.	resources and services and affiliations, funding, and peer supports.

Table IX Child and adolescent mental health services

Authors/date Country	Design	Sample	Methods	Research Aim	Findings/Outcomes	Recommendations
Barnes (2020) United Kingdom	Qualitative Guideline Pathways	Convenience sample with adolescents and their primary caregivers from 18 secondary schools in the United Kingdom.	National Institute for Clinical Excellence guideline for diagnosing ADHD used. Developing prospective structured Pathway.	To investigate adherence to the NICE guideline for diagnosing ADHD.	Findings demonstrate that in CAMHS the gold standard practice for diagnosing ADHD should be the adoption of clear, protocol-driven pathways to support appropriate access and treatment for young people and their families.	Within a London NHS Trust, CAMHS are developing structured pathways for assessing and diagnosing ADHD in young people.
Beatty et al. (2019) Ireland	Longitudinal study over 5 year period	Quantitative method. Convenience	Comparative study between MHS's and Jigsaw Galway with individuals attending secondary MHS's who had been referred to or from Jigsaw Galway.	To compare individuals referred from Jigsaw to adult MHS.	Findings indicate that a recent act of self-harm was more prevalent in individuals referred from Jigsaw to the adult MHS.	To optimally address young people's MH difficulties, education sessions for clinical staff working in primary care, Jigsaw Galway and the MHS are supporting clinicians in choosing the best referral pathway.
Cha et al. (2019) USA	Semi-structured interviews	Convenience n=30	Undocumented migrants who have access to healthcare, and college students at the University of California.	To examine a unique population of undocumented immigrants - to identify how immigration status hinders mental health se rvice utilization.	Students expressed low perceived need because they normalised mental strain and stigma as a natural product of their unstable immigration status.	Little is known about how undocumented immigrants navigate healthcare utilisation issues apart from access. Solutions are needed to address psychosocial barriers, as well as the larger political and social context that produces them.
Cho et al. (2021) USA	Qualitative Two multidisciplinary surveys	Convenience n=2,575 (combined surveys)	Evidence Based Assessment (EBA). Pre-treatment, ongoing, and post treatment assessments.	To examine when, how, and under what conditions clinicians conduct EBA.	Clinicians reported frequent pre-treatment, ongoing, and post treatment assessments. The use of standardised measures was rare.	Findings indicated a lack of practical assessment tools that may have been a barrier to the use of standardised measures in EBA of youths. More practical measures and clinician training

						may improve the integration of measures into routine practice. Assertive community treatment (ACT) an established treatment for adults has an emerging evidence base for improving outcomes in youths.
Daubney et al. (2021) Australia	Intervention	Convenience Sample with adolescents who are difficult to engage with.	ACT is explored with The Assertive Mobile Youth Outreach Service (AMYOS) of Children's Health Qu eensland, Australia.	To explore the use of ACT with adolescents, who are difficult to engage with through traditional psychiatric services.	AMYOS clinicians were engaged with adolescents in reducing risk of harm, support recovery, improve functioning and engage with education and vocational pathways.	
Desrochers (2019) USA	Qualitative	Framework	Framework, known as multi-tiered systems of support for delivering mental and behavioural health Services.	This chapter outlines the extent of school mental health services offered by professionals and the outcomes obtained.	Little awareness among the public on the role of MH professionals employed in the high school public-system exists. Focus is on the role of school counsellors in helping with adjustment problems and post-secondary planning	Practical suggestions to professionals and parents for improving school-based systems including staffing, recognition and promotion of advantages to student mental health from mental wellness to crisis intervention.
Flynn et al. (2019) Ireland	Intervention and outcomes	n=84 Convenience Sample Clinicians from seven CAMHS teams.	16-week Dialectical Behaviour Therapy for Adolescents (DBT-A) Intervention and outcome measures: DBT training programme delivered to adolescents with emotional and behavioural dysregulation.	To describe the implementation and effectiveness of a 16 week DBT-A in CAMHS.	Clinically significant treatment effects were achieved for internalisation and anxiety symptoms. The use of DBT-A is indicated for treating adolescents with emotional and behavioural difficulties.	Adolescents' causal beliefs are likely to have implications for the way they seek help and engage in treatment, making it important to understand how adolescents understand their difficulties.
Green et al. (2019) Australia	Descriptive	Convenience Research conducted with residents	Sub-acute youth mental health residential service model, Youth Prevention and	To identify if Youth Prevention and Recovery Care (Y-PARC) service aligns with recovery-oriented care.	Practice at Y-PARC aligns with recovery-oriented care. Long-term negative consequences and high	Findings document problems young people have in receiving appropriate services when at risk of hospitalisation and to those transitioning out of

		n= 288 young people	Recovery Care (Y-PARC) service.		costs of untreated mental illness in the 16-25 age group were identified.	hospital inpatient units and highlight a need to improve the appropriateness and continuity of services for this group.
Gray et al. (2019) Wales	Evidence Based Technique	Convenience n=88 users of mental health services	WARRN is a formulation-based technique for the assessment and management of serious risk (e.g. violence for users of MHS's which has been adopted across CAMHS in Wales.	To evaluate the perceptions of clinicians on the use and effectiveness of WARRN, Applied Risk Research Network (WARRN).	Clinicians believed that WARRN had saved lives and had created a common language and understanding that improved communication and was having a very positive effect on service user well-being and safety.	The first report of a formulation-based approach to the management of serious problem behaviours in CAMHS services recommends implementation in other services.
Henderson et al. (2020) NP	Intervention	Convenience sample	YouthCan IMPACT integrated youth services project based Consolidated Framework for Implementation Research (CFIR).	To identify if integrated youth services project improves youth mental health systems.	This integrated youth services project improves youth mental health systems and acknowledges the international movement toward developing community-based service hubs that provide collaborative care to youth.	The need for members of key stakeholder groups, including staff, youth, and caregivers to be involved in the development and execution of the project to ensure effective implementation.
Hoch et al. (2020) NP	Quantitative Survey Audit	n=7695 Comparative study between children with ASD, developmental disabilities, and other mental health diagnosis	Diagnosis involves screening (e.g. depression).The Social Communication Questionnaire (SCQ) (screening tool to measure for the assessment of autism spectrum disorder) (ASD).	To compare exposure to potentially traumatic events and trauma-related diagnoses in children with mental health diagnosis.	Findings indicate that diagnosis, number and type of negative life events and children's locations predicted trauma reports and trauma diagnoses.	The sensitivity and specificity of the questionnaire when used with older children in the context of community CAMHS is unclear.

Horwitz et al. (2019) USA	Qualitative	Convenience n=89 Documentary analysis	Managing and Adapting Practice (MAP). Evidence-based practice following training sponsored by New York State (NYS).	To document rates of sustained use with clinicians of an evidence-based practice following training.	Clinician characteristics found related to sustained use in EBP by using the MAP. 80% reported continued use of MAP.	Results may be used to identify clinicians who are likely to discontinue use of EBP.
Hoyland et al. (2018) Australia	Descriptive Co-design of services	Convenience sample In Children's Health Queensland Hospital, Health Service and Health Consumers	Collaborative partnership by Co-designing services for young people with young people.	To co-design services for young people with young people.	Partnership advocates perseverance, commit to action, value experiences, listen to young people and provide what they want.	Partnership was rewarding and improved service delivery and consumer outcomes in peer support roles, within this setting.
Iorfino et al. (2019) Australia	Mixed methods and Survey	Convenience sample n=2,254	Clinical Staging as adjunct to diagnosis.	To explore Clinical Staging as an adjunct to diagnosis to address emerging psychiatric dis orders.	Differential rates of progression from earlier to later stages of anxiety, mood, psychotic, or comorbid disorders were observed, indicating the need to plan stage-specific clinical interventions.	Enhanced long-term care for those who are most at risk of developing life-threatening or chronic psychiatric disorder is critical. The longer-term utility of this system has not been established.
Kehoe et al. (2020) Canada	Qualitative Descriptive	Convenience Descriptive	Co-design workshop to develop a family focused model of care.	To identify known best practice, and evaluate the importance of taking a family-focused, therapeutic approach to adolescent family violence, in place of a punitive one.	The use of a co-design workshop to develop a family focused model of care to address the needs of young people who use violence and their families in the home.	The co-dependence of the parent–child bond, lack of maturity in the adolescent and often related issues of disability or mental illness make these young people vulnerable. Further research is indicated.
Lorentzen et al. (2020) Norway	Intervention	Convenience n=163	The Structured Material for Therapy (SMART) in CAMHS utilised.	To investigate the effectiveness of a 6-week diagnostic cognitive behavioural therapy (CBT) for anxiety	Findings indicate that clinically significant treatment effects were achieved for	SMART may be considered as a first step in a stepped care model for anxiety and/or depression treatment in CAMHS.

				and depression in adolescents.	internalisation and anxiety symptoms.	
Malla et al. (2019) Canada	Descriptive	Convenience n=14 Model for transformation of services for youth with mental health and substance abuse problems.	Mapping of services followed by training, active stakeholder, early case identification, initiatives providing rapid access and assessment of problem.	To assess the principles guiding service transformation in culturally diverse sites with homeless youth and substance abuse problems.	Methods vary depending on prevailing resources, culture, geography and the population to be served and how each community can best utilize the extra resources for transformation.	When assessing indicators of mental health among children and adolescents with a history of adverse childhood experiences, non-suicidal self-injury should also be taken into account.
Piccone et al. (2018) Queensland, Australia	Qualitative	Descriptive Convenience sample	Partnership approach as co-creators in the development of new mental health services.	To explore partnership in the context of co-creators.	Partnership has led to a high level of participation and inclusion of people with lived experience of MH illness. Positive co-creators in development identified.	Transition from earlier to later stages of anxiety, mood, psychotic, or comorbid disorders are associated with the time course of these transitions.
Quintyne and Harpin (2020) United Kingdom	Qualitative	Convenience sample Descriptive	Homelessness is described by Centrepoint as 'the hidden homeless' that includes young people who may sleep on their friends' or extended family's couches.	To examine how homelessness influences access to services provided by Local Authority's.	If a young homeless person presents at a hospital, there is an opportunity for them to be directed to appropriate supports, critical when young people have an identified mental health need.	Adolescents need to be identified as surfers by clinicians so that support may be offered. Adolescents also need to receive community-based support when planning for discharge from hospital.
Rosen et al. (2020) USA	Qualitative	Convenience sample Descriptive	Framework development.	To identify the training required by psychiatrists and health professionals in ensuring the mental health of their communities.	Community psychiatrists and mental health professionals of the future need to be trained in nano to macro skills and to take responsibility for the mental health and wellbeing of their communities.	Too few training programmes emphasise public advocacy in working with service users, families, social movements, and the media to improve mental health and wellbeing of communities.

Sarmiento and Reid (2020) Canada	Quantitative	Survey n = 1802 across five Mental Health agencies.	Survey undertaken with five mental health agencies in Ontario, Canada.	To examine the predictors of re-assessing community-based care.	Findings show that 30% of children who had an episode of care re-accessed services again within 4 years and the median time to re-access was 386 days.	Little research is available in this area. A better understanding of the factors that influence recurrent service use may facilitate this process for families.
Vallianatos et al. (2019) Canada	Systematic research	First year students attending post-secondary schools in Canada.	ACCESS Open Minds University of Alberta, Canada (ACCESS OM UA) is focused on improving mental health services for youth and represents a systematic effort to support not just mental health, but the full student.	To describe demands for mental health services in post-secondary institutions and key features of a response to these needs.	ACCESS OM UA approach requires ample time to consult, develop rapport between staff and stakeholders across diverse units and develop processes in keeping with local opportunities and constraints.	Service transformation grounded in community based research allows for incorporation of local knowledge, expertise and opportunities. Ongoing efforts will continue to monitor changing student needs and to evaluate and adapt the transformations as needed.
Vankanegan et al. (2019) NP	Qualitative Descriptive	Convenience sample Group work in Community-based mental health setting.	One type of Activity-based adventure therapy (AT) group practice.	To explore the impact of adventure therapy (AT) group practice, on youth in a community-based mental health setting.	Positive outcomes for youth participating in AT found. A recent treatment: Assertive community treat ment (ACT) shows promise for improving outcomes in this group.	Research has focused on AT use in residential settings, but little research exists on adventure therapy in a community setting. This study will add to research and knowledge in AT.
Williamson and Ennals (2020) Australia	Qualitative Intervention	Convenience n=6 youth and 3 families in community settings	Sensory modulation assessment and intervention and co-creation.	To explore the experiences of 6 young people and 3 families who engaged in sensory modulation assessment and intervention.	Young people and their families' valued the positive experiences of sensory modulation through the process of co-creation, supporting occupational participation in young peoples' activities of daily living.	Sensory modulation is used to develop self-regulation and enable occupational participation. Further research with a larger sample is needed.

