The Psychiatric Nurses Association

Submission to the National Economic and Social Forum (NESF) on Mental health and Social Inclusion

Introduction

As a society, even now and especially in the past we didn't recognize the need of particular groups or individuals in our communities, this is especially true of people with mental health difficulties. The Global Burden of Disease (2000) has clearly shown that psychiatric conditions such as depression, substance abuse, suicide, and violence in its many forms are adversely affecting the physical and mental health, quality of life, and overall functioning of a significant number of citizens worldwide. The Psychiatric Nurses Association identifies the urgent need to address the mental health care needs of individuals, families, and groups to improve their access to, and attainment of, quality mental health care in a variety of settings and environments.

Significant drivers of social exclusion such as low educational attainment, concentrations of worklessness, health inequalities, concentrations of crime and poor quality environments and homelessness need to be made priorities over the coming years if we are to consider mental health at a population level. Mental health policy must also

> *"deliver mental health activities capable of improving the well- being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems".* World Health Organization (2005)

A lot of money is spent through public services on the most socially excluded people. But much of this spending is directed at managing the symptoms of exclusion once problems have become entrenched.

Social Exclusion

Social exclusion happens when people or areas face a combination of linked problems such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime, bad health and family breakdown. It is often linked to the disadvantage they face at birth. This is of particular significant for those members of the population who experience mental health difficulties. Mental health problems affect one in four of the Irish population at some point in their lives (Expert Group on Mental Health Policy, 2006). In the not so distant past, in the mental health service there was a heavy reliance on curing the sick and the "management of illness" rather than focusing on promoting positive health and well being. Traditional approaches to mental healthcare delivery have ensured that service users have inherited a paternalistic approach to healthcare provision placing the patient/service user as a passive recipient of care. This has hindered mental health service users in their recovery and maintenance of "mental wellness".

Social exclusion is both a major consequence of and contributor to mental health problems (McDaid 2004). Anyone can be affected by mental health problems, but people from deprived backgrounds are at significantly greater risk. Often mental health problems can spark off a chain of events, such as loss of employment leading to debt, housing problems, and relationship breakdown. Identifying and tackling barriers to positive mental health is an important element in addressing the severity and specificity of the

multiple needs each person with a mental health problem faces, the complexity of their problems often makes it difficult for them to access or gain benefit from services.
The impact of mental health problems over time varies significantly. About half of people with common mental health problems are no longer affected after eighteen months, but lower socio – economic status, the long term sick and unemployed are more likely still to be affected. (Singleton & Lewis 2003). Approximately one – quarter of people with schizophrenia will make a good recovery with some form of treatment within five years, two thirds will experience multiple episodes with some degree of disability, and between one in ten and one in six will develop severe long term disabilities. (Bird 1999).Although severe mental health problems can be especially disabling, common mental health problems can also have a major impact on people's lives, however early intervention and a drive to maintain an individual's social support can prevent the cycle of social exclusion.

Throughout the history of mental health services in Ireland, psychiatric nurses have faced these issues on a daily basis, both working in the acute admission departments & in community settings, many of our members have articulated the deficits in the systems on an almost continual basis. Heretofore the psychiatric services coming from an institutional setting right through to present community services have provided a social service for those individuals often rejected stigmatized or ignored in Irish society.

As a representative body representing primarily psychiatric nurses, nurses working within the learning disabilities and general nurses working in specialist practice areas,
The Psychiatric Nurses Association welcomes the fact that the National Economic Social Forum has established a Project Team to examine issues of mental health and social inclusion. It endorses a collaborative model of care as recommended by the Expert Group on Mental Health Policy's report "*A Vision for Change"* (2006) a positive response to accommodate individual needs and differing contributions to people with mental health problems. The PNA supports the "Vision" espoused to in the report and embodied in the policy

"….to create a mental health system that addresses the needs of the population through a focus on requirements of the individual".

And its core values and principles must underpin the dimensions of equality and integration in this project's aim to identify and tackle barriers to positive mental health.

The PNA endorses the draft terms of reference prepared by the project team and in consultation with its members has identified underlying causes of social exclusion experienced by those with mental health problems as some of the following:

- Stigma & Discrimination. – Many people fear disclosing their condition even to family and friends. Stigma and discrimination are underlying causes of social exclusion and one of the greatest barriers to social inclusion. It was one of the issues highlighted continuously throughout the consultation process for *The*

Vision for Change policy (2006). Stigma and discrimination can affect people long after the symptoms of mental health problems have been resolved and often leading to relapses and intensifying existing problems.

