Mental health interventions

3

What are you finding out?

In this chapter we look at the diverse needs of people with mental health problems and focus on the key principles for supporting individuals. The main service interventions within mental health are addressed together with a discussion about their strengths and limitations. In addition we will look at the barriers an individual may face in accessing interventions.

The reading and activities in this chapter will help you to:

1. Explain the following key principles for working with an individual to identify their needs:
   a. needs-led not service-led approach
   b. person-centred
   c. promoting self-direction
   d. focusing on strengths, hope and recovery.
2. Describe the range, complexity and inter-related nature of the following needs:
   - physical
   - practical and financial needs
   - social
   - psychological/intellectual and emotional
   - cultural
   - spiritual.
3. Explain how diversity and difference may influence the identification of needs.
4. Describe the strengths and limitations of the main interventions that are used within the mental health system and explain how an individual may access a range of intervention options in their local area:
   a. medication
   b. electro-convulsive therapy
   c. talking and other therapies
   d. psychosocial interventions
   e. complementary
   f. spiritual and religious support
   g. arts therapy
   h. physical activity and diet
   i. self-management approaches and social prescribing
   j. peer support
   k. work, education and volunteering
5. Explain the strengths and limitations of the main service interventions in mental health:
   - in-patient treatment
   - home treatment
   - crisis services
   - assertive outreach.

6. Explain the barriers an individual may face in accessing a range of intervention options in their local area and identify factors that may underpin the choice of intervention from the point of view of service users and mental health practitioners.
7. Explain the importance of the key principles in selecting interventions in relation to:
   - individual needs and wants
   - avoiding unwanted effects
   - equality of opportunity
   - promoting social inclusion
   - a collaborative approach
   - sharing information
   - strengthening networks of support
   - anticipating setbacks and promoting problem solving
   - focusing on recovery.

Assessment criteria covered in this chapter

Reading this unit and completing the activities will provide you with the knowledge, understanding and skills required to meet the assessment criteria listed below.

City & Guilds Level 3 Diploma in Mental Health Care (QCF) (600/5241/7)		
Understand mental health interventions (R/602/0153)		
Learning Outcome 1 Understand the needs of people with mental health problems.		
Assessment Criteria	Page reference	Activity

1.1 Explain the following key principles for working with an individual to identify their needs:
    a.   needs-led not service-led approach
    b.   person centred
    c.   promoting self-direction
    d.   focusing on strengths, hope and recovery
	p. 46	Evidence activity 3.1, p. 48

1.2 Explain how a person with mental health problems may have needs in common as well as individual needs	p. 48	Evidence activity 3.2, p. 50

1.3 Describe the range, complexity and inter-related nature of the following needs:
    a.   physical needs
    b.   practical and financial needs
    c.   social needs
    d.   psychological needs
    e.   cultural needs
    f.   spiritual needs
	p. 48	Evidence activity 3.2, p. 50

1.4 Explain how diversity and difference may influence the identification of needs:
    a.   gender
    b.   age
    c.   culture
    d.   beliefs
    e.   sexual orientation
    f.   social class
    g.   ability
	p. 50	Evidence activity 3.3, p. 52

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Learning Outcome 2 Understand the strengths and limitations of the main interventions in mental health		

2.1 Describe the argument for and against the two main physical interventions that are used within the mental health system:
  a. drug treatment
  b. electro-convulsive therapy
	p. 52	Evidence activity 3.4, p. 58

2.2 Explain the strengths and limitations of other interventions that may be available to people with mental health problems:
  a. complementary/alternative approaches for example acupuncture, reflexology
  b. 'food and mood'
  c. self-management approaches
  d. talking therapies
  e. arts therapies
  f. peer support
  g. social prescribing (eg bibliotherapy, green gyms)
  h. work, education and volunteering
  i. spiritual support
	p. 52	Evidence activity 3.4, p. 58