Wright et al. (2019) USA	Mixed methods	Convenience n= 101 Community therapists provided information about n = 267 youth clients and n=685 psychotherapy sessions.	Implementation of evidence-based practices (EBPs).	To explore therapist-reported caregiver attendance in treatment sessions as a quality indicator in the community implementation of EBPs.	The patterns of actual caregiver attendance appeared consistent with empirically informed practice parameters for involvement of caregivers in treatment.	The rates of caregiver attendance in externalising-focused sessions were suboptimal, and the gender difference in these rates, dis-favouring girls, suggests targeted areas for quality improvement.

Table X Digital Tele-Health in mental health care

Authors/Date Country	Design	Sample	Methods	Aims	Findings/Outcomes	Recommendations
Anyaegbu (2021) Australia	Digital SMS	n=7 (SMS) reminder programme on patients who attended 496 depot clinic appointments.	SMS reminders: reducing DNA at a CMHC depot clinic.	This evaluation assessed the effect of an inexpensive short message service (SMS) reminder programme.	Findings indicate that the average DNA reduced from between 5% and 12%. Attendance correlated with frequency of depot administration.	SMS reminders could provide an inexpensive way of achieving reductions in DNA at CMHT depot clinics. Further research with a larger and randomised sample size is indicated.
Bakker et al. (2018) On line apps	RCT	A randomized controlled trial of three smartphone apps for enhancing public mental health.	Three MHapps included CBT toolkit app MoodKit, mood tracking app MoodPrism, and CBT strategy app MoodMission used.	To compare the efficacy of three publicly available MHapps to a waitlist control condition in a community sample, in which no MHapp was provided.	Compared to the control condition, all MHapp groups experienced increases in mental wellbeing. MoodKit and MoodMission groups experienced decreases in depression, and no groups experienced effects on anxiety. Mediated regressions increased coping self-efficacy, rather than emotional self-awareness.	MHapps appear to be an effective solution for improving public mental health, notably by improving users' confidence in their ability to cope. Increasing coping self-efficacy contributes to positive effects on mental on health.
Bonfils et al. (2018) NP	Qualitative Digital decision support system	(N=12) staff members that were integral to the CommonGround implementation in 4 treatment teams in a CMHC.	Semi structured interviews CommonGround is (part of a larger group).	To explore the implementation process of one SDM intervention-CommonGround-That utilizes peer specialists and a computerized decision support centre to promote SDM.	Programme barriers found were: technological difficulties, increased staff burden, contextual barriers (e.g., poor fit with service structure, decision support centre location, low staff investment and high turnover.	This implementation of CommonGround was limited as a result of programme and contextual barriers. Future implementations strategies are needed to maximise implementation by increasing awareness, buy-in, and utilization.
Cliffe et al. (2020) United Kingdom	Qualitative	n=154 CMHS Professionals.	Questionnaire Clinicians' use of and attitudes towards technology to	To explore the use of, and attitudes towards, using technology with	Child MH professionals perceived themselves as being competent at using	Despite positive attitudes towards technology, newer technologies were rarely used by MH child professionals. An

			provide and support interventions in CAMHS. .	children and adolescents in CMHS's.	technology and to be helpful in their clinical practice. Benefits were identified as accessibility, convenience and appeal, and as a preventative psychoeducational tool rather than a replacement for face-to-face therapy. Helplines and websites were most frequently used. Newer technologies (computer games) were rarely used.	overall lack of knowledge about resources along with concerns about safety and reliability may account for the slow uptake of technology within CAMHS. These issues need addressing to maximise implementation, perhaps through training or workshops.
Fehily et al. (2020) Australia	Electronic Technology Telephone	n=373 adult clients of one Australian CMHS. Telephone interview and self-reported as not meeting Australian National Guidelines for smoking, nutrition, alcohol consumption and/or physical activity.	Descriptive statistics summarised awareness and use of the New South Wales Quitline® and Get Healthy Service® for participants with lifestyle risk factors addressed by each service.	To determine the prevalence of, and factors associated with, awareness and use of telephone-based behaviour change support services among clients of a CMHS.	Awareness (16%) and use (2%) of the Get Healthy Service was lower than that of Quitline (89%; 18%). Television was the most common source of awareness (40 % Get Healthy Service; 74 % Quitline.	Opportunities exist for increasing awareness and use of both services, particularly the Get Healthy Service, among clients of CMHS's. Strategies to optimise reach for this population group are recommended.
Kelly et al. (2020) Australia	Qualitative .	(n=43) participants. 8-session telephone delivered coaching engaged with Neami National, Australian CMH organisations.	Participants randomised to the Treatment Condition were offered BHC. 8-session telephone delivered coaching intervention. Participants in the waitlist Control Condition	To evaluate the feasibility of peer-workers facilitating a telephone delivered healthy lifestyle intervention within community based mental health settings and to examine	The average number of sessions completed in the Treatment Condition was 5.7. Seventeen completed at least half of the sessions, and nine completed all eight sessions. When compared to the Control Condition, people in the Treatment	Good retention rates and high consumer satisfaction ratings in the Treatment Condition demonstrated that peer-workers delivered treatment to the satisfaction of consumers.

			completed treatment as usual.	preliminary outcomes of the intervention.	Condition showed greater treatment effects on smoking and leisure screen time.	
Kjelsaas et al. (2019) Social media	Digital Facebook	n=26 MHS clients. from a CMHS provided access to their Facebook page.	Seven aspects of 3,674 Facebook posts were coded, and cross-lagged multi-level models were estimated over three periods.	To examine the relationship between Facebook use and wellbeing.	Some aspects of Facebook use were related to wellbeing within the same period. This pattern of relationships did not emerge longitudinally. Facebook use was neither helpful nor harmful over time among people with mental health problems.	Given the prevalence of social networking, a clearer understanding of its impact on well-being is critical for mental health providers. Facebook has the potential to forge social connections for those who are socially isolated.
Mahmoud et al. (2021) Chicago, Illinois	Qualitative	Planning and Implementing Tele psychiatry obtained from Data Bases in a Community Mental Health Setting.	A Case Study Report. Data analysed from findings gathered from the organization's secondary archival data, highlighted process and outcome evaluations of the programme.	To report the planning and implementation of a tele-psychiatry program adopted by a CMH organization in suburban Chicago (2017 -2019). .	Results show high levels of patient engagement compared to in-person service modality and an increase in the number of patients served, efficiency in service delivery, decreases in patient wait time and positive feedback from patients, families, and staff members.	Successes and challenges encountered by the organisation were found which were synthesised into practical applications recommended for similar initiatives.
Mc Clellan et al. (2020) Internet based survey	Mixed-methods	Sample n=100 Clinician telehealth attitudes in a rural community mental health centre setting.	Internet-based survey.	To examine rural clinical mental health staff members' attitudes toward telehealth.	Findings indicated that 89% reported a favourable or neutral opinion of telehealth and 100% reported their agency provided one or more clinical services via Telehealth. Organisations technological capability to provide services via	Researchers and trainers should focus on increasing knowledge about the effectiveness of telehealth and provide clinicians with safe opportunities to gain comfort and competency, with the technology needed to provide these types of specialized services.

					telehealth predicted clinicians' willingness to consider providing services via telehealth.	
McKellar and Hanson (2020) Australia	Qualitative	Framework Report	Older persons in South Australia. The Oaktown report drew national attention to the care of older people with complex clinical needs.	The working group developed a framework as a blueprint for organisational culture reform built around a central philosophy of compassionate relationship-centred care. In response a working group was set up to engage in a co-design process under the governance of the Oakden Response Oversight Committee.	The study philosophy is supported by four priorities: developing a values-based workforce, cultivating psychological safety, facilitating excellence in care and providing transparent accountability in providing a way forward for South Australian older persons' mental health services.	This Report may provide insight into similar processes of co-design and culture change in other service contexts.
Rice et al. (2018) Australia	Qualitative	n=25 recruited from Head Space enhanced primary care early intervention centres.		To explore the use of Headspace enhanced primary care early inter-vention centres.	Barriers found include: male role expectations; talk therapy as unknown territory; difficulties navi-gating the system and in-take processes. Facilitators include positive initial con-tact; effective cross-sector partnerships; availability of male practitioners and use of targeted messaging.	Given the ongoing low rates of help-seeking, high rates of suicide and other adverse outcomes for young men, priority research and clinical attention is needed for this group.
Rowntree and Feeney (2019) Ireland	Quantitative	n=900 Survey of outpatients attending an Irish general adult mental	Self-selecting and self-administering of survey to determine Smartphone and video game use and perceived effects in	To enhance our understanding of video and smartphone game use, and perceptions, among outpatients attending an Irish	The response rate was 13% (n = 93). Younger patients were significantly more likely to own a smartphone. Those who played videogames were	Individuals' gaming use and age did not significantly impact on whether they were positive or negative in their opinions towards video and smartphone games. None reported

		health service	a community mental health service. Ireland	general adult MHS.	significantly younger than those who did not. Younger age persons is more likely to have heard of, and used, Pokémon GO. Over 19% played video games. 24% of those with smartphone played games on it daily.	specifically using games for health reasons.
Silva et al. (2020) Portugal	National Survey	Barriers to MHS utilisation in Portugal	Data obtained from the 2009 National Mental Health Survey.	To identify barriers to MHS utilisation in Portugal.	This study identifies factors associated with non-treatment. Barriers included the need for specific mental health policies to allow greater access to MHSs and the need for interventions to support treatment and utilisation.	Even though this study identifies factors associated with non-treatment, findings providing useful evidence to develop policies and effective interventions.
Tobitt and Percival (2019) Internet survey On line	Quantitative	Digital A survey of mobile, computer and Internet use In a community mental health rehabilitation centre.	Surveys with service-users on use/non-use of technologies, and interest in technology interventions and support; and with placements on facilities and support available to service-users.	To gauge levels of engagement with mobile phones (Internet-enabled or cell phone), computers and the Internet in the specific population of CMH rehabilitation.	Levels of engagement were substantially less than those recorded in the general UK and other clinical populations: 40% regularly use mobiles, 18% computers, and 14 % the Internet. Users of all three technologies were younger than non-users. Of surveyed placements, 36% provide a communal computer and 39% IT skills sessions.	Community mental health reha bilitation service-users risk finding themselves excluded by a "digital divide". Need to action to ensure equal access to online opportunities, including healthcare innovations mentioned. Clinical and policy implications were discussed. Users of mobiles and computers were more likely to live in lower support/higher independence placements.

Table XI Ethnicity

Name/Date /Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Doré-Gauthier et al. 2019 Montreal, Canada	Intervention	Team created in Montreal, Canada	An Assertive community intervention team (IACIT).	To explore an Assertive community intervention team (ACIT) offering outreach interventions, housing support and integrated care for early psychosis and substance use disorder (SUD).	The addition of this intervention was associated with earlier housing stability and reduced total hospital days compared to early intervention (EIS) alone	Interventions for homeless youth suffering from first episode psychosis and comorbid substance use disorder (HYPS) remains under researched. A new dimension is added with this study.
Kisely et al. (2020) Queensland, Australia	Databases	*n* = 14,864 Compulsory com munity treatment included both community t reatment orders and forensic orders.	Queensland Databases searches	To investigate whether people from indigenous or culturally and linguistically diverse backgrounds were more likely to be on compulsory community treatment and to assess the impact of such treatment on service use over the following 12 months.	Findings indicate indigenous Australians and people from culturally and linguistically diverse backgrounds are more likely to be placed on compulsory community tr eatment.	The evidence for effectiveness remains inconclusive.
Morawa and Erim (2020) Germany	Mixed Methods	n=255 German native and cancer survivors.	Surveys and Interviews	To compare depressive symptoms and mental health care use in German native and cancer survivors with Turkish or Polish migration background.	Results indicate no substantial differences between migrants and native cancer survivors. High levels of migrants´ good language proficiency, long duration of stay in Germany eliminated inequalities caused by migration status in depressive symptoms and mental health care use.	These positive results indicate continuation of the services offered to migrants.