- Segmentation of Services & Social Support Networks - People with mental health problems struggle to access basic services in addition often local groups within communities e.g. arts, sports, heritage are not aware how their services could benefit people with mental health problems and how they could make their services more accessible. The *All Ireland Survey on Social Capital and Health (2004)* reported benefits for health and mental health from social capital factors. Inadequate social capital was found to have an independent negative effect on mental health: a lack of neighbourhood trust, a high level of problems in the local area, poor level of local services, infrequent contact with friends and a lack of social support.
- Issues relating to Unemployment & Housing – Many people lose jobs that they might have kept had they received better support. Professionals not having the time, training or local contacts to help people move into work. There is little prospect of accessing work for people whose housing is unstable .People with mental health problems are particularly likely to have vulnerable housing. Some sectors of the population have higher rates of homelessness.
- Lack of resources / investment in the concept of mental health recovery and prevention.- *The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* set out standards of care to be observed in psychiatric hospitals – under funding heretofore has brought the standards of facilities in Irish mental health services into question. Moreover funding has not been distributed effectively or according to need The *Vision for Change(2006)* recommends considerable investment in the mental health services in addition people with mental illness / disorder want to be treated as persons of worth and dignity, who have the right and ability to aspire to goals that they choose, not those chosen for them. Involving service users in mental health services goes beyond simply carrying out a consultation process. Service users must be at the centre of decision making at an individual level in terms of the services available if we are to adhere to the principles of recovery.
- Lack of previous government policy to support families/ carers / communities – Social isolation is an important risk factor for deteriorating mental health and suicide. Mental health problems can have a particularly strong impact on families- both financially and emotionally.

Stigma

Cultural meanings of mental illness have real consequences in terms of whether people are motivated to seek treatment, how they cope with their symptoms, how supportive their families and communities are, where they seek help, the pathways they take to get services, and how well they fare in treatment. Stigma creates fear and so makes it very difficult for people to seek help if they need it. People with mental health problems may at times have difficulty coping with the tasks and interactions of daily life. Their disorder may interfere with their ability to feel, think or relate to others. Most people with mental health problems are not violent. One of the main obstacles they face is the attitudes that people have about them.

The "cultures of silence" has helped create significant barriers for people who wish to use the mental health services. Many of our members have reported particular problems in rural areas where community psychiatric nurses are recognised when calling to service users' houses and confidentiality/subtlety within the neighbourhood is less than ideal.

In addition the situation is sometimes made worse by some branches of the media who use negative and emotionally charged words to describe individuals or conditions.

Are we tapping into the various types of community energy and capability in an effort to address stigma & discrimination?

One of the more poignant remarks made as part submission to the Expert Group in the *Vision for Change (2006)* stated

"a mental health system that has mental health as its goal, not mental illness as its obsession , is far more likely to counter stigma". Expert Group on Mental Health Policy (2004a)

Currently many of our members are engaging in various responses at a local level to combat stigma. Psychiatric nurses across the board are involved in activities such as Mental Health Association, public speaking campaign within schools, they are involved in information sharing networks both with voluntary organisations , parent's council's, youth organisation's ,clubs, and other statutory services within communities.

Many suggestions have been made in an attempt to combat stigma, both to the Expert Group in the Vision for Change 2006and to the Mental Health Commission. Included in these suggestions are, there needs to be an active mental health promotion campaign using the media and high profile people who have experienced mental health difficulties.

People also need to be trained in self awareness to help them identify their own mental health difficulties. Parents, teachers and others need to know how to identify children and adolescents suffering distress.

Effective mental health promotion needs to identify the right messages to give to a wide range of audiences e.g. school children, teenagers, lone parents, people living alone and so on. Psychiatric nurses will continue to contribute to this agenda drawing from evidence base and clinical knowledge combined with core knowledge of their working environment and potential audiences.

Finally it has been drawn to our attention by members that there are ongoing concerns about the extent to which insurance companies risk and outcome information is based on the real experiences of people with mental health problems, and whether staff have

enough knowledge of mental health issues to assess applications. This needs to be addressed as a matter of priority, people with mental health problems could struggle to access basic financial services as a result of their mental health problems.