2.3 Explain the strength and limitations of the main forms of service interventions in mental health:
  a. in-patient treatment
  b. home treatment
  c. crisis services
  d. assertive outreach
	p. 58	Evidence activity 3.5, p. 61

2.4 Explain how an individual may access a range of intervention options in their local area	p. 52	Evidence activity 3.6, p. 61

2.5 Explain the following barriers that an individual may face in accessing a range of intervention options in their local area:
  a. service or professional bias
  b. financial barriers
  c. equalities issues
  d. availability
  e. physical access
	p. 58	Evidence activity 3.6, p. 61

Learning Outcome 3 Know the key principles and factors that underpin the choice of mental health interventions.		

3.1 Identify factors that may underpin the choice of intervention from the point of view of:
  a. service users
  b. mental health practitioners
	p. 60	Evidence activity 3.6, p. 61

3.2 Explain the importance of applying key principles in selecting interventions in relation to:
  a. individuality of experiences, needs and wants
  b. avoiding unwanted effects
  c. equality of opportunity
  d. promoting social inclusion
  e. a collaborative approach
  f. sharing information
  g. strengthening networks of support
  h. anticipating setbacks and promoting problem solving
  i. focusing on recovery
	p. 62	Evidence activity 3.7, p. 62

City & Guilds Level 3 Diploma in Mental Health Care (QCF) (600/5241/7)		
Promote equality and inclusion in health, social care or children's and young people's settings (Y/601/1437)		
Learning Outcome 1 Understand the importance of diversity, equality and inclusion		
Assessment Criteria	Page reference	Activity
1.1 Explain what is meant by • diversity • equality • inclusion	p. 51	Evidence activity 3.3, p. 52

NCFE Level 1 Award in Mental Health Awareness (QCF) (501/0253/9)		
Develop an awareness of mental health (K/600/6596)		
Learning Outcome 3 Be aware of some of the responses to mental health issues		
Assessment Criteria	Page reference	Activity
3.2 Identify possible responses that can be made to support an individual with mental health problems	p. 52	Evidence activity 3.4, p. 58
3.3 Outline factors which can have an impact on whether a response will work	p. 58	Evidence activity 3.5, p. 61
Learning outcome 4 Be aware of cultural diversity in relation to mental health issues		
4.2 Give examples of barriers that may exist for different cultural groups accessing services	p. 60	Evidence activity 3.6, p. 61

1 Explain the key principles for working with an individual to identify their needs

The key principles when working with anybody in care work are to ensure that they maintain their independence and to encourage those individuals with disabling conditions, including those with mental health issues, to maximise their own potential and independence. This means that care workers must have a good understanding of the diverse needs of individuals.

The importance of understanding the value of equality and the respect for diversity and inclusion in all types of care work is paramount.

When an individual with mental health issues first comes into contact with health professionals they are likely to be in a most vulnerable state, and it is at this point that the care professional recognises that person as an individual with their own needs and preferences with respect to the care they require. The way in which the care professional deals with the individual will have a 'direct impact on either increasing equality and nullifying discrimination and disadvantage, or helping to reinforce, perpetuate or even increase inequality, discrimination and disadvantage' (Tilmouth et al., 2011).

A comprehensive assessment of the individual's care needs is therefore crucial and involves taking into account their preferences with respect to their physical and mental support needs, assessing the medications or treatment they require and determining any specialist needs, such as preferred methods of communication and language and the social interests, religious and cultural needs of individuals.

By placing the individual's preferences and best interests at the centre of everything the care worker does, the individual is empowered to take responsibility for communicating their own decisions about their lives.

This way of working with people has led to a number of care assessment approaches.

Needs-led not service-led approach

In recent years the needs-led approach to care has replaced purely service-led provision. A service-led provision refers to looking at the services that are available and then finding the best fit for the service user. The alternative, needs-led, approach is a more user friendly approach and is the preferred method. Needs-led means identifying an individual's needs and planning the best way that they can be met irrespective of what is currently available. So, in assessing an individual with mental health needs, the care plan would be reviewed on the basis of whether or not the service they currently use is the best one to meet their needs.