Salami et al. (2019) Alberta, Canada	Qualitative	n=53 immigrant service providers recruited from nine immigrant serving agencies in Alberta, Canada.	Focus group interviews.	To explore immigrant service providers' perceptions of access to and use of mental health services for immigrants and refugees.	Barriers to access and use of mental health services include language barriers, cultural interpretations of mental health, stigma around mental illness, and fear of negative repercussions when living with a mental illness.	Strategies to improve MHS delivery include developing community-based services, attending to financial barriers, training immigrant service providers, collaboration across sectors in MHS delivery, and advancing the role of interpreters and cultural brokers.
Stanley et al. (2018). Huston, Texas	RCT	Interventions for improved worry and generalized anxiety disorder-related (GAD) - symptoms.	Randomized, controlled study Interventions	To determine whether Calmer Life (CL) improved worry and generalized anxiety disorder-related (GAD-related) symptoms.	Worry and GAD-related symptom severity, anxiety, depression, sleep issues, trauma-related symptoms, functional status, quality of life, service use and satisfaction found. Both interventions showed similar improvements at 6 and 9 months, but some remained.	Either intervention for both areas improved worry and generalized anxiety disorder-related (GAD-related) symptoms and may be useful for low-income older adults, immigrant community based outreach and underserved older adults with identified clinical worry/anxiety.
Villani and Barry (2021) Ireland	Qualitative	(n=25 adults) Method: Interviews	Perceptions of mental health use among the Traveller community in Ireland. .	To explore Travellers' perceptions of mental health and its determinants and relevant factors for promoting positive mental health and wellbeing among Travellers in Ireland.	Travellers conceptualise mental health mostly in negative terms and show lack of awareness of the concept of positive mental health. The centrality of cultural identity and social-emotional skills emerged as key factors in promoting positive mental health among Travellers.	Community mental health promotion initiatives should focus on reducing discrimination, enhancing social and emotional wellbeing and self-esteem, improving living conditions, reducing mental health stigma and promoting Traveller culture and positive self-identity.

Table XII Medication prescribing in mental health care

Authors/Date/ Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Andersen et al. (2020) Denmark Germany USA	Multi-national randomised trial	n=693. Comparison made between the CRA-S and MET.	MET included four manualized sessions aimed at increasing motivation to change and establishing a change plan. CRA-S consisted of up to eight further optional, manualized sessions aimed at helping to implement change.	To examine whether adding the Community Reinforcement Approach for Seniors (CRA-S) to Motivational Enhancement Therapy (MET) increases the out-patient settings in Denmark, alcohol treatment centres in Germany and addiction care centres in the United States in people aged ≥ 60 years with alcohol use disorder.	Findings indicated that In older adults with an alcohol use disorder diagnosis, adding the 'community reinforcement approach for seniors' intervention to brief out-patient MET treatment did not improve drinking outcome.	Further research is indicated to determine the negative drinking outcomes found.
Gannon et al. (2020) NP	Qualitative	Patients with schizophrenia and other psychiatric disorders at a community mental health centre.	Quality Improvement project.	To undertake a quality improvement (QI) project aimed to bolster ACM de-prescription with clinically appropriate patients with schizophrenia and other psychiatric disorders at a community mental health centre.	Results suggest that de-prescription of ACM in this setting can occur with prescriber education and support. Concurrent agonist treatment is also explored.	Further exploration relating to concurrent agonist treatment may be beneficial for patients with schizophrenia and other psychiatric disorders.
Hackett and Fitzgerald (2020) Ireland	Mixed methods	One community mental health ser vice area in Ireland.	To improve and standardise metabolic screening practices in a population serving	To explore the number of people prescribed antipsychotic medication at risk of developing metabolic syndrome, in one community mental	There is evidence that many individuals are on higher doses of antipsychotic drugs than is required for optimal functioning yet there are	Guidelines on how to reduce doses of antipsychotic medication recommended.

			approximately 57, 000 people.	health service area in Ireland.	limited guidelines on how to reduce them.	
Hager et al. (2019) NP	Group Concept Mapping	Convenience Community mental health and primary care	Decision-making model bridging community mental health and primary care in medication monitoring in patients with psychiatric conditions.	To identify Group Concept Mapping engagement process between community mental health and primary care	Group Concept Mapping provides a strategic process to allow future shared decision-making among stakeholders.	This decision making model is applicable to many health systems. Engagement and coordination is also called for with substance use disorder and requires further exploration.
Hunt et al. (2019) USA	Intervention	n= 50 US States PDMP reports	All fifty states in the US have implemented PDMP. Many states mandate PDMP checks before clinicians prescribe controlled substances.	To explore a Prescription Drug Monitoring Program (PDMP) to control prescription drug abuse.	Over one third of all patients reported an addiction disorder or a diagnosis of chronic pain. Red flags were found on PDMP reports and were associated with important patient characteristics and diagnostic factors.	Prescription drug monitoring is widespread in many countries. The study explores the associations between patient characteristics and red flags found on PDMP reports and prescriber behaviour in community mental health agencies.
Iheanacho et al. (2020) NP	Evaluation	Convenience n=107	Medication-assisted treatment (MAT) training.	To evaluate the impact of a 1-day medication-assisted treatment MAT training for community mental health clinicians.	Post training indicates that a brief MAT training can increase clinicians' confidence and readiness to address SUDs and improve their understanding of the disease model of addiction.	A key limitation is clinicians' reluctance to include MAT in their routine practice. This may be due to low confidence about managing SUDs and limited awareness of the disease model of addiction. This study indicates that MAT helps to overcome this reluctance.
Jessell et al. (2020) USA	Quantitative	n= 48,679 individuals with mental disorders receiving Opioid Agonist treatment in CMHC.	Survey Data was obtained from the Registered Persons Database, Emergency Department visits, National Ambulatory Care Database	To explore the prevalence rates of prescribing benzodiazepines with a sample of individuals with and without co-occurring substance	Findings show that of those prescribed a benzodiazepine, 35 % had a co-occurring SUD and 32% had an anxiety.	These findings indicate that a considerable number of people with a documented co-occurring SUD are prescribed benzodiazepines in CMHCs, a practice that poses risks for dependence and overdose.

		Data Base	hospitalisations and using data from the Discharge Database.	abuse disorders (SUDs) in community mental health settings.		
Johnson et al. (2019) USA	Mixed methods	Three CMHTs participated n=356 patients and n=847 prescriptions.	Intervention Medicines reconciliation quality improvement in community mental health team general practice interface.	To increase the proportion of patients with no psychotropic drug discrepancies at the community mental health team general practice interface.	One CMHT improved medicines reconciliation accuracy and demonstrated significant reductions in prescribing discrepancies. One in three patients had ≥ 1 discrepancy involving 20% of prescribed. 68% of psychotropic drugs were not recorded in general practice electronic prescribing systems.	A multidisciplinary team approach to sharing and addressing prescribing discrepancies may lead to Improved prescribing accuracy and to reduce avoidable drug-related harms to patients.
Latorre et al. (2020) NP	Qualitative	Comparative study. Individuals in Community mental health centres.	Individuals with a diagnosis of schizophrenia spectrum disorder, treated in community mental health centres.	To explore the effectiveness of long-acting injectable antipsychotics (LAIs) compared to oral medications, in terms of "clinical process management.	Hospitalisation and emergency visits were significantly decreased with the use of LAIs. Planned visits were increased suggesting reduced hospitalisation rates and emergency visits.	Recommendations are that LAIs should be considered as a cost-effective treatment in the management of schizophrenia under routine conditions.
Li et al. (2020) China	Survey	Convenience n=145,860 patients, with severe mental disorders.	Measures for managing patients with mental illness in communities, in China.	To explore the association between medication adherence (MA) and disease stability (DS), and their area variations.	Findings indicate that rates of stability and adherence varied from 28–64% to 29–63%. Medication adherence was found to be positively associated with disease stability.	Large variations in the rate of DS and MA among municipalities could reflect management differences at this level that need addressing.
Morin et al. (2020)	Web streaming video	n=774 Multidisciplinary team involving	Web streaming video of medical education accredited modules	To explore the relationship between concurrent physician-	The outcomes included all-cause mortality. Findings indicate that opioid	Positive outcomes from Opioid agonist treatment and concurrent mental health

Ontario, Canada		clinical pharmacists and psychiatrists and nurse practitioners in Ontario.	and other supports provided to psychiatrists and nurse practitioners over a one-year period.	based mental health services, all-cause mortality, and acute health service use for individuals enrolled in Opioid Agonist Treatment.	agonist treatment and concurrent mental health services can improve clinical outcomes for complex patients.	services were associated with enhanced use of acute care services.
Paton et al. (2019). United Kingdom	Qualitative S	Survey Fifty-eight mental health services Submitted data on 2,172 episodes of acutely disturbed behaviour in inpatient mental health services.	QI Project initiated by the Prescribing Observatory for Mental Health and conducted in inpatient mental health services, in the United Kingdom.	A quality improvement programme addressing prescribing practice for acutely disturbed.	Benzodiazepine alone was administered in 60% of episodes where oral medication only was used and in 39% of episodes where parenteral rapid tranquillisation medicine was used, suggesting that 25% were at least 'extremely or continuously active' in the hour after rapid tranquillisation was administered.	These findings indicate that the current management of acutely disturbed behaviour with parenteral medication may fail to achieve a calming effect in up to a quarter of episodes.
Rowntree et al. (2020) Ireland	Data from Business Intelligence software	Data Bases	Data to obtain details of all psychiatric medications prescribing by the Community Mental Health Service (2005 to 2016).	To obtain details of psychiatric medications being prescribed by one Community Mental Health service in Ireland.	Olanzapine was the most commonly prescribed medication throughout but its use declined by one-quarter over the study period. Clozapine, quetiapine, aripiprazole and haloperidol prescribing increased.	This community mental health service prescribed less of the most psychiatric medications in 2016, than had been the case in 2005, despite an increase in the numbers of patients seen over the same period. It is not clear if this pattern is echoed in other services.
Steingard (2018) NP	Qualitative Outcomes and intervention	n=67 Patients at a community mental health centre	A study of 5 year outcomes with intervention	To study 5 year outcomes with individuals who received treatment at a community mental health centre and were offered the opportunity	Forty expressed interest in tapering and 27 declined. Most patients succeeded at making modest dose reductions. At 5 years, there were no significant differences in the two	One positive outcome was that patients were able to engage with professionals which did not result in widespread discontinuation of the drug.

				to gradually reduce their doses of antipsychotic drug in collaboration with the psychiatrist.	outcomes measures: rate of hospitalisation and employment status.	
Williams et al. (2021) England	Quantitative	Survey n=3,795 Inpatients with an anxiety or depressive disorder with or without a comorbid substance use disorder residing in Inpatient psychia tric wards in England.	Evidence of poorer quality of care for inpatients with anxiety and depressive disorders with comorbid substance use disorders highlights the need for more to be done to support these patients.	To review the quality of care received by inpatients with an anxiety or depressive disorder with or without a comorbid substance use disorder in patients admitted to inpatient psychiatric wards in England.	Findings indicate that 14% had a secondary diagnosis of a substance use disorder. Patients with substance use disorders were less likely to have had care plans that were developed jointly with input from both patient and clinician and less likely to have had their medication reviewed either during the admission or at follow-up after discharge.	Discrepancies in care quality may be contributed to the poor treatment outcomes experienced by patients with substance use disorders. Strategies to reduce this inequality are necessary to improve the well-being of this group.

