For Policy.
For Practice.
For Impact.

Scalability Assessment of the North Dublin Psychology Suicide Assessment and Treatment Service (SATS)

SUMMARY REPORT

January 2021

Background to the Scalability Assessment

In April 2019 the HSE National Office for Suicide Prevention (HSE NOSP) contracted the Centre for Effective Services (CES) to conduct a scalability assessment to test the feasibility of scaling-up the North Dublin Adult Mental Health approach to implementing the Collaborative Assessment and Management of Suicidality (CAMS) in their Suicide Assessment and Treatment Service (SATS). This Summary Report presents the findings of this scalability assessment.

Adult Mental Health, North Dublin Psychology Department, Suicide Assessment and Treatment Service (SATS)

The North Dublin Suicide Assessment and Treatment Service (SATS) was established by the HSE Adult Mental Health Psychology service. The primary intervention delivered by the SATS is the Collaborative Assessment and Management of Suicidality (CAMS) model. CAMS is an evidence-based therapeutic framework designed to wrap around pre-existing mental health interventions of all types and can be delivered by all mental health staff. The CAMS intervention prioritises the suicidal service users' point of view in collaboratively identifying the drivers of their suicidal thoughts and feelings, and planning treatment accordingly. The CAMS model includes collaboratively addressing the tasks of risk assessment, risk management, and treatment planning. Central to the CAMS approach is the use of the Suicide Status Form (SSF), which is a multipurpose assessment, treatment planning, tracking and outcome tool that acts as a clinical 'roadmap.' It enables co-authoring of therapeutic goals, joint identification of problems to address and agreeing the length of time required.

The SATS is the service structure by which the CAMS model is delivered. Each Psychologist allocated to the Community Mental Health Teams (CMHTs) in the catchment area has clinical time dedicated to providing suicide specific mental health care to suicidal service users using the CAMS intervention. This service provision was developed using additional working hours available following implementation of the Haddington Road (Croke Park) Agreement. This provided the capacity for work with approximately 20 suicidal service users in the catchment area at any given time. With an average of 12 weeks required per CAMS intervention, this equates to approximately 70 suicidal people per year being assessed and treated specifically for suicidality by the CMHT's Psychologists. The SATS provides a timely and responsive treatment pathway for suicidal service users within the CMHT structure. The CAMS model provides a clinical frame that accommodates the acute risk management phase of each suicidal service user's struggle, and longer-term suicide specific care. Since July 2012, over 180 service users have availed of this service development. Referrals are made verbally within standing CMHT structures, typically during the weekly CMHT meeting. An internal audit of this service activity has been carried out.

Assessing the Scalability of the SATS/CAMS approach

Following a review of the literature on scalability, for the purposes of this report, the following definition of scale-up is offered: "Increasing the reach or impact of an intervention that benefits people in an intentional manner with a view to sustainability or meeting the need."[1] Related to the definition of scale-up, is the concept of 'scalability', which here is taken to mean the ease or difficulty of achieving scale-up in practice.

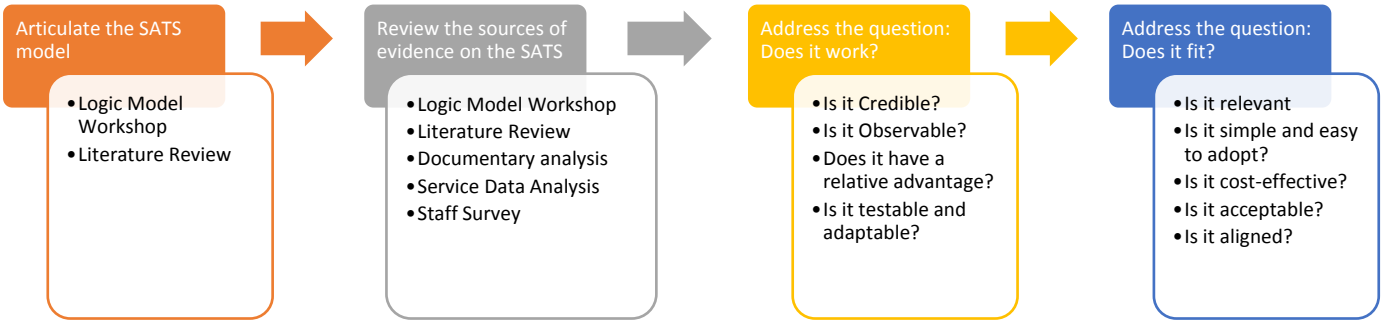
A scalability assessment seeks to understand how easy (or otherwise) it would be to increase the reach or impact of an intervention that benefits people (the SATS/CAMS approach in this instance) in an intentional manner with a view to sustainability or meeting the need for the intervention. Consistent with other approaches, this scalability assessment addresses the following questions:

1. What do you want to scale? (Articulate the model)
2. Does it work? (Is it credible, observable, testable and adaptable? Is there a relative advantage?)
3. Does it fit? (Is it relevant, simple, easy to adopt, cost -effective, acceptable and aligned?)

The sources of evidence consulted to address the questions in the scalability assessment include:

- *Literature, documentation and research* on the SATS structure, the CAMS intervention, and relevant policy documents.
- Notes of the *Logic Modelling workshop* and the agreed Logic Model.
- An *online survey*[2] with North Dublin Mental Health staff
- An analysis of *Service/outcomes data* from the implementation of the CAMS intervention through the SATS. This data was gathered from the Suicide Status Forms (SSF), the core assessment tool that had been completed by clients during their CAMS interventions.

CES approached the scalability assessment as illustrated in Figure 1.



[1] An assessment of scalability was made by CES, informed by existing frameworks, guides, checklists and tools associated with the scalability or scaling up of interventions from the literature, including the scalability assessment guides produced by the New South Wales Government (Milat, 2014), NESTA (Gabriel (2014), the WHO and ExpandNet (2010), MSI (Cooley & Ved, 2012), and the Save the Children foundation. See Appendix 1 of the full Report for an overview of the scalability and assessing scalability, including how this definition was arrived at.

[2] The survey was circulated widely i.e. to 130 mental health staff across North Dublin; 23 responses were received, representing a response rate of approximately 21%. Although not a large response rate, it is typical for a survey of this sort. Stakeholders have different levels of interest and influence. Those who responded to the survey have a highly level of interest and influence. Of the 27 respondents to the survey, 30% were psychologists, 33 % were nurses, 25% were occupational therapists, and 11% were social workers. No psychiatrists responded to the survey

Scalability Assessment

Articulating the SATS Model (i.e. developing a Logic Model)

This phase of the Scalability Assessment was focused on understanding and articulating the Adult Mental Health North Dublin Psychology Suicide Assessment and Treatment Service (SATS) model from the perspective of those delivering it. This understanding and articulation was developed based on three activities:

1. Reviewing documentation provided by the Adult Mental Health North Dublin Psychology Mental Health Team
2. Reviewing academic literature on the CAMS approach
3. Collaboratively developing a logic model articulating the SATS/CAMS approach with those delivering it.

This phase culminated in a logic model for the SATS/CAMS approach co-developed by staff involved in its delivery and informed by service documentation and academic literature (see Figure 1). Once the logic model was developed and agreed, the scalability assessment moved on to addressing the questions of whether it works and whether it fits.

Does it work?

As part of the first step in articulating the model, the evidence on perceived effectiveness was reviewed. When addressing the question of whether the SATS approach works, CES considered the following factors:

- Credibility: Is it perceived as *credible*?
- Observability: Are the results *observable*?
- Relative Advantage: Is there a *relative advantage* to the SATS approach over existing practice?
- Testable and Adaptable: Is the SATS approach *testable and adaptable*?

When the answer to each of these questions is 'yes', scale-up is thought to be easier; when the answer is no scale-up is more challenging. Each of these factors is discussed in this report in turn and assigned a qualitative rating: "Scale-up is easier"; "Scale-up will have some challenges" and "Scale-up will be more difficult".