Although the needs-led approach has certainly improved the delivery of care for service users it is still fraught with difficulties.

One of the problems is that the identification of 'needs' is a highly subjective process. Another, is that 'needs' change over time, and there is no specified point at which the work can be said to have been achieved. Needs also have a tendency to multiply and, once they are identified, others also become apparent and there appears to be no end to the work being done for the client. This means that care work can frequently lack direction and purpose and it becomes almost impossible to measure success or failure.

Person-centred

Person-centred care is another way in which care work has been delivered and, in 2004, the government promoted this approach as 'the essence of high-quality service delivery'. The value of person-centred planning was seen to be a way of moving:

> 'away from mass produced services. Services that too often created a culture of dependency and move towards a future that seeks to develop the potential that is in every single individual.'

> (Ladyman, 2004)

Person-centred care, then, was seen as a way of encouraging the person to become independent and to develop more of a partnership approach to their care. It is a process of life planning in care, based upon the principles of inclusion and the social model of disability. Individuals in the care process are thus seen as the experts in their own lives and care provision is to meet their needs as they see them.

Promoting self-direction

Following on from the person-centred approach, if an individual is to be more independent in their own care they need to become self-directed or guided by their own principles and values. Some of these values may include the ability to make their own choices in their care, and to have more control over the support and assistance they access.

This process became popular in care work and self-directed support was born. The personalisation agenda (2008) came about as a means to empower citizens to become full and active members of their communities. In order to achieve this, the government examined key work force policy issues and explored how these would need to be adapted to enable self-directed support and individual budgets. Self-directed support, therefore, is one way in which an individual can have real power and control over their life and individuals are now able to direct their own care or support in a number of different ways. One of these ways is by means of the allocation of a personal health budget. A personal health budget is an allocation of resources made to a person with an established health need and is used for the purchase of the care that the person or their representative believes they need. It was thought that this sort of support would empower people to shape their own lives according to their own specific needs.

Focusing on strengths, hope and recovery

Solution Focused Therapy (SFT) is a particular model in mental health practice that is based upon the role of strengths in recovery and has been implemented widely in New Zealand, Canada, North America, Japan and the UK. The model is based upon the notion that people with mental health problems have resilience that can be used to enhance their recovery.

Resilience describes an individual's ability to recover from difficult or stressful situations and it appears to be a quality that some people possess in abundance, whilst others lack this ability to bounce back after certain events.

The focus of mental health treatment over the last 100 years has been on the deficits, disorders and the problems an individual is having. This is a somewhat negative assessment of their situation. In this model, it is the strengths and resources that individuals' possess that are the main focus. One of the assumptions is that individuals have strengths, skills and abilities on which recovery can be built; and although the individual may have serious symptoms and distress, the practitioner using this model acknowledges that there is a positive aspect to some behaviour. For example, the following represent how the model finds the strengths underlying a problem area.

Table 3.1 Problem areas (from Scottish Recovery Network: www.scottishrecovery.net)

Patient misses appointments	Person attends some appointments
Client mixes with bad peer group	Person has a network of friends
Client is in perpetual crisis	Person continues to exist despite the stress
Client resists agency intervention	Person believes in using own strategies
Client is co-dependant	Person has a close mutually supportive relationship
Patient is paranoid	Person is afraid and the fear may be justified

You can see from the above example that each problem can be viewed in a negative and a positive way just by looking at it from a different perspective.

This type of model focuses upon promoting self-efficacy, aims to give individuals a belief in their own abilities and competencies and can be said to be a truly self-directed, person-centred approach to care. The individual is helped to take control of the goals they wish to achieve to enable them to have the future they want. Even in a vulnerable state an individual will still have some strength in one or other area of their life, and if mental health practitioners take the time to look for these strengths, 'they will find them'.