Table XIII Intellectual Disability in mental health care

Authors/date /Country	Design	Sample	Methods	Research Aim	Findings/ Outcomes	Recommendation
Whittle et al. (2019) NPhttps://web-b-ebscohost-com.proxy.library.rcsi.ie/ehost/viewarticle/render?data=dGJyMPPp44rp2/dV0+njisfk5Ie46bNJrqe0TrCk63nn5Kx95uXxjL6orUmvpbBIsKeeTrirrlKwqJ5Zy5zyit/k8Xnh6ueH7N/iVauos1Cwp7BOt66ki+fau1Hgr6994Ku3Rd+v33urqrdO4KO2Ua+rq1C227VOta+xUbCstFju2uFF9KPxffHp63/wpq8+6tfsf7vb7D7i2LuI8e/mPvLX5VW/xKR57LOwSK+uq02vqLJKq6auSaTc7Yrr1/JV5OvqhPLb9owA&vid=53&sid=	Mixed Methods	Qualitative study Convenience	Interviews and focus groups conducted with people with intellectual disability, carers and service providers.	Barriers and enablers identified across four key dimensions of access: utilisation of services; service availability; relevance, effectiveness and access and equity and access. These factors operated at both systemic and personal levels.	Experiences of access to mental health services and insight into the ways users, carers and service providers navigate an often hostile system were determined.	Empirical evidence of anecdotal experiences of access to mental health services and insight into the ways users, carers and service providers navigate an often hostile system. Further directions for research are indicated.

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Table XIV Mental Health for LGBTQ +

Authors/Date/ Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Baams et al. (2018) USA	Survey On-line	Convenience n=25,844 college students enrolled in 76 schools, the majority being graduate students (43%) and reported as non-Hispanic White (70 %).	Use of MHS among college students by sexual orientation.	To examine differences between LGBTQ + students and heterosexual students in terms of counselling and mental health services received.	Gay males and lesbian/gay and bisexual females reported receiving more counselling from counsellors, therapists, psychologists, and/or social workers or with MHS's than heterosexual students. Bisexual males and LGBTQ females were less likely to seek help from a parent or family member compared with heterosexual males and females, respectively.	Important differences by sexual orientation in terms of seeking and receiving MHS's were found. Findings suggest that certain groups of LGBTQ students do not find support with their clergy and family, which may indicate a lack of understanding or acceptance of LGBTQ+ issues.
Brooker et al. (2019) United Kngdom	NHS England Commissioning Guidance	Community mental health teams (CMHTs), (CAMHS) or crisis teams needed.	The contribution of MHS to a new strategic direction for sexual assault and abuse services in the UK calls for clear pathways between SARC's and MHS's.	To establish if The NHS England commissioning guidance for Sexual Assault Referral Centre (SARC) is working.	Few mental health services had formally negotiated pathways with SARCs. Conversely there were several examples of good practice.	There is an important role for CCG and NHS England commissioners and the Care Quality Commission (CQC) in improving the relationships between SARCs and Mental Health Services.
Delaney and McCann (2021) Ireland	Qualitative	Convenience n=4	Interviews	To explore the personal experiences of transgender people with Irish mental health services identifying as transgender and having experienced accessing Irish mental health services.	Three themes emerged: affirmative experiences, non-affirmative experiences and clinician relationship. Lack of information and non-affirmative experiences are contributing to poor clinician–patient	Nurse managers can support a transgender-positive organisational approach to care by ensuring policies, practices and the environment are supportive of sexual and gender expression by role modelling attitudes of respect and inclusivity. Strategies need to provide appropriate, responsive

				.	relationships with transgender populations and impacting attrition.	services to transgender people so as to develop confident and knowledgeable staff.
Higgins et al. (2021) Ireland	Quantitative	Convenience n=1,064	Anonymous online survey design to LGBTQ + participants aged 14–25	To explore the barriers to accessing mental health services from the perspectives of young LGBTQ + people.	Barriers to accessing MHS's were interlinked across three levels: individual; sociocultural; and mental health system. Cultural competency training for practitioners, which address issues and concerns pertinent to LGBTQ + young people are identified.	Nurse managers can use the findings to advocate for practice and organisational change within their services and to ensure that care and support is responsive and sensitive to the particular needs of LGBTQ + young people.
Hughes et al. (2020) United Kingdom	RCT Intervention	Convenience n=22	The Respect study of a sexual health promotion intervention for people with serious mental illness (SMI). The sexual health outcom es for the intervention group changed in favour of the intervention.	To establish the acceptability and feasibility of a trial of a sexual health promotion intervention for people with SMI in the UK. .	The methods of recruitment, quality of the participant information, data collection, and intervention were deemed to be acceptable to the participants.	Retention rates and completeness of data in both groups indicate that it is acceptable and feasible to undertake a study promoting sexual health for people with serious mental health illness. A fully powered RCT is required to establish effectiveness of the intervention in adoption of safer sex in this group.
Rees et al. (2020) NP	Qualitative	Convenience n= 14 studies	Descriptive Literature Review	To identify the mental health needs of the LGBTQ+ communities and their experiences of accessing mental health care.	Findings were related to experiencing stigma and staff's lack of knowledge and understanding of LGBTQ+ people's needs. A need for mental health care that promotes the principles of equity, inclusion and respect for diversity was identified.	Services that promote health equity and self-acceptance are important for LGBTQ+ communities. Mental health nursing education needs to incorporate models that promote equity, inclusion and respect for diversity regarding this group of people.

Table XV Mental health for mother and infant

Authors/Date/country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Acri et al. (2018) USA	Quantitative	Survey Convenience Sample: n=320. Children and caregivers with depression.	Children (aged 7-11 years) and their caregivers took part.	To examine the relationships between caregiver depression and perceived barriers to treatment.	Caregiver depression is associated with adversities to the child, caregiver, and family. Caregiver depression is associated with the quantity and type of barriers to access.	The need to engage caregivers in child mental health treatment as well as their own mental health treatment to reduce the occurrence of untreated depression and its effect upon the child is recommended.
Ayres et al. (2019) Queensland, Australia	Quantitative	Survey n=218 women accessing mental health services in a hospital	Study Groupings: Women not offered a referral; Women who were offered a referral but did not engage; Women who engaged.	To identify barriers and facilitators to women accessing perinatal mental health services in a hospital.	38 % of participants did not believe themselves knowledgeable about mental illness in the perinatal period, and 15% did not recall being asked about their mental health during pregnancy. Of those who recalled being asked about their mental health 37% were offered a referral. Of these 36% accepted, and out of this group, 40% attended.	Perinatal mental health service engagement could be improved by health services by ensuring universal screening and actively engaging women in the process: assisting with childcare; improving appointment immediacy and accessibility; and educating health care professionals about their influence on women's engagement.
Brown et al. (2020) South Africa	Qualitative	Convenience n=14 key participants Clinic-level approach to mental health.	Use of Human Rights-Based mental health policy. To determine if social determinants are absent from the clinic-level approach to mental health.	To investigate barriers to accessing perinatal mental health care.	Findings indicate that physical health was prioritised over mental health at the clinic level; and there were insufficient numbers of antenatal and mental health providers to ensure	The implementation of human rights-based mental health policy has been inadequate. Lack of context-specific provider training and support has undermined the quality of mental health promotion and care.

					minimum essential levels of perinatal MHS's.	
Jankovic et al. (2020) United Kingdom	Quantitative	n=615,092 Survey	Data from two datasets from the National Commissioning Data Repository, the Acute Inpatient Dataset and Mental Health Services Dataset in the UK.	To explore access rates to secondary mental health services, including involuntary admissions to psychiatric inpatient care and patterns of engagement for ethnic minority women aged 18+ who gave birth in 2017 in the United Kingdom.	Findings indicated that out of 615,092 women who gave birth 3.5% started a contact with MHS's during the perinatal period, 3% were admitted to inpatient care (39.5% involuntarily). Ethnicity data were available for 98% of the study. Black African, Asian and White Other women had significantly lower access to CMHS's and higher percentages of involuntary admissions than White British women.	Research is needed as to why Black African, Asian and White Other women had significantly lower access to community mental health services and higher percentages of involuntary admissions than White British women.
Kapadia et al. (2018) England	Quantitative	Survey Data extraction n=2260 women	Nationally representative data from the English Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC).	To explore ethnic differences in women's usage of mental health services, and if social networks are independently associated with service use, and if the association between women's social networks and service use varies between ethnic groups.	Findings indicated that Pakistani and Bangladeshi women were less likely than White women to have used mental health services. Frequent contact with relatives helped to reduce mental health service usage.	An increase in perceived inadequate support in women's close networks was associated with increased odds of using mental health services.
Klawetter et al. (2020) USA	Intervention infant and early childhood	Low income mothers and families	Warm Connections is an innovative integrated behavioural health pr ogramme delivered	To explore if an innovative integrated behavioural health programme may reduce stress and increase	Findings suggest that Warm Connections may reduce distress and increase parenting efficacy among low-income	Integrated behavioural health approaches can improve access to health services by locating services in community-based settings routinely

	mental healt h (IECMH) framework		in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).	efficacy among low income mothers.	mothers and support further research of this programmes feasibility.	accessed by low-income families.
McDonald and Acri (2018) USA	Environment al Scanning	Convenience n= 19 agencies and n= 46 practitioners in three districts representing socioeconomicall y disadvantaged areas	Environmental scanning of 19 mental health agenci es and 46 private practitioners	To conduct an environmental scan of mental health agencies and practitioners in districts representing the most socioeconomically disadvantaged areas in Harlem, New York.	Mental health care remains largely inaccessible for mothers living in poverty, particularly if they are Spanish speaking. Information about services, wait times, and supports offered to consumers to attend was obtained.	Systems-level changes are needed in order to provide affordable, accessible treatment and reduce the risk of maternal depression upon the family.
Viveiros et al. (2018) Canada	Qualitative	Convenience n=16 Interviews	Canadian mothers who had received or were currently receiving midwifery care and self-identifying as having experienced or experiencing perinatal mental heal th concerns took part.	To explore the factors midwifery care recipients perceive to prevent or facilitate access to mental health care during the perinatal period in Canada.	Cultural values, knowledge, relationships, flexibility, and system gaps were found to hinder or facilitate access. Discharge from midwifery care at six weeks postpartum impeded care access to perinatal mental health services. Stigma, fear, broken referral pathways, distant service location, lack of number/capacity of specialised services and cost barriers were identified.	Continuity, community, and advocacy were viewed as facilitators to accessing care. Expansion of midwives' scope of practice, Information and midwives' knowledge and experience has the potential to greatly improve access. As Information and midwives' knowledge/experience were viewed as context-specific factors that could hinder or facilitate access research needs to include context in future research.

Table XVI Professionals in mental health care

Authors/Date/ Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Boland et al. (2019) Ireland	Mixed Methods	Convenience Sample of CMH teams for adults. Literature Review and National Survey.	Secondary analysis of a national survey of service users to assess their views. There is limited evidence regarding CMH teams from the perspective of service users.	To compare findings from the literature which were found to originate from a predominantly professional viewpoint.	Mental health social workers' roles are summarised as: approaches to practice, involvement, and scope of support. The presence of these features was largely not substantiated by the survey results. When nurses and social workers were compared, results were either the same for both professions or favoured nurses.	Findings point to the difficulty of articulating the social work contribution, to the limitations of the secondary data, and the need for further research to improve the understanding of the MH social work role and how it is experienced by service users. Research evidence is needed to underscore social work specific contribution and to ensure that the role is not subsumed within generic practice.
Chan et al. (2021) England	Mixed methods	n=193 Longitudinal Study	Independent accommodation for users of CMH rehabilitation team.	To investigate outcomes for users of a community rehabilitation team and service user characteristics associated with successful progress along the rehabilitation pathway.	Successful move-on by 23% of those who were residing in supported accommodation and had good functioning at transfer, while those with a serious physical health condition were less likely to achieve successful move-on.	Investment in improving functioning and physical health may facilitate successful move-on. Most supported accommodation services aim to offer time-limited support, but this is not always achieved as most service users do not progress successfully to more independent accommodation within 4 years.
Ehrlich et al. (2020) Queensland, Australia	Qualitative	Literature Review. Inter professional clinical care team	Paper explores how peer support work is constructed and how teams respond to the inclusion of peer	To explore the implementation of a newly formed community based mental health team.	Peer support workers' are able to navigate a legitimate place within care teams and bring value to the team once they establish legitimacy	Peer support workers facilitate egalitarian spaces for non-peer staff and consumers to frankly discuss the lived experience of mental illness as a carer or consumer.

