

DESCRIPTION AND EVALUATION OF HUMAN SERVICES AND DIRECTORIES DESDE

An international classification of human services

Manual
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DESDE (version 2023) is an updated version of DESDE-LTC (Description and Evaluation of Services for Long Term Care in Europe) (Salvador-Carulla et al., 2011) adaptation of the 'European Service Mapping Schedule' (ESMS) (Johnson et al, 2000) and the 'Description and Evaluation of Services for Disabilities in Europe' (DESDE) (Salvador-Carulla et al, 2006) which was incorporated into the REMAST tool for integrated local service assessment in mental health care (Salvador-Carulla et al, 2015). These instruments have been developed in the context of a series of international projects funded by the European Commission between 1994 and 2014: EPCAT, MHEEN, DESDE-LTC, REFINEMENT and PECUNIA. DESDE has been developed by the PSICOST international reference network

For further information on DESDE please visit <http://www.edesdeproject.eu/https://www.canberra.edu.au/research/centres/hri/research-projects/glocal> or Asociación Científica Psicost <https://psicost.org/>.
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A note on the language

There is a substantial disparity in the terminology used for describing human services across different sectors, countries and regions. The language used for describing the service categories coded in this manual may not be fully aligned with the terminology and the models of service delivery used in every specific sector or every country. The original instrument and core service categories were health related. The expansion of the instrument into other sectors has been taken into account in this version. The DESDE terminology is employed for international comparability following a consensus based standard vocabulary and classification of services. This terminology is not intended to replace the current terms used for naming and understanding service provision in any particular region or sector. However, the consistent application of standardised category labels provides a common language for meaningful comparisons of service across regions, both nationally and internationally. The designated name of the services should be provided together with the assigned international code using DESDE. A semantic mapping of the local terms to DESDE codes is recommended to improve the use of this system for local planning. This instrument is accompanied by a glossary of terms agreed by a consortium of international experts (Montagni et al, 2017).

Content

INTRODUCTION	4	A. ACCESSIBILITY CODING BRANCH	32
<i>a. GENERAL PRINCIPLES</i>	4	S. SELF-HELP AND VOLUNTEER CODING BRANCH	35
The importance of a common terminology.....	4	O. OTHER (VISIT) CODING BRANCH	37
The importance of context.....	4	D. DAY CARE CODING BRANCH	46
What is DESDE?.....	5	R. RESIDENTIAL CODING BRANCH	51
The ESMS/DESDE system of service assessment.....	5	SECTION C	57
What is the target population of DESDE ?.....	6	SECTION D	58
What is the structure of DESDE?	6	<i>SERVICE INVENTORY (LISTING)</i>	58
<i>b. GENERAL GUIDELINES</i>	6	<i>D1. PRINCIPLES FOR SERVICE TEAM INVENTORY</i>	58
The Desde Taxonomy Of Human Services At Micro-Organisation		<i>D2. GUIDELINES FOR COMPLETING THE SERVICE INVENTORY..</i>	58
Level	7	REFERENCES	62
SECTION A	15	ANNEX A Section D inventory	64
<i>LOCAL AREA MAPPING</i>	15	ANNEX B	68
A1. The Sector Cluster (SC)	15	GLOSSARY	68
A2. Target Population	18	ANNEX C ICD CODES	77
SECTION B	20	ANNEX D OTHER SERVICE TEAMS AND PROGRAMS	78
<i>SERVICE FUNCTION MAPPING (MSF CODING)</i>	20		
Principles For Coding Service Teams	20		
B1. The Main Service Function.	20		
B2. Additional Extension Codes (Qualifiers).....	20		
B3. Guidelines For Coding	25		
GUIDANCE CODING BRANCH	27		
I. INFORMATION	27		
E. EVALUATION (TEST AND ASSESSMENT)	29		

INTRODUCTION

a. GENERAL PRINCIPLES

The importance of a common terminology

Service is an umbrella term with different meanings. In the context of the DESDE system, a service refers to the standard organisation of care or other support delivery at the local level (Salvador-Carulla et al., 2015). A 'service team' refers to a stable group of people delivering a service who work together on a routine basis and in a common environment to meet the defined needs of a specific group of individuals. In this context, human services are different from policies, programs and interventions. For example, in health the purpose is to improve individual or population health, to diagnose or improve the course of a health condition and/or its related functioning. In social care, the purpose may be to improve an individual's life skills, or support greater social participation.

In this manual we use health and social care as the reference sectors, although DESDE can be adapted for the classification of other human services (such as justice, education, housing, employment etc.). Human services include, but are not limited to, the provision of support and care. Support involves providing aid, assistance or encouragement to someone in various aspects of their life. It encompasses actions aimed at helping individuals achieve their goals, overcome challenges, or improve their wellbeing. Support can be emotional, practical, or informational. It can include providing guidance, resources, advice or practical assistance in areas such as education, career development, mental health, personal growth or activities of daily living. Support can be offered by professionalsthe other hand, care generally refers to the

provision of assistance, attention, or concern for the wellbeing, safety and nurturing of individuals. It involves attending to someone's physical, emotional or social needs with compassion, empathy and sensitivity. Care can be provided by family members, friends or professionals and is often associated with activities such as medical care, personal care, childcare, care of older people, or specialised care for individuals with disabilities or chronic conditions, organisations or social networks.

The importance of context

Evidence alone does not make decisions. Evidence on interventions and services cannot be translated into implementation without a detailed knowledge of the local area in which the intervention takes place (Raine 2016). Similarly, an in-depth understanding of the local context is crucial to the implementation of any new strategy, and local context shapes the lens through which policy makers appraise the salience of evidence (Oliver et al, 2014).

Evidence-informed policy combines 'global evidence' available from around the world with 'local evidence' from the specific setting in which decisions and actions will be taken (Oxman et al, 2009). From an ecosystem services approach (Costanza 2014) we focus on services in the intersection between built and human capital to promote human wellbeing. For example in the health sector, this has been defined as the healthcare ecosystem framework (Furst et al., 2021). This should include a standard analysis of the boundaries and physical characteristics of the area; the relevant social and demographic determinants of health and wellbeing of the general population in this area; the specific characteristics of the target group: (for example, in health, data on prevalence and incidence of the target condition); the characteristics of the agents that operate in the defined area (carers, professionals, care teams, organisations),

and their connections and interactions, including resource utilisation and demand. Evidence must also be supported and supplemented by the expert knowledge of the people working within the system, and the experience of those using the services provided by the system (Furst et al., 2021).

What is DESDE?

The ‘Description and Evaluation of human Services and DirectoriEs’ (DESDE) is an instrument for the standardised description of human services, including crisis, acute, and continuous support and care. based on the identification and coding of service teams, and usable for international and multi-sectorial analysis of any type of human service. It is based on an ontology-driven, hierarchical, alpha-numerical tree taxonomy of the main service function provided by a team within an organisation.

The ESMS/DESDE system of service assessment

The origin and development of the European Service Mapping Schedule (ESMS)/DESDE system as a system of classification of health and social care is described elsewhere (Romero-Lopez-Alberca et al., 2019).

The ESMS/DESDE approach applied the basic principles of population epidemiology to the description of service delivery (service availability and capacity). DESDE is based on the ecological production of care model incorporated to the Tansella & Thornicroft Care Matrix for the assessment of mental health care (Tansella & Thornicroft, 1998). DESDE is intended to compile information on input (DESDE Section B) and resource utilisation (DESDE Section C) at the meso-level (e.g. health/social catchment

areas) and micro-level (e.g. individual services) as defined at a modified version of the Care Matrix (Rosen et al., 2020). We focus on analysis of the input at the micro (individual service) and nano (individual user) level. This information can be aggregated at meso level (e.g. a municipality) to provide contextual information on the provision of services at meso-level (catchment area). It can be further aggregated to provide information on care availability at macro-level (region or country level).

DESDE allows the following tasks to be carried out in a standardised way:

1. Compiling a standard directory of all human services in catchment areas using an international coding system. This directory is multi-sectoral and includes the provision of health, social, employment, education, housing, justice and other services provided by the public, private and/or voluntary sectors.
2. Describing the number and characteristics of service teams in a catchment area for system analysis and mapping.
3. Identifying the availability, diversity, placement capacity and workforce capacity of the service teams operating in a catchment area (local system).
4. Measuring and comparing the levels of provision/ availability (section B) and utilisation (section C) of service teams between different catchment areas using an international coding system.
5. Comparing the structure and organisation of service teams in different catchment areas.
6. Recording changes over time in service teams available within a catchment area.

Section B of DESDE provides basic information to understand the local service delivery system. Information on the governance,

management and financing of the individual service being assessed is gathered in section D.

What is the target population of DESDE ?

The ESMS/DESDE system classifies service teams according to the specific target population served. The target population should be formally described using DESDE. For example, health conditions can be described using the International Classification of Diseases (ICD) (<https://www.who.int/standards/classifications/classification-of-diseases>) or an equivalent international or national classification system: and disabilities and services for older people may require the use of the International Classification of Functioning (ICF) (<https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health>), or any other official register for coding the target population. A full description of these target groups is provided in Section A.

What is the structure of DESDE?

DESDE uses a multiaxial coding system. The code thread includes: a) a code of the sector cluster (health, social, justice, education, employment, housing); b) a code of the geographic area; c) a code of the target population; d) a code of the Main Service Function (MSF) and e) extension codes (qualifiers). The coding of MSFs is the core component of DESDE. The coding follows the DESDE taxonomy tree system.

This instrument can be used in two ways: i) a simple description cataloguing service teams by the main service function available in the catchment area (eg Fernandez et al., 2015); and ii) a complex quantitative assessment incorporated to decision support tools to

compare service delivery across several catchment areas or in the same area over a defined period of time (eg Almeda et al.,2022).

Basic training on the use of DESDE is required before the instrument can be used. A training package is available online (<https://www.canberra.edu.au/research/centres/hri/research-projects/glocal>) However, it does not replace in-depth training provided by the PSICOST team and the DESDE consortium.

b. GENERAL GUIDELINES

Service teams to be included: DESDE can code all the existing service teams within any given organisation within a catchment area. In order to make comparison across territories it is recommended to clearly define the perspective of the evaluation (i.e. society as a whole, public health planner, health care company, users and families, etc).

The mapping of the service provision system could be represented in several layers of information.

It is important to note that there are different units of analysis used in service research, and that like-with-like comparisons must be made across a single 'unit of analysis' group. Different units of analysis include macro-organisations (e.g. Accountable Care Organisation, ACO), meso-organisations (e.g. a hospital), micro-organisations (e.g. an acute ward in a general hospital) or smaller units within a service: for example in healthcare these smaller units may include Service Teams, Care (Provision) Teams, Care (Provision) Programs, Main Service, Modalities of Care, Clinical Units, (Care) Intervention pathways or trajectories, programs, (Care)

Intervention Packages, Intervention clusters, Interventions, Activities, and Micro-Activities within an intervention.

DESDE is focused on the evaluation of a defined target group within a local catchment area (Section A), the availability, diversity and capacity of service teams according to Main Service Functions (Section B), the utilisation of service teams in the local area (Section C) and the characteristics of the service teams and services available in the area (Section D). Every single service is an aggregate of care teams described using one or more codes based on the main care structure/activity offered by the service team (Main Service Function).

Services located out of the catchment area but that are used by residents from this area could be included in the local mapping. This will require information on utilisation that could be obtained either from local or national registries or from the collection of data on service utilisation in section “C” (optional). For residential and day service categories, a service out of the catchment area will be coded when at least 10% of its clients come from the catchment area. In the case of “other direct care or support” services, a service out of the catchment area will be counted when over 20% of their clients come from the catchment area. Services that are located within the catchment area but that do not provide support to local residents at the time of be coded, but will not be included in the mapping of service availability.

Specific acute and chronic (long term) care services in a catchment area that do not meet DESDE inclusion criteria could be listed in an appendix.

The Desde Taxonomy Of Human Services At Micro-Organisation Level

From an onto-terminology approach, the description of human services should be based on a practical taxonomy and its related glossary of terms. The ESMS/DESDE system provides a full taxonomy of the Main Service Functions of micro-organisations. A “micro-organisation” is a small, organised unit with a specific function, a common set of users, technologies and professionals who work directly with these users (adapted from Donaldson, M. S., Mohr, J. J., & Institute of Medicine, 2001).

Service Clusters (SC)

Service Clusters in the DESDE framework are the “customary grouping of inputs of human services provision. For example, in the case of health systems these can be called “clinical micro-systems” of care (Institute of Medicine, 2001). A Service Cluster is a combined and coordinated set of inputs (including structure, staff and organisation) for delivering human services at micro-organisation level. It refers to a small group of professionals who work together on a regular basis to provide support to a discrete and formally defined subpopulation of users in an explicit environment or setting. The explicit objectives of Service Clusters are to improve wellbeing. In the health sector this includes individual or population health and wellbeing: to diagnose, assess, inform and/or improve the course of a health or other condition and/or its related functioning in identified persons either individually or in groups. Service Clusters have common health, or social and business aims, linked processes, shared information environment and produce common performance outcomes (Institute of

Medicine, 2001). They evolve over time and are often embedded in meso-organisations.¹ “Service Clusters” should be differentiated from “Sector Clusters”. Sector clusters refer to the main sector of human services such as health, social care, justice, education etc.

Inclusion criteria of Service Clusters

Service Clusters are classified according to two main attributes: time continuity and organisational stability. Time continuity refers to the stability over time of the inputs which make up the Service Cluster (structure, staff and users). Organisational stability is usually characterised by an administrative unit with an organised set of structures and professionals that provide support within a service. The main unit of analysis of a Service Cluster is its Service Team which is described according to its Main Service Function (MSF). The DESDE instrument provides: 1) identification of the individual Service Team; and 2) coding of the Main Service Function according to the DESDE taxonomy.

Exclusion criteria of Service Clusters

Exclusion criteria are important to differentiate Service Clusters from other components of the production of human services (input / throughput / output) and other arrangements in the service system that are not coded by the ESMS/DESDE. Service Clusters DO NOT refer to:

Other components of the production of care:

1. Care products, tools, and medical devices. injections, radiology or surgical material:

Service providers: the organisations providing support are not coded in DESDE. For example, in the health sector, providers are coded in SHA 2.0 (System of Health Accounts) (OECD, WHO, Eurostat, 2011).

Service Staff not arranged by Service Clusters. The listing of professionals in a service can be coded using International Standard Classification of Occupations (ISCO) (ILO, 2014).

2. Process of service provision or throughput: service interventions are not coded by DESDE. For example, in the health sector, interventions can be coded using the International Classification of Health Interventions (ICHI) (WHO 2020) (Castel Pietra et al., 2018).

3.- Other organisations as part of the larger system excluded from DESDE:

3.1 Settings at other levels of organisation. Organisation systems at meso-level include groupings of service teams or structures that comprise different services within a larger organisation are excluded. Examples are general hospitals, large social care institutions, schools or prisons.

3.2 General service teams for the general population or large groups within it (e.g. older people, migrants, etc.) should not be included in the mapping of services for specific target populations such as mental health, multiple sclerosis or dementia. However it is important to take into consideration general services that assist a

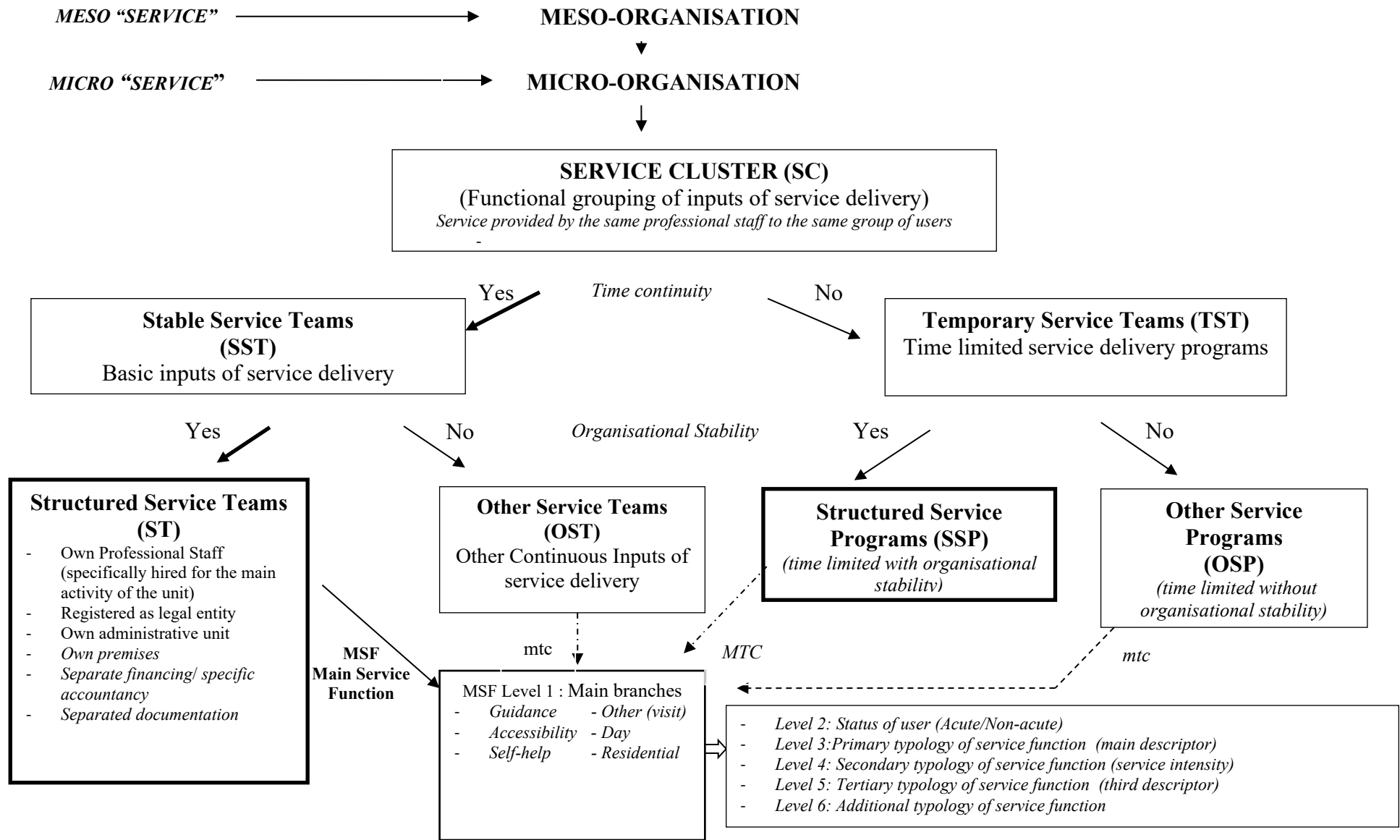
¹ Meso-organisations typically comprise more than three Service Clusters and can be provided in more than one setting (adapted from Donaldson, M. S., Mohr, J. J., & Institute of Medicine, 2001).

significant number of the defined target group. This is the case in those services where more than 20% of users are people within the defined target group included in the aims of the service. General care is important for many users within most specific groups, but generic services are not specifically planned for the target group. Services delivering primary health care, which may include some kind of care for specific groups but do not provide any specialist care for the defined group should also be excluded unless it is otherwise specified in the study. Services in which over 50% of users are from the target population but in which the target population is not the specific aim of the service (eg aged care services in which >50% of residents have dementia but older people generally, and not specifically people with dementia, are the actual target population) may be included but are not indicated as “specialised”.

Service Teams

Service Teams are the minimal unit of analysis of services at micro-level. A Service Team is a small functional group of professionals who work together on a regular basis to fulfil the specific needs of a discrete subpopulation of users. They are the main unit of analysis of services. In health care, they are synonyms of “clinical micro-systems” of care, and are characterised by organisational stability. They have common clinical or social and business aims, linked processes, shared information environment and produce common performance outcomes. They evolve over time and are often embedded in meso-organisations (Donaldson, M. S. et al., 2001). According to their time continuity they are divided in two types: Stable Service Teams (SST) and Temporary Service Teams (TST). The types and characteristics of these categories of service teams are shown in Figure 2.

