Crisis Resolution Services

Model of Care

May 2023

HSE Crisis Resolution Services, Model of Care

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Foreword

This Model of Care for Crisis Resolution Services was developed as a direct recommendation of Sharing the Vision - A Mental Health Policy for Everyone. It arose from the recognition that those experiencing mental health crisis need specialist services to provide brief intensive supports in a timely way, to assist the individual service user in their recovery journey.

The needs for this service development are increasing, with 15,723 admissions to Irish psychiatric units and hospitals in 2021 and 1% to 3% of Emergency Department attendances being mental health presentations. Self-harm, suicidal thoughts, substance misuse, anxiety/ depression, and psychotic illness are the most common mental health presentations at triage in the Emergency Department (ED) setting. Crisis Resolution Services will be central to the acute mental health care pathway.

There are two key service components in Crisis Resolution Services. The first is the development of Crisis Resolution Teams (CRTs), which will play a vital role by providing intensive treatment in the patient's home and the community, as an alternative to a hospital admission. The CRT will use the skills of the multidisciplinary team to assess the service user's needs and to develop an individual care plan that supports the individual on their recovery journey.

The second is the development of Crisis Cafés. The Café team will provide an out-of-hours friendly and supportive community crisis prevention and crisis response service, often in the evenings and at weekends in a café style/non-clinical safe environment. The Café service will support individuals and their family members/carers to deal with an immediate crisis and to plan safely drawing on their strengths, resilience and coping mechanisms to manage their mental health and well-being. This Model of Care clearly outlines the functions and operational requirements for both CRT's and Crisis Cafés, which will cater for a small group of service users with the greatest needs.

In conclusion, we would like to thank each member of the National Crisis Resolution Services Steering Group, for their dedication and commitment to this project and who worked diligently to enrich the final document with their own perspective and experience. We wish to formally acknowledge our colleagues in CHO 4 who provided valuable input to the design of the Crisis Resolution Team, through their experience of establishing crisis resolution services in recent years. We would also like to thank the project team Michelle Butler and Sinead Hardiman for their efforts in driving this work forward and for leading on the design and development of this Model of Care.

John Meehan,
HSE Assistant National Director for Mental Health Planning,
Co-Chair of the National Steering Group.

Dr. Amir Niazi,
HSE National National Clinical Lead for Mental Health,
Co-Chair of the National Steering Group.

Message from the National Director, Change and Innovation

It gives me great pleasure as the National Director for Change and Innovation to present the Model of Care for Crisis Resolution Services. This Model of Care is part of the HSE Mental Health Reform plans outlined in the National HSE Corporate Plan, aligned to the national strategic policies of Sláintecare and *'Sharing the Vision: A Mental Health Policy for Everyone'*.

This Model of Care specifically addresses the needs for people experiencing mental health Crisis, through the development of Crisis Resolution Services, consisting of two key components (i) the Crisis Resolution Team and (ii) the Crisis Café, which will be promoted as the *Solace Café*. Our vision for Crisis Resolution Services is *'To provide integrated Crisis Resolution Services to people referred with the right response at the right time for the right amount of time to enable and empower people on their recovery journey'*.

The new HSE Crisis Resolution Service Model of Care aims to provide mental health intensive supports in individuals' homes or communities as an alternative to hospital admission. This approach is important for individuals who suffer from mental difficulties for several reasons:

1. Timely and person-centred support: The model recognises that people experiencing mental health crises require specialist services that can provide brief intensive support in a timely manner. By offering support in the home or community, the model aims to respond quickly to individuals' needs and empower them on their recovery journey.

2. Avoiding hospital admission: Hospital admissions can be distressing and disruptive to individuals' lives. By providing intensive supports outside of hospital settings, the model seeks to offer an alternative response and reduce the need for inpatient admissions when appropriate. This can help individuals maintain a sense of normalcy and continuity in their daily lives.

3. Multidisciplinary team approach: Crisis Resolution Teams play a vital role in this model by delivering intensive mental health interventions and support in the patient's home and community. These teams consist of professionals from various disciplines who assess the individual's needs and develop an individual care plan tailored to support their recovery journey. This multidisciplinary approach ensures that individuals receive comprehensive and holistic care.

4.Community crisis prevention and response: Crisis Café teams, operating in a non-clinical safe environment, provide an out-of-hours service aimed at preventing crises and offering support during evenings and weekends. These teams offer a friendly and supportive space where individuals and their family members/carers can manage their mental health and well-being. The Crisis Café service emphasises effective signposting to relevant services provided by the HSE and other third-sector and statutory providers.

5. Learning and evaluation: The pilot implementation of the Crisis Resolution Service will undergo an independent evaluation over the testing phase of 18-24 months. This evaluation will help assess whether the desired outcomes are being met and inform future development of the service. By continuously learning and adapting based on the evaluation results, the HSE can improve the model and ensure it effectively meets the needs of individuals with mental difficulties.

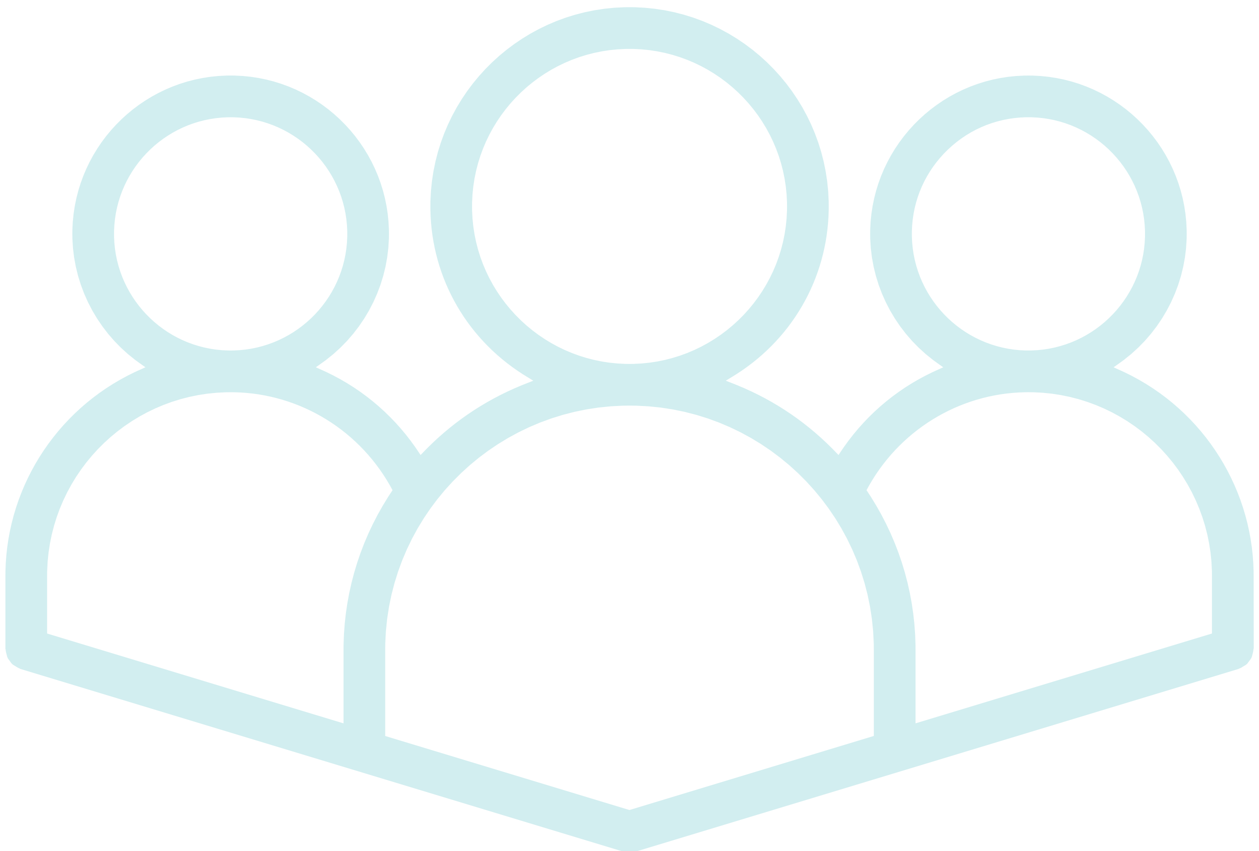
Overall, this new Model of Care for Crisis Resolution Services aims to provide more accessible and personalised support to individuals with mental health difficulties, empowering them on their recovery journey and offering an alternative to hospital admission when appropriate.

I would like to thank all members of the National Crisis Resolution Services steering group, for their commitment, insight and collaboration in the development of this Model of Care. I would like to thank my Mental Health colleagues and my change and innovation team for all their work in designing and developing this Model of Care and for supporting the learning sites in their implementation planning and delivery.

I would like to take this opportunity to acknowledge the work and commitment of the five learning site teams in accepting to co-design and to pilot implement this exciting and innovative initiative.

I would also like to express my gratitude to all the key stakeholders that we engaged with in the design and development of this initiative.

Yvonne Goff
HSE National Director, Change and Innovation



CRS National Steering Group Members

Name	Role	Representing
John Meehan	HSE AND Mental Health Planning and Head of National Office for Suicide Prevention (Joint Chairperson)	Mental Health Planning
Dr. Amir Niazi	HSE National Clinical Advisor and Group Lead (NCAGL) Mental Health (Joint Chairperson)	Mental Health Clinical Programmes
Brian Higgins	HSE AND Change and Innovation for Mental Health Services and Disability Services	National Mental Health - Change and Innovation
Dr. Karen O' Connor	National Clinical Lead, Early Intervention in Psychosis (EIP) Programme	National Clinical Programme EIP
Ned Kelly	Area Director of Nursing, National Representative	National Area Director of Nursing group
Derek Chambers	Policy Implementation Lead	National HSE Mental Health Operations
Aisling Duffy	Senior Project Manager	National HSE Mental Health Operations
Michael Ryan	Head of Mental Health Engagement and Recovery	National HSE Mental Health Operations
Daniel M Flynn	National Principal Psychology Managers Group Representative	National Principal Psychology Manager Group
Clem McLoughlin	Occupational Therapist Manager-in-Charge III	National Occupational Therapist Managers Representative
Donal O'Malley	Principal Social Worker in CH East	National Principal Social Worker Representative
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Annabel Meehan	Director of Nursing, Saint John of God Community Mental Health Services	CHO 6
Michelle Butler	General Manager, National Mental Health Change and Innovation	National HSE Mental Health - Change and Innovation
Sinéad Hardiman	Business Manager, National Mental Health Change and Innovation	National HSE Mental Health - Change and Innovation

Executive Summary

This Model of Care has been developed as an initiative of the HSE Mental Health Services. Crisis Resolution Services (CRS) in this Model of Care, have two key service components, which are interconnected and should be integrated in service delivery. The first key component is the Crisis Resolution Team and the second is the Crisis Café (Solace Café).

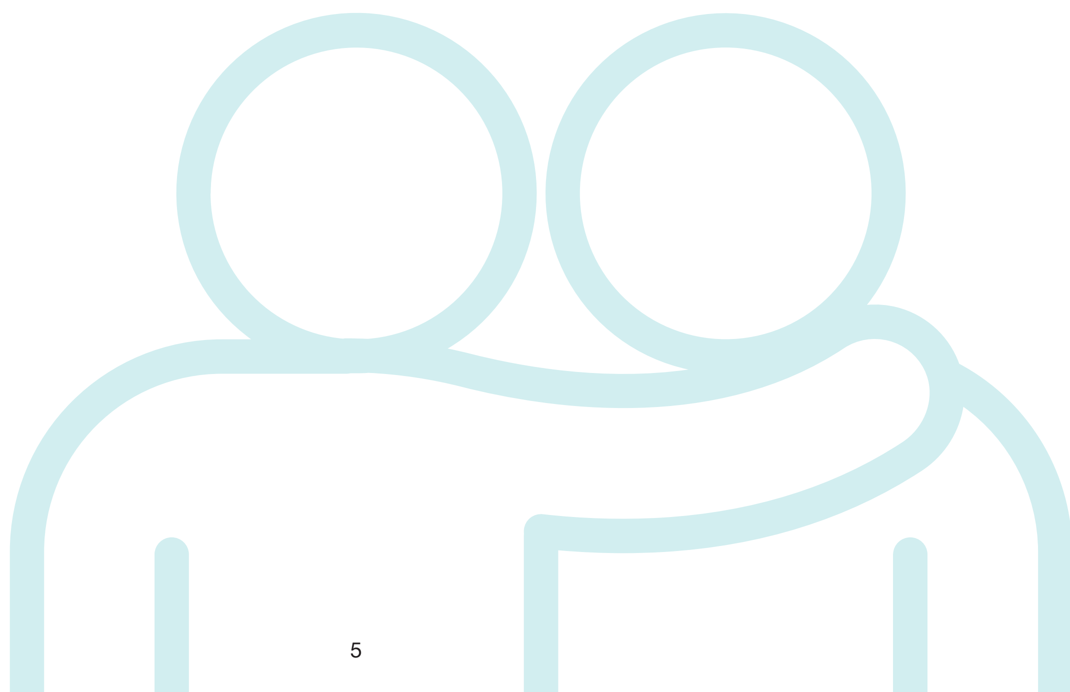
The Vision for Crisis Resolution Services is:

> ***'To provide integrated Crisis Resolution Services to people referred with the right response at the right time, for the right amount of time to enable and empower people on their recovery journey'.***

CRS are intended to be an integral part of each community Mental Health Service into the future. This Model of Care describes a service pathway that supports individuals to:

- access brief and intensive multidisciplinary, community-based assessment and treatment from the CRT when experiencing acute crisis, for which community-based or home treatment would be appropriate;
- access help through the Crisis Café (Solace Café) for people experiencing Mental Health difficulty, mental health distress or are experiencing a crisis by providing clear supports and effective signposting to services provided by the HSE and other third sector and statutory providers.

The Crisis Resolution Services, Model of Care seeks to empower and enable service users to take an active role in their care and recovery process. CRS seek to enable and support the active involvement of family, carers and significant others by working to build, increase and enhance the service user's resilience to enable them to respond to, and manage the current crisis, and any crises that may occur going forward.



Definition of Crisis

What defines crisis is individual to the person or family experiencing it, however, a crisis is also short-term. Some shared characteristics are that a mental health crisis happens when a person has a significant problem, sequence of events or significant mental health issue, resulting in them becoming emotionally overwhelmed and they are not able to cope or be in control of their situation.

Definition of Crisis Resolution Team

Crisis Resolution Teams (CRTs) are community-based multidisciplinary teams that provide rapid assessment and intensive support to individuals who are in a mental health crisis. CRTs can provide an alternative to inpatient admission in the service user's own environment and/or in a community setting, with the active involvement of service users and their family, carers and supporters, and interagency liaison with local partners. Support from these teams is time-limited, providing intensive intervention and support with sufficient flexibility to respond to different service user or carer needs for an average period of up to six weeks. The service will be service user centred and recovery-focused. Typically, this entails a range of multidisciplinary team therapeutic approaches, including medication management, psychological interventions, peer support and evidence-informed family or social interventions, utilising the person's own lived experience and strengths as much as possible. CRT's will also play a role in supporting out-of-hours Crisis Cafés.

Definition of Crisis Cafés

Crisis Café (Solace Café) provide an out-of-hours friendly and supportive community crisis prevention and crisis response service often in the evenings and at weekends in a café style/non-clinical safe environment. The Café service will support individuals and their family members/carers to deal with an immediate crisis and to plan safely drawing on their strengths, resilience and coping mechanisms to manage their mental health and well-being. Attendees can access coping strategies, one-to-one peer support, and psychosocial and recovery supports provided by paid core staff, assisted by a team of appropriately trained volunteers, working on a pro-rata basis. Those who attend will be signposted to relevant mental health and well-being services and community supports as required.

Current Mental Health Context for Development of Crisis Resolution Services

Sharing the Vision: A Mental Health Policy for Everyone notes that while people in need of support or urgent care attend Emergency Departments, significant stakeholder consultation carried out to inform policy development pointed to the need to prioritise the availability of non-Emergency Department (ED) based out of hours alternatives offering referrals to Mental Health Services.

The National Emergency Medicine Programme indicate that 1% to 3% of ED attendances are mental health presentations. Self-harm, suicidal thoughts, substance misuse, anxiety/ depression, and psychotic illness are the most common mental health presentations at triage in the ED setting[1]. Furthermore, it is estimated that one in every four adults will experience at least one diagnosable mental health difficulty in any given year[2], with the corresponding figure for children aged 5-16 being one in ten[3]. Occupancy levels in acute inpatient facilities indicate that the acute inpatient system is under considerable stress. The National Psychiatric Inpatient Reporting System (NPIRS) Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2021, reports 15,723 admissions to Irish psychiatric units and hospitals in 2021.

The organisation and delivery of HSE Mental Health Services and supports into the future, requires the development of stepped care approaches, to ensure each person can access a range of options matched to their needs. For the service user this means access to the supports needed, as close to home as possible and at the level of complexity that best corresponds to the individual's needs and circumstances.

It is envisaged that through the delivery of CRS, alternative pathways of crisis response will provide responsive and timely input required by services users, and positively impact on acute inpatient admissions, bed capacity and presentations to Emergency Departments.

Implementation of the Pilot Model of Care

This Model of Care will be tested across five learning sites incorporating a rural and urban mix. There will be an independent evaluation undertaken of the implementation of CRS over the testing phase 18-24 months, in line with the Standard Operating Procedure and the Model of Care. On completion of the mixed methods evaluation across the five CRS learning sites, the pilot Model of Care will then be reviewed and optimised by the National Steering Group for Crisis Resolution Services. Plans will then be put into place to support the mainstreaming and upscaling of CRS within HSE Mental Health Services.

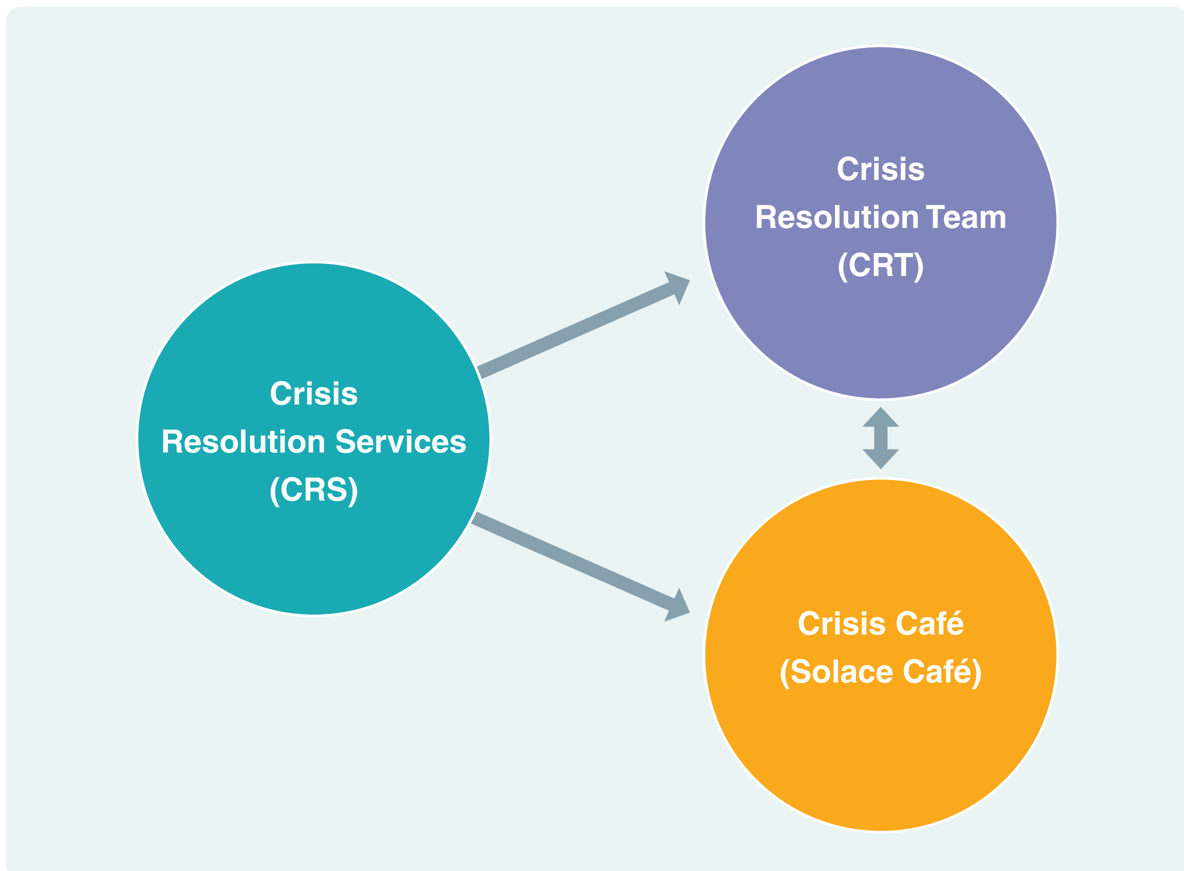
1. Doherty K, Cassidy E, McDaid F. 2020
2. World Health Organisation (2001) The World Health Report 2001. Mental Health: New Understanding, New Hope. Geneva: WHO.
3. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (Pg 4- 5)

Introduction

Model of Care for Crisis Resolution Services

This Model of Care has been designed and developed to specifically outline how Crisis Resolution Services (CRS's) for those over 18 years of age in Ireland, should be organised and integrated across health and community services. Crisis Resolution Services CRS's in this Model of Care, have two key service components, which are interconnected and should be integrated in service delivery. The first key component is the Crisis Resolution Team (CRT) and the second is the Crisis Café (Solace Café).

