PEOPLE BEFORE PROFIT

FIGHTING FOR WORKERS & ECO-SOCIALISM

Mental Health Policy

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Principles

1. Mental Healthcare Service Delivery be underpinned by a Human Rights based approach. Health Care including any aspect of mental health support will be founded upon the patients' right to personal autonomy and to give informed consent to treatment, medication, and supports and prohibiting methods of restraint and treatment without consent.

2. Prevention is the best way to reduce pressure on services. A functioning mental health system requires the reduction of the social determinants or causes of health problems and requires the availability and ease of access to social supports including decent standards of accommodation, employment, welfare, and education.

3. Mental Healthcare Services will be integrated with all other Health Services ensuring good mental health supports for those whose primary concern is physical health and good physical health care for those whose primary concern is mental health.

4. Communities, workers, service users and their families are partners in the design and delivery of mental health services at all levels.

5. Removal of mental health provision from religious orders to secular delivery suitable for a multicultural society. Cultural awareness training to be disseminated to and taken up by mental health service providers. This should be delivered in partnership with organisations such as Traveller organisations or others working with cultural minority groups.

6. Establishment of an All Ireland National Health Service (NHS) for a fully staffed public health service, available to all, to cover all health issues with an emphasis on mental health needs and social determinants of ill-health. This service is free at the point of use. It will be paid for through progressive taxation. Therapies should have an agreed ending and not be cut off because of resource issues. An All Ireland NHS prioritises prevention and early intervention by first line 'triage teams' and is democratically controlled by local community health councils. The 'crisis café' drop-in model should also be extended given the success of pilot schemes in relation to delivery and integration of community mental healthcare. All private organisations delivering health and social care should be taken into public ownership as part of the NHS and run on a not-for-profit basis.

7. Everyone will be offered a choice of adequate support for any mental health difficulty and service will never be refused because they do not fit the 'eligibility criteria' for a diagnosed psychiatric illness or because they have a 'dual diagnosis' or additional health or social care need including such issues as: use of currently illegal drugs or drug misuse, intellectual disability, or homelessness.

8. Mental health difficulty is an issue which has to be addressed in the communities that people live in and with a recovery orientation.

9. Mental health recovery should be understood as a purposeful journey, of self-determined personal development, from any initial trauma or beginning to a personally meaningful life within society. A journey that is founded on hope for the future, self-esteem, belief in abilities, and trust in others. It entails the regaining of a sense of identity distinct from medical diagnostic labels and engagement with society. It includes recognition of our human frailties and the positive and negative influences in one's life and bolsters the determination to maintain mental well-being by addressing these issues with and without support.

10. We recommend that the use of seclusion be declared an unnecessary and unlawful infringement on personal rights with no safeguarding benefit or therapeutic value. In addition, we recommend that: involuntary hospitalisation, the use of physical restraint, the use of Electroconvulsive Therapy (ECT), and

the use of single or multiple psychoactive drugs as first line treatments be restricted. Particular consideration should be given to evidence-based concerns for the level of use, safety and efficacy as well as the reasons for the recommendations to assist an informed choice between the various interventions in a timely manner.

11. In all situations of conflict between service users and services there should be ease of access to a second opinion. In addition, access to mental health tribunals and a right to advocacy supports will be implemented. Increased civilian participation in tribunals and an emphasis on accountability to the tribunals regarding available choices is key to building and maintaining trust during recovery. Oversight in cases of involuntary hospital admission and/or treatment should be provided without unnecessary delay and before the implementation of any detention or treatment orders.

12. Suddenly stopping medications is known to cause withdrawal symptoms often severe and long-term, in a significant number of people. Stopping medication should not be done alone. It requires advice and assistance. Requests for support to safely reduce or stop medication by careful, tapered (stepwise) reduction programmes which include psychological and social strategies which should be provided locally and promptly.

Key Demands

1. Mental health services should be fully funded to adequately train and retain required staff levels. No aspect of the health service should be run on a for-profit basis.

2. We would create a network of community care centres with free GP care for all. The community care centres should act as hubs that provide GP services and basic diagnostics. They should be staffed with a multidisciplinary team who are direct employees, they will deal with both physical and mental health issues.

3. The current system of separating medical services between 7 hospital groups and 9 Community Healthcare Organisations (CHOs) is problematic as it is uncoordinated and chaotic. We propose that hospital groups and CHOs are integrated and governed by health councils in an All Ireland NHS.