Evidence Activity

3.1 Activity

Reflect on the four approaches in Section 1 and say which you use the most and why.

How and when might you opt to use an alternative approach?

2 Describe the range, complexity and inter-relatedness of the following needs: physical, practical and financial needs, social, psychological/intellectual and emotional, cultural and spiritual

In Chapter 1 we very briefly looked at Maslow's Hierarchy of Needs and we shall expand upon the concept here (see Figure 1.1).

In order to stay healthy, individuals need to have a number of basic needs met. In health and social care settings these are often recalled by the mnemonic PIESS: physical, intellectual/psychological, emotional, social, spiritual. Sexual needs are also included in some literature.

We all know we need food, water and shelter to survive, but according to Maslow our basic essentials go far beyond just these needs. In addition we also need to grow as human beings by engaging with others, and through stimulating ourselves intellectually and emotionally.

For Maslow, each need has a specific order of attainment; in other words we need to meet the lower order needs before we progress to the higher needs. In Chapter 1 we showed that this pyramid of needs starts with the basic items of food, water and shelter. These are followed by the need for safety and security, then belonging or love, self-esteem, and finally, self-actualisation or meeting our highest potential. Other writers have contested the hierarchical nature of Maslow's model, however, and say that needs are sought simultaneously. Burton (1990), whilst agreeing in part with Maslow, took the concept further.

His list of human essentials includes:

- **Safety/Security** – the need for structure in our lives, predictability, stability and freedom from fear and anxiety.
- **Belongingness/Love** – the need to be accepted by others and to have strong personal ties with one's family, friends and identity groups. This links in with
- **Identity** – defined by Burton as 'a sense of self in relation to the outside world'. Identity becomes a problem when it is not recognised as legitimate, or is considered inferior or is threatened by others with different identifications. Linked to our identity are:
- **Cultural security** – or the need for recognition of one's language, traditions, religion, cultural values, ideas and concepts. Here we would include spiritual needs.
- **Self-esteem** – This refers to our need to be recognised by others as strong, competent and capable. We also need to appreciate these qualities in ourselves. In addition we need to know that we have some effect on our environment.
- **Personal fulfilment** – the need to reach one's potential in all areas of life.
- **Freedom** – is about having the capacity to exercise choice in all aspects of one's life and having no physical, political or civil restraints.
- **Distributive justice** – is the need for the fair allocation of resources among all members of a community. We might also include here the need for finance and practical support.
- **Participation** – is the need to be able to actively participate in and influence society.

(Adapted from http://www.beyondintractability.org/bi-essay/human-needs [accessed on 1/11/12])

Burton further argues that when these needs are unmet, conflict in the individual arises and this is potentially when physical and mental health suffers.

Let's look at examples of this within mental health.

Case study

John

John, 76, was a widower living in a small rural village. He had a part-time job as a gardener for local people. He ate well, growing most of his own food, and usually slept soundly, although he did not feel particularly rested on waking. Recently he had begun to wake in the early hours and found it difficult to get back to sleep.

He consulted his GP about his feelings of depression and the low moods which were affecting his whole enjoyment of the job he loved and his life in general.

The GP found John to be in good physical shape, but further examination revealed that the thing John seemed to have missing from his life was social contact. His solitary life at home and within his job, which brought him into little contact with people, was affecting his mood. His social needs were unmet. He spent a great deal of time alone and sometimes saw nobody for days on end.

Figure 3.1

This simple example shows that without regular contact with others our mental condition can deteriorate, and this has been demonstrated in the literature with work on social isolation amongst the elderly and those with mental health conditions.

We also need to take care of the physical aspects of our lives. If our diets suffer and we miss out on sleep and exercise, our psychological state can be at risk. Again, there is research to suggest that school children who have poor diets fare less well than those who have good diets (WHO, 2000, Feinstein et al., 2008).