CRS's are intended to be an integral part of each community Mental Health Service into the future, through the provision of CRT's and out-of-hours Crisis Cafés. The development of CRS's is an important step in the journey to provide a modern, responsive and fit for purpose mental health service. It concentrates on the provision of mental health care when people need it most, in their homes rather than in hospitals, with the aspiration that these services will help to build greater resilience in our communities, contribute to the de-stigmatisation of mental health problems, and support service users in their recovery journey.



What is a Model of Care?

A Model of Care describes the way that health services are designed and delivered for a person, as they progress through the stages of a condition, injury, or event[4]. A Model of Care approach, is an approach to the design and delivery of health care services using information based on patient needs and clinical best practice, to determine how services should be organised and integrated across sectors, professions, and settings (i.e., what type of care should be delivered, where that care should be delivered, and who should deliver that care)[5]. The Models of Care approach is informed by a number of key principles: quality improvement; evidence-based practice; project management; and, change management[6].

The Purpose of this Model of Care for Crisis Resolution Services

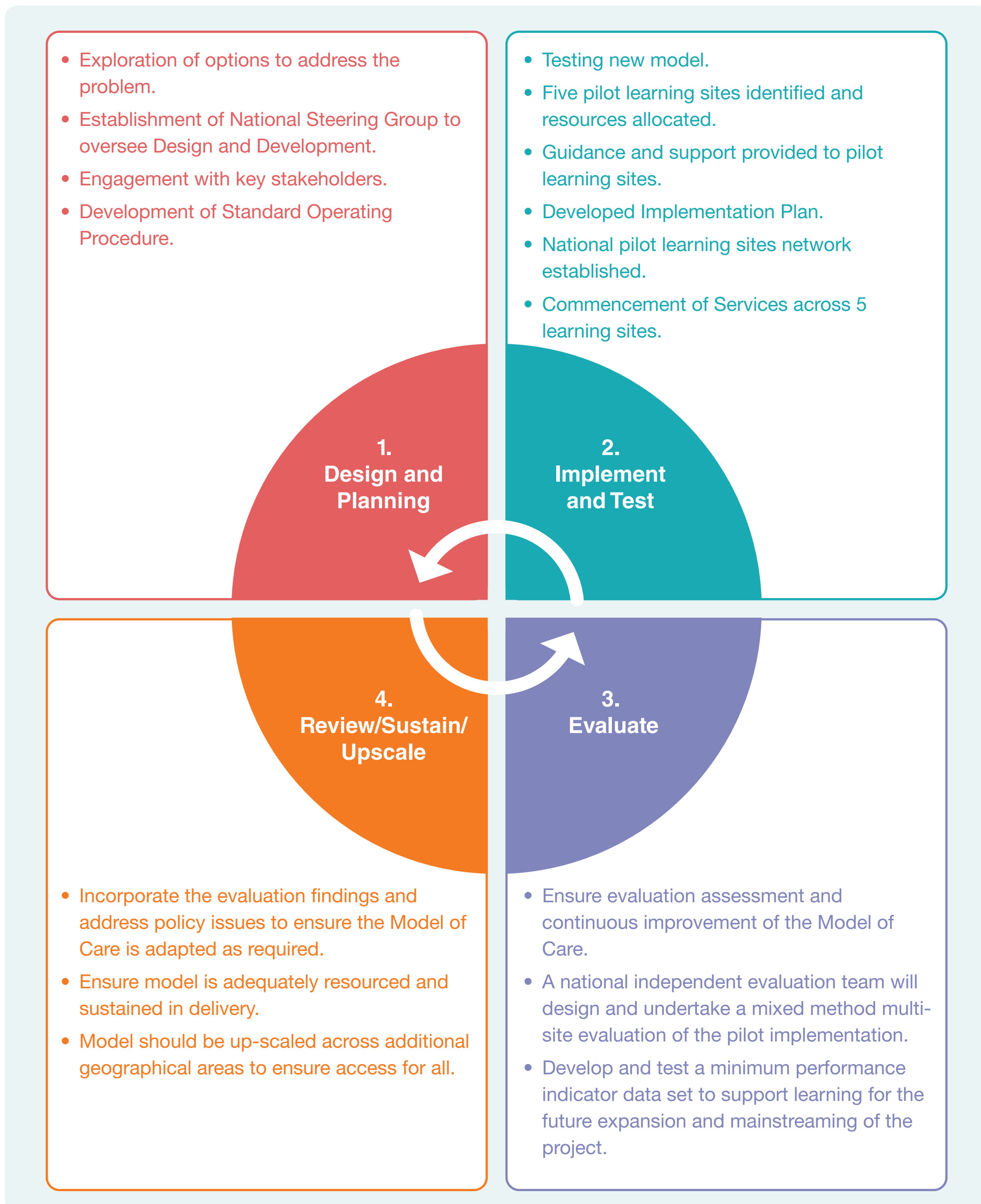
- To clearly define what we mean by CRS's, CRT's and Crisis Cafés.
- To define and explain how the specific needs of people over age 18, who are experiencing a mental health crisis are met, through the provision of specialist CRS's.
- To outline the core clinical and operational requirements for the implementation of CRT's and Crisis Café (Solace Café) in line with best practice and best evidence.
- To support the development of a comprehensive Crisis Resolution Mental Health Community-based Service across the learning sites to improve services for service users and to meet the increased demand placed on Community Mental Health Services, Acute Inpatient, Units GPs, Liaison Psychiatry and Emergency Departments.
- To ensure that the CRS meets the mental health needs of the public as much as possible in response to the needs of people experiencing a mental health crisis.
- To establish the protocols to support the development of CRS's, which ensures equity of service to all service users in crisis as required.
- To meet the requirements of the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from Approved Centre Sept 2009[7] to ensure high standards and good practices around person centeredness and recovery focus in the delivery of Crisis Resolution Mental Health Services.

4. Agency for Clinical Innovation, (2013).
5. Cancer Care Ontario's (CCO's) Models of Care program (2011).
6. Davidson et al. (2006). Beyond the rhetoric: what do we mean by a 'Model of Care'? Australian Journal of Advanced Nursing. 23(3):47-55.
7. *Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from Approved Centre Sept 2009.*

The CRS Model of Care – 4 Phase Cycle Process

The Model of Care Process applied for the Pilot Crisis Resolution Services Model of Care is informed by an implementation science approach. This process involves a 4 phase cycle for implementing new pilot models of care incorporating 1) design and planning, 2) implementation, 3) evaluation and 4) review, sustain and up-scale.

Figure 1: Crisis Resolution Services Model of Care - 4 Phase Implementation Process



Phase 1 – Design and Planning

This phase incorporated the process of exploration of options and ideas to address the need for CRS's, resulting in the development of a plan for the service delivery and the implementation of the services. The HSE Mental Health Integrated Care Team provided the initial governance and oversight required ensuring that CRS's design and development was included in the HSE Corporate Plan and the HSE National Service Plan.

Following this, a project team was assigned to undertake early exploration of the concept, review literature and facilitate engagement meetings with key stakeholders. This process informed the initial resource model, to enable incorporation into the health service estimates planning process for design, development and pilot implementation.

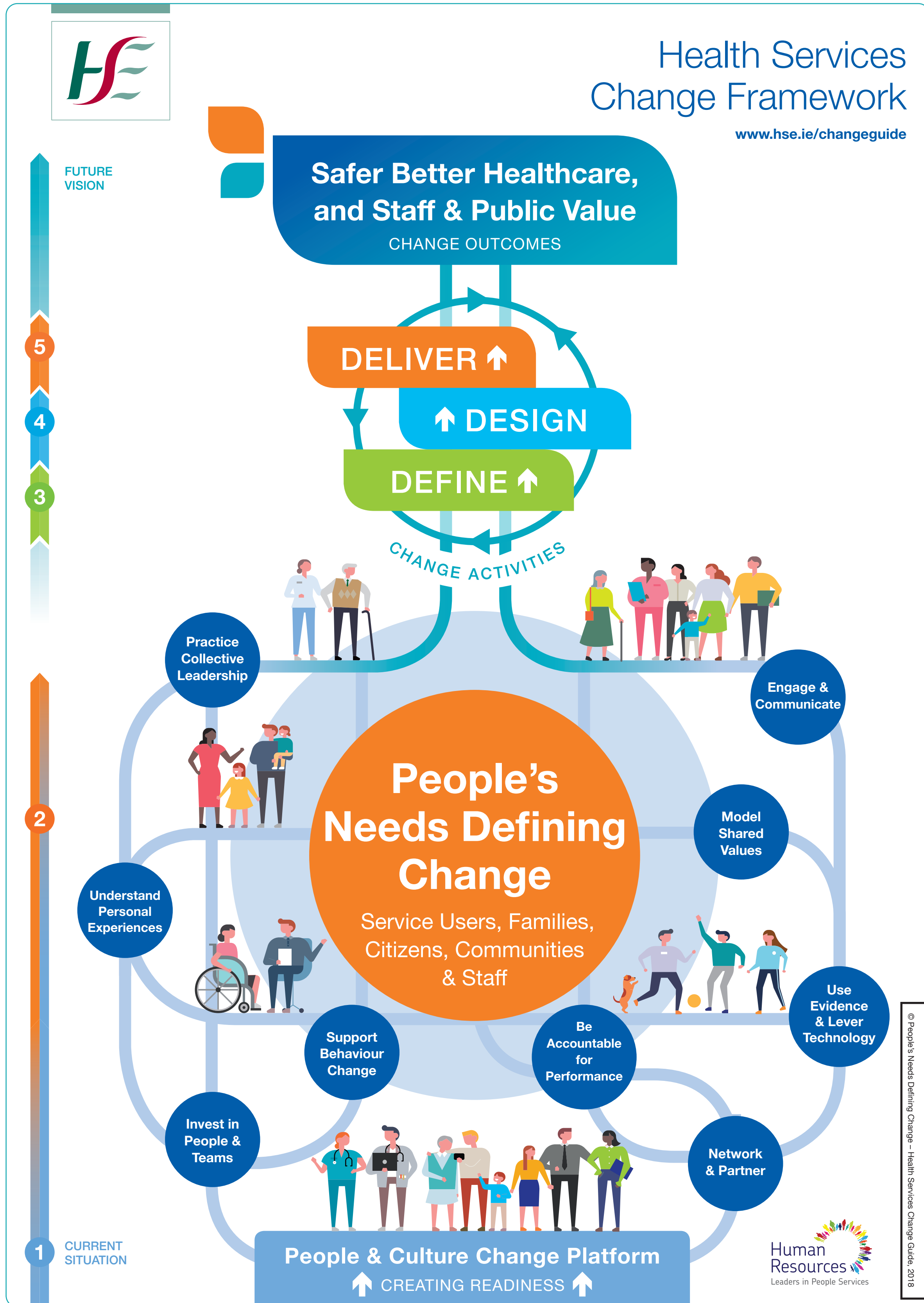
HSE Mental Health Change and Innovation led the Model of Care design, planning and development process. The National Crisis Resolution Services Steering Group was established in December 2021, to oversee the design and development of a Pilot Model of Care for CRS's to include CRT's and Crisis Café (Solace Café). Membership included representatives from each learning site, national representatives from each of the core staff disciplines aligned to CRS's, National Mental Health Clinical Programmes, Mental Health Engagement and Recovery, Mental Health Operations, Planning and Change and Innovation.

Working with key stakeholders (service users, clinicians, health and social care professionals, healthcare management and service providers) the overarching aim was to identify, design and develop this innovative new Model of Care for CRS's that are person-centred, evidence-based and high quality services. This included reviewing international evidenced based best practice and engaging with key stakeholders internationally and in Ireland who are already providing CRS's to inform the design and planning process.

The HSE Organisation Development and Change team presented the Health Services Change Framework to the National Steering Group to support them in this design and planning phase (Figure 2). Following this, two standard operating procedures were developed one for the CRT's and one for the Crisis Cafés (Solace Café) – to inform practice in line with the Model of Care and these were approved by the National Steering Group in February 2023.

More information on the core design components of both CRT's and Crisis Cafés (Solace Café) are outlined in detail in Section 4.

Figure 2: Health Services Change Framework



Phase 2 – Implement

This phase involves implementation and testing of the new Model of Care for CRS's. The first phase of implementation should primarily focus on the ecological fit between the innovation and the host setting[8]. Five learning sites were identified by the HSE Mental Health Integrated Care Team. Resources were allocated for pilot implementation of the CRS Model of care for both CRT's and Crisis Café (Solace Café). Particular consideration was given to a number of core requirements, viewed as central to the successful development of the initiative as follows.

- Demand and capacity across HSE Mental Health Services.
- Rural and urban mix of locations.
- The required resources (financial, capital, workforce) to implement CRS's on a phased basis.
- Identification of innovation champions across the system to support the development.
- Evidence within the system of readiness to implement.
- Consideration to population need across HSE Mental Health Services.
- Access to existing Mental Health Services and supports.
- A commitment to delivery and implementation of the pilot Crisis Resolution Services in their CHO area.

The delivery model for CRS learning sites is based on a population catchment area of 120,000 people. This is in line with international evidence and best practice, and available resources. All learning sites are represented on the National Crisis Resolution Services Steering Group, which meets monthly, and provides ongoing operational insight and guidance to support the implementation process, identifying key enablers and potential barriers to implementation.

A significant focus in this phase is on providing guidance and support from Mental Health Change and Innovation for learning sites to implement the new Model of Care. Terms of reference and CRS recruitment documentation have been developed for the local CHO learning site implementation teams, and detailed implementation plans provided to teams to support operationalisation and implementation of services. A National CRS Learning Sites Network has also been established to support the teams in the delivery of this new innovative service. More information on implementation of this Model of Care is outlined in Section 6.

8. Meyers et al. (2012a)

Phase 3 – Evaluate

The learning sites are commencing operations in 2023 with the aim of delivering CRS's with fidelity to the Model of Care in 2023 and 2024. This phase ensures evaluation assessment and continuous improvement of the models for CRT's and Crisis Cafés (Solace Café). A national independent evaluation team will design and undertake a mixed method multi-site evaluation of the implementation of CRS's over the testing phase 18 months in line with the Standard Operating Procedures and the Model of Care. They will also develop and test a minimum performance indicator data set to support learning for the future expansion and mainstreaming of the project. The evaluation and monitoring of the learning sites will be undertaken alongside delivery, with the final evaluation report to be completed in 2025. More information on the Monitoring and Evaluation of this Model of Care is outlined in Section 7.

Phase 4 – Review, Sustain, and Upscale

This is an important phase of the implementation process as it involves the key steps to be taken to review, sustain and upscale the delivery of the Crisis Resolution Services Model of Care to ensure all geographical areas are resourced to deliver this Model of Care.

Step 1: Completion of mixed methods evaluation across the five learning sites.

Step 2: National Steering Group to review the evaluation findings to inform what outcomes were achieved and where improvements or changes to the Model of Care are required.

Step 3: The pilot Model of Care will then be reviewed and optimised by the CRS National Steering Group.

Step 4: Ensure alignment with National Policy and Strategy and to address any arising policy issues from delivery to ensure that the final Model of Care will work as effectively as possible.

Step 5: Develop a CRS resourcing strategy to support the mainstreaming and upscaling of CRS within HSE Mental Health Services.

Step 6: Plan to incrementally scale up the delivery of CRS across additional geographical areas to ensure access for all.

Step 7: Secure resources for delivery in line with a revised Model of Care.

More information on the Review, Sustain and Upscale for this Model of Care is outlined in Section 8.

CRS Model of Care Design and Developmental Timeline 2021 to April 2023

Implementation of new innovative and evidence-based approaches to service delivery are estimated to take two to four years. Our Implementation journey began in 2021. Figure 3 outlines the progress achieved in the design and development of the CRS Model of Care from January 2021 to April 2023.

Figure 3: CRS Model of Care Design and Development Timeline

May 2022

- National Steering Group review first draft of the CRS Standard Operating Procedure.
- CRT Recruitment resources provided to pilot implementation teams.

June 2022

- Learning sites progressing local plans.

July 2022

- National Steering Group review second and third draft of the CRS Standard Operating Procedure.
- National Steering Group review Café branding options.
- Learning sites progressing local plans.

August 2022

- National Steering Group subgroup established to further progress the Crisis Café Standard Operating Procedure.
- Learning sites progressing local plans.

September 2022

- National Steering Group review fourth draft of the CRS Standard Operating Procedure.
- National Steering Group approve the CRT Standard Operating Procedure.
- Learning sites progressing local plans.

October 2022

- Learning sites progressing local plans.

November 2022

- National Steering Group review of draft of the CRS Standard Operating Procedure.
- Learning sites progressing local plans.
- Stakeholder Consultation and Engagement.

December 2022

- Learning sites progressing local plans.
- Stakeholder Consultation and Engagement on CRS.

January 2023

- Learning sites progressing local plans.
- Implementation support resources provided to pilot implementation teams.
- Learning Site implementation plans developed.

February 2023

- Learning sites progressing local plans.
- Standard Operating Procedure for Crisis Cafés approved by National Steering Group.
- 1st CRS National Learning Site Network meeting held.
- Branding for Crisis Café agreed by National Steering Group – Solace Café.

March 2023

- National CRS Data subgroup established.
- Learning sites progressing local plans.
- Crisis Café – Solace recruitment resources provided to pilot implementation teams.

April 2023

- CRS Model of Care approved by National Steering Group.

May 2023

- External evaluation consultants appointed.
- Learning site teams commence implementation of services.

Section 1

National Strategy and Policy Context to Crisis Resolution Services

National Strategy and Policy Context to Crisis Resolution Services

Government strategy and policy guides and directs the reform of health policies. The three primary strategies informing this Model of Care are Sláintecare, Sharing the Vision – A Mental Health Policy for Everyone and Connecting for Life - Ireland's National Strategy to Reduce Suicide. This Model of Care for CRS was developed as a direct recommendation of Sharing the Vision – A Mental Health Policy for Everyone. It arose from the recognition that those experiencing mental health crisis require specialist services to provide brief person-centred intensive supports in a timely way to assist the service user in their recovery journey, and to seek to offer an alternative response to inpatient admission, when appropriate. This Model of Care for CRS is also part of the HSE and Sláintecare mental health reform plans, which are incorporated in the National HSE Corporate Plan and are resourced under the HSE National Service Plan.

Figure 4: Strategy and Policy Guiding the Reform of Mental Health Services

1.1 Sláintecare

Sláintecare is the ten-year all Government programme to transform how we deliver our health and social care services in Ireland, building towards equal access to services for every citizen based on patient need and not their ability to pay.