A Logic Model for the SATS/CAMS Approach

Developed by practitioners in collaboration with the Centre for Effective Services in a workshop held 22nd May 2019

Patient Situation Analysis
2008 was accompanied by an increased rate of suicide in Ireland
Suicidal individuals have a lack of adaptive coping skills
Feelings of stigmatisation and shame due to suicidality
Perceived lack of understanding of suicidality in society

Practitioner Situation Analysis
Reluctance to work with suicidal patients due to risk of suicide and risk aversion
Lack of support and guidance for practitioners treating suicidality
Perceived lack of skills and expertise to address suicidality
Risk of practitioner burn-out
Sense of responsibility for negative outcomes

Health System Situation Analysis
Extra staff hours from HRA
Increased focus on accountability
Risk aversive system
Limited suicide-specific interventions
Focus on assessing risk of suicide rather than suicidality
Treatment involves medication and/or hospitalisation rather than addressing suicidality
Impetus for change in Connecting for Life and HSE National Service Plan 2019

Strategies
Ring-fence time to implement a CAMS (a suicide-specific intervention, supported by 4 RCTS and correlational studies) with suicidal patients. This approach:
- Is flexible; can be adapted to the needs of the patient presenting with suicidality
- Can be used by a multi-disciplinary team
- Involves the patient as a partner
- Targets resources to suicidal patients
- Provides structure and is evidence-based

Inputs
Champion(s) for the approach
Time ring-fenced to work with suicidal patients
Referrers (e.g. GPs, Psychiatrists, Emergency Department)
CAMS Training (offered twice a year)
CAMS resources (e.g. guide book and Suicide Status Form templates – Initial session, interim session, final session)
Management support
Management buy-in
Supervision (clinical, line management)
Proven track record
Team meetings to allocate cases
Premises (to deliver sessions)
IT (data entry and analysis)

Outputs / Activities
Awareness raising with referrers
Referrals
Staff trained in the CAMS approach
CAMS sessions with suicidal patients (approx. 6 to 8 sessions)

Completed SSFs provide:
- Collaborative assessment of suicidal risk
- Collaborative treatment plan
- Documented clinical tracking of suicidality
- Documented resolution of suicidality

Referrals to other relevant services (if required, once suicidality is resolved)

Patient Outcomes
Reduction in suicide as a coping mechanism
Increased desire to live
Increased adaptive coping skills
Reduced feelings of stigmatisation
Increased validation of feelings
Increased legitimisation of feelings
Increased likelihood that other issues can be identified and addressed
Increased likelihood that client will seek help in the future if needed
Reduced likelihood that client will be suicidal in the future.
Increased self-efficacy and empowerment

Practice Outcomes
Increased confidence in working with suicidal patients
Increased knowledge of how to work with suicidal patients
Increased competence in working with suicidal patients
Increased data on suicidal patients
Increased demonstrability of quality of care provided
Increased ability to manage caseloads / prioritise case work with suicidal patients
Increased ability to communicate practice to other stakeholders

Service Outcomes
Improved access to effective therapeutic interventions
Improved care pathways for suicidal patients
Reduction in suicidal patients on waitlists
Decreased inappropriate medication of suicidal patients
Decreased inappropriate hospitalisation of suicidal patients
Increased awareness of the CAMS approach
Increased referrals to other appropriate services
Increased interdisciplinary working

Credibility: Is the SATS approach perceived as credible?

An intervention is credible when it is based on sound evidence, has been subject to independent external evaluation, there is evidence that the model works in diverse social contexts, and when the model is supported by eminent individuals and institutions. For the purposes of this scalability assessment, these aspects were considered, and the following issues were explored;

- Staff perceptions on the credibility of the model
- The evidence on efficacy (RCT studies) and effectiveness (non-randomised trials).

- *Strengths:* The scalability assessment suggests that overall, the CAMS intervention as delivered through the SATS is perceived as credible both in the academic literature and by mental health staff in North Dublin. Extant studies of the approach appear robust. The intervention has been subjected to independent external evaluation in other jurisdictions. There is evidence to suggest the intervention works in diverse social contexts. The model is supported by eminent individuals and institutions internationally, having demonstrated capacity to serve as the core mental health treatment planning tool for a treating team or individual clinician in many high profile sites in the US (e.g. the Menninger Clinic and Johns Hopkins University Counselling Centre) and it is designed to meet Health Insurance Portability and Accountability Act (HIPAA)requirements in the US.