			support workers as team members.		They are able to traverse the care landscape.	
Fehily et al. (2020a) Australia	Qualitative	n= 811 Survey Intervention	Participants randomised to receive usual care (preventive care in routine consultations; n = 405) or usual care plus the offer of an additional consultation with a specialist preventive care clinician (n = 406	To explore the effectiveness of offering clients an additional consultation with a specialist clinician embedded within an Australian community Mental Health service in increasing client-reported receipt of, and satisfaction with preventive care.	For each component of care, there was a significant intervention effect for at least one of the individual risk behaviours. High levels of satisfaction with preventive care ranged from 77% (assessment) to 87% (referral), with no significant differences between conditions.	The intervention had a significant effect on the provision of the majority of recommended elements of preventive care. Further research is needed to maximise its impact, including identifying strategies to increase client uptake.
Fehily et al. (2020 b) Australia	Randomised Control Trial	Professional Economic evaluation of an intervention by a specialist preventive care clinician in a community men tal health service.	RCT Participants were randomised to receive usual care or usual care plus the offer of an additional preventive care consultation with the specialist clinician.	To undertake an economic evaluation of the specialist clinician model; designed to achieve policy concordant preventive care delivery by an occupational therapist.	Clients accepted referrals to two free telephone-based chronic disease prevention services. There was a significantly greater increase from baseline to follow-up in the intervention participants accepting referrals to both telephone services, compared to usual care.	The evaluation indicates that this model of care involved a low per client cost whilst increasing key preventive care delivery outcomes. Additional modelling is required to further explore its economic benefits.
Fukui et al. (2019) United Kingdom	Mixed methods	Convenience n=186 Mental health providers. Four from two multidisciplinary teams within the same United Kingdom NHS teams.	Interviews	To examine the potential impact of supervisory support on turnover intention and actual turnover.	Increased supervisory support was associated with lower turnover intention 6 months later and reduced actual turnover 12 months later. All participants emphasised the stressful nature of their role, yet coping strategies were evident.	Supervisory support is an important role for direct supervisors in attending to care providers' emotional support needs, which may reduce turnover intention and actual turnover.

Hall et al. (2021) Australia	Quantitative	n=537 Pharmacist activities observed by consumers and perceived role/s of pharmacy staff.	Survey method Consumer perceptions of community pharmacy based promotion of mental health and well-being.	To explore consumer opinions of mental health (MH) promotion in the community pharmacy setting.	Pharmacy was viewed as a suitable environment for this promotion by 25% and linked to national campaigns particularly those with lived experience by 33%. Lack of privacy and busy pharmacy environment seen as barriers.	There is a clear potential for mental health promotion within community pharmacies. These findings highlight a missed opportunity for pharmacists to engage with consumers about MH and well-being, even though community pharmacies are accessible health care destinations.
Isobel et al. (2021) Australia	Qualitative	n = 64 clinicians n = 9 senior managers	Potential for implementation of Trauma Informed Care into mental health services.	To explore the potential for implementation of Trauma Informed Care into MHS's and presents the perspectives of clinicians and senior managers.	Managers need leadership, access to resources, relevant and accessible training and support for staff. Resolution of wider systems issues and clarification of the concept and actions of TIC in order to be trauma informed were identified.	The findings have implications for any service, team or individual seeking to implement TIC within mental health.
Jørgensen et al. (2020) Six European countries	Qualitative	Convenience n=20 Hospital mental healthcare and community mental healthcare sectors.	Interviews with Healthcare professionals and service users.	To explore healthcare professionals' and users' experience of coherent inter-sectoral care occurring between hospital mental healthcare and community mental healthcare.	Findings point to healthcare professionals experiencing barriers such as a lack of common language, not feeling involved and lacking coherence in their processes.	Findings indicate the need for better management practice, support, training and supervision of staff as the foundations of safe practice.
Kellett et al. (2020) NP	Qualitative	n=33 Community psychiatric nurses and n=193 adults	Standard nursing care model and cognitive behavioural therapy intervention.	To explore the application of a community mental health nursing (CMHN) model to improve the life skills	Findings show that there was a significant difference before and after the implementation of the intervention.	CMH Nursing models using CMH Nursing CBT interventions can be used to improve life skills and work productivity of people with schizophrenia to

		CMH Nursing Model and CBT Intervention.		and work productivity of adult people with schizophrenia.		strengthen the ability to live in the community.
Kim et al. (2018) NP	Evidence Based Practices Multi-level Model	Multiple EBP interventions with clinicians and children in CAMHS.	Sustainment phase of a system-driven implementation of multiple EBPs delivered in children's mental hea lth services.	To identify correlates of therapist emotional exhaustion, a key aspect of burnout, during the sustainment phase of a system-driven implementation of multiple EBPs.	Indices of organisational climate were unrelated to exhaustion. Therapists' work hours, caseload, number of EBP's delivered were associated with increased emotional exhaustion. Activities associated with EBP implementation (e.g., hours spent in EBP-related activities, supervision or consultation, or outcome monitoring), were not associated with emotional exhaustion.	Therapists' knowledge and confidence delivering EBPs and their positive perceptions of EBPs were protective against emotional exhaustion, but these perceptions did not buffer the risks associated with heavy workload. Staff workload needs to be addressed by organisations.
Maddox et al. (2020) USA	Qualitative	Convenience n=22 autistic adults with MHC experience n=44 CMH clinicians, n=11 CMH agency leaders.	Focus groups Interviews to explore perspectives from clinicians, staff and autistic adults on improving CMHS for autistic adults.	To identify ways to improve CMHS's for autistic adults for treatment of their co-occurring psychiatric conditions.	All reported clinicians' limited knowledge, lack of experience, poor competence, and low confidence working with autistic adults. Disconnect between the CMH and developmental disabilities systems exist that results in autistic adults being turned away from services when they contact the MHS division and disclose their autism diagnosis during the intake process.	Further efforts are needed to train clinicians to work more effectively with autistic adults and to increase coordination between the mental health and developmental disabilities systems.

Smith et al. (2020) USA	Quantitative	(n=15,520) Data base analysis of discharges and appointment following discharge.	Survey of Inpatient psychiatric discharges.	To examine inpatient psychiatric discharges to determine associations between scheduling an outpatient mental health appointment as part of discharge planning and attending outpatient care following discharge.	OPD appointments were scheduled with a mental health provider as part of discharge planning. These patients were more likely to attend an outpatient MHS within 7 and 30 days compared to those who did not have an appointment scheduled.	This finding indicates that scheduling is an effective and low-resource discharge planning practice that should be an important target for inpatient psychiatric clinical quality measurement and improvement.

Table XVII Therapies CBT in mental health care

Authors/Date /Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Bartram and Stewart (2019) Canada and Australia.	Survey	Comparable data obtained from the Canadian Community Heal th Survey (2011-2012) and the Australian National Survey of Mental Health and Well-Being (2007).	Income-based inequity is measured by need-standardised concentration indices.	To compare income-based inequities in access to psychotherapy and other mental health services in Canada and Australia.	Utilization of psychologist services is more concentrated at higher income levels than the other provider groups in both countries, and may be more pro-rich in Canada than in Australia. The distribution of unmet need for psychotherapy was expected (as a negative indicator of access).	As psychotherapy was made universally affordable for the first time in Australia in 2006, a possible backlog effect may have driven up both service utilisation and unmet need, particularly among lower-income Australians.
Blood (2020) Australia	Group DBT	n=56 adults offered a 20-week DBT group with n=8	Group dialectical behavioural therapy (DBT)for binge-eating disorder (BED) Outcomes from a community case series. Measures of eating disorder pathology, anxiety and depression and emotion regulation were completed at the start and end of treatment and at one-month follow-up.	To explore the effectiveness of group DBT for BED in community eating disorder service.	Attrition rate was 16%. Abstinence rates (no objective binges in the previous month) were 60% at the end of treatment and 50% at follow-up. Reductions in eating disorder psychopathology (but not in mood) by end of treatment and improvements maintained at follow-up.	Group DBT is an acceptable and effective treatment for adults with BED when delivered in a routine community setting. Teaching new emotion-regulation skills, rather than changing mood per se suggested.
Chilton et al. (2019) Wales	Qualitative PEG) programme.	n=15 service users Semi-structured interviews	Interpretive phenomenological analysis. Social support and	To investigate the experiences of individuals with a range of complex mental	Outcomes included forming meaningful therapeutic relationships in countering incompatible	Findings support the use of integrated treatment programmes in mental

			therapeutic peer group facilitation. A qualitative study of an integrated group treatment for dual diagnosis service users in CMHS .	health and coexisting substance misuse problem.	environmental and situational stressors, such as self-regulatory control, self-awareness of a need for change.	health services with a dual diagnosis population group.
Crits-Christoph (2020) USA	Mixed Methods Models	n=97 Assessments of adherence and competence rated on one early session of CT.	Compensatory skills measured by Ways of Responding Commun ity Version at baseline and months 1, 2, and 5. Symptom severity evaluated using Hamilton Rating Scale for Depression at baseline &1,2 and 5 months.	To examine the association between adherence and competence in cognitive therapy (CT) techniques and change in positive compensatory skills and depressive symptoms within a CMHS.	Adherence associated with linear change in positive compensatory skills from baseline to month 5. Competence associated with positive compensatory skills. High adherence in improvements.	Results support the hypothesis that use of CT techniques is associated with change in compensatory skills in a community mental health setting.
Karaman et al. (2020) Turkey	Descriptive PSST training Comparative Study	n=22 patients receiving PSST n=21 CMHC service and n=21 control group. Followed up in Psychotic Disorders OPD Clinic as control group.	The Social Functionality Scale (SFS), Personal and Social Performance Scale (PSP) and the Positive and Negative Syndrome Scale (PANSS). Patients receiving PSST in addition to CMHC service.	To explore the effect of adjunct Psychosocial Skills Training (PSST) on social functioning for schizophrenia patients who receive service in CMHC who received routine case management and occupational therapy.	At end of follow-up period, there was a significant decrease in PANSS total scores, a significant increase in PSP and SFS total. No change in control group.	The psychiatric rehabilitation in CMHC has a positive effect on the social functioning and clinical symptoms of schizophrenic patients. Adjunct PSST to routine service seems to help relieving clinical symptoms.

Lim (2020) Korea	Non-randomized parallel controlled study.	n=47 Participants completed tasks to assess social cognition and functioning, neuro-cognition, and psychiatric symptoms before and after treatment. https://web-a-ebscohost-com.proxy.library.rcsi.ie/ehost/viewarticle/render?data=dGJyMPPp44rp2/dV0+njisfk5Ie46bNJrqe0TrCk63nn5Kx95uXxjL6orUqupbBIsKeeUbiosFKwq55Zy5zyit/k8Xnh6ueH7N/iVbCmtUu3qLZOtKmki+fau3mup+J54dviRePb4nmrquB54qO2e7apq020299+sq3ieuSqtljx2/GL5+XsheXoskiuraSE3+TlVePkpHzgs+GF4	Non-randomized parallel controlled study. Patients assigned to either the SCST + treatment as usual (TAU) group (n = 21) or the TAU only group (n = 26).	To adapt a group-based social cognitive skills training (SCST) programme and evaluate its feasibility and preliminary effects among community-dwelling individuals with schizophrenia.	Drop-out rates low in both groups (over 12 weeks). Attendance rates for SCST program high (86 %, mean sessions attended = 20.56/24 sessions). The SCST + TAU group demonstrated significant improvements in facial affect recognition, social functioning, and psychiatric symptoms compared to the TAU only group.	The adapted version of the SCST program is feasible for implementation and demonstrates promise for enhancing social cognition and functioning in Korean outpatients with schizophrenia.