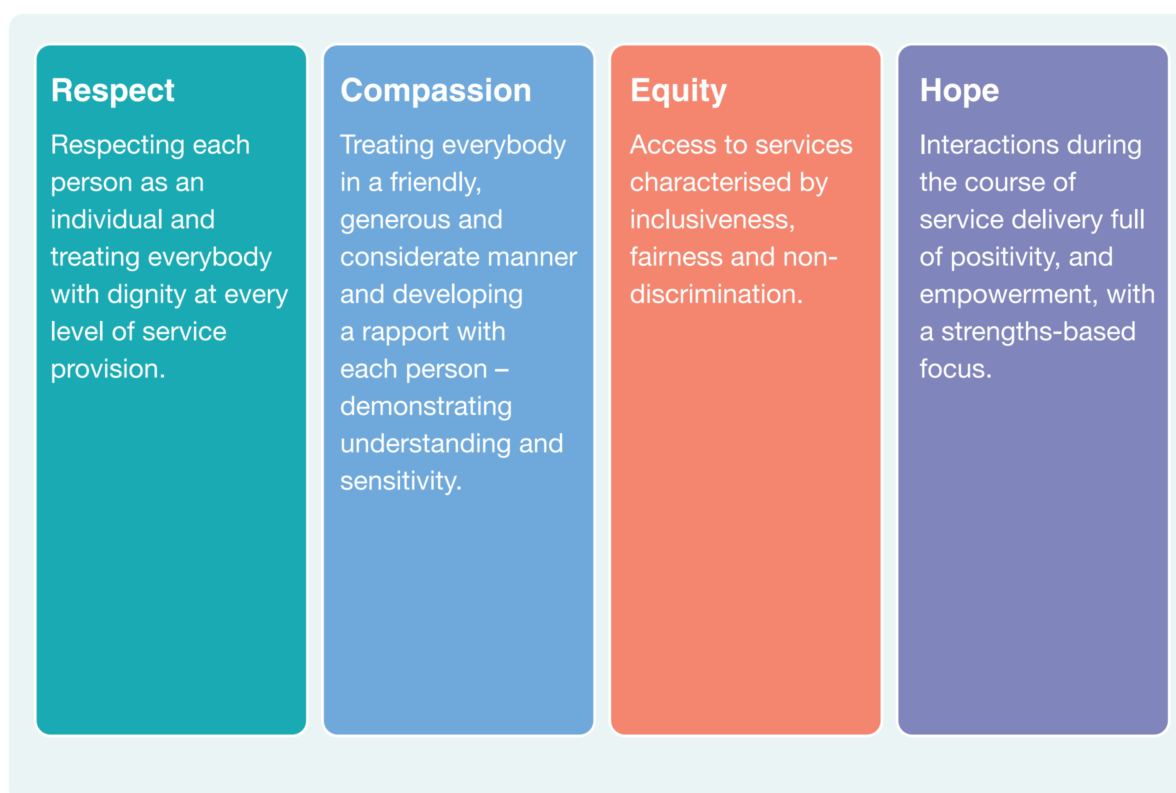
By putting people at the centre of the health system and developing primary and community health services, the Department of Health and HSE are working together to provide new models of care that allow people to stay healthy in their homes and communities for as long as possible.

Sláintecare aims to deliver one universal health service for all, providing *"the right care, in the right place, at the right time"*.

1.2 Sharing the Vision – A Mental Health Policy for Everyone

Sharing the Vision – A Mental Health Policy for Everyone, outlines national objectives and deliverables that build on the previous 10-year policy, A Vision for Change (2006-2016). The refreshed policy is strongly rooted in developing a broad-based, whole-system, population-wide Mental Health policy that is closely aligned to the main provisions of Sláintecare. The policy is underpinned by the following core values.

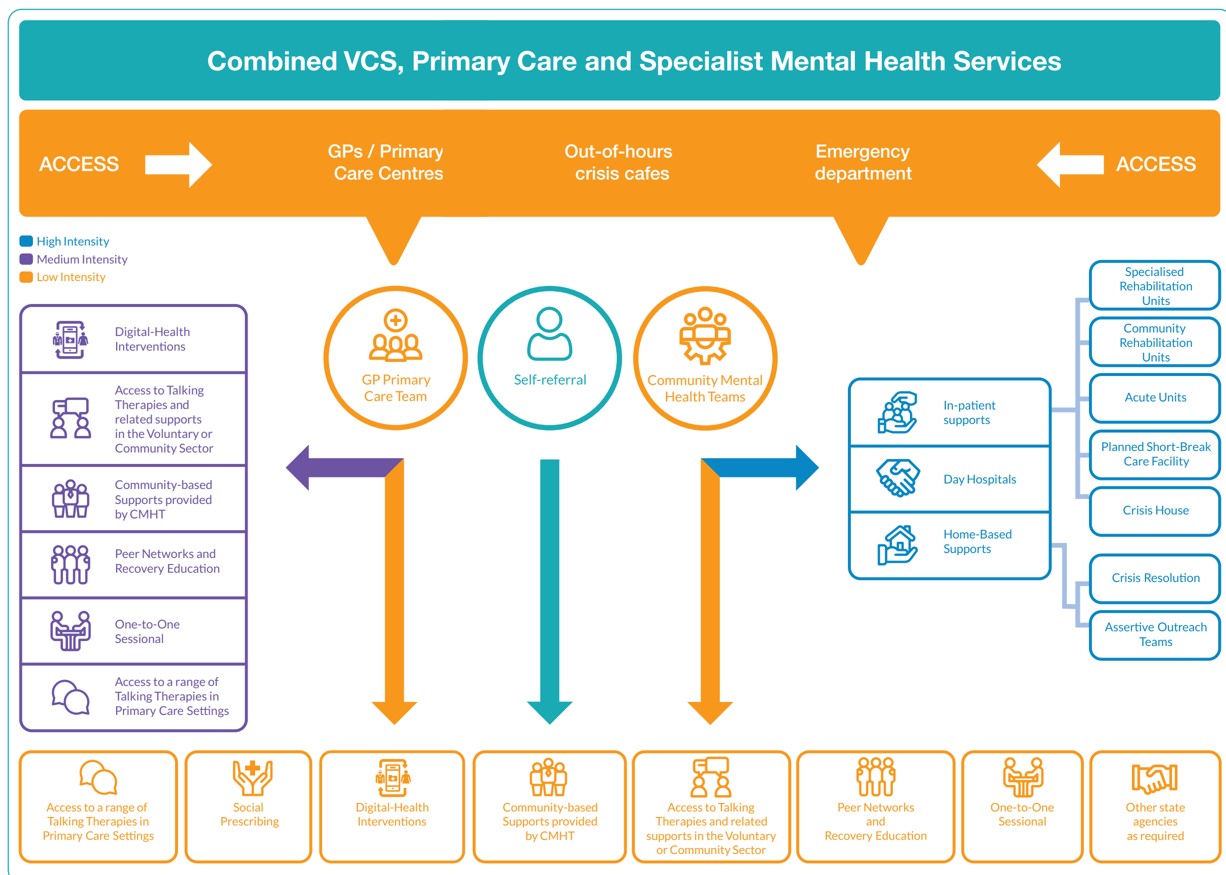
Figure 5: Sharing the Vision – A Mental Health Policy for Everyone, Core Values



These values provide the framework for the implementation of the CRS delivery model. The policy was informed by a major stakeholder consultation process undertaken by the Oversight Group and supported by the Department of Health. Following stakeholder engagement and noting the recommendations contained within the Joint Oireachtas Committee on the Future of Mental Healthcare report, the Oversight Group report highlighted the need to consider the adequacy of acute inpatient beds provided for the general adult and older adult population. Recommendations to address capacity and additional service supports, noting the stakeholder consultation process, prioritised the availability out-of-hours alternatives offering referral to Mental Health Service that are not based in ED's.

The Service Access, Coordination and Continuity of Care Domain under Sharing the Vision – A Mental Health Policy for Everyone, seeks to ensure service users and their families, carers and supporters have timely access to evidence-informed supports through Mental Health Services that are evidence-informed and recovery-oriented, adopting trauma-informed approaches to care, based on lived experience and individual need. It notes that while people in need of support or urgent care attend Emergency Departments, stakeholder consultation prioritised the availability of non-ED-based, out-of-hours alternatives offering referrals to Mental Health Services[9]. Figure 6 outlines Sharing the Vision's envisaged continuum of Mental Health Services and Pathways.

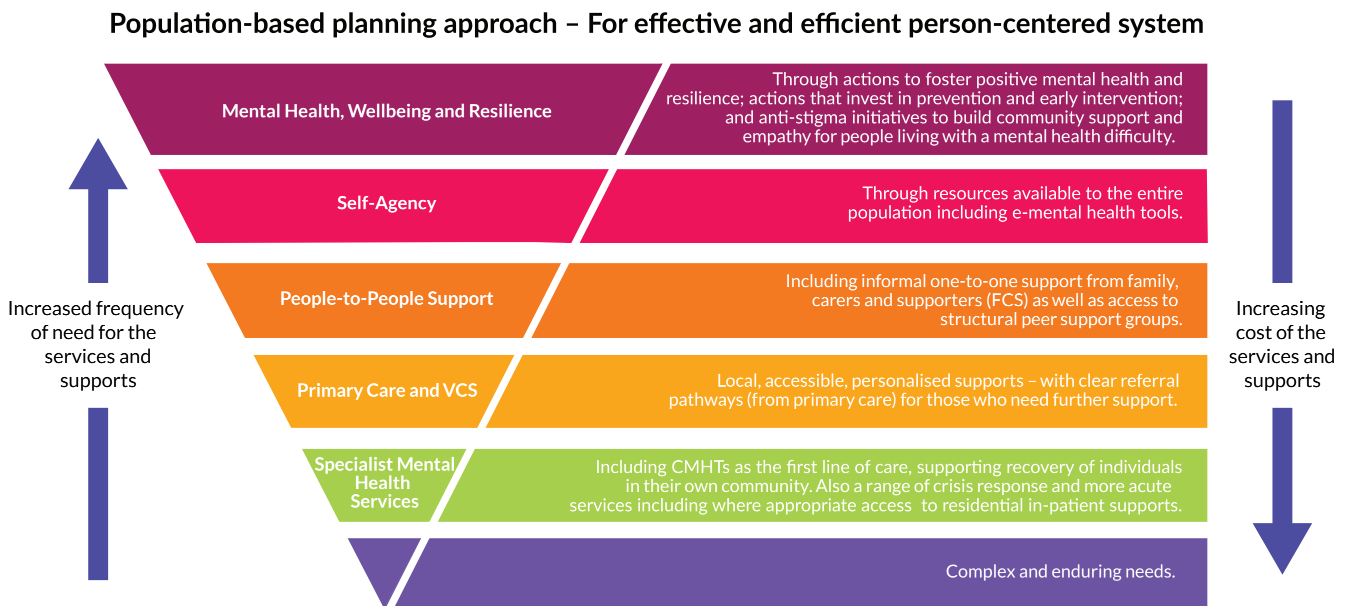
Figure 6: Envisaged Continuum of Mental Health Services and Pathways from Sharing the Vision



9. Sharing the Vision – A Mental Health Policy for Everyone, pg 45.

The coordination of Mental Health Services takes place using a ‘stepped care’ approach to improve and maintain continuity of care. Figure 7 outlines the tiered responses to need, and the level of intervention required at that point in the service user’s health experience. Sharing the Vision is underpinned by a population-based planning approach which helps to guide the distribution and development of Mental Health Services and supports in Ireland in response to need. Individuals move through different levels of support and services, from informal care and support in their own community to primary care, to specialist Mental Health Services, all based on their Mental Health needs[10].

Figure 7: Population-based Planning Approach for Mental Health



10. Sharing the Vision – A Mental Health Policy for Everyone, pg 18

1.3 Connecting for Life – Ireland's National Strategy to Reduce Suicide

Connecting for Life is Ireland's national strategy to reduce suicide. Connecting for Life sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing.
There are seven strategic goals in Connecting for Life.

1. Better understanding of suicidal behaviour.
2. Supporting communities to prevent and respond to suicidal behaviour.
3. Targeted approaches for those vulnerable to suicide.
4. Improved access, consistency and integration of services.
5. Safe and high quality services.
6. Reduce access to means.
7. Better data and research.

1.4 HSE Corporate Plan 2021-2024

The HSE Corporate Plan 2021-2024 sets out the key actions that the HSE will take over the timeline of the plan to improve our health service and the health and well-being of people living in Ireland.

Objective 4 of the HSE Corporate Plan seeks to 'Prioritise early interventions and improve access to person-centred Mental Health Services'. Recognising the challenges in accessing Mental Health Services, and the significant positive impact early intervention for mental health issues and timely access to treatment can have on individuals and their families; it seeks to focus on addressing the mental health needs of the population through a focus on the requirements of the individual. It promotes the development of service delivery models that are integrated and person-centred, whereby people will be able to access care when and where they need it.

One of the strategies to deliver on this objective is to 'provide greater access and reduce waiting times for Adult Mental Health Services by resourcing homebased CRT's and Crisis Cafés nationally.' The implementation of CRT's and Crisis Cafés in five learning sites offers one step forward in progressing the delivery of Objective 4.

1.5 National Service Plans 2021, 2022 and 2023

National service planning is the means by which the organisation implements its Corporate Plan on an annual basis. The objectives and enablers as set out in the HSE Corporate Plan are the key foundations for service planning. The strategic goal for Mental Health Service planning, in collaboration with other services, is to promote the mental health of our population, support those seeking recovery from mental health difficulties and suicide prevention. Priority areas for action reflect a commitment to the implementation of national mental health policy, a continued focus on the design and development of evidence-based, recovery-focused services that are timely and clinically effective, while also ensuring that the views of service users, family members and cares are incorporated, and that the provision of service is by highly trained and engaged staff.

The National Mental Health Integrated Care Team provides governance, oversight and strategic direction to all Mental Health Service planning activity. This team includes membership across Mental Health Clinical Programmes, Mental Health Operations, Mental Health Engagement and Recovery, Mental Health Planning, Mental Health Change and Innovation, Finance and HR. Meeting monthly, the team provides the overarching governance required to support the implementation of the mental health components of the HSE National Service Plans. Resourcing for Crisis Resolution Services has been secured under the 2021, 2022 and 2023 national service planning process.

1.6 Mental Health Change and Innovation

The Mental Health Change and Innovation Team led on the design and development of this Model of Care and provide implementation support to the learning sites. The Change and Innovation sub-function of the HSE is accountable for planning and delivery of priority strategic change programmes across the HSE, aligned with strategic objectives. The function is responsible for expert input into the development of strategies and implementation plans, and coordinates delivery of prioritised programmes. The function also supports implementation of programmes by providing change and readiness capabilities and delivers a systemic approach to improving change capacity across the whole organisation, and drives interventions, optimisation, and innovation for the HSE.

Section 2

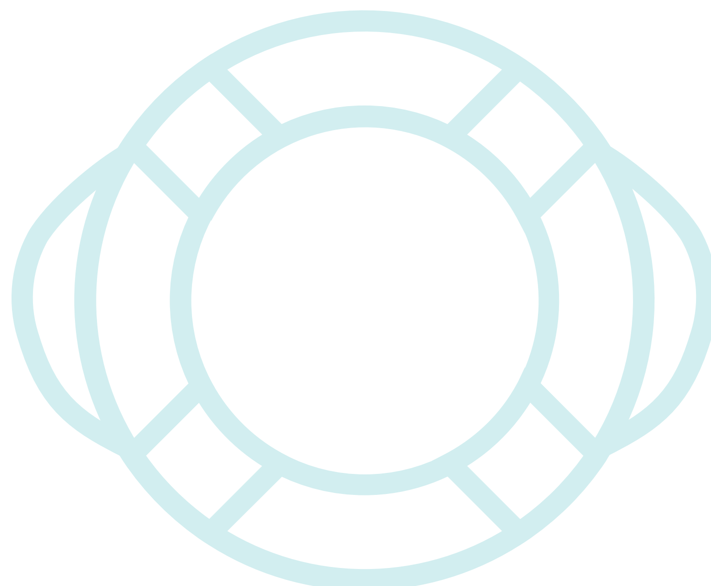
Current Context of Mental Health Services and Need for Crisis Resolution Services

Current Context of Mental Health Services and Need for Crisis Resolution Services

There are many challenges nationally and globally to the delivery of Mental Health Services. The World Health Organisation's Global Burden of Disease cites depression and anxiety as being significant contributors to morbidity and mortality, and emerging evidence is that women and children are disproportionately affected in our post pandemic world. Ireland is emerging from the pandemic with the true impact on the nation's mental health, yet untold. The emerging literature suggests an increase in presentations to ED's, a 300% increase in Eating Disorder presentations, and a significantly detrimental impact on the wellbeing of our older and younger populations. The importance of having systems that are responsive, sustainable and agile was never more apparent, and the over reliance on our hospital infrastructure has been made clear.

The HSE vision for *'A healthier Ireland with the right care at the right time and in the right place'* is ambitious, positive and we embrace it. National policy maps out a journey to reach this destination, a destination that is not fixed, is always evolving and will continue to come across new challenges.

The investment in Mental Health Services and the recognition that physical health and mental health should have equity of funding is now in sharp focus. The development of CRS is an important step in the journey to provide a modern, responsive and fit for purpose mental health service. It concentrates on the provision of mental health care when people need it most, through the CRT, in their homes rather than in hospitals, through the Crisis Cafés (Solace Café) providing responsive and preventative supports, information and signposting with the aspiration that these services should help to build greater resilience in our communities, decrease pressure on our hospital infrastructure (wards, ED's), reduce morbidity and mortality, and contribute to the de-stigmatisation of mental health problems.



Emergency Presentations to Hospital Emergency Departments

The National Emergency Medicine Programme indicate that 1% to 3% of ED attendances are mental health presentations. Patients may be brought to the ED by ambulance, family, Gardaí or may come in by themselves. Self-harm, suicidal thoughts, substance misuse, anxiety/ depression, and psychotic illness are the most common mental health presentations at triage in the ED setting[11].

The National Self-Harm Registry Ireland (NSHRI), operated by the National Suicide Research Foundation (NSRF) and funded by the HSE National Office for Suicide Prevention, collects data on self-harm presentations to hospital ED's in the Republic of Ireland. Data briefings provides information on the monthly number of self-harm presentations to 22 hospitals over a specified period. The NSHRI recorded a total of 3,792 self-harm presentations to the 22 hospitals during January-June 2021, equivalent to 21.0 self-harm presentations per day. A total of 7,679 self-harm presentations to these 22 hospitals were recorded for the same months of 2018-2019, equating to a rate of 21.2 per day.

Admissions and re-admissions to Irish Psychiatric Units

The National Psychiatric Inpatient Reporting System (NPIRS) Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2021[12], reports 15,723 admissions to Irish psychiatric units and hospitals in 2021. There were 5,758 first admissions, and 9,965 re-admissions, accounting for 63% of all admissions, unchanged from the last number of years. The rate of re-admissions increased from 203.6 in 2020 to 209.3 in 2021. It is important to note admissions and discharges represent episodes or events rather than persons, and so one person may have several admissions during the course of a year, with each admission recorded separately. Admissions do not necessarily represent incidence of mental illness but rather the activity of in-patient services.

The 2021 report also outlines the types of admission, noting depressive disorders accounted for the highest proportion, 23% of all and 25% of first admissions, schizophrenia accounting for 21% of all and 16% of first admissions, and neuroses accounting for 10% of all and 14% of first admissions. Furthermore, the rate of involuntary admissions increased from 51.7 per 100,000 in 2020 to 56.7 in 2021, while the rate for first admissions increased from 19.9 in 2020 to 20.8 in 2021.

11. Doherty K, Cassidy E, and McDaid F. 2020

12. The National Psychiatric Inpatient Reporting System (NPIRS) Annual Report 2021

Referral source analysis shows:

- 16% of all admissions were referred by the Emergency Department or the assessment unit attached to a general hospital;
- 11% were referred by a GP or the out-of-hours GP/primary care service;
- 9% were referred by another hospital (psychiatric or general hospital);
- 6% were referred by the justice system (Garda/prison/courts);
- Almost 6% were referred by a community Mental Health Team (CMHT) or sector team;
- 5% were self-referrals;
- 5% were referred by an outpatient clinic or day hospital/day centre;
- 5% were referred by another service;
- 35% had an unknown or unspecified referral source.

