

RECOMMENDATIONS

COMMUNITY AND PRIMARY CARE

Illness Prevention

1. Employers, educational establishments and community groups must promote and ensure the mental well-being of those for whom they have responsibility
2. Commissioners of mental health services must seek to develop and expand the range of voluntary services in order to provide a planned and quality-assured profile of care available to service users at primary care level.

User and Carer Involvement

3. All community and primary care mental health service provided by and commissioned by statutory services must have service users, their carers and families involved in the development, delivery, monitoring and evaluation of services.

Advocacy

4. Community and Primary care organisations must ensure that advocacy arrangements are developed within primary care settings.

Person-Centred Planning

5. Community and Primary care organisations should facilitate person-centred planning.

Primary Care Teams

6. Membership of the primary care team should be clearly defined and each team should have the full complement of professionals. Organisational barriers should not impede effective multi-disciplinary working.
7. There should be targeted investment in the development of primary care teams to promote better recognition of common mental health problems and clear working arrangements for managing such problems.

Working Arrangements

8. Statutory mental health services must have seamless management arrangements between secondary and primary settings in order to maximise the efficiency and effectiveness of service delivery.
9. New working arrangements in primary care should seek to maximise treatment of mental health problems in primary care.

Assessment

10. All primary care teams must have access to a named mental health professional in order to provide timely, appropriate and accessible assessment, and management of people with mental health problems.
11. Mental health services must be planned, integrated and accessible in order to provide timely, accessible and appropriate assessment and treatment in a manner valued by service users, their carers and by practitioners.

Identification and Accessibility

12. Community mental health services must be sited within the community they serve and must be accessible, targeted and appropriate.

Out of Hours Services – The Need for Mental Health Services not Confined to Office Hours

13. The means of access to out-of-hours mental health services should be stratified according to clinical need and to comprise face-to-face contact, telephone advice and arrangements for organisation of services during subsequent working days.

Formal Screening Tools

14. Formal screening tools should be used to support trained practitioners in a global assessment of at risk populations.

Skills and Competencies

15. People receiving care at primary care level must have access to a high standard of psychosocial care and to specific psychological therapies delivered by people working in managed clinical teams.
16. All practitioners offering psychological therapies must have assured levels of qualification, experience, supervision and monitoring.

Use of Medication

17. Those responsible for prescribing physical treatments in mental illness must be encouraged, within a multidisciplinary framework, to develop protocols for the prescribing, monitoring and review of treatment regimens according to evidence-based guidelines.

Research, Education, Development and Clinical and Social Care Governance

18. The Department of Health, Social Services and Public Safety must ensure that there are mechanisms to identify examples of good practice and to encourage widespread implementation of these.
19. Local statutory mental health providers must be funded for, and take responsibility for, the continued professional development of primary and secondary care staff by ensuring targeted and audited learning. The Review commends the use of multi-disciplinary models of learning.

SECONDARY MENTAL HEALTH SERVICES – PART 1

Person-centred Care

20. The optimal size and configuration of mental health services should be the subject of review by the Department. This should reflect the Review's consideration of the issues and principles, in relation to service configuration.
21. Each Trust should adopt a planned approach, including sequencing, to the whole system of mental health service provision and organisation in their area, involving all statutory and independent providers.
22. Service vision, plans and strategy should be needs driven based on local assessment.
23. Representative service users and carers must be involved in service planning, development, delivery and monitoring.
24. Agreed protocols for the transitional needs of younger people and older people must be established.
25. The needs of current long stay residents in mental hospital settings must be considered throughout the change process of the Framework strategy.
26. The needs of people requiring specialist services (Chapter 6) and the interface with Learning Disability, Forensic, Alcohol and Substance Misuse Services, services for younger people and older people, must be considered within service plans for Adult Mental Health.
27. Services must be underpinned by good managerial cohesion, information management, team working and communication.

Living in the Community

28. Community Mental Health Teams should be established for all sectors to provide an essential element of future mental health service provision.
29. People with severe and enduring mental health needs should be provided with yearly review including multidisciplinary review of treatment plans and risk assessment.

