Mental Health Nurse Managers Ireland

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Mental Health Nurse Managers Ireland assessment of progress of the Implementation of Vision for Change to date

Introduction

A Vision for Change was broadly welcomed by Mental Health Nurse Managers Ireland (MHNMI). Vision for Change proposed a framework for promoting mental health at all levels of society and for delivering specialist care to everyone who needed it. It highlighted both strengths and inadequacies of existing mental health services and outlined strategies for building on the innovations heralded by Planning for the Future in 1984.

Central to the development of these strategies was the concept of service user involvement, mental health promotion, establishment of community mental health teams and the provision of an effective community based service. MHNMI recognised that the recommendations made in a Vision for Change had the potential to bring about profound change to the nature of mental health service delivery.
The proposed changes was greeted with optimism however MHNMI had reservations and expressed concerns that the substantial level of funding necessary for the successful implement Vision for Change would actually materialize.

We have outlined general observations regarding the implementation received from members of MHNMI throughout the country.

- The concept of partnership has never been discussed at the coalface level and advocacy groups in many areas do not extend beyond catchment management level.

- There has been no change to the practice of mental health promotion and with the non-replacement of team members who have left this is further than ever from the focus of CMHTs

- Social inclusion and geographical inclusion are not the same thing. The concept of social inclusion seems to be interpreted as placing mental health services in a building or town as opposed to integrating them with other employment or education services. In many places this results in the 'mental health house' easily identified by the group of people standing smoking at the door.

- Sporadic evidence of the service user/advocacy involvement at coalface, with no clear directive regarding training, funding, roles and responsibilities

- There is a lack of "real" service user representation on the second monitoring group, this follows on from the VFC original group which had only 1 real service user on the 'expert' group.

- The 3rd world status of IT infrastructure in the HSE is hindering basic communication and information sharing. Contrary to the claim in the implementation plan (page 15) the "Wisdom" information system falls far short of what is required. Mental Health and indeed health care in general should be developing a proper Electronic Patient Record system incorporating all the data sets and information required to inform strategic planning.

- The claim on page 13 of the implementation plan that "it was concluded that by and large, any pockets of deprivation within a given catchment area will be balanced by other more affluent areas" is strange in the extreme. This is contradicted in the same document on page 35 where it is stated that "The HSE will take cognisance of local deprivation patterns when planning and delivering mental health services".

- The lack of spend in specific mental health projects is and always has been evident. It is difficult to access the real spend on mental health but it falls far short of the promised €25ml per annum promised and this was before the recession hit us. Compare this to the Australian mental health strategy which has guaranteed the equivalent per capita amount of €250ml over the five years of the plan.i.e €50ml per year.

- The Organisational structures of mental health services is in a state of complete "Flux" there appears to be no set direction or strategy being followed. Executive Clinical Directors are being appointed but no Executive Directors of Nursing to compliment this. There is a complete breakdown in the mental health nursing managerial structures, with only just over one third of the Director of Nursing posts filled with appropriately appointed Directors through the LAC, the rest are in acting positions

Community Mental Health Teams

- The current moratorium on recruitment has prevented developments in this area. Indeed services are currently struggling to maintain existing levels of services without the development of any other services in line with VFC.

- The lack of line management structure from a multi-disciplinary perspective results in a destructive operational team environment.

- The overall level of resources allocated to CMHT's remains very low in proportion to the overall level of human resource in the mental health service. There remains a reliance on traditional acute and long stay inpatient beds and community residence sectors.

- A substantial number of CMHT's are poorly resourced and do not include the required overall compliment of staff.

- Some of the work that has been achieved is now being lost as a result of the moratorium and / or an overly cumbersome administrative process in filling posts that are not covered by the moratorium such as social work. An increasing number of clinical nurse specialist positions are not being replaced resulting in an overall de-skilling of services on offer to the patient and increase in waiting times for the services that are on offer.