Mental Health Crisis Calls – National Emergency Operations

The National Ambulance Service is the statutory pre-hospital emergency and intermediate care provider for the State. The National Ambulance Service responds to over 300,000 ambulance calls each year via 999/112 call outs. The National Emergency Operations Centre (NEOC) processes Mental Health calls over two sites: Tallaght and Ballyshannon. There are two possible routes by which a Mental Health crisis call can be received – via the emergency route (999 call), or via the Mental Health signposting desk operating from NEOC Tallaght.

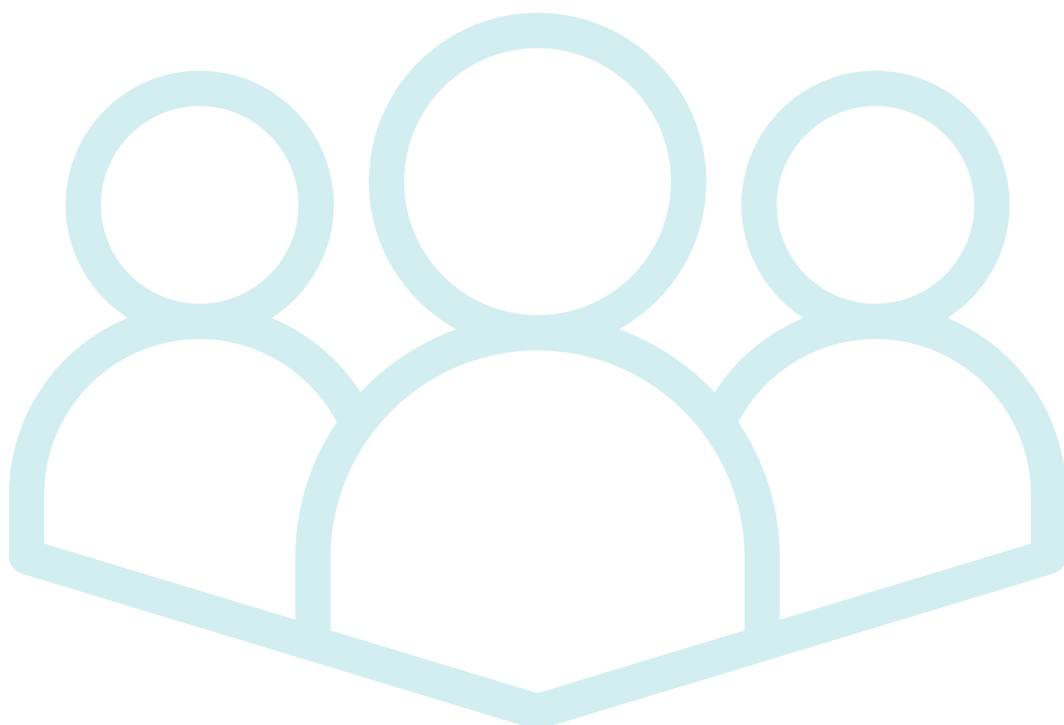
Figure 8: Mental Health Related Calls 2019, 2020 and 2021

2019			2020			2021		
Total Calls Received	999	Signposting	**Total Calls Received**	999	Signposting	**Total Calls Received**	999	Signposting
7,686	7,229	457	**10,270**	8,339	1,931	**11,073**	8,973	2,100

Health and Wellbeing of the Population (Mental Health)

The Healthy Ireland Framework 2013-2025 supports Government's response to Ireland's changing health and wellbeing profile. Each year a national population survey is completed, providing key insights into the health and wellbeing profile of the nation. Findings under the section Mental Health and Suicide Awareness[13] from the Healthy Ireland Survey 2021 provide important context in the development of Crisis Resolution Services.

- 30% of respondents say their mental health worsened since the beginning of the public health restrictions in March 2020. 64% report no change, with only 5% saying their mental health has improved.
- Among those whose mental health has worsened, 28% say it has declined "a lot", while 71% say it has declined "a little".
- Negative mental health was measured, using the Mental Health Index-5 (MHI-5). The average MHI-5 score in this wave is 76.0 - a decline from an average score of 81.2 in the 2016 Healthy Ireland Survey.
- 1 in 8 respondents report losing someone close or very close to them by suicide.
- 6% of respondents report having attempted to take their own life at some point in the past.

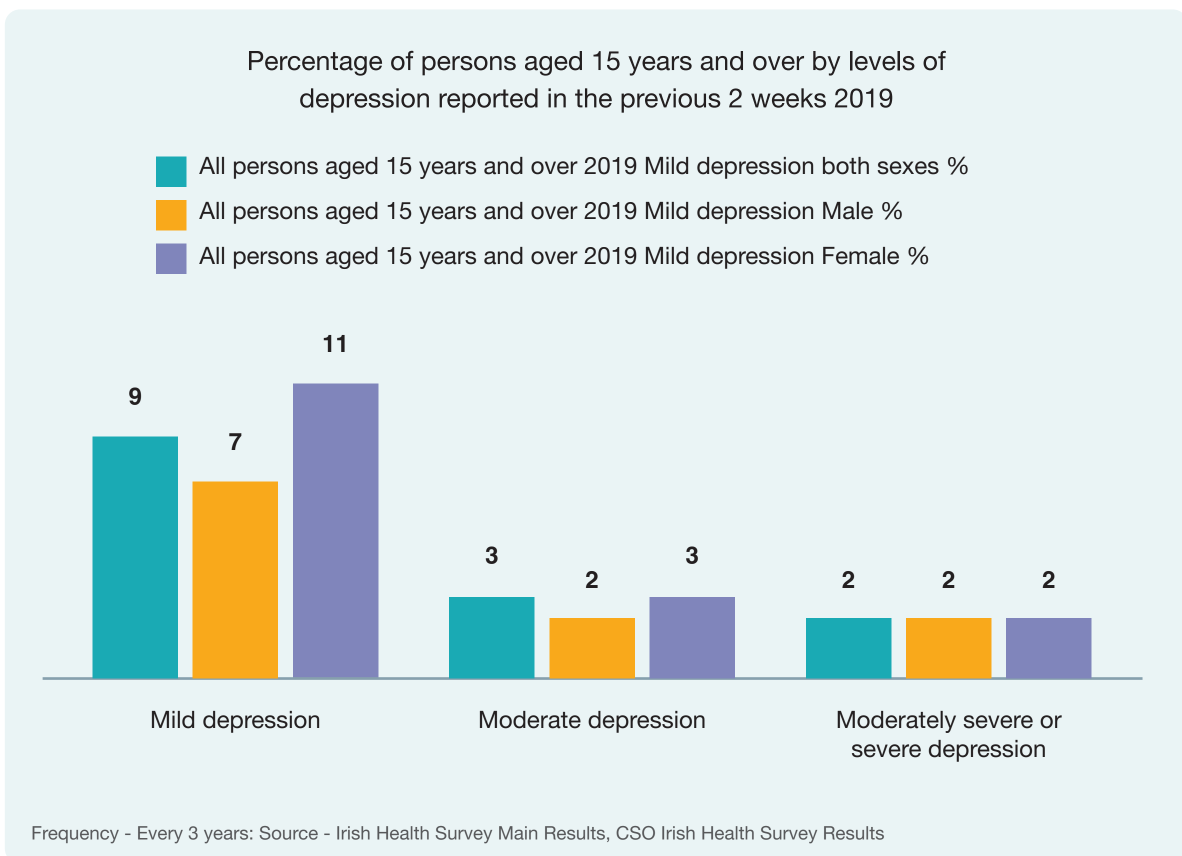


13. Healthy Ireland Survey 2021

Reported Levels of Depression

The well-being Information Hub (developed and maintained by the Central Statistics Office) reports on the well-being of the nation. It covers the broad range of life in Ireland, across 11 themes of well-being (based on an international framework developed by the OECD). The statistics are sourced from a broad range of sources, mainly from the Central Statistics Office, but also sources across the government system. Under the domain Mental and Physical Health, the information hub provides data on Population Reporting Depression. Statistics for 2019 (the most recent survey completed) are in Figure 9.

Figure 9: Levels of Depression Reported



Frequency - Every 3 years: Source - Irish Health Survey Main Results, CSO Irish Health Survey Results

This data demonstrates the need for Crisis Resolution Services offered through CRT's, and Crisis Cafés (Solace Café).

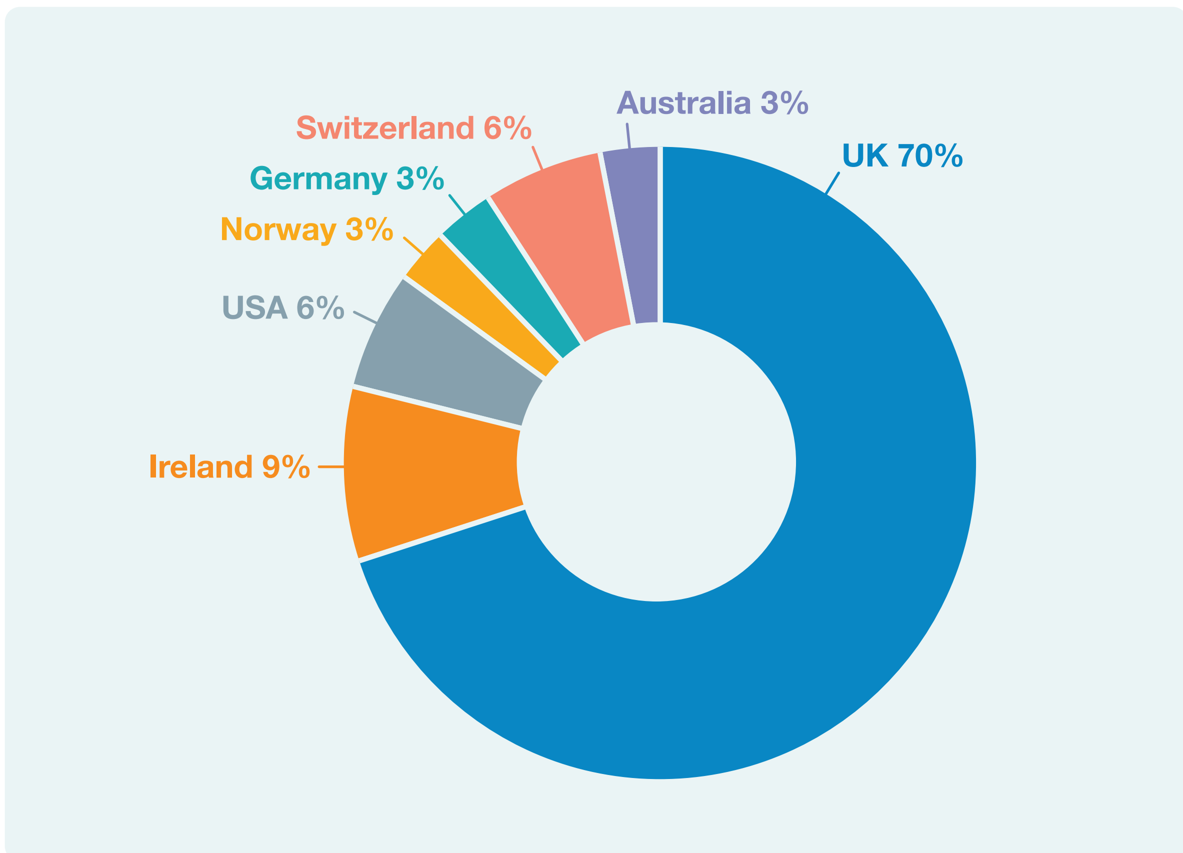
Section 3

Literature Review Informing the Design Phase of Crisis Resolution Services

Literature Review Informing the Design Phase of Crisis Resolution Services

This Model of Care for Crisis Resolution Services (CRS) has been informed by national and international best practice. A rapid review incorporating thirty-five papers from seven countries informed the core components of the design and development of the CRS Model of Care. The types of interventions and models explored in the selected studies included different aspects of CRS's. This involved examining the impact and implementation of both CRT's and Crisis Cafés, including, the effect of CRS on admissions to inpatient psychiatric units, model description and design, potential system level impacts, service user impacts, service user experiences, provision and impact of peer support, implementation learning and fidelity measurements.

Figure 10: Literature review and % distribution of influence by Crisis Resolution Practice across seven countries



3.1 Literature Findings on Crisis Resolution Teams

CRT's are multidisciplinary teams that provide rapid assessment and intensive home treatment for a limited period during a crisis[14]. CRTs have emerged from a deinstitutionalisation movement and form part of national and international Mental Health strategies to reduce acute admissions to psychiatric wards by providing acute outpatient and home-based treatment[15]. The provision of CRS's has evolved over many decades and there are exemplars of service models that are viewed as setting the foundations of CRS's internationally. These were developed in the USA, Australia, UK and Norway, with examples outlined below.

The Denver system

The network of supports developed in Denver, Colorado, included crisis assessment at home within a 24 hour period, links to hospital and community treatment options and family sponsor homes, where families were paid to accommodate 1-2 patients in crisis but supported fully by a home treatment team[16].

The Barnet Family Service

This was a brief family support intervention designed to avert admission to acute psychiatric care. It resulted in a specialist team dedicated to admission diversion and home treatment, with infrequent visits by clinical staff[17].

The Madison and Sydney Teams

Components of these services share some of the current practices seen in CRTs today. The Training in Community Living programme[18] in Madison, Wisconsin, USA was a hybrid CRT and Assertive Outreach Teams (AOT) model. Similarly, patients recruited at the point of acute admission were diverted if possible, to a home treatment plan[19].

Yardley Psychiatric Emergency Team

This was viewed as the UK's first full implementation of a CRT model and established by Hoult from the Sydney CRT[20]. Replicas of the approach were adapted in health centres prior to being nationally mandated in the NHS Plan in 2000. The aligned Implementation Guide for the Mental Health Policy by the Department for Health, UK, established 335 CRTs in England with a required case load of 20-30 patients, totally 300 a year and access to be available 24 hours over a 7 day week[21].

14. Dalton-Locke et al, 2021
15. Hasselberg et al, 2021
16. Polak & Kirby, 1976
17. Scott & Star, 1985
18. Stein & Test, 1980
19. Hoult, 1991
20. Minghella et al, 1998
21. Johnson, 2018

Norway Approach

Following on from this, the health authority of Norway in 2005, moved to implement the CRT model in all community Mental Health centres, and by 2010, a national survey reported that 51 of 76 centres had done so.

Recommended Components of Crisis Resolution Teams

There are recommended components that are important in the development on CRT's[22].

- Multidisciplinary teams should be capable of delivering a full range of acute psychiatric interventions in the community.
- Senior psychiatrists should be working within the team alongside members of the other Mental Health professions.
- The service should be targeted at people who in the absences of the CRT would require admission to an acute hospital bed or acute day hospital.
- Rapid assessment should be offered within the community.
- Intensive home treatment should be offered rather than hospital admission whenever initial assessment indicates this is feasible.
- Low patient/staff ratios should allow for increased contact and engagement as required.
- If patients are already on the caseload of other community services (e.g., Community Mental Health Teams), the CRT should work in partnership with these services.
- Out of hours availability of CRT staff should be factored in where feasible.
- A team approach to caseload should be applied with caseload shared between clinicians and at least daily handover meetings for review of patients.
- The intensive treatment programme should be short-term, with most patients discharged to continuing care services (if needed) within 6 weeks.

3.2 Literature Findings on Crisis Cafés

The Crisis Café Model (Solace Café) is based on experienced staff and volunteers providing a non-clinical, creative recovery model aimed at reducing crisis presentation and when appropriate, directing people away from clinical services such as ED[23]. Crisis Cafés have emerged in the redesign of Mental Health Services as a transformative element of recovery-oriented care. They have been found to fully engage the experience, capabilities and compassion of people who have experienced mental health crises[24].

22. Department of Health, 2001; Johnson, 2008; Johnson 2018; Dalton-Locke et al, 2021

23. NHS, 2021

24. SAMHSA, 2020

The main remit of a Crisis Café is to provide a place other than hospital ED's, where people in crisis can go to for support and signposting to other crisis services. They are often referred to as 'safe havens' or 'recovery cafés' and are typically provided by voluntary sector organisations[25]. The general aim of a Crisis Café is to provide out-of-hours mental health support and to deliver the following key outcomes[26].

- Prevent escalation of mental health problems and thereby avoid a mental health crisis.
- Prevent unnecessary referrals to secondary Mental Health Services, A&E departments and other emergency and out-of-hours services.
- Improve mental health and wellbeing.
- Provide a place of safety and respite during a crisis.
- Reduce isolation.

Crisis Cafés are intended to de-escalate and support people to identify the triggers for crisis and personal strategies for preventing and resolving crisis. Including individuals with lived experience (peers) as core members of a crisis café team supports engagement efforts through the unique power of bonding over common experiences while adding the benefits of the peer modelling that recovery is possible[27]. The recommended components, which are important in the development of Crisis Café include[28]:

- Crisis Cafés should offer a safe and welcoming environment for people in emotional distress with referral routes to clinical crisis teams and community Mental Health Teams.
- NGOs should have a central role in the provision and governance of Crisis Cafés.
- Peer supporters/educators should be a core part of the provision in Crisis Cafés.
- There should be an emphasis on the psychosocial Model of Care in Crisis Cafés.
- There should be a memorandum of understanding between NGO providers of Crisis Cafés and public sector services to be able to respond quickly to prevent further escalation of the crisis.

The CORE study identified examples of CRS that included Crisis Cafés. These are often referred to as 'safe havens' or 'recovery cafés', and are typically provided by voluntary sector organisations. Crisis Cafés were available in approximately a third of adult CRT catchment areas in 2019 (29%), up from 15% in 2016. In most catchment areas, at least one of the Crisis Cafés was provided by the voluntary sector (83%), and opened outside office hours, seven days a week for at least four hours each day. They found that most allowed members of the public to attend without an appointment (68%) while a smaller proportion were service user led (19%).

Newbigging et al, (2017) suggested that the NGO sector may occupy a specialist 'niche' within a wider ecosystem of mental health crisis support. The value of the NGO sector is in its capacity to offer 'an alternative and complementary service, adjunct to statutory crisis provision through providing a non-medical response that focuses on the person's situation and seeks to empower them in dealing with their crisis[29].

25. Dalton-Locke et al, 2021
26. Wells et al, 2019
27. SAMHSA, 2020
28. Department of Health, 2001; Johnson, 2008; Johnson 2018; Dalton-Locke et al, 2021
29. Newbigging et al, 2020

The UK have Crisis Cafés in operation, such as the Aldershot 'Safe Haven Café', which we have engaged with a number of times in the design and development of the Model of Care and they have been very supportive in sharing their learning and experiences to date. The Safe Haven Café in Aldershot aim to offer:

- A supportive environment for people experiencing a deterioration or crisis in their mental health.
- An alternative to the Emergency Department.
- Provision of a more responsive and tailored approach for people experiencing mental health difficulties.
- Prevention and earlier access to treatment and interventions.
- Encouragement for self-management and independence.
- Where necessary, onward referral to other appropriate services.
- Care planning/crisis plan development.
- Established strong links with other NHS organisations and other local services.

The evaluation of the Safe Haven Aldershot service found that 13% attended because they were in crisis, 56% attended to prevent a crisis, 23% attended for social supports and 7% reported attendance for other reasons.

3.3 Literature Findings on the Service User Perspective and Experience of Crisis Resolution Services

The design of the pilot CRS Model of Care is informed by findings from various studies focused on the service users' perspective of the critical factors required in order for CRS's to be responsive to the needs of individuals. Critical factors include the organisation of CRS care (accessibility and speed of response), the content of Crisis Resolution work and the role of CRS's within the health system[30]. Most mental health service users and carers value the basic principle of crisis management at home[31]. Service users value CRT input and speak about 'care', 'compassion', 'guiding me through a crisis', and 'helping with thoughts of despair and suicide'[32]. Service user satisfaction with CRS was recorded as higher than inpatient treatment across a number of studies. The relational feature of care and the responsiveness of the professionals (including peers) were cited as recurring outcomes in terms of service user experience[33].

