Irish Institute of Mental Health Nursing

Mental Health National Programme Plan - Submission Form

1. Organisation/Professional body

Irish Institute Mental Health Nurses

2. Contact Name

Prof Agnes Higgins (Chairperson)

3. Contact details

Email: ahiggins@tcd.ie **Address:** School of Nursing and Midwifery Trinity College Dublin **Phone number**: 01 8963703

Clinical Programme Area of Interest

- First Episode Psychosis Early Intervention X☐
- Early Detection of Eating Disorder X☐
- Management of Self Harm presentations to ED's X☐

Section 1: A National Mental Health Programme Plan

Please comment on

Aims and Principles of the Programme Plan

We support the overall broad aims of the promotion of recovery, participation in the community, and the development of partnerships with the voluntary and community sectors to ensure that outcomes are successful and relevant to the needs and aspirations of individuals. However, we are disappointed that the draft programme as presented has a singular perspective, namely bio-medical. . While the aims and principles of this draft programme plan are in line with mental health policy, these continue to be situated and expressed within the narrow confines of the bio-medical approach towards mental disorders and thus this draft plan for future development continues to operate from the disease perspective. . This is evidenced in the emphasis placed on illness identification and treatment rather than moving to a position in which human distress is understood in ways which relate to people's lived experiences of their distress. While it is very helpful to situate the plan within a recognised framework, we are of the view that further clarification of how the concepts of values based care and recovery will be operationalised.

The concepts for improved Mental Health Care in Section 1.3 are in effect the principles, and the programmes should be underpinned by the principle of Recovery, with emphasis on the essence of the individual's experience and the nature of the relationship with people including service users/health care professionals/voluntary organisations/ etc. The essence of good mental health care is often defined by the nature of the relationship; and specifically the therapeutic relationship. Thus the centrality of the professional/service user relationship must be emphasised throughout the programmes. Rather than focusing solely on a categorical model of illness or the absence of illness, emphasis needs to be placed on exploring dimensional models and recognising the role health professionals play across the continuum of health in developing meaningful relationships based on respect, values and the promotion of positive health and well being and achievements.

Reference solely to evidence based medicine in 1.3.2 ignores other forms of knowledge and research, and the lived experience of the individual. The proposed programmes need to take cognisance of current developments in research and recognise that empirical evidence alone is no longer considered to be the universal measure. Recognition of other forms of knowledge emanating from the personal perspectives of service users and their carers is required if services are to meet the expressed policy directives.

There is a requirement in developing any future programme to do so with all stakeholders present and engaged. Thus all health and social care professionals who will be charged with delivery of these programmes must be engaged in all phases of development. There are numerous opportunities to incorporate the nursing role and in particular expanded nursing roles. This wider approach is not reflected in the construct of the programmes

thus far. Neither is their evidence of involvement of service users, family/carers or wider groups.

A key aim of the programme appears to be having evidenced based interventions that are standardised across the country, with a focus on outcomes for the individual and their family; this should be an explicit statement.

Outline of the Programme Plan

In keeping with our previous comment, that is the exclusive adoption of a bio-medical perspective, terms including serious mental disorders, complex psychological conditions and common mental health problems, are again entirely grounded in that sole approach. Given that this plan represents an opportunity to configure services differently to meet future needs, and given the commitment to adopting a recovery oriented and inclusive approach to engage service users and their carers, it is imperative that how we define mental health issues include the perspective of those who have the lived experience of these issues. Therefore any future working definitions need to be arrived at in collaboration with service users and all professional groups.

While we appreciate that any plan must be developed incrementally and decisions need to be made as to prioritising which areas to address first, we would appreciate an explanation as to the decision making processes which identified the care programmes selected. While each area identified is important, all are relatively small in terms of population based mental health requirements. Furthermore, while addressing self harm presentation to accident and emergency is required, the available evidence clearly indicates that a community based approach to detection and intervention in self harm needs to be prioritised. As we are all aware, those presenting to accident and emergency represent the 'tip of the iceberg'.

The outline plan is brief and somewhat underdeveloped. There is a clear focus on implementing elements of Vision for Change such as CMHT, we are of the view that is would be useful to explore in greater depth how a wider public health perspective might be achieved.

We support the aim of 'well-trained, fully staffed, community-based multidisciplinary CMHTs (Community Mental Health Teams' being put in place for all mental health services, we would like to see greater emphasis on the role of peers, and experts by experience in the CMHTs.

The different strands on page 13 possibly need some pictorial table representation to outline the range & type of clinical programmes that require development over the coming years. This table would compliment/expand upon the programme stages outlined in the strands in Table 1.1

Governance and Organisational Structure

Although recovery and values are mentioned at the outset of the draft document, the principles of recovery based services and professional practice cannot be detected as key drivers of this plan. Failure to embed these key principles and values as the foundation upon which all future plans are developed and ultimately delivered, will result in a continuation of the usual practices and maintenance of the status quo.

This is clearly evidenced in the proposed governance and organisational structures being proposed.

The Governance arrangements continue to be focussed exclusively on medical leadership. The document 1.6 states "*Clinical Leads supported by advisory teams which include representatives from General Practice, Nursing AHP Project & Programme Managers.... Regional Leadership is represented by Executive Clinical Directors. These will play a leading role in developing the new structures nationally*"

Worryingly there is no real evidence of involvement of service users, family/carers or wider groups being included within these structures. Furthermore, these statements vest the sole leadership in one discipline and relegate all other professionals working and contributing to mental health care to advisory roles. The success of the envisaged new system will require the leadership roles of all health professionals to develop, implement and evaluate new, innovative and fit for purpose programmes. We strongly recommend that governance structures recognise and be inclusive of the leadership/oversight role of all disciplines involved in bringing the programmes to fruition.

