

Minutes Galway Sub-Committee – 10/07/07

Attended by:

- Galway Team: Declan (community representative), Paul (YAP), Geraldine (YAP), Caroline (GAF nurse), Delia, Trish, John
- Headstrong: Emma, Conor, Bob, Tony, Faye

Draft Agenda

1. Jigsaw Galway – where we're at
2. Key principles of service provision – i.e. what's driving this?
3. Jigsaw Pillars – e.g. clinical pathways, service integration, youth participation, evaluation
4. What will Jigsaw Galway look like after:
 - 31st Dec 2007
 - 1 year
 - 3 years
 - 5 years
 - 10 years
5. Resources and financial projections
6. Governance structure
7. What will success look like?

Agreed Priority for Today's Meeting

- To address the real urgency which emerged from the last meeting of the Project Team: *to articulate specific steps that will be taken to incarnate Jigsaw and address practical issues around the specific activities and targets for this year*

Some General Issues Addressed

Role of HSE in Jigsaw

- Fiona expressed concern that the HSE is only one player in Jigsaw, yet it is the only service provider that has been meaningfully engaged in the planning phase. Engaging the HSE is only one step in the process, bringing other services along with the changes we're talking about is another issue.
- Jigsaw will need to be closely aligned with current plans to change the structure of HSE systems to ensure that Jigsaw remains compatible with the HSE over the next 2/3 years as these changes come onboard. As Fiona put it, we can sell people the vision, but we have to do it knowing they are already being asked to change
- It was noted that Alex & Priya see Jigsaw as only one wheel turning within a huge system (HSE) where all the wheels are turning. We need to be conscious of the bigger picture and the wider process of change management within HSE that's already underway

Declan's group - Role of web-based initiatives

- Declan explained he was representing a local group of business men interested in funding a mental health awareness campaign. He was clear that reconfiguration of the HSE and service providers is not their area of expertise, or of interest in pursuing. They are specifically concerned with filling a gap in

the current system around raising awareness of mental health issues among young people. He felt that their strength was in realising their weaknesses very quickly (namely their lack of mental health expertise).

- Declan was clear that they did not want to get involved in a huge mental health problem with a lot of talking and no action. Their objective is to develop a programme of awareness in Galway sooner rather than later. However they also recognise that they need the input of mental health professionals and services to provide the back-end of such an awareness campaign which is where they see the overlap between their interests and Jigsaw.
- There was consensus among the sub-committee that web-based supports will have to form part of Jigsaw. It was noted that this is an area which Headstrong have given considerable thought to as a vital strategy toward engagement
- John to follow-up with Declan on what he can report back to his group following this meeting. They are eager to do something but want to do the right thing. Tony suggested a possible role would be to use the group as the PR team for Jigsaw Galway
- Concluded in a discussion on other initiatives to develop online support, mainly ISPCC and Spunout, how to link with these services Concerns over Spunout's Tough Times Campaign were raised. Declan agreed there was a phasing issue in that we first need to build a product, then promote it.
- Declan's challenge to the group was to come up with a solution for the 18-25 year olds
- He expressed an interest in sitting on steering group as a community representative

Language and Stigma

- Declan expressed concern over the amount of 'mental health language' the group was using, he suggested this could scare young people off. He is interested in developing a 'youth speak approach' (links in with ReachOut!)
- Emma agreed that what we are trying to sell is a 'very clinical product', we need to give a lot of thought to how to wrap it in a youth-friendly way so that it is perceived by young people as something they would want. To create a language that's not already tied down by negative associations e.g. 'fuckedupedness'
- Tony suggested we need to achieve a balance between not using threatening language while not side-stepping 'mental health' altogether, talking about 'growing pains' can make it sound very patronising
- Delia also agreed that language creates a huge barrier. There is a need to deconstruct mental health terminology, young people are scared of 'seeing a shrink' what that might involve and imply for them. We need to find a balance between not using too much 'mental health, mental illness' language but at the same time to realise that for some young people their problems are very serious and can lead to suicide.
- Caroline referred to a similar challenge she has come across, that when you refer a young person to 'a counsellor', that's often the point where they stop engaging with her

Community Empowerment

- Declan expressed an interest in developing a ‘community chain of care’ in which ordinary concerned citizens could be made aware to look out for young people in crises. Suggested developing training in this area as an immediate area of action we could undertake.
- One possible mechanism to brand such an initiative would be to develop a logo that could be displayed in windows of taxis, clubs, shops etc. where staff had been trained in ‘supporting young people’
- Linking in with efforts to get young people to use In Case of Emergency (ICE) numbers as starting point

Addressing Stigma

- NB to maintain an independence from the Gaf – any association would immediately exclude certain groups of young people
- Need ‘soft access points’ – e.g. get condoms, free STD tests, run wide-range of classes, organising ‘risk activities’ not associated with any particular clique of young people
- Work with schools – e.g. Traxside (Australia) approach of a ‘mobile outreach unit’ delivering information to schools; using YAP to go to schools was also seen as important. While it was agreed we need to involve guidance counsellors in Jigsaw, there was also consensus that they need to change their image, many young people have concerns re: confidentiality and anonymity of accessing their services. Having mandatory sessions with guidance counsellors was seen as a possible solution.
- Developing awareness was seen as important but equally we need to ensure we have a serviced to advertise

Stepping Back – How did we arrive at this point?