A pertinent finding from studies focused on the service users' perspective was for CRT to be responsive to the basic needs of individuals as a primary facet of their crisis presentation and crisis recovery. There was a consensus among service users, carers and many clinicians that CRTs should offer holistic care and provide medical, psychological and practical help as required to resolve mental health crises. This should include opportunities to form relationships

30. Morant et al, 2017
31. Johnson, 2013; Morant et al, 2017
32. Tracey, 2017
33. Morant et al, 2017; Dalton-Locket et al, 2021

with staff and talk through problems, access to brief psychological interventions, and help with urgent practical problems, such as lack of food, money or shelter[34]. Critical ingredients identified by servicer users and carers of CRTs were organised under the following structures[35]:

- The organisation of CRS's:
  - Accessibility and speed of response
  - Regularity, reliability and clarify
  - Flexibility
  - Staff continuity
  - Staff mix and experience
- The content of CRT work
  - Involving the whole family
  - Emotional support
  - CRT interventions
- Role of CRT's within the care system
  - Gatekeeping acute inpatient care
  - Providing home-based treatment
  - Continuity and communication with other services

In line the HSE Best Practice Guidance for Mental Health Services, the CRS Model of Care seeks to ensure service users are valued, their rights are protected, and diversity is respected. Throughout the pilot implementation phase, the lived experience and perspective of service users, family and carers will be incorporated into service delivery, and will further support and refine service delivery and service improvement into the future for CRS. The perspectives of service users will remain critical at all stages of the development, implementation and review of the pilot Model of Care. This will ensure that issues arising from the experience of service users and their family/carer are considered and reflected in the decision-making process.

In conclusion, we would like to acknowledge the work undertaken on the Crisis Resolution Services Rapid Review in January 2021 by Dr Katrina Collins and Kate Wilkinson.

33. Morant et al, 2017; Dalton-Locket et al, 2021
34. Lloyd-Evans et al, 2020
35. Morant et al, 2017

Section 4

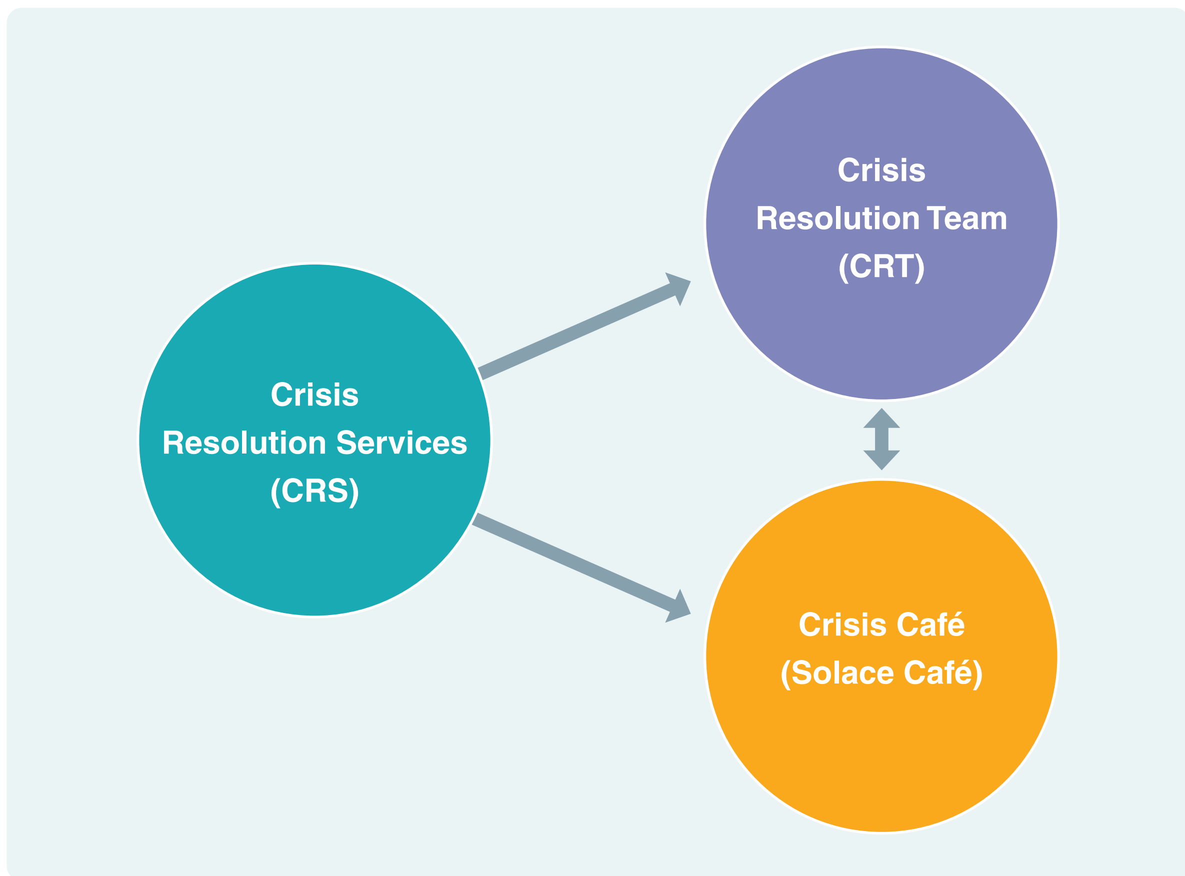
Irish Model of Care for Crisis Resolution Services

Irish Model of Care for Crisis Resolution Services

4.1 Crisis Resolution Services

CRS's are intended to be an integral part of each community Mental Health Service into the future. CRS's in this Model of Care, have two key service components, which are interconnected and should be integrated in service delivery. The first key component is the CRT and the second is the Crisis Café (Solace Café).

Figure 11: Key Components of Crisis Resolution Services



4.1.1 The Vision for Crisis Resolution Services

The Vision for Crisis Resolution Services is:

> ***'To provide integrated Crisis Resolution Services to people referred with the right response at the right time for the right amount of time to enable and empower people on their recovery journey'.***

4.1.2 Definition of Crisis

What defines crisis is individual to the person or family experiencing it; however, a crisis is also short-term. Some shared characteristics are that a mental health crisis happens when a person has a significant problem, sequence of events or significant mental health issue resulting in them becoming emotionally overwhelmed and they are not able to cope or be in control of their situation.

4.2 Crisis Resolution Teams

4.2.1 Definition of CRT

CRT's are community-based multidisciplinary teams that provide rapid assessment and intensive support to individuals who are in a mental health crisis. CRTs can provide an alternative to inpatient admission in the service user's own environment and/or in a community setting, with the active involvement of service users and their family, carers and supporters, and interagency liaison with local partners. Support from these teams is time-limited, providing intensive intervention and support with sufficient flexibility to respond to different service user or carer needs for an average period of up to six weeks. The service will be service user centred and recovery-focused. Typically, this entails a range of multidisciplinary team therapeutic approaches, including medication management, psychological interventions, peer support and evidence-informed family or social interventions, utilising the person's own lived experience and strengths as much as possible. CRT's will also play a role in supporting out-of-hours Crisis Cafés.

4.2.2 Core Values of Crisis Resolution Teams

The CRT will operate within the following core values.

- We will provide timely care services that promote recovery and hope, honoring the choices and preferences of the person as much as possible.
- We are committed to equity, diversity and inclusiveness.
- Within legislative constraints, we will empower everyone to exercise personal choice and responsibility for themselves and their health.
- We will deliver evidence-based practice.
- When deciding on treatment options, dialogue will take place with the service user, informing them of the best practice evidence in clinical intervention and clinical judgement following assessment, to support the service user make an informed decision about their care and treatment.
- We will co-produce a care plan in partnership with the service users, carers, statutory and non-statutory organisations where appropriate, in order to provide an integrated service.
- We will promote the discharge of service users as soon as they are ready to return to the community. We will offer service users support to make this transition and develop a crisis plan to empower individuals to address any future stress.
- We will promote open communication for all.
- We will meet national and local policies, professional codes of conduct and the legal and ethical framework in the provision of care.
- We will seek investment in training and development for staff in order to build a skilled and compassionate workforce.

4.2.3 CRT Working Principles

- People experiencing a mental health crisis should receive timely care in the least restrictive environment suitable for them.
- Pharmacological and bio-psycho-social treatments will be considered.
- People experiencing a mental health crisis and their families or carers will be supported to be involved in making decisions about their care as fully as possible.
- Families or carers of those experiencing a mental health crisis will be supported appropriately in their own right, and involved with their loved one’s care as much as possible, and if agreement is received with the service user.
- The CRT will support early discharge from inpatient services for those service users who would benefit from the service.
- The CRT will be appropriately trained and supported to carry out their jobs competently, safely, and with regard to their wellbeing as practitioners.
- Care from the CRT will be available to all regardless of disability, sex, gender identity, gender expression, sexual orientation, marital status, ethnicity, race or religion.
- The CRT will have good links with other Mental Health and physical health services and social care.

4.2.4 CRT Aims and Objectives

The aims and objectives of the CRT are to:

- Provide brief and intensive multidisciplinary, community-based assessment and treatment for individuals experiencing acute crisis, for which community-based or home treatment would be appropriate.
- Provide a multi-disciplinary holistic, comprehensive health assessment and crisis intervention care plan, focusing on the immediate psychological, physical, social and occupational needs to deescalate or contain the crisis for the individual.
- Deliver a crisis response service user care pathway that will empower and enable those using the service to take an active role in their care and recovery process and to enable active involvement of the family and carer's/significant others.
- Build, increase and enhance the service user's resilience to enable them to respond to and manage the current crisis, and any crises that may occur going forward.
- Ensure timely CRT response to all appropriate referrals.
- Ensure that individuals experiencing acute crisis are supported and attended to in the least restrictive environment as is clinically possible.
- Act as an alternative care pathway to hospital admission.
- Provide a time-limited intervention (up to six weeks) that has sufficient flexibility to respond to differing service user needs.
- Support the service user in learning through experience and with the aim of preventing future crisis through post-event reflection on the crisis.
- Facilitate early discharge option from acute inpatient wards as a transitioning support to the Community Mental Health Team.
- Develop collaborative partnership working arrangements with other services to enable appropriate alternative pathways to admission.

4.2.5 Who is the CRT for?

CRT's provide a service for people over the age of 18, experiencing an acute mental health crisis, where it is determined the needs of the service user could be met more effectively in the community, through rapid response and time-bound intensive intervention rather than inpatient admission.

A CRT service user may be presenting in crisis and/or in need of a short period of intensive community treatment. However, the service user needs to be willing to engage with the team in order to avail of the service.

4.2.6 CRT Exclusion Criteria

This CRT is not usually appropriate for individuals:

- with high levels of disorganisation and/or severe psychiatric/behavioural disturbance, at a severity at which an admission to a high dependency unit would be required
- assessed as currently at imminent, high risk of serious harm to self/others or if there is a significant risk of violence in their home setting
- with a primary diagnosis of organic brain injury and dementia
- with a medical illness, which may require medical assessment
- who have a primary diagnosis of active substance misuse, which impairs one's ability to engage collaboratively in resolving the crisis or the primary response to an overdose
- displaying signs of intoxication – until such time that an accurate Mental Health assessment is possible
- under 18 years of age – children and young people are seen by the Child and Adolescent Mental Health Service (CAMHS)/the Liaison Non-consultant Hospital Doctor (NCHD), the NCHD on-call/their GP
- who are unaware of the referral or unwilling to accept the referral and not willing to engage with the team

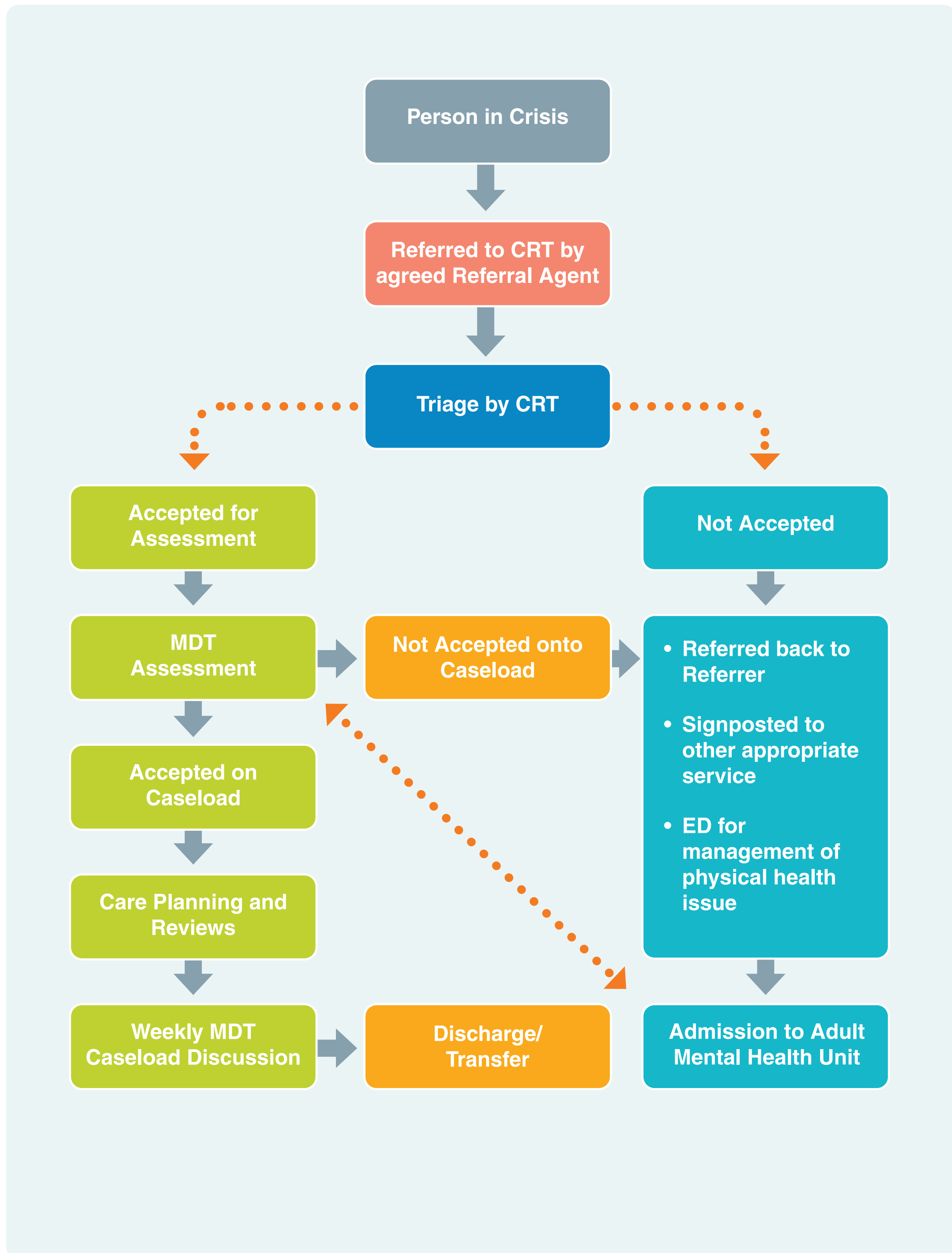
When considering home-based treatment an underlying principle is that, the safety of staff is paramount and therefore if the person or the circumstances of their living arrangements poses a risk to healthcare staff, then they would be considered not to be eligible for home-based support from the CRT. In these situations, it may be possible to support individuals with appointments at other locations, for example in Primary Care Centres, Day Hospitals etc.

4.2.7 CRT Referral Pathway

The CRT will receive referrals for service users 18 years of age and older from:

- a General Practitioner;
- any member of the Community Mental Health Team;
- a member of the liaison psychiatry team in the CRS learning site location hospitals;
- authorised officers;
- mental Health In-patient Units.

Figure 12: Crisis Resolution Services Referral and Care Pathway



4.2.8 The CRT Process

There are five stages in the process of crisis resolution.

1. **Triage and confirmation of assessment with service user.**
2. **Assessment.** Accepting the referral and assessing the crisis. Identifying the contributory factors, the modifying factors and the strengths, which might help the individual to resolve the crisis, and finding out who is involved in the crisis.
3. **Crisis Care Planning.** To develop strategies for managing the crisis in the community setting. This draws on the range of professional and personal skills available in the team and from the person themselves and their support network.
4. **Crisis Intervention.** Carrying out the interventions as set out in the Crisis Care Plan.
5. **Crisis Resolution.** Identifying when the crisis is resolved to a level where the individual feels safe and no longer requires intensive support from the team, and identifying the tasks that should be completed prior to transfer of care to the agreed Adult Community Mental Health Team as appropriate, or to another appropriate service, or to the person's own self-care processes.

This is not a linear process. Indeed, at a single point in an individual's care, all aspects of this process may be active. It is also important to note the inter-dependence of each of these stages to support the service user and to enable their recovery journey. For example, if the assessment is inaccurate, the planning and intervention are very likely to be ineffective.

4.2.9 Individualised Treatment for CRT Service Users

The CRT will collaborate with service users, families and caregivers to provide an alternative to inpatient hospital care within their community. It recognises that for many people an inpatient hospital admission can be a disruptive and traumatic experience, particularly for those experiencing their first or early contact with HSE Mental Health Services. The CRT will allow greater adaption of care provision and setting to suit the needs of the individual person, whilst seeking to minimise distress with the experience of accessing Mental Health Services in the community.

Through the adoption of strengths-based and person-oriented practice principles, the service user is an integral and equal member of the care team. Working in collaboration with their family/caregivers, other supports and the CRT, the person will be supported to make informed decisions regarding their care, from the best available evidence presented to them in an age and culturally/linguistically appropriate format. The inclusion of caregivers in decision-making is considered central to care delivery with the CRT; however, it is at the consent of the service user only.

Clear goals will be formulated in conjunction with the service user and their family/carers and tailored to their individual needs. All subsequent management decisions about duration of CRT engagement, nature of visits, treatment, interventions and discharge processes, will be made in collaboration with the service user and their caregivers with these goals in mind – noting consent is required from the service user as to who should be involved in their care from a family/service user perspective.

4.2.10 Features of CRT Treatment

- Treatment is person-centred and recovery-focused.
- Service users and where appropriate their families will plan care in partnership with the CRT.
- A designated named key worker will facilitate and coordinate each service users care planning and care. Contact details for the named key worker and CRT will be supplied to service user and carers on admission to the CRT.
- Staff will have frequent contact with service users as agreed within the care plan. This includes face-to-face contacts, telephone contact and video calls, graduating down towards discharge.
- Onward referral planning will begin upon engagement with the CRT.
- The CRT will refer on to alternative services as clinically indicated.

4.2.11 CRT Interventions

Interventions will be multidisciplinary and typically include:

- Risk assessment and management of the person and other's safety.
- Mental state examination.
- Medication management: monitoring and management of side effects, concordance training, education and information provision on medication.
- Provision of recovery-oriented interventions: goal setting, self-management and development of a personalised recovery plan.
- Practical help with basics of daily living e.g.
  - Help with housing, benefits and childcare
  - Distress tolerance, problem solving etc.
  - Education and involvement of carers/ family members to facilitate recovery
- Interventions aimed at increasing resilience e.g. problem solving, stress management, brief supportive Psychological Therapies and counseling, relapse prevention plan, safety planning, focused CBT skills, anxiety management and psychosocial education.
- Trauma Informed Care.
- Family and/or carer support and interventions (with service user consent):
  - Ongoing explanation and communication with family/carers
  - Education about the crisis and the service user's illness
  - Arrange practical help as needed
- The promotion of psychosocial education and leaflets, and attendance at groups.
- Support phone calls provided regularly based on clinical and psychosocial needs.
- Liaison with inpatient and community teams, GPs, private providers and NGOs as appropriate.
- Referral to appropriate services for continuity/transfer of care.

- Linkage with a GP – if a person does not have a GP, then the CRT will support the person in obtaining a GP.
- Development of a collaborative crisis plan with the individual and significant other/s.
- Support in engaging with social inclusion services such as Individual Placement and Support, Recovery Education and community resources.

4.2.12 CRT Care Planning

The care plan will be formulated at the start of the CRT intervention process and will be reviewed regularly and will be dynamic and adaptable depending on the service user's progress. It will outline the agreed detail on the number of visits and level of multi-discipline input from the CRT. It will be inclusive of (but not limited to) information on the following:

- Pharmacotherapy.
- Psychosocial interventions.
- Peer and Recovery supports.
- Substance use disorder treatment.
- Physical health monitoring and lifestyle interventions.
- Frequency of visits and who will attend.
- Estimated onward referral date and onward referral plans.
- Emergency Care Plan, that provides service user and carers with instructions regarding how to access services in the case of unforeseen emergencies, including what protective/risk factors to consider based on individual needs.