30. Where CMHT's are providing input to Primary Care then the seamlessness of provision must be addressed including the identification of a named individual on the CMHT for Primary Care staff. In addition to service support such input has an important educational role. (see Chapter 3).
31. The relationship between each CMHT and local primary care and A&E services should be clearly defined and agreed by both provider and referring services.
32. CMHT's must be adequately staffed with a range of health and social care professionals. The Review recommends a minimum provision of 50 care staff/100,000 adult population, including community rehabilitation.
33. Staff must be appropriately trained and skilled, embracing leadership, team working and therapeutic skills.
34. CMHT's must be provided with detailed information on the numbers and needs of individuals with mental health problems in their area.
35. CMHT's must have access to a range of community facilities and services including day hospitals, day activities, special accommodation, vocational and leisure services, voluntary and user led facilities.
36. Where other community teams, for example, Crisis Resolution Teams, are separate from CMHT's, then good interface arrangements including the involvement of key workers of known service users is essential. Arrangements for dealing with crises must be agreed with each service user and their key carer.

In Times of Crisis

Crisis Resolution Services

37. Crisis Resolution Services (CR) must be available and accessible to each Trust's catchment area.
38. CR Services should be accessible to General Practitioners, A&E Departments, Community Mental Health Teams, Social Services, and Police.
39. CR Services should be available on a 24 hour basis subject to demand.
40. CR Services must be the gatekeeper for hospital admissions.
41. CR Teams must be appropriately resourced and skilled to deal with the range of healthcare and social situations for people in mental health crisis, their carers and families, including risk management.
42. There should be a single system of co-ordinated acute and crisis care, including Crisis houses and inpatient provision.

Day Hospitals

43. Within each Trust consideration should be given to providing day hospital provision as an alternative to acute admission and complementing Crisis Resolution Teams.

Acute Inpatient Services

44. Acute inpatient services should be based on well designed facilities and close to the community they serve such as General Hospitals sites.
45. The quality of inpatient services should be the subject of both regional and local review.
46. Acute inpatient services must be of high quality and provide an appropriate range of assessments, treatments and services including intensive nursing services.
47. Acute inpatient services must deliver a therapeutic and safe atmosphere and be sensitive to gender and cultural needs.
48. Appropriate training and supervision should be provided for all inpatient staff.
49. Each provider must designate a lead clinician or manager to take overall responsibility for inpatient services.

Promoting recovery

50. The service requirements of people with severe and enduring mental health needs should be given the highest priority.
51. The requirements of those with severe and enduring mental health should be clearly defined for each Trust's catchment area.
52. Identifiable services promoting recovery should be established within each Trust for people with complex needs and providing comprehensive coverage of the Trust area.
53. Care plans embracing risk assessment should be provided for all people with complex needs, based on a multi-disciplinary approach and when required a multi-programme approach. Risk assessment should include accommodation needs. Users and where appropriate, carers, must be involved in care planning.
54. The introduction of step-down facilities should be considered to facilitate discharge from inpatient care.
55. A range of community support services must be available to facilitate recovery of people with complex needs.
56. Every effort must be made to de-stigmatise and normalise, making maximum appropriate use of ordinary facilities and resources.

57. Staff must be provided with appropriate training in services promoting recovery, including risk assessment and its management.
58. Assertive Community Treatment (ACT) should be provided for service users with highest levels of disability and greatest vulnerability, particularly those who have difficulty maintaining links with existing services.
59. Staff involved with ACT must be provided with the appropriate training including assessment and planning, direct service provision and teamworking.
60. Assertive Community Teams must be adequately resourced – an optimal individual caseload for delivering care is 10-12.

Younger People Entering Adult Life

61. Separate age-appropriate services for younger people with a first episode of psychosis should be established.
62. Services should be gender and culture sensitive.

Adults with Mild Learning Disability

63. Adults with mild learning disability should be facilitated in accessing adult mental health services as a first preference. The preferences of people already within either adult mental health services or learning disability services should be respected.
64. Adult Mental Health services should be resourced to include people with mild learning disabilities. Additional time is required for assessment and for consultation between professionals within and across programmes of care.
65. Cooperative working, sharing of facilities and expertise between adult mental health services and learning disability services must be established in each Trust area.
66. Training opportunities must be provided for local health professionals providing services for people with mild learning difficulties.