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Lucid et al. (2018) Washington, USA	Questionnaires and Multilevel modelling EBT	*n* = 56 supervisors and clinicians *n* = 207	Specific EBT, Trauma-Focused Cognitive Behavioural Therapy (TF-CBT). Understanding intensity of EBT focus.	To examine factors associated with the intensity of EBT.	33% of the variance in clinician report of EBT supervision intensity clustered at the supervisor level and implementation was the only significant factor associated with EBT supervision intensity.	Implementation efforts to address the extent to which EBTs are expected, rewarded, and supported within an organisation are needed.
Maddox (2019) USA	Quantitative	n=100 clinicians.	Factors Influencing the Use of Cognitive–Behavioural Therapy with Autistic Adults: Clinicians.	To examine factors that may influence clinicians' use of CBT with autistic adults	Clinicians reported stronger intentions, more favourable attitudes greater normative pressure and higher self-efficacy to start CBT with non-autistic adults than with autistic adults. Clinicians' attitudes was predictor to begin CBT for anxiety.	Findings are valuable for designing effective, tailored implementation strategies to increase clinicians' adoption of CBT for autistic adults.
Reding (2018) NP	Qualitative EBT	n=133 Community providers. EBT introduction.	Therapies implementation in a changing landscape: Provider experiences during rapid scaling	To examine service providers' perspectives on a rapid shift to mandated evidence-	Negative responses. Comments re practice context and support uniformly negative. Comments re treatment fit	Results illustrate the intended and unintended consequences of large-scale implementation efforts on community providers, and may aid implementation

		Inductive coding process to capture themes present in qualitative feedback.	of use of evidence-based treatments.	based treatment delivery.	and therapeutic consequences more balanced. Treatment fit most commonly cited; the fit to therapist (e.g., ease of use) was predominantly positive in contrast with the fit to client (e.g., flexibility) subcategory, which was predominantly negative.	researchers and system decision makers optimise the conditions under which community providers are asked to implement evidence-based treatment.
Saha, McCarthy, and Dillon et al. (2019) South Australia	Case Report	One sample. Fortnightly PP sessions trialled for 5 months, augmenting treatment as usual.	Psychodynamic Psychotherapy (PP) for non-compliance: .Patient being administered depot medication under community treatmen t order (CTO).	To outline the use of psychodynamic psychotherapy (PP) as an adjunct to treatment as usual for addressing challenging behaviours in a patient with schizophrenia under the care of a CMHT.	Psychodynamic psychotherapy proved effective. Improved compliance and engagement. On receiving medication, mental state improved and hospitalisations decreased.	Further research could lead to a better understanding of how and in what contexts, psychodynamic therapy and psychodynamic thinking can be utilised.

Table XVIII Psychiatry of later life

Authors/Date/ Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Frank et al. (2018) Germany California	Qualitative	n=156. Older adults with mental illness	Contextual predictors (e.g. physical access, residence) and personal predictors (e.g. perceived social support, life satisfaction, openness to experience)	To explore the factors associated with older adults' attitudes towards seeking mental health services.	There are unmet needs. Female gender, urban residence, personal and vicarious experience with psychotherapy & higher perceived social support were each associated with more positive attitudes towards seeking MHS.	Designating a distinct administrative and leadership structure, enhancing and standardising outreach and documentation of unmet need, promoting training of providers and increasing service integration efforts will enhance older person care.
Knight et al. (2020) https://web-b-ebscohost-com.proxy.library.rcsi.ie/ehost/viewarticle/render?data=dGJyMPPp44rp2/dV0+njisfk5Ie46bNJrqe0TrCk63nn5Kx95uXxjL6orUmvpbBIsKeeS7irt1Kupp5Zy5zyit/k8Xnh6ueH7N/iVauos1Cwp7BOt66ki+fau1Hgr6994Ku3Rd+v33urqrdO4KO2Ua+rq1C227VOta	Qualitative Mixed Methods	N=94 Convenience Sample Older adults participated in focus groups and in-depth interviews and some by survey.	Older adults from remote, regional and urban areas returned surveys (n=23) Participants were asked to identify psychological problems, how to seek help, perceived barriers to access, support available and views of service use.	To investigate older adults' access to mental health services.	Inner regional older adults reported more access problems than urban or outer regional participants. Older adults have a good understanding of mental health disciplines and were able to identify depression and substance abuse but had difficulty recognising anxiety, when to seek help. Self-sufficiency was implicated as a psychological barrier to accessibility.	Barriers need to be considered by all professionals working with older adults, in particular GP's who were identified as expert health advisors. Using a decision framework of recognizing psychological problems, deciding to seek help, and choice of help are recommended.

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McKellar et al. (2020) South Australia	Mixed Methods	Co-design process involving literature review, gallery walks and focus groups. Under Governance of the Oakden Response Oversight Committee.	Co-designed framework for organisational culture reform Responding to the Oakden Report. Working group set up.	To provide a way forward for South Australian older persons' mental health services after The Oakden Report.	The working group developed a framework as a blueprint for organisational culture reform built around a central philosophy of compassionate relationship-centred care, supported by four priorities: values-based workforce, psychological safety, facilitating excellence in care and providing transparent accountability.	Findings may provide insight into similar processes of co-design and culture change in other service contexts. The Oakden Report documented failures in governance, clinical practice and organisational culture occurring at the Oakden Older Persons' MHS which drew national attention to the care of older people with complex clinical needs and which leads the way in older person care.
Yamada et al. (2020)	Qualitative	N=2,050 Data bases	Secondary analysis of data collected in a	To describe the attitudes of individuals	Eighty per cent agreed spirituality was important	Mental health service recipients who currently find spiritual

California		Convenience Descriptive analysis. A multiple regression model was conducted to identify predictors of interest in integrating spirituality into mental healt h care.	2009 grassroots initiative generated survey used to explore the Integrating spirituality and mental health perspectives of adults receiving public mental health services.	receiving mental health services in California, regarding spirituality.	and spiritual practices helpful to their mental health. Prayer (73%), meditation (47%), attending religious services (40%), spending time in nature (41%) and reading sacred texts or spiritual self-help books (36%) were also important.	practices to be helpful are particularly receptive to integration of their spirituality into recovery and wellness programmes.
Yun et al. (2020) South Korea	Survey	Convenience Intervention n=254	Screening Questionnaire BS4MI-elderly for common mental illne sses of the elderly, that covers dementia, depressive disorder sleep issue.	To assess a comprehensive screening questionnaire termed BS4MI-elderly, for common mental illnesses of the elderly.	This comprehensive screening tool could be a useful instrument for screening the elderly thus enhancing their satisfaction with mental health services.	Screening interventions for early detection and proper management of mental illness can help to prevent severe deterioration. Due to limited resources choices may have to be made.

Table XIX Wellness and wellbeing

Authors/Date /Country	Design	Sample	Methods	Aim	Findings/Outcomes	Recommendations
Chiang et al. (2020) Hong Kong	Qualitative	n=37 Data collected through individual semi-structured interviews including people discharged from an Integrated Com munity Centre of Mental Wellness, their family and staff members.	A qualitative approach with an interpretative phenomenological analysis was utilized for this study. .	To explore the community life experiences of people after their discharge from the ICMHS.	Timely support, family presence, support to family members in the community and better social networks were key experiences of ICMHS clients. Six themes found "timely support," "family presence," "better family relationships," "expanding social networks," "letting go" and "better self-efficacy and self-care," "timely support" and "family presence." People who had received the services of ICMHS continued to engage in more social activities.	The study provides a more comprehensive understanding of the experiences of clients, family and staff about the community life of people post-ICMHS, providing insights and clearer directions for research and practice development. Better promotion is needed for the public to realise the services and to support mental health clients.
Frawley et al. (2019) Ireland	Mixed methods	n=54 Questionnaire participants at a national training programme to support the engagement of service users, their families and carers in MHSs.	A participant exit survey, Using the Student Assessment of Learning Gains (SALG) instrument. Used SPSS version 24 software and applied directed content analysis to the narrative. Participants identified training topics of importance to them, what they learnt and what helped their learning.	To evaluate a PPI training programme across nine regional administrative units in a national mental health service.	A total of 54 participants yielding a response rate of 60%. Mean SALG score yielded was 3.97 indicating very good to excellent learning gains from the programme. Narrative comments indicated an overall positive experience but also that all stakeholders should work together to co-produce the training.	The evaluation of the training programme to support the roll-out of this initiative offers lessons to others who may wish to pursue similar structures in other jurisdictions. Relevance statement mental health engagem ent and PPI are key principles underpinning modern mental health services. This paper discusses the evaluation of a PPI training programme and offers practical insights as to how such initiatives can be implemented.

Kinnafick et al. (2018) United Kingdom	Qualitative	n=11 healthcare assistants from a large UK-based secure mental health hospital.	Qualitative semi-structured interviews. Thematic analysis was used to analyse the data.	To explore healthcare assistants' perceptions of exercise and their attitudes to exercise promotion for adult patients in a secure mental health hospital.	Themes found: Exercise is multi-beneficial to patients. Perceived barriers to effective exercise promotion. Strategies for effectives exercise promotion. Healthcare assistants considered exercise to hold patient benefits. Core organisational and individual barriers limited healthcare assistants' exercise promotion efforts. An informal approach to exercise promotion deemed most effective to some, whereas others committed to more formal strategies including compulsory sessions.	Healthcare assistants are intimately involved in the daily lives of patients and should be considered integral to exercise promotion in secure mental health settings. With education and organisational support, healthcare assistants can identify individual needs for exercise promotion leading to efficient person-sensitive interventions.
Lara-Cabrera et al. (2020) Norway	Systematic Review	Protocol for a systematic psychometric review In mental health settings	Review protocol is registered in the International Prospective Register for Systematic Reviews. Main bibliographic databases searched. Psychometric properties will be evaluated according to the Consensus-based Standards for the Selection of Health Measurements Instruments.	To synthesise evidence of the psychometric properties of the Five-item World Health Organization Well-being Index in mental health settings and critically appraise the methodologies of the included studies.	Results of this psychometric review will synthesise the psychometric properties of the Five-item World Health Organization Well-being Index in mental health settings and identify possible gaps in the literature regarding methodological quality and its reliability, validity, and responsiveness to change.	Well-being Index is an increasingly used patient-reported outcome measure. It is simple to collect, free to use, and consists of five questions using positive health statements. There is a need to summarise the existing evidence of the psychometric properties of this questionnaire. The proposed study's findings will contribute to future research for midwives and nurses in different settings to pick an effective, appropriate questionnaire to evaluate patient well-being.

McCaffrey (2017) USA	Qualitative	n=6 service users Evaluating music therapy in adult mental health services. Tuning into service user perspectives.	Semi-structured interviews to describe lived experience of attending music therapy sessions. Interpretative phenomenological analysis. Interview transcripts were analysed. https://web-b-ebscohost-com.proxy.library.rcsi.ie/ehost/viewarticle/render?data=dGJyMPPp44rp2/dV0+njisfk5Ie46bNJrqe0TrCk63nn5Kx95uXxjL6orUmvpbBIsKeeS7irt1Kupp5Zy5zyit/k8Xnh6ueH7N/iVauos1Cwp7BOt66ki+fau1Hgr6994Ku3Rd+v33urqrdO4KO2Ua+rq1C227VOta+xUbCstFju2uFF9KPxffHp63/wpq8+6tfsf7vb7D7i2LuK+N6kjN/du1nMnN+Gu6ewTrentVGwqqR+7ejrefKz5I3q4vJ99uoA&vid=21&sid=9b91eb59-a9ac-496b-	To furnish holistic descriptions of practice so as to augment existing understanding of what may be afforded to those who attend music therapy sessions.	Six themes found. “Music therapy offers an opportunity to be meaningfully occupied”, “Involvement in music therapy can pose challenges”, “Music therapy offers an agreeable process”, “Group music therapy fosters reciprocity”, “Music therapy is flexible and adaptable” and “Lack of musical instruction can cause frustration”.	Findings relating to meaningful occupation, challenge, reciprocity and frustration extend understanding of what music therapy can offer to service users in mental health provision.

			8915-88e767939266@pdc-v-sessmgr01 .			
Stamboglis, et al. (2020) England	Quantitative	Survey Analysis based on patient-level responses from the community mental health s urvey, which is run annually by the Care Quality Commission (CQC) (2010 - 2013).	Repeated cross-section analysis, identifying factors associated with patient satisfaction via a multi-level ordered probit model, including both patient- and provider-level variables. Hospital-specific effects via empirical Bayes estimation identified.	To explore the key factors associated with patient satisfaction with CMHS's in England. Compared providers' performance on patient satisfaction.	Patient characteristics such as older age, being employed, and being able to work, are associated with higher satisfaction. Being female, service contact length, time since last visit, condition severity and admission to a mental health institution were associated with lower satisfaction. Treatment type affects satisfaction, with patients receiving talking therapies or being prescribed medications being more satisfied.	This study identifies the need for service integration, with patients experiencing financial, accommodation, or physical health needs being less satisfied. At a provider level a negative association between the percentage of occupied beds and satisfaction was identified. Having a care plan is associated with higher satisfaction. Seeing a health professional closer to the community improves satisfaction, with patients seeing a community-psychiatric nurse, a social worker or a mental-health support worker being more satisfied.