FIGURE 2. -THE HIERARCHICAL TAXONOMY OF HEALTH-RELATED CARE



Stable Service Teams: operational definition

In order to code a care setting as a Stable Service Team the following inclusion criteria should be followed (Table 1):

Table 1. Selection criteria for the identification of Stable Service Teams

CRITERIA TO IDENTIFY A STABLE SERVICE TEAM	
Criterion	
A	Has its own professional staff
B	All activities are used by the same clients
C	Time continuity
D	Organisational stability
D.1	The service is registered as an independent legal organisation (with its own company tax code or an official register). IF NOT:
D.2	<i>The service has its own administrative unit and/or secretary's office IF NOT:</i>
D.3	<i>The service fulfils two additional descriptors</i>
D3.1	<i>It has its own premises and not as part of other facility</i>
D3.2	<i>It has separate financing and specific accountability</i>
D3.3	<i>It has separate documentation when in a meso-organisation</i>

Main Service Functions: operational definition

The Main Service Function is the main DESCRIPTOR of the 'generic function' provided by the Stable Service Team. These generic functions describe the primary and defining activity carried out by the service team.

The main generic functions in DESDE are described according to the six main branches of the taxonomy:

- the user sleeps in the setting- "R (residential)
- the user is seen in a face to face contact- "O" (Other-visit)
- the user spends a significant part of the day in the premises- "D" (Day)
- the user is provided access to a service (and not direct care or support)- "A" (Accessibility)
- the user receives guidance (information or evaluation of their needs) only - "G" (Guidance)
- the user is provided support by a volunteer or self help service- "S" (Self help or Volunteer).

Every service function is described in simple language and has a specific alphanumeric code (for example: provides night accommodation for acute users in a setting with 24-medical care: R2). These codes are defined by a series of identifiers hierarchically arranged in 6 levels:

-First Level: Main branch (or main function of care): Guidance (Evaluation and Information)) Accessibility, S) Self-care and voluntary, D) Day services, R) Residential care. O) Other Direct services (Visit)

-Second Level :This level typically relates to the status of the service users, for example in the health system, it would relate to the clinical

or functional status: i.e. a crisis situation will define the service team as “acute care”.

-Third Level: This level usually describes the main general typology of the service function (for example in health and social care it can be home & mobile/non-mobile, physician or non-physician cover).

-Fourth Level: This level typically refers to the intensity or level of engagement between service and service user that the service team can offer

-Fifth Level: Provides an additional identifier of the service characteristics.

Hierarchy of Main Service Functions

Services provide a wide array of activities. The DESDE system identifies a significant activity of the service as the Main Service Function. In some cases, a service can not be identified by a single Main Service Function. In this case, principal and second Main Service Functions can be registered.

To select one activity provided in the service as its principal Main Service Function, DESDE follows a rule based on the hierarchical order of their main branches: R>D>O>A>G> S (i.e. availability of Residential services in a single Service Team prevails over availability of Day services; and Accessibility prevails over Information, The principal Main Service Function descriptor should be identified by the official name and description of the service, but this is not always the case.

Coding of the Main Service Function is based on the actual activity and performance of the service team, and not on its theoretical purpose or its official name. On some occasions the team provides

the activity registered in its name while also providing another activity of a higher order according to the classification rules of DESDE. In this case the higher rank branch is used for coding the service, and the second order branch that officially defines the service is coded using an additional DESDE Main Service Function or an extension code.

Main Service Function descriptors do not overlap and cannot be double counted.

In order to code the Main Service Function for a single Service Team, the subsequent criteria should be followed:

Inclusion criteria (Main Service Function)

Principal Main Service Function: The definition and description provided by DESDE for a given code fits with the main purpose/aim/objective of a Service Team AND with its main activity. In case of disagreement between the defined aim and the actual current main activity of the Service Team, the actual main activity will be used for selecting the Main Service Function code. Cut-off points are provided when necessary to allow coding based on the main activity/performance of the Team.

Second Main Service Functions: Additional Main Service Functions should be used to describe the range of main activities whenever the main characteristics of the Service Team cannot be registered using a single DESDE code. In this case the service team should be described using MORE THAN ONE main descriptor. For instance, in health care, the acute unit of a hospital may also provide 24-emergency non-mobile care, which is a distinct descriptor different from R2 (principal main descriptor) and for a different set of users

(emergency care users in a crisis). In this case the care team has one Service Team, coded 'R2,' with an "other care team" label 'o3' associated to it. The final code will be "R2, o3". If it is not possible to identify which is the principal Main Service Function, both Main Service Functions will be coded in capital letters, for example R11, O8.

If the Service Team fulfils criteria for time continuity and same staff, but the activities of the service are available for multiple users different from the target group that defines the Service Team. In this case, the main user group could be used to select the principal Main Service Function, and the other user groups used to select additional Main Service Functions.

The subsequent criteria should be followed when registering second order codes:

-The additional main activity is critical to differentiate the Service Team from other related Service Teams both from the perspective of users and managers. Following the previous example ("R2, o3"), an acute residential unit in a general hospital with outpatient emergency care would clearly differ from a similar unit without emergency care. Registering a secondary Main Service Function instead of an additional qualifier should clarify that the unit fits the criteria for Main Service Function. In some exceptions, the target can not be defined as the individual. For example, in postnatal units, where the mother and the baby are being cared for, or where the service is treating the user and the carer of the user.

-A significant part of the activity of the service team is related to another DESDE code apart from the principal code.

-The additional activity provides the official definition of the service and cannot be coded using additional extension codes

Exclusion criteria (Main Service Function)

Exclusion criteria are important to differentiate Main Service Functions from other units of analysis in human services research.

Team Activities: Main Service Functions are not simple activities of the service team. Main Service Function descriptors are based on the main activities or functions that are critical to compare service teams across different territories and sectors. Service teams should fit one code, and it is unusual that a service team would be assigned more than three codes. Check the inclusion criteria mentioned above carefully before coding a service team activity as a Main Service Function.

Activities of the Service Team that are not its Main Service function may be defined using different units of analysis For example, in health services research, the following units of analysis have been defined :

Modalities of Care describe a main type of intervention (or activity) that can possibly be applied to achieve one of the restricted number of tasks that together comprise the whole range of care provided by a Service Team (De Jong, 2000).

Packages of Care. A cluster or set of integrated care interventions designed for the same group of users and provided by different staff teams. Packages of care may be delivered by a single Service Team or by a group of integrated Service Teams.

Intervention Programs: a set of activities programmed within a limited period of time (normally less than 1 year, and no longer than 3 years) without a stable structure in time. In some occasions Service Teams develop from programs which are re-edited through the years.

Other components of the production of care: care products, 'goods', tools or devices/ are other input components of the production model. Health care products such as injections, radiology or surgical material

SECTION A

LOCAL AREA MAPPING

Service Teams are classified using a code thread divided in to 4 sections.

The first section includes the sector cluster, and the code of the geographic area.

The second section includes the target population codes (age, gender, health condition or reason for using the service, specific population group etc).

The third section refers to the code of the Main Service Function and its extension qualifiers.

Finally, *the fourth section* includes other codes such as professional occupation.

A1. The Sector Cluster (SC)

The definition of sectors in human services research is ambiguous with overlapping across areas. For example, community residential care can be assigned to the health sector, the social sector or housing, depending on the local funding organisation and culture.

DESDE provides a code for the “Sector Cluster” that identifies the main sector to which a service can be assigned regardless of the local regulation.

Six major “clusters” have been identified:

CH: Cluster Health
CJ: Cluster Justice
CS: Cluster Social
CE: Cluster Education
CW: Cluster Employment (Work)
CD: Cluster Housing

This additional axis is only needed in the case of evaluations of the whole system to differentiate the different sectors being evaluated. It requires a hierarchical structure to avoid duplication.

The main driver of this code is the target population of the service. Therefore, a service designed for a target population with a specific medical condition (identified by an ICD code) will be considered “Cluster Health” regardless of the funding agency, regulation, governance etc. A housing service for a target population of people with severe mental disorders will be coded as “CH” (Cluster Health), even if it is managed by social services.

The hierarchical structure of sector classification follows the rule:

CH>CJ>CS>CE>CW>CD

A service can not be assigned to two different sector clusters, and the cluster to which it is assigned using the DESDE system may differ from that ascribed locally.

DESDE provides a description of the sector, the management and the funding in Section D: Service Team Inventory.

Defining geographic areas

DESDE has been designed for service comparison across defined geographical areas. Boundaries of health, social care, education, justice and other local administrative areas should be taken into account. The national and international classification of areas that could allow comparison across jurisdictions should be considered and agreed upon. Levels are adjusted to international partnerships, national borders, administrative boundaries, zoning for planning (health, social, education, etc.), census levels and statistical areas, postal codes or urban and rural districts. For example in Australia, areas are officially classified according to the population size into Statistical Areas (SA1 etc).

Different geographical areas are coded in relation to the sector cluster that is being described. Thus, health areas are designed by capital letter "H", social areas by "S", educational areas by "E", justice areas by J. In relation to health jurisdictions, DESDE has provided a standard typology of health care areas that has been used in the Atlases of Health Care and which is provided below.

The definition of clusters of areas or jurisdictions that can be compared like-with-like is extremely difficult due to their diversity in size, population, governance, urbanicity, and other factors. DESDE refers, mainly, to small catchment areas within every field at a "H4.1" level (see territorialisation levels description below). Typically, small social areas may be broader than small health areas; and areas for specialised care (i.e. mental health) may be smaller than areas for more general health conditions but larger than primary care areas. Comparison areas in DESDE may be extended to maximum administrative territorial specific health care areas (H3.1) depending on the location used in the country or region of reference and the territorial divisions of the geographical region being evaluated.

H0: Macro level

H0: Pan-national level

H0.1 Global: World

H0.2 Pan-national: For instance: Americas, PAHO, WHO region, European Union

H1: National level

H1.1 Large countries For instance: Chile, USA

H1.2 Small countries (Typically below 1 million population) For instance: Belize, Andorra

H2: Regional level

H2.1 States and regions within a country For instance: Bío-Bío (Chile), Texas (USA), Mexico D.F (Mexico), Australian Capital Territory (Australia)

H2.2 Provinces, counties For instance: Miami Dade County (Florida, USA), Vizcaye (Basque Country, Spain), Hunter Valley region (New South Wales, Australia)

H2.3 Metropolitan urban areas For instance: Mexico city (Mexico), Santiago de Chile (Chile), Barcelona (Spain), Melbourne (Victoria, Australia)

H3: Meso Level

H3.1 Health districts

For instance: The Talcahuano (Bío-Bío, Chile), Western Sydney (New South Wales, Australia)

H3.2 Catchment Areas for a reference General Hospital

For instance: Hospital of Concepción (Bío-Bío, Chile), Hospital of Basurto (Basque Country, Spain) (approx. 70,000 to 200,000 inhabs.)

H3.3 Other Jurisdictions larger than Catchment Areas for a reference Specialised Care Centre (H4.1) and lower than Catchment Areas for a reference General Hospital (H3.2)

For instance: Catchment area of the Day Hospital of Uribe (Basque Country, Spain)

H4: Micro level

H4.1 Catchment Area for a reference Specialized Community Centre

For instance: COSAM Mental Health Community Centre (Chile), USMC Mental Health Community Centre (Andalusia, Spain) (approx. 120,000 to 20,000 inhabs)

H4.2 Other Jurisdictions larger than the Minimum Local Health Administrative Area (H5.1) and lower than Meso level areas (H3.3)

H5.1 Minimum Local Health Administrative Area

For instance: Catchment Area of a Primary Care Centre (approx. 50,000 to 10,000 inhabs)

H5.2 Other jurisdictions smaller than H4

For instance: Postal codes and census areas in urban districts
Health areas can also be matched according to population size, although huge variability exists even within the same country. The original service classification tool from which DESDE has evolved, the European Service Mapping Schedule (ESMS) was intended for administrative territorial areas of specialized mental health care based on a population size of below 1 million inhabitants (H3.1). As an approximation, a prototype H3.2 refers to an area between 200,000 and 700,000 inhabitants; H4.1 to an area between 150,000 to 20,000 inhabitants; and H5.1 to an area between 10,000-50,000 inhabitants.

Area qualifiers: In order to provide a better understanding of the local system, the following qualifiers in italics can be added to the areas selected at microlevel

Cities (or densely populated areas)

— small spatial units that have at least 50 % of their population in urban centres;

Towns and semi-dense areas (or intermediate density areas)

— small spatial units that have less than 50 %

of their population in urban centres and no more than 50 % of their population in rural grid cells

Rural areas (or thinly populated areas)

— small spatial units that have more than 50 % of their population in rural grid cells. (Eurostat 2021)

Remote

Zonified

Nested

Ill-defined boundaries

The World Health Organisation has additionally classified the following world region groupings:

WHO African region

WHO Region of the Americas

WHO SouthEast Asian region

WHO European region

WHO Eastern Mediterranean region

WHO Western Pacific región

A2. Target Population

The 'default population' to which the DESDE is intended to be applied should be specifically defined.

Codes For The Target Population

a. Age Groups

The main target group of the service team according to age group can be coded as follows:

- GX All age groups
- NX None/undetermined
- CX Child & Adolescents (e.g. 0-17)
- CC Only children (e.g. 0-11)
- CA Only adolescent (e.g. 12 – 17)
- CY Adolescents and young adults (e.g. 12-25)
- AX Adult (e.g. 18-65) typically any population above 18
- AY Young adults (e.g. 18-25)
- OX Older than 65
- TC Transition from child to adolescent (e.g. 8-13)
- TA Transition from adolescent to adult (e.g. 16-25)
- TO Transition from adult to old (e.g. 55-70)

b. Specific Population Groups

An additional capital letter can be added to the end of the age code to identify gender/orientation specific services:

- M Male
- F Female
- FN First Nations
- LGBTIQ+ Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and others
- CALD Culturally and Linguistically Diverse

For example a service for adolescent women could be coded as CAF (CA: Adolescent; F: Female).

c. Main need of the Target Group (*Diagnosis or primary reason for using the service*)

(i) *Clinical Diagnosis*

In the coding of health services, diagnostic target groups can be identified by International Classification of diseases (ICD) codes in brackets after the age group code, but before the DESDE code. A full list of the codes most commonly used in DESDE coding can be found in Annex C. Diagnostic categories can be downloaded from the following website

<http://apps.who.int/classifications/icd10/browse/2010/en#V>

ICD-T When there is not a specific diagnostic group defined by the care team or it covers all types of disorders

[X] When the care team includes all types of an ICD section the letter of the section will be coded. For example [F] for mental disorders.

[Fx-x] When there is a general category but the specific diagnosis is not identified:

[F70-79] Intellectual disability

[Fx] When there is a specific diagnosis described in the care team (i.e [F50] for Anorexia)

For example: A [F20] – D1.2 for describing Day Acute Care teams for Adults with Schizophrenia.

(ii) *Functional groups.*

The target population of services that provide interventions for functional problems can be described with International Classification of Functioning, Disability and Health (ICF) codes (WHO 2001). ICF also includes the severity level and this allows the description of services exclusively aimed at subgroups of population

defined by severity (e.g. mild, moderate and severe groups within the stepped care model in mental health).

(iii) Target groups with Specific Social Needs.

ICD-10 “Z” codes for describing “Factors influencing health status and contact with health services” have been used to describe target groups with special social needs such as homelessness (Z59.0), extreme poverty (Z59.5), child abuse (Z62.81). ICD-10 CM also provides additional codes such as “T” codes for describing the target group of services for victims of domestic violence (T74: Adult and child abuse, neglect and other maltreatment). A full list of target group codes is available in Annex C

(iv) Extended Or Related Target Groups.

Section ‘e’ of ICF includes codes for referring to the nuclear family (e310), the extended family (e315), peers and other relationships and carers. These codes can be used for coding services aimed at providing care to the social network of the user:

(e310x) family (nuclear or extended)
(e32x); Friends, acquaintances, peers, colleagues, neighbours and community members

Selecting parts of the DESDE

Completion of the whole instrument would provide a comprehensive mapping of the structure and level of service team provision in a local area. However, it will not always be possible or necessary to use the full instrument schedule, and respondents may use those sections of the Tree and parts of DESDE which best meet their needs.

For example, the instrument can be used to map residential services used alone if this is the only aspect of the service team provision which is of interest. For the purpose of comparative studies, it is important that the same portions of DESDE be used in each local area.

SECTION B

SERVICE FUNCTION MAPPING (MSF CODING)

Principles For Coding Service Teams

The aim of Section B is to produce a comprehensive categorisation of the service teams for a defined target group in the local population, classified according to function, availability and setting. It includes the third and fourth sections of the coding thread: namely, the Main Service Function, and optional additional characteristics (called qualifiers or extension codes).

Section B is aimed at describing routine maximum care team performance during a defined period of time. It should not be used to provide a description of a team's theoretical capacity, or high intensity provision which is clearly unusual within the setting and does not represent typical provision in a reference year. DESDE coding is based on the highest activity within a given period of the team which fits into the range of minimum performance requirements defined in the instrument and agreed for every code (e. g. D1: 20%).

B1. The Main Service Function.

There are six mapping branches in the taxonomy tree. Each branch is identified in the taxonomy tree by the first letter of the branch name: 1) Residential; 2) Day services; 3) Accessibility services; 4) Guidance services (Information and Evaluation); 5) Self-help and volunteer services; and 6) Other (Visit) direct support .

Sub branches of each mapping branch include numerals, which together with the alphabetic code from the main branch, identify the

final Main Service Function code of a Service Team. Branches and sub branches are described in full in this section.

Some Service Teams may well meet the criteria for Main Service Function in more than one branch of the tree. This will occur especially in areas with highly integrated community care teams in which, for example, the same team may provide emergency, continuing care and day care teams - more details are given in the glossary.

B2. Additional Extension Codes (Qualifiers)

The DESDE coding can be complemented by optional codes which provide additional information on the service team characteristics.

Extension codes for describing complementary characteristics of main service functions

A series of qualifiers have been incorporated to facilitate a quick appraisal of those service characteristics which may be relevant to local policy or for a specific research. These descriptors are optional. They are related to the general description of the Service Team provided at Section "D", and therefore they are not part of the hierarchical tree structure of the DESDE system. These optional qualifiers are represented as small letters which can be added at the end of the alphanumeric coding to provide additional information about the location where the care team is provided (eg a hospital setting), specific characteristics of the service teams described (e.g., liaison care teams), the means by which the service team is delivered (e.g., eHealth/telecare). A number of these additional qualifiers are related to larger organisations in the local system where the service team is located (e.g. general hospitals).

“a” Acute care (complementary)

This qualifier describes acute service delivery which is provided for users in a crisis situation within a non-acute, non-residential setting

(branches “O” and “D”) but which does not fit criteria for a separate Main Service Function. As an example, this may be relevant to differentiate ambulatory facilities with the capacity to provide acute care in working hours care as an ordinary activity from those ambulatory centres that do not provide acute care at all.

“b” Bundled care

This qualifier describes episode-related service provision, usually provided for non-acute users within a time limited plan (e.g. in health care, three months of brief psychotherapy or skill development). The ‘b’ qualifier is only assigned when at least 80% of the service provided is short- time limited and episode-related.

“c” Closed care

This qualifier describes secluded services with high level of security provided under locked doors. Usually these units are for crime & justice users or persons with mental illness, assessed as being high risk for themselves or others. The availability of a single room for seclusion within an acute ward does not qualify the service team as closed care. Extension code “q” which indicates a higher than typical level of an attribute may be used to indicate very high level of security.

“d” Domiciliary care

This qualifier describes services provided entirely at the home of the user. If a service team provides mobile home care as part of a broader or more general activity it should not be coded as “d”.

“e” eCare

This qualifier includes all services relying on information and communication technologies (ICTs) (e.g. telecare/telemedicine, teleconsultation, teleradiology, telemonitoring).telehealth, digital

Specialist technical devices for healthcare professionals (robotics and advanced systems for diagnosis and surgery; simulation and

modelling devices; healthcare grids, tools for training) are NOT included in this coding.