- The CAMS intervention is seen as credible by those delivering the intervention in North Dublin. The SATS appears to be less well understood than the CAMS approach, however mental health staff who were familiar with the SATS approach saw it as credible.

- *Challenges:* Overall the SATS is less well understood among mental health staff in North Dublin than the CAMS intervention. This however does not appear to present a major barrier to its functioning. While the evidence for the CAMS intervention is seen as strong, there is limited data available to evaluate the overarching SATS.

Conclusion: **Yes, overall.**

Overall, the SATS is seen as credible, particularly the CAMS intervention. More studies on the CAMS intervention are welcomed, and while independently replicated RCTs are present, further studies which do not include the developer of the approach as an author would further support the CAMS. More data should be collected on the overall SATS approach to enable monitoring and evaluation. There are indications that better awareness and communication around the SATS approach are warranted.

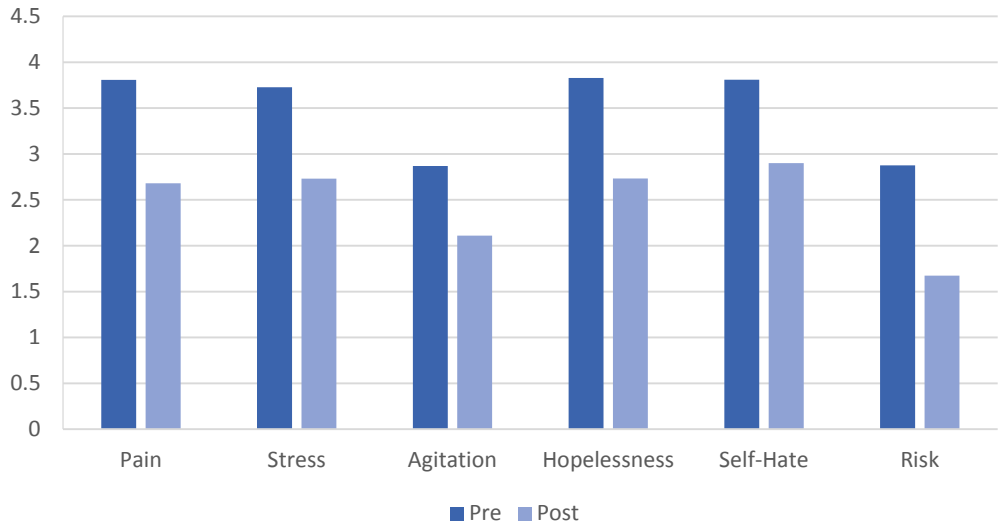
Observability: Are the results observable?

The observability of results is concerned with the extent to which the impact of the intervention is observable; that the impact is clearly associated with the intervention; and that accessible evidence and documentation are available[3].

- *Strengths:* The CAMS intervention has a built-in service user treatment and outcome tracking mechanism through the central role of the Suicide Status Form (SSF) used in each CAMS session. This provides a clear record of each service user's journey through the CAMS intervention. Practitioners who have used the intervention report seeing positive results for service users, and analysis of the SSF data outlined in this report support this observation.

- Data were available for 182 service users who received CAMS treatment between 2012 and 2019. Matched data from two time points (a first CAMS session, and the last recorded session they attended) were available for 138 service users for the 5 core rating scales of the SSF (pain, stress agitation, hopelessness, self-hate). Analysis (paired-sample t-tests and Wilcoxon Signed Ranks Test) suggested significant difference in pre- and post-intervention scores across all domains of the SSF. Thus, the available service data suggests that the CAMS intervention, as it is used in the SATS, is likely to be effective, with encouraging results for those who received the intervention.

Figure 3: Suicide Status Form (SSF) Pre- and Post-Intervention Scores (n=138)



- *Challenges*: To fully maximise the records generated through the CAMS intervention and to analyse and communicate the outcomes associated with it would require dedicated monitoring and evaluation of resources. To date this has been achieved in North Dublin on an ad hoc basis through Assistant Psychologists. This is not a guaranteed resource, and due to its ad hoc nature, consistent capacity for analysis cannot be guaranteed. In a context of scaling up, consideration would need to be given to how to resource this across different service settings and providers.

