



Horatio input in the EU regarding the development of the EU Mental Health Pact, Issues in Mental Health of Young People and the Contribution of Nurses in Youth Well Being

Martin Ward RMN, Dip Nurs, RNT, Cert Ed, NEBSS Dip, MPhil Chair, Horatio European Expert Panel of Psychiatric Nursing, Director, MW Professional Development Ltd UK, *Co-ordinator Psychiatric Nursing Studies programmes – University of Malta.*

Roland van de Sande, MSc.In Nursing, PhD candidate, Horiatio/European Psychiatric Nurses. *Senior Lecturer, Hogeschool Utrecht, University of Applied Science, Department of Nursing Researcher / Practice Development Nurse, Bavo-Europoort Mental Health Trust, Rotterdam*

Introduction

From the start Horatio has contributed in the development of the EU consensus paper on child and adolescent mental wellbeing, was invited in the EU high level conference in Brussels in June of 2008 where an EU-wide pact will be launched by Health Care Ministers. This is the route that the EU Health Commission has chosen for the next stage of the original EU Green Paper on mental health (EU 2005). We would see our aim as working complementary with other disciplines to ensure the roles and responsibilities of specialist psychiatric nurses, properly trained and resourced, are protected and made central to any strategic proposals. Whilst some might argue that other clinical professions offer similar therapeutic interventions to children in need of mental health care it is the nurses' unique relationship with such individuals that enables them to connect more effectively and engage in more assertive treatment management. If eventually a role that combines psychotherapeutic interventions and case management should emerge from these discussions, and the eventual pact documents to be launched in 2010, then this at least would provide an indication of the place psychiatric nursing within the multi-agency model.

Identified problems

Whilst there have been a plethora of recent reports, declarations and policy initiatives indicating that mental health generally is seen as an important area for development the fact remains that the one subspecialty which lacks any real continuity of approaches is that of child and adolescent mental health (EU 2004). The Florence Declaration (ESCAP 2007) stated that 80% of young people in Europe report good psychological wellbeing but that one in five has cognitive, emotional or behavioural difficulties and a further one in eight suffer from a diagnosable mental disorder. As an example of this the mean average of adolescents in Europe who do not complete their formal education is approx 15% (Fryers 2007) – with 80 million people world-wide being totally illiterate - whilst figures for crime amongst youth offenders has tripled in the last decade (Home Office 2008).

The Mental Health Foundation (2006) indicate that the number of suicides in young people in Northern Ireland has overtaken road accidents as the main cause of deaths whilst also stating that

an estimated one in 17 adolescents may be self harming in some way. In addition to these statistics, indicators in other, non-clinical, domains show that education, social networking, the law and family life have all been casualties of a growing downward trend in youth mental health. The Irish National Office for Suicide Prevention (2007) has the following explanation for this phenomenon; due to threats of stigmatization juveniles are rarely engaged in mental health support pathways which can result in a critical delay of early recognitions of warning signs (Kerkhof, 2008). For this reason the increased presence of clinical nurse specialists in child and adolescent services is urgently needed. Those specialist professionals are trained to integrate complete psychosocial and psychiatric assessment, brief interventions such as cognitive behavioral or problem solving interventions and provide consultation and (family based) counseling activities.

In several European countries the number of nurses with mental health specialist training at advanced and academic level are on the increase. Those scientific practitioners are able in to work in relative autonomous practice and serve the whole workforce with evidence based input in day to day practice. By integrating assessment expertise, problem solving interventions, consistent medication management and evidence informed practice those professionals can make the difference in the improvement of clinical decision-making in the monitoring of high risk patients (van de Sande 2007, van der Plas et al, 2010). In several countries community based care psychiatric nurses play a key role in the early recognition of alarming symptoms and the long term monitoring after suicide attempts or self harming behavior. An outreaching assertive approach of qualified community psychiatric nurses is especially needed in case of the following present risk factors; lack of insight, lack of social support, chronic drug and alcohol abuse, and difficult to engage in supporting services (Mulder et al 2005, van de Sande 2007). Systematic follow-up of discharged involuntary admitted patients is crucial to prevent severe and stigmatizing escalations in the community (Salize & Dressing 2005).

High incidences of PTSD, ADHD, substance misuse, eating and conduct disorders and suicide associated with depression all show a marked upward trend in young people in Europe. However, reports show that clinically ill individuals are not necessarily the main problem but rather those who are suffering the consequences of increased stress due to the pressures of their daily lives.

