Green Party Mental Health Policy

~~October 2015~~

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1. Summary & Key Points

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We in the Green Party emphasize proactive measures to promote mental/emotional wellbeing from earliest years when the foundations for a solid sense of security and self-esteem are laid down. We believe that treatment of mental /emotional distress or disturbance should be based on a holistic and integrated model which includes recognition of psycho-social factors, and which facilitates maximum recovery towards full psychological health and social functioning.

Key Points

- We support the full implementation and resourcing at national level of the policies of 2006 'V*ision for Change'* [AVFC] into mental health care; emphasis being on recovery, and on facilitating full information and choice for patients around their treatment.
- Upon discharge, all patients should be followed up by professional community support staff, such as community mental health nurses, who would be integrated with Community Mental Health Teams.
- We support resources for full multidisciplinary CMHTs as well as for adequate staff in rehabilitation accommodation.
- We support the integration of access to psychotherapy, counselling and social care services into all CMHTs and primary care teams, including the CAMHS service.
- We support the provision of drop–in centres which will be integrated with CAMHS, which would cater for persons up to 18 years.
- We support the adequate resourcing of Authorized Officers to implement necessary detention orders and phase out the removal of section 9 (a)from the Mental Health Act 2001 under: *Involuntary admission of persons to approved centres,* which allows a family member to instigate involuntary detention.
- We support the removal of the word '*unwilling*' from Section 59 (b) of the Mental Health Act 2001 under: *Consent to Treatment.* We will ban the use of ECT against a person's will. Instead our policies will focus on early awareness and intervention in mental /emotional distress. Ensure immediate implementation of the Capacity Bill.

- We support mandatory regular and independent reviews of patients on long term drug therapy; these should be replaced with psycho-social forms of therapy or support wherever possible.

- We support the nationwide implementation of the SCAN crisis response service for suicidal persons.
- We believe that continuity of midwife care should be provided for women before and during childbirth. Specialist mother and baby units where the mother and baby are not separated will be made available to post-natal women suffering mental/emotional difficulties. We support the full resourcing of a full range of therapeutic services, including community supports, social care workers and/or psychotherapists, being available to such women during pregnancy and the peri-natal period.
- We support a policy of interdisciplinary networking in statutory mental health care settings.
- We advocate availability of professional clinical support for practitioners working with distressed persons.
- We believe that education of mental health professionals ought to provide a psycho-social and relational balance to the medical model; we advocate for funding to implement increased experiential learning, and group dynamic experiential learning in all institutions caring for emotionally vulnerable persons.
- We advocate for the appointment of a Mental Health Promotion Officer in schools to provide emotional health programmes and reinstate the discontinued guidance counselling service.
- We support the integration of addiction services with mental health and social care.

2. Policy

2.1. Introduction

The Green Party strongly advocates an approach to mental health policy that stems primarily from a paradigm of prevention and which considers psycho-social factors underpinning mental/emotional health.

Recognizing that experiences arising in relationship with others, especially during childhood, including social deprivation, family dysfunction, neglect, ill-use, loss, trauma or misunderstandings during developmental years, underpin a lot of mental/emotional distress in adult life, we advocate for prioritising the place of relationship and associated power-dynamics in all professional encounters with sufferers.

We believe in a holistic view of mental/emotional wellbeing**,** with the emphasis being on laying a solid social and family foundation for babies, children, and adolescents to develop healthy self-esteem and confidence in their own initiative.

2.1.1. Principles:

- We support a rebalancing of the power-dynamics within the mental health sector, which currently is predominantly medical in its form of treatment.
- We believe in structures that empower sufferers of mental and emotional distress.
- We believe that treatment decisions should always be taken with the full involvement of the sufferer wherever possible.
- We believe that full information on a broad array of treatment options, and not just those from a medical or pharmaceutical perspective, should be made available to sufferers.
- We believe that relationally based approaches to treatment should take precedence over coercive approaches.
- We believe that community support should form a seamless intervention with hospital care, offering continuity of professional involvement and re-integration into community life.

- We support the earliest possible intervention, preferably in the community, in cases of mental/emotional distress.
- We support relationally-based education and practitioner support for professionals working with the emotionally distressed
- We advocate preventative measures through support for emotional health in childhood.
- We support a public education programme on the experience of difficult emotions being a normal part of human experience for everyone, thereby reducing stigma.