People Becoming Older with Enduring or relapsing Mental Illness

67. Locally agreed arrangements for meeting the needs of people who enter old age with enduring or relapsing mental illness should be agreed.
68. Local population needs of people entering older age and their carers should be assessed.
69. The treatment and care needs of individuals graduating from adult mental health services to services for older people should be the subject of review.

People with Challenging Behaviour

70. Trusts must plan for the needs of people with challenging behaviour.
71. Community mental health services should have the capacity to provide intensive support and treatment in the community for people with challenging behaviour. This should include where appropriate multiprogramme networking.
72. Specialist accommodation in the community should be developed with appropriate levels of skilled staff to provide treatment and care for people with challenging behaviour. (See Recommendations 138 & 141).
73. Services must include the provision of local intensive care and low secure inpatient services.
74. Low secure units should develop an ethos of rehabilitation within a secure setting, and have close links with rehabilitation and Assertive Outreach services.
75. Low secure units should include a 'step-down' function for the Regional Secure Unit.
76. Staff employed in settings where there may be people with challenging behaviour, including CMHTs, ACTs and low secure units, must have appropriate training that focuses on the needs of people with chronic severe mental illness, including training in forensic mental health, risk assessment and risk management.
77. Longer term high quality hospital provision should be provided as necessary for a small group of people whose behavioural problems are often chronic and severe (c.f. p14).
78. The level of need for low secure provision should be the subject of needs assessment.
79. Further research is required on the particular therapeutic interventions that have the potential to ameliorate behavioural problems in the context of severe mental illness.

People with Severe Mental Disorder and Substance Misuse (Dual diagnosis)

80. Trusts should make provision for people with mental health problems and co-existing alcohol or drug misuse.
81. Local prevalence and needs of people with dual diagnosis should be assessed.
82. For people with dual diagnosis, a single service should provide for their needs:
 - The needs of those with severe, enduring and relapsing mental illness should be met by adult mental health services
 - The needs of those with less severe need but requiring secondary care services, should be met by adult mental health services, unless their substance misuse is their more dominant need.

- For those with less severe mental health needs whose dominant problems are substance misuse, their needs can best be met by substance misuse services.
 - For people with personality disorder and substance misuse agreed arrangements need to be established between specialist services for people with personality disorder and substance misuse services.
83. Comprehensive assessment of mental health problems with substance misuse and relevant physical health problems is essential.
 84. Adequate numbers of staff must be provided with appropriate training in the assessment and management of the needs of people with dual diagnosis.
 85. Staff working in Adult Mental Health Services should have competence in the identification, assessment and appropriate specific evidence based interventions for substance misuse.
 86. Staff working in substance abuse service require training and regular updates on the recognition of mental disorders, risk assessment, and be competent in evidence based treatment of mental health problems.
 87. The needs of offenders and ex-offenders with mental health problems and co-existing alcohol or drug related problems should be addressed.

People in General Hospital Settings

Liaison Services

88. Appropriate education should be provided to general hospital staff to allow them to undertake psychosocial assessments.
89. General hospital staff should be trained in mental health awareness to prevent people with mental health needs feeling stigmatised or prejudiced.
90. General ward staff should, where necessary, have access to appropriately trained and experienced mental health professionals.
91. Acute hospitals should ensure that appropriate liaison services are identified.
92. Clear referral protocols should be in place.
93. Liaison Services should provide prompt same day assessment to assess risk, identify mental illness, and advise on physical and appropriate psychological treatments and follow up.
94. In view of the unpredictability of crises, it is important that appropriate services are available 24 hours per day 7 days per week including Accident & Emergency Departments.

95. Liaison Services must be able to access addiction services quickly for patients who are willing to avail of them.
96. Comfortable, confidential and safe accommodation must be provided to interview service users in A&E environments and general hospital settings.
97. Policies outlining the support procedures from security staff should be established.
98. All people with deliberate self-harm should be offered psychosocial assessments.
99. People with problems relating to addiction attending A&E should be able to avail of prompt access to community addiction services.
100. Young people attending A&E with mental health problems should be seen by those with appropriate expertise. Clear protocols authorising responsibility (based on relevant expertise) should be in place between Liaison Teams and CAMHS teams.

