Mental Health Engagement Framework

2024–2028

HSE Mental Health Engagement & Recovery

enhancing engagement
MENTAL HEALTH ENGAGEMENT FRAMEWORK

Contents

Foreword

I am pleased to write this foreword for the *Mental Health Engagement Framework 2024-2028.* It brings from theory to practice the centrality of lived experience to the continuous improvement of mental health services. The framework builds on the success of the National Office of Mental Health Engagement and Recovery Office (MHER)'s provision of guidance and support in relation to mental health recovery since 2016.

The first objective of MHER's Strategic Plan *Engaged in Recovery 2023-2026 - To co-produce an enhanced good practice model for meaningful engagement in mental health services* - is realised in this framework and its accompanying guides. The framework and guides will be used by mental health staff and others to inspire and create more engagement activity. They also offer new opportunities for people with lived experience to become involved in mental health engagement whether it is a one-off event or becoming a member of a regional or national volunteer panel or a local forum.

The framework aligns with mental health policy implementation at a national and international level for example, the shared aim held by both the World Health Organisation's *Meaningful Engagement Framework* and the *Sláintecare Action Plan* to have patient engagement play an essential role in its successful implementation. It also supports staff to respond to their responsibilities to listen to and act upon service improvement ideas from people with lived experience.

This practical document reflects the insights and experience gathered by the National Office of Mental Health Engagement and Recovery (MHER) and its commitment to ensuring that the voices of people with lived experience inform service delivery, design, development, and improvement. The Office is continually learning how to best learn from, and with experts by experience to enable the production of such contemporary and useful documents. For the first time in Mental Health Engagement in the HSE, this framework introduces measurement via co-produced Key Performance Indicators. This builds on the MHER's commitment to collecting data and providing evidence for the efficacy of its approaches.

Importantly, the framework highlights the value and expertise of lived experience as an equal and essential partner in a recovery-focused mental health service alongside its clinical, social and community partners. I look forward to seeing this framework implemented in the coming years, in the knowledge of the relationship and trust building it will incur and the evidence it will produce.

I believe that the work that MHER delivers and enables is core to ensuring that Ireland continues to be recognised as a world leader in the reform of mental health services to one where the centrality of lived experience is the norm.

Dervila Eyres

Assistant National Director, Head of Operations HSE Mental Health Services

Introduction

The Health Service Executive's (HSE) National Office of Mental Health Engagement and Recovery (MHER) is committed to continuous learning and continuous improvement. It acknowledges that its approach needs to be regularly reviewed and that cultural change takes time. The Mental Health Engagement Framework is a response to the call for the further embedding of lived mental health experience to improve mental health services.

MHER, and in particular the Enhancing Engagement Steering Group for this framework are determined to follow Maya Angelou's approach to success.

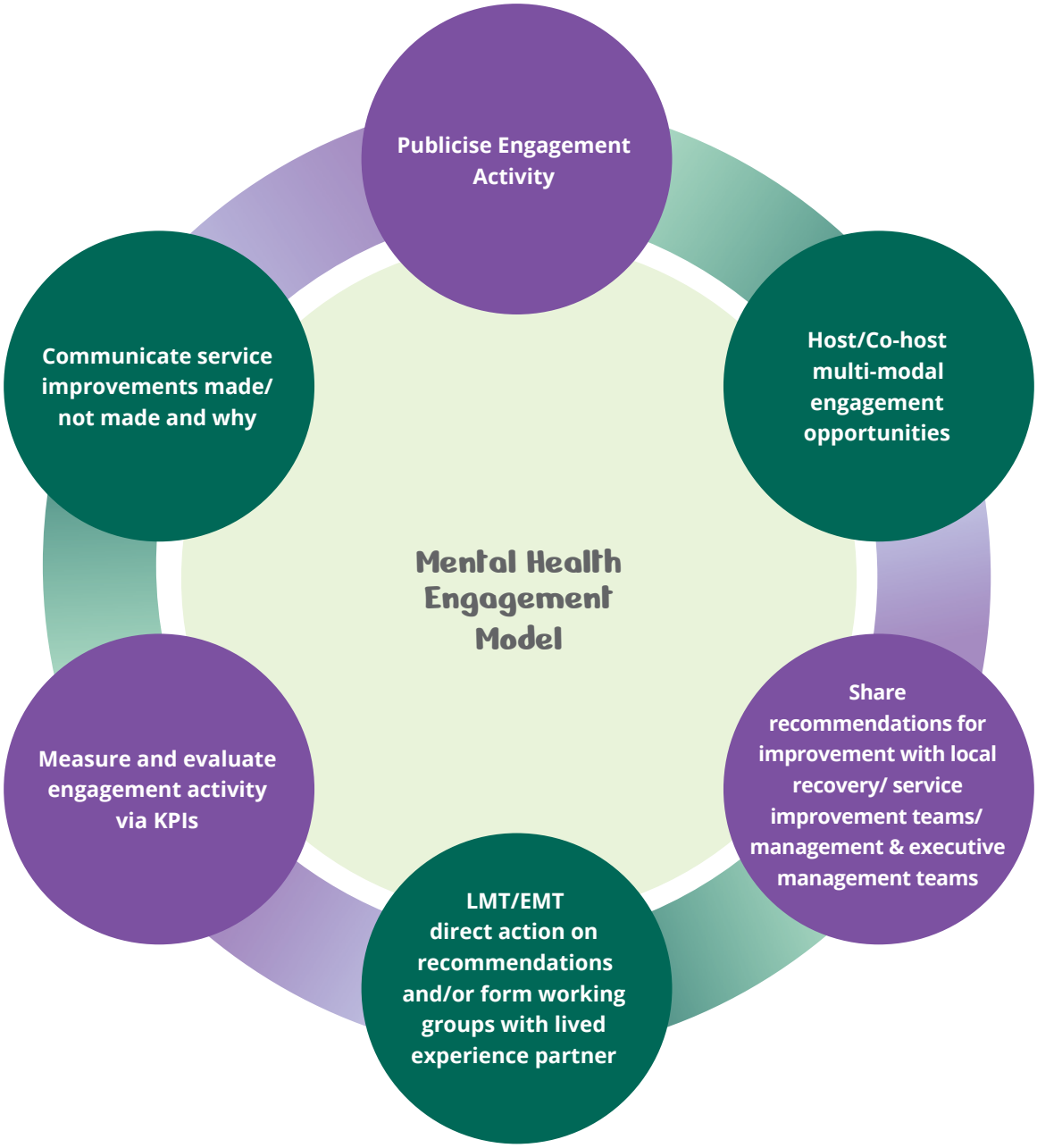
> "I did what I know how to do. Now that I know better, I do better.