1. Bob suggested we focus the discussion today by reflecting on the process that has lead us to this point.
2. It was agreed that we began with a range of individual perspectives, following a huge amount of collective effort, data collection and evaluation we developed a shared purpose and set of goals. These goals reflected what we heard and listened to (see handout on intervention goals) and were divided on three levels: young people, services and the community

Intervention Goals

1. For Young People

Summarised main issues which emerged:

- Sense of disconnection among young people
- Stigma
- Improving a sense of wellbeing
- How to support young people who are struggling

In addressing these issues we need to maintain a balance between developing universal and targeted approaches. Our vision is not only to provide services for young people in crisis but to look at a much broader level at prevention efforts (links in to Declan’s interests)

2. Service System

- Unifying concept = continuous quality improvement across the system (e.g. best use of data, evidence-based approaches)
- For young people and families to have an authentic, active and influential voice
- Strategic use of resources
- Improving engagement and movement within the service system to ensure that young people can access the appropriate level of support

3. *Community Level*

- To destigmatise mental health and mental illness and raise awareness
- Develop a greater sense of community ownership, tolerance and support
- Pro-active – Mental health promotion and focus on well-being

Concluded that while the above are long-term goals, it is important to keep them in mind in discussing the activities we are going to prioritise in coming months. We need to constantly link specific goals to long-term goals to balance our long-term aspirations with how we can get to a point where they are achieved.

Framing Discussion Re: John's 5 Core Components

Based on all the discussion and research that had been collated, John broke down Jigsaw into 5 core components:

1. Treatment and support
 - Immediate ways we can support young people
2. Capacity Building
 - Building multiple access points and increasing the capacity of local community-based supports
3. Risk-Reduction, Prevention & Education
 - Not implying Headstrong has to do it all, often other people doing it already, issue is how best to link in and partner with them
4. Clinical Pathways
 - Separate sub-group working to develop seamless pathway in and out of services
5. Research, Monitoring and Evaluation
 - Very important, especially as we're a pilot site, need to establish an example of best-practice and demonstrate we're making a difference

Components 1, 2 & 3 we're prioritised for discussion today

Feedback on The Fit Between Our Long-Term Goals and John's 5 Components

- Concern was expressed that these components don't map back on to our long-term goals as clearly as they should. E.g. how do they tackle stigma
- Paul felt the long-term goals sounded very aspirational and abstract. Fundamentally, he felt we had two goals: ensuring young people can access a point of engagement, and that they can get to an appropriate service from there. Without these, we have nothing. He also warned we need to be mindful that the real key to success will be how we are perceived by young people themselves.
- Tony suggested it would be more effective to put the core value of each component at the centre of the diagram

- It was suggested that while all the actions listed in the diagrams were needed, it would be helpful to sequence them to elaborate a sense of how these activities link back to long-term goals. Values and functions are getting mixed up in the current diagrams. Declan strongly agreed with this opinion
- Declan suggested that there was a danger in getting lost in what is a huge and ambitious programme. He proposed a helpful way to frame the discussion would be to start with suicide as ‘the ultimate end game’. We could use that as a starting point, and take baby steps to work backwards on how to address challenges in the short-term, create awareness etc.

Using Case Studies to Explore the Challenges in Current System: Caroline’s Experience

- Current challenges:
 - time constraints, networking with GPs, communication channels, no case management. ‘I act as a key worker in a way but there are too many steps involved in accessing support’
- The group discussed Caroline’s current experience as an example of the situation that front-line staff are currently facing. They then tracked how the specific steps Jigsaw would take would tackle some of the challenges which she identified.
- Caroline presented two case studies:
 - a 20 year old male at risk of leaving home, little prospect for employment, concerns over psychosis, saw psychotherapist once but then cut contact.
 - A 14-year old girl who presented with her mother, a lot of conflict between them, followed-up but didn’t show up for next appointment. Re-engaged a few months later following a crisis around stealing in school, at-risk of expulsion, referred to counsellor. Mother also needed counselling. 6months after initial request from local Community care team received notification she was put on waiting list

Issues for developing CYD which emerged from case-study discussion

- Initially assessment and engagement need to be prioritised – brief intervention model. This is a function of the Triage team in YAT
- Need to avoid ‘passing on the book’, repeat assessments – Trish stated there is some room for flexibility within the referral system using the e.g. of Laradoon Family Centre where referrals don’t have to come from GP. It was also noted that the young person doesn’t necessarily need to present to the GP him/herself, the GP could ‘rubber stamp’ the onward referral
- Need for an advocacy service – we would need to establish permission from hospitals to get access to inpatients
- Need for a broader ‘youth service’, providing links with housing authorities, Fas etc.
- Family therapy would need to be available in CYD. Where does this fit in and who would do it? It was suggested that family therapy is already available in Galway through the psychological services, linking with them would be important.