These stress factors include:

- Bullying
- Emotional stress
- School fear
- Bereavement
- Boys and girls issues
- Pregnancy and sex education
- Child abuse
- Child carers
- Emotional literacy
- Exam stress
- Racism
- Peer support
- Refugee issues
- Families
- Broken marriages
- Stigma
- Gay and lesbian issues

In young people the absence of appropriate coping and decision making skills seem to be the primary cause of concern. There is also evidence to suggest that physical health too is deteriorating amongst certain young age groups, specifically in the area of obesity, respiratory diseases and diabetes. Thus the balance between the sociological, psychological and physical wellbeing of a high percentage of European youth is negatively affected by their ability to lead a mentally healthy life, or lifestyle. Nurses have since decades provided holistic care and this largest workforce in healthcare is crucial in ensuring the continuity of care.

Whilst it is true that their physical health and even social abilities may improve with age, we know that developmental psychiatric disorders rarely have a spontaneous remission and may cause social adaptation or mental disorder in adult life if not diagnosed or treated in childhood. Furthermore, European research tells us that even in the most extreme of circumstances when we do treat young people in-patient psychiatric settings we cannot really predict the outcome of such care (Hoger et.al. 2002), therefore low threshold monitoring of e.g. community psychiatric nurses can be of great value. The importance of monitoring as such is stipulated by findings that individualized early recognition and early interventions in psychosis and depression can result in a more favorable course of psychiatric illness (Lappin et al 2007). Severe untreated psychiatric symptoms are often reported in the phase of adolescence, often those symptoms are presented in the spectrum of behavioral problems to social and healthcare services. A similar tendency is reported in untreated anxiety disorders in the critical development stage in adolescence (Henning et al 2007). Therefore proficient psychopathology knowledge of nurses can combat the delay of adequate treatment. At present across Europe several initiatives are in process to promote more psychiatric orientated components in basic nursing training and continuous education.

The situation is further exacerbated because as young people change and grow so rapidly there are high co-morbidities between disorders and the propensity of one condition to change into another makes our present diagnostic system extremely questionable. In this sense it is important to view childhood mental health issues, no matter what their cause or intensity, as being lifespan issues. So, mental health problems prevented or effectively dealt with in childhood may prevent social impairment and social exclusion for life. Resolving mental health problems in childhood is therefore cost effective in the long term because they have less chance of becoming long term chronic mental health problems in adulthood whilst allowing the individual the opportunity to lead a satisfying and independent life.

Dealing with these issues

Whilst there are a considerable number of screening, monitoring and treatment modalities that can be adapted to child and adolescent care most authorities agree that no one approach covers every eventuality. Additionally, national care structures and philosophies can only be successfully employed EU-wide if adapted to fit host nation systems (Klosterkotter 2005). For any health or social care option to have good outcomes it would seem that it cannot function independently of other options. Any strategy for the prevention and treatment of childhood mental health problems has to integrate a wide range of different factors, including:

- Cultural factors, e.g. child poverty and human rights
- Developmental factors, e.g. identity and self confidence
- Age factors e.g. decision making and interpersonal skills development
- Social factors, e.g. family, friends and community networks
- Personal factors e.g. emotional literacy, sexuality
- Clinical factors e.g. evidence-based knowledge, treatment options, psychopharmacology
- Risk factors e.g. self harm, aggression toward others, suicide, abuse

- Multi-agency factors e.g. health, social and education service collaboration
- Legal issues e.g. youth and mental health legislation
- Research issues e.g. ethical considerations, outcomes analysis, dissemination
- Resource factors e.g. personnel and specialist training

What is clear is that health promotion, prevention and treatment options have to be properly coordinated whilst collaboration between agencies and the whole of the youth support system has take place to achieve successful outcomes for child and adolescent mental wellbeing.

The role of psychiatric nursing

The necessity to provide specialist psychiatric nurses to contribute to this agenda is undeniable. It is probably the case that these nurses cannot contribute much of the educational, health promotional or even screening activities, but their presence in liaison consultation, treatment, support and health monitoring is vital. Nurses from a psychiatric background, with child and adolescent post registration training, should be in place to provide the coordination and treatment management for care pathways and dedicated interventions with a nursing perspective. A nurse specialist is trained to integrate multi-level risk assessment, psychosocial interventions, somatic monitoring and medication management (van de Sande 2007). This calls for the development of specialist training programmes and raises questions about the availability of such resources, and their develop and expansion across EU countries. Continuity of academic and professional development for basic level psychiatric nurses within the member states is still far from being a reality (Nolan & Brimblecombe 2007). At the moment we only have the WHO curriculum as a baseline resource (WHO 2003). Creating a training and skills development programme that could be accessed throughout Europe is not beyond the scope of an institution or agency with current involvement in psychiatric nurse education. However, such a programme would need to be structured in such a way that it incorporated the multi-agency collaborative approach and factors listed above. Again, this is achievable but demands the motivation from some source or another to implement it. This may be possible through some form of multi-professional and/or cross agency generic training.

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