It is a response to feedback from multiple stakeholders who recognise that we have achieved a lot through the existing mental health engagement structures but there is still a need to strengthen the voice of lived experience to inform service improvement, and thereby the recovery orientation of services.

The model and *Framework for Mental Health Engagement* were developed to answer the expressed needs of stakeholders including people with lived experience (PWLE) of using mental health services, their families, carers and supporters, senior leaders in mental health services and mental health engagement and recovery workers.

In brief, these needs are

- **Clarity of the role of the National Office of Mental Health Engagement and Recovery (MHER)**
  See MHER's Strategic Plan **Engaged in Recovery 2023-2026**
- **Clarity on the types of mental health engagement**
  See the Mental Health Engagement graphic on **p.23**
- **Optional ways of being involved in mental health engagement**
  See the framework actions in this document on **p.26** and MHER's **Guide to Mental Health Engagement Methods**
- **Measurement of mental health engagement**
  See co-produced Key Performance Indicators in this document **p.28**
- **Closing the feedback loop in mental health engagement**
  See the **Mental Health Engagement Model** on the following page



Glossary

PWLE	People with Lived Experience
MHER	National Office for Mental Health Engagement and Recovery
HSE	Health Service Executive
LMT	Local Management Team
EMT	Executive Management Team
RHA	Regional Health Area
NGO	Non-Governmental Organisation
WHO	World Health Organisation
UNCRPD	United Nations Convention for the Rights of Persons with Disabilities

Let's talk **reasons**

Why do we need a Framework for Mental Health Engagement?

This work emerged from a review of the National Office of Mental Health Engagement and Recovery's ten years of experience in a systems approach to engagement. It is based on the learnings gathered about the successes of engagement and the barriers that prevent meaningful engagement. The project also reviewed international activity in engagement. It is upon analysis of these two factors that this framework is based. The framework will support service improvement in the development, design and delivery of mental health services.

The HSE mental health services have both a policy and contractual responsibility to provide the best outcomes for people using services. Mental health engagement is one of the significant ways in which this responsibility can be realised.

This framework describes engagement, supports and opportunities for better and more mental health engagement as well as a structure for taking action and a measurement tool to embed empowering lived experience expertise and partnership working in mental health services.

Mental health staff would like more clarity on what engagement involves and how they can become more involved with it. People with lived experience, their families, carers and supporters want to make sure their voices are heard and that the expertise of lived experience leads to real service improvements that are implemented.

The framework reflects the principles, values, and strategic actions of several government programmes, policies and strategies both nationally and internationally where there is an increased focus on working in partnership with people with lived experience, their family members, carers and supporters in mental health settings. Recovery principles have emerged as a driving force behind public mental health policies. The Health Service Executive (HSE) , along with healthcare systems around the world, is responding to the demand of "nothing about me, without me" and the requirement to shift from "what's the matter" to "what matters to me"[1]. This approach requires moving away from existing "one size fits all" interventions and strategies towards bottom-up, inclusive co-creation processes.[2]

In short, this document describes an enhanced engagement framework that will lead to more effective involvement of people with lived experience of mental health services in the improved design, delivery, and development of mental health services. It also highlights how and why mental health service staff can be part of this process, and how service accountability and governance can be strengthened and improved.

Within this document, there is a set of new and existing actions to develop mental health engagement in mental health services. Accompanying documents will support the practical implementation of this framework and can be found on the MHER Office website **here**. Information on policy alignment can also be found on the website.

1. Roseman, D., Osborne-Stafsnes, J., Amy, C.H., Boslaugh, S.,Slate-Miller, K. (2013). Early Lessons From Four 'Aligning Forces for Quality' Communities Bolster The Case For Patient-Centered Care. Health Affairs 32,NO 2.(2013);232-241. DOI:10.1377/hlthaff.2012.1085

What is mental health **engagement?**

Note: Mental Health Engagement is **not** a complaints mechanism. There is a comprehensive complaints and compliments system in the HSE called Your Service, Your Say

It is a purposeful attempt to work in reciprocal, respected relationships with people with lived experience of mental health challenges who have used services, and their families, carers and supporters, to improve those services. The National Office of Mental Health Engagement and Recovery adheres to the World Health Organisation's description of Meaningful Engagement:

Meaningful Mental Health Engagement is a respectful, dignified and equitable process of integrating individuals with lived experience across a range of processes and activities, transferring power to people, valuing lived experience as a form of expertise, and applying this to improve health outcomes.[2]

2. World Health Organisation https://iris.who.int/bitstream/handle/10665/367340/9789240073074-eng.pdf?sequence=1

What is the **purpose** of the framework?

Note: Decision-making processes in Mental Health Engagement can include policy advice, strategies, standards, and codes of practice, designing processes, services, public infrastructure and public spaces, and carrying out research projects.

The purpose of the framework is to enhance the way mental health engagement happens in Ireland's mental health services, by providing tools to increase accountability, governance, and guidance on how to work in partnership with people with lived experience. The long term impacts of mental health engagement activity are better mental health outcomes for individuals due to improved services that are satisfying places to work.

The mental health engagement methods described in the accompanying **guide** aim to support and influence decision-making on mental health service improvement at a strategic and local level.

Who is this framework for?

Engagement is everybody's business and so this framework is for all stakeholders of mental health services. In particular the framework welcomes the engagement of the following people:

Mental Health Professionals

– this framework will help guide you on your engagement journey so you can best contribute to your responsibility for working collaboratively with people with lived experience. This will support you to achieve local and national policy and strategy goals that incorporate the perspectives of people with lived experience and deliver better recovery outcomes for service users.

Mental Health Administrative Roles

– this framework will help you to understand what meaningful engagement is and what role you play in its promotion, adoption and measurement.

People with Lived Experience of Mental Health Services

– this framework will provide you with several options for engaging with your mental health service to improve them, you can choose the method that works best for you at any point in your recovery journey.

Families, Carers and Supporters

– this framework will provide you with several options for engagement with mental health services so that you can choose the method that works best for you to inform service improvement.

How was this framework developed?

In 2021, the National Office of Mental Health Engagement and Recovery (MHER) established a multi-stakeholder National Steering Group from Enhancing Engagement in Ireland.