The care plan will be discussed at each weekly Multi-Disciplinary Team (MDT) meeting. Care plans must be flexible enough to respond rapidly to changes to the needs of the person, their choices and preferences and the clinical situation. A care and safety plan will be developed and a copy given to the service user and with the service user's consent to their carer. All care plans will be recovery-focused, will work to enable greater self-management, and work on relapse prevention strategies. There should be a shared understanding of what happened and why. All care planning will also consider onward referral pathways at an early stage of intervention.

4.2.13 Key Worker Role and Function on the CRT

- A key worker is the service user's designated point of contact on the CRT.
- The key worker role will be assigned to the team member where their primary support and care need is under their specialist discipline.
- The key worker will coordinate each service user's individual care plan and coordinate the provision of evidence-based interventions by multidisciplinary team members throughout their engagement with the CRT service. A holistic, collaborative, optimistic and recovery-focused approach will underline all of their work with the service user and their family/supporters/carers.
- All CRT members in the CRT caseload management will undertake the key worker role.
- Key to this role is assertive engagement and assessment with service users presenting in crisis, with provision of day-to-day clinical services including psychosocial interventions, development of individual care plans, and the provision of education and support for the service user and their family/supporters/carers.

4.2.14 Crisis Relapse Prevention

The CRT will help identify early warning signs of relapse and will formulate an appropriate management/relapse prevention plan, which will include early intervention crisis plans by the individual and the CMHT if appropriate in future. It is important to empower service users to become aware of their early warning signs and to support them to learn strategies to prevent progression into a full relapse. The CRT and the CMHT will encourage and help the person develop an advance directive to support their treatment in a future crisis, should they so wish.

4.2.15 CRT Staffing

In order to offer a genuine alternative to hospitalisation there is recognition that the CRT should be staffed by a multidisciplinary team, which consists of the following disciplines.

- Adult Consultant Psychiatrist
- Senior Registrar
- Nursing - Clinical Nurse Managers, Clinical Nurse Specialists
- Senior Clinical Psychologist
- Senior Social Worker
- Senior Occupational Therapist
- Admin Grade IV

CRT's will engage and collaborate with the Solace Café team as required and as per local memorandum of understanding agreements in each learning site.

All MDT team members share equal responsibility for service provision. All MDT team members report to the Consultant Psychiatrist for day-to-day clinical governance and their individual discipline for line management and supervision on their clinical practice.

4.2.16 Location of CRT Care Provision

CRTs will provide a blended approach to the location of treatment for the service user, with a mix of care in the home, community setting or virtually as deemed appropriate. Consideration to the needs and circumstances of the person, and health and safety policy requirements for staff will be central to all decision-making. Where a person or the circumstances of their living arrangements poses a risk to healthcare staff, then they would be considered not to be eligible for home support from the CRT. In these situations, it may be possible to support individuals with appointments at other locations, for example in Primary Care Centres, Day Hospitals etc.

4.2.17 CRT Operating Hours

The CRT service will work within extended hours of operation with a shared rota across the MDT and optimally offering a seven-day service. Core hours will be delivered into the early evening and will be needs and demand led. CRS require an integrated approach to service delivery with existing Mental Health, Primary Care and Acute services.

4.3 Crisis Cafés – Solace Café

Solace CAFÉ
Hope • Comfort • Support

4.3.1 Definition of Crisis Cafés (Solace Café)

Crisis Cafés (Solace Café) provide an out-of-hours friendly and supportive community crisis prevention and crisis response service often in the evenings and at weekends in a café style/ non-clinical safe environment. The Solace Café service will support individuals and their family members/carers to deal with an immediate crisis and to plan safely drawing on their strengths, resilience and coping mechanisms to manage their mental health and well-being. Attendees can access coping strategies, one to one peer support, psychosocial and recovery supports provided by paid core staff, assisted by a team of appropriately trained volunteers, working on a pro-rata basis. Those who attend will be signposted to relevant mental health and well-being services and community supports as required.

4.3.2 Aim of Crisis Café (Solace Café)

To provide an out-of-hours, friendly and supportive community-based adult crisis prevention and crisis response service, often in the evenings and at weekends in a café style/non-clinical safe environment through social, peer support, crisis support and recovery based supports and services.

4.3.3 Crisis Café (Solace Café) Objectives

- To increase early access to help for people experiencing mental health difficulty, mental health distress or are experiencing a crisis by providing clear supports and effective signposting to services provided by the HSE and other third sector and statutory providers.
- To enable service users by supporting them to enhance their coping mechanisms and provide them with management techniques to help reduce the risk of or relapse of crisis.
- To offer a supportive, calm, safe and reassuring environment for people experiencing or in recovery from a period of mental health crisis that is responsive to the individual needs of people attending.
- To provide a responsive and tailored approach to support the improvement of the mental health and wellbeing of people using the service.
- To support individuals, their family, carers and supporters to prevent, reduce and de-escalate any immediate crisis and to provide on-going management and build resilience for the service user, family/carer.

4.3.4 Crisis Café (Solace Café) Values

Value	Description
Recovery Orientated	Service focused on the key recovery principles of hope, connectedness, empowerment, the creation of meaningful roles and identity in which service users are assisted to define what recovery means to them.
Comprehensive	High-quality community Mental Health Service that provides a range of comprehensive options for service users, rooted in evidence-based best practice.
Promotion of Choice	Provision of opportunities for service users to build social roles and positive self-identity.
Collaborative Services	Café services and supports are delivered through a combination of the unique lived experience of the service user and family members and the professional expertise of staff. In this way, services will actively seek out service user and family members' feedback that allows meaningful participation and representation of service users and family members at all stages of service planning, delivery and evaluation.
Enabling Environment	Importance of creating a calm, respectful and hopeful environment. This is based on the establishment and maintenance of safe and supportive relationships between staff, service users and family support systems. In this way, services place a key emphasis on staff availability to service users and thereby promote respectful interactions by building understanding and collaborative relationships.
Positive Risk Management	Services recognise the skills, talents and resilience of service users. This is balanced with identification of risk and vulnerabilities. In collaboration with service providers, service users, family members and key stakeholders, risk assessment and safeguarding become a negotiated process that maximises service user autonomy and personal responsibility.
Holistic	Holistic approach focused on individual needs and preferences recognising that, primarily a range of social, economic and environmental factors determines people's health.
Partnership	Utilise and build on the local community assets in developing and delivering the service or activity.

4.3.5 Who is the Crisis Café (Solace Café) for?

The Solace Café provides a psychosocial and crisis support service for people, their family and supporters aged 18 years and above who find themselves in need of support for their mental health difficulties, within the designated catchment area of the CRS. The Café is targeted for those who:

- Need support with their mental health or in caring/supporting someone with a mental health issue.
- Have wider social needs that affect their mental health and wellbeing.
- Present with psychological distress, who are not presenting with any immediate risk of self-harm/suicide or harm to others.
- Do not need a clinical environment or increased observation level to manage level of distress or maintain safety.
- Do not have a physical health need that requires qualified medical intervention.
- Are in distress and have never sought formal support.
- Provide care and support as family members and friends/carers to people close to them who are experiencing distress and require urgent support.
- Are engaged with HSE Mental Health Services, that may benefit from additional peer and social support/guidance or direction on how best to access further social and community supports.

4.3.6 Exclusion Criteria

While the Solace Café aims to provide a holistic, supportive and inclusive environment for people requiring support for a mental health crisis, the Café service is not appropriate for individuals with:

- Significant risk of violence to self or to staff.
- Primary diagnosis of organic brain injury and dementia.
- Medical illness, which may require medical assessment.
- Signs of intoxication.

4.3.7 Crisis Café (Solace Café) Service Supports

The Solace Café service will offer an out-of-hours friendly and supportive, non-clinical community crisis prevention and crisis response service with social, peer and crisis supports and information from trained professionals and support staff and volunteers in a relaxed, accessible, inclusive, safe and comfortable environment for individuals, family members, carers and supporters, enabling de-escalation, resilience building, psychosocial and recovery supports.

4.3.8 Crisis Café (Solace Café) Setting

Solace Café will provide out-of-hours, friendly and supportive community-based adult crisis prevention and crisis response service, often in the evenings and at weekends in a café style/ non-clinical safe environment. The service will be managed by an identified community partner, working collaboratively with the HSE to deliver a quality service in a location and setting deemed appropriate by the CHO and the community partner.

4.3.9 Referrals and Referral Policy

The following can make referrals to the Solace Café with the consent of the service user

- Local NGO and Community partner agencies.
- Primary care providers.
- NGO stakeholders.
- Any member of the Community Mental Health Team.
- A member of the Liaison Psychiatry Team.
- Any member of the CRT.
- Self-referral.

Where a referrer is unsure of the appropriateness of a referral this can be discussed with the Solace Café Operations Manager/ Service Coordinator.

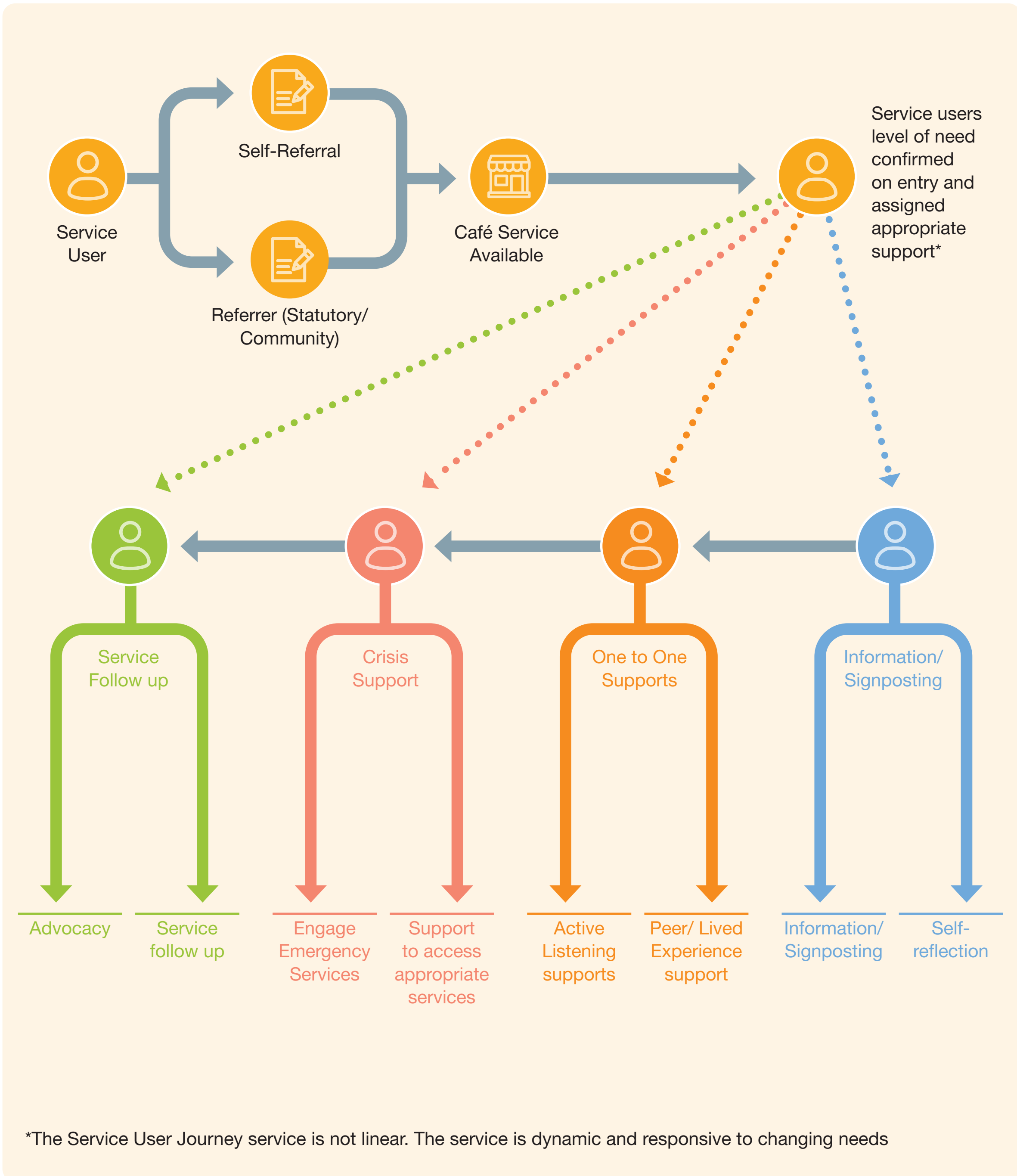
4.3.10 Service User Journey and How to access the Crisis Café (Solace Café) service?

The Solace Café service user journey process is outlined in Figure 13. The service user will be able to either self-refer or will have been referred by one of the agreed statutory or community partners. The service user level of need will be assessed on receipt of referral and or entry to the service as outlined in the image below and they will be assigned appropriate support.

There will be a hybrid booking system to support access to the Solace Café service in order to ensure a safe service with appropriate number of staff and to ensure that the service users' needs can be best met for both walk ins and appointment bookings. Service users can book the following supports by appointment following referral.

- One to one peer supports.
- One to one session for advice and information.
- Signposting – Assistance with navigating and re-engaging with mental health, community and health and well-being services both locally and nationally.
- Peer led support in developing recovery practices.
- Individual and group learning opportunities to help.
  - Build strengths
  - Identify positive coping strategies
  - Increase resilience
  - Enhance problem solving skills
  - Enhance recovery practices

Figure 13: Service User Journey Process



4.3.11 Staffing

In order to offer a safe and supportive service, Solace Café will be managed by a core team of qualified staff and volunteers:

- Café Operations Manager;
- Service Coordinators x 2;
- Peer Connectors x 3;
- Administrator;
- Trained volunteers.

Solace Café Operations Manager

The Solace Café Operations Manager will manage all planning and operational functions of the Café, providing oversight on the day-to-day operation of the Café and leadership across the service. The Operations Manager will work to ensure the service is of the highest quality and will support the continued growth and development of the service. The Operations Manager will lead the team, in providing support and practical assistance to service users, and will facilitate and support information sharing to promote choice, self-determination and opportunities and connection with local services and supports as required. They will manage relevant linkages with other HSE Mental Health Services and community-based support programmes. The Operations Manager will work alongside service users on a one to one and / or group basis.

Solace Café Service Coordinator

The Solace Café Service Coordinators will support the Café Operations Manager with the planning and operational functions of the Café, and will provide oversight on the day-to-day operations of the Solace Café and the provision of quality support services. The Coordinators will provide leadership on shifts across the service and will supervise designated café support staff and volunteers. The Coordinators will work alongside peer support staff and volunteers to ensure services are of the highest quality and support the continued growth and development of the service.

Solace Café Peer Connectors

Peer Connectors are skilled individuals who have had personal lived experience of mental health issues/challenges or experience in supporting someone with mental health challenges, who can respond to human distress in a recovery-oriented way. The role of the Peer Connector is to support service users, family members/ significant others who are experiencing mental health challenges and who require help connection and reassurance.

Solace Café Administrator

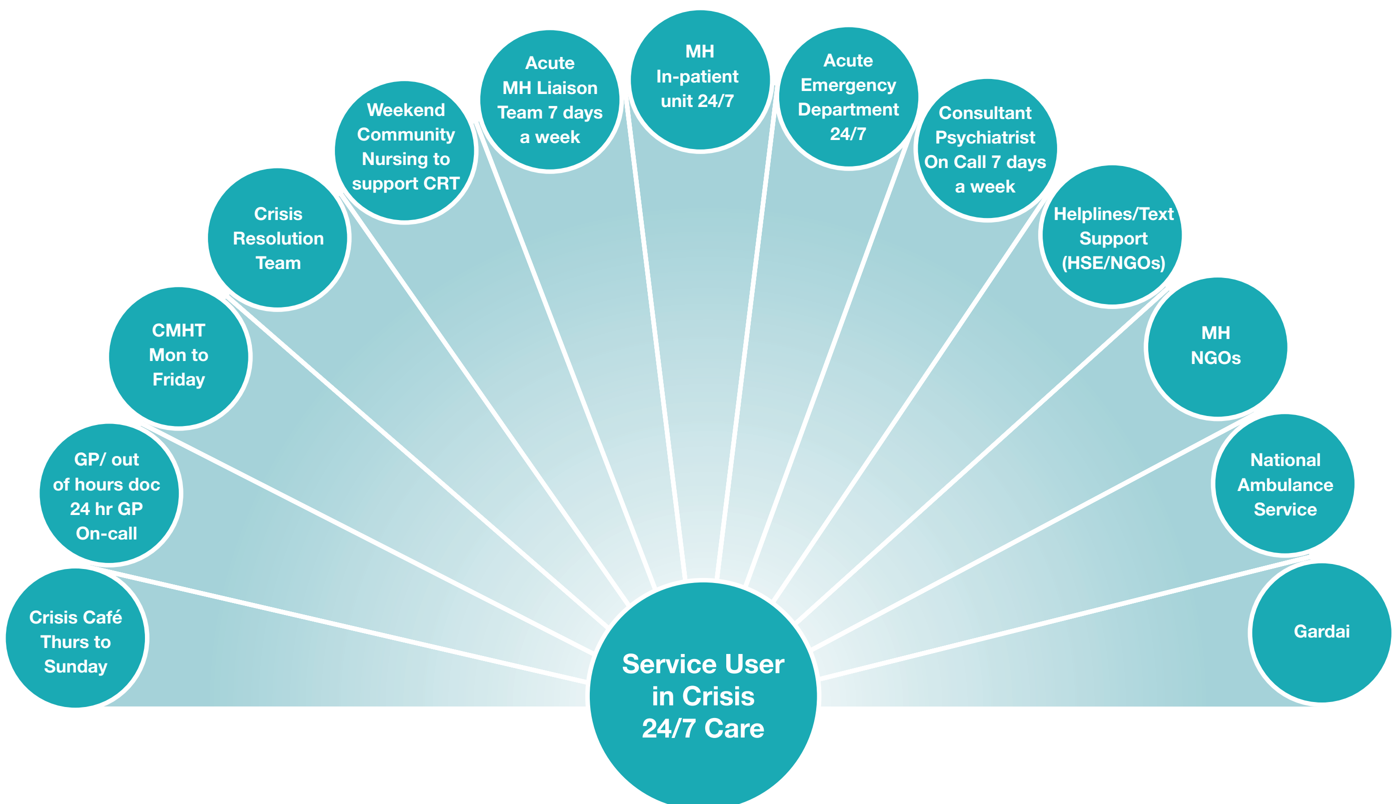
The role of the Café Administrator is to provide administrative support for the community café, managing all administrative and functional requirements to ensure the efficient day-to-day delivery of service.

4.4 Integrated Approach to Delivering Crisis Resolution Services

CRS requires an integrated approach to delivering a 24/7 multi-agency approach to service delivery with existing Mental Health, Primary Care, Acute services and Community Services.

This Model of Care requires a systemic change in practice across a number of services in order to provide an integrated seven day, 24 hour service for those in crisis. A key challenge for CRT's and the Crisis Cafés (Solace Café) is to achieve good integration with other key parts of the service system.