4. Integrating the HSE and community voluntary training though health councils would reduce cost and lead to the upskilling of all stakeholders. Long term, this will facilitate the reduction of the reliance on specialist mental health services.

5. Service provision will be governed by the implementation of the Convention on the Rights of Persons with Disabilities (CRPD enacted 2018) and abide by the principles of article 3 of the convention to all practices, procedures and policies delivered by all mental health disciplines who will integrate CRPD training into their professional training courses. In conjunction with the Department of Health, liaison, oversight and compliance of CRPD implementation will be conducted by the Irish Human Rights and Equality Commission. PBP supports the European Disability Forum and Mental Health Europe in calling for the draft protocol of the Oviedo convention to the CRPD to be withdrawn as it weakens protections against coercion in mental health services.

6. Mental Health Community Liaison Officers will ensure a sustained collaboration between all sectors of health and social supports, physical health support, addiction services, and mental health promotion and education. They can support the individual and supporter/ family member in negotiating their health needs and navigate the system to get best individual health care in their community at any given time.

7. Experts by experience will be employed as equal members of the secondary care multidisciplinary

team and their role in service provision will include: the provision of on-going client support, advocacy, representation on decision making and planning committees, provision of recovery education, facilitation of social and cultural amenities, and liaison with community organisations.

8. It is recommended that the service user is centred in mental health recovery and assisted by fully staffed 'triage' multidisciplinary teams. These triage teams have a horizontal structure and should be the point of contact in first instances of mental health problems. The team make-up may change should long-term or specialised care be required. These team members have equal status and should be employed by the HSE.

9. A robust accountable referral and support system is needed to integrate the individual into the mental health and physical health systems. This includes a no wrong door approach. Services should not turn away individuals presenting with needs inappropriate to their service but should be responsible for then linking the individual with appropriate services.

10. The allowance in the MHA for treatment without the consent of a person with decision-making capacity for up to 3 months of Electroconvulsive Therapy (ECT) or ongoing medication should be removed. Treatment without consent should be subject to an adequate process of establishing the person's capacity. Access to tribunal review should be ensured so all alternative avenues have been offered and tried, before any exceptional implementation of treatment without consent is approved and initiated. Services should enact and adhere to the Assisted Decision Making (capacity) (2015) legislation.

11. We recommend the creation of a citizen oversight committee to determine whether controversial treatments such as ECT can be used under any circumstances. Decisions such as involuntary hospitalisation or detention should also have citizen oversight.

12. The involuntary detention of a person under a 'renewal order' should not exceed a period of 3 months at any given time. A person who is detained against their will, who has a renewal order of their detention made, should be able to apply for a review of the extension of their detention by a tribunal before implementation of that order.

13. In all consultations on a health issue, including a mental health issue, by service users with the NHS, there should be a written, accountable, binding, mutually agreed care plan to support their mental health needs. The All Ireland NHS will be jointly and severally liable to ensure continuity of appropriate care across the lifespan.

14. Modern mental health services offer a severely restricted range of support services with an almost exclusive reliance on drug (increasingly multidrug) treatment and time-restricted psychotherapy usually limited to Cognitive Behavioural Therapy and Mindfulness. Multidisciplinary teams at primary and secondary care levels should offer a choice of recovery-focused approaches especially 'Psycho-Social' supports such as Counselling and Psychotherapy which are not limited in time or method. These teams should assist with accommodation, employment, welfare, social prescribing, drug-free mental health wards, and the Open Dialogue method, all of which should be resourced and available locally.

15. Marginalised and minority groups currently experience greater mental health issues and there needs to be equality of access to appropriate services. Failure to implement recommendations and act on ethnic equality monitoring by collecting and acting on data potentially puts more lives at risk for Travellers and other minority ethnic groups which already have higher mortality and morbidity rates, particularly in relation to mental health.

16. Mental healthcare service-users should have the right to work, as well as the right to be off work.

17. In regards to Dementia, all recommendations of the World Health Organisation 'Dementia A Public Health Priority" (2008) should be implemented.

18. We recommend the provision of psychologists in the Irish Prison Service be increased to reflect the needs of prisoners and at least meet the international minimum standard. Periods of detention should focus on rehabilitation and integration with well resourced staff and facilities. The current move to have the HSE and HIQA responsible for the provision of health and mental healthcare services should be implemented immediately.