Suggestions

Mental health needs to be integrated into ordinary medical centres in order to reduce stigma. But also promote opportunities for the wider community to access mental health service facilities, e.g. use facilities for evening courses or concerts

The PNA supports the roll out of Primary Care Teams as part of the *Primary Care Strategy (2001)* which will provide the expertise of clinical nurse specialists interfacing with service users as part of an overall holistic approach to care in the community environment.

Resources to raise awareness of stigma and discrimination towards people with mental health problems, including a focus on ethnicity and gender need to be made available by the Department of Education for use within the SPHE programme in schools.

Prevention and Recovery

Heretofore and still unfortunately the manner of delivering services have made it difficult for disadvantaged people to make contact or benefit from available provision. Services may not be accessible, may not be perceived as appropriate or may not meet clients complex needs.
High need individuals may lack basic skills, have mental health problems, be misusing substances and be at risk of debt or homelessness. Yet they are often also unable or unwilling to navigate their way through public services to get the support they need. Their contact with services is instead frequently driven by problematic behaviour resulting from their chaotic lives- such as anti social behaviour, criminality and poor parenting- and management revolves around sanctions such as prison, loss of tenancy and possible removal of children. The cost of this chaos is high. At the same time, their poor outcomes continue, causing harm to themselves, their families and their communities.
There needs to be clear responsibilities and tailored responses for those with chaotic lives and multiple needs. Many submissions to the Expert Group on the Mental Health Strategy A *Vision For Change (2006)* said that a partnership between service users, service providers and public and private funded bodies was necessary in the successful organisation and delivery of a new mental health service. A true shift to a community oriented model requires a change in culture and systems described and purported to in *A Vision For Change (2006).* The culture must change from illness focus to person centered and recovery focus, which requires a shift from mental illness to mental health. Psychiatric nurses see the service user in the context of their family, their work and leisure pursuits, as members of their neighbourhood and the wider community. Consistency of care delivery and meeting the needs of service users/ relatives is the ultimate aim of all nurses, however "first class accommodation is needed" if community care is to be successful. This requires significant capital funding.

In addition scoping work is required to ascertain a better understanding of:

- The lifetime costs and current service use of people who are frequent users of multiple services
- What is already being done by local areas to improve outcomes for people with chaotic lives and multiple needs and what current structural issues hinder local agencies in working together?

It must be ensured as laid down in *The Vision for Change (2006),* service users become self advocates and involved in policy making. Peer support is also vital.
A client centered approach is critical, with individual tailored help and support that can address different sets of multiple needs through a single phone call or one stop shop. The key worker approach within multi disciplinary teams as recommended by the Mental Health Commission would help individuals understand what services and benefits are available and negotiate access to a range of options.

User involvement in the design and delivery of services is also recommended by the Expert Group on Mental Health Policy 2006 and the Mental Health Commission. The literature is clear that the involvement of patients in their own care is beneficial. The

philosophy of "normalisation" places emphasis on the fact that people with mental health problems should have the right to enjoy a decent life, as normal and as full as possible. These changes now place greater emphasis on social inclusion, empowerment, community adjustment, advocacy (whether it be self advocacy or citizen advocacy), and person centred planning. It must be clear that individuals have a right to take up opportunities that are available, but also that alongside rights come responsibilities for the service users. We need to aim for a more balanced approach between preventative and remedial support.
The Health service Executive in its first Corporate Plan 2005 – 2008 lists four corporate objectives for care delivery1 which endorse a person centred approach and commitment to listening to service users.

As part of this process the Health Service Executive has established a number of Expert Advisory Groups to advise on the organisation and development of health and personal social services in a number of areas. The purpose of an Expert Advisory Group is to bring the expertise of the clinical and health community and the voice of patients / clients and service users to a more influential role within the HSE.

In order to provide flexible opening hours to enable people in employment, or who have other commitments during the day to access services the PNA is of the view that building capacity at the front line is essential. This will go some way to ensure that good services are tailored to complex multiple needs, and championing the voice of those with mental health problems at all stages of the delivery chain.
The PNA has long since held the view that people need access to help 24 hours a day, seven days a week and that the service users should have a choice about the services he/she wants to access. Nurses recognise the importance of families and carers in the treatment and well being of service users and their involvement in all stages of treatment if the service user so wishes. Quite often as a result of the therapeutic relationship the psychiatric nurse has established he/ she is well placed to ascertain the level of input the service user may desire and levels of confidentiality within the person's close network.