2.2. Policy Details

2.2.1. Background-Socio-Cultural Influences Past and Present:

There is now a greater understanding and slowly diminishing stigma in Irish society around mental/emotional health. However the understanding of the 'causes'/origins of mental/emotional distress or disturbance and consequently models of treatment, is still primarily derived from the medical model in our main psychiatric centres, with inequalities and variable implementation of the more holistic psycho-social forms of intervention recommended in the Government 2006publication '*A Vision for Change'* (AVFC) [Mental Health Reform report 2015].

Anecdotal evidence suggests that medical psychiatry dominates our mental health system, much more so than in other European countries and is instrumental in its focus on functioning and fixing symptoms to the neglect of facilitating self-expression by patients. The ever-present risk of engaging in social control through our mental health care practices is a legacy of our 'asylum' history and it remains a subtle but enduring feature of our mental health system, where control of symptoms takes precedence over developing a relationship open to hearing the sufferer's experiences. An '*us well - you sick'* attitude, even if unspoken, between professionals and the distressed person, contributes to their sense of stigma and alienation from 'normal' society [Goffman 1961; Hochschild 1983; Pilgrim & Rogers 2005]. Medicalised diagnoses can also ignore the underlying antecedents and meaning of the sufferer's experience [British Psychological Society 2011].We need a radical shift to a holistic approach, based on frontline psycho-neurological research which illustrates the mutual interaction of psyche and soma, and the significance of relational experience [Schore 2003, 2009, 2012], and which would rest on valuing the principle of containment in *relationship* as a key healing aspect for those who can benefit from this, as opposed to over-reliance on continuing suppression of emotional responses offered by drug therapy.

The Green Party mental health policy places emphasis on

- early intervention,
- adequate supports during emotional development in childhood,
- community interventions and support as far as possible,
- promoting recovery,
- autonomy and treatment choice for sufferers.

Special attention should be given to the emotional well-being of marginalized groups, and their integration into society. We also believe that time needs to be given to the unexpressed *emotional* component of mental illness, in listening to a sufferer's experience, as opposed to focussing on the immediate 'fixing' of a problem.

Promoting discussion and understanding of how some of our cultural values militate against emotional well-being is needed too. These include

- the celebrity culture with its focus on the perfect body-image,
- our time-poor quick-fix society---which prioritizes predictability and control,
- our obsession with success and strength/invulnerability,
- the erosion of personal and sexual boundaries among our young adolescents through online social media culture.

All of these influence the emotional health and maturity of our society. The focus on psycho-social health should begin in schools, and form part of a wider public discussion.

2.2.2. Child Development

Good experiences in earliest relationships of infancy and childhood help to protect later adult citizens from mental/emotional difficulties [Bowlby 1988; Mahler 1974, 89-106; Ainsworth et al 1978; Winnicott 1979, 1988]. There are ample research findings which correlate adverse factors in childhood with poor mental health later in life [Gammelgaard 2010]. A more coherent public health policy would emphasize the mental/emotional health of parents as significantly influencing the growing child's emotional development and the all-important bonding experience with their babies.

Barnardos have highlighted the well-researched effects on children's emotional well-being of parenting experience [Gerhardt 2014; Department of Health and Children 2009], and the dominance of the medical model in treatment of parents' emotional difficulties. They express concern at large numbers of parents who are routinely on medication to cope with anxiety or stress, with many GPs failing to explore other psycho-social or community-based options for support. Alongside the stigma which leads parents to fear losing their children, the fragmented and

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uncoordinated nature of services offered to parents and children, added to the context of lack of an out-of-hours social work service means children are often left at risk. Barnardos is a strong advocate for supporting families facing challenges in a holistic manner; '*a family model stresses a systems and ecological approach to… assessment and intervention*'; it includes dynamic understanding of how multiple factors within and between individuals and their environments interact over time.[Patients. Parents, People: *Towards integrated supports and services for families experiencing mental health difficulties*, [Barnardos Conference June 2014]

They organize various inter-agency family support programmes, such as *'Infant Matters'* which has been shown to successfully facilitate new mothers in bonding with their baby, and the '*Strengthening Families Programme'* [SFP] which offers support to families towards improving emotional development in older children. They work with CAMHS and accept referrals from community professionals. As the above research shows, such programmes are both socially beneficial and therefore cost-effective and should be more availed of, as they would save resources in the long term as well as promote emotional resilience and facilitate inter-cultural relationships. Voluntary community support programmes such as '*Home-Start'*, an international community scheme who train local volunteers with parenting experience to offer emotional and practical support for families in difficulty, widely available in England and Scotland, could usefully be developed in Ireland. [www.homestartireland.ie]

The involvement of fathers has been shown to positively affect the small child's development, as well as reducing maternal stress and promoting more secure maternal/infant attachment. [Department of Health and Children 2009]. The Green party supports increasing paternity leave in the child's first 3 years.