In addition to the above basic needs, as a counsellor I often see people who seem to have all these needs met and are in happy fulfilled lives yet still seek help with mental health issues. The need for purpose in life and meaning is a strong urge without which a person can feel worthless or lacking in direction. The need to have a reason for being, improving on existing skills and expanding horizons, all provide a sense of progress and achievement. Equally we need to feel safe and secure and connected to others.

We can see here that the whole concept of 'needs' is complex, and mental and physical health and wellbeing are maintained only when we are able to meet all these needs in one way or another. Unmet needs may lead to conflict in the individual affecting mental and physical health, but can also leave a person open to discrimination and prejudice. In the next section we look at this in more depth.

Evidence Activity

3.2 Activity

Compile a case study for one of your clients and describe the range of needs they have. Say how they inter-relate and affect the condition they present with and how you are empowering them to meet these needs.

3 Explain how diversity and difference may influence the identification of needs, including references to gender, age, race and culture, sexual orientation, social class, ability

The Equality and Diversity Agenda has been rolled out into almost every part of our lives and requires attention in everything we do. But how do diversity and difference impact upon the identification and the meeting of the needs of an individual with mental health issues?

First, let's be clear about two of the terms. Equality involves fairness and diversity involves valuing difference (Thompson, 2011, p. 9). As Thompson points out, what connects the two is not the level of equality or the fact that something is different, it is the discriminatory response that the inequality or difference provokes in others.

Difference only matters when you are treated less well on the basis of your difference.

Our values, beliefs and attitudes are usually deeply ingrained and they are reinforced by our cultural context which leads us to believe certain things about groups of individuals. It is only when these values and beliefs are challenged, either by new information or different experiences, that the idea that these beliefs may be flawed is demonstrated.

We might be of the opinion that discrimination is often perpetuated unwittingly and that it is unintentional. It may also arise from ignorance, commonly held beliefs or stereotypes that are not challenged. Whatever way you view it, discrimination has no place in care work and your role as a care professional must ensure that anti-discriminatory practice is promoted as a key organisational value.

Time to reflect

Access your own organisation's anti-discriminatory practice policy. How well is it promoted within the work setting?

A prejudice is an attitude or belief that is based on a faulty and inflexible generalisation. We all have them. Many of the prejudices that are held lead to negative emotions and discriminatory actions, although prejudice does not necessarily cause one to discriminate unfairly.

Prejudice can lead to unacceptable behaviours, from harassment and bullying to a substantial abuse of power over others, which leads the perpetrators to violate and infringe others' rights. If this is found to occur there must be penalties for failing to comply with organisational values. However, it is not just individuals and groups that can be prejudiced and discriminatory. As Thompson (2011, p. 32) points out, significant structural barriers exist that discriminate negatively on individuals. For example, women still have discriminatory experiences in health care and the work place and an individual's sexual orientation may also lead to differential treatment by others. In terms of social class, as a society we continue to battle with health differences and a life expectancy which reduces with the type of work we do or the income we have. So how can we ensure that the needs of our mentally ill clients will be met despite their differences?

Overcoming issues with equality and diversity

Examining beliefs and values and questioning why we might hold a particular belief is the first step to breaking down prejudice. In addition, raising awareness about equality, diversity and inclusion, and encouraging debate and devising strategies of care that empower people, are essential.

With respect to needs, we must recognise that individuals are unique beings with different needs and vulnerabilities at different times. If we are to meet these needs effectively, we need to engage with people as individuals, to identify their differences and then address their specific needs. By adopting a 'fair' approach to care work we ensure that individuals receive equally good standards of service and similar consideration and respect.

One method is to adopt an equal opportunities approach which ensures that all individuals have the same opportunities to achieve good outcomes. People with mental health issues often find that they are stigmatised by society and are dealt with in a less than fair way in many areas of their lives. In addition to the mental health issue they may also find that they are treated differently because of other irrelevant criteria such as gender, age, race and culture, sexual orientation, social class or ability.