‘e’ can be added at the end of the DESDE code to differentiate a team that has been coded as “Other (visit)” from teams providing support face-to face if more than 80% of service delivery is provided this way.

“f” Far-away

This qualifier describes teams available for a defined population but too distant to be accessed on a routine basis. This additional descriptor does not depend on the distance of the team from an individual user, but from a target population quarter (e.g. a municipality). The suggested cut-offs for assigning this code are as follows: 1) Residential teams: 100 kms; 2) Other Direct Support non-mobile: 70 kms; 3) Day services: 50 kms. This coding is not intended for mobile “Other” teams or for eHealth. For example, the hospital acute ward assigned for a rural area is in a city 130 kms away from the main location in the rural area; or the assigned day care centre for this area is located in a town 70 kms away from the rural area).

“g” Group

This qualifier refers to “Other (visit)” services where most support is provided through group activities (typically over 80% of their overall activity).This excludes family therapy.

“h” Hospital (Care provided in a hospital setting)

This qualifier describes non-residential services (“O”, “D”) provided in a meso-organisation registered as a “hospital” but which are different from acute residential care (e.g. an outpatient unit or a day hospital placed in a general hospitasetting in order to differentiate these teams from similar units placed in the community). Also describes non acute residential care normally found in the

community (R8-R13) but which in this case is located in a health care campus or cluster and cannot be coded as R4-R6.

This code excludes “Long-Term Institutional Care settings which are coded as “i”.

“i” Institutional care

This qualifier describes residential facilities characterised by indefinite stay for a defined population group, which usually have over 100 beds and which could be described as “Institutional care”.

This additional code may provide relevant information with regard to the balance of care in specific areas such as mental health, intellectual disabilities or age, where large long-term residential care characterised an “institutional” care model (e.g acute, time-limited and indefinite stay: R2.i, R4.i, R6.i).

“j” Justice services

This qualifier describes teams whose main aim is to provide support for crime & justice users (security or prison hospitals, surveillance wards for patients under justice custody, physical disability and psychiatric units in prisons and regional security units). These units may also be coded in an independent tree due to the special characteristics of the target population.

“k” carer

This qualifier describes teams whose main aim is to provide support by peers, family members or other ‘non-professionals’ who are paid for their work and where typically most (over 90%) of the staff is non-professional. Codings are specified in the target group section. Most of the workforce have less than 6 months of training

“l” Liaison care

This qualifier describes liaison” teams where specific consultation and care is provided for a subgroup of users from a different main target population (e.g., liaison psychiatric care teams for oncology

patients) usually located in another area of care (e.g. outpatient consultation on Intellectual Disabilities to a general medical care team or consultation on mental disorders to the general medical care teams of a hospital). A liaison care team provided to inpatients from other wards within the same general hospital will be counted as low mobility “Other (visit)” care.

This qualifier excludes activities which are part of the other team (e.g. psychology care provided by a psychologist within the oncology unit) will not be counted as a liaison care team.

“m” Management

This qualifier describes teams whose main aim is defined as management, planning, coordination or navigation of service provision, but which also include several forms of direct support as part of the coordination of their activity (e.g., the team typically provides therapeutic counselling as part of its case management activities). These teams cannot be coded as A4, but they should be differentiated from other direct support teams. These teams may include intensive case management, assertive outreach, assertive community treatment, disease management, or even personalised care.

“n” Novel

This qualifier describes facilities of recent creation in hospital clusters or hospital campuses or community centres with partial residential support that do not fulfil previously established criteria for typical hospitals or residential facilities. Detailed description of these services should be provided in section D ” observations”. If a sequential study is run, special attention to whether this type of service is still novel in the region

‘o’ ‘On call’

Physician higher level of training and responsibility
This qualifier describes residential services with an on call physician. The physician is not formally on duty at the centre part of

the day, usually at night. Physicians on call are used frequently (e.g. at least 4 times a week).

‘p’ Primary Care (Specialised Care provided in a primary care centre)

This qualifier describes specialised ambulatory support provided at the “primary service centre” by a qualified specialist from the specialised centre.

For example in health care: psychiatric care which is provided by a specialist entitled to prescribe specialised treatment including psychotropic drugs in the primary care centre on a regular basis, even though the specialist is based at the Community Mental Health Centre (CMH). This care team is not a mere consultation-liaison care team mainly supporting physicians from the primary care centre. This additional descriptor is added to the Main Service Function code provided by the CMH at the “mental health tree”. In addition, the care provided at the primary care centre generates in this case a new Main Service Function at the primary care centre. In this example the main identifier of the users is that they are recipients of ‘generic medical care’ but they pertain to a subgroup with specific psychiatric problems which is identified and treated. Therefore the full coding of this service at the primary care centre will be: A [ICD-T] [F0-F9] O8.1 while the additional code of the Mental Health Centre will be [F0-F9]-O8.1-p.

“q” Quite

This qualifier indicates that the main attribute of the service (e.g., mobility, intensity) is significantly higher/greater than for other teams similarly coded. For example, a “q” qualifier in a “low mobility” service indicates that the mobility of the team is at the higher rank within the “low mobility” group (typically between 20 and 49% of the overall activity performed in the centre). A “q” qualifier in the “high mobility” category indicates that the mobility of the team is higher within the “high mobility” group (typically between 80 and 98% of the overall activity performed in the centre).

“r” Reference main type care in an area

This qualifier describes the main and/or official referral team provided at the local area, in areas where care or support has been organised by quarters or “sectors”. This optional descriptor is particularly relevant in mental health to differentiate the reference mental health centre from other outpatient units in the same local area, or the referral acute hospital care team from other acute units which could also be used by the same target group within the local area. “r” and “t” describe the main location of a clinical team with a series of satellites or tributary services. This qualifier includes official doorkeeping to more intense levels of care.

“s” Specialised care

This qualifier describes teams designed for a specific subgroup within the target population attended by the system at the local area (e.g. care teams for Elderly persons with Alzheimer’s disease within the “E” group, or care teams for Eating Disorders within the “Mental Disorder” group). When used in aged care it could be used for a service specialised in dementia with behavioural problems.

“t” Tributary

This qualifier describes satellite units of service delivery dependent from a main team. Typically the team itinerates to different settings where they provide the service on a regular basis (e.g. Royal Flying Doctors care team in rural Australia), or part of the team is permanently in the setting but it does not qualify as a Service Team due to its dependency from the headquarters (e.g., satellite ambulatory mental health centres in Girona -Spain). Satellite units are therefore Other Service Teams and their Main Service Function is coded in lowercase, with the “t” qualifier.

“u” Unitary

This qualifier describes single-handed service teams where the service is typically delivered by a single health or social care professional (eg psychiatrist, psychologist, nurse, social worker). In

health care, this descriptor allows differentiation of local systems where the service is provided mainly by community centres and teams from those where care is mainly delivered by single professionals in individual practices. In residential care, this qualifier identifies presumed residential services provided by a single health care professional to the residents (e.g., cluster of residential apartments)

“v” Variable

This qualifier is used when the code applied at the moment of the interview could vary significantly in days or weeks

“w” Whole.

This qualifier indicates that the service only provides the extreme level of the activity described by the Main Service Function. For example in “low mobility” Main Service Functions a “w” qualifier indicates that there is no mobility of the staff so this care team is entirely “non- mobile”. On the contrary when this code is applied to a “high mobile” Main Service Function it indicates that all the activity of the team is mobile. For example the “w” qualifier attached to a low mobile “Other(visit)” service indicates that this service is fully non-mobile (O9), whilst the same qualifier applied to a mobile service (O6) indicates that 100% of its activity is mobile. Likewise a “w” qualifier attached to an “S” code indicates that a self-support service is exclusively run by un-paid peers.

“x” & “y” Open Qualifiers

Additional qualifiers “x”, “y” could be added to describe extra information required by a specific research or requested by the funding agency or organisation for management or governance purposes. For example, these descriptors can be used for describing transportation to the care team or catering care teams if the agency wants to incorporate this type of delivery to the coding and mapping. The addition of other optional qualifiers requires a formal definition of the descriptors added in every specific project.

“z” qualifier

This qualifier is used to identify services providing preventive type care to the target group:

“z1”- *Universal-- all population*

“z2”-*Selective for specific group (at risk, eg a specific at risk demographic group)*

”z3-*Indicated (high risk eg specific individuals at risk)*

If over 20% of the consumers have the targeted diagnosis in a “preventive” service then the service is not preventive but targeted (eg F0-9) with a z qualifier

A preventive psychosocial service coded as Z (ICD target pop) will also have z qualifier

When needed, other optional codes could be added depending on the specific objectives of the research.

These additional codes are represented with the Greek alphabet

Π (Pi): Private

Private” refers here to financial restrictions in access to the service: i.e. the consumer pays an out-of-pocket fee for service, without a significant reimbursement or copayment by the public system; or the activity is covered by a fully private insurance not incorporated in the compulsory insurance scheme of the jurisdiction. “Private” as service ownership and management is registered in section D of the instrument.

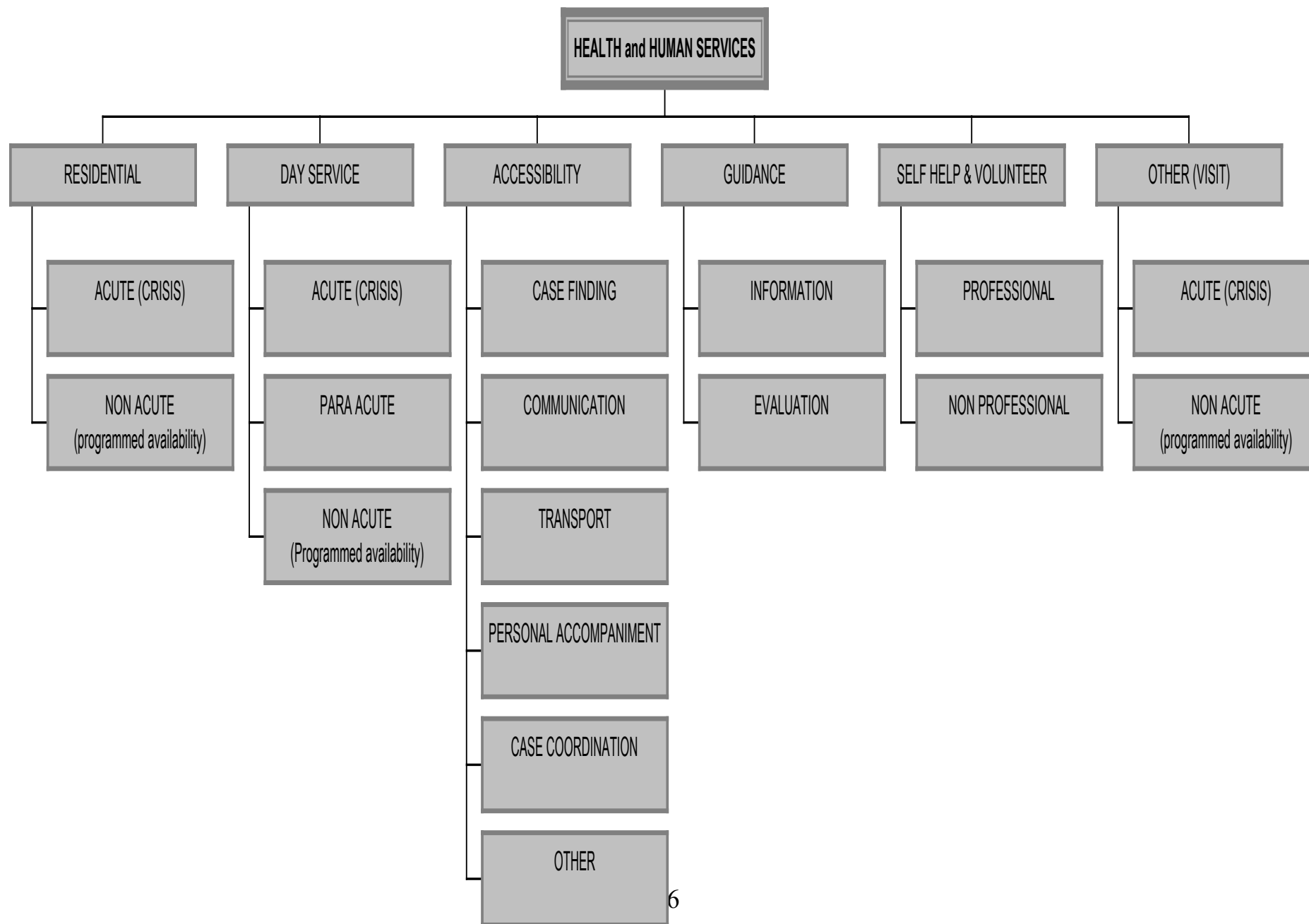
Tau : Τ services intended as training facilities for students, where the students provide support under supervision of qualified staff

B3. Guidelines For Coding

Stable Service Teams are classified according to a number of descriptors (types and qualifiers), such as main branch, status of user, care typology, intensity, time of stay, and mobility. These descriptors provide a classification based on the “Main Service Function.” as described in the six main branches.

The coding system follows the original order used in the European Service Mapping Schedule (ESMS) (Johnson et al., 2000) designed to be used for mental health care teams and its adaptation for disability care teams (DESDE) (Salvador-Carulla et al., 2006), and other human services. Due to this the codes do not follow an ordinal arrangement in Branch “D” (Day Care).

The coding system should be filled after completing “Section D” taking into account the information provided there.



GUIDANCE CODING BRANCH

The Guidance coding branch is sub divided into Information and Evaluation sub branches.

I. INFORMATION

Services whose main aim is to provide users from the defined target group with information related to their needs.

This team does not provide subsequent monitoring/follow-up, evaluation, guidance or direct care provision.

I1 ONE EPISODE OR ACUTE

Service Teams which usually provide information to users from the defined target group, on a single or a limited number of episodes during a defined period of time. These teams (i) provide information in response to a crisis, deterioration in physical or mental state, behaviour or social functioning which is related to the condition or individual's circumstances; and (ii) can usually provide a same day response during working hours or at least within 72 hours after the care demand. At least 20% of the users in the last twelve months do meet the criteria for acute episode

I.2.1 Health Related

I.2.2 Social Related

I.2.3 Justice Related

I.2.4 Education Related

I.2.5 Housing Related

I.2.6 Work related

I2 CONTINUOUS

These Service Teams provide users with ongoing information, involving regular contact with a service which may be long term if required. These teams may also provide acute/emergency information on a regular basis, however this should comprise less than 20% of the ordinary activity of the team.

I.2.1 Health Related

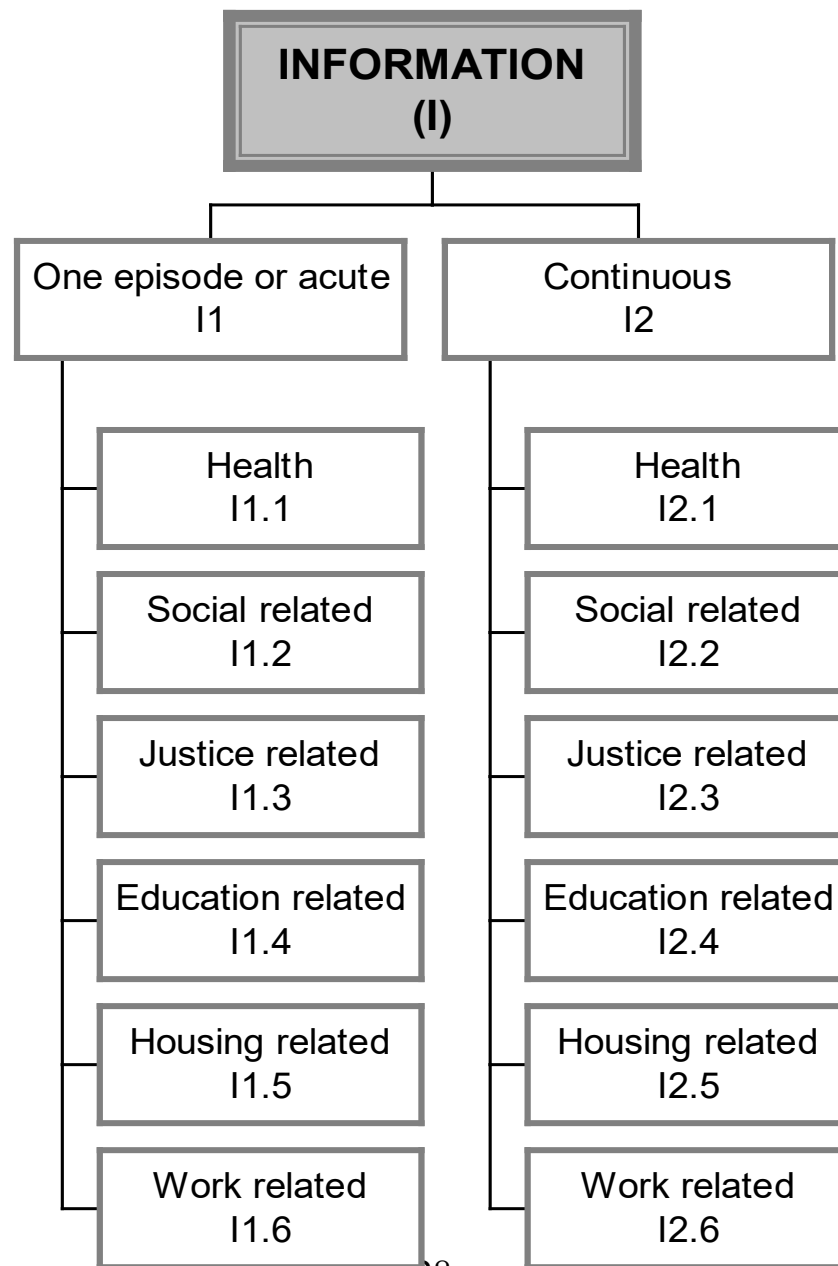
I.2.2 Social Related

I.2.3 Justice Related

I.2.4 Education Related

I.2.5 Housing Related

I.2.6 Work related



E. EVALUATION (TEST AND ASSESSMENT)

Service teams whose main aim is to provide users from the defined target group with a “Test” or “Assessment” service:

TEST Performing a specific review or examination using a questionnaire or a rating scale or other instrument such as the International Classification of Health Interventions (ICHI) (WHO, 2020).

ASSESSMENT Evaluating a health condition, functioning, behaviour, or need for intervention (ICHI).

Evaluation excludes “practical support”

E1 ONE EPISODE

Service teams which usually provide assessment to users from the defined target group, on a single or a limited number of episodes during a defined period of time. These teams (i) provide assessment in response to a crisis, deterioration in physical or mental state, behaviour or social functioning which is related to the condition or individual’s circumstances; and (ii) can usually provide a same day response during working hours or at least within 72 hours after the care demand. At least 20% of the users in the last twelve months do meet the criteria for acute outpatient care for crisis.

E1.1 High mobility

Here, contact with users occurs in a range of settings including users’ homes, as judged most appropriate by professionals and users. For an evaluation team to be classified as high mobility, at

least 50% of contacts should take place away from the premises at which the evaluation team is based.

- E1.1.1 Health related**
- E1.1.2 Social related**
- E1.1.3 Justice related**
- E1.1.4 Education related**
- E1.1.5 Housing related**
- E1.1.6 Work related**

E1.2 Low mobility

At least 50% of contact with users takes place at the premises at which the evaluation team is based.

- E1.2.1 Health related**
- E1.2.2 Social related**
- E1.2.3 Justice related**
- E1.2.4 Education related**
- E1.2.5 Housing related**
- E1.2.6 Work related**

E2 CONTINUOUS

These Service Teams provide users with ongoing evaluation, involving regular contact with a professional, which may be long term if required. These teams may also provide acute/emergency evaluation on a regular basis, however acute evaluation activities should comprise less than 20% of the ordinary activity of the team.