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Education

Young people who may become overwhelmed by challenges arising from adverse social circumstances, before having had the chance to grow and mature in awareness, need to be helped in developing constructive coping skills as a key measure in preventing later addiction.

Developing self-acceptance of their own individual qualities necessarily involves the child developing self-awareness and understanding of their own and others' emotions [Gilligan 2015 p29-34], thus supporting the development of emotional intelligence and resilience as they grow

into adolescence. The Green Party would support the imparting of emotional awareness skills to children at an age-appropriate level, particularly for those from socially deprived backgrounds.

A whole school approach to prevention and early intervention rather than remediation can help to ameliorate shortcomings in traditional school-based psychological services, as focussing on individuals rather than populations have been found to be a less effective use of services. An alternative 'ecological model' of service delivery would address the growing mental health and education problems currently being encountered [Gutkin 2012: pg1-20]. International research has shown that routine screening results in better outcomes in terms of mental health [Husky et al 2010; Weist, 2007]. Therefore, the Green Party proposes the appointment of a mental health promotion officer in all schools as a cost effective way to implement prevention of mental ill health. This social worker could offer both career guidance counselling, one to one counselling as well as group work of a preventative nature, addressing particular emotional concerns of teenagers such as body-image and eating difficulties before problems develop. As well as meeting school needs, s/he would also provide links with families and community groups. School counselling interventions produced quite large effect sizes in areas of discipline, problem solving, and increasing career knowledge [Whiston & Quinby, 2009].

Countering our intense cultural drive for success would help our young people to manage inevitable failure in some areas of their life in a way that does not define *them* as failures. Finding ways to support young people's developing initiative and to define their own experience of themselves would help them to avoid developing a distorted identity through identification with unhelpful cultural pressures.

2.2.3. Care for Women with Mental/Emotional Health Difficulties

The gender imbalance in psychiatry, which sees more women receiving diagnoses of mental/emotional disturbance, has been long recognized and still exercises subtle cultural effects [Chesler 1972; Showalter 1987; Ussher 1994]. The Mental Health Commission's recurrent findings show that significantly more female than male patients are given ECT [MHC 2010; 2012; 2014].

The Women's Aid Impact Report 2014 details over 16,000 disclosures of domestic abuse against women and almost 6,000 cases of abuse against children. Concurrently, Women's Aid has had a 20% cut to its statutory funding by Tusla, the Child and Family Agency. The Green Party believes that this cut needs to be reversed immediately.

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Women with mental health difficulties during pregnancy have special difficulties in accessing services; one of the issues creating a barrier is a lack of trusting relationships with health care staff members, which leads them to feel unsafe at this critical time. Women's' voices have not been adequately heard; according to a Trinity College Dublin report [2009]. Maternity care in western society has become increasingly medicalised with reluctance being shown by professionals to engage with women about emotional issues; this has led to a diminution of emphasis on the importance of women's experiences during pregnancy and childbirth. The report also states that women are twice as likely to be prescribed psychotropic drugs as men, and were unhappy about the imposition of the biomedical solutions in the treatment and prevention of depression during pregnancy and in the peri-natal period, fearing the effects on the foetus and on their ability to bond with and care for their babies. Specialist mother and baby units are non-existent in Ireland (NWCI and NDA 2005 in the above TCD report).We need to ensure that our peri-natal services are cohesive and working to a high-standard. As recommended by the report, the Green party would instigate provision of a continuous relationship with a trusted professional (midwife), and a social care worker if needed, throughout pregnancy and post-natally for all women.