"It will require a change from institutional warehousing of the mentally ill to a proactive community integrated approach". Expert Group on Mental health Policy (2004a)

The PNA holds the view that ultimately this project must promote multi agency working to address multiple problems. We believe that services should be incentivised to work around individuals as opposed to individuals working around the service. This will allow for professionals to provide a coordinated and personalised response that is based on a full understanding of an individual's problems .Initiatives such as linking with probation

[1] We will improve people's experience of our services and their outcomes through developing, changing and integrating our services, in line with best practice.
This means that our services will be person centred, offering choice wherever possible. We will support individuals and their families to be actively involved in decisions about their health and care.
We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users patients, staff, not for profit / Voluntary / Community sector and other stakeholders. This means that we are committed to listening and learning from the experience of our service users partner service products, staff and other stakeholders.

services to support the person with resettlement difficulties and consider issues such as employment, housing and family ,training on vocational and social issues is also required with the other agencies involved in an individual's care i.e. staff in organisations such as Fas, social welfare, housing, community care etc all of which should support an integrated programme of care.
However key barriers which currently inhibit this approach need to be addressed, problems such as:

- Cultural barriers to the sharing of information
- Uncoordinated geographical boundaries between service providers
- Separate budget problems, often referred to as downstreaming it is the experience of some of our members that often mental health services incur the cost of intervention, while another service benefits from the saving. Examples such as responsibility for improving the educational attainment of a child diagnosed with Attention Deficit Disorder lies with the department of education, but the cost of failure tend to be picked up by mental health services, criminal justice services, or indeed community care services.

There is approximately 6,000 psychiatric nurses involved in delivering mental health services in Ireland. A significant proportion of our members are still involved in health treatment and care in an inpatient setting. This requires working in a specific way and not usually in a multidisciplinary team. This has serious implications for training and education.
The ideology of community based multidisciplinary service provision conveys many benefits to both service users and the mental health professionals working on the team, however the PNA is of the view that consideration must be given to ensuring adequate training both at undergraduate and post graduate level is included for all members of the proposed teams. As we embark on a new era with new legislation and policy a combination of measures are required to ensure the effectiveness of the proposed multidisciplinary teams, these will include team development training, management skills, communication skills, IT skills and formulation of policies and integrated management systems all of which will require capital expenditure both in the initial stages and ongoing in the teams lifespan.

Homelessness

People can find themselves homeless for a variety of reasons such as drug addiction, alcoholism, disability or lack of family ties. Being homeless makes it very difficult for people to access mental health services; such is the catchment area structure of mental health service provision. People in this situation need proper housing with the appropriate supports

People with mental health problems are one and a half times more likely than the general population to live in rented housing, with higher uncertainty about how long they can remain in their current home. Many people with mental health problems feel that they are

not offered the same choices as other people when seeking a new home, and they are frequently obliged to take hard to let accommodation. In the age of the Celtic Tiger it has been the experience of our members that very often they find themselves on domiciliary visits calling to service users who in live sub standard accommodation in unsatisfactory living conditions.

The Commission on the Status of People with Disabilities defined housing as "the base from which people participate in society and can reflect as well as dictate their level of participation". Responsibility for social housing is within the remit of the Department of the Environment and Local Government. However, it is local authorities who directly administer most of the public housing schemes in Ireland. Grants and funding related to housing and accommodation are either through these bodies or the Department of Social and Family Affairs.

The PNA urges a note of caution in relation to the Expert's Group view that local authorities take responsibility for housing those individual's with mental health problems in the future. Unless adequate funding for such housing is made available, this policy is doomed to failure. It is our view that vulnerable adults with mental health problems should be housed in more mature settled areas, in the past there have been difficulties for this group in newer areas especially at the onset when the area is struggling to get established. In addition we would recommend the inclusion of our nurse specialists as members of the decision making housing committees, we feel they have a wealth of knowledge to contribute, both clinically, geographically and in the overall demographic profile of an area, in addition this would also enable the liaison process between health and housing services.

The PNA puts forward the following suggestions for staff within the housing and mental health services

Housing Services

That staff liaise with mental health services so that they are aware of local mental health facilities, and build links between services.

That staff in housing departments work with residents and mental health professionals to ensure that tenancies are sustained by providing clear advice on such matters as benefit entititlement and by ensuring appropriate support services are put in place.

Mental health training be made available to better understand the needs of this client group- People with mental health problems should be involved in the delivery of this training.