E2.1 High mobility (as in E1.1)

- E2.1.1 Health related**
- E2.1.2 Social related**
- E2.1.3 Justice related**
- E2.1.4 Education related**
- E2.1.5 Housing related**
- E2.1.6 Work related**

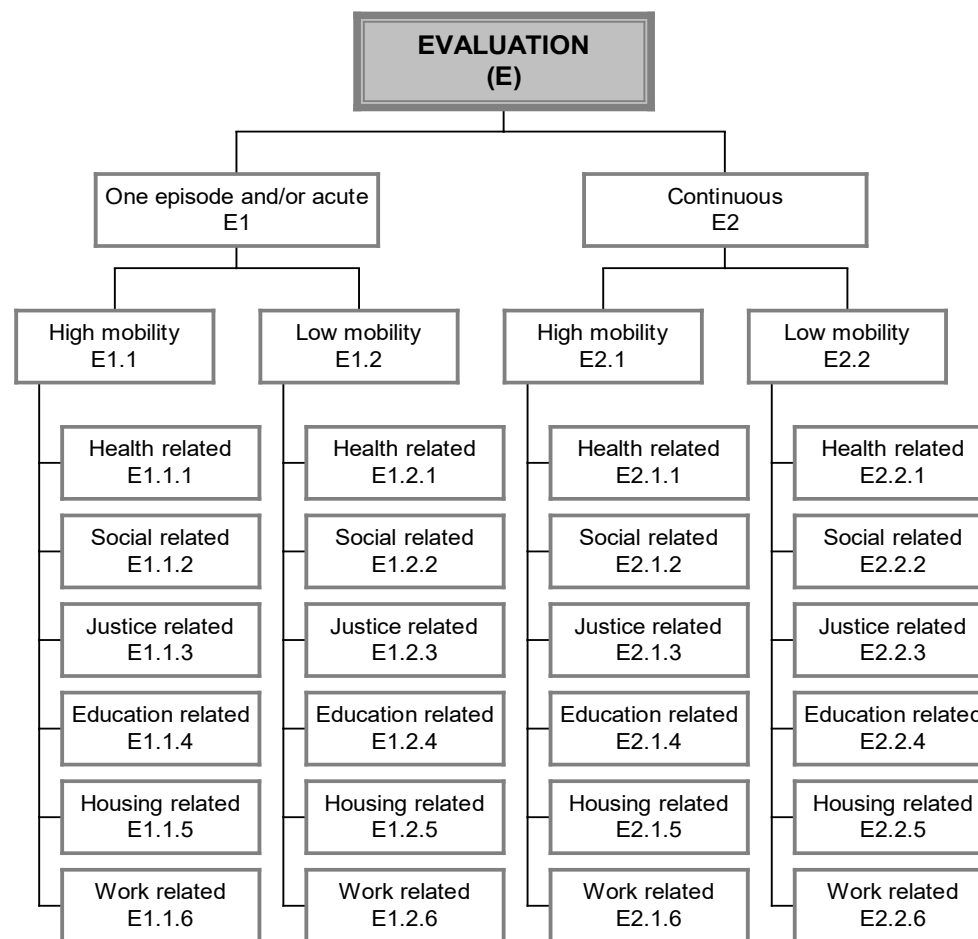
E2.2.2 Social related

- E2.2.3 Justice related**
- E2.2.4 Education related**
- E2.2.5 Housing related**
- E2.2.6 Work related**

E2.2 Low mobility (as in E1.2)

- E2.2.1 Health related**

EVALUATION CODING BRANCH



A. ACCESSIBILITY CODING BRANCH

Service Teams whose main aim is to facilitate accessibility to care or support for users. These teams do not provide direct care or support themselves.

A0 CASE FINDING

Service teams whose main aim is to proactively identify or re-engage with previous users with a certain condition or exposure. For example access cascade screening, assessment, and review of their condition or other purposes. This code does not refer to assertive outreach teams.

A1 COMMUNICATION

Service Teams whose main aim is to facilitate the access to information by the user. Sign language and healthcare related translation care teams are included in this section

A2 TRANSPORT

Service Teams whose main aim is to facilitate the physical mobility of users with long term care needs.

A2.1 Health related transport

A2.1.1 Ambulance

A2.1.2 Other transport

A2.2 Non health related transport

This includes teams whose main aim is to facilitate the physical mobility of the user (e.g. transportation care teams). It does not include mobility devices (e.g. wheelchair)

A3 PERSONAL ACCOMPANIMENT

Service Teams whose main aim is to provide paid personal accompaniment. Personal accompaniment does not include any

type of direct care or support provision. Unpaid or voluntary accompaniment is classified in branch "S".

A4 CASE COORDINATION

Service Teams whose main aim is to navigate and facilitate the access, management and cohesion of care and supports for the user. It includes coordination, planning and accessibility to different types of care or support teams, professionals and tests by users with long term care needs. Case coordination does not include any type of direct service provision.

A4.1 Acute case coordination

Acute case coordination Service Teams provide coordination in or right after a crisis, deterioration in physical or mental state, behaviour or social functioning related to the condition or circumstances; and can usually provide a response within less than 72 hours. For example, a Service Team which provides care coordination and planning before discharge from hospital.

A4.1.1 Health-related

Service Teams that provide case coordination mainly for health-related care.

A4.1.1.1 High intensity. These are teams which have the capacity to make face to face contact with users at least three times per week when clinically indicated.

A4.1.1.2 Medium intensity. These teams do not have the capacity to supply three times weekly contact to users, but which can provide contact at least once a fortnight when indicated.

A4.1.1.3 Low intensity. These teams do not have the capacity to see service users as often as once a fortnight.

A4.1.2 Non-health related

These acute Service Teams provide case coordination mainly for non-health related support (education, social services, home support, daily activities, employment).

A4.1.2.1 High intensity. These are teams which have the capacity to make face to face contact with users at least three times per week when clinically indicated.

A4.1.2.2 Medium intensity. These teams do not have the capacity to supply three times weekly contact to users, but which can provide contact at least once a fortnight when indicated.

A4.1.2.3 Low intensity. These teams do not have the capacity to see service users as often as once a fortnight.

A4.2 Non-acute case coordination

These Service Teams provide non-acute coordination of services including regular contact with the user, which may be long term if required.

A4.2.1 Health related

A4.2.1.1 High intensity. These are Service Teams which have the capacity to make face to face contact with users at least three times per week when clinically indicated.

A4.2.1.2 Medium intensity. These teams do not have the capacity to supply three times weekly contact to users, but can provide contact at least once a fortnight when indicated.

A4.2.1.3 Low intensity. These teams do not have the capacity to see users as often as once a fortnight.

A4.2.2 Non health related

A4.2.2.1 High intensity. These are services which have the capacity to make face to face contact with users at least three times per week when indicated.

A4.2.2.2 Medium intensity. These services do not have the capacity to supply three times weekly contact to users, but can provide contact at least once a fortnight when indicated.

A4.2.2.3 Low intensity. These services do not have the capacity to see users as often as once a fortnight.

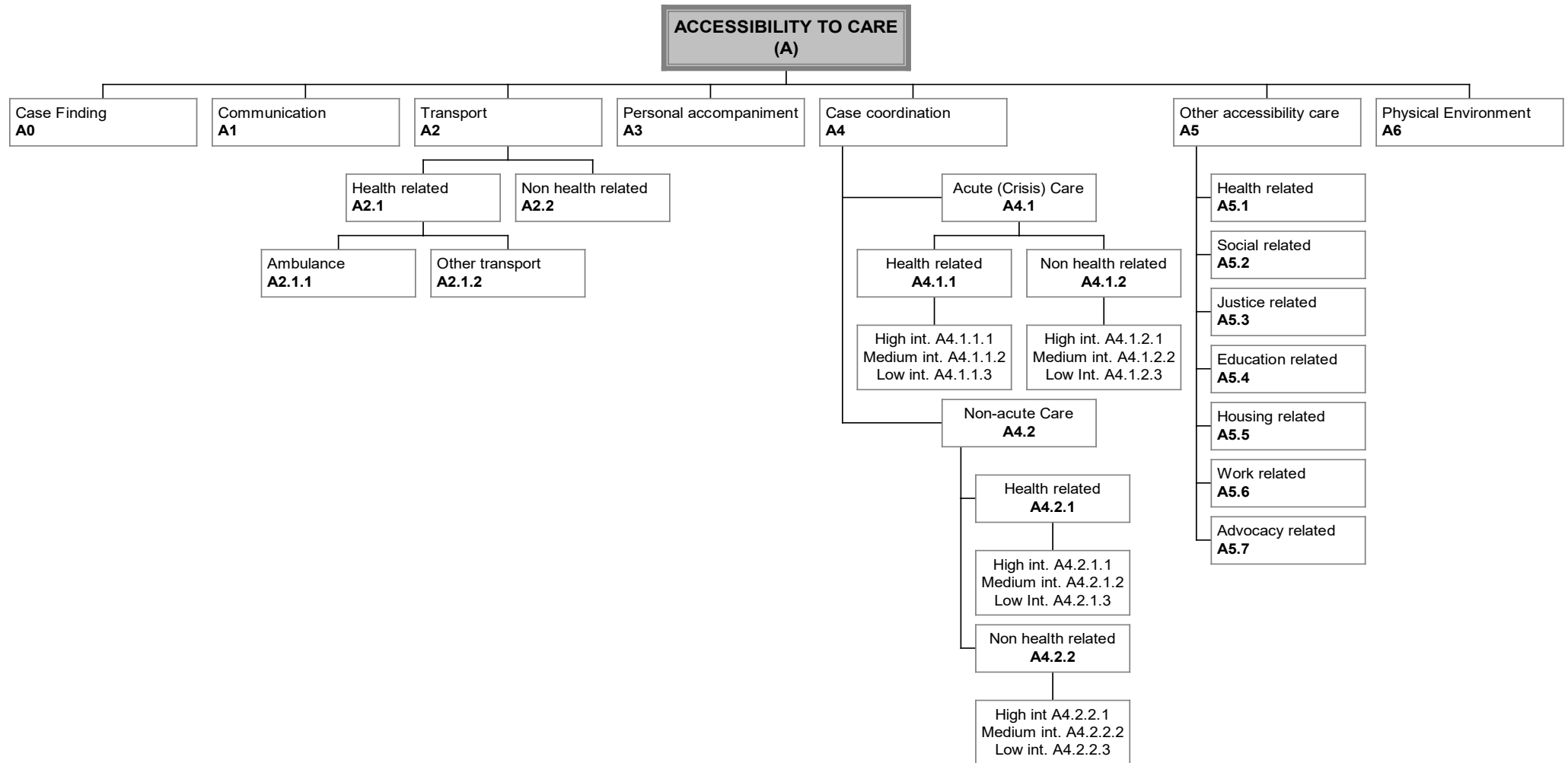
A5 OTHER ACCESSIBILITY SERVICES

Other accessibility services whose main aim is to facilitate the access to care or support but which do not include any type of direct service provision.

A5.1 Health related**A5.2 Social related****A5.3 Justice related****A5.4 Housing related****A5.5 Work related related****A5.6 Advocacy**

A6 Physical Environment Services who make physical changes to an indoor or outdoor environment (ICHI) and whose main aim is to facilitate the access to care and which do not include any type of direct service provision

ACCESSIBILITY TO CARE CODING BRANCH



S. SELF-HELP AND VOLUNTEER CODING BRANCH

The aim of these Service Teams is to provide users with support, self-help or contact. The service is provided by un-paid staff who provide accessibility, guidance, other (visit), day and residential care or support (as described in other branches).

S1 NON PROFESSIONAL (NP) STAFF

Service Teams where graduate professionals providing assessment, interventions or support to users with long term care needs comprise less than 60% of total full time equivalent personnel. Typically, over 95% of staff are unpaid, although administrative and management personnel may be paid.

Self-help groups conducted by users, informal care associations of mutual help and care teams entirely provided by volunteers are included in this section

S1.1 S-NP- Guidance

S1.2 S-NP- Accessibility

S1.3 S-NP Other (Visit)

S1.4 S-NP Day

S1.5 S-NP Residential

S2 PROFESSIONAL (P) STAFF

Services where at least 60% of staff are graduate professionals trained or specifically qualified for providing assessment, intervention and support to users. Typically, over 90% of staff are unpaid, although administrative and management personnel may be paid

Service teams run by un-paid professional and specialised volunteers on a regular or stable basis.

S2.1 S-P Guidance

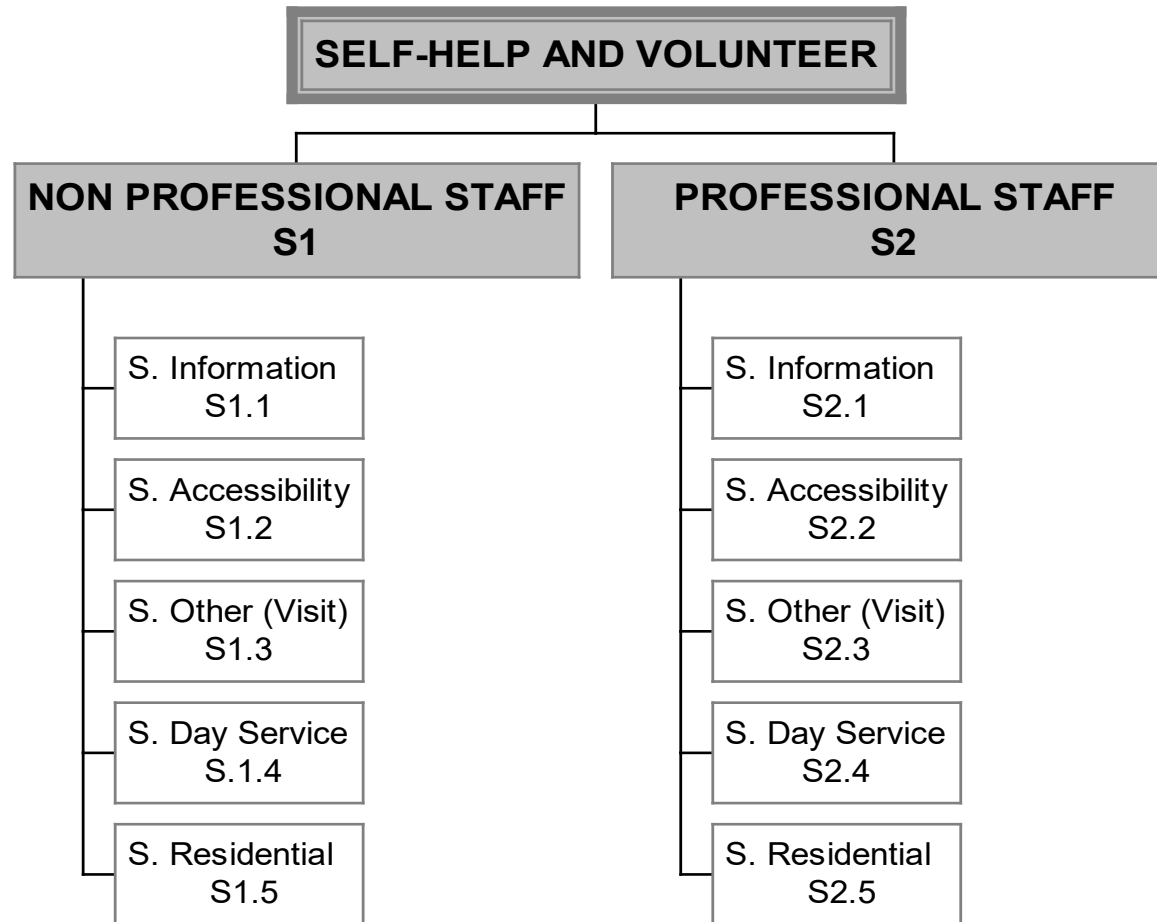
S2.3 S-P Accessibility

S2.4 S-P Other (visit)

S2.5 S-P Day

S2.6 S-P Residential

SELF-HELP AND VOLUNTEER CODING BRANCH



O. OTHER (VISIT) CODING BRANCH

O OTHER (VISIT)

These are services which involve a visit between the user and the provider of the service. The visit is for a specific purpose related to the user's needs and is time limited. It includes outreach and centre based services. The visit does not include overnight accommodation.

Two major characteristics define this type of service: Acuity (acute and non-acute) and Mobility (low and high mobile).

ACUTE (CRISIS) (O1-O4)

These emergency services (i) provide assessment and initial treatment or response to a crisis, deterioration in physical or mental state, behaviour or other immediate need and (ii) can usually provide a same day response during working hours or at least within 72 hours after the demand. At least 20% of the users in the last twelve months do meet the criteria for acute support

HIGH MOBILITY (HOME & MOBILE) (O1-O2)

At least 50% of visits take place away from the main setting of the team.

Mobility can be further described using additional qualifiers. A 'w' (whole) qualifier describes teams that provide all their services away from the main setting. A 'q' (quite) qualifier describes services where over 80% of visits meet the criteria for high mobility. A 'd' qualifier indicates that the service is always delivered at the home of the user.

For some teams, the main site of provision may vary from day to day (e.g. teams in rural areas which move from village to village) – this does not mean they should be classified as 'home & mobile' unless staff go and do work at locations away from that day's main site. Typically these sites are coded as a low-mobile "satellite service" of a main location and are described with a "t" qualifier.

Services provided on-line or by telephone which are not associated to the delivery of specific interventions at home are coded as "low mobile" with an "e" and "d" descriptor.

O1 24 hours

Acute care or support teams with high mobility and which are available 24 hours a day, 7 days per week.

O1.1 Core health

Mobile Service Teams whose main goal is clinical crisis support, available 24 hours a day, and where some of the staff are tertiary (minimum three year trained) qualified health care professionals (Medicine, Nursing, Physiotherapy, Rehabilitation Medicine and Psychology). Typically, at least 10% of the staff will have some type of core health qualification. For example, outreach crisis teams who are available 24 hours a day.

O1.2 Non health related

Mobile Service Teams whose main goal is the provision of non clinical crisis support, available for 24 hours a day. If this team includes core health professionals, they comprise less than 10% of direct support staff. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O1.2.1 Social support

Mobile Service Teams whose main goal is the provision of non clinical crisis support, available for 24 hours a day, and where some of the staff are tertiary (minimum three year trained) qualified social care professionals (e.g. social workers, case managers, educators and trainers, occupational therapist, employment support professional). Typically, at least 10% of the staff will have some type of tertiary social professional related qualification. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O1.2.2 Other support

Mobile Service Teams who provide non clinical crisis support for daily living activities, skill training etc, and are available 24 hours a day. Less than 20% of staff have a tertiary (minimum three year trained) social professional qualification.

O2 Limited-Hours

These Mobile Service Teams provide crisis support but are not always available (opening hours less than 24 hours, 7 days per week).

Service Teams should not be classified as “24 hours” and limited-hours” at the same time: if there is a period of time during the week when the team is not available, this team must be classified as “limited hours”.

O2.1 Core Health (as in O1.1)

Mobile Service Teams whose main goal is clinical crisis support, available for limited hours, and where some of the staff are tertiary qualified (minimum three year trained) health care professionals (eg Medicine, Nursing, Physiotherapy, Rehabilitation Medicine and Psychology). Typically, at least 10% of the staff will have some type of core health qualification.

O2.2 Non health related (as in O1.2)

Mobile Service Teams whose main goal is the provision of non clinical crisis support, available for limited hours. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O2.2.1 Social professional support (as in O1.2.1)

Mobile Service Teams whose main goal is the provision of non clinical crisis support, available for limited hours, and where some of the staff are tertiary qualified (minimum three year trained) social care professionals (e.g. social workers,

case managers, educators and trainers, occupational therapist, employment support professional). Typically, at least 10% of the staff will have some type of social professional related qualification. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O2.2.2 Social vocational support (as in O1.2.2)

Mobile Service Teams who provide non clinical crisis support for daily living activities, skills training etc, available for limited hours. Less than 20% of staff have a tertiary (minimum three year trained) social professional qualifications

This code may include teams whose main care function is to provide support for daily activities provided at home just in crisis situations during a limited time during the week (i.e. due to illness of main carer). This is a marginal code.

LOW MOBILITY (LOW & NON-MOBILE) (O3-O4)

Service teams whose main purpose is to provide non-mobile support but that may also provide some mobile service. Providing mobile support activities comprises **less than 50%** of their overall activity. The mobility of the teams can be further described using additional qualifiers. A ‘w’ (whole) qualifier describes services that have no mobility at all and where all the care is provided in the service premises. A ‘q’ (quite) qualifier describes low-mobile services that have a significant mobility component in their usual service delivery provision. Typically, between 20 and 49% of their overall activity is mobile. A ‘d’ qualifier indicates that all service provision takes place at the home of the user.