2.2.4. Suicide

Adolescence can be a time of change and difficulty for many young people, and unfortunately also a time of increasing suicide risk; this applies especially to those who grow up in less than ideal situations or in our care system. The figures on deaths of young people (196 children between 2000 & 2010) while in care or known to the HSE should be a cause of grave concern. [Shannon & Gibbons 2012]. There is a need to improve the overstretched service to adolescents, where CAMHS lacks fully-staffed multi-disciplinary teams. At present there is limited service offered to 16-18 yr olds [HSE 2010; MHC 2010]. There is need for a mandatory outreach policy for young people who fail to engage with the service. Jigsaw, part of the Headstrong youth mental health programme, complements, strengthens, and integrates mental health services and supports

currently available within the primary care system in providing a number of easily accessible youth user-friendly centres as a first level contact for those from 12-25 who can self-refer, or be referred by various agencies, and receive counselling or onward specialist referral if needed. Their goal is early intervention, thus pre-empting crisis levels of distress. Evaluation shows preliminary findings as promising [Illback & Bates 2011]. As 75% of mental health problems occur prior to age 25, the Green Party supports Headstrong's proposal to invest in providing availability of Jigsaw hubs nationwide offering early intervention strategies targeting youth at risk of developing mental health problems and which focus on community prevention programmes [Headstrong Sept. 2015]

Suicide has become an increasing problem over recent decades especially in young males. A timely and sensitive response is required which is accessible outside normal working hours and minimizes the likelihood of stigma and ongoing reliance on the psychiatric system. In suicidal emergencies, when the sufferer is overwhelmed by their usually buried unbearable emotions, timely access to a therapeutic relationship can often support an individual who may be open to this, in beginning to accept these emotions rather than return to their usual coping defence of repression, and so pre-empt an on-going situation of suicidal risk [Hale 1991 in Maxwell pg71]. This would require swift access to professional therapeutic services from emergency departments.

The recent pilot project of two SCAN services in South Dublin and Wexford—currently continuing only in Wexford—provides a timely response, though at present during GP hours only. It offers a speedy response by a specially trained SCAN nurse to a person in suicidal crisis at their GP surgery, thus containing the initial extremes of anxiety evoked in all those affected, with an onward referral system to appropriate community services including counselling and/or community care supports. Research shows that this has resulted in a significant reduction in admission to psychiatric services. [HSE 2012]

2.2.5. Sexual Abuse

There is an abundance of research to show that sexual abuse during childhood has major disruptive effects on adult functioning including mental health. There is evidence that up to a third of people attending psychiatric services have experienced sexual abuse at some point in their lives

and most often in childhood [Muenzenmaier et al 1993; Mulder 1998]. A psychiatrist study found four times greater incidence of 'severe and disabling' disorder involving attendance at mental health services among abuse survivors [Spataro et al 2004]. Childhood sexual abuse [CSA], as also physical/emotional abuse, was found to increase the risks of later multiple forms of mental health problems including suicidality; rates being over twice as high among those with a history of CSA [Hornor 2010; Australian Institute of Family Studies 2013]. However in 2013 a report by Mary Flaherty, CEO of CARI, stated that both the HSE's child and adolescent mental health services for children specifically exclude child sexual abuse, as in the absence of symptoms such as depression, it is not considered a mental health issue. HSE focus on addressing past abuse, thereby ignoring children who are being abused today [the journal.ie. Apr 15th 2013].We advocate prioritizing of psychotherapy treatment for children who have been abused in the immediate past at a level at least equal to that currently available to adults who have suffered historical abuse, thus preventing later mental/emotional distress.

We support training of professional staff in primary care and psychiatric services to recognize potential victims of sexual abuse and make appropriate referral to specialist services. We also support increased funding for the National Counselling Service and Rape Crisis centre networks. We agree with the ISPCC recommendations of enhanced online legislation and that the Government should ensure the Implementation of the EU Directive on sexual abuse, sexual exploitation of children and child pornography, as well as increased education of parents and children. [ISPCC Report 2011]

2.2.6. Addiction

The Green Party Policy on Mental Health acknowledges the enormous problem which active addiction is having on our communities. There is a gap between mental health and addiction services which results in many people ending unassisted in a revolving door situation. Joined up thinking along with a containing network is needed for those persons self-medicating with drugs or alcohol to manage internal distress. This requires collaboration between addiction services, and social services to address the vicious cycle of community deprivation/unemployment /poverty /which feeds addiction.

2.2.7. In-Patient Care

In severe crises, if a person/sufferer/patient is so distressed that care in the community or their usual home setting is unsafe, or likely to be unsuccessful, admission to a 'social asylum' (in the old meaning of respite/refuge), or a treatment centre where the person is removed from any current social stresses is likely to be required. However, if the person is unwilling to enter a care setting voluntarily, the issue of power and control becomes central, which can compromise a climate of emotional tranquillity and support.