Mental Health Services

An individual's housing situation should be examined when they first access a mental health service by a designated member of the MDT. If that individual is homeless they

should be referred to the local housing authority however and a designated member of the team work with housing services to address and support their needs.

Mental health Services already offer informal support to housing services. While this needs to continue formal support structures should also be established such as referral protocols .

Regular meetings/good practice forums between housing and mental health services will increase a greater understanding of each other's roles, pressures and priorities.
Implementation of joint training to raise awareness of, increase understanding and deal with mental health problems and housing/support needs should also be invested in.

The development of agreed joint protocols between services on hospital admissions and discharges so that people with a mental health problem who might be homeless or vulnerable to homelessness are identified and their support/housing needs are addressed as part of a planned discharge.

Education
Involvement in learning can have a positive effect on someone's mental health. In addition to acquiring new skills, learning can promote confidence and give people a greater sense of purpose. It allows people to meet other students and make new friends, and access to better jobs and housing. however particularly at the outset, it may be necessary to provide additional support, especially if the student is moving away from home to study and having to form new support networks. All learning institutions need practical and user – friendly mental health policies, along with a holistic approach towards mental health. In addition staff in the institution also require training and education to raise awareness about the needs of learners with mental health problems, and confidence in working with this group. This would include looking at issues such as a
focus on early intervention rather than crisis intervention myth busting information sheets to de mystify mental health.
Psychiatric nurses are well placed to deliver on such programmes, as there has been much collaborative work carried out since the introduction of the nursing degree programme to third level institutions. The PNA welcomes the opportunity for staff especially nurses to improve on these links between education and health to ensure easier referral routes to the college, and to ensure that learning can take place as part of an individual's overall care package.

<u>Employment</u>

Evidence (Crowther et al 2001) shows that people with severe mental health problems can and do want to work but often those who are in contact with mental health services do not receive any help to find work although they state they would like to receive it. In addition job search must be driven by the individual's choice and preference, and not based on availability of sheltered employment in an area.

Under the Employment Equality Act 1998 and 2004 employers have an obligation in terms of recruitment, retention and rehabilitation of people with disabilities. This definition is quite broad as it includes a wide range of physical, psychological and social disorders as well as applying to previous disabilities, current disabilities and those which may exist in the future

The Guidelines on Equal Opportunities Aspects of Employing People with Disabilities Health Service Employers Agency (2006) seeks to encourage employers to look beyond their legal requirement and use best practice to accommodate the needs of people with disabilities. These are of particular relevance in the context of this project and its work when addressing the major difficulty of those individuals with mental health problems. The Psychiatric Nurses Association is aware from discussions with its members that there is a pervasive fear among people with mental health difficulties especially service users that they will not be accommodated within the working environs / entitled to the same rights and entitlements as other staff. In addition individuals have a fear of losing benefits, i.e. social welfare, medical cards etc.

The following points taken from this document are significant, both from a strategic position and of relevance to working professionals in mental heath service delivery who actively encourage service users back into the workforce.

The Disability Act 2005 is a positive action measure designed to advance and underpin participation by people with disabilities in everyday life.

It establishes a statutory basis for mainstreaming.

Mainstreaming places obligations on public service providers to support access services and facilities for people with disabilities to the greatest possible extent. The Act contains several provisions to promote mainstreaming. They include an obligation on public service bodies to be pro- active in the employment of people with disabilities. The Act also gives legal status to the 3% target for the employment of people with disabilities.

<u>The Duty to make Reasonable Accommodation</u>

The type of reasonable accommodation required must be determined on a case – by – case basis to meet the scientific work – related needs of the individual. This may be done as part of the pre employment medical assessment stage in consultation with the Department Head and prospective employee. The purpose of the pre employment medical is to assess the capability of the person to perform the full range of duties of the job and not "fitness" in general. Where the individual has an impairment or mental health difficulty which may impact on his/ her ability to do the job, the onus is on the employer to make "reasonable accomodation"to facilitate that person.

Under the Act the employer is required to take "appropriate measures" to enable a person who has a disability to have access to employment, to participate or advance in employment or to undergo training "unless the measures would impose a disproportionate burden on the employer". A record of adjustments made for employees with disabilities should be retained to inform future actions and allow for evaluation and review.