O3 24 hours (as in O1)

Low or non mobile Service Teams which are available 24 hours a day, 7 days per week.

O3.1 Core Health

Low or non mobile Service Teams whose main goal is clinical support, who can provide crisis support 24 hours a day, and where some of the staff are tertiary qualified (minimum three year trained) health care professionals (Medicine, Nursing, Physiotherapy, Rehabilitation Medicine and Psychology). Typically, at least 10% of the staff will have some type of core health qualification.

Examples are Emergency Units in General Hospitals which can provide specific crisis support related to the needs of the target population and are available for 24 hours a day. These teams should provide specific care for a defined specific population group. For example care for mental health users is provided by health professionals with specialised training in mental health.

O3.2 Non health related

Low or non mobile Service Teams whose main goal is the provision of non clinical crisis support, available 24 hours a day. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O3.2.1 Social professional support

Low or non mobile Service Teams whose main goal is the provision of non clinical crisis support, available for 24 hours a day, and where some of the staff are tertiary qualified (minimum three year trained) social care professionals (e.g. social workers, case managers, educators and trainers, occupational therapist, employment support professional). Typically, at least 20% of the staff will have some type of social professional related qualification. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O3.2.2 Social vocational support

Low or non mobile Service Teams who provide 24 hour non clinical crisis support for daily living activities, skills training

etc. Less than 20% of staff have social professional qualification

O4 Limited-hours

These low or non mobile crisis services services are not always available (opening hours less than 24 hours, 7 days per week).

Service Teams should not be classified as “24 hours” and “ limited hours” at the same time - if there is a period of time during the week when the team is closed and do not allow visits this must be classified as limited hours”.

O4.1 Core Health

Low or non mobile Service Teams whose main goal is clinical care, who can provide crisis support for limited hours, and where some of the staff are tertiary qualified (minimum three year trained) health care professionals (Medicine, Nursing, Physiotherapy, Rehabilitation Medicine and Psychology). Typically, at least 10% of the staff will have some type of core health qualification.

Examples are Emergency facilities in outpatient and primary care centres, or in Mental Health centres which can provide specific support to users under a crisis situation in a limited-hours capacity.

O4.2 Non health related

Low or non mobile Service Teams whose main goal is the provision of non clinical crisis support, for limited hours. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O4.2.1 Social professional support

Low or non mobile Service Teams whose main goal is the provision of non clinical crisis support, for limited hours, and where some of the staff are tertiary qualified (minimum three year trained) social care professionals (e.g. social workers, case managers, educators and trainers, occupational therapist, employment support professional). Typically, at

least 20% of the staff will have some type of social professional related qualification. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O4.2.2 Social vocational support

Low or non mobile Service Teams who provide limited hours crisis support for daily living activities, skills training etc. Less than 20% of staff have a tertiary social professional (minimum three year trained) qualification.

NON-ACUTE (O5-O10)

These Service Teams provide users with ongoing care including regular contact with the service provider which may be long term if required. Continuing Service Teams may also provide acute/emergency support on a regular basis. However, this acute support should be less than 20% of the ordinary activity of the team.

HOME & MOBILE (O5-O7)

At least 50% of visits undertaken by these Service Teams take place away from the main setting of the team.

Mobility can be further described using additional qualifiers. A 'w' (whole) qualifier describes teams that provide all their services away from the main setting. A 'q' (quite) qualifier describes services where over 80% of visits meet the criteria for high mobility. A 'd' qualifier indicates that the service is always delivered at the home of the user.

O5 HIGH INTENSITY

These are Service Teams providing mobile non acute support which have the capacity to make face to face contact with users at least three times per week when indicated.

O5.1 Core Health (as in O1.1)

Mobile Service Teams whose main goal is non acute clinical care and where some of the staff are tertiary qualified (minimum three year trained) health care professionals (Medicine, Nursing, Physiotherapy, Rehabilitation Medicine and Psychology). Typically, at least 10% of the staff will have some type of core health qualification.

O5.1.1 3 to 6 days a week care

Mobile Service Teams with at least 10% core health professionals that provide non acute clinical care for users with a frequency lower than 7 days/week 3 hours/day.

O5.1.2 7 days a week

Mobile Service Teams with at least 10% core health professionals that provide non acute clinical care for users a minimum of 3 hours/day with a frequency of 7 days/week.

O5.1.3 7 days a week including overnight support

Mobile Service Teams with at least 10% core health professionals that provide non acute clinical support for users with a frequency of 7 days/week including overnight care.

O5.2 Non health related (as O1.2)

Mobile Service Teams whose main goal is non acute non clinical support and which have the capacity to make face to face contact with users at least three times per week when indicated. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O5.2.1 Social professional support

Mobile Service Teams whose main goal is the provision of non acute non clinical support and where some of the staff are tertiary qualified (minimum three year trained) social care professionals (e.g. social workers, case managers, educators and trainers, occupational therapist). Typically, at least 20% of the staff will have some type of social professional related qualification. If this team includes core

health professionals, they comprise less than 10% of direct support staff.

O5.2.1.1 3 to 6 days a week

Mobile Service Teams with at least 20% tertiary qualified social professionals who provide non acute non clinical support to service users with a frequency lower than 7 days/week 3 hours/day.

O5.2.1.2 7 days a week a minimum of 3 hours/day

Mobile Service Teams with at least 20% tertiary qualified social professionals who provide non acute non clinical to support service users with a frequency at least 7 days/week 3 hours/day

O5.2.1.3 7 days a week including overnight care

Mobile Service Teams with at least 20% tertiary qualified social professionals who provide non acute non clinical support to service users with a frequency of 7 days/week including overnight support

O5.2.2 Social vocational support. Mobile Service Teams whose main goal is the provision of non acute non clinical support, who provide support for daily living activities, skills training etc. Less than 20% of staff have a tertiary (minimum 3 years training) professional qualification.

O5.2.2.1 3 to 6 days a week

Mobile Service Teams with less than 20% tertiary qualified social professionals who provide non acute non clinical support to users with a frequency lower than 7 days/week 3 hours/day.

O5.2.2.2 7 days a week a minimum of 3 hours/day support

Mobile Service Teams with less than 20% tertiary qualified social professionals who provide non acute non clinical support to users with a frequency at least 7 days/week 3 hours/day.

O5.2.2.3 7 days a week including overnight support

Mobile Service Teams with less than 20% tertiary qualified social professionals who provide non acute non clinical

support to users with a frequency of 7 days/week including overnight support

O6 MEDIUM INTENSITY

These are Service Teams providing mobile non acute support which do not have the capacity to provide support three times weekly contact to users, but can provide contact at least once a fortnight when indicated.

O6.1 Core Health

Mobile Service Teams whose main goal is non acute clinical care, can provide contact at least once a fortnight when indicated, and where some of the staff are tertiary qualified (minimum three year trained) health care professionals (Medicine, Nursing, Physiotherapy, Rehabilitation Medicine and Psychology). Typically, at least 10% of the staff will have some type of core health qualification.

O6.2 Non health related

Mobile Service Teams whose main goal is non acute non clinical support, and can provide contact at least once a fortnight when indicated. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O6.2.1 Social professional support

Mobile Service Teams whose main goal is the provision of non clinical support, can provide contact at least once a fortnight when indicated, and where some of the staff are qualified social care professionals (e.g. social workers, case managers, educators and trainers, occupational therapist, employment support professional). Typically, at least 20% of the staff will have some type of social professional related qualification

O6.2.2 Social vocational support

Mobile Service Teams whose main goal is the provision of non acute non clinical support, can provide contact at least

once a fortnight when indicated, and who provide support for daily living activities, skills training etc. Less than 20% of staff have a tertiary (mínimum 3 years training) professional qualification.

O7 LOW INTENSITY

These mobile Service Teams do not have the capacity to attend service users as often as once a fortnight.

Examples for branches O5 to O7 –Community nurse teams and support teams are a good example for these branches.

‘High intensity’, ‘medium intensity’ and ‘low intensity’ are mutually exclusive – if a Service Team is able to offer contact 3 days a week it will be classified as “high intensity” even if some of the users have a lower contact frequency than that. If a team is able to offer contact once fortnightly but not 3 days a week is considered “medium intensity” even if the contact is lower. Only teams unable to offer contact at least once fortnightly will be classified as “low intensity”.

O7.1 Core Health

Mobile Service Teams whose main goal is non acute clinical care, who do not have the capacity to attend service users as often as once a fortnight, and where some of the staff are tertiary qualified (minimum three year trained) health care professionals (Medicine, Nursing, Physiotherapy, Rehabilitation Medicine and Psychology). Typically, at least 10% of the staff will have some type of core health qualification.

O7.2 Non health related

Mobile Service Teams whose main goal is non acute clinical care, and who do not have the capacity to attend service users as often

as once a fortnight, If this team includes core health professionals, they comprise less than 10% of direct support staff.

O7.2.1 Social professional support

Mobile Service Teams whose main goal is the provision of non clinical support, who do not have the capacity to attend service users as often as once a fortnight, and where some of the staff are qualified social care professionals (e.g. social workers, case managers, educators and trainers, occupational therapist, employment support professional). Typically, at least 20% of the staff of have some type of social professional related qualification.

O7.2.2 Social vocational support

Mobile Service Teams whose main goal is the provision of non acute non clinical support, who do not have the capacity to attend service users as often as once a fortnight, and who provide support for daily living activities, skills training etc. Less than 20% of staff have a tertiary (mínimum 3 years training) professional qualification.

Low mobility (Low and Non- mobile) (O8-O10)

Service teams whose main purpose is to provide non-mobile support but that may also provide some mobile service. Providing mobile support activities comprises **less than 50%** of their overall activity. The mobility of the teams can be further described using additional qualifiers. A ‘w’ (whole) qualifier describes services that have no mobility at all and where all the care is provided in the service premises. A ‘q’ (quite) qualifier describes low-mobile services that have a significant mobility component in their usual service delivery provision. Typically, between 20 and 49% of their overall activity is mobile. A ‘d’ qualifier indicates that all service provision takes places at the home of the user.

O8 HIGH INTENSITY

These are Service Teams providing low or non mobile, non acute support, and which have the capacity to make face to face contact with users at least three times per week when indicated.

O8.1 Core Health

Low or non mobile Service Teams whose main goal is non acute clinical support, which have the capacity to make face to face contact with users at least three times per week when indicated, and where some of the staff are tertiary qualified (minimum three year trained) health care professionals (Medicine, Nursing, Physiotherapy, Rehabilitation Medicine and Psychology). Typically, at least 10% of the staff will have some type of core health qualification

O8.2 Non health related

Low or non mobile Service Teams whose main goal is non acute non clinical support, and which have the capacity to make face to face contact with users at least three times per week when indicated. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O8.2.1 Social professional support (as in O5.2.1)

Low or non mobile Service Teams whose main goal is the provision of non acute non clinical support, which have the capacity to make face to face contact with users at least three times per week when indicated and where some of the staff are tertiary qualified (minimum three year trained) social care professionals (e.g. social workers, case managers, educators and trainers, occupational therapist). Typically, at least 20% of the staff will have some type of social professional related qualification. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O8.2.2 Social vocational support (as in O5.2.2)

Low or non mobile Service Teams whose main goal is the provision of non acute non clinical support, which have the

capacity to make face to face contact with users at least three times per week when indicated who provide support for daily living activities, skills training etc. Less than 20% of staff have a tertiary (minimum 3 years training) professional qualification.

O9 MEDIUM INTENSITY (AS IN O6)

These are Service Teams providing low or non mobile non acute support which do not have the capacity to provide support three times weekly contact to users, but can provide contact at least once a fortnight when indicated.

O9.1 Core Health (as in O6.1)

Low or non mobile Service Teams whose main goal is non acute clinical care, can provide contact at least once a fortnight when indicated, and where some of the staff are tertiary qualified (minimum three year trained) health care professionals (Medicine, Nursing, Physiotherapy, Rehabilitation Medicine and Psychology). Typically, at least 10% of the staff will have some type of core health qualification.

O9.2 Non health related (as in O6.2)

Low or non mobile Service Teams whose main goal is non acute non clinical support, and can provide contact at least once a fortnight when indicated. If this team includes core health professionals, they comprise less than 10% of direct support staff.

O9.2.1 Social professional support (as in O6.2.1)

Low or non mobile Service Teams whose main goal is the provision of non clinical support, can provide contact at least once a fortnight when indicated, and where some of the staff are qualified social care professionals (e.g. social workers, case managers, educators and trainers, occupational therapist, employment support professional). Typically, at least 20% of the staff will have some type of social professional related qualification.

O9.2.2 Social vocational support

Low or non mobile Service Teams whose main goal is the provision of non acute non clinical support, can provide contact at least once a fortnight when indicated, and who provide support for daily living activities, skills training etc. Less than 20% of staff have a tertiary (minimum 3 years training) professional qualification.

O10 LOW INTENSITY

These low or non mobile Service Teams do not have the capacity to attend service users as often as once a fortnight.

O10.1 Core health

Low or non mobile Service Teams whose main goal is clinical care, do not have the capacity to attend service users as often as once a fortnight, and where some of the staff are tertiary qualified (minimum three year trained) health care professionals (Medicine, Nursing, Physiotherapy, Rehabilitation Medicine and Psychology). Typically, at least 10% of the staff will have some type of core health qualification.

O10.2 Non health related

Low or non mobile Service Teams whose main goal is non acute non clinical support, and who do not have the capacity to attend service users as often as once a fortnight, If this team includes core health professionals, they comprise less than 10% of direct support staff.

O10.2.1 Social professional support

Low or non mobile Service Teams whose main goal is the provision of non clinical support, who do not have the capacity to attend service users as often as once a fortnight, and where some of the staff are qualified social care professionals (e.g. social workers, case managers, educators and trainers, occupational therapist, employment support professional). Typically, at least 20% of the staff will have some type of social professional related qualification.

O10.2.2 Social vocational support (as in O.7.2.2)

Low or non mobile Service Teams whose main goal is the provision of non acute non clinical support, who do not have the capacity to attend service users as often as once a fortnight, and who provide support for daily living activities, skills training etc. Less than 20% of staff have a tertiary (minimum 3 years training) professional qualification

Examples of branches O8 to O10 – Outpatient clinics and community mental health centres where less than 50% of the contacts with users take part outside the setting are examples to be classified in this section.

O11 OTHER NON ACUTE

“Other (Visit)” support not described elsewhere

O11.1 Daily Life Activities

Service Teams who provide support for domestic tasks only for people in the target population eg cooking, cleaning, gardening

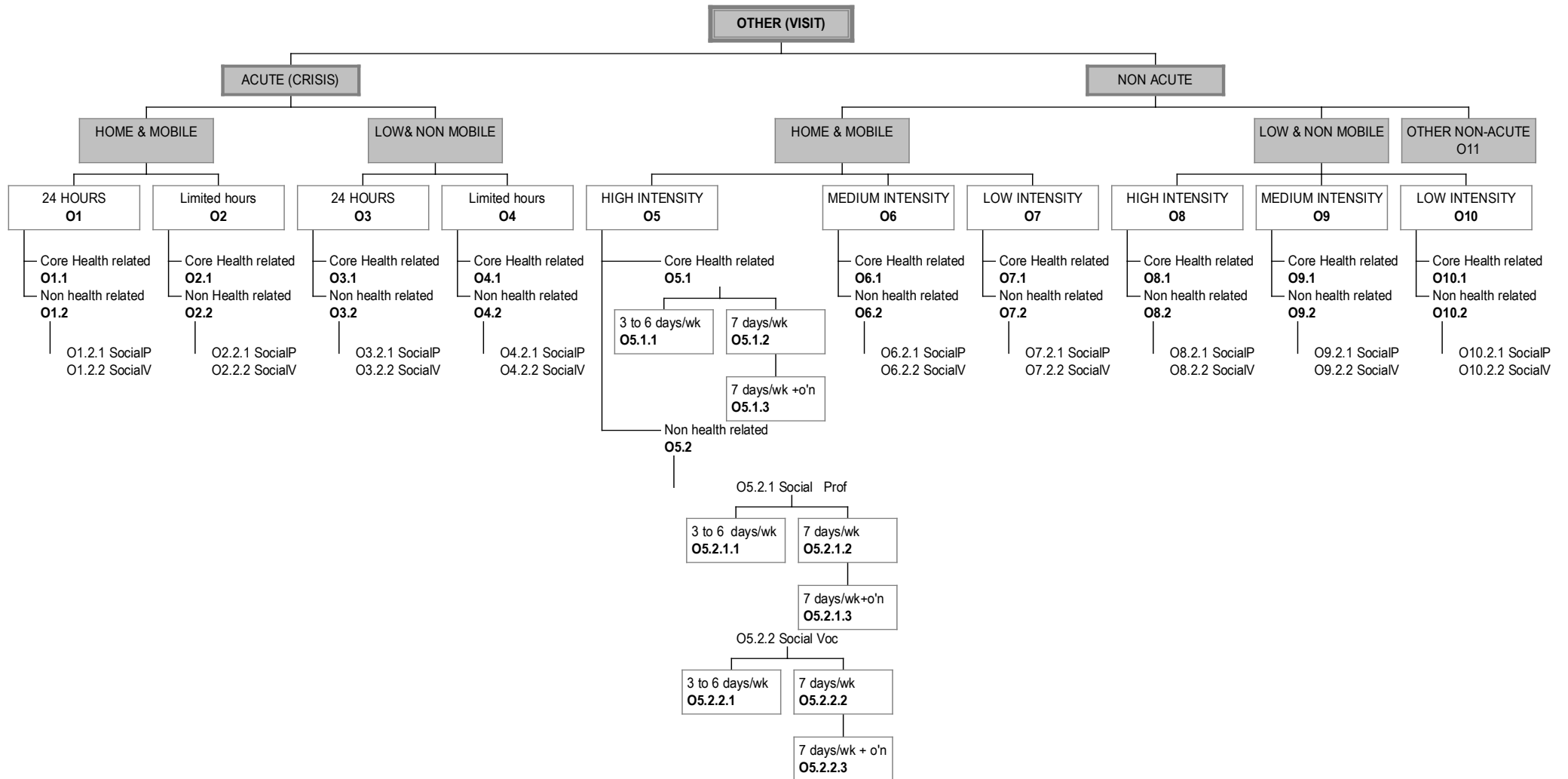
High Mobile (over 50% outside premises)

- w qualifier Only mobile
- q qualifier over 80% mobile
- no qualifier from 50-79% mobile

"d" is added for care only at home but it is not usually needed

Low Mobile and Non Mobile (below 50% outside premises)

- "q" qualifier: 20-49%
- no qualifier: below 20% mobile
- w qualifier: Only non-mobile



D. DAY CARE CODING BRANCH

Codes do not follow an ordinal ranking arrangement in this branch

These are Service Teams which (ii) provide a structured or non structured combination of services (iii) the user is able to spend the majority of the day at the service if wished or indicated

PARA-ACUTE

Service Teams providing a single episode or mainly a short term service that is programmed (non-acute), but that resembles or is near to services providing acute interventions. Due to the nature of the defined intervention and its associated potential for a novel adverse response in an individual patient, has a heightened risk of rapidly progressing to an acute or emergency situation. The capacity to provide the appropriate immediate response to an event of a crisis due to the intervention is considered a core part of the responsibilities of this team. Examples: day services that include administration of a general anaesthetic; Electro Convulsive Therapy or chemotherapy units.