Perinatal Services

101. Comprehensive Assessment of Maternal Health must include Mental Health.
102. Protocols for the management of women who are at risk of a relapse or recurrence of a serious mental illness during the perinatal period must be in place in every Trust providing maternity services.
103. Women who have a past history of serious non-postpartum psychiatric illness should be offered assessment by a psychiatrist in the antenatal period and a management plan instituted regarding the high risk of recurrence following delivery.
104. Substance misuse services should be accessible throughout antenatal care.

Treatments and Interventions

General

105. A workforce strategy developing psychological therapy services must be addressed as a matter of urgency.
106. A Northern Ireland-wide training strategy to improve access to psychological therapies and psychosocial interventions must to be developed as a matter of priority.
107. Psychological therapy services must be organised in ways that promote the use of psychological interventions in routine practice.
108. Those responsible for prescribing physical treatments in mental illness must be encouraged within a multi-disciplinary framework, to develop protocols for the prescribing, monitoring and review of treatment regimens according to evidence-based guidelines.

Schizophrenia

109. Medication, psychological and social interventions must be integrated within a complete package of treatment, care and support.
110. The choice of antipsychotic should be made jointly by the individual and the clinician responsible for treatment.
111. Motivational interviewing should be available in order to enhance concordance.
112. The prescription of antipsychotic medication should conform to best practice based on the most up to date evidence based guidelines.
113. Antipsychotic drugs, atypical or traditional should not be prescribed concurrently except for short periods when one medication is being discontinued and a different anti-psychotic drug being introduced.
114. If a patient has had two anti-psychotics (including one atypical) each for 6-8 weeks without improvement, clozapine should be considered.
115. All families who have a member diagnosed with schizophrenia should be offered family intervention.
116. People with schizophrenia, especially those with residual symptoms should be assessed for CBT suitability.

Major Depressive Disorder

117. In severe illness, treatment with antidepressants is recommended and newer drugs have advantages both in side effect profile and safety in overdose.
118. A variety of adjunctive treatments are recommended for refractory illness.
119. ECT should be available for the treatment of severe depression and may be first line treatment in life threatening situations.
120. CBT and IPT should be available as treatment options in major depressive disorder.
121. Psychodynamic psychotherapies should be considered as treatment options in major depressive disorder
122. The use of ECT must comply with current Best Practice Guidelines of the Royal College of Psychiatrists.

Bipolar Affective Disorder

123. Prevention of new episodes is advocated from as early in the illness course as is acceptable to the individual and their family, and on a long term basis, because of the high risk of relapse and progression to more frequent episodes.

124. Service users taking mood stabilisers must have appropriate monitoring.
125. The needs of carers and families of individuals with bipolar disorder must also be considered.
126. Family psychoeducational approaches should be considered for bipolar disorder.

Physical Health

127. The assessment of people with more severe mental health needs must include assessment of physical health needs.
128. Registers should be established of people with severe mental health needs at primary care level.
129. Local providers of services should agree which service (primary or secondary) will take responsibility for monitoring physical health.

SECONDARY MENTAL HEALTH SERVICES – PART 11

Education, Training, Occupation

130. People with severe mental health needs should be offered an early opportunity to participate in a full occupational assessment. This should be reviewed on an annual basis as part of the service user's review.
131. Assessment should be conducted by an OT with the emphasis on quality of life, time management and occupational issues.
132. More straightforward and flexible social security benefits should be introduced to facilitate the transition from benefits to work.
133. A comprehensive range of occupational services must be provided within each Trust area and should include access to voluntary work, educational and leisure opportunities.
134. Day care services should provide a comprehensive range of activities and opportunities to support the different needs of service users.
135. Vocational specialists with mental health expertise should be commissioned to enhance the rehabilitative function of CMHTs.