- Parental Involvement - This raised questions over the sequencing of providing an intervention for the parent of a young person. When this was necessary would the initial meeting with the CYD involve both the young person and parent together, or as a separate but parallel process
- Demonstrated the need to link in with adult services as presentations of complex family difficulties will highlight gaps within service provision for adults
- Illustrated need for a web-based service if client disengages
- Need to link with schools
- Consensus that a skill mix within triage will be essential, CPN would be the best-trained to fill many of the roles needed. It will be important there are health professionals on team rather than just mental health professionals. Community Welfare Officer should be included in Triage.
- Transitional homelessness is a big problem in our target group, need to link in with Focus Ireland, Simon Community who are currently setting up a crisis B&B in Galway
- Navigating existing waiting lists for onward referrals will be a major challenge to the CYD. We need to ensure that the back-up service is there, and is accessible to the team.
- Demand versus supply – phasing and sequencing issues re: establishing CYD & increasing capacity within existing services through service development

Framing the Discussion Around the CYD

This was agreed to be the best approach as the idea of a central location (CYD) came up a lot in the discussion. As a starting point, issues to be addressed were identified as:

- What would it look like?
- Who would work there?
- How would we prevent it from becoming stigmatised?

Tony identified four themes to be addressed within this discussion:

1. Involving young people in CYD
2. Engaging those at-risk through multiple points of engagement
3. Linking these to appropriate levels of supports: CYD as a central point, service development, capacity building
4. Monitoring Impact – re: levels of integration, waiting lists, clinical outcomes etc

We need to articulate:

- Vision
- Structures
- Functions
- Activities

Initial Function of CYD

- It's about a start, creating and demonstrating a model, showing how it can work then selling it. We are still at the product development phase, need to let it grow organically, have a driver (John).

- Initially, the CYD will serve as a form of needs assessment, giving us a realistic sense of the demand that is out there
- We need to include 3 elements conjointly:
 - Strong service provision
 - Building systems capacity
 - Involving community

Anticipated Challenges to CYD

Not developing ‘another clinic’

- what would make us different from services already there? If we are developing a ‘core team’ in CYD to deliver triage, how will we manage its caseload so as to avoid developing waiting lists, this is what has happened in the Drug Task Force
- Need to develop a brief intervention model that allows us to develop a crisis response service without taking on the responsibility of delivering a longer-term service
- Danger that all your doing is taking people away from another service (e.g. Samaritans) versus targeting young people who aren’t engaging at all.
- Doing the job of the HSE for them – e.g. not responsibility of CYD to develop 24 hour services

Not recreating the Gaf

- Need to avoid developing the Gaf with an outreach team, needs to be something more than that e.g. triage capacity, extent its linked in with other services etc.

Stigma

- Avoiding stigmatising service

Accessibility

- 24/7 opening hours

Creating a Service for Dominick St.

- Are we developing a service to fit a building? Should the conversation be about creating a ‘movement’ rather than a ‘building’?

Developing Shared Understanding of Purpose of CYD

- We need to develop a common language among stakeholders to ensure everyone has a shared understanding of the roles the CYD aims to fulfil. E.g. articulating the difference between ‘outreach work’ and ‘community work’ – to demonstrate that Jigsaw and the CYD go far beyond simply providing mental health care in a community setting, rather they aim to work with a young person in a very flexible manner, wherever they feel safe and comfortable

Engaging Psychiatry

- Delia saw the greatest challenge in engaging psychiatry as being involving the adult services. She was confident that her team were open to the Jigsaw model and that they would ‘row in behind the 12-16 year olds’. It is the 16-24 year olds that will be the greatest challenge. The reality is that the quality of service provision within the adult services is very poor. It was agreed we will need to find ‘work around solutions’. Tony suggested the CYD could put in place a primary care, youth specific team to contain the problem
- It was suggested it may be helpful to position Jigsaw as providing a way back out of the psychiatric services, into the community when selling it to psychiatry. It is in this re-integration that they may welcome support

- It was agreed the CYD will need to establish an active role with in-patient services.
- Shifting from hospital-based to community-based services is a huge paradigm shift for psychiatry. We need to address fears over what role they will be left with if services become community-based
- Tony needs to broker a relationship with adult psychiatry
- We need to engage CPNS