D0.1 Single episode. Service Teams which usually provide day support to users experiencing a deterioration of their health state (or other target condition) on a single or a limited number of episodes of care during a defined period of time

D0.2 Continuous Service Teams which usually provide day support to users experiencing a deterioration of their health state (or other target condition). Support is provided on a continuous base – non episodic, at least 5 days a week

D02.1. Time limited (eg Chemotherapy)

D02.2 Non time limited (eg Haemodialysis)

CONTINUOUS ACUTE CARE

Service Teams where (i) users are regularly admitted because of a crisis or a deterioration in physical or mental state, behaviour or social functioning related to their health or social/psychosocial or

other condition; (ii) alleviating this crisis/deterioration is the main purpose of the facility

D1 Continuous acute care

Service Teams providing support on a continuous base –non episodic, at least 5 days a week- during a limited period of time. Support from these day services is organised to provide an alternative to hospitalisation or to accelerate discharge from inpatient units before the crisis is ended or the user is stable. At least 20% of the users in the last twelve months do meet the criteria for acute care for crisis.

Day hospitals are usually included in this section.

Admission to the service is usually available within less than 4 weeks from the crisis onset for users discharged from an acute residential unit (R2 or R3) or alternative to hospitalisation. At least 80% of the users in the last twelve months are admitted within less than four weeks of the crisis onset (in any other case classify the facility as D4.2.).

D1.1 High intensity

Can provide care similar to that of level of professionals is the same as those for crisis in residential hospitals.

Day hospitals included in this section are focused on care for users with a crisis or significant aggravation of their health status which is associated to a risk for themselves, their family or others needing immediate care. These teams are an alternative to hospital admission. The user would have needed hospitalisation in a local area without this facility.

D1.2 Lower intensity

All day continuous acute care facilities that do not meet the criteria for acute care for crisis.

Day hospitals included in this section are also focused on care for users with a significant aggravation of their health status which is associated to a risk for themselves, their family or others needing

immediate care. These teams are NOT designed as an alternative to hospital admission but as a complementary system to hospitalisation that allows early discharge before the crisis is over. The user would have needed a longer hospital stay in a local area without this facility. Intensive case management care teams may be coded here.

NON ACUTE

Service Teams providing long term non crisis support to people in a day service setting

WORK

Work Service Teams which provide users with the opportunity to work for pay.

D2 High intensity work

High intensity work services are available for users who attend for at least the equivalent of four half days per week. Not all users need attend as frequently as this for the care team to be classified as 'high intensity', but it should at least be possible for them to do so.

D2.1 Ordinary employment

Users with registered disabilities are paid at least the official minimum wage and the organisation follows standard work regulations in the open market. Where there is no minimum wage, DESDE suggest calculating an expected level based on starting salaries for similar jobs advertised in the local press over the past month. However employees with registered disabilities may have not obtained this work through fully open competition - their jobs may in some way specifically reserved for users with disabilities depending on national/regional or local regulations.

D2.2 Other work.

The organisation follows specific work regulations for users with registered disabilities. Employees are paid at least 50%

of the usual local minimum wage for this form of work. Where there is no minimum wage, we suggest calculating an expected level based on starting salaries for similar jobs advertised in the local press over the past month. The work may be in a work setting specifically for people with disabilities or in a setting where some workers are not users with specific support needs related to the target condition or needs.

D6 Low intensity work

Service Teams where users usually attend the service for less than the equivalent of four half days per week.

D6.1 Ordinary employment (as in D2.1)

D6.2 Other work (as in D2.2)

WORK RELATED CARE

These are Service Teams where users carry out an activity which closely resembles work for which payment would be expected in the open market, but where users are not paid or are paid less than 50% of the usual local expected wage for this form of work. Where there is no minimum wage, we suggest calculating an expected level based on starting salaries for similar jobs advertised in the local press over the past month.

D3 High intensity work-related support. High intensity work services are available for users who attend for at least the equivalent of four half days per week. Not all users need attend as frequently as this for the care team to be classified as 'high intensity', but it should at least be possible for them to do so.

D3.1 Time limited.

These are Service Teams where users perform a work related activity that has a time limit. It includes Service Teams giving courses for Occupational Training for a fixed time period e.g. 2 years.

D3.2 Time indefinite

Services where users carry out a work related activity that does not have a fixed time limit. It includes other occupational centres and workshops that have the aim of social and labour integration. When a centre offers training or continuing occupational care to the same group of people for long periods of time (i.e. more than 2 years) the facility is not coded as “time-limited” even when it has different programs with a time limit (i.e. individuals use the centre for a period of time longer than the duration of a course).

D7 Low intensity work-related support Service Teams where users usually attend the service for less than the equivalent of four half days per week

D7.1 Time limited (as in D3.1)

D7.2 Time indefinite (as in D3.2)

NON WORK STRUCTURED DAY SUPPORT (D4,D8)

Service Teams providing day support where the user is expected to be involved in structured non-work related activities for a specific period of a minimum of 25% of opening hours. These services provide structured activities different from work and work-related care. Such activities may include skills training, creative activities such as art or music and group work.

D4 High intensity structured day support. High intensity work services are available for users who attend for at least the equivalent of four half days per week. Not all users need attend as frequently as this for the care team to be classified as ‘high intensity’, but it should at least be possible for them to do so

D4.1 Health related

Service Teams whose main function is to provide clinical long term support (physical, psychological and/or social).

Typically, at least 20% of staff are tertiary qualified health professionals with at least a four year university degree in a health profession.

Service Teams in facilities for physical rehabilitation and social or psychological rehabilitation are included in this section. Facilities aimed at improving social aspects of long-term care by health professionals are included here (i.e. social skills workshops)

D4.2 Education related

Service Teams that offer training registered and approved as part of the official national or regional education and training system, with an official curriculum. This includes centres for Special Education and Occupational Training.

D4.3 Social related

Service Teams that offer structured activities related to social and culture participation. This includes centres that offer non-official complementary education and training, as well as support to education. Sports activities, social clubs which enable social contacts in a structured way and workshops whose main goal does not include social and labour integration are also included

D4.3.1 Social

D4.3.5 Cultural

D4.3.6 Physical exercise

D4.4 Justice related

Service Teams that offer structured activities related to an individual’s participation in the justice system.

D4.5 Housing related. Service Teams that offer day services related to housing needs.

D4.6 Other structured day support

Service Teams in settings that do not meet criteria for “health promotion, education or social and culture participation activities” which offer some kind of structured activity. It includes teams aimed at prevention.

D8 Low intensity structured day support Service Teams where users usually attend the service for less than the equivalent of four half days per week

- D8.1 Health related**
- D8.2 Education related (as in D4.2)**
- D8.3 Social related (as in D4.3)**
- D8.4 Justice related (as in D4.4)**
- D8.5 Housing related (as in D4.5)**
- D8.6 Other structured (as in D4.6)**

SEMI STRUCTURED and NON STRUCTURED DAY SUPPORT (D5, D9)

Service Teams where work or other structured activities are not available for individual users or are only available less than 25% of the opening hours, so that the main functions of the team are the provision of social contact, practical advice and/or support.

Social clubs with paid staff that meet the criteria for “non structured care” are included in this section.

D5 High intensity (as in D2)

D5.1 Semi structured support

Service Teams that provide the opportunity to take part in semi structured care (work or other) activities :services provide structured activities but users can attend the service for a period of time and participate in activities of their choosing rather than according to an individual planned program.

D5.2 Non structured

Service Teams providing non acute day support and where work or other structured activities are not available

D9 Low intensity non-structured day support Service Teams where users usually attend the service for less than the equivalent of four half days per week

D9.1 Semi-structured support

Service Teams that provide the opportunity to take part in semi structured care (work or other) activities: services provide structured activities but users can attend the service for a period of time and participate in activities of their choosing rather than according to an individual planned program.

D9.2 Non structured

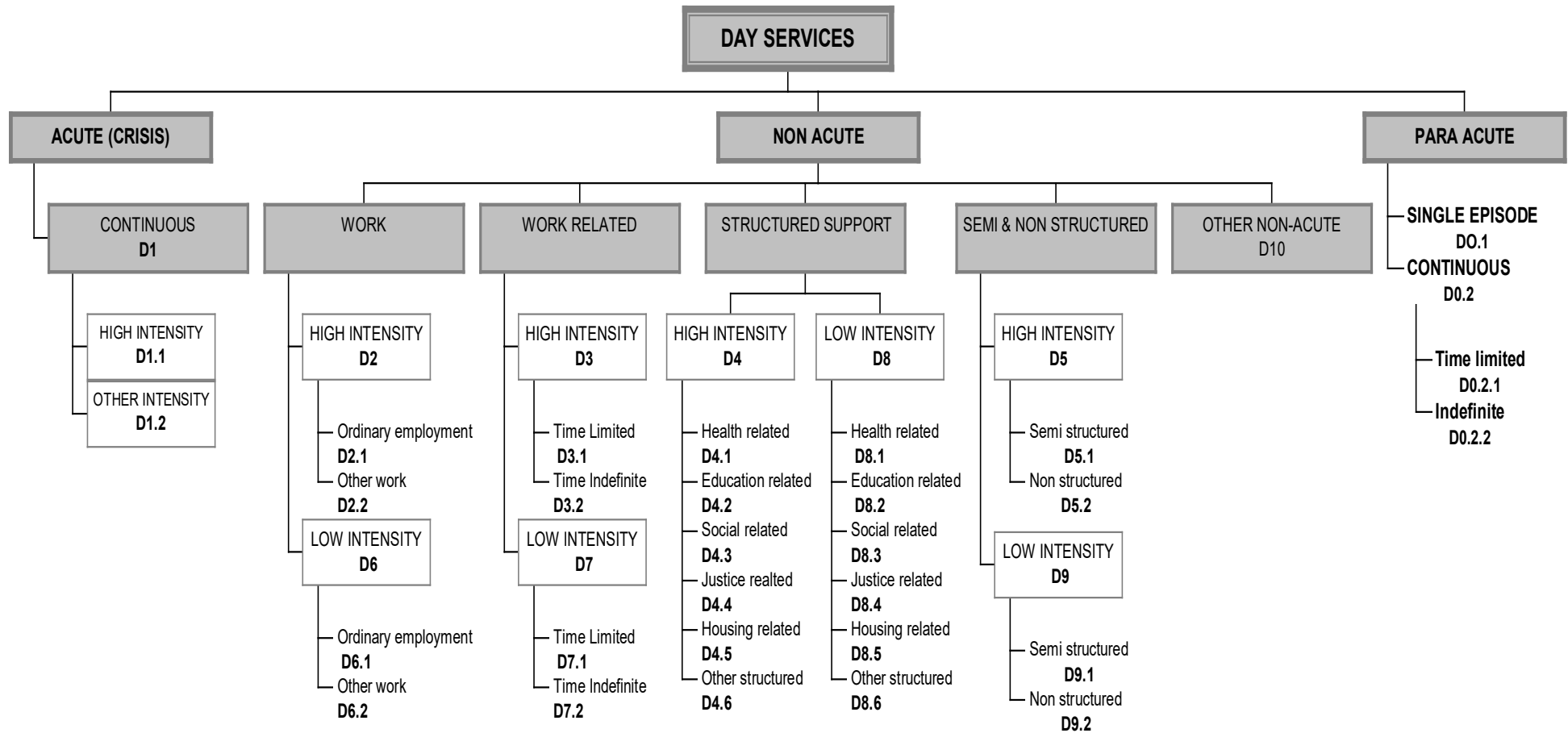
Service Teams providing non acute day support and where work or other structured activities are not available

D10 Other non-acute

Other non-acute day support not classified anywhere else.

Service teams offering support in a high intensity basis outside the premises of the centre and outside the houses or formal residence of the users (hostels, hotels etc.) for a short period of time (weekends etc.)

DAY CARE CODING BRANCH



R. RESIDENTIAL CODING BRANCH

Service Teams which provide beds overnight for users for a purpose related to the clinical or social management of their health or social condition - users do not make use of such accommodation simply because they are homeless or unable to reach home.

ACUTE

Service Teams to which (i) users are admitted temporarily because of a crisis, a deterioration of their physical or mental state, behaviour or social functioning which is related to their health or social condition (ii) admissions usually available within 24 hours (48 hours for social) (iii) At least 20% of the users in the last twelve months do meet the criteria for residential acute care for crisis.

24 HOUR PHYSICIAN COVER

Service Teams within hospitals or within other residential meso-organisations which provide 24 hour cover by a registered physician (including medical residents).

Note: if the physician is not formally on duty at the centre part of the day (usually at night) then the Service Team should be given the “o” (on-call) qualifier: “This qualifier describes residential services with an on call physician. The physician is not formally on duty at the centre part of the day, usually at night. Physicians on call are used frequently (e.g at least 4 times a week)”.

R0 NON-HOSPITAL

Service Teams providing acute care (as defined above) with 24-hours physician cover outside the location of a registered hospital (e.g high intensity nursing homes with 24 hour medical care which have less than 20 beds and which are not registered as hospitals).

Example branch R0 are acute care teams for specific conditions with 24-hour physician cover but which are not registered as hospitals at national, regional or local level. (i.e. some residential care teams with low provision for persons with mental illness, geriatrics or brain Injury)

This is a residual code which should be registered only after a careful assessment.

HOSPITAL

Hospitals are meso-organisations with a legal recognition in most countries. This legal recognition of registered hospitals can be used as the basis for identifying hospital teams. In those countries where there is no legal basis for deciding what are hospital care teams and in those cases where doubt exists, care teams should be classified as hospital teams if they have more than 20 beds and 24 hour physician cover. A stakeholder group and/or local or regional health officers should be consulted where there is doubt about which care teams should be viewed as hospital care teams or not.

R1 HIGH INTENSITY

Service Teams providing acute care (as defined above) to which users are admitted due to a deterioration of their physical or mental status, or other exacerbation of their functioning or circumstances. This deterioration is directly related to their reason for using the service and is severe enough to require a very high level of monitoring and support. The ratio between direct support professionals (eg nurse, teacher) and service user is high: an indicative ratio of one professional to one to three service users.

Example branch R1 –These care teams include intensive care facilities for the target condition.

R2 MEDIUM INTENSITY

Service Teams providing acute care (as defined above) in a registered hospital and which provide 24-hours physician cover

Users are admitted to the service due to a deterioration of their physical or mental state, behaviour or social functioning requiring monitoring and support but at a lower level than that described in R1. The ratio between direct support professionals and service users is medium: an indicative ratio of one professional to four or more service users.

Example branch R2 –Hospital units where routinely admissions from a specific local area are included. It also includes acute units from general hospitals, psychiatric hospitals and other specialist hospitals. A ward which is placed within a meso-organisation and which lacks direct 24-hour physician cover, should be coded here if there is 24-hour physician cover available at the meso-organisation which could provide acute treatment if necessary.

If these residential facilities also offer outpatient emergency care (besides acute residential care) to the specific target group they will be classified in both branches (R2 & O3) if the emergency care thus provided is in the same hospital by staff of the care team being described.

R2.1 Medium intensity for very short stays. As in R2, but typically, the length of stay cannot exceed 72 hours

R2.2 Medium intensity other stays. As in R2, but typically, the length of stay does not exceed 30 days

R3 NON-24HOURS PHYSICIAN COVER

Service Teams providing acute care (as defined above) that do not provide 24 hour physician cover.

R3.0 Hospital

Service Teams providing acute care (as defined above) in a registered hospital, but without 24-hours physician cover.

Example code R3.0: Some registered hospitals may provide low intensity acute care without 24-hour medical cover (i.e. some acute

wards at specialised psychiatric hospitals, some hospitals for geriatric users, or some hospitals for brain Injury). A hospital ward which does not have 24-hour medical cover but where this provision is available at the meso-organisation where the care team is placed, this care team should NOT be coded here.

This is a residual code which should be registered only after a careful assessment.

R3.1 Non-hospital. Service Teams providing acute care (as defined above) outside a registered hospital and without 24-hours physician cover.

R3.1.1 Health related. Service Teams providing acute care (as defined above) in residential settings aimed at providing specific clinical care, and where a part of the staff are tertiary qualified (minimum three year trained) health care professionals (Psychology, Medicine, Physiotherapy, Nursing); or the equivalent training, but which do not provide 24 hour physician cover.

Example branch R3.1.1 –It includes a range of Service Teams providing non-hospital beds which may be used as alternatives to hospital admission. Facilities such as crisis houses, crisis hostels or emergency beds in community primary care or mental health centres should be placed here. “Residential facilities” with high intensity medical staff but without 24 hour medical cover are included here (i.e nursing homes)

R3.1.2 Non health related

Service Teams providing acute care (as defined above) in residential settings outside a hospital, and which do not include tertiary qualified health professionals as described in R3.1.1

R3.1.2.1 Social related support

Non health related Service Teams as in R3.1.2 where some of the staff are qualified social care professionals (e.g. social workers, case managers, educators and trainers, occupational therapist, employment support professional). Typically, at least 20% of the

staff will have some type of social professional related qualification. If the team includes core health professionals, these must be less than 10% of direct support staff

R3.1.2.2 Other support Non health related teams as in R3.1.2 where less than 20% of staff have a tertiary (minimum 3 years training) professional qualification.

NON ACUTE (PROGRAMMED AVAILABILITY)(R4-R13)

Service Teams that provide residential support related directly to the individual's specific need to that is typically scheduled or planned in advance. They do not provide acute or crisis support.

24 HOURS PHYSICIAN COVER (R4-R7)

HOSPITAL

These are Service Teams providing residential support at facilities officially registered as 'hospitals' at national, regional or local level.

R4 Time-Limited

These are Service Teams providing residential support with 24 hour physician cover at facilities where a fixed maximum period of residence is routinely specified (temporary stay). A Team should be classified as time-limited if a maximum length of stay is fixed for at least 80% of those entering the facility.

Example branch R4 – It includes units for rehabilitation or community therapeutic programmes that specify a fixed length in months or years.

R6 Indefinite stay.

These are Service Teams providing residential support with 24 hour physician cover at facilities where a fixed maximum period of residence is not routinely specified

Example branch R6 - It includes nursing homes for older people where users are admitted for an indefinite period of time and are assisted by the staff 24 hours/day.

NON-HOSPITAL

These are Service Teams providing residential support with 24 hour physician cover at facilities that are NOT officially registered as 'hospitals' at national, regional or local level.

R5 Time limited (as in R4).

R7 Indefinite stay (as in R6)

(e.g therapeutic communities, nursing homes with 24 hour medical care which have less than 20 beds and which are not registered as hospitals).

NB:Care teams coded as R5 and R7 should include a qualifier code due to the diversity of services in this category.

NON-24H PHYSICIAN COVER (R8-R13)

Non acute Service Teams providing residential support that do not provide 24-hour physician cover.

TIME LIMITED (R8-R10) (AS IN R4)

R8 24-h support.

Service Teams that provide residential care during non working hours but where there is a procedure that guarantees that the user receives 24 hours care.

Example branch R8 – It includes living care teams that provide non acute care from 3 pm until 8 am because all users are at work from 8 am to 4 am. Careers can stay for the whole day in the residential facility when it is needed (e.g. if a user get ill).

R8.1. Less than 4 weeks.

These are Service Teams that provide 24 hour residential support and the stay is usually limited to a short time- typically less than four weeks

R8.1.1 Core health related. These Service Teams provide 24 hour residential support for up to four weeks, by highly skilled clinical staff- typically a nurse or psychologist.

R8.1.2 Non health related. These Service Teams provide 24 hour support for up to four weeks, does not include 24 hr health professionals

R8.2 More than 4 weeks. Service Teams that provide 24 hour residential support: this support is time limited but typically over 4 weeks

R8.2.1 Core health related. Service Teams that provide 24 hour support for over 4 weeks including 24 hour support by highly skilled clinical staff- typically a nurse or psychologist.

i.e. Respite units that admit users with severe problems

R8.2.2 Non health related. Service Teams that provide 24 hour support for over 4 weeks, do not include 24 hr support by core health professionals

R9 Daily support

Service Teams at residential facilities where members of staff are regularly on site at least five days a week for some part of the day, with responsibilities related to the monitoring and clinical and social care of the user.

R9.1 Less than 4 weeks. Service Teams at residential facilities where members of staff are regularly on site at least five days a week for some part of the day, and where the stay is less than 4 weeks.

R9.2 Over 4 weeks. Service Teams at residential facilities where members of staff are regularly on site at least five days a week for some part of the day, and where the stay is typically over 4 weeks.