In February 2022, a National Project Manager was appointed to work with the Steering Group which comprised members of the MHER national team, one Head of Service (Mental Health), People with Lived Experience of Mental Health Services, a Family Member with Lived Experience, Area Leads for Mental Health Engagement and a Recovery Coordinator.

While feedback and ideas for improvement have been gathered from people who use our services, their families, carers, and supporters since the introduction of our first Engagement Structures in 2016 (Partnership for Change)[3] this information was not always put to practical use. As a result, the development of this framework focused on:

- gathering and sharing **good practice** for engagement
- figuring out how to offer **choice** in the ways we engage
- the development of key performance indicators so that engagement is **plugged into our mental health system**
- figuring out how to **collect data** under the current governance structure
- supporting **the role** of the area leads for mental health engagement
- clarifying the **support and guidance role** of MHER

The framework is informed by information from multiple stakeholders gathered between 2019 and 2024 including:

- 1:1 interviews with MHER staff and aligned professionals in mental health services
- Mental Health Engagement Conference Feedback 2019 and 2022
- Survey with Area Leads for Engagement in 2019
- Forum Member and other Volunteer Surveys from 2019 and 2023
- Just Economics Report on Engagement 2020
- Action Research Mental Health Service Leaders Genio 2021
- Area Leads for Engagement Meeting minutes 2022-2024
- Engagement and Recovery Alignment Meetings 2022-2024

3. https://www.lenus.ie/handle/10147/617212

Together is **better**

The benefits of staff working in partnership with people with lived experience of mental health services:

Engagement is not just an aspiration for good interactions between people with lived experience of mental health services, their families, carers, supporters and those who work within the mental health system.

It consists of vital approaches that **honour human rights** and represent genuine partnerships to deliver the best outcomes at individual, organisation and system level.

The benefits are experienced by all stakeholders and range from individual recovery benefits through to moral and legal benefits within systems. The World Health Organisation has recognised that the empowerment of mental health service users and carers **leads to tangible biological, psychological and societal benefits.**[4]

People with Lived Experience (PWLE), their families, carers and supporters have **important knowledge and insight.** They know their own needs and can play an active role in decisions that impact them. What others think matters to a person with lived experience or family member may not matter to them. Engagement findings help services and staff use this information for the continuous improvement of our mental health services.

4. World Health Organization Regional Office for Europe. User empowerment in mental health: A statement by the WHO regional office for Europe. Copenhagen: World Health Organisation; 2010. https://www.academia.edu/27555757/Mental_Health_in_Europe_the_need_for_a_common_language_standard_classification_criteria_and_official_communication

Engagement of people with lived experience in recovery-focused services can also lead to the healing of historical traumatisation within services for both users of the services and providers of the services. It can promote **cultural change.**[5]

Full and meaningful participation by PWLE, their families, carers and supporters can support **more effective and efficient services,** delivering benefits for clinicians, policy makers and funders, as well as for people with lived experience and their families, carers and supporters.

Including **Creative Engagement** methods as suggested in the accompanying Creativity & Mental Health Engagement Guide offers significant benefits for PWLE from an individual through to a cultural level.[6]

Mental Health Engagement offers staff a process for living up to **contractual requirements** to work in partnership with PWLE to improve health outcomes.

5. https://www.mentalhealthcommission.gov.au/getmedia/afef7eba-866f-4775-a386-57645bfb3453/NMHC-Consumer-and-Carer-engagement-a-practical-guide

6. https://journals.sagepub.com/doi/10.1177/2752535X231175072

Article 4.3 of the UNCRPD states:

"In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organisations."

Furthermore, the Engagement Cycle[7] used by the National Health Service (NHS) in the UK lists the benefits of engaging people who use health services in the following manner:

Moral

Many believe that being engaged in decisions about planning, designing and delivering services is a fundamental right.

Business

Engaging people in planning, monitoring and improving health services can make sound business sense by increasing quality and effectiveness and reducing cost.

Social and political

Engaging people in planning, monitoring and improving health services can lead to more trusting and confident relationships between local stakeholders.

Health

There is growing evidence that patient and public engagement (PPE) can deliver improvements, such as more responsive services, improved outcomes, patient experience, shared decision-making and self-care.

Legal

Ireland ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)[8] in 2018 and as such there is a legally binding obligation to adhere to its articles.
(adapted for Ireland)

7. https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2018/06/The-Engagement-Cycle-Overview-PDF-final.pdf

8. https://www.gov.ie/en/publication/b47d7-what-is-the-uncrpd/?gclid=Cj0KCQiApOyqBhDlARIsAGfnyMqNYSzSLkJQN4UmwxqXqyIO2Frr2WNWrzeXiUDUIOXgCwXdWHLxbKgaAqbpEALw_wcB

Lived Experience in Mental Health Engagement and Recovery

What is Lived Experience?

Incorporating the 'patient voice' into healthcare organisations is a phrase that is becoming more common. While there is an overlap between lived experience and the patient's voice, they are often defined as distinct concepts.

Lived experience encompasses the **entire person's journey** and personal insights from living with a health condition.

In contrast, the **'patient voice'** refers to the active involvement and expression of patients' perspectives within the healthcare system. In essence, lived experience provides the foundation for the patient voice, shaping individuals' unique perspectives and informing their active participation and contributions to healthcare decision-making and advocacy.[9]

The Lived Experience foundation is further described as what someone has experienced first-hand, especially when it gives the individual knowledge or understanding that people who have only heard or learned about such experiences do not have. Related terms that are sometimes used include: experts by experience, lived expertise, living experience, patient expert.

Lived Experience in this mental health context is the expertise and knowledge that comes from living with and managing a mental health difficulty periodically or on an ongoing basis, including the experience of using mental health services.

9. https://www.patientexperienceagency.com.au/blog/the-fundamentals-of-lived-experience

Lived experience encompasses the entire person's journey and personal insights from living with a health condition.

How is Lived Experience of Mental Health Services applied by individuals?

Lived experience may have both a therapeutic and service improvement value and is unique to each service user, family member, carer and supporter.

It has a range of applications including: service improvement, recovery education, peer support working, peer leadership, management and service planning and evaluation. The points below describe the different ways lived experience can be personally integrated and applied for both personal and professional applications.

1.

Lived experience of having a mental health challenge and managing it on a day-to-day basis, this may include using mental health services. This experience is unique to each person and must be respected and valued in all interactions with that person in terms of care treatment and recovery.

2.