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Admission to care settings

This should be voluntary if at all possible. In cases of danger to the person's own safety/well-being or to that of others, compulsory admission for a limited period may be necessary. We believe that a family member should never be the formal applicant for a compulsory admission, though of course they can request an assessment from an independent M H professional, who would make an application for compulsory admission if they felt this was required. This is how things operate in England, where a psychiatric social worker makes the application for involuntary admission. The Expert Group Review of the Mental Health Act: 2015 recommends that Authorized Officers should perform this role, therefore removing the burden of this responsibility from families with the ensuing risk of compromising family relationships.

Promoting autonomy:

Service users' involvement in treatment plans should be mandatory where at all possible so engaging the person as a participant in their recovery. Unless contra-indicated and against the person's wishes, significant family members/carers should also be involved.

Medication Treatment

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This should be seen as being *Emergency Care* and reviewed with the person as soon as practicable, staying with their wishes around ongoing treatment as much as possible. The Green Party believes that regular independent reviews of patients on long term drug therapies which dull their emotional responses should be mandatory.

We propose that the Long Term Illness Scheme would be expanded to include patients over 16 with prescriptions for mental illness. However we require that there be regular reviews of medication prescriptions, and that for those who suffer ongoing mental/emotional distress or dysfunction, multidisciplinary interventions including psychological and social interventions be made available

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Electro-Convulsive-Therapy:

The Green Party has serious misgivings about human rights issues related to ECT. While the previously divergent implementation of this practice has been declining over the years, there is a valid opinion that it should not be possible to administer ECT to a patient who is unwilling to receive it. [Mental Health Commission 2014]. We understand that there are debates underway on amending the Mental Health Act 2001 around compulsory administration of such treatment and the issue of capacity to consent. [Dept of Health 2015]. We would consider that the need to give a person ECT is an indication that they have not had appropriate therapeutic interventions at an earlier stage, and have been allowed to reach a serious level of mental/emotional dysfunction. However we accept that there are people who wish to be 'treated' by others as others see fit, and do not want, or feel unable, to participate in taking responsibility for their recovery.

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Use of Seclusion & Restraint [S&R]:

Research has shown the link between S & R, emotional suppression in staff, consequent negative effects on the therapeutic alliance and consequent escalating of aggression [Moran et al 2009 pg602]; therefore it needs to be to used minimally /judiciously if at all. This underscores the importance of appropriate education and clinical support/supervision for mental health practitioners.

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2.2.8. Community Care:

Patients should never be discharged back to the same emotional context from which they were admitted, without ongoing continuity of care and the support of a Community MH Practitioner to support the sufferer in making the necessary changes in their psycho-social context to minimize the likelihood of relapse. Use of independent psychological services, if the patient is open to this,

should be encouraged in the absence of appropriate availability in statutory services or inappropriate waiting times.

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Long-term Residential Care

We believe that the care of those with established and enduring mental/emotional problems, who cannot cope independently, necessitates supportive social care in the community with adequate numbers of staff trained in interpersonal and therapeutic skills as noted above. Only this will ensure that we as a society care adequately for our most vulnerable population. We will also prioritize the disciplinary inclusiveness of Community Mental Health Teams in order to work towards engaging the influence of a broad range of treatment disciplines in mental health care.

2.2.9. Mental Healthcare Systems

Social Attitudes in Mental Healthcare Systems

Within our health service there is increasing dissatisfaction among many professionals and service-users with the predominantly medical approach of many of our mental health services, chiefly seen in over-reliance on medication

In many jurisdictions, the medical model approach to mental health has been a failure. Psychiatrist Dr. Pat Bracken, author of 'Psychiatry in a post–modern world' perceives current psychiatric practice as bio-reductionist in orientation, being too focussed on the brain and instrumental technological interventions, while failing to take account of human contextual factors. It is threatened with '*corruption of the academic environment by the interests of the pharmaceutical industry'* [Bracken 2008]. Bracken maintains that psychiatry needs to develop a form of medical practice that is adequate in its engagement with human meaning, i.e. beliefs, behaviours, emotion, and relationships; this viewpoint is emphasized by the user/survivor movement, and is documented in the Dept. of Health Service user consultation process [Crowe 2004]. Rather than relying on evidence-based practice, from the perspective of a listening approach which fosters subjective expression by the sufferer- *'years of psychotherapy research* [show] *that it is the non-specific aspects of therapy that determine outcomes'* –(i.e. the therapeutic relationship documented in much research) [Bracken: ibid]. Promoting a community development approach to