For example, it would be discriminatory to impose an age limit as the only criterion for qualifying for psychotherapy treatment. This is because age is irrelevant. If the person has the potential to benefit from the treatment, irrespective of their age, they should have the same opportunity to access it; preventing their access would be unfair.

By adhering to an equal opportunity approach practitioners are required to reflect on potential and actual barriers to opportunities and propose and implement active intervention to overcome these barriers.

This approach to managing difference and diversity has had significant success in improving equality and inclusion. Much of this improvement has been brought about by anti-discriminatory legislation such as the Sex Discrimination Act 1975, Equal Pay Act 1970, Race Relations Act 1976, Disability Discrimination Act 1995 and Equality Act 2010.

The law, together with changes to practice, has had a positive impact on many discriminatory practices, and there has been a change in approach to equality which now focuses much more positively on celebrating difference and diversity rather than seeing inequality as a barrier to be overcome. Humans are all unique, which means we all have a personal set of attributes, skills, needs and preferences which comprise our differences.

Raising awareness and challenging attitudes can have a significant impact on breaking down discrimination and prejudice. Prejudice may be a strong, culturally held belief, but it is important that everyone is aware that prejudice leading to discriminatory behaviour cannot be tolerated and that individuals are encouraged, supported and protected to speak out. Creating a culture of discussion and tolerance is important in developing an open-minded community and, until this is done, an individual with mental health issues may find that they are continually ostracised and are at risk of not having their needs met.

Evidence Activity

3.3 Activity

Using the case study from the previous activity, describe how your client is affected by issues relating to equality, diversity and inclusion. Describe an incident in which the client was dealt with in a less than fair manner and expand upon the outcomes for your client. How would you change the situation?

4 Explain the strengths and limitations of the main interventions that are used within the mental health system and explain how an individual may access a range of intervention options in their local area

In this section we will look at what happens when a person first presents with a mental health issue and go onto discuss the care plan and treatments available to sufferers.

There are so many types of intervention for the treatment of mental illness it is important that an initial assessment is carried out. The first step for anyone who feels they are in need of help or for somebody who is displaying symptoms is to contact the GP or the community mental health team. Occasionally the individual themselves will be unaware of their symptoms and the family may be the first to notice uncharacteristic behaviour. They can also refer to the CMHT or GP. At the initial assessment a diagnosis will be made based on the symptoms the person has. The doctor will then decide on the best treatment for the symptoms and their underlying causes. If the symptoms change, or more information about the person and their illness becomes known, then the treatment can be changed to a more appropriate one.

Access to the mental health service is likely to be through the GP or the local Emergency department and these professionals can make an assessment and prepare a care plan. They may also refer for psychological therapy.

Mental health treatment is largely carried out in the community rather than in hospitals and the care team will comprise:

- **A case manager** who is a health professional who oversees the individual's treatment and ensures they have access to all the services they need (for example, housing and employment support). They also provide help for the family and have an educative role. They bring together a number of different practitioners from a wide range of disciplines to ensure that the care provided is of a holistic nature.
- **Crisis teams** that consist of mental health professionals who assess and support individuals who are seriously affected by mental illness. Hospital admission may be an option in severe cases and this team can arrange this.
- **Support teams** who provide long-term support to the individual in their home. They help to maintain a useful treatment plan and try to reduce the number of admissions to hospital a person may need.

When the individual has been assessed the teams will decide upon the best intervention for the particular symptoms and the person themselves. In the following text we look at some of the interventions available.

Time to reflect

What services are available in your local area?

Medication

There are a number of different types of medication to treat the numerous types of mental illness:

- Antidepressants help to treat depression and are successful in about 60 to 70 per cent of individuals. They are also used (in combination with psychological therapies) to treat phobias, anxiety disorders, obsessive compulsive disorders and eating disorders.