Recovery experience is the process by which a person manages their mental health difficulty and achieves personal goals and ambitions in their life regardless of the ongoing presence or severity of that difficulty. Recovery experience has value in supporting others in recovery and in informing service improvement.

3.

Expert by experience is when a person has reconciled and integrated their lived and recovery experience into their lives and can look objectively at those experiences. Experts by experience are essential to inform service improvement. This stage aligns with the description of 'patient voice' as described the patient experience agency referenced above.

Note: While it is very useful to categorise the evolution of lived experience that may occur in one's recovery journey, the value and integrity of any individual's lived experience should never be diminished in comparison to another who may be a different place on their recovery journey.

Note: MHER recognises the value of lived experience expertise. In the current environment (2024) where remuneration for engagement activity is not yet available, the MHER Office offers alternative value in exchange for expertise. This alternative value was created based on volunteer feedback in 2023 and 2024 and includes but is not limited to personal development training opportunities, supervision, and support.

How is Lived Experience expertise applied in the paid Mental Health Engagement Structure?

The National Office of Mental Health Engagement and Recovery has an associated structure within the Irish mental health services that illustrates a range of paid applications of lived experience as described here:

A primary desirable criterion for all of these roles is lived experience of mental health services that aligns with the description of an Expert by Experience.

- **The Head of the National Office of Mental Health Engagement and Recovery (MHER) is a senior manager in the HSE National Mental Health Operations Team.**
- **The National Office of Mental Health Engagement and Recovery (MHER) consists of a Senior Project Manager, 3 Programme Managers and 2 Administrators.**
- **There is a management role of Area Lead for Mental Health Engagement in every HSE Regional Health Area.**

This structure is established nationally and its application locally is dependent on local organisational commitment and resource allocation.

The Mental Health Engagement structure is complemented by a community of workers, many of whom have lived experience. These roles are focused on recovery including full mental health service teams, in particular, the roles of Peer Support Workers, Family Peer Support Workers, Recovery Coordinators, Peer Educators, Recovery Education Facilitators and Individual Placement and Support Workers.

For more information on these roles or to contact members of staff please reach out to **mhengage@hse.ie**

Understanding what **matters**

Guiding principles of the framework

The guiding principles for this framework are informed by existing engagement models as well as a number of HSE policies and implementation plans such as *Sharing the Vision*[10], *New Directions*[11], the *National Healthcare Charter*[12] and *A National Framework for Recovery in Mental Health*[13].

The National Office of Mental Health Engagement and Recovery (MHER) has embraced many international principles in the development of the Office itself, for example, the approach to recovery education has created a space for learning and co-produced modules. At a service level a renewed focus on recovery orientation has imbued hope in large parts of the mental health system. The local, area and national forums for engagement have provided people with lived experience of services an opportunity to share information and inform decision-making in many parts of the country. Additionally, multiple paid peer roles are now embedded within community mental health teams, and collaboration with external stakeholders is evolving.

10. https://www.hse.ie/eng/services/list/4/mental-health-services/mental-health-engagement-and-recovery/sharing-the-vision/

11. https://www.hse.ie/eng/services/list/4/disability/newdirections/

12. https://www.hse.ie/eng/about/qavd/complaints/ncglt/toolkit/complaintsofficerstoolkit/national-healthcare-charter.pdf

13. Recovery Oriented Services - HSE.ie

The purpose of the principles is to guide and underpin all activity in mental health engagement. MHER promotes pragmatism in their application and understands that principles might be incrementally applied in the complex system of mental health services.

Principle	What does this mean
Person-Led	Create an environment that accepts and values the uniqueness of everyone's experiences and perspectives on services. Make people feel like they belong, that they matter. Embrace the curiosity, creativity, and expertise of all stakeholders.
Respect	Hold authentic motivation to work together to improve services. Be empathetic, civil, and transparent in all communications. Listen to, learn about and challenge assumptions. All stakeholders have access to relevant and credible information related to engagement objectives, and practical support to strategically engage in conversations and decision-making.
Collaboration	Aim to work in co-production. Be in genuine, trustworthy partnerships. When co-production is not possible, be clear that you agree to engage to inform, educate, consult, involve or co-design.
Equity	Be inclusive of diverse experiences and perspectives. Give weight and dignity to the specific experiences of people from seldom heard communities, and oppose all forms of discrimination whether based on ability, ethnicity, age, gender, social circumstances, religious belief or sexual preference.
Response	Take action with the intent to impact the information received in a timely manner. Where this is not possible, be clear about the reason. Focus on growth and positive change, and develop better outcomes, services and experiences.
Empowerment	Build relationships where people feel comfortable to discuss their feelings and what they want, focus on strengths and abilities, respecting the decisions a person makes about their own life.
Accountability	This principle expects organisations to live up to their commitments, for instance in the delivery of services and behaviour towards all stakeholders and the collection of evidence for engagement. Close the loop by reporting back to stakeholder groups and evaluating all efforts.
Acknowledgment	Promote and celebrate the value and success of engagement activities to underline its impact and inspire future engagement.
Courage	Hold a willingness and ability to lead and to challenge the status quo when necessary.

Please find two examples of international principles considered during the Steering Group exploration in the **Appendix 5.**

How do we **understand** Mental Health Engagement?

The National Office of Mental Health Engagement and Recovery has developed a way of understanding and describing mental health engagement with this diagram. It highlights that all forms of engagement are of high value and demonstrates that co-production is the most effective way for services to work in partnership with people with lived experience.

Different points in the diagram will be relevant to stakeholders at different times, for example, a new staff member may need to be **informed** about recovery principles at the start of their career and may be in a position to **co-produce** a policy at a later stage, or a volunteer with lived experience may want to build their capacity to engage with service improvement by **educating** themselves further before working in **co-design**. Similarly, people with lived experience of services may also have a great knowledge of systems and peer support and may lead a project altogether. There is also the possibility of people being out of practice with engagement and therefore wanting to **involve** themselves in different ways to refresh their knowledge and practice.

The relationship between stakeholders is key to good engagement and is built on good communication and developing trust. The sharing of resources and informing stakeholders, often framed as the least collaborative type of engagement[14], is actually an essential part of building that relationship and moving towards other forms of engagement such as co-design, for example.

14. https://www.healthcareexcellence.ca/en/resources/engagement-capable-environments/

Types of Mental Health Engagement

CO-DESIGN:
Identify and create a plan, initiative or service, that meets the needs, expectations and requirements of all those who participate in, and are affected by the plan.