[3] Cooley, L. and Ved, R. and Fehlenberg, K. 2012. "Scaling Up – From Vision to Large-Scale Change: Tools and Techniques for Practitioners". Management Systems International (MSI).

- As would be expected, the service data available relates to clients' cognitions and affect over time using measures that form part of the CAMS intervention. Data on longer term outcomes is lacking, and there is no comparison group available. This makes it difficult to determine whether the outcomes are a result of the CAMS intervention rather than the passage of time (from crisis point). However, the wider academic literature with 8 correlational trials and five Randomised Control Trials[4] would support the link between the intervention and positive service user outcomes.

- While the CAMS approach provides a useful mechanism for tracking outcomes for service users, the overall SATS approach is less easily observed. Data collection on the number of cases referred to the SATS, or the proportion of relevant cases benefitting from the SATS approach, for example, is not readily available.

Conclusion: **Yes, partially.**

The issue of resourcing ongoing monitoring and evaluation of an intervention to address suicidality, or any issue in the health service, is not unique to SATS or CAMS. The clear records provided by the SSF (used in the CAMS intervention) are a strength of the approach and facilitate communication between stakeholders as well as laying a good foundation for any potential monitoring and evaluation activities. Consideration should be given to how to monitor and evaluate the overall SATS approach.

[4] At the time of undertaking the scalability assessment. This body of research is continually growing,

Relative Advantage: Is there a relative advantage to the SATS approach over existing practice?

The scalability assessment explored the potential relative advantage of the SATS structure and the CAMS intervention over other approaches to addressing suicidality.

- *Strengths*: Currently, there are few suicide specific interventions. Dialectical behaviour therapy (DBT) is a 'go-to' approach for suicidal service users, however the threshold for referral to DBT is relatively high and the intervention is resource intensive. The CAMS approach is potentially applicable to a wider number of suicidal people, and research suggests that it may show effectiveness more quickly than DBT, and that service users may prefer the approach[5] [6]. However, this is not to say that DBT should no longer be used as in some cases it is the more appropriate intervention.

- The CAMS process is collaborative and involves the generation of suicide specific treatment goals. It can function as the core mental health treatment planning tool for a treating team or an individual clinician. The CAMS process provides a comprehensive risk assessment that can allow individuals to be discharged from inpatient care with a treatment plan for their suicidality in place. The CAMS documentation could transfer effectively between clinicians thus facilitating continuity of care between treatment environments.

- Compared to once-off interventions such as Applied Suicide Intervention Skills Training (ASIST) and STORM, CAMS has a stronger evidence base and helps service users to address their suicidality over time. When the SATS approach is operating as intended, suicidal service users are not placed on waiting lists and receive the intervention in a timely fashion. The primary advantage of the SATS is that it allows clinicians dedicate time specifically to working with suicidal service users as a priority within their caseloads.

- *Challenges:* The SATS approach relies on mental health staff ring-fencing time to working directly with suicidal service users. Anecdotal evidence suggests that a risk adverse culture may make this seem like a significant and difficult challenge to address.

Conclusion: **Yes, for many service users.**

There is a relative advantage to the SATS structure. The CAMS intervention in particular may be a preferred treatment option for some suicidal service users (Comtois et al., 2011). The SATS may be challenging to resource in new settings or areas in that it requires ring-fencing time or supporting the prioritisation of suicidal service users amongst caseloads. As with any suicide-specific intervention, staff will need to be supported to avoid burn-out.

[5]Ryberg, W., Zahl, P. H., Diep, L. M., Landrø, N. I., & Fosse, R. (2019). Managing suicidality within specialized care: A randomized controlled trial. Journal of affective disorders, 249, 112-120.
[6] Comtois, K. A., Jobes, D. A., S. O'Connor, S., Atkins, D. C., Janis, K., E. Chessen, C., ... & Yuodelis-Flores, C. (2011). Collaborative assessment and management of suicidality (CAMS): Feasibility trial for next-day appointment services. Depression and Anxiety, 28(11), 963-972.

Testability and adaptability: Is it testable and adaptable?

The easier an intervention can be trialled on a small scale by potential adopters without a large commitment of resources and the easier it is to adapt it to new contexts while retaining its effectiveness, the more scalable the intervention is.