R10 Lower support

These are Service Teams at residential facilities where the care team user resides for some purpose related to the management of his/her health condition and where there is a direct link between residing in the facility and some support from staff, but where staff are regularly present fewer than five days per week

R10.1 Less than 4 weeks. These are Service Teams at residential facilities where staff are regularly present fewer than five days per week, and where the stay is less than 4 weeks

R10.2 Over 4 weeks. These are Service Teams at residential facilities where staff are regularly present fewer than five days per week, and where the stay is over 4 weeks

Examples R8 to R10 – Residences, houses for groups, therapeutic communities and other specifically designed care teams for users with long term care needs are classified in this section as long as they specify a fixed period of stay

For example, care teams that offer rehabilitation programmes with a fixed period of time or those offering temporary stay.

NON-LIMITED (INDEFINITE) STAY (R11-R13) (AS IN R6)

Service Teams at residential facilities where no duration of stay is specified and that offer permanent accommodation when required.

R11 24-h support (as in R8)

R11.1 Less than 5 years Stay is not limited but usually is less than 5 years

R11.1.1 Core health related Health related (health professionals 24 h) – Service Teams that provide 24 hour residential support for an indefinite period including 24 hour support by highly skilled health professionals (typically a nurse or a psychologist).

R11.1.2 Non health related. Service Teams that provide 24 hour residential support for an indefinite period, does not include core health professionals

R 11.2 Over 5 years. Stay is not limited but usually is more than 5 years

R11.2.1 Core health related. Health related (health professionals 24 h) – Service Teams that provide 24 hour residential support for an indefinite period, typically over 5 years, which includes 24 hour support by highly skilled health professionals (typically a nurse or a psychologist).

R11.2.2 Non health related. Service Teams that provide 24 hour residential support for an indefinite period, but typically over 5 years, which do not include 24 hour support by core health professionals

R12 Daily support.

Service Teams at residential facilities where members of staff are regularly on site at least five days a week for some part of the day, with responsibilities related to the monitoring and clinical and social care of the user.

R12.1 Less than 5 years. As in R11.1

R12.2 Over 5 years As in R11.2

R13 Lower support

These are Service Teams at residential facilities where the care team user resides for some purpose related to the management of his/her health condition and where there is a direct link between

residing in the facility and some support from staff, but where staff are regularly present fewer than five days per week

R13.1 Less than 5 years. Stay is not limited but usually is less than 5 years

R13.2 Over 5 years. Stay is not limited but usually is more than 5 years

Example branches R11 to R13 – It includes residential facilities where no duration of stay is specified and offer permanent accommodation when required.

R14 Other residential care

Service Teams at residential non-acute facilities not classified elsewhere.

This code is used for residential facilities that cannot be classified elsewhere. Usually these facilities require a detailed explanation of their characteristics at section D and/or other codes from non-residential branches to understand its MTC. A possible example is a Hostel close to a care centre (usually a hospital), whose main aim is not to provide care but just accommodation for users attending a care facility. However the local officer judges that this care team, which is publicly funded, is a critical component of the care system of the local area and therefore it should be added to the local mapping.

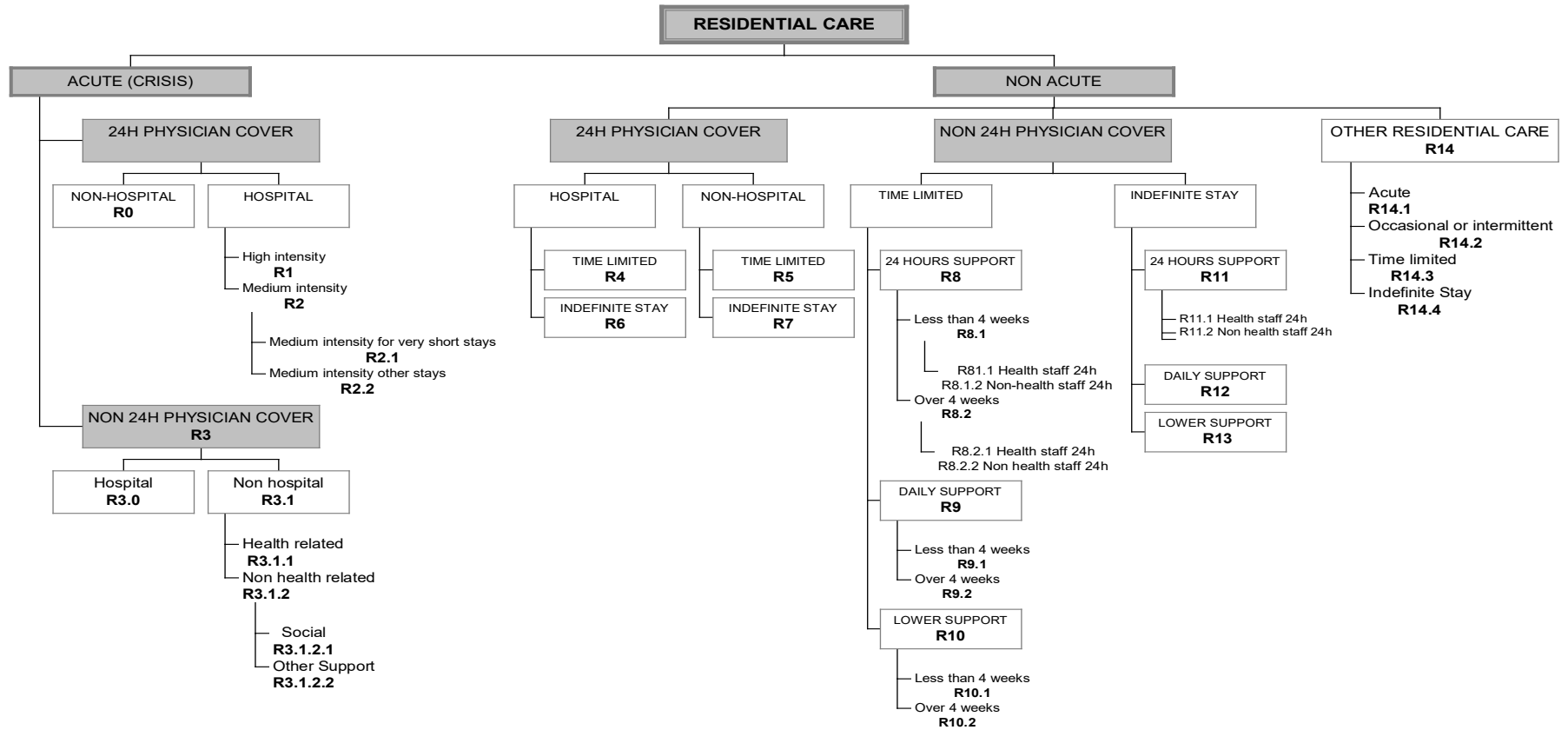
When necessary a secondary code can be assigned to further describe these services.

R14.1 Occasional or intermittent

R14.1 Time limited

R14.3 Indefinite

RESIDENTIAL CARE CODING BRANCH



SECTION C

**CARE USE MAPPING
(MTC COUNTING)**

Section C-under construction.

SECTION D

SERVICE INVENTORY (LISTING)

D1. PRINCIPLES FOR SERVICE TEAM INVENTORY

This section supplements Section B by allowing for a more detailed listing of local Service Teams and a description of their characteristics (care team listing or catalogue).

You can find Section D Form (Service Team Inventory) in Form 3 of DESDE-LTC 2.0 Forms and Templates

The Service Team Inventory Form must be copied as many times as required to review all local care teams- the inventory forms are therefore not numbered.

In addition in the DESDE-LTC 2.0 Forms and Templates, you can find Template 1 (Mapping of Care team Availability in the Area - Care team Listing) where you can compile a list of all the care teams located in the reference area.

D2. GUIDELINES FOR COMPLETING THE SERVICE INVENTORY

Below some instructions are specified for filling each item in the questionnaire:

NAME OF THE SERVICE TEAM

Complete name of the team

DESDE CODES OF STABLE SERVICE TEAMS

Provide the codes for the care team Main Service Functions according to Section B guidelines.

If also coding the team according to functioning, service provider, or interventions:

I-ICF CODE

Provide the care team code according International Classification of Functioning, Disability and Health (ICF)
<http://www.who.int/classifications/icf/en/>.

-SHA 2.0 CODE

Provide the care team code according the International Classification for Health Accounts (SHA 2.0).

http://ec.europa.eu/health/ph_information/dissemination/hsis/hsis_10_en.htm.

-ICHI CODE

Give the care team code according the International Classification of Health Interventions (ICHI)

<http://www.who.int/classifications/ichi/en/>

SETTING

Give the following care team data:

Region in federal country (if appropriate), county council, department, province (as appropriate), borough or municipality (as appropriate) and post code of the care team.

Address, Telephone, Fax, e-mail and web address of the care team. (Where applicable) Tax Registration, Charity Registration etc of the care team as a legal entity.

OFFICIAL STARTING DATE OF THE CARE TEAM

LOCATION. Is the care team freestanding or located within a larger institution (meso-organisation) for “Long-Term Institutional Care”:

LOCAL DEFINITION OF THE SERVICE TEAM

For example: day centres, sheltered workshops, mental health centres, nursing homes, psychiatric hospitals, etc.

SECTOR

TYPES OF SECTORS USED IN THE ATLAS OF INTEGRATED CARE

The Atlases of Integrated Care use the DESDE coding for classifying local services. The representation of the information on the sectors is usually limited to services designed for a specific target group so the information on the macro-organisation of care by sectors is not needed. Other typologies of the macro-organisation and the meso-organisation of care are relevant for representing the Atlas information.

“Sectors” for representing Information on the Balance of Care
The analysis of the balance of care by sectors is relevant for national comparisons. In this case we use the definitions provided at country level. For example in Australia the Integrated Atlases of MH Care provide “donut” representation of the balance of care provided by the health sector, NGOs, Justice, Community care, Education. However these comparisons are limited when used for analysing the balance of care across different countries

“Sectors” defined by the Main Service Function
The Integrated Atlases of care also provide information according to the “Main Service Functions” that differentiate “Core health” and “Other care” services in relation to the staff available in the services. “Core-health” staff refers to health professionals such as physicians, nurses and psychologists. The classification is based on their capacity to provide these interventions in the workplace, regardless of whether they actually provide these interventions or not. The definition and analysis of the core-health services has been provided in Cetrano et al, 2018.

PROPERTY, MANAGEMENT AND FUNDING SOURCE

Property: Provide the name of the entity owner of the property.

Management agency: Provide the name of the agency responsible for the employment of staff and the management of the care team.

Main funding source: Specify if the funding is public, private or other

Legal System: First identify if profit or NFP, then specify further- Describe the legal status of the care team (Registered Charity, Foundation, Cooperative, Social Firm, Public Corporation, Private Company or Others.

Typology of access: it is defined as public or private depending on the level of universal access by the target population -subsidised or not, 'universal, quasi universal, mixed or restricted through payment mechanisms or other'

7. AVAILABILITY

Specify the availability of the care team evaluated according to the criteria of each type of care.

-Phone Assistance Care team

Give the number of terminals of the care team specifying occupied and available terminals.

-Home Assistance Care team.

Give the total number of users specifying number of hours users/month occupied and available

-Day Care team

Give the total number of places offered by the care team specifying occupied and available places.

-Residential Care team

Give the total number of places/beds offered by the care team specifying occupied and available places.

IF RESIDENTIAL/DAY CARE IS AVAILABLE

Describe the total number of beds/places available at the care team and the number of beds/places assigned to the target population occupied and available.

-Limited time stay

Provide the number of limited-stay beds/places available at the care team for the target population.

8. PRICE (FARE/TARIFF)

Only for Phone Assistance.

Specify cost per month/user and cost per year/user.

Only for Home Assistance

Specify public price, cost per month/user and agreed price.

Only for Residential and Day Care Care teams.

Specify beds/places public price, agreed price and private price and the interval of prices per bed.

9. SPECIFIC ACTIVITIES

Specify if the care team offers specific and permanent activities for users with long term care needs, provide the name of the activity, whether it is for an individual or for a group, and the number of hours and days per week that it is available. Whether this activity has an specific budget and setting (different from the care team) and if it is authorised by the appropriate authority.

INTERVENTION PROGRAMMES OFFERED BY THE CARE TEAM. Specify if the care team offers specific programmes for people with long term care needs, the timetable when they are available (hours and days per week) length and whether these programmes are authorised by the appropriate authority.

OTHER SPECIFIC ACTIVITIES

Records if there is a specific activity offered by the care team for LTC care team users excluding transport and meals.

10. STAFF

Provide International Standard Classification of Occupations (ISCO-08) Code

<http://www.ilo.org/public/english/bureau/stat/isco/index.htm>

Specify the actual occupation of staff, not their academic training and/or qualification.

Count professionals according to FTE (full time equivalent) rates.

Include percentages for the division of professionals among different MTCs of the same SCT (ex. R2 70% of a psychiatrist, O3.1 30% of a psychiatrist)

11. PURPOSE AND MODEL OF CARE -ask the following questions:

Do you have a written model and is it operationalized eg with KPIs?

What is the purpose of the service?

If there is an evaluation system eg KPIs, which do these refer to?

12. LOCAL AREA OF SERVICE TEAM USERS

Specify if the care team is available for users, either at Local/ County/Province/Region /National/or Other territorial levels (i.e mental health areas).

13. Admission requirement

Specific admission criteria for a new user (Age, Gender and Type of Long Term Care user that is attended at the care team).

14. USER PROFILE

The main target groups for whom the care team is intended.

Specify:

Type of Long-Term care. In the case that the person fulfils the criteria for more than one target group (i.e. being over 65 years and having a mental disorder) detail them.

Age range

Number of users/contacts for every type of health condition

15. OPENING HOURS

Specify the hours and days of care team availability.

16. Maximum frequency of attendance/contact (maximum performance)

Specify the maximum number of times a care team user can be actually assisted by the care team if they require need in ordinary care conditions. This assistance can be daily (specify 1, 2 or 3 times/day), weekly (specify more or less than 3 times/week), fortnightly or monthly

17. SPECIFIC DATE INFORMATION HAS BEEN REGISTERED

Specify the date when data has been collected.

18. LINKS WITH OTHER CARE TEAMS

Any major joint working or exchange of staff which takes place regularly with any other long term care care teams should be described - e.g. visits to a hostel by members of the local community mental health team.

19. NAME OF THE EVALUATOR**20. OBSERVATIONS**

This final section provides an opportunity to document additional details or characteristics of the evaluated care team that have not been captured elsewhere in the instrument and what the assessor continues to be important to document.

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ANNEX A Section D inventory

Name of interviewer and name and role of interviewee	
Date of interview	
List the names of service teams in the organisation	
The following questions apply for each team	
Name of team	
Setting	Address
	Webpage
	Tax Registration, Charity Registration etc of the care team as a legal entity. (Likely at organisation rather than team level)
	Official starting date
Local definition of the team eg day centre, nursing home, preschool, detention centre	
Area of coverage	
Opening hours Specify the hours and days of team availability.	
Target population Specific admission criteria for a new user (Age, Gender and Type of service user).	
Sector-health, social, education, justice etc	

What is the Main Service Function of the team? (Please refer to DESDE instrument for full definitions of each of the following branches of Main Service Function).

1. IF RESIDENTIAL (Facilities which provide beds overnight for users for a purpose related to their reason for using service- users do not make use of such teams simply because they are homeless or unable to reach home).

Acuity- is the service provided acute or non acute? (acute: users are admitted because of a crisis, a deterioration of their physical or mental state, behaviour or social functioning which is related to their health or social condition; admissions usually available within 24 hours for health or 48 hours for social admissions)
What is its setting (eg hospital/non hospital)/school/justice facility?
Does the service provide 24 hr physician cover- if so is this on premises or on call- if on call, how many times a week is the physician typically called?
How long is the usual or typical length of stay?
How many hours of support are provided (is there staff on site 24/24; daily; lower
If 24 hour support is provided, is there continuous surveillance (eg a psychiatric intensive care unit)?
Is the facility a secure facility (ie locked doors)?

2. IF DAY SERVICE (services which (i) are normally available to several users at a time); (ii) provide some combination of relevant activities or treatments (iii) have regular opening hours during which they are normally available: and (iv) expect service users to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the team is not simply based on individuals coming for appointments with staff and then leaving immediately after their appointments)

Acuity- is the service provided acute or non acute? (acute: users are regularly admitted because of a crisis or a deterioration in physical or mental state, behaviour or social functioning related to their health or social/psychosocial or other condition; alleviating this crisis/deterioration is the main purpose of the facility).

Does the service provide employment or work related support; is it structured/non structured/other

If work: ordinary (open employment) or other (supported but at least 50% of market wage)

If work related (< 50% of market wage): time limited or not

If non work structured care: health/education/social/other

Intensity-how often can users attend the day centre if they wish?

3. IF ACCESSIBILITY (Services whose main aim is to facilitate accessibility to other services for users. These care teams do not entail direct service provision)

What type of support is the service providing access to? (is it a case finding service, providing communication or physical mobility support, personal accompaniment, case co-ordination, or other type of access to services?)

If case co-ordination: what is the level of acuity?

Intensity-how often can the service engage with service users if required?

4. IF GUIDANCE:

Is the team providing either information or professional assessment only:

(i) Information (Services whose main aim is to provide users from the defined target group with information for their needs- does not entail subsequent monitoring/follow-up, evaluation, guidance or direct care provision)

Or

(ii) Evaluation (Performing a specific review or examination using a questionnaire or a rating scale or other instrument; evaluating a health condition, functioning, behaviour, or need for intervention-excludes practical support)

If information only: is it interactive (face to face or other) or non interactive (eg a webpage)?

If evaluation: is this a one off evaluation; or does the team provide ongoing assessment?

5. IF SELF HELP AND VOLUNTEER (over 90% of direct support staff are unpaid)

Are at least 60% of the direct support staff graduate professionals in a relevant discipline?

Type of support (residential, day as above)

6. If Other (services which (i) involve contact between staff and users for some purpose directly related to their reason for using the service; and (ii) are not provided as a part of delivery of residential or day and structured activity care teams, as defined above)

Acuity-is the service able to provide support within the same day or within at least 72 hours?

Mobility-is at least 50% of the support carried out away from the premises at which the team is based?

Intensity- how often can the service engage with service users if required?

<p>STAFF Count professionals according to their occupation in FTE (full time equivalent) rates. Include background profession if possible (eg whether a Case manager is a nurse, or a social worker)</p>	
Property, management and funding	Property: Provide the name of the entity owner of the care team
	Management agency: Provide the name of the agency responsible for the employment of staff and the management of the care team
	Main funding source

	Legal System: Describe the legal status of the care team (Registered Charity, Foundation, Cooperative, Social Firm, Public Corporation, Private Company or Others)
Model Of Care - do you have a written model and is it operationalized eg with KPIs?	
What is the purpose of the service?	
If there is an evaluation system eg KPIs, which do these refer to?	
Is there a fee to users of the service?	
Other activities/Main Service Functions carried out by this team(target pop,type of service provided as above))	
Links with other teams: Which other organisations in your region do you receive/send referrals to, or have links with?	
Any recent changes in your service provision, and reasons if so?	

What gaps in the system have you identified in your experience?

ANNEX B GLOSSARY

Acute or crisis services

Emergency services which (i) provide assessment and initial treatment or response to a crisis, deterioration in physical or mental state, behaviour or other immediate need and (ii) can usually provide a same day response during working hours or at least within 72 hours after the demand.

Availability

The presence, location and readiness for use of services or other organisational units in a health or human services organisation or a catchment area at a given time. A service is available when it is operable or usable upon demand to perform its designated or required function. Opening times and placement and workforce capacity are some indicators of care availability.

Placement Capacity is the maximum number of beds in residential care and of places in day care in a care delivery organisation or a catchment area at a given time. Finally, workforce capacity is the maximum number of staff available in a care delivery organisation or in a catchment area at a given time. Care workforce capacity usually refers to paid staff providing direct care (e.g. it excludes voluntary care providers and administrative staff). It is typically measured in Full Time Equivalents (FTE) (see definition).