Accommodation

136. Trusts should ensure that a complete range of accommodation is available to meet the needs of people with mental health problems.
137. Supporting people partnerships between the Trusts, Boards, N. Ireland Housing Executive and voluntary sector should be sufficiently flexible to make timely response to the accommodation needs of people with mental health problems.
138. Service users should have choice of accommodation appropriate to their needs.
139. Service users should be given maximum independence through appropriate levels of support.
140. Discharge protocols should ensure that people leaving mental health facilities have appropriate accommodation.
141. Staff working in residential settings should have adequate support and training.
142. Statutory services should provide support to residents and staff to optimise community living and prevent unnecessary hospital admission.
143. Appropriate support and services should be provided to reduce the risk of homelessness in people with mental health needs.
144. Service principles must underpin the development of standards and must focus on the needs and rights of individuals.
145. Monitoring and evaluation of services should be a continuous process and involve users and carers.
146. Care environments and practices should be designed to maximise personal autonomy and reduce the risks of institutionalisation.

Social Security Benefits and Support

147. The social fund should be reviewed with a view to ending loans as the main form of discretionary financial support.
148. An exemption to the single room rent should be made for people with mental health difficulties.
149. People with severe mental health problems should be exempt from prescription charges.
150. Trusts must ensure that people with mental health problems have access to independent dedicated advice and advocacy services to provide assistance in dealing with social security problems.

151. People with mental health problems wishing to work and who have been on benefit for long periods should be provided as necessary with intensive support.
152. Rules encouraging a return to work should be made more flexible and easier to understand.
153. All frontline benefit advisers, social security decision-makers, medical referee service staff and appeal tribunal members should receive mental health awareness training, part of which should involve interaction with people directly affected by mental ill health.
154. Medical assessors must have appropriate skills in assessing the mental health needs of applicants. Consideration should be given to greater use of mental health specialists (medical and non-medical).

Personal Life, Family and Culture

155. The distress accompanying mental illness and its impact on an individual's personal life, including a sense of stigma, needs to be recognised and acknowledged by mental health professionals.
156. The importance of the relationship between service providers and service users in the maintenance of self-esteem, hope and self-worth needs to be recognised and valued by providers.
157. Service users and where appropriate carers, family and friends should be provided with relevant information in clear and simple terms.
158. The information and communication needs of service users in situations of non-voluntary admission require special attention.
159. Within a multi-cultural society, the service user's specific communication, cultural, spiritual and religious needs must be recognised and acknowledged.
160. Services must be sensitive to the cultural needs of people from ethnic minority communities.
161. Priority must be given to improved methods of communication and information for people from ethnic minorities, including the use of interpreters and translators.
162. Staff training should be provided appropriate for the needs of local ethnic minority communities.
163. Advocacy services should be sensitive and appropriate for the needs of people from ethnic minority communities.

Advocacy

164. Independent advocacy services must be established in all Trusts providing mental health services.

165. Advocates should be involved in service planning and development
166. Advocates should be given access to appropriate service information
167. Advocates should receive support as necessary from Trust staff

Carer and Family Needs

168. Boards and Trusts must fully implement existing policy and legislative obligations relating to carers.
169. The needs of carers, children and other relevant family members, should be identified at assessment.
170. Key carers should be provided with appropriate support, education and information to carry out their role, as partners with the service user.
171. Agencies should accord carers equal status with other providers of care.
172. Key carers should be offered an annual assessment and a written care plan.
173. Family interventions should become an integral part of mental health practice.
174. Training programmes for dealing with mental health problems should be made available to all carers.
175. Trusts should make available dedicated carer and family workers.
176. Trusts should ensure that a range of support services in the form of helplines, self-help groups, directories of services, help with social security benefits and respite opportunities, is provided for carers and families.
177. Service users who are parents should be supported in their parenting role.
178. Children of people with mental health problems should be provided with appropriate support in their day-to-day lives and measures taken to support them in times of crisis, including the availability of a confidante.
179. Hospitals must ensure there are suitable visiting arrangements for families.
180. Agreed protocols must be established between Child and adolescent services and Mental Health services where children may require protection.
181. The services of appropriately trained professionals should be made available for key carer.
182. Staff training must include engagement with carers and the assessment and management of their needs as carers.