LIVED EXPERIENCE-LED:
People with Lived Experience lead their own decisions, solutions and activities, and may collaborate or seek support in doing so.

EDUCATE:
Provide opportunities to learn more about plans, proposals and processes to help people to understand problems, alternatives and solutions.

INVOLVE:
Work with people throughout a process to ensure their concerns and opinions are included in the decision-making process and in the development of alternative solutions.

CO-PRODUCE:
Implement, deliver and evaluate supports, systems and services, where PWLE, carers, supporters and staff work in an equal and reciprocal relationship.

INFORM:
Provide information to people and let them know what has been decided and what is going to happen.

CONSULT:
Obtain feedback on plans, proposals and processes that may influence current and future decisions and assist with the development of alternative solutions.

Note: The diagram's development was informed by Arnstein's Ladder of Participation,[16] Rocha's Ladder of Empowerment,[17] Lundy[18] and Harts'[19] models for children and youth engagement, and Western Australia's Mental Health and Alcohol and Drug Engagement Framework.[20]

Also of importance is understanding that co-production and co-design have important similarities in their efforts to enable PWLE, families, supporters and staff to work together in new ways. For example, the principles of co-production (such as equality, diversity, accessibility and reciprocity) and the principles of co-design are both enacted through similar mechanisms, such as dialogue, empathy, creativity and self-efficacy.[15]

In our mental health services, it is a multi-level process by which:

1. Service users, family members and carers engage with their mental health service providers for their recovery journey and beyond (individual and interpersonal)
2. It also relates to integrating PWLE, family members and carer perspectives in the design, development and delivery of services (community and organisational)

This framework is primarily concerned with level two of the engagement process but promotes that engagement is everybody's business and so can also support thinking and action on an individual and interpersonal level.

The HSE is focused on good quality engagement which involves relationships between all people involved with mental health services as well as the feedback process and the accountability structure that acts upon it. It is central to other lived experience led programmes and with recovery education. Recovery education enhances learning opportunities for people who are interested in learning about and contributing to meaningful engagement. For further information about Recovery Education, please click **here.**

15. Arnstein, S. (1969.) A ladder of citizen participation. Journal of the American Planning Association, 35(4), 216–224.

16. https://www.cambridge.org/core/elements/coproducing-and-codesigning/157832BBAE1448211365D396CD110900

17. Arnstein, S. (1969.) A ladder of citizen participation. Journal of the American Planning Association, 35(4), 216–224.

18. Rocha, E. M. (1997). A ladder of empowerment. Journal of Planning Education and Research, 17, 31–44.

19. https://www.qub.ac.uk/Research/case-studies/childrens-participation-lundy-model.html

20. Hart, R. A. (1992). Children's participation: From tokenism to citizenship. Florence, Italy: United Nations Children's Fund International Child Development Centre.

Ready to **begin**

Getting Started with Mental Health Engagement

This framework has been developed to support regional areas to map out their mental health engagement responsibilities and activities. It is supported by a set of co-produced key performance indicators. All actions align with Ireland's Mental Health Policy *Sharing the Vision.*

What are the objectives of this framework?

1. To offer choices to regional management to include in their annual regional service plan (RSP).
2. To support the work of the Head of Mental Health Services and the Executive and Area Management Teams (AMT).
3. To be a guide for the governance and work of the Area Leads for Mental Health Engagement.
4. To offer multiple opportunities for people with lived experience, their families, carers and supporters to engage in service improvement.

It responds in particular to the call for accountability in mental health engagement.

Mental Health **Engagement** Framework Actions

A menu of options for inclusion in Regional Service Plans.
In the absence of an Area Lead for Mental Health Engagement, the Head of Mental Health Services will nominate a member of their team to coordinate Engagement activities and measurement.

Action	Rationale	Intended outcome	Frequency	Responsibility
Create a Lived Experience Volunteer Panel	To offer choices and options to those who wish to volunteer their lived experience expertise to improve services. Provides the service with capacity to involve lived experience	Lived Experience Membership of local groups e.g. MH Consortium, Policy Development Group, Quality & Safety Group	Rolling recruitment	Area Lead for MHER and the Area Management Team (AMT) Support and value for volunteer Engagement provided by MHER
Create an Engagement Network	To enhance the connection between statutory and voluntary services	Improved sign posting to support services and vice versa. Collective, localised problem-solving. Responds to Rec 26 from *Sharing the Vision.*	Review membership annually	Area Lead for MHE and the Area Management Team
Set up Community of Practice for Mental Health Engagement and Recovery staff	To build a community of local workers and a support system for mental health engagement and recovery workers	Joined up thinking, local problem-solving, collaboration, support, and influence	Quarterly	National Office of MHER with local leads for Engagement and Recovery
Co-produce staff awareness events about Engagement and Recovery structures and opportunities	Work with PWLE to build and refresh all staff knowledge of engagement and recovery opportunities	A connected recovery-oriented service and informed stakeholders	Twice per annum	Area lead for MHE, Recovery Coordinator and discipline leads

Action	Rationale	Intended outcome	Frequency	Responsibility
Run a Digital Survey	To provide alternative anonymous options to engage	Reach a broader population	At least once per annum	Anybody who wants to gather opinions on service delivery. MHER can supply a co-produced survey (MyExperience) on a Smart Survey platform)
Host Engagement events (such as a Recovery Conversation Café) with an established feedback loop to local management and/or Local and Area Forums	To bring the voices and recommendations of PWLE directly to the management team to influence change & suggest improvements	A transparent quarterly gathering of specific information that can respond to suggestions for improvement	4-8 per annum	Area Lead for MHE, AMT and selected subject expert colleagues
Represent MHE at national level	Geographical representation on national working groups	A balanced influence and national voice for each area	1-2 groups per annum	Area Lead for MHE /Head of Service Nominee
Create a Mental Health Engagement and Recovery Newsletter	To ensure that all stakeholders learn about changes implemented, opportunities to engage, and recovery education activities of interest in the region	An informed and engaged stakeholder population interested in engagement	Quarterly	Area Lead for MHE /HOS nominee and Recovery Coordinator
Review Your Service Your Say	To ascertain if any themes emerge for service improvement	An opportunity to engage with PWLE and family experiences and views. Opportunity to join the dots between both processes.	Quarterly	Area Lead with YSYS team
Host a Regional Town hall Meeting	Moderated solution-focused recovery conversation to build trust, faith, and a belief in genuine partnership working to improve and sustain good services	To establish trust, transparency and partnership. To close the feedback loop.	Twice per annum	Head of Service team with Area Lead for MHE
Attend National Engagement Events	Ensure that people with lived experience of services and Senior Management's ideas for service improvement are shared and acted upon (where possible) at a national level	Geographical representation in the development, design and delivery of engagement activity.	Once every 2 years	Area Leads, Head of Service, service users involved/interested in volunteer panels, forums etc

Measurement and Governance of Mental Health Engagement Activity

Key Performance Indicators (KPIs)

The framework is complemented by a set of agreed KPIs for Mental Health Engagement.