Figure 14: Integrated approach to service delivery to support those in Crisis



Section 5

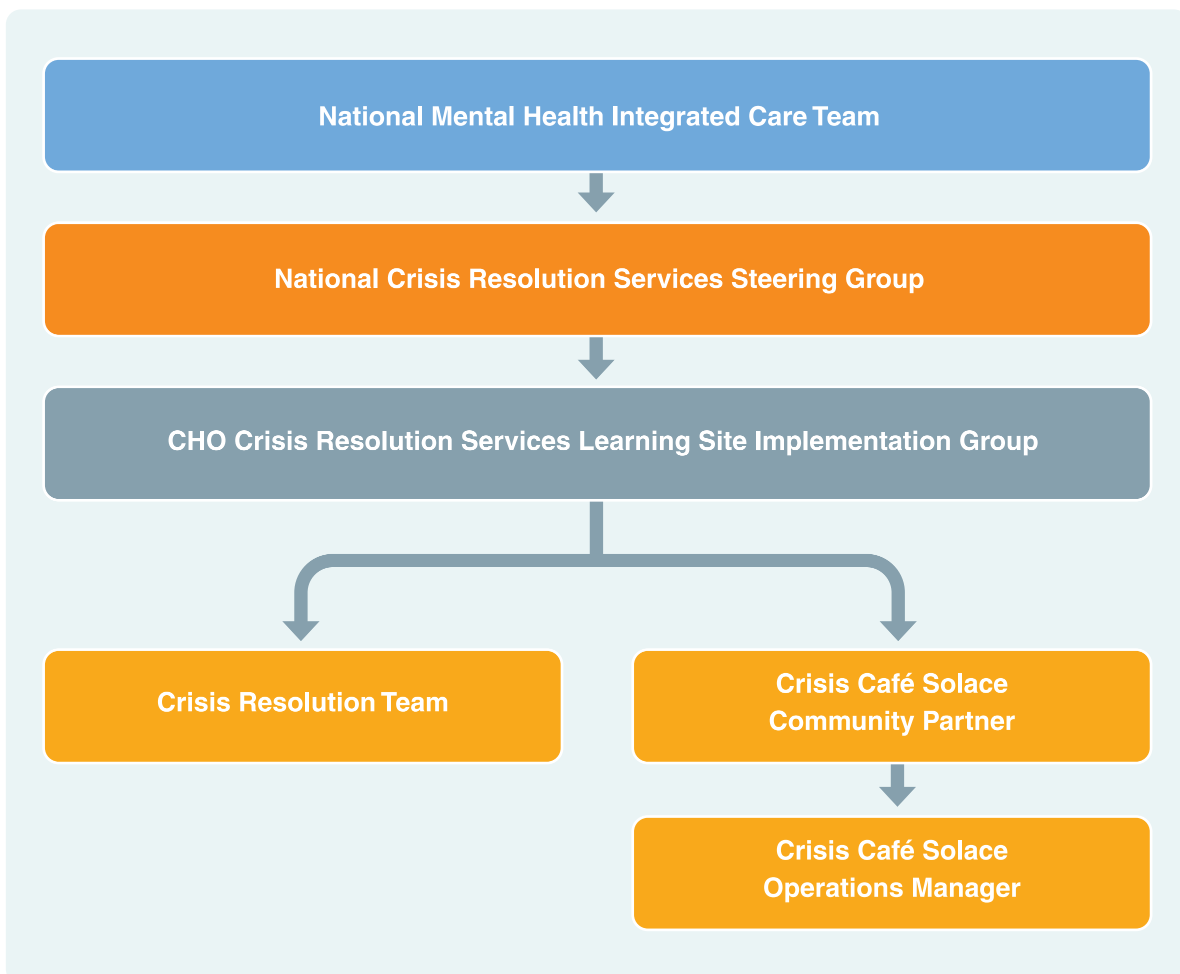
Governance of Crisis Resolution Services

Governance of Crisis Resolution Services

5.1 Crisis Resolution Services Governance

Strong governance and oversight is essential to the successful implementation of new innovative services. The HSE National Mental Health Integrated Care Team provides governance, oversight and strategic direction to all Mental Health Service planning activity. This team includes membership across Mental Health Clinical Programmes, Mental Health Operations, Mental Health Engagement and Recovery, Mental Health Planning, Mental Health Change and Innovation, Finance and HR. Meeting monthly, the team provides the overarching governance required to support the implementation of the Mental Health components of the HSE national service plan.

Figure 15: Crisis Resolution Services Governance



The overall organisational responsibility for the implementation of CRS's is led by the HSE National Mental Health Integrated Care Team; informed and guided through the work of the National CRS Steering Group. The HSE Mental Health Change and Innovation project team led the CRS Model of Care design, planning, development and implementation process.

The National CRS Steering Group was established in December 2021, to oversee the design and development of a Pilot Model of Care for CRS to include CRT's and Crisis Café (Solace Café). Membership included representatives from each learning site, national representatives from each of the core staff disciplines aligned to CRS, National Mental Health Clinical Programmes, Mental Health Engagement and Recovery, Mental Health Operations, Planning and Change and Innovation.

The CRS learning sites are accountable to their local CHO Area Mental Health Management Team, which will then be accountable to the National Mental Health Integrated Care Team governance structures.

An NGO or community partner on behalf of the CHO area will be selected as a community partner to manage the Crisis Café (Solace Café) under an agreed service level agreement. The CRT and the Solace Café Community Partner lead and Café Operations Manager will establish appropriate linkages as required.

5.2 CHO Crisis Resolution Services Learning Site Implementation Group

There is evidence that creating implementation groups that actively work to implement interventions results in quicker, higher-quality implementation. Each of the five learning sites have established learning site implementation groups. The implementation groups are responsible for all elements of the management, oversight and monitoring of the Crisis Resolution Services (CRT and Crisis Café (Solace Café)) for the CHO area. The CHO, CRS local implementation group will be the governing body of the project providing strategic leadership and governance oversight ensuring:

- Fidelity with the National Model of Care for CRS;
- That the service meets the needs of the CHO learning site, agreed catchment area and is fully integrated with all other Mental Health Services and wider statutory and community and voluntary services;
- That all developments are agreed, overseen, implemented and monitored against the local area implementation plan.

The local implementation group will have the delegated authority to make decisions that are in accordance with the objectives, approach and scope of the project as set out in the Model of Care for CRS. The local implementation group is expected to make key operational decisions, and to guide the CRT and Crisis Café (Solace Café) Community Partner in the execution of the Café project and ensure effective oversight through receiving regular reports and reviewing the results of project evaluations that will take place periodically.

Monthly meetings need to be held to ensure strong governance and oversight. Membership to include:

- Head of Service Mental Health.
- General Manager, Mental Health, CHO.
- Executive Clinical Director.
- CHO Discipline leads for CRT.
- Agreed CRT representative/s.
- Café Operations Manager.
- NGO/Community Café Partner Senior Lead.
- Person with lived experience.

5.3 NGO / Community Partnership and Management

The literature review findings presented the value of the NGO sector is in its capacity to offer ‘an alternative and complementary service, adjunct to statutory crisis provision through ‘providing a non-medical response that focuses on the person’s situation and seeks to empower them in dealing with their crisis’[36]. Therefore each of the CHO learning sites are engaging with the NGO sector to work collaboratively together to provide Crisis Resolution Services.

A service level agreement will be in place between the HSE and the identified Community Partner to provide overall management and the delivery of the service. The Service Level Agreement will provide the appropriate mechanism through which all planning, reporting and monitoring of service delivery will be carried out, including fidelity to both the Model of Care and Standard Operating Procedure.

36. Newbigging et al, 2020

Section 6

Implementation

Implementation

6.1 Definition of Implementation

Implementation is the carrying out of planned, intentional activities that aim to successfully turn evidence and ideas into policies and practices that work for people in the real world. It is about putting a plan into action the *'how'* as well as the *'what'*[37].

6.2 Introduction to Our Approach to Implementation of Crisis Resolution Services

This section aims to outline the key components and enablers of *'how'* to successfully implement the Crisis Resolution Services Model of Care by applying an implementation science approach and framework. Working closely with the five implementation learning sites, we have collectively developed and agreed dedicated implementation systems and standard operating processes in order to collectively achieve our vision, which is ***'To provide integrated Crisis Resolution Services to people referred with the right response at the right time for the right amount of time to enable and empower people on their recovery journey'.***

6.2.1 What is Implementation Science?

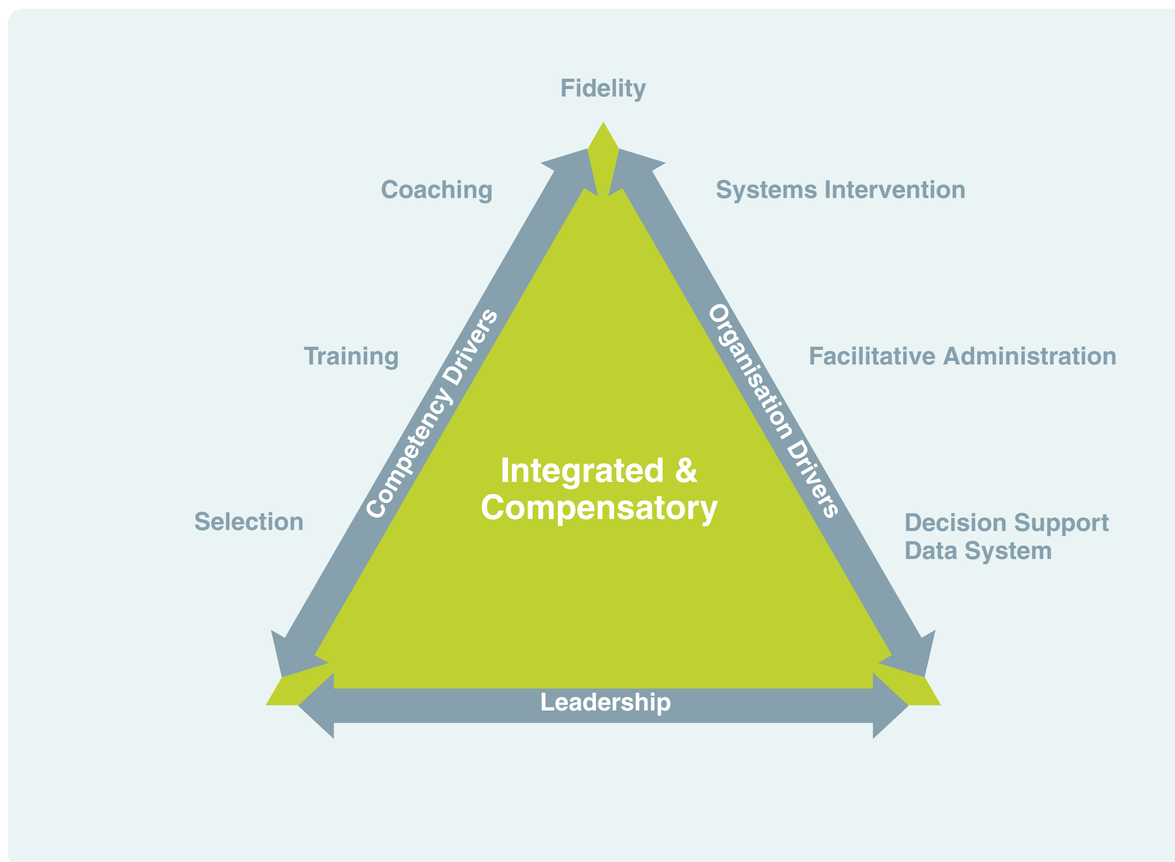
Implementation science is the scientific study and inquiry of methods and strategies that facilitate and promote the adoption and integration of evidence-based practice and research into regular use by practitioners and policymakers. It seeks to identify specific activities, contexts and other factors that increase the likelihood of successful implementation and lead to improved outcomes for people. It also assists in the identification and addressing of the barriers that slow or halt the uptake of proven health interventions and evidence-based practices.

6.2.2 Implementation Drivers

Implementation Drivers are the key components needed to develop, improve and sustain the ability of the learning sites, the CRT's and the Crisis Café (Solace Café) staff to implement this innovative Crisis Resolution Services Model of Care as intended that will benefit service users and their families. There are three categories of Implementation Drivers, which are Competency Drivers, Organisational Drivers, and Leadership (Figure 16).

37. Burke et al, (2012)

Figure 16: Implementation Drivers



1. Competency Drivers are the key capacity building activities required to develop, improve and sustain the core elements required to successfully deliver and implement the Crisis Resolution Services Model of Care as intended with fidelity to the Model of Care in order to benefit service users and their families. Building staff capacity is a core component of implementation and is pivotal in ensuring that the desired outcomes are achieved[38]. Careful staff selection, quality training and on-going coaching and assistance are all crucial in building capacity in staff for effective implementation. The Competency Drivers are Selection, Training, Coaching and Fidelity Assessment.

1.1 Selection refers to the purposeful process of recruiting, interviewing, and hiring *'with the end in mind'*. Selection through an active *implementation lens* includes identifying skills and abilities that are pre-requisites and/or specific to the innovation or programme, as well as attributes that are difficult to train and coach. A consistent recruitment approach for Crisis Resolution Services has been supported and applied across all learning sites for both the CRT's and for the Crisis Café (Solace Café) with a view to selecting the right staff with the right skills for these positions.

38. Burke et al, (2012)

1.2 **Training** through an active implementation lens is defined as purposeful, skill-based, and adult-learning informed processes designed to support staff in acquiring the skills and information needed to begin using a new programme or innovation. New staff for both the CRT's and the Crisis Café (Solace Café) team will receive a period of induction, where they are introduced to all key stakeholders, provided with a copy of the CRS Model of Care and a copy of the CRS Standard Operating Procedures. All staff will be required to complete mandatory training and other relevant training courses to enhance their skills and knowledge.

1.3 **Coaching** is a necessary component for promoting professional confidence and ensuring competence in the delivery of CRS. Coaching is defined as regular, embedded professional development designed to help staff to use the CRS Model of Care as intended. Evidence states that training alone is not enough, as only 5% of knowledge gained through training is applied in practice. Therefore, there is a need to combine training and coaching to ensure successful implementation of new innovative services.

Supervision, monitoring and support are active coaching processes that need to be embedded in the CRS learning sites to support adherence to effective practices and quality instruction. This coaching approach also supports the development of judgment needed to differentiate instruction, use data for decision-making, and engage in evidence-based and evidence-informed instructional and innovation practices. The CRT will be supported in performance development and clinical supervision and are required to maintain their endorsements, registrations, credentialing and eligibility for membership of professional associations, and adhere to the continuing professional development requirements of these regulatory or self-regulatory entities. The Crisis Café (Solace Café) team will be supported in performance development and enhancement of skills and knowledge to support the delivery of the service.

The role of support and supervision is considered central to ensure staff wellbeing and effective performance of roles. Supervision requirements will reflect the operational functioning of each individual Crisis Resolution Service and will support fidelity assessment in each learning site. Quality coaching offers critical support for trying out new approaches during that 'awkward stage' just after initial exposure through training, and helps staff persist in developing skill, judgment, and the artful and individualised use of the new Crisis Resolution Services.

1.4 **Fidelity Assessment** refers to measuring the degree to which CRT's and Crisis Café (Solace Café) teams are able deliver the Model of Care as intended and the degree to which service users can use the services as intended. Fidelity assessment measures the extent to which an innovation is implemented as intended. Did we do what we said we would do? This Fidelity Assessment will be built into the monitoring and evaluation processes for CRT's and Crisis Café (Solace Café) teams.

2. Organisation Drivers – are the key mechanisms to create and sustain hospitable organisational and system environments, which enable and result in effective and integrated CRS's. This requires an integrated approach to delivering a 24/7 multi-agency approach to CRS delivery with existing Mental Health, Primary Care, Acute services and Community Services. This Model of Care requires a systemic change in practice across a number of services in order to provide an integrated seven day, 24 hour service for those in crisis. The Organisation Drivers are the organisational, administrative and systems components that are necessary to implement new CRS's. Organisation Drivers include Decision Support Data Systems, Facilitative Administration and Systems Intervention.

2.1 The Decision Support Data System (DSDS) is a system for identifying, collecting, and analysing timely, reliable data that are useful to the Crisis Resolution implementation learning sites across the CRT's and the Crisis Café (Solace Café) teams for decision-making and measurement of achievements and outcomes. There is more information on this implementation driver in Section 7 Monitoring and Evaluation.

2.2 The Facilitative Administration Driver focuses on the internal processes, policies, regulations, and structures over which a health service has some control. Health Service governance and the Implementation Teams are responsible for activating this Driver.

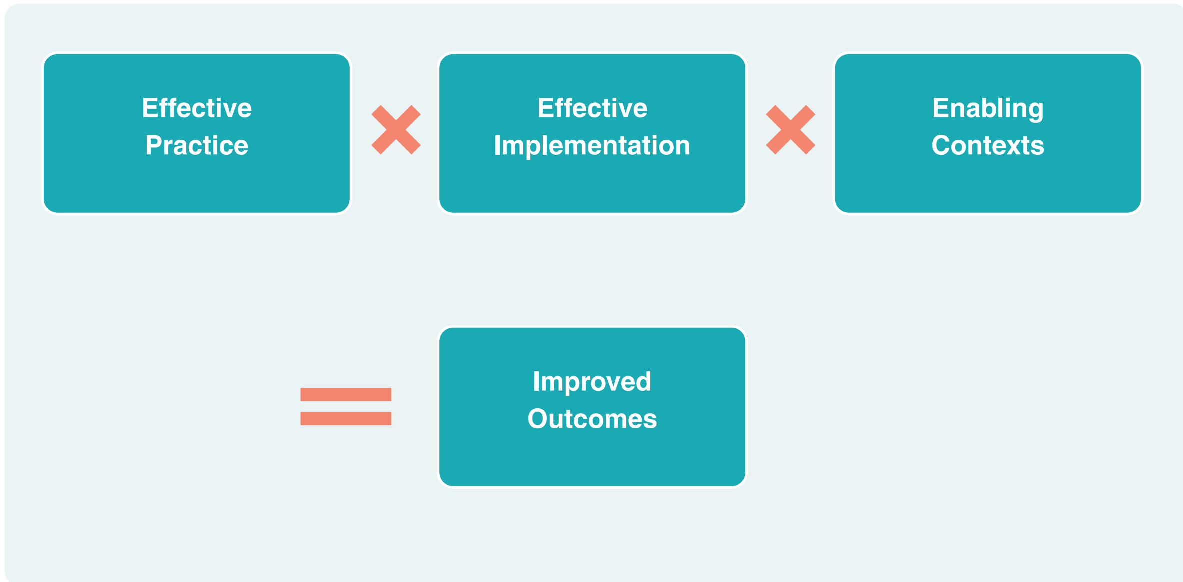
2.3 The Systems Intervention Driver is focused on the external variables, political and government policies, environments, systems, structures that influence, or have impact on the implementation of CRS. HSE governance and local learning site implementation teams may identify barriers during the implementation process that are beyond their level of authority/control and will need to strategise and escalate issues to the attention of those who can address such barriers.

3. Leadership/Governance – The Governance for Crisis Resolution Services is outlined in Section 5. A key driver for successful implementation of Crisis Resolution Services is Leadership. Leadership includes elements of team work, control, decision-making, effectiveness of organisational structures and issues related to empowerment[39]. Leadership needs to focus on providing the right leadership strategies for different types of leadership challenges. These leadership challenges often emerge as part of the change management process needed to make decisions, provide guidance, and support organisation functioning. Implementation leaders or champions are the early adopters of change[40]. They take positive action to encourage others to participate in the implementation process, and provide direction and vision for implementation, overcoming challenges that occur during the process. The use of the Leadership Driver in the context of active implementation focuses on leadership approaches related to transforming systems and creating change.

39. Helfich et al. (2009)

40. Burke et al, (2012)

Figure 17: Active Implementation Formula



For successful implementation, we propose applying the active implementation formula (see above), positive outcomes for service users represent the "*why*" in the equation. It is why we want to improve to ensure effective Crisis Resolution Services for service users. The "what" in the equation is the detail of Crisis Resolution Services as outlined in Section 4 and in the detailed Standard Operating Procedure which incorporates effective practice and effective implementation. The enabling contexts are the resources required such as staffing, finance and infrastructure required to deliver CRS. If all components are collectively delivered it will ultimately result in improved outcomes for service users.

4. Integrated and Compensatory – A key feature of Implementation Drivers is their integrated and compensatory nature:

4.1 Integration – means that the philosophy, goals, knowledge and skills related to the programme or practice are consistently and thoughtfully expressed in each of the Implementation Drivers.

4.2 Compensatory – means that the skills and abilities not acquired or supported through one driver can be compensated for by the use of another driver.

6.2.3 CRS Implementation Teams and Implementation Planning

As outlined in Section 5 Governance of Crisis Resolution Services, implementation teams have been established in each of the five CHO learning sites. There is evidence that creating implementation teams that actively work to implement interventions results in quicker, higher-quality implementation. High quality implementation is central to support the achievement of positive outcomes. The development of dedicated implementation plans with clear expectations of staff and implementation team members will facilitate and ensure successful implementation of programmes and services. Each Crisis Resolution Learning Site Implementation team will develop a Crisis Resolution Implementation Plan using a dedicated planning template, outlining the steps required to support successful implementation. The plan will act as a consistent progress-monitoring tool; supporting teams to identify key milestones achieved, potential risks and challenges arising.