PEOPLE WITH SPECIAL NEEDS

Services for People with Eating Disorders

183. A network of people interested in and committed to developing services must be established – this is already underway through the formation of the REDWG.
184. Service planning must involve clinical leaders, users and carers and clinical managers.
185. Assessment of need must be undertaken with the specific goal of informing service development.
186. Further work needs to be done to develop the proposed service model. This should include further consideration of good practice models elsewhere and advice from experts on service level interventions.
187. The recruitment, training and retention of qualified staff to work within the service should be taken forward as a matter of urgency.
188. A core specialist team should be trained to provide a specialist service and support and train non-specialist practitioners; the creation of specialist posts must be prioritised.
189. Tiers 1 & 2 of the service should to be strengthened in tandem with any specialist services; the development of locally-agreed management protocols and referral pathways must be established.
190. The development of regional inpatient services, although a longer-term goal, should be planned for in a strategic and coordinated manner.

Services for People with Brain Disease or Injury

191. Services should be developed to address the needs of carers and families including partnerships across statutory and non-statutory sectors.
192. Emphasis should be placed on the development of day care, respite, residential and supported living for people who present with emotional, cognitive, behavioural and mental health problems.
193. Priority should be given to the establishment and development of brain injury teams throughout Northern Ireland.
194. A consultant neuropsychiatry post should be established to provide input to the regional brain injury unit, to the neurobehavioural unit and a liaison role to acute hospital settings, local mental health services and community brain injury teams.
195. A neurobehavioural unit should be enabled to develop as a regional specialist service. This might provide services on an all Ireland basis.
196. A workforce strategy is required to ensure that there are sufficient numbers of appropriately qualified staff, across the range of disciplines, required to enable service developments in this area.

197. Attention to skill mix and opportunities to develop new job roles is required.
198. Attention to the training and ongoing development needs of specialist staff is required. A training strategy should be developed.
199. Formal links between brain injury services are essential for staff development and service networking.
200. Opportunities for collaborative working amongst professional groups across specialist brain injury services should be pursued by joint appointments, staff rotations, staff placements.
201. Specialist services should provide training and support to local community services and to care staff working in acute hospital, residential and day care settings.
202. Service planning must involve clinical leaders, users and carers and clinical managers.
203. Information including local data is required to plan and develop services sensitive to need. An information strategy is required.
204. The development of care pathways is required to develop links and networks between different services and service components.
205. Partnerships between statutory and voluntary sectors and within statutory sector organisations (health, housing, education, employment and training) should be pursued, to ensure a comprehensive range of service provision.

Services for Deaf People with Mental Health Problems

206. There should be a tiered approach to the provision of Mental Health Services for Deaf People.
207. Service User and Carer involvement in planning and monitoring services should include deaf people and people who acquire deafness in adulthood.
208. Deaf Awareness training, appropriate technology and access to communication support, especially interpreters, are essential for those working with the Deaf Community.
209. The deaf service user must be given full information about his or her rights and referred as soon as possible to specialist services if they are required.
210. Primary Care Teams should be provided with appropriate information about Mental Health & Deafness services to enable them to refer service users for specialist assessment.
211. There should be effective interfaces and liaison between Primary Care, Social Services, Voluntary Organisations and the Deaf Community.

212. Protocols for effective joint working between local Community Mental Health Teams and services and the specialist mental health service for deaf people should be developed.
213. For deaf people being assessed for in-patient admission, protocols must be developed for the use of interpreters and other relevant professionals such as Social Workers with deaf people, in addition to the Approved Social Worker.
214. During the admission period, appropriate and accessible communication support must be provided within a maximum of 24 hours.
215. All service users should be enabled to give fully informed consent for their treatment, or to appeal against it.
216. Staff in Community Mental Health Teams and services must be provided with knowledge and skills to enable them to work, if necessary through interpreters, with deaf people, including staff in day services and out of hours services.
217. The specialist Mental Health Service for Deaf People must:-
 - develop a multi-disciplinary team which should include deaf professionals
 - provide assessment and treatment for service users at clinics in all the Health and Social Services Boards and in the community
 - work jointly with:
 - primary care
 - local mental health teams
 - other specialist mental health services including Learning Disability, Old Age Psychiatry, Forensic and Psychological therapy services.
218. The Specialist Mental Health Services for Deaf People should work with other agencies including Education, Social Services, the Independent Sector, Deaf Community Organisations, Employment and Housing to develop person centered care packages appropriate to deaf people.
219. The Specialist Mental Health Services for Deaf People should develop a teaching/liaison role and should carry out Audit and Clinical research
220. Long-term plans should be developed for the local establishment of in-patient facilities, possibly on an all-island basis.
221. Long-term plans should include programmes and supported housing for deaf people and people who acquire deafness in adulthood.
222. Provision should be made for deaf children and adolescents with mental health problems.