30. Appendix II: PESTLE

Table XX PESTLE analysis concepts comparison: MHC Framework (2007)

Australian Framework (2017)	**MHC Framework (2007)**	**MHC Framework(2022) What is required**	**Australian Framework (2014)**	**MHC (2007)**	**MHC (2022) What is required**	**Australian Framework (2014)**	**MHC Framework (2007)**	**MHC Framework (2022) What is required**
Domain 1: PESTLE-Service culture-Social, Culture, feel valued-safe Communication-promotes hope and optimism	√ √ √ √	√ √ √ √	**Domain 2-** Person centred-Holistic-responsiveness to ethnic minorities, responsive to refugees and immigrants, responsive to gender, age, culture, spirituality, diversity, responsive to LGB+, responsive to families, carers and support.	√ √ √ √	√ √ √ √ √ √ √ √ √ √ √ √	**Domain 3**- Supports Personal Recovery-promoting autonomy and self-preservation-focusing on strengths and personal responsibility, collaborative relationships and reflective practice.	√ √ √ √ √	√ √ √ √ √ √ √

Domain 4- Organisational commitment – Workforce development and planning-recovery promoting partnerships-- commitment-culture-valuing.	√ √	√ √ √ √ √	**Domain 5**- Social inclusion-social determinants of health-Mental health and wellbeing-Advocacy-challenging Stigma and discriminatio n-partnerships with communities.	√ √ √ √ √ √ √ √	√ √ √ √ √ √ √ √ √			

PESTLE analysis comparisons with MHC Quality Framework (2007) Ireland and Australian Framework (2014)

Table XXI Quality in mental health: MHC (2007) definition of quality

MHC 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 people who 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.

MHC Quality Framework (2007)

Table XXII PESTLE Analysis- Recommendations for MHC Framework

Political, Organisational and Service User Factors	**Environmental Factors**	**Social Factors**
Additional Political, Organisational and Service Users Factors are directly related to mental health and obtained from the current evidence review. Recommended for inclusion in new framework (2022). • Organisational services • Structure • Corporate Governance • Service planning • Service users • Community based services • Clinical processes • Therapeutic environment • Detection • Interventions • Advocacy • Outcomes and interventions Relevant Factors from PESTLE will also be included in the new framework.	Additional Environmental Factors are directly related to mental health and obtained from the current evidence review. Recommended for inclusion in new framework (2022) • Hygiene processes • Health and Safety • Corporate Social Responsibility • Sustainability • Nutrition • Storage standards • Customs, Norms and Values • Barriers to access Relevant Factors from PESTLE will also be included in the new framework.	Additional Social Factors are directly related to mental health and obtained from the current evidence review. Recommended for inclusion in new framework (2022) • Recovery • Health Promotion • Lifestyles • Health consciousness • Ethical concerns • Cultural Norms and Values • Sex roles and distribution • Religion and Beliefs • Racial Equality • Birth Control • Education level • Minorities • Crime levels • Leisure time • Product quality • Customer Service, • Non-national people • Suicide Relevant Factors from PESTLE will also be included.
Technology	**Legislation/Laws**	**Economic**
Additional Technology Factors are directly related to mental health and obtained from the current evidence review. Recommended for inclusion in new framework (2022) • Innovative mobile digital care pathway tools	Additional Legislation/Laws Factors directly related to mental health and obtained from the current evidence review. Recommended for inclusion in new framework (2022). • MHC • Codes of Practice • Evidence Based Practice	Additional Economic Factors directly related to mental health and obtained from the current evidence review. Recommended for inclusion in the new framework (2022). • Quality focused • Quality based service • Quality based care

• Use of social media, Smart phone apps, SMS reminders • Video games • Video conferencing • Photo Voice Relevant Factors from PESTLE will also be included.	• Consumer Rights • Evidence Based Practice • LGBDQ+ • GDPR • Equality • Laws relating to ethics and governance • Rights • Forensics Relevant Factors from PESTLE will also be included	• Quality focused medication management Relevant Factors from PESTLE will also be included.

MHC Quality Framework -Proposed Factors for Inclusion in 2022 Framework

Table XXIII: PESTLE Analysis MHC Quality Framework (2007) Summary of Factors

Pestle Analysis Political No 1

The Quality Framework Standards (2007) were analysed from the perspective of Political Factors. These Standards from PESTLE include community based services, prevention, detection and intervention and promotion, therapeutic interventions, clinical processes, therapeutic community environment, advocacy, empowering and paediatric supports and outcomes, service planning, outcomes and communications and support. PESTLE Concepts No 1 relate to Political, Organisations and Service Users Government Policy and include Political Stability Foreign trade Labour law, Tax policies, Freedom of press, Government regulation and deregulation, Political action committees, Government involvement in trade unions and agreements, Voter participation rates, Amount of government protests, Level of government subsidies, Lobbying activities and Size of government budgets. The majority of Political Factors identified in the PESTLE Model are relevant to mental health. Those Political Factors directly related to mental health are presented in Table XX111.

PESTLE Environmental Factors Analysis No 2

The Quality Framework Standards (2007) were analysed from the perspective of Nutrition and Storage**.** These Factors from PESTLE Climate change, Environmental policies, Nutritional Policies, Storage Processes, Pressures from NGO, Natural disasters, Air and water pollution, Recycling standards, Attitudes towards green products, Support for renewable energy and Carbon Footprint. Those Factors directly related to mental health are presented in Table XX111.

PESTLE SOCIAL Factors Analysis No 3:

The Quality Framework Standards (2007) were analysed from the perspective of Social Factors**.** These Standards from PESTLE include Birth rates, Death rates, Number of marriages, Number of divorces, Immigration and emigration rates, Life expectancy rates, Age distribution, Wealth distribution, Social classes, Per capita income, Family size and structure, Buying habits, Attitudes towards government, work, saving, Investing and retirement. Those Factors directly related to mental health are presented in Table XX111.

PESTLE Technological Factors Analysis No 4:

The Quality Framework Standards (2007) were analysed from the perspective of Technology Factors. These Standards from PESTLE include: Technology incentives, Automation, R&D activity, Technological change, Access to new technology, Level of innovation, Technological awareness and Internet infrastructure, Communication infrastructure,

Life cycle of technology. The majority of Technological Factors identified in the PESTLE Model are relevant to mental health. Those Factors directly related to mental health are presented in Table XX111.

PESTLE Legislation Factors Analysis No 5

The Quality Framework Standards (2007) were analysed from the perspective of Legislation Factors**:** Discrimination, Employment, Antitrust, Consumer protection, Copyright & patent , Health & safety, Education , Data protection, LGBDQ+, GDPR, Equality and Laws relating to ethics and governance. The majority of Legislation Factors identified in the PESTLE Model are relevant to mental health. Those Factors directly related to mental health are presented in Table XX111.

PESTLE Economic Factors Analysis No 6:

The Quality Framework Standards (2007) were analysed from the perspective of Economic Factors**:** Economic growth, Quality Focused approaches to service delivery, Funding availability, Employment rates, Growth rate, Interest rate, Inflation rate, Exchange rate, Credit availability, Level of disposable income, Propensity of people to spend, Government budget deficits and Unemployment trends. Those Factors directly related to mental health are presented in Table XX111.

(PESTLE Analysis of MHC Quality Framework 2007)

Table XXIV: Detailed PESTLE analysis of Mental Health Quality Framework (2007)
Pestle Analysis Political No 1

- The Quality Framework Standards are analysed from the perspective of political factors. These Standards include community based services, prevention, detection and intervention and promotion, therapeutic interventions, clinical processes, therapeutic community environment, advocacy, empowering and paediatric supports and outcomes, service planning, outcomes and communications and support. A discussion on Politics Factors is presented.

- **Community Based Services Standards 1,2,4**
- 1.3 Each service user receives mental health care and treatment from a community based service that addresses changing needs at various stages in the course of his/her illness and recovery process. 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, 1.3.4, 1.3.5 The service user experiences receipt of care/treatment based on his/her identified needs as documented in the individual care and treatment plan.
- 1.3.6 The mental health service monitors its performance in relation to this standard as part of a quality improvement process.
- 4.1.6 Service users are supported in exercising control over their belongings and personal space in in-patient or community residential settings.
- 4.1.9 The environment in which the service user is accessing a mental health service is appropriate to those using the service.

Prevention, Detection and Intervention & Promotion Standards

- 1.4.1, 1.4.2, 1.4.3 Service users receives mental health care and treatment from a community based service that addresses prevention, early detection, early intervention and mental health promotion.
- **Therapeutic Intervention Standards**
- 1.5 Therapeutic services and programmes to address the needs of service users are provided.
- 1.5.3 Service user recovery is facilitated by the provision of appropriate programmes based on identified needs and delivered in the most appropriate environment.
- 2.2.2 Information is communicated and re-communicated and explained if needed in a way that is easily understood by the service user. 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.

- **Clinical Processes Standards 1,2, 6**
- 2.2.1 b The MHC's rules governing the use of Electro-convulsive therapy (ECT), seclusion and mechanical means of bodily restraint and the codes of practice on the use of physical restraint in approved centres and to the admission of children are adhered to (Mental Health Act 2001).
- **Care Planning Standard:** One of the key aspects of holistic service delivery (MHC Mental 2005a, p46) 1.1 Approved centres adhere to Regulations 15, 17 and 19 -General Health (Mental Health Act 2001 (Approved Centres) Regulations 2006).
- **Individualised Care Planning 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.
- 1.1.2 The development of the individual care and treatment plan has input from service users, MDT, and family/advocate.
- 1.1.3 The Care and Treatment Plan reflects the assessed needs of the service user.
- 6.1 Families, parents and carers are empowered as team members receiving information, advice and support as appropriate at every stage of the person's illness and recovery process (MHC, 2005a, p88).
- 6.1.1, 6.1.2 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 and they receive information about the services available, how they work and how to access them, especially in a crisis.
- 6.1.3 Families/chosen advocates experience support from the MH team through an assigned member of staff and based on identified need.
- 6.1.6 Families/chosen advocates have access to the service user's key worker subject to service users' consent.

Therapeutic/community environment Standards 1, 3, 6

- **Outcomes for Child Services**
- 6.1.4, 6.1.5, 6.1.6 Specific outcome criteria for child services in place. Parents/guardians are partners in the treatment processes, receive clear information about treatment processes, follow-up and outreach services. MHS has a policy regarding the implementation of this standard and monitors its performance as part of a quality improvement process.
- **Empowering Approach Standards**
- **3.0** An empowering approach to mental health service delivery is beneficial to both people using the service and those providing it. 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, 3.1.3 Mental health services make accessible information available to service users on the care and treatment they receive.
- 3.1.4 Where necessary, service users have access to interpretation services (including sign language translators).

- **Attitudes towards service users care plan Standards**
- 1.1.4 The individual care and treatment plan is evaluated with the service user in a comprehensive and timely manner.
- 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 (MHC, 2005b) and is maintained within the service user's clinical file. Standard 1.1.6 adheres to all guidelines.

Paediatric Services Standard 3

- 3.2.4 Valid consent is obtained from service users in relation to care and treatment and the provision of confidential information.
- 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.
- 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 MHC'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 including children and those with intellectual disability by providing services that are compatible with relevant rights-based legislation.

Service Planning Standard 8

- 8.3.6 MHS has a documented quality improvement plan and associated continuous quality improvement programme, implements the quality improvement plan on an ongoing basis and regularly monitors its performance against it.
- 8.3.7 MHS 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.
- **Formal Communication Links Standard 1**
- 1.5.5 CMHS 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, 1.5.7, 1.5.8 MHS has established formal links with mainstream health services, social welfare services , Education services, housing authorities and quality improvements standards are in place.
- **Communication infrastructure** S**tandard 2**

- 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 MHS The mental health service has a policy in place regarding the implementation of this standard.
- 2.2.5 MHS monitors its performance in relation to this standard as part of a quality improvement process.
- **Integration of Services Standard 2**
- 2.3.1 MHS works with service user groups and community agencies to promote meaningful integration within local communities.
- 2.3.2 MHS works with staff to promote positive working relationships in accordance with agreed national policies/ guidelines (National Disability Authority 2001).