mental health would engage the whole community in a democratic debate about mental health, thereby reducing social exclusion and stigma. Dr Bracken has written of the unwarranted power psychiatrists hold in our paternalistic system: '*the ways that problems were formulated by mental health staff as psychiatric issues were sometimes contrary to the ways patients saw their problems and what was needed to solve them'*. Historically *'theological coercion* [has been] *replaced by psychiatric coercion'* [Bracken 2012]. Dr Terry Lynch, GP and practising psychotherapist and author, maintains that mental health problems are "*fundamentally emotional and psychological in origin*" [Irish Times article: Carl O'Brien February 14, 2012] with frequent loss of one's sense of self. A practice that does not promote reconnection to the individual's emotionally based subjective experience – i.e. their core self, is markedly deficient. He maintains that in Western culture generally there is a taboo on emotional expression [Lynch 2011].

The Expert Group on Mental Health Policy stresses the need to move beyond the current biological and illness-focused mental health services to a more 'biopsychosocial model' of practice. They were of the opinion that *'the artificial separation of biological from psychological and social factors has been a formidable obstacle to a true understanding of mental health… [*and resulted in*] …lost opportunities for the provision of psychological and social interventions for people'* [AVFC 2006: pg18].

Critical Voices Network [CVN], a grass roots consumer online network, offers testimony from individuals who have recovered their emotional health without drugs after years in the psychiatric system, while the growth of '*Hearing Voices Networks*' attests to the growing recognition that many psychiatric 'symptoms' are derived from buried painful experiences [Dillon 2011]. Dillon, who advocates supportive group listening to sufferers –'experts by experience', is an internationally respected speaker, writer, trainer and activist, who has lectured and published worldwide on hearing voices, psychosis, dissociation, trauma, abuse, healing, and recovery. She works with the Foundation for Excellence in Mental Health Care, to advance the development of the Hearing Voices Approach in the U.S.A. and is co-author of numerous publications 2009-2013.

Promoting autonomy and informed choice around treatment needs effective communication of full and unbiased information relating to all treatment options, including 'talking therapies', from both *independent sources* and the Health service. Except in severe crises, the sufferer should be given adequate time to make a decision through a non-judgmental, non-pressured approach. Engaging

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without bias and supporting the choice of the patient even if this is against our own view is crucial. We need to create an emotional climate which gives *time* to *listen* and facilitates acceptance of illogical, irrational and unpredictable emotional experiences rather than immediately medicating or persuading it away by goal-directed therapies. Such an approach will facilitate an increase in self-awareness, personal emotional resilience, and constructive coping skills based on a positive sense of self-worth in the patient. [Maxwell 1990: pg1-5].

In our current resource-poor mental health system, a person often has to repeat a traumatic experience in shifting between multiple care-workers due to frequent staff changes, which can often replicate the original emotional wounding. This is best addressed by providing sufferers with dedicated professional key-workers with whom they can develop a continuous relationship.

Education of mental health professionals

Students in the various mental health professions traditionally have little formal contact with one another, and experience very little collaborative learning to promote teamwork. A Mental Health Commission Report [2010] states that teams with higher levels of collaboration had improved patient outcomes and lower stress levels amongst staff. Strong allegiances to professional cultures, conflicting power relations, and ideological differences with concerns about overlapping professional boundaries within mental health teams are barriers to collaboration based on mutual respect between disciplines. These problems need to be addressed in the education of future mental health professionals. The Green Party supports the assertion in this report that mental health education should include:

- some forms of psychotherapeutic skills,
- increase the level of service-user involvement,
- focus on recovery/social inclusion,
- community based approaches,
- clinical supervision/personal development.

Redressing the current overemphasis on cognitive learning methods would require increasing use of experiential methods such as

- interpersonal group work to facilitate interactive interpersonal learning
- interdisciplinary education at undergraduate level
- undergraduate learning within health care settings
- inter professional practice collaboration.

We have been shocked in recent years at the abusive treatment of vulnerable citizens in our institutions, within and without mental health care. Progressive interpersonally focussed education of all mental health professionalswould contribute to enhanced awareness of how unhealthy power-dynamics or processes of 'group-think' compromise relationships with patients, as well as between professionals. The Green Party advocates that education for all mental health professionals on the relational basis of the link between neurological and emotional development in childhood should be mandatory [Schore 1994].