- *Strengths:* The SATS structure, and in particular the CAMS intervention, has the potential to be tested by users on a limited scale, and does not require an overhaul of regular working structures or functions. The CAMS element of the intervention is a flexible therapeutic framework to guide practice, rather than a new type of therapy. This means it can be adopted by a wide range of different practitioners working from different mental health disciplines.

- *Challenges:* The SATS structure was developed using additional working hours available following implementation of the Haddington Road (Croke Park) Agreement. This provided the capacity for work with approximately 20 suicidal service users in the catchment area at any given time (with approximately 2 cases/psychologist and approximately 10 psychologists at any given time). With an average of 12 weeks required per service user, this equates to approximately 35-70 people per year being assessed and treated specifically for suicidality by the Community Mental Health Team's (CMHT) Clinical Psychologists. It will likely be difficult for other areas to be able to 'ring fence' hours to dedicate to delivering SATS/CAMS given the current pressure on resources.

Conclusion: **Yes, particularly the CAMS element.**

The model appears testable and adaptable, but more guidance would be required on how services or mental health teams should allocate time to implementing the CAMS intervention, and to support staff implementing it. Anecdotal reports would suggest that the use of a 'champion' model has been effective in other services. Supervisory and managerial supports are deemed essential.

Does it fit?

When addressing the question of whether the SATS approach fits, this scalability assessment considered the following factors:

- Relevance: Is the SATS approach *relevant* to the work of potential implementers and funders?
- Simple and adoptable: Is the SATS approach *simple and easy to adopt*?
- Cost-Effectiveness: Is the SATS approach *cost-effective*?
- Acceptable: Is the SATS approach *acceptable* to service users and other stakeholders?
- Aligned: Is it *aligned* with national and local policy directives?

When the answer to each of these questions is 'yes', scale-up is thought to be easier; when the answer is 'no', scale-up is more challenging.

Relevance: Is the SATS approach relevant to the work of potential implementers and funders?

This scalability assessment considered whether staff currently involved in the delivery of the SATS approach felt it addressed an objectively and subjectively significant persistent problem.

- *Strengths:* Respondents to the staff survey tended to agree that the CAMS intervention meets an important need in the area where they work. Respondents agreed even more strongly that the approach meets an important national need. The literature review indicates that the CAMS intervention can be successful with a wide range of different service users, and can be implemented in diverse organisational settings, suggesting the approach has applicability beyond the North Dublin Adult Mental Health context. Overall, the SATS approach, and the CAMS intervention, addresses a need sharply felt by beneficiaries, including service users, service providers and the wider healthcare system.

- Respondents to the staff survey indicated that they felt the CAMS intervention would fit well in the Irish Mental Health system.

- *Challenges:* Respondents to the staff survey were less positive about the leadership support for the SATS structure in their Community Mental Health Team, although over half did feel that that the approach receives support from leadership.

Conclusion: **Yes, to some.**

The CAMS approach and SATS structure address issues that staff feel are important, however the level of leadership support currently experienced is good but not optimal. In order to facilitate scale-up, leadership support is an important enabler and should be secured at an early stage of any planned scale-up activity.

Simple and easy to adopt: Is the SATS approach simple and easy to adopt?

The scalability assessment considered the extent to which the SATS structure was simple and adoptable in other contexts.

- *Strengths:* The SATS approach and the CAMS intervention are relatively simple, comprised of few components and require limited changes to practice that theoretically do not conflict with the culture of potential adopting organisations. Any changes required appear to be implementable within existing systems, infrastructure and human resources. The model is compatible with a range of professional philosophies and approaches.

- The components and activities associated with the CAMS element of the SATS approach have low technical sophistication. The key elements are clear and easily replicated, with few components, all of which could in theory be added on to existing systems. While there is a training requirement, this does not appear to be burdensome. Additionally, supervision enhances implementation of the intervention, but this is true for any approach to working with service users experiencing suicidality.

- *Challenges:* The plan for scale-up is yet to be determined, and so it is unclear at this stage how many decision makers would be involved in agreeing to adoption of the model. The number of decision makers involved may be numerous, and this would pose a challenge for scale-up.