6.2.4 Implementation Support Resources

A suite of standardised implementation resources have been developed by the Mental Health Change and Innovation team to support learning sites as they progress through the stages of implementation to ensure consistency of implementation approach across all of the site. Resources developed include:

- Standard Operating Procedure for CRT's;
- Standard Operating Procedure for Crisis Café (Solace Café);
- Terms of Reference for Crisis Resolution Services Learning Site Implementation Teams;
- Crisis Resolution Services Standardised Implementation Plan template;
- Sample job descriptions for CRT's and Solace Café staff;
- Standardised recruitment packs for Solace Café partners;
- Solace Café Branding Guidelines and branding materials;
- Standardised Service Level Agreements for Solace Café community partner funding arrangements.

6.2.5 Crisis Resolution Services Learning Site National Network

A dedicated Crisis Resolution Services Learning Site National Network has been established as a Community of Practice to create and encourage opportunities for both the learning site implementation teams and the CRS staff to learn from each others experience, to address common challenges as they arise, and to develop networking opportunities across the five learning sites. This network will further inform the implementation and evaluation process, acting as an active feedback loop throughout the testing phase.

Section 7

Monitoring and Evaluation

Monitoring and Evaluation

7.1 Monitoring and Evaluation Process

Monitoring and evaluation are essential to determine whether desired indicators are being met and outcomes being achieved. Such activities also help to identify risks to implementation and inform future actions[41]. Appropriate reporting and review mechanisms must be in place to facilitate this process. Evaluation relates to how an organisation measures its performance, and how (or whether) feedback is provided to people within the organisation, as well as the quality of measurement and feedback[42].

To ensure that the HSE, CRS Model of Care improves access, outcomes and is cost-effective, it will require a robust evaluation framework to be established. An independent evaluation team will be commissioned to design and undertake a mixed method multi-site evaluation of the implementation across the learning sites. This will ensure appropriate evaluation assessment, continuous improvement of the CRS Model of Care and will support learning for the future expansion and mainstreaming of CRS's.

To inform the evaluation process a review of international best-practice standards for evaluation was undertaken. The CORE Fidelity Scale has been widely referenced and used for CRS's. The development and testing of the CORE Fidelity Scale provides reassurance about the critical ingredients and measurement of a CRS that has produced outcomes to improve the mental health of individuals in crisis and/or at risk of relapse. The thematic subscale areas around which the CORE Fidelity Scale was constructed are:

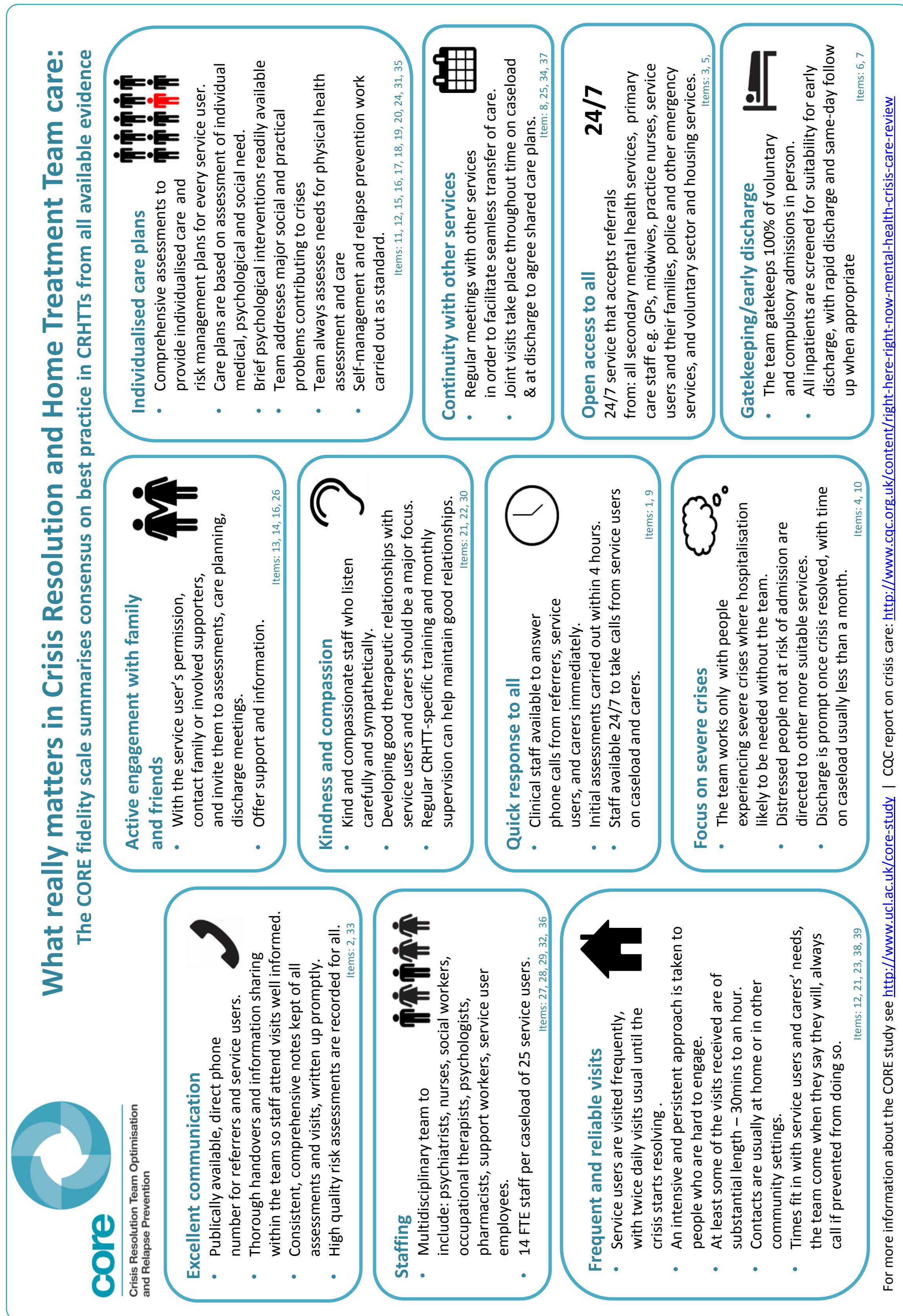
- Access and Referrals
- Content and Delivery of Care
- Staffing and Team Procedures
- Timing and Location of Care

The CORE Study, UK[43]

Following completion of the CORE study in the UK an evidence-based resource pack was developed to support the design and implementation of CRTs with a psychometrically validated fidelity scale. This resource offers practical resources, case examples, monitoring, evaluation methods, and operating procedures. They are organised under the four parts of the fidelity scale to support high quality service provision. Figure 18 is an illustration of a consensus on best practice in CRT from available evidence and serves as a key document for design and implementation.

41. Burke et al, (2012)
42. Helfich et al. (2009)
43. Dalton-Locket et al, 2021

Figure 18: The CORE Fidelity Scale[44]



44. UK Core Fidelity Scale for Operation of CRT for 24/7 reference only

7.2 Crisis Resolution Services Monitoring and Evaluation Framework

A monitoring and evaluation framework for CRS for both CRT's and Crisis Café (Solace Café) will seek to identify minimum data outcomes to support the systematic evaluation of CRS into the future; and will encompass:

- **Service User Outcomes** (the service user, family, carer and supporters);
- **Service Level Outcomes** (incorporating clinical and service level outcomes for CRT's and service users);
- **System Outcomes** (the health and community system incorporating stakeholders across the healthy system and within communities).

Performance indicators and outcome measures will be developed and tested to reflect service provision by all of the stakeholders involved, including service users, family/carers, clinicians and service management. As a new service development, measurements will need to evolve and develop throughout the testing phase. On-going monitoring and feedback loops will be incorporated into the CRS delivery for both the CRT's and the Crisis Café (Solace Café), to maximise the opportunity for service delivery to respond to the needs of stakeholders engaged with the service.

The development of a Minimum Data Outcomes Framework for CRS will be central throughout the testing phase to support the ongoing monitoring and evaluation of CRS into the future. Standardised scales will be employed in consultation with all of the learning sites to support benchmarking against international evidence and practice. The perspectives of service users will remain critical at all stages of the development, implementation, evaluation and review of the pilot Model of Care. This will ensure that issues arising from the experience of service users and their family/carer are considered and reflected in the decision-making process.

To complement the Service User Outcomes, the Service Level Outcomes and the System Outcomes outlined above and to encourage a consistent approach to data collection across all five of the CRS learning sites across both services encompassing CRS's. Minimum performance indicators will be set from the following:

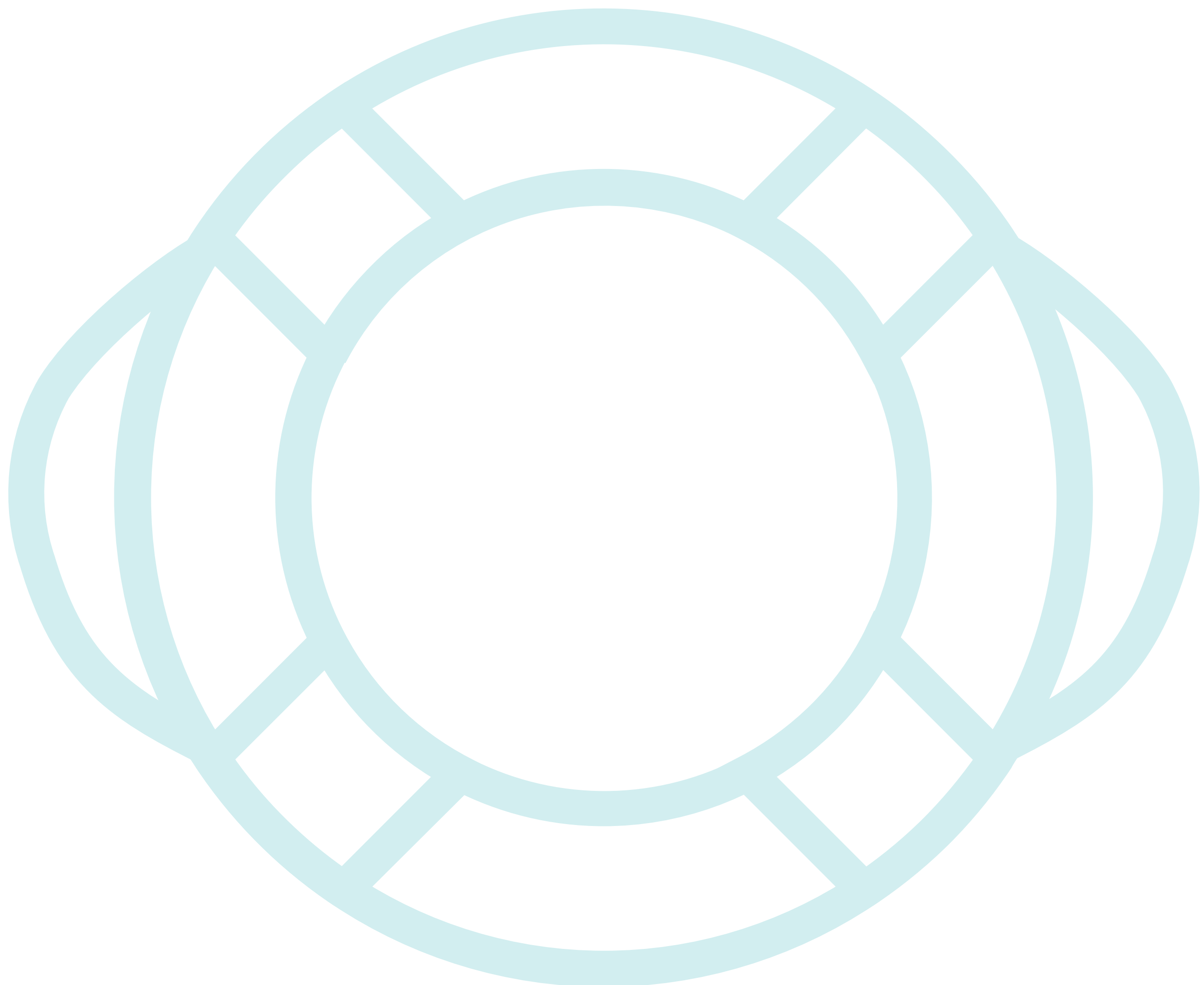
- Referral numbers received
- Referrals accepted
- Assessments completed
- Interventions provided
- Caseload numbers
- Demographics of service users
- Onward referrals
- Duration of treatment
- Referral source
- Referral Reason
- Referral Time
- Time from referral to assessment
- Time to finalise Individual Care Plan (ICP)
- Service user satisfaction
- Family carer satisfaction
- Effectiveness of the intervention in reducing distress/ alleviating crisis
- Service user understanding of CRS
- Family/ Carer understanding of CRS

7.3 Progress Reporting and Performance Reviews

- Monthly Learning Site Implementation Team meetings will provide the governance and oversight and feedback mechanisms required to actively assess progress developments and address risks or issues escalated via the CRT and Solace Café Service.
- Monthly learning site reports will be submitted nationally for ongoing monitoring of the implementation of Crisis Resolution Services.
- Agreed performance indicators will be collated by each learning site as appropriate to both services to capture core data to inform service design.

7.4 Feedback Mechanisms

A range of feedback mechanisms will be applied as appropriate to the service (CRT and Solace Café) to promote continuous quality improvement throughout the testing phase.



Section 8

Review, Sustain and Upscale

Review, Sustain and Upscale

The final phase of the Model of Care for CRS Implementation Process is review, sustain and upscale.

Review

Following completion of the mixed methods evaluation across the five Crisis Resolution learning sites of the implementation of the CRS Model of Care, the findings will inform what outcomes were achieved and where improvements or changes to the Model of Care are required. The findings will also provide evidence as to the feasibility and acceptability of the CRS Model of Care, as well as insight into the challenges associated with implementing and delivering a CRS.

The pilot Model of Care will then be reviewed and optimised by the National Steering Group for CRS, whilst also ensuring alignment with national policy and strategy and to address any arising policy issues from learning site delivery to ensure the final Model of Care is working as effectively as possible.

Sustain and Upscale

This phase will include the development of a CRS resourcing strategy to support the mainstreaming and upscaling of CRS within HSE Mental Health Services. This Strategy will clearly outline the required allocation of resources to fully implement the revised Model of Care for CRS and will include plans to incrementally scale up the delivery of CRS across additional geographical areas to ensure access for all.

Finally the most important ingredient to successful sustaining and upscaling of the CRS Model of Care is to secure resources for delivery as per the revised Model of Care.

Figure 19: Process to Review, Sustain and Upscale Crisis Resolution Services

Glossary of Terms

Acute Inpatient Care: Care provided on a residential psychiatric ward in a hospital.

Administer Medication: To prepare and check medications, ensuring that the right amount goes to the right person at the right time.

Carer: Also described as a friend or family member. A person who looks after a person with Mental Health problems. The term usually refers to an informal carer, e.g. a relative or friend.

Carer Link/Lead/Champion: A staff member within a team nominated to promote the recognition of, and support for carers.

Carer Support Service: A local service, which may provide information, individual support and peer support for carers.

Caseload: This is the number of service users receiving crisis resolution treatment.

Clinical Supervision: Clinical supervision provides an opportunity for staff to; reflect on and review their practice; discuss individual cases in depth and change or modify their practice and identify training and continuing development needs.

CNM3: The Commission on Nursing identified the Clinical Nurse Manager (CNM) post as the highest frontline clinical management grade. The definition and operationalisation of the CNM 3 post have evolved over time into a multitude of roles. As well as being responsible for a department, the grade has been used as a mechanism to appoint senior nurses into specialist posts such as quality improvement leads.

CNS: The Clinical Nurse Specialist role will encompass a major clinical focus, which comprises assessment, planning, delivery and evaluation of care given to patients/clients and their families in hospital, community and outpatient settings. The specialist nurse or midwife will work closely with medical and para-medical colleagues and may make alterations in prescribed clinical options along agreed protocol driven guidelines. The specialist nurse or midwife will participate in and disseminate nursing/midwifery research and audit and provide consultancy in education and clinical practice to nursing/midwifery colleagues and the wider interdisciplinary team. A nurse or midwife specialist in clinical practice has undertaken formal recognised post-registration education relevant to his/her area of specialist practice at level 8 or above on the NQAI framework1. Such formal education is underpinned by extensive experience and clinical expertise in the relevant specialist area. The level of practice of a CNS/CMS is higher than that expected of a staff nurse or midwife.

Conflict Resolution/De-escalation: Resolving a conflict situation and preventing it from becoming a major incident.

Consultant Psychiatrist: a Consultant Psychiatrist has a Medical Degree (MD) and is a medical doctor who further trains for 7-8 years in psychiatry, which specialises in the care and treatment of people with mental illness and mental disorders. They assess patients, make diagnoses, they may investigate medical problems, offer advice, and recommend different treatments including medication, counselling or other life style interventions.

Crisis: What defines crisis is individual to the person or family experiencing it, however, a crisis is also short-term. Some shared characteristics are that a mental health crisis happens when a person has a significant problem, sequence of events or significant mental health issue, resulting in them becoming emotionally overwhelmed and they are not able to cope or be in control of their situation.Crisis Plan: A document drawn up by a person when they are well, usually with their Key worker. It includes relapse warning signs, what they can do to manage the situation themselves, who to contact and when, and what has been helpful and unhelpful in the past.

Implementation Fidelity: Implementation fidelity refers to the degree to which an intervention or programme is delivered as intended.

Independent Advocate: A person who helps views of service users to be heard by service managers and protects vulnerable people.

Line Management: A process that provides an opportunity for staff to evaluate their performance, set objectives that align with the organisation's objectives and needs of the service, and identify areas for further training and development. A supervisor with authority and responsibility for the supervisee carries it out.

Logic Model: A logic model is a graphic illustration of the relationship between a programme's resources, activities, and its intended effects. Logic models clearly and concisely show how interventions affect behaviour and achieve a goal. They can be described as road maps that specify causal pathways and the step-by-step relationship between planned work and intended results. Specifically, a logic model is a visual way to illustrate the resources or inputs required to implement a programme, the activities and outputs of a programme, and the desired programme outcomes (short-term, long-term).

Management Supervision: Usually a one-to-one meeting in which a staff member is supported by a more senior staff member to reflect on their work practice.

Multi-Disciplinary Team (MDT): A team made up of staff from different kinds of health professionals.

Mental Health Act: A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interest or for the safety of themselves or others.

Mental Health Advocacy: A group of people with similar experiences who meet to discuss and put forward shared views to service managers.

NICE: National Institute for Health and Clinical Excellence. Publishes guidance for health services

Occupational Therapist (OT): A healthcare profession offering support to people with physical, psychological and social problems to enable them to live life to the fullest. Occupational therapists help people to do the everyday activities they want and need to do when faced with illness, injury, disability or challenging life circumstances or events.

Peer Connector: A service user or carer employed by the team to support other service users and/or carers.

Positive Risk Taking: Allowing people to take responsibility for their actions, to empower them and to improve understanding of decision-making and consequences.

Primary Care: Usually the first port of call for health problems. Includes general practitioners (GPs), dentists, community pharmacies and high street optometrists.

Psychologist: A psychologist is trained to work with individuals and families of all ages with a wide range of difficulties in mental and physical health. This can include anxiety, depression, psychosis, eating disorders, learning difficulties and family and relationship issues. They aim to reduce psychological distress and promote psychological wellbeing by working in partnership with the service user.

Psychosocial Interventions: Therapeutic interventions focused on addressing a person's psychological, emotional, social and occupational needs

Reflective Practice: A process of reflecting on one's professional practice and interactions with others for the purpose of better understanding and learning from one's experience and that of others. Reflective practice plays a key role in the provision of safe, high quality care, and in the ongoing improvement of service delivery. Reflective practice can be carried out at the level of the individual as well as team, in order to improve effective team working.

Service Users: People who are under the care of the team and receive treatment.

Social Worker: Social workers are professionals who aim to enhance overall well-being and help meet basic and complex needs of communities and people. Social workers work with many different populations and types of people, particularly focusing on those who are vulnerable, oppressed and living in poverty.

Triage: To screen information about a person referred to a service to see if they are appropriate for the service.

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