Services for People with Psychological Trauma

223. The development and expansion of evidence-based services including CREST guidelines to address psychological trauma should be taken forward with urgency.
224. Service planning must involve clinical leaders, users and carers and clinical managers.
225. To facilitate progress, a coherent tiered strategy should now be developed.
226. An audit of what is currently available (i.e. resources and skills), tested against the CREST guidance (2003), should be undertaken.
227. Primary care staff (and other front line services) should be provided with the necessary guidance, training and support in the detection, preliminary intervention and appropriate referral of people with trauma related needs.
228. A human resource plan, which addresses staff levels and qualifications, training and re-training, should be developed.
229. Future service configurations should build upon the experience and expertise that has been developed in both the statutory and non-statutory sectors.
230. The expertise developed in the non-statutory sector should inform the development of the overall trauma network.
231. Pre-professional training for health and social care professions should include appropriate content on the conceptualisation, recognition and treatment (including referral) of psychological trauma.
232. Advanced training for the treatment of PTSD (and related conditions) should follow current evidence-based guidance on the management and treatment of psychological trauma.
233. Further research should be commissioned into the prevalence of trauma related needs including the specific needs arising related from the civil conflict.
234. Health promotion programmes to address the specific needs of those affected by traumatic events should be developed in line with evidence-based practices and principles.
235. Organisations which employ people who, in the course of their work, may be exposed from time to time to traumatic experiences should put in place measures relevant to the nature of the work and risks.

Services for People with Personality Disorders

236. Specialist services for people with personality disorder must be established to augment secondary care services.
237. Service planning must involve clinical leaders, users and carers and clinical managers.
238. Service requirements should be the subject of needs assessment.
239. In line with services in the rest of the UK, residential and day treatment services for people with personality disorders should be established in N. Ireland.
240. Specialist services must provide support and education for services at secondary level.
241. Specialist multi-disciplinary teams should be established to provide assessment, education and support to other services who may come into contact with people with personality disorders. Staff appropriately trained psychological therapies must be appointed.
242. Specialist services for people with personality disorder should co-ordinate with other mental health services such as forensic services, substance misuse and learning disability services.
243. Education and support for staff in the diagnosis and management of people with personality disorders must be provided.
244. Awareness of the needs of those with personality disorders should be increased among such services as Primary Care, A&E, perinatal services, medical and surgical staff.
245. User and Carer initiatives to support sufferers and carers of those with personality disorders should be facilitated.

Services for Able Adults with Autistic Spectrum Disorders

246. A community needs assessment of able adults with Autistic Spectrum Disorder should be carried out as a priority.
247. A regional multidisciplinary team specialising in services for able adults with ASD (Tier 3 services) must be established as a priority.
248. Service planning must involve clinical leaders, users and carers and clinical managers.
249. Local services including voluntary sector services must be developed to provide psycho-education, support and interventions following confirmation of diagnosis.
250. A senior manager in each Trust should have responsibility for adults with AS/HFA.

251. Specialist supported housing and respite provision should be commissioned, with specialist residential provision available within each Board area.
252. People who are in contact with a service already should not be precluded from accessing another following consultation regarding their needs.

Services for People with Disorders of Gender and Sexuality

253. People with disorders of gender and sexuality in N Ireland should be offered the full range of services which have been shown to produce positive therapeutic outcomes.
254. Service planning must involve clinical leaders, users and carers and clinical managers
255. As contact with services is often long term the majority of provision should be local and community based, with appropriate access to regional specialist services when required.
256. Services should be community based and people centred, taking into consideration a social model of health.
257. Regional services should be targeted at individuals with the most complex needs.
258. There is a need to evaluate the workforce requirements for service changes and for training.