These KPIs were co-produced by a subgroup of the *Enhancing Engagement Project* in the MHER office. They were developed with stakeholders with lived experience in engagement and recovery roles, service improvement roles and senior management in Mental Health Operations.

The data collectors in each region will be the **Area Lead for Engagement or a Head of Service nominee.** The Engagement Programme Manager in MHER will collate these reports monthly. The purpose of these KPIs is not a performance review but rather a report that will identify good practice, support resource allocation and address any gaps that MHER can support.

The national steering group selected four KPIs for Mental Health Engagement. The KPIs are quantitative in nature with one opportunity to share qualitative information.

Metrics:

1.
Number of engagement events held
Event type: Information/Education; Consultation/ Involvement; Co-design/Co-production; Community of Practice

2.
Number of people attending events
Population type: Inpatient, Outpatient, Community, Children & Youth, Family, Carers, Supporters, Other

3.
Number of service improvement recommendations
brought to the Area Management Team/Local Leadership from engagement events

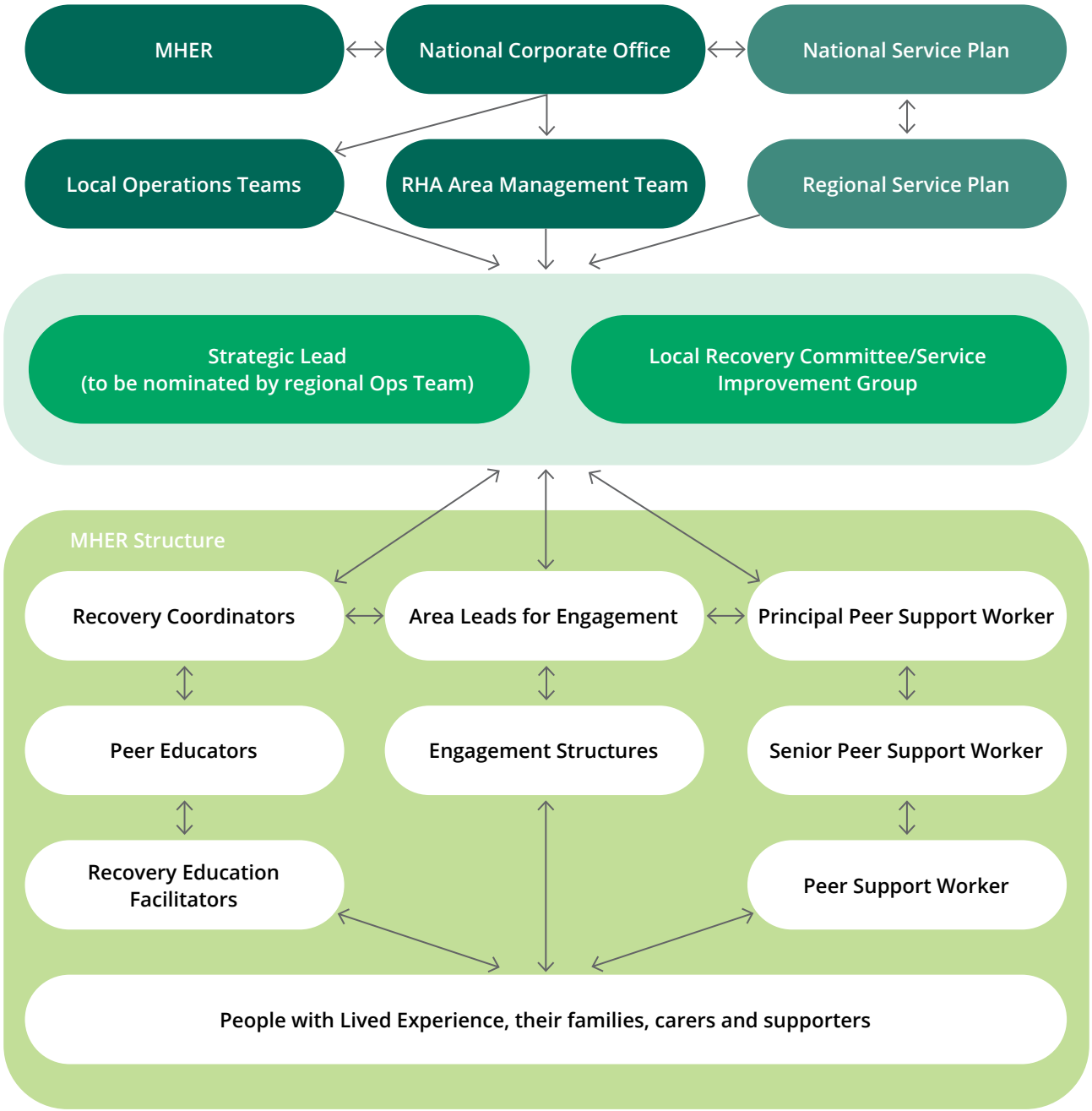
4.
Number of changes made
because of recommendations brought to the Area Management Team/Local Leadership

Free writing section to provide a description of changes or progress made/not made (No more than 25 words).

To access the excel version of the KPIs please contact mhengage@hse.ie

Governance

For genuine work in mental health engagement and recovery to become embedded in mental health services, organisational commitment is key. This framework proposes a governance pathway to achieving this. Please see the graphic below:



Enablers for Mental Health Engagement

Change is dependent on how persuasive an early adopter is and how receptive an organisation is.

Therefore, **organisational commitment** is key across roles from senior leaders through heads of discipline to frontline staff, see *Action Planning for Effective Mental Health Engagement* in Appendix 1. Organisational commitment ranges from attitudinal support to resource allocation.

Mental health service staff are key to enabling strong engagement in mental health services and it is important that staff is not only educated and informed about the evidence underpinning engagement methods and their policy and contractual obligations for involving people with lived experience, but also advised of the benefits to their practice and work satisfaction. Flexibility and autonomy with space to learn is key for staff to benefit from and embrace mental health engagement. For some it will be an entirely new approach.