Care provider see also Service provider

An individual or an institution helping in identifying or preventing or treating illness or disability in a systematic way. An individual health care provider is also known as a health worker and may be a health care professional within medicine, nursing or allied health professions. An institutional health care provider is also known as a health facility and

includes hospitals, clinics, primary care centres and other service delivery points.

Case management

A multidimensional and collaborative process involving a set of interventions for assessment, planning, coordinating and review of the options and services required to meet a client's mental health-related needs, and support her/him to reach her/his goals related to participation in life roles. Case management is broadly considered, in particular in the field of mental health, as a component of "integrated care"/"care coordination".

Catchment area

A geographical area which determines entitlement to localised services, usually based on residency. These services are usually provided within the catchment area, but in the case of more specialist services may be provided elsewhere.

Chronic care

Long-term medical care lasting usually more than 6 months especially for individuals with chronic mental or physical impairment.

Clinical

Involving or relating to the direct medical treatment or testing of patients

Clinical assessment

An evaluation of a patient's (mental) health condition and prognosis based on information gathered from multiple source of data including the patient's health and treatment history.

Community care

Services (including mainly social services) and support to help people with care needs to live as independently as possible in their communities.

Community mental health centre

Found in some countries, a CMHC is a mental health treatment centre located in a catchment area close to the homes of mental health service users. It features a series of comprehensive services performed by mental health professionals and all aimed at providing a coordinated program of continuing mental health care.

Psychotherapeutic services can be inpatient, outpatient, therapeutic rehabilitation, emergency, day treatment, screening and personal home services.

Community mental health team

A multi-professional team offering outpatient and mobile services which is often located in a neighbourhood catchment area close to the homes of service users. It may be based in a community mental health centre. Services may be delivered in people's own homes.

Features

include offering a series of comprehensive services by one or more team members, provision of continuity of care, linkages to a variety of health and social services, etc.

Community based service

It is a service targeting a group of individuals or a geographic community, i.e. only a short distance from the users' residence. It is centred in and around a particular community which can be represented by cities, municipalities, schools etc. Services may be delivered at facilities in the local area, in other local settings or in service users' homes.

Consultation/liaison service

In mental health, specialist within psychiatry dealing with the overlap of physical and mental health care. It provides timely psychiatric consultation to patients in medical/surgery units and utilises a multi-disciplinary team approach (psychiatry, psychology and nursing) for assessment and treatment. It mainly consists of psychiatric or psychological management, liaison with the referring

treatment team, ongoing monitoring of mental health status during hospitalisation and facilitation of transfer to other mental health services.

Crisis support see Acute care

Day services

Provide service provision which (i) is normally available to several consumers at a time (rather than delivering services to individuals one at a time); (ii) provide some combination of treatment for problems related to long-term care needs: e.g. providing a structured activity, or social contact and/or support; (iii) have regular opening hours during which they are normally available: and (iv) expect consumers to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the service is not simply based on individuals coming for appointments with staff and then leaving immediately after their appointments).

The service delivery is usually planned in advance.

Day hospital

A specific type of day care provided in a special clinical facility or a hospital setting where structured treatments, occupational programmes and diagnostic procedures may be performed. Service users return home or go to their usual hospital ward at the end of the day.

Disability

An umbrella term covering impairments (problems in body function or structure), activity limitations (difficulties in executing a task or action), and participation restrictions (problems in involvement in life situations). It is a complex phenomenon reflecting the interaction between features of a person's body and features of the society in which (s)he lives.

Domiciliary care

A home-based assessment and support service for people who need help with the activities of daily living. The service aims to help people live independently in their own homes and target groups covered can include people with disabilities, older people and all those with chronic physical and/or mental health problems.

Early intervention

A process of assessment and therapy provided to young people to prevent disability, delay or detect disability.

Emergency health care

All those services (e.g. delivered in a hospital, hospital ward, or emergency room (see definition); mobile crisis intervention teams) which provide immediate treatment to patients 24 hours a day, 7 days a week. In many countries (e.g. Norway, the UK), the general emergency services are also likely to provide emergency services for people with mental health disorders, including for immediate treatment after deliberate self-harm or other suicidal acts. These are typically the first point of entry-which refer the patient to specific/acute psychiatric services.

Employment service

Employment services are usually funded and often provided by government. Their aim is to help people who are unemployed, or registered as unable to work because of disability, return to competitive employment. At a minimum services provided include information provision, employment guidance counselling and job searching. Perhaps less common are services related to employability or skills assessment, job coaching and supported employment, job matching and individualised career or job planning. Many employment services focus on the entire population, but there may also be specialist employment services

may focus on the specific needs of people with mental health problems. See also supported employment.

Facility

Something that is built, installed, or established to serve a particular purpose like a hospital.

Forensic service

A service providing assessment and treatment of people with a history of criminal offending or at risk of offending. "Forensic" means related to or associated with legal issues. People may be referred for assessment by the police, courts, prison, other health or mental health services or justice agencies, and may have a mental illness or mental disorder. Treatment may be provided in the community, in hospital or in prison.

Full Time Equivalent

The workload expressed in terms of the number of days equivalent of one employee working full time, calculated as the ratio of the total number of paid hours during a specific period (part time, full time, contracted) by the number of working hours of full-time workers in that same period.

General health care

Care provided in a hospital setting or within a community or at home. It includes all services and treatment aimed at improving a person's basic state of health, i.e. physical, mental and social well-being, without targeting specific diagnostic groups.

General practitioner

Single-handed practice or group practice of one/several general doctors/physicians with no secondary care specialisation.

Health care ecosystem

The organization of people, institutions, and resources to deliver health care services to meet the health needs of target populations.

Hospital

The neutral term "hospital" refers to any institution based in one or more buildings providing medical and surgical treatment and nursing care for sick and injured people. This institution can also provide more specific treatment like obstetric or psychiatric care. Basically; it is a place where people who are ill are looked after by doctors (general practitioners or specialists), nurses and other health professionals.

Information service

Its main aim is to provide information and assessment to users. This care does not entail a subsequent monitoring/follow-up of the user.

Inpatient care

Care provided with the use of a bed overnight.

Institution

Facility which provides health care and related services mostly to individuals that are living in the facility (see also Institutional Care).

Integrated care

The management and delivery of health and social care services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health and social care systems.

Intensity of care

The capacity of a service provider to engage directly with service users to provide the indicated service: for example, twice a week, daily. Also expressed by ratio of staff to service user.

Intervention

An activity or set of activities aimed at modifying a process, course of action or sequence of events, in order to change one or several of their characteristics, such as performance or expected outcome.

Local authority

Local tier of government that has responsibility for ensuring the provision of publicly funded services in a specified geographical area. It may also have the power to collect taxes.

Long Term Care

This is a blanket term that brings together a range of services for persons who are dependent on help with basic activities of daily living (ADLs) over an extended period of time. This range includes medical and/or social services designed to help people who have disabilities or chronic care needs. Services may be short or long-term and may be provided in a person's home, in the community, or in residential facilities.

Long term residential support

This type of support is provided in a residential setting such as a nursing home where service users live rather than living in their own home or family home. Paid staff or volunteers (families and friends are usually not involved in this type of care) help service users with everyday activities.

Macro (in relation to geographical area)

It is a geographical area selected as a reference area in terms of representativeness. It must include the study area and it is recommended to choose a macro area with a population between 1,500,000 and 10,000,000 inhabitants

Main Service Function (MSF)

It is the major descriptor of the Stable Service Team (see definition) in relation to its more relevant, general and meaningful activity or 'generic care function'. Six descriptor levels define the MSF

according to the health status of the user (acute/non acute), the category, intensity and other specification of the care activity

Mental disorder

This is an umbrella term referring to many different disorders that affect the mind. These illnesses can be either non-psychotic (e.g. depression and anxiety) or psychotic (e.g. schizophrenia and bipolar disorder) or an organic brain disorder (i.e. a damage to brain tissue caused by diseases like dementia or alcoholism), a personality disorder (i.e. an enduring disturbance in the way a person interact with others) or an intellectual disability (e.g. a disability caused by problems with brain development). Generally speaking, a mental illness is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning.

Mental health

The WHO defines mental health as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Mental health care

The provision of services, treatments, medications, programmes and all other health related actions aimed at maintaining and improving the emotional and mental wellbeing of people.

Meso organisation

A health or human service organisation which includes several services within the same location (i.e. a general hospital).

Mobile mental health service

Health care and non-health care services that are delivered outside of hospitals or other ambulatory care facilities. Instead services may interact with patients in their own homes or in other settings in the areas in which they live. This for instance includes assertive outreach teams, social care provided at home and the like (EXAMPLES: Mobile outpatient service delivered at a patient home; Assertive outreach team (assertive community treatment); Home treatment team; Crisis resolution

Municipality

A political unit like a city, a town or a district with its own local government.

Need

Need is based on the population's ability to benefit from care including broad domains of health and social functioning, which are necessary to survive and prosper in the community. A need covers all aspects of an individual's life and mental wellbeing – for example accommodation, daytime activities, management of physical and mental health symptoms of poor health, childcare, money, psychosocial distress, and personal relationships.

Non Government Organisation

Any non-profit organisation that is recognised within local law. Many NGOs provide health and social care services; some advocate or lobby policymakers and other actors to improve service of provision and outcomes for their interest groups.

Nursing home

An institution providing residential care to people requiring continual (usually 24 h) nursing care and having significant difficulties in managing their daily living activities. Physical, occupational and other rehabilitation activities are provided within this setting which can be run publicly and/or privately.

Occupational therapy

Occupational therapy is defined in the English National Health Service as the assessment and treatment of physical and psychiatric conditions using specific activities to prevent disability and promote independent function in all aspects of daily life. Occupational therapists work with people of all ages to help them overcome the effects of disability caused by physical or psychological illness, ageing or accident.

Other (visit) care

Care provision typically (i) involves contact between staff and consumers for some purpose related to management of their condition and its associated clinical and social difficulties and (ii) are not provided as a part of delivery of residential or day services.

Out of pocket payment

A charge that individuals must pay personally for the use of a service sometimes at the point of service and sometimes at a later point in time. In some cases a proportion or all of the out of pocket payment can be reimbursed. Out of pocket payments can take different forms, they can be a fixed fee or proportional to the total costs of the service received. There may also be ceiling on the maximum level of out of pocket payments in a defined time period. In the case of long stay residential care, especially care provided outside of the health sector, there may be substantial regular out of pocket payments for care, often charged by the week or month.

Primary health care

While used in different ways in different health care systems health medical care is often the first level of contact people have with the health system in relation to their health. In many countries it is used to refer to primary medical services such as general practitioner or family practice services provided by primary care physicians, nurse-practitioners (nurses with some prescribing powers) and practice-

based colleagues such as nurses and physiotherapists. More broadly it can also refer to other community based services such as dentists, opticians and podiatrists.

Psychiatrist

A medical doctor who has received a university post-graduation in psychiatry with at least two years training in psychiatry.

Psychologist

Generally, a graduate professional having received education and training from a university level school of psychology. That of psychologist is a broader concept than clinical or therapist since a psychologist can be trained in organizational, occupational, educational, social, developmental etc. Whereas psychologists especially trained in clinical psychology are called clinical psychologists. However, in some countries, like Austria, psychologists are not allowed to practice psychotherapy without special training and psychotherapists do not need a degree in psychology.

Psychosocial Problem

Any problem related to one's psychological development in and interaction with a social environment. It could refer to the lack of development or atrophy of the psychosocial self, often occurring alongside other physical, emotional or cognitive dysfunctions.

Psychotherapist

Either a psychiatrist, a psychologist, a psychiatric nurse or a psychiatric social worker practicing psychotherapy, i.e. the treatment of mental health problems through talking and counselling and other psychological techniques designed to encourage communication of conflicts and insight into problems. In some countries, e.g. Austria, psychotherapists do not

need a degree in psychology.

Public

Services that are funded through taxes or other public financing resources like social health insurance.

Recovery

In mental health it is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is defined by 8 fundamental components: hope; medication/treatment; empowerment; support; education/knowledge; self-help; spirituality; employment/meaningful activity.

Referral

An authorisation from a medical profession to another medical facility or professional in the health and /or social care system. In gatekeeping system a referral is usually required from primary care doctors in order to access publicly funded specialist services.

Rehabilitation

It refers to all services which are a part of a programme aimed at enhancing social skills, facilitating integration into working life and developing independent living skills after an illness or an injury.

Residential Support

Care provision of beds overnight for patients for a purpose related to the clinical and social management of their care needs -patients are not intended to sleep there solely because they have no home or are unable to reach home.

Residential Facility

A place where a group of people with mental health problems reside in a community setting. This live-in institution is licensed by or under

an official authority and includes: room and board, supervision, support services and nursing care. Custodial care is also provided and a professional trained staff supervise the facility at least once a day.

Seclusion

The supervised confinement of a mental health service user in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.

Secondary Health Care

Medical care provided by a specialist or facility that requires more specialist knowledge, skill, or equipment than available in primary care.

Sectorisation

Establishment of a catchment area where services are provided for all residents. For instance, there will be specific mental health service structures responsible for providing mental health services to everyone in the catchment area.

Self-help & Voluntary Care

Its main aim is to provide users with self-help or contact, with unpaid staff that offers accessibility, information, day, outpatient and residential care (see definitions).

Service

Umbrella term that encompasses many different units of analysis in service research. At the micro-organisation level of care delivery it describes a combined and coordinated set of inputs (including structure, staff and organization) that can be provided to different user groups under a common domain (e.g. child care), to improve individual or population health, to diagnose or improve the course of a health condition and/or its related functioning.

Service User

The term 'service user' is often used as an alternative to the use of the word patient when speaking about people with mental health problems who are in receipt of services. The term patient is seen as too 'passive', implying that individuals do not have a say over any treatment and support they receive. It has there been seen to be politically inappropriate by service user groups and many mental health professionals.

Services Inventory

A list of services, organised into Stable Service Teams by their Main Service Functions, for a specified geographical area. The inventory includes address, number of staff, opening times, users and contacts registered in a year, type of care provided etc. Services are coded through a specific classification tool.

Service Mapping

Service mapping is an instrument for a standardised description and classification of services within a defined geographical area. When mapping services, the different levels of service provision are also categorised. A visual representation of results can be given by plotting services on a map to indicate their spatial distribution.

Social Care

Social care covers a wide range of services to help people live independently. It can include services provided in people's homes to help them with everyday activities of daily living as well as the provision of day services that individuals can choose to attend. Services are often funded and provided by local government or contracted to not for profit or for-profit organisations. See also Social Welfare and Social Services.

Social Services

A wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships. This covers social care services, but also other activities such as providing support to local communities and monitoring the safety of vulnerable people, such as children and older people. In some situations social services will be synonymous with social welfare services also providing final support, help with accommodation and education etc. See also Social Care and Social Welfare.

Social Firm

A business created for the employment of people with a disability or disadvantage in the labour market.

Social Worker

A professional with a graduate level qualification in the field of social work.

Stable Service Team

Minimal set of inputs with temporal continuity and organisational stability for delivering health related care to a defined and identified group of users in a specific location. It is usually composed of an administrative unit with an organised set of structures and professionals. Stable Service Teams are the minimal micro-level functional systems of care organisation. Within the production model of health-related care (input-throughput-output), Stable Service Team refers only to input functions of care that are stable and continuous over time and not to other organisational arrangements, tangible inputs (devices, facilities), or procedure

Supported Employment

It refers to both the development of employment opportunities and on-going support for those individuals to maintain employment on the open labour market. It can provide assistance such as job coaches, assistive technology, specialist job training and individually

tailored supervision (EXAMPLE: Supported employment programs).

Supported Housing

Support for independent housing can take different forms including houses or flats for one or more people without any on-site support, or blocks of houses or flats for single or shared use with an on-site manager or support worker providing support. In some cases residence will be time limited while in other instances it will be seen as a potential permanent dwelling.

Tele-assistance

A service supporting people in their own home by using information technology systems, for instance to monitor their health status. It can be used to allow professionals to remotely assist each other, e.g. when a doctor remotely assists another doctor carrying out a medical or surgical act, or in assessing images, even within the framework of an emergency. Other examples include remotely assisting a first-aid worker or any person providing medical assistance to someone in danger while waiting for the arrival of the doctor.

Vocational Rehabilitation Service

A service to enhance and support people with long term health problems and disabilities to prepare for, obtain or return to employment. It can take many different forms. For example, a vocational rehabilitation counsellor helps the user throughout all this process by understanding the abilities, strengths, priorities and capabilities of the user.

Voluntary Care

Unpaid services which are nonetheless provided by a non-profit and non-governmental organisation. Service provider does not receive public funding for the several social activities provided (e.g. visiting inpatients, working alongside the emergency services and providing

support for disabled and sick people). Staff are unpaid and on a free voluntary basis. The aim of voluntary care facilities is to provide users with mental health need, with support, self-help or contact. There could exist in some countries voluntary organisations which are contracted and paid to provide services.

Work-related activity

A facility where users carry out an activity which closely resembles work for which payment would be expected in the open market, but where users are not paid or are paid less than 50% of the usual local expected wage for this form of work.

ANNEX C ICD CODES

ICD CODE	Description
F00-F99	Mental disorders general
F01-F03	Dementia
F10-F19	Mental and behavioural disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood (affective) disorders
F40-F49	Neurotic, stress-related and somatoform disorders
F50-F59	
F50	Eating disorders
F53	Puerperal psychosis: also proxy for perinatal mental health disorders
F60-F69	Disorders of adult personality and behaviour
F70-F79	
G00-G99	Diseases of the nervous system
G35	Multiple Sclerosis
R41.81	Age related cognitive decline
T14.91	Suicide attempt
Z55-Z65	Persons with potential health hazards related to psychosocial circumstances
Z59	Problems related to housing and economic

	circumstances
Z62.21	Child in welfare custody
Z62.81	Personal history of abuse in childhood
Z63	Other problems related to primary support group
Z65.9	Problem related to unspecified psychosocial circumstances
ICF	Problems related to functioning
E310x	Section 'e' of ICF includes codes for referring to the nuclear family (e310), the extended family (e315), peers and other relationships and carers. These codes can be used for coding services aimed at providing care to the social network of the user

ANNEX D OTHER SERVICE TEAMS AND PROGRAMS

Other Service Teams

This is a minimal set of inputs organised for delivering human services characterised by time continuity, but which lack organisational stability criteria or attributes described for Stable Service Teams. This team cannot be described as a part of a Service Team: and typically, professionals delivering care belong to a larger unit.

A typical case of OST are 'clinical units' within 'care teams' of general hospitals or other health-related meso-organisations (e.g. an eating disorder clinical unit within a psychiatric inpatient care team in a general hospital, or the acute emergency care function provided by the staff of a specific psychiatric care team at the emergency room). These are coded with lower case Main Service Function codes (d1.1 etc.) to differentiate them from Main Service Functions of Stable Service Teams.

Temporary Service Teams (TST)

A temporal grouping of inputs of service delivery at micro-organisational level. This arrangement of inputs lacks stability over time.

Value: In the DESDE-LTC the value provided for this descriptor is three years.

SSP (Structured Service Programs)

This refers to the minimal set of inputs with organisational stability for delivering health-related care to a defined and identified group of users in a specific location, but which lack continuity over time. It is usually composed of an administrative unit with an organised set of

structures and professionals. It differs from Stable Service Teams through its lack of time continuity.

DESDE provides a cut-off value of three years for defining 'time continuity'. This is based on the DESDE rule that service delivery programs with organisational stability that last more than three years may have further continuity over time. Service delivery programs should be distinguished from other planning and policy care provision programs which address target groups of unidentified individuals or the general population. These policy programs are implemented at meso- or macro-organisation level, and are not provided in a single service cluster. Of course a regional planning program could be implemented in a specific service cluster, but the policy planning and its local implementation should be coded separately.

In DESDE Main Service Functions of Structured Service Programs are identified by codes in italics (A4) to differentiate them from Stable Service Team descriptors.

OSP (Other Service Programs)

This is the minimal temporal set of inputs organised for delivering a service but which fulfils neither organisational stability or temporal stability criteria (attributes). These are similar to clinical units but designed for a fixed period, without continuity over time. In DESDE-LTC, OSP MSFs could be identified with codes in lower case and italics (a4).