Main Issues Discussed Re: CYD

Opening Hours

- There was debate over the extent of out-of-hours service provision CYD should provide. Suggested that at the least, it should be open in evenings, and possibly should include a crisis line at night. Opening later in morning instead of at 9am. Linking in with West Doc would be important as they already provide a 24/7 service.
- Trish reported that the HSE are currently in process of developing an out-of-hours mental health service both nationally and for the West. It would most likely take the form of a call centre as current research suggests that there is not enough demand for implementing a full out-of-hours team.
- Currently, there is 24 hour support from HSE as technically a young person can be seen and assessed at any time of day or night through A& E, however this is very medical, not ideal. It is not accessible or user-friendly
- Zone operates on a 9-5 basis with a crisis line for existing service users. This was not seen to be ideal.
- Concluded that there is a need to address the gap in an out-of-hrs service, but not necessarily to provide it directly

The Reception

- Possibly first point of contact should not even involve having to engage with a person directly, but to get information, leaflets, maybe fill out a card, put it in a box and come back later
- Having food, tea and coffee near the entrance
- Receptionist will be very important, need someone friendly, bubbly but sensitive. Some people will find a very bubbly person threatening so he/she would need to have an intuition about who to approach, who to give space
- The receptionist should only make appointments, give you tea/coffee, act as a central point of contact, discreet, so nobody would know why you were there
- As a crisis response service, the CYD was not seen as the appropriate stage to provide peer support – peers could be threatening

Governance of CYD

It was agreed that there will need to be a clear governance team as well as an executive team operating below it

Governance Team Structure

- Priya has suggested a small governance team of:
 - Chair – Priya
 - General Manager – Alex
 - Consultant Psychiatrist – Delia
 - Community Representative – Declan

- Headstrong Representative – Tony
- In Attendance – John reporting to the team
- This team would represent a Headstrong-HSE partnership
- Fiona suggested the team should also include a consultant psychiatrist from the adult services

Staff of CYD **see Conor's minutes on further discussion in follow-up meeting*

Structure

- Irrespective of who pays for staffing, there will need to be a core and an ancillary team.

Size

- Initially:
 - Core = triage team of 3 & outreach team of 3, receptionist (this team would need to include a FT counsellor)
 - Sessional = GP, psychiatrist, CWO, family therapy worker, possibly a social worker
- Issue over size of Dominick St. re: accommodating team

Recruitment

- The YAP must be involved in recruiting all of the staff from the outset to ensure quality control. We need to set the precedent early and insist that the triage team must be newly appointed, and interviewed by the YAP

Function of Triage Team

- The function of this team for many young people will be a broker function (e.g. accompanying young person to their first appointment) but for others the level of engagement will need to be much more intensive
- Consensus was that we need to separate the triage team and the outreach team in our thinking
- Initially, it was suggested we consider thinking of the Triage team in less concrete terms, more as a virtual team, where participating members of existing services come in to CYD on a rotational basis. This suggestion was rejected, the consensus was that we need to establish a core team
- Providing counselling is not anticipated to cause a problem as these services are readily available to 'buy in'

Structure of Triage Team

- Skill mix is vital – health, mental health, addiction, eating disorders etc
- Size of team – Priya talked about 6-8 people but we need to start small and let it grow. Maybe begin with a core of 3 or 4 staff, work out a chain of command, build first line of response then let it grow
- Titles – generic titles e.g. 'support workers'
- Gender balance
- Targeting young males – very few young men comfortable in one-on-one
- Flexibility to combine CYD and outreach approach
- 'Key worker' – NB that even if you're referred on you can still come back to same person for support
- It was agreed it will be important to have a psychiatrist in the CYD, available to the Triage team if GPs are to feel comfortable in referring a young person in crisis directly to the YAT. It is unclear at this stage whether this person will come from CAMHS or AMHS

- Clinical supervision will be essential, the core team will need to meet on a weekly basis to discuss cases
- All staff members must be trained in basic Jigsaw triage

Prevention and Education Component of CYD

Important component as we are building a system of care that's not just about the deep-end

- Need someone in a Health Promotion Officer role (with different title) addressing issues such as:
 - Mapping and linking existing services
 - Filling in gaps
 - Developing resources

Currently the HPO (Edel O'Donnell) dedicates less than 10% of her time to this role.
- Where does community development, animation fit in?
- Who's going to go out in the community and make sure that all the projects are collaborating?
 - Suggested this is John's role
 - Fiona argued that this may need a separate person as in DTF, divided into two positions: Fiona's and the Regional Drug Task-Force Coordinator who is responsible for pulling all the services together and reporting back to Fiona
- Maybe at some point we will need a service manager