Sharing **good practice** can support and inspire stakeholders to get involved in mental health engagement. See MHER's *Good Practice* document here for ideas.

Meaningful communication about mental health engagement is important as staff tend to be more committed to an outcome if they choose to be involved themselves rather than 'being told'. Organisations can ask themselves the following questions and communicate their responses.

- **Why is engagement important?**
- **Who is engagement important to and why?**
- **What mental health engagement work is already underway in my region?**
- **What shared work could unite stakeholders and improve services for everybody?**
- **What will deepen our connection to each other and mental health engagement?**

Note: The adoption of engagement techniques is not enough to guarantee that power will be equalised between participants. Reflective practice is essential to facilitate engagement opportunities that can empower, rather than perpetuating inequities. Without this critical reflection, it is likely that there will be little trust between staff and people with lived experience that could result in missed opportunities and the elimination of the value of engagement. (See appendices for ideas on reflection).

It is important to **explore and understand multiple perspectives** particularly in mental health as systems have followed a patriarchal and medicalised model in the past. Furthermore, there is historical traumatisation experienced by people with lived experience and trauma experienced by staff who were trained this way and thought they were healing and helping.

Understanding power imbalances and how they play out in communication and reciprocal respect. There is recognition that services and systems can re-traumatise people. Services can cause harm due to ways of working, for example, risk management. Mental Health Engagement can address these imbalances by acknowledging all stakeholders' lived experience expertise and practice wisdom by working in genuine reciprocal partnerships.

In mental health engagement it is essential that all people with lived experience, their families, carers and supporters have access to having their voices heard regardless of the size of their population or their circumstances. For additional ideas for strong Mental Health Engagement access our *Guide to Working with Seldom Heard Voices* **here.**

For more information, guidance and support contact MHER at **mhengage@hse.ie**

Flexibility and autonomy with space to learn is key for everyone to benefit from, and embrace, mental health engagement.

Appendices

Appendix 1:
Key Performance Indicator Excel Sheet

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**METRICS**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
2	**Number of engagement events held**												
3	Information/Education												
4	Consultation/Involvement												
5	Co-design/Co-production												
6	Community of Practice												
7	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
8													
9	**Number Attendees of engagement events held**												
10	Information/Education												
11	Consultation/Involvement												
12	Co-design/Co-production												
13	Community of Practice												
14	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
15													
16	**Populations engaged with (please insert x)**												
17	Inpatient												
18	Outpatient												
19	Community												
20	CAMHs												
21	Family/Supporters												
22	Other												
23		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
24													
25	**Number of service improvement recommendations brought to the Area Management Team/Local Leadership from engagement events**												
26	Number of service improvement recommendations												
27	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
28													
29	**Number of changes made because of recommendations brought to the Area Management Team/Local Leadership**												
30	Number of changes made												
31	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
32													
33	**Free writing section to provide a description of changes made/not made (No more than 130 letters)**												
34													
35													
36													
37													
38													
39													
40													

For downloadable copy please contact **mhengage@hse.ie**

Appendix 2:
Action Planning for Effective Mental Health Engagement

Critically reflexive questions and actions to take (adapted from Harris et al, 2023)[21]

Q: Why? Why are we engaging in this work and what are the key drivers of mental health engagement? ☐

A: Assess individual, community and organisational readiness to engage. Then embed a commitment to engaging PWLE within organisational documents.

Q: Why now? ☐

A: Reflect on the timing of the initiative—is there sufficient lead time to build relationships with PWLE and to engage them from end-to-end?

Q: Who? Who is well suited for the role(s)? ☐

A: Recruit two or more PWLE as part of a commitment to having multiple lived experience perspectives. How many people should be recruited?

Q: Whose voices are included/excluded? ☐

A: Create opportunities for training, capacity-building and peer support for all interested parties.

Q: Who is well-positioned to offer support and guidance to PWLE? ☐

A: Who can be a champion for change within the organisation?

Q: How? How can we create supportive practices and processes? ☐

A: Provide recovery and engagement training and orientation for all team members.

Q: How will we engage in ongoing assessment? ☐

A: Create opportunities for relationship- and trust-building on the team.

Q: How will we evaluate our approach? ☐

A: Co-develop supportive policies and practices, including compensation for planning, participation and evaluation.

21. Harris H, Clarkin C, Rovet J, et al. Meaningful engagement through critical reflexivity: engaging people with lived experience in continuing mental health professional development. Health Expect. 2023;26: 1793-1798. doi:10.1111/hex.13798

Q: How will we foster supportive environments for collaboration?

A: Explore complementary skill sets and perspectives on the team and how to create space for all team members to share those perspectives.

Q: How will we navigate decision-making, conflict and differences of perspective?

A: Set aside time for regular debrief discussions.

Q: How will we hold ourselves accountable for our engagement strategy?

A: Establish channels for formal and informal feedback to improve the programme and increase the quality of the experience for PWLE.

Q: What? What role will PWLE have in the programme, educational initiative or team?

A: Support autonomy and self-determination with respect to role title and language, and the level and scope of involvement.

Q: What have we done to clearly articulate and communicate the expectations of all team members?

A: Collaborate on curriculum development, didactic presentations, programme evaluations and so on.

Q: What biases or assumptions are shaping our perspectives and decisions?

A: Consider leadership and supportive roles for PWLE.

Q: What training and/or resources are needed to foster receptive contexts for lived experience engagement and leadership?

A: Explore openness to share and relinquish power.

Appendix 3:
Mental Health Engagement Event Evaluation/Preparation Checklist (Staff)

(Based on the Mental Health Engagement Continuum)

This checklist for Mental Health Engagement Events can support individuals and services to review and plan for their commitment to mental health engagement activity.

1. Inform

- How did you make sure that people with lived experience were aware of the event/programme or initiative as early as possible?
- What accessible materials did you provide to support the information?
- Was the space safe, accessible and comfortable?
- How did you know that people were attending on a voluntary basis?
- Did you provide contact details/website for further information/ reading after the event?
- Was support provided to those who may have become anxious, upset in anyway? Samaritans present, list of support services etc.

2. Educate

- How did you make sure that people with lived experience were aware of the event as early as possible?
- How was the engagement for this event planned? Were materials provided in advance?
- What type of facilitation method did you use? Focus groups, world café etc.
- How did you check for understanding? Group feedback, evaluation forms etc.