In practice "appropriate measures" means effective and practical measures, where needed in a particular case, to adapt the employer's place of business to the disability concerned, including:

- The adaptation of premises and equipment;
- Patterns of working time;
- Distribution of tasks or the provision of training or integration resources

The HSEA –EA's document also recommends consideration should be given to proactively seeking applications from people with disabilities i.e. positive action. It advises that advertisements be placed with training placement officers, supported employment programme offices or specialist agencies where they are more likely to be seen or brought to the attention of people with disabilities who may be interested in applying. In order to encourage applications from people with mental health difficulties who do not wish to work full- time the terms and conditions that currently apply to the job should also be reviewed in order to identify the scope for greater flexibility. These could include reviewing traditional attendance arrangements and consider whether request to work part- time or atypical hours can be facilitated, allowing absences during work hours for rehabilitation, assessment or treatment, making changes to work hours making reasonable adjustments to the duties of the job. Equally it is important to maintain regular contact with employees who are absent due to injury / mental health difficulties in order to establish whether any assistance can be provided to facilitate the person's return to work or thereby maintain employee morale. The social aspects of the work environment are equally important and every effort should be made to include the individual in lunch breaks and social activities. A buddy system, where experienced members of staff are responsible for integrating new members of staff is one option which might be explored. Equally it is important to create awareness amongst existing staff of their role in helping the new employee to settle in to the job and feel part of the team.
Training for staff in issues relating to mental health is necessary to promote communications, challenge preconceived ideas and stereotypes and foster a positive working environment in which the individual can realize their potential.
Employees with mental health difficulties should enjoy the same opportunities as other staff to develop full and rewarding careers. Like all other staff they are entitled to be considered for more demanding work or greater responsibility based on clear and objectives assessments of their aptitudes and abilities and encouraged and facilitated to maximise their experience in a range of activities within their employment.

The PNA recommends the inclusion of a designated member of the multi disciplinary team to provide vocational support, with employment an integral part of the overall care plan. Continual assessment of people's needs with support adjusted as necessary and assistance in career progression must be an integral part of this individual's remit. In addition training on the positive effects of employment on mental health by supported employment providers, people with mental health problems and successful employers (credible champions) should be incorporated along with job swaps/work shadowing

between health and social care and Fàs staff to increase understanding about respective roles and the opportunities available
Promoting enterprise and self-employment is another alternative approach. Quite often people with mental health difficulties are attracted to self employment. This again is a role for that designated member of the MDT team to take on board as part of an overall care package.
A coordinated response to this issue might also include innovative approaches such as regular meetings between Fàs and Community Mental Health teams in each locality. Outreach- Fàs staff/ Community Welfare Officers providing advice in health settings such as psychiatric units, day centres, etc.

Supports

Strengthening Communities

> *"The emphasis in government action has, been on uniformity of services, universality of access and centralized control over allocation of resources allied to enforced accountability of those in receipt of State support."* Healy (2005)

The complex nature of mental illness and the diversity of environments in which people come from require a serious approach to empower citizens and communities. The "one size fits all" model is no longer a viable option and undermines the motivational base for contributors other than state bodies. Letting go of excessive and over-detailed control is intrinsic to valuing, rewarding and recognizing community's effort and achievements and has an important impact on capacity of individuals and groups to play a more effective role in society. Local strategies have the flexibility and the knowledge to take into account rural or geographically dispersed populations or services, the age/ethnicity profile, transport links and areas of deprivation.

It is commonly accepted that networks represent a potentially powerful lever for change (Pettigrew et al, 1992).They create a channel for knowledge to cross boundaries created by workflow, functions, organisation, professional discipline, geography, and time. They provide the means to move local know- how to collective information and promote the uptake of beneficial practices across operations and regions.

"Social Capital" measured as inter – personal trust, social support and number of friends is a strong correlate and important explanatory variable of subjective well – being
This is confirmed in research including analysis of data from a survey of adults in Ireland (Healy, 2005.)

Effective communications play a significant role in supporting people and partnership working to improve services and outcomes for people who use services and their families.
Communication technologies particularly the internet and mobile communications have had a significant impact on our ability to develop partnerships and form networks with

others. These technologies support increased capacity for partnerships, coordination and knowledge (Tuomi 2002)
"Knowledge Community(KC)" developed in partnership with key stakeholders and the National Institute for Mental Health (NIMHE) in the United Kingdom is an example of a people focused solution to support knowledge sharing and learning across diverse communities of practice and interest lead by the public sector .The KC enables people across health and social care to find and connect with other people and information to contribute to the improvement of services and the well being of vulnerable people. People use the KC to establish groups which supports networking activities. People come together to plan and develop shared work together more effectively. People also debate, review and recommend what works in practice.