Outcomes Focus Standard 7

- 7.4 MHS care and treatment is outcomes-focused to improve the quality of MHS. Services need to be monitored and evaluated to establish what is working and what needs to be done differently" (MHC, 2005 a, p104).
- 7.4.1 MHS 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 MHS routinely monitors the health outcomes of service users (survey's, QoL, consultation on health status, functioning, and experiences).

Corporate Governance Standard 8

- In order to improve the quality of mental health services, it is 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, p 104).
- 8.3 Corporate governance underpins the management and delivery of the mental health service.
- 8.3.7 MHS implements a clinical governance system for improving clinical practice. This may include Risk management, Clinical audit, Education and training, Evidence-based care and treatment and Legal compliance.

PESTLE Analysis Environmental No 2

Nutrition and Storage Standard 4

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

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, 4.2.3 Service users' dietary needs are assessed, they receive a well-balanced diet that incorporates choice of menu and is available at time intervals appropriate to the service users identified needs. MHS has a policy regarding the implementation of this standard with reference reception, storage, preparation and distribution of food to prevent food borne illnesses. MHS monitors its performance in relation to this standard as part of a quality improvement process.

Environmental Factors and Policies Standard 4:
A quality physical environment 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 and on their recovery processes (Mental Health Commission, 2005a, p70).

Environmental Structures Standard 4

- 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.
- 4.1.8 MHS 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.
- **Service Users Processes Standard 4**
- 4.1.2 Service users receive care and treatment in an environment that is clean, tidy, peaceful, safe and well-maintained.
- 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.
- **Air, waste and water pollution Standard 4**
- 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.

PESTLE Analysis SOCIAL No 3

- **Educational Development Standard 7**
- 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. 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)
- **Educational Structures Standards 7**
- 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 and ethnicity, membership of the Traveller community or social class.
- **Educational Processes**
- 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, 7.1.10 The mental health service has a policy regarding the implementation of this standard and monitors as part of a quality improvement process.
- **Continuous Professional Development**
- **Rationale:** Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service.
- 7.2 The mental health service is managed and delivered by staff in receipt of planned training and continuous professional development as training is a key element in the delivery of a quality mental health service (MHC, 2005a, p98).
- 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.
- 7.2.5 The mental health service keeps an accurate record of staff training, qualifications and supervision received.
- **Education for Others**
- 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.
- 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, 7.2.8 The mental health service has a policy regarding the implementation of this standard and monitors its performance as part of a quality improvement process.
- **Lifestyles Standard 2.1**
- **Religion and Spiritual 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.
- 2.1.5 Service users experience receipt of care that respects confidentiality, privacy, autonomy and dignity.
- **Cultural Norms and Values Standard 2**
- 2.1 Service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences **Rationale**: The Mental 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).
- **Ethical concerns Standards 2**
- 2.1.1, 2.1.5, 2.1.6 When making a decision about the care and treatment of a person due regard shall be given to the need to respect the ethical values of the person to dignity and autonomy.
- 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 that are acceptable to them (Mental Health Act, 2001)
- **Health consciousness/Recovery Focus Approach** 3, 1
- 3.5.1 MHS's 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 society.
- 3.5.3 Staff are skilled in the recovery approach of the mental health service.
- 3.5.4, 3.5.5 Service users receive a mental health service in settings that foster and maintain community links and retain as much control over his/her life as possible and family/chosen advocate are involved in planning, evaluation of recovery, treatment and support services.
- 3.5.6, 3.5.7 MHS has a policy regarding the implementation, monitoring and performance of this standard (QIP).

- 1.5.3 Service user recovery is facilitated by the provision of appropriate programmes and therapeutic interventions that are based on identified needs and delivered in the most appropriate environment.
- **Health Promotion Standard 1**
- 1.4 As evident in Standards 1.4.1, 1.4.2, 1.4.3. 1.4.5 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. 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).

Technological Factors Analysis No 4

- Just one standard exists in the 2007 Framework. **Standard 8.2.5:** An agreed set of national mental health performance indicators addressing needs, inputs, processes and outcomes is developed. The indicators must meet the needs of all stakeholders for planning, evaluating and monitoring mental health services, be clearly defined, unambiguous and measurable and have clear and agreed upon data standards and format.

PESTLE Analysis Legislation No 5

- Relevant Legal factors include Mental Health Acts, immigration laws, employment laws, consumer protection, health and safety laws, copyright and patent laws. Although these factors may have some overlap with the political factors, they include more specific laws in this context such as discrimination laws, employment laws, consumer protection laws, copyright and patent laws, health and safety laws, LGBD+, GDR, equality, laws relating to ethics and governance.
- **Service user Rights Standard 2**
- The fundamental principle underpinning MHS is that the interests of service users are paramount [Section 4] and as such is adhered to (Mental Health Act 2001).
- 2.2.1 MHS complies with relevant legislation, regulations, professional standards and codes of ethics protecting and respecting the servicer user rights (Regulations 7, 8, 11, 20, 30, 31 (Approved Centres Regulations 2006).
- 2.1.5 Service users experience care that respects confidentiality, privacy, autonomy and dignity.
- **Discrimination Laws Standard 2,3**
- 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.
- 2.1.6 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 and disability, ethnicity, membership of the Travelling community or social class.

- 3.1.5 Making 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 MHS 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.
- **Employment laws: Standard 2**
- 2.2 Service user rights are adhered to.
- 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 belief.
- 2.2.1 MHS complies with relevant legislation, regulations, professional standards and codes of ethics protecting and respecting the rights of the service user.
- **Mental Health Laws: Standards 1.2.3, 1.2.4, 1.2.5, 1.2.6, 1.2.7, 1.2 8, 1.2.9**
- **MHC's** codes of practice regarding admission, transfer and discharge to an approved centre as in Section 33 (3) (e) of the Mental Health Act 2001 and communication, planning and document are adhered to.
- **Consumer Protection laws Standard 2**
- The Mental 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).
- 2.1: Respect for service users, values, beliefs and experiences.
- 2.2.1 MHC's rules governing the use of ECT, seclusion and mechanical means of bodily restraint and codes 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.
- **Equality of Status Standard 3**
- **Rational:** A quality service will accord them service users' 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)
- 3.2 Service users are empowered regarding their own care and treatment by exercising choice, rights and informed consent.
- 3.2.2, 3.2.3, 3.2.4, 3.3.5 Services are provided that are compatible with legislation In relation to service users consultation, rights, choices or alternative choices, consent.
- **Equality of Services Standard** 5

- 5.1.1 MHS ensures equality in accessing a service regardless of the service user's gender, marital status, family status, sexual orientation, religion, age, disability and 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 services available to them including access.
- **Access and Equality for Minority Groups Standard 5**
- 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.
- **Health and safety laws Standard 2**
- 2.1 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 [Mental Health Act, 2001 Section 4(3).
- 2.1.5 Service users experience receipt of care that respects confidentiality, privacy, autonomy and dignity.
- **Education laws Standard 2**
- **Data protection laws Standard 2:**
- 2.1.7 MHS has a policy in place regarding the implementation of Standard 2.
- 2.1.8 MHS monitors its performance in relation to this standard as part of a quality improvement process.
- **Peer Supports and Advocacy Standard 3**
- 3.3 Peer support/advocacy is available to service users in recovery process (MHC 2005a, p66).
- 3.3.1 Approved centres adhere to the relevant sections of Regulation 20 -Provision of clear Information to Residents, of the Mental Health Act 2001 (Approved Centres) Regulations 200A clear, accessible mechanism for participation in the delivery of MHS is available to service users and participants in the planning, implementation, evaluation and review of their own care and treatment.
- 3.4.2, 3.4.3 MHS provide a mechanism for obtaining collective feedback from service users at service/multi-disciplinary level and a mechanism for involvement, development and evaluation is in place.
- **Discrimination Laws Standard 2**
- 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.
- 2.1.6 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 and disability, and ethnicity, membership of the travelling community or social class.
- 3.1.5 Making 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 MHS 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.
- **Employment Laws: Standard** 2
- 2.2 Service user rights are adhered to.
- 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 belief.
- 2.2.1 MHS complies with relevant legislation, regulations, professional standards and codes of ethics protecting and respecting the rights of the service user.
- **Mental Health Laws: Standards** 1.2.3, 1.2.4, 1.2.5, 1.2.6, 1.2.7, 1.2 8, 1.2.9
- **MHC's** codes of practice regarding admission, transfer and discharge to an approved centre as in Section 33 (3) (e) of the Mental Health Act 2001 and communication, planning and document are adhered to.
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- **Equality of Status Standards 3**
- A quality service will accord service user's 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)
- 3.2 Service users are empowered regarding their own care and treatment by exercising choice, rights and informed consent.
- 3.2.2, 3.2.3, 3.2.4, 3.3.5 Services are provided that are compatible with legislation In relation to service users consultation, rights, choices or alternative choices and consent.
- **Equality of Services Standards 5**
- 5.1.1 MHS ensures equality in accessing a service regardless of the service user's gender, marital status, family status, sexual orientation, religion, age, disability and 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 services available to them including access.
- **Access and Equality for Minority Groups Standard 5**
- 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.
- **Health and Safety laws Standard 2**
- 2.1 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 [Mental Health Act, 2001 Section 4(3).
- 2.1.5 Service users experience receipt of care that respects confidentiality, privacy, autonomy and dignity.
- **Education laws Standard**
- **Data Protection laws Standard 2:**
- 2.1.7 MHS has a policy in place regarding the implementation of Standard 2.
- 2.1.8 MHS monitors its performance in relation to this standard as part of a quality improvement process.

Evidence Based Practice Evaluation Standard 8

8.1.1 The mental health service complies with all relevant Codes of Practice issued by the MHC under Section 33 (3) (e) of the Mental Health Act 2001.
8.1 The mental health service is delivered in accordance with evidence-based codes of practice, policies and protocols as mental health services should be striving towards evidence-based codes of practice (Mental Health Commission, 2005a, p101).
8.1.2, 8.1.3 The mental health service has evidence-based policies and protocols to underpin practice and 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.

PESTLE Analysis Economic FACTORS No 6

- Economic analysis relates mainly to economic factors some of which are relevant for the purposes of the Framework. These are budgetary, availability of funds, access to quality services and are analysed from the quality perspective**.** The Quality Framework acts as a driver for change in mental health policies, practice and structures at local, regional and national levels. The Quality Framework has budgetary implication. Funding and budgeting are the main economic and mental health service drivers for recruitment and training of staff and for delivery of services, and budgets need to be allocated to these areas, all with the emphasis on quality.

- **Quality Improvement Processes:** Stakeholders identify a seamless service as an essential component of a quality service and the MHS has a policy in place regarding the implementation of this standard as part of a quality improvement process.

Access to Quality Services: MHS is accessible to the community and is available on a 24-hour basis, seven days a week and its location is accessible both geographically and physically and monitors its performance as part of a quality improvement process.

- **Delivering a Quality Service** ensures that staff skills, expertise and morale are key quality influencers , uses proven quality and safety methods and complies with relevant legislation and regulations. Approved centres adhere to all Regulation of the Mental Health Act 2001 (Approved Centre) Regulations 2006.
- **Risk management ensures** that a whole system approach to risk in delivering quality care is in place and an effective risk management system is communicated by education and compliance. MHS staff receive training in quality and safety improvement and access to evidence based resources and MHS has a policy regarding the implementation, monitoring and performance of quality improvement initiative for adults and children.
- MHS has a documented quality improvement plan and associated continuous quality improvement programme for service planning and implements the quality improvement plan on an ongoing basis and regularly monitors its performance against it. MHS monitors its performance in relation to this standard as part of a quality improvement process.
- **Implementing Quality Improvements through Technology**
- MHS has operational plans based on the service plan which establishes timeframes, responsibilities and targets for implementation and MHS manages its budget in accordance with nationally accepted accounting practices and allocates a portion of its budget for the provision of staff development and for the participation of service users in the service. MHS, in implementing quality improvements through technology, has operational plans based on the service plan which establishes timeframes, responsibilities and targets for implementation. Recommendations include all forms of Technology pertaining to quality.