3. Consult

- How did you make sure that people with lived experience were aware of the event as early as possible?
- How did you ensure that people with lived experience and other stakeholders were aware of the scope of their involvement at this event? Seeking feedback on existing proposals, policies etc.
- Did you make clear the topics on which you want to hear views?
- What type of feedback methods were employed? Written, spoken, creative, online, in-person etc.

Overarching Questions

Are changes being made (big or small) as a result of your Engagement Activity?

Are you gathering broader perspectives from People With lived Experiences? More voices, more people from different backgrounds and experiences with mental health services?

Are products (strategies, frameworks, actions) being produced with genuine lived experience perspectives built in?

How and when did you communicate the outcome or expected outcome of this engagement?

- Were you clear about who would receive and consider this feedback?
- How did you show that you were committed to being informed by their views?

4. Involve

- How did you make sure that people with lived experience were aware of the process as early as possible?
- What type of engagement methods were employed? Written, spoken, online, creative, in-person etc
- How did you support people with lived experience to sustain their involvement? Time, travel, liaison, supports, expenses.
- How did you check-in with people with lived experience about their experience of involvement at key points in the process? Concerns, opinions

5. Co-design

All of the above and...

- How did you make sure that PWLE were prepared for the co-design process?
- How did you make sure that you invited participation from PWLE who were interested in the problem-solving issue?
- Did PWLE contribute directly to the design of a solution to a pre-determined issue?

6. Co-produce

All of the above and...

- Did PWLE produce a concrete output in an equal and reciprocal relationship with other stakeholders?

7. Lived Experience-led

- How did you ensure that your contribution is of a collaborative or consultative value only?

Appendix 4:
Addressing Barriers to Mental Health Engagement

The questions below can support reflection on engagement practices and can help identify ways to address barriers to successful mental health engagement opportunities.

- What is the typical story that is told about engagement processes in the HSE?
- Is it always positive, negative or both?
- What are the typical reasons given in the HSE for engagement not producing a positive outcome?
- Are they internal to the HSE or external?
- What types of engagement behaviour are not talked about in the HSE, but you have seen or experienced?
- What happens in your organisation when engagement with a particular stakeholder is seen to be going nowhere?
- Are senior management willing to get involved if an engagement process is seen to be non-productive?
- Has the HSE experienced a previous non-productive engagement with a stakeholder and then subsequently been able to successfully engage with them?
- What, if anything, did you learn from this process?
- How was this learning utilised across the organisation later on, if at all?
- Are lessons from non-productive engagement experiences utilised in stakeholder planning exercises in your organisation or in strategy formation for interaction with stakeholders?

Appendix 5:
Examples of international principles considered during the Steering Group exploration

1.

In 2021 Healthcare Excellence Canada (HEC), an organisation with a relentless focus on improving healthcare with and for everyone in Canada, launched a self-assessment tool for patient engagement that was underpinned by the following principles:

1. Information Sharing
Communicate and share complete, unbiased information with patients and families so they can effectively participate in care and decision-making.

2. Participation
Encourage and support patients and families to participate in care and decision-making at the level they choose.

3. Collaboration
Collaborate with patients and families in policy and programme development, implementation and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.[22]

22. https://www.mhc.wa.gov.au/media/2532/170876-menheac-engagement-framework-web.pdf

2.
The National Alliance for Mental Illness (NAMI) produced a report which outlined *12 Principles for Advancing A Culture of Engagement in Mental Health Care:*

1. Make successful engagement a priority at every level of the mental health care system. Train for it. Pay for it. Support it. Measure it.
2. Communicate hope. For those who feel hopeless, hold hope for them until they experience it themselves.
3. Share information and decision-making. Support individuals as active participants in their care.
4. Treat people with respect and dignity. Look beyond the person's condition to see the whole person.
5. Use a strengths-based approach to assessment and services. Recognize the strengths and inner resources of individuals and families.
6. Shape services and supports around life goals and interests. A person's sense of wellness and connection may be more vital than reducing symptoms.
7. Take risks and be adaptable to meet individuals where they are.
8. Provide opportunities for individuals to include family and other close supporters as essential partners in their recovery.
9. Recognize the role of community, culture, faith, sexual orientation and gender identity, age, language and economic status in recovery.
10. Provide robust, meaningful peer and family involvement in system design, clinical care and provider education and training.
11. Add peer support services for individuals and families as an essential element of mental health care.
12. Promote collaboration among a wide range of systems and providers, including primary care, emergency services, law enforcement, housing providers and others.

Acknowledgements

Members of the National Steering Group for Enhancing Engagement 2022-2024

- Michael Ryan (Head of Mental Health Engagement & Recovery)
- Jessica Curtis (National Senior Project Manager, MHER)
- Linda Moore (Head of Mental Health Services, CHO 6)
- Niall O' Baoill (Volunteer, person with lived experience expertise)
- Patricia Fallon (Volunteer, person with lived experience expertise)
- Sushil Teji (Volunteer, person with lived experience expertise)
- Pat Smyth (Recovery Coordinator (retired), CHO 2)
- Bridget Harney (Service Improvement Lead, CHO7)
- Emma Maguire/Sean O'Connell/Fionn Fitzpatrick (Area Leads for Engagement)
- John Healy (Deputy Executive Director, Genio)
- Jacopo Villani (Programme Manager, MHER)
- Niamh Wallace (Former Chair of Steering Group, now Head of Service, Health and Wellbeing, CHO 3)
- Louise Conlon (Programme Associate, Genio)

Subgroup members

KPI Subgroup Jessica Curtis (chair), Susan Moy (Business Manager, CHO6), Sushil Teji, Philip Flanagan (Service Improvement Lead, Mental Health Operations)

CAMHS Engagement Sub Group Jessica Curtis (chair), Sarah Hennessy (General Manager, Children and Youth Mental Health Operations), Emma Maguire, Nicole Troy (Recovery Education Facilitator, National Forensics Mental Health Service), Sylvia Campbell (former Youth Advocacy Programme), Sylvia Cahill (Principal Social Worker, CHO 9), Sarah Donnelly (Director of Nursing, Lucena), Margaret Gallagher (Legal and Policy Manager, Children's Rights Alliance), Chloe Costello (Recovery Educator, Discovery College, CHO 2)

Digital Sub Group Sushil Teji (chair), Jacopo Villani, Margaret Keane (Recovery Educator, ARIES Recovery Education service, CHO 3)

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