Also in the UK, the Care Services Improvement Partnership (CSIP) is commissioned by the Department of Health and other agencies to help services implement national policies for local benefit. Included in their main objectives are to support community based action to improve health and wellbeing and system reform, the way in which health and social care fit together to achieve a more joined up experience for people. By doing so they work to support effective partnership working, policy implementation, service improvement and people and outcome focused change.

Effective collaboration improves the experience and outcome of care for people, and also benefits team members themselves and the organisation. (Borrill et al, 2002; NCEPOD, 2002). Networks and strategic partnerships enable local, regional and national teams to coalesce around common issues and lack of joint working at local level has been one of the key reasons for lack of progress in delivering sustainable social economic and improved public services that meets the needs of local people within their communities who experience mental health difficulties. A combination of organizations and the community working together, co operating will have a greater chance of success.

The PNA is of the view that self organising networks , alliances and other forms of collaborative working play a significant role in how we improve services and outcomes for people an their families with mental health problems. They deliver collaborative advantage. The PNA believes that a local strategic partnership model / framework in communities should be the starting point towards collaborating services with a similar philosophy as advocated by the CSIP. Such partnerships are key to tackling deep seated multi faceted problems experienced by people with mental health difficulties requiring a range of responses. In addition the PNA recommends the development of newsletters, intranet to keep people informed of any changes to services where services do not operate from a fixed building/ base.
To date psychiatric nursing has in essence been at the frontline in attempting to advocate on behalf of service users, and cultivating mutual help and self help. They are indeed an expert resource when it comes to forming collaborative strategic partnerships in the future. Community Mental Health Nurses will play a vital role in such partnerships, in terms of combining local community knowledge and profiling individuals with mental health problems who may require assistance from various services. They are intrinsically

linked at the interface of communities and at the “nerve centre” to identify unique community “capabilities”.

Conclusion

If we recognise human need and potential we must also respect it. Respect for people should be at the heart of every public policy and community initiative. The creation of formal links with all areas involved in the individual – community care, child and family services, health promotion, public health, drugs services, acute services and education is essential in addressing equality and disadvantage dimensions to social inclusion.
In addressing barriers to positive mental health , it is paramount we see " capabilities" not "needs" only across the social spectrum , from the individual, right through to his immediate support network right across the local community into the national agenda on social inclusion.

The PNA welcomes this renewed drive to improve the life chances and opportunities of the most disadvantaged and "hard to reach" in society.
The roll out of this project is timely as we go forward with the implementation of a new national mental health strategy, ultimately we must focus on reducing and preventing the harm and cost caused by social exclusion to individual's their families and communities. The PNA is of the view we need a radical revision of our methods for tackling social exclusion for people with mental health problems. We need to personalise our services, be more persistent and coordinated, and fit them around the needs of individuals if we are going to tackle one of the most complex issues in today's society. Tailored help is needed to address their needs, and passing vulnerable people from service to service is good neither for them nor for the wider community. Primarily the approach taken should entail early intervention, systematically identifying what works; better co-ordination of the many separate agencies; personal rights and responsibilities; intolerance of poor performance, and fundamentally changing the way we deliver and support those who are at their most vulnerable in times of crisis. We need to explore how to extend data sharing in relation to multi agency working. In addition we need to accelerate measures to encourage employment for those suffering from more severe mental health problems, including the encouragement of individual placement and support approaches and anti stigma employer base campaigns. Successful approaches to preventing homelessness rely upon identifying the key signs that the individual is at risk of losing a tenancy-be it mental health problems or loss of employment. Anticipating the risk and then intervening is the way forward, as previously mentioned a designated member on the multi disciplinary team with a strong focus on issues of employment, housing and life coping skills is considered by the PNA as a positive step towards integration of services and enabling the recovery process.

A vital tool of successful multi agency working is the use of information and communications technology (ICT). These have helped to increase efficiency and productivity in the private sector for some years. The potential is there to go further for ICT between public services to improve service delivery.

Government needs to promote transparency of the downstream costs associated with mental health problems and social exclusion.

This project offers an opportunity for the least advantaged, so that they enjoy more of the choices, chances and opportunities that the rest of society takes for granted.
We as a professional organisation look forward to evolvement of the NESF project and its work; we value the opportunity to contribute to the agenda of equality and integration for people with mental health problems going forward.