  There are side effects as with any medication and the prescriber will highlight the main ones to the individual. These may include dry mouth, constipation, a sedative effect which can affect driving or operating machinery, sleep problems, weight gain, headache, nausea, gastrointestinal disturbance/diarrhoea.
- Antipsychotic medications are used to treat psychotic illnesses such as schizophrenia and bipolar disorder. Again, there are general side effects but the newer antipsychotics are more reliable. Some of the older drugs were known to cause stiffening and weakening of the muscles and muscle spasms.
- Mood-stabilising medications are helpful for people who have bipolar disorder (previously known as manic depression). Lithium carbonate can help reduce the incidence of major depression and can help reduce the manic or 'high' episodes.
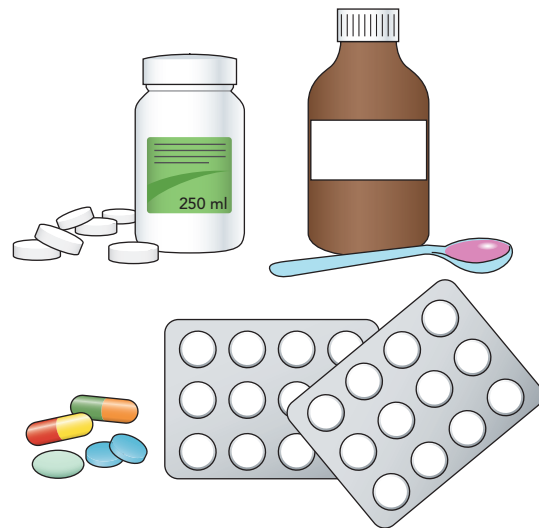
Electro-convulsive therapy

ECT, despite being a somewhat controversial treatment, is still prescribed for some cases of severe mental illness. It was widely used in the 1950s and 1960s but fell into disrepute due to the damaging physical effects. However, more sophisticated methods for carrying out the treatment have now made it useful in some severe cases of mental illness.

Figure 3.2 Medication

ECT consists of causing a seizure much like an epileptic fit by passing an electrical current through the brain. Research suggests that the treatment effect is due to the fit rather than the electrical current, having observed cases where individuals feel better following seizures.

Some doctors believe that severe depression is caused by problems with certain brain chemicals and subscribe to the notion that a 'fit' causes the release of these chemicals.

The National Institute of Health and Clinical Excellence (NICE) have ruled that the treatment should only be used in severe depression, severe mania or catatonia and in the case of severe depression, only when other treatments have failed.

The limitations of this treatment are mainly due to the fact that as a major procedure it involves the use of a large number of treatments requiring the person to undergo a number of general anaesthetics, in itself a risk. Short term effects of this include:

- headache immediately after ECT
- aching muscles
- feeling muzzy-headed
- nausea
- distress after the treatment causing the individual to be tearful or frightened
- loss of memory
- confusion.

In the longer term the side effects may include memory problems and there is evidence that some people have felt that they have lost skills or that they are no longer the person they were before ECT (Rose et al., 2003).

Talking and other therapies

Psychosocial interventions

As we have seen, some drug therapy can cause side effects and can change an individual's mood by affecting the balance of chemicals. This can often help but the underlying problem is not necessarily being dealt with and withdrawing the drugs may cause the problem to resurface. By talking through an issue with a trained counsellor or psychotherapist really effective results can be seen.

Talking treatments can help an individual to overcome emotional difficulties by reframing the thought process going on behind the issue. They can free the person from self-destructive ways of feeling, thinking and behaving.

The National Institute for Health and Clinical Excellence (NICE) has suggested forms of talking treatment that are brief, cost-effective and supported by clinical evidence. These include the use of CBT or Cognitive Behavioural Therapy which has been the talking treatment of choice for a number of years now. However, research is now showing that other forms of treatment are more effective although these are not always available on the NHS.

There are a variety of talking treatments available from the NHS or in private practice. Some therapies may last for several years, while others take just a few sessions and they are offered in group or individual sessions.