Any other comments

The mental health information system is possibly the single biggest enabler to support programme development and delivery as the patient journey in mental health is complex, with multiple contacts with various health professionals between community and hospital settings. The acquirement of an integrated IT system should support the availability of timely information and subsequent choice/ alternatives for people availing of services and for staff delivering services.

Although we support the overall recommendations of the VfC, we are concerned that the plan outlined continues the narrow perspective, reflected in the overtly 'mental disorder' language and outlook, without giving adequate and sufficient recognition and acknowledgement of critiques and concerns expressed by many diverse voices about such narrow perspectives. Similarly,

An *Evaluation of the Clinical Nurse & Midwife Specialist & Advanced Nurse and Midwifery Practitioner Roles in Ireland* (Begley et al 2011), clearly demonstrated that care provided by Clinical Nurse Specialists and Advanced Nurse Practitioners is, cost efficient, improves waiting times and satisfaction with services. Most importantly the

study demonstrated significantly improved clinical outcomes for patients/ clients. The report strongly recommends that all service planning and service development activities be inclusive of these roles where appropriate. It is our view that this recommendation should be given serious consideration in the future design and development of the clinical programmes. The nursing profession would welcome the opportunities through role expansion to undertake broader assessment, initiate programmes and interventions and refer for medical consultation where indicated. Similarly, expanded nursing roles permit discharge of service users from programmes and referral onwards and outwards. The concept of specialist within a generalist team implies different team members will be required to develop specialist skill sets and assume a lead role for that programme within the team. Again this would be in keeping with expanded and advanced nursing roles and a framework for role expansion exists within the profession.

The representation of the various groups in the Appendix are skewed towards a minority of professionals (psychiatrists and clinical psychologists). There needs to be greater involvement of other disciplines. In addition, the service user and carer representation is weak, and does not reflect the various service user voices spread across the country. The importance of the role of the voluntary sector is acknowledged, but it is not clear what role it is to play. There is no voluntary representation in any of the working groups.

There is always a tension that any form of specialisation nullifies generalist skills so it is important that generic mental health skills (Therapeutic Relationships, Listening, Self awareness) & values (Recovery, partnership, respect, dignity etc) are valued and identified less the pursuit of emerging clinical programmes detract from core mental health services.

In summary the programmes are welcomed, however we are disappointed at the over emphasis on the medical paradigm of 'illness' and the failure to incorporate nursing and service user perspectives into the current design. Mental Health Nurses have been to the forefront in developing and delivering many innovative services and alternatives to hospital based treatments and are ideally positioned to contribute in a positive manner to this initiative.

Section 2: An Early Intervention Programme for First Episode Psychosis

Please list the *objectives and targets* that you think should be included in the programme under the following heading:

Quality:

Education need to be focused at a wider community level, including community based groups that engage with people across all life stages; suggestions include primary, secondary and third level education, national parents networks; sporting organisation,

voluntary groups, active retirement groups etc. Utilising established national organisation including GAA, ICA, Macra etc.

Access:

All people should have equal access to rapid assessment and skilled intervention regardless of geographic location. Emphasis needs to be placed on understanding and responding to the persons experience in the context of their lives as opposed to viewing the distress within an 'illness' lens.

Costs:

Governance structure:

Sessional or part time basis – need to consider how this will be configured given other demands of case load. Areas requiring further consideration include

- impact on rapid access within 72 hours
- impact on development of expertise
- facilitation of training and development
- support further development and research

Any other comments:

There need to greater recognition of the roles that Advanced Nurse Practitioners and clinical nurse specialists can play in designing, developing and delivering early intervention services.

Section 3: An Early Intervention Programme in Eating Disorders

Please list the *objectives and targets* that you think should be included in the programme under the following heading:

Quality:

Education need to be focused at a wider community level, including community based groups that engage specifically with younger people. Emotional wellbeing and mental health needs to be addressed at curriculum levels within primary, secondary and third level education, national parent's networks; sporting organisation etc

Under treatment and interventions CBT, Family Therapy and Self help seem to be the primary ones identified. Although CBT and Family Therapy are the therapies that have the most RCT evidence, others such as couple therapy, group therapy, interpersonal therapy and dialectical behavior therapy, solution focused brief therapy, working with familes and carers, psyco-education should be included as options.

Access:

All people should have equal access to rapid assessment and skilled intervention regardless of geographic location.
Need some reference to eating disorders not otherwise specified (EDNOS) and in particular Binge Eating Disorder (BED).

Costs:

Governance structure:

Any other comments:

Again, there is a need to recognise the roles that Advanced Nurse Practitioners and clinical nurse specialists can play in designing, developing and delivering services. Currently the is an ANP working in this area, although she is within the private sector, greater collaboration with private sector eating disorder services would ensure that that expertise is tapped into.
There is a need to consider and specifically address shared care with GP's within the document.

Section 4: Management of Self Harm among Service Users presenting to Emergency Departments

Please list the *objectives and targets* that you think should be included in the programme under the following heading:

Quality:

Access:

Costs:

Governance structure:

Any other comments:

Need to address issues of self harm across life span, with a community based approach to detection and intervention in self harm prioritised.