- The original SATS approach involves ring-fencing time for practitioners to implement the CAMS intervention. As noted, this may be challenging for adopting organisations in their contexts. However, the barriers to implementation, like ring-fencing of time, are achievable, and the positive outcomes provide considerable potential reward in service improvement. Respondents to the staff survey were not sure how easy it would be to replicate the SATS structure.

Conclusion: **Yes, but it requires clear articulation.**

As an approach to working with service users experiencing suicidality, the CAMS approach is simple and compatible with a wide range of work practices, philosophies and theoretical perspectives. When being adopted, the SATS structure would need some adaptation to suit contextual factors, but the model appears to be able to accommodate that.

Cost effectiveness: Is the SATS approach cost-effective?

A scalable intervention is ideally more cost-effective than existing and/or competing interventions.

- *Strengths:* The original SATS model was developed and implemented within existing organisational, technical, human and financial resources. The training requirement is not intense compared to other approaches, and the CAMS element can potentially encompass a wider range of service users than the DBT service. Some research findings indicate that service users who have received the CAMS intervention show lower healthcare utilisation than service users who received other treatment options[7].

- *Challenges:* This report did not seek to conduct a cost-benefit analysis - this limits the ability to address this question authoritatively.

Conclusion: **The SATS approach is likely to be cost effective. However, this was difficult to determine within the scope of this report.**

The SATS approach, and the CAMS element, are likely to be cost-effective. However, this is difficult to determine in the context of the scope of this report.

[7] Jobes, D. A., Wong, S. A., Conrad, A. K., Drozd, J. F., & Neal-Walden, T. (2005). The collaborative assessment and management of suicidality versus treatment as usual: A retrospective study with suicidal outpatients. Suicide and Life-Threatening Behavior, 35(5), 483-497.

Acceptability: Is the SATS approach acceptable to service users and other stakeholders?

This scalability assessment considered the likelihood that the SATS structure, including the CAMS element, would be acceptable to stakeholders, including target groups when scaled up.

- *Strengths:* Respondents to the staff survey indicated that the SATS structure has a positive impact on both suicidal service users and on Community Mental Health team members who work with suicidal service users. This suggests that the approach is likely to be acceptable to staff who would implement the approach, as well as service users who would engage with it.

- Research indicates that service users have positive perceptions of the CAMS intervention, compared to other treatment modalities[6]. Added to that, findings from the staff survey indicated that the majority of respondents feel that the CAMS approach has a positive impact on professionals' relationships with service users, and that it would be a good fit for all Community Mental Health Teams indicating a good degree of acceptability among frontline staff and service users.

- *Challenges:* While there is evidence that staff and service users who have been involved in the delivery of the SATS approach and / or the CAMS intervention find it useful, other perspectives are lacking. A limited response to the staff survey, and the lack of responses from psychiatry staff, limit the generalisability of these findings. However, given the primary source of referral for CAMS intervention comes from Psychiatry colleagues, this is suggestive of tacit support.

Conclusion: **Yes for staff, however there is limited evidence from some key stakeholders, including service users.**

The SATS approach is likely to be acceptable to service users and practitioners implementing the CAMS approach. Less is known about acceptability among other stakeholders. Achieving buy-in from stakeholders at every level should be an early focus for any scaling efforts.

Aligned: Is the SATS approach aligned with national and local policy directives?

The scalability assessment considered whether the SATS approach is consistent with national or local policy directives and its alignment with the broader strategic context. In addition it also assessed whether the SATS structure and CAMS intervention would likely be compatible with other interventions being implemented in the settings where the SATS structure could be scaled to.

- *Strengths:* The SATS approach, particularly the CAMS intervention is well aligned and consistent with national policy directives and is not likely to conflict with local policies. While a scale-up plan has not been developed at this stage, the contexts within which the SATS approach would be scaled to are likely to be comparable to the North Dublin context in many relevant respects.

- *Challenges:* Even though the SATS structure and the CAMS intervention are well aligned with national and local policies and broader strategic goals, scale up is likely to be frustrated by competing priorities. For example, the current Covid-19 pandemic may divert attention from a range of other priorities.

Conclusion: **Yes, in theory. Shifting priorities may pose a challenge.**

There is strong alignment of the SATS approach with national and local policy directives and broader strategic goals. However, in a context of shifting priorities, attempts to scale-up the approach should involve demonstration of the continued relevance and need for the approach, and how it can help to address emergent needs.