- There is a significant lack of administrative support resulting in most team members spending an unsatisfactory amount of time on administrative duties to the detriment of patient care.

- The concept of a team is not being embraced in practice as disciplines such as psychology and social work are not fully based in the team but shared with community care structures. Often these individuals are re-assigned by their head of discipline without any communication with the mental health team. The negative impact of this on the concept of a team should not be under-estimated

- The merging of existing Mental Health Catchment areas to form the expanded areas of 300,000 population has not taken place. Neither has discussion taken place in relation to the nursing management structure of these expanded catchment areas particularly in relation to Directors and Assistant Directors of Nursing.

Management Structures

- Dominance of medical model within Catchment Management Team permeates decision making.

- A lack of knowledge among many members of Catchment Management Team results in indecision and inefficiencies. Heads of discipline such as social work and psychology do not work in and are not based in mental health services while others such as health promotion representatives have a tenuous link, at best, to core mental health services.

- Many team members are dispersed across a range of geographical sites that leads to inefficiencies such as a lack of cohesion, communication difficulties, and uncoordinated activities.

Mental Health Services for Older People:

- Nothing has changed as a result of the publication of Vision for Change in relation to services for older people. In fact the situation has worsened. For example: The closure of the new acute psychiatry of old age unit attached to the psychiatric unit in Portlaoise with the transfer of the staff to other areas. Limited number of new services developed, and where they have, complete lack of resources.

- Complete under development of day hospital and Day Centre facilities throughout the country.

- Non replacement of nursing staff and other staff in exiting services.

- No acute assessment beds opened in the acute psychiatric units as proposed in the Vision for Change.

Mental Health Services for people with Intellectual Disability

- There has been no implementation of the recommendations in relation to the development of Mental Health of People with an Intellectual Disability.

- There has been no posts or capital developments to meet the recommendations.

- There was a sub group set up under Mr Hugh Kane to examine what this would look like. The report was completed and nothing appears to have been developed.

- There are a number of Psychiatrists in post but there has been no development of teams or catchments areas or acute admission units.

Education, Training and Manpower Planning.

- There is no evidence of spend as promised in training and upskilling staff to redistribute to community teams, except for local initiatives. There is a complete lack of support for those undergoing further training and educating themselves to provide a better service.

- This is a key issue for future mental health service if the overall package within a Vision for Change is to be achieved. Linkage with third level institutions and the nursing curriculum must be established for undergraduates to ensure that training reflects this new domain. In addition the analyses of current staff i.e. their training and associated competencies must be conducted.

Mental Health in Primary Care

- There is no co-ordination of primary care development and mental health development in any meaningful way and where it has happened it is a matter of bi-location as opposed to integrated location of services. There is no attempt at primary care and mental health care meeting on a regular basis to discuss complex cases and share ideas.

- It is important that research in this area be conducted to establish outcomes for those with mental health needs who are treated within this care area without redress to secondary care. The establishment of liaison and access between primary and secondary care and a mechanism of shared care needs to be planned taking cognisance of current arrangements that are effective in care delivery.

- Co-location of Primary care teams and CMHTs each with defined and appropriate space and specialist human resources needs consideration. However caution so as not to move specialist mental health resources to primary care, where such resources could become blocked with the provision of “talking therapies” at the expense of those most in need of specialist mental health care. The development of protocols and policies at a national as well as a local level must be given priority to ensure resources are targeted to those who most need them.

Priorities regarding implementation of Vision for Change 2010

- Determine what is deliverable, however small and commit to it
- Transparent and equitable reinvestment of funds generated through sale of lands
- Balance implementing Vision for Change with maintaining service delivery at safe levels
- National audit of service developments in line with Vision for Change
- Prioritise recruitment and filling of vacant posts across all disciplines
- Address the role, function, funding, responsibilities and challenges of Vision for Change implementation group against the current crisis and dilution of mental health services, e.g. Driving a strategy with no DOHC support or funding.