The onset of mental/emotional distress needs to be seen as an opportunity not just for treatment, but also for personal growth and maturation. This would facilitate both improved functioning *and* emotional wellbeing in the sufferer's own life, confer benefits in relationships with family and work colleagues, and improve productivity and work satisfaction. We believe that psychological therapies are "*fundamental to basic mental health services*" as stated in Govt 2006: '*A Vision for Change'* [AVFC Annex 11.1] and offer both clinical benefits and cost effectiveness.

The Green Party supports the statutory regulation of the 'new' professions of counselling and psychotherapy. Recent Irish research shows that psychotherapy interventions are both therapeutically effective and cost-effective [Carr 2007]. Roth & Fonagy [2005] in the UK review the increasing body of research into the cost-effectiveness of psychotherapeutic interventions, they also find that cost-benefit in broader terms such as reduced hospitalization or use of other medical interventions is favourable; however a clear comparative economic evaluation along specific lines is not possible between such interventions and medication treatment, or between various modalities of psychological intervention themselves. This is due to multiple factors: the paucity of research so far; lack of long-term follow-up; the variety and complexity of mental/ emotional disturbance, difficulty of evaluating effectiveness along narrow specific lines in what is a complex difficulty in a variety of complex personalities in treatment with individual and uniquely different therapists. Researchers largely agree that the quality of the relationship with the practitioner is

what most influences outcome irrespective of the modality of psychotherapy involved. Clearly social benefits in terms of improvement in peoples' life experience, employment, and social functioning such as parenting roles, are self-evident and beyond economic evaluation. Our Dept. of Health also agrees with the growing evidence which supports the cost-effectiveness of psychological therapy through better outcomes and cost reductions in many aspects of health care. They include serious mental illnesses in this evaluation. [AVFC Annex 11.1.1]

Integration of Psycho-Social Factors into Mental Health Practice

In Health Care /Community Settings Inter-professional consultation, collaboration and liaison at Primary Care Level should be employed to determine if medication, psychological therapy or a combination of both should be used to best serve an individual's needs at a given point in time. Currently the situation is uneven countrywide and access to medical forms of treatment or to the psychological therapies is too often dependant on whether the GP is open to counselling and/or psychotherapeutic intervention, has access locally to a competent professional, or on whether the person is able to ask for what s/he needs. We will create multi-disciplinary care teams /centres which will include access to social support services and psychotherapy or counselling.

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2.2.10. Ecology and Mental Health

The Green Party recognizes the link between individual wellbeing–which lends itself to community cohesion and resilience—and the care of global systems needed for human survival. Research has shown that mental health benefits can be derived from involvement in gardening and food growing, and of course exercise [mind.org.uk]. Community, social and therapeutic gardening projects contribute to building cohesion and resilience in local communities; the Green Party supports an interdepartmental strategy for the development of allotments, community gardening, school gardens, and the home grown food sector.

2.3. Costing

A functional mental health care system requires joined-up thinking and an integrated approach to mental health care practice between relevant departments such as Health & Children, Social Protection and Education. There are possibly too many disparate groups and services being funded from the public purse, without the necessary cost benefit analysis, e.g. in areas such as suicide prevention and drug/addiction services. There needs to be a rationalisation and streamlining of services based on evaluative measurements of effectiveness. A mechanism for auditing and evaluating the effectiveness of such services needs to be rolled out, and a body of knowledge to be built within an Irish context in the coming years. The Green Party advocates for a 1% annual increase for 5 years in the health budget to go specifically to mental health, targeting resources on the preventive measures, which have been shown to be the best cost saving strategy.

There is a need for further resources in the area of intervention when problems are at an early stage, e.g. when picked up in G.P. level The Green Party supports an expansion of HSE counselling in primary care, and similar psychological programmes to meet the needs of the general population, and not just those on medical cards. We advocate for the provision for access to public counselling and psychotherapy services which are part funded by the person seeking help where a contribution can be made.

The Green Party would welcome an analysis of how much money would accrue from the sale of dormant psychiatric hospitals. We would propose that any money raised from such sales should be ring-fenced for funding mental health care.

END

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Document Control

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Version	Project Phase	Date Released	Contributor(s)	Description
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