Overall conclusions

The SATS structure, including the CAMS intervention, appear to be scalable interventions. The scalability assessment indicates that it is clear what the approach is, and there is evidence to support that it 'works', and it 'fits':

- **It works:** There is evidence to support its efficacy and effectiveness, it is perceived as effective, the results are observable to both implementers and beneficiaries, it has some notable relative advantages over other approaches, and it is testable and adaptable.

- **It fits:** There is evidence to suggest that it is seen as relevant and acceptable to stakeholders, including the target group, the approach is simple, the approach is likely to be cost-effective (although a full cost-effective analysis was not conducted as part of this scalability assessment), and it is aligned with national and local policy directives.

The CAMS intervention appears to be the most scalable aspect of the SATS structure and should form the primary focus of planning for the next stage of scale-up.

Limitations of methodology

These findings should be understood bearing the following in mind:

- The response rate to the staff survey was low (although in line with response rates to surveys in general) and some key perspectives (e.g. psychiatry) were absent. However, the respondents did represent a good spread of disciplines and community mental health teams and locations across the North Dublin Mental Health Services.

- The research literature and service data analysed for this scalability assessment was limited to what existed and was available at the time the scalability assessment was undertaken. This research base was not developed with a scalability assessment in mind, and while useful, it did not necessarily cover all aspects relevant to a scalability assessment.

Next steps

If it is decided that the SATS structure and/or the CAMS intervention is to be scaled up, this report recommends the following steps should be considered[8]:

1. Determine the approach to scale-up
2. Establish the preconditions for scale
3. Plan for implementation
4. Monitor and evaluate

1. Determine the approach to scale-up

This involves articulating the planned approach or strategy for how the intervention will be scaled up. The literature describes a number of ways an intervention can be scaled, and the following three approaches may be the most relevant in this context:

[8] See for example Cooley, L. and Ved, R. and Fehlenberg, K. 2012. "Scaling Up – From Vision to Large-Scale Change: Tools and Techniques for Practitioners". Management Systems International (MSI).

- **Horizontal scaling up:** this occurs when innovations are replicated in different geographical sites or are extended to serve larger or new categories of populations.
- **Vertical scaling up:** This occurs when formal government decisions are made to adopt the innovation on a national or subnational level and it is institutionalised through national planning mechanisms, policy changes or legal action.
- **Collaboration:** This occurs when the work of implementing and scaling-up the intervention is shared through formal partnerships, strategic alliances and coalitions. Whether this approach is relevant for scaling up the SATS structure or the CAMS approach depends on the overall vision for scale-up - if the intention is to work with other organisations such as NGOs, this approach may be worth considering.

Once the approach to scale-up has been agreed, a plan should be developed that summarises the need for the intervention, the vision behind it, and the evidence underpinning it. The plan should include a clear description of proposed actions, timetables, roles, responsibilities, and resources for scaling up.

2. Establish the preconditions for scale-up

Demonstrate the effectiveness and relative advantage of the intervention to relevant decision makers, funders, and opinion leaders to show it is necessary, desirable and feasible using appropriate channels.

3. Plan for implementation

Identify and make any necessary changes to the intervention to ensure it works in the new context or contexts in which it is to be scaled. Ensure responsibilities are clearly allocated and efficient mechanisms are established to coordinate the scaling up effort.

4. Monitor and evaluate

Ensure that adequate procedures for documenting the progress, lessons learned, and impact of the scaling up effort are in place.

Final thoughts

The conditions are never ‘ideal’ for successful scaling up. Every context or environment brings with it both opportunities and challenges. In order to achieve the desired goals of scaling up the SATS structure, or the CAMS intervention, the approach adopted should ensure that the need for, and effectiveness of the approach, are demonstrated relative to national and regional policy priorities; that it is adaptable to new ways of working; and that it is acceptable to both staff and target groups.

This report was produced by the Centre for Effective Services (CES, www.effectiveservices.org) and was written by Lisa Ann Kennedy, with research support from David Beatty and Mary Murphy.

This report was commissioned by the HSE National Office for Suicide Prevention (NOSP).