Individual counselling focuses on an individual's current problem, perhaps bereavement or a relationship issue that is causing distress, and the counsellor's ability to listen but not to advise or offer a personal opinion is designed to help an individual to arrive at their own solutions.

Cognitive behavioural therapy (CBT) examines an individual's thought processes and shows how thinking, feeling and behaviour can result in unhelpful patterns. By restructuring how the individual approaches their depression or anxiety new ways of thinking and acting are developed. This sort of therapy usually includes tasks or homework to try outside the therapy sessions.

Group therapy can help an individual to deal with issues relating to and communicating with other people. They are also designed to help the individual become more self aware. With groups of 8 to 12 people this type of therapy can be intimidating, and requires careful handling, but in a group environment, opportunities may arise to hear other points of view about their concerns and to learn how their behaviour affects other people. It provides a safe environment in which the individual can be vulnerable or assertive and can try out new behaviours.

Psychological or psychosocial treatments include therapies such as inter-personal psychotherapy. This sort of therapy addresses the individual's relationships and interactions with others and shows how they are affecting their own thoughts and behaviours. For an individual with a mental illness, stress may be caused by a difficult relationship and improving this part of their life may improve their quality of life overall. This therapy may be useful in the treatment of depression.

Psychotherapy

Similarly to counselling the aim of psychotherapy is to help an individual to understand what lies behind their behaviours and the way they interact with other people and why they feel the way they do. Talking through experiences and releasing painful feelings enables an individual to manage the situation they are in and helps them to understand how they can improve their life. Understanding what has shaped their life can empower an individual to access the reasons behind their self-destructive patterns of behaviour and this can help to overcome specific problems, such as an eating disorder or lack of confidence.

There are many types of therapy that come under the umbrella term 'psychotherapy'. There are therapists who will encourage the person to talk mainly about early childhood, and they may come from a Freudian or Jungian background. They may be interested in the dreams an individual has and will work with these in the sessions. Others, systemic and relational psychotherapists, will be more interested in the relationships the person has and will try to determine how these impact upon the individual's life. An existential psychotherapist adopts a philosophical method of therapy and tries to understand the inner conflict within an individual which they believe is due to confronting certain givens of existence. These givens are the inevitability of death, freedom (fear), responsibility, isolation and meaninglessness within life all causing tension.

Complementary

The Rethink Mental Illness website provides a useful list of complementary therapies that may be useful for helping individuals with mental distress. The website makes the point that complementary therapies adopt a more holistic approach to treating individuals with the focus on physical, psychological and spiritual needs rather than merely looking at the symptoms of the illness. Treatments include massage, aromatherapy, reflexology, acupuncture, shiatsu, exercise, yoga and tai chi.

The more unconventional medicines are homeopathy and herbal medicine, and some newer therapies, such as music therapy, animal-assisted therapy and meditation, are also becoming more popular.

Spiritual and religious support

Some individuals have a deep faith in a higher being and this can help them in times of great distress. There is increasing agreement between health professionals that some aspects of spirituality have real benefits for mental health and as such should form a part of the assessment of an individual.

Spirituality does not necessarily require a link to a religion but involves experiences of:

- a sense of meaning and purpose in life
- a sense of belonging
- a sense of connection of 'the deeply personal with the universal'
- acceptance, integration and a sense of wholeness.

(http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/spirituality.aspx)

These experiences are part of being human and they are clearly present in all of us.

For the person with a mental health problem, there needs to be recognition of the spiritual side of their treatment. This requires the health professional to ensure that the person is able to engage in activities such as those outlined below.

- creative art, work or enjoying nature
- to feel safe and secure
- to be treated with dignity and respect
- to feel that they belong, are valued and trusted
- time to express feelings to members of staff
- the chance to make sense of their life – including illness and loss
- permission/support to develop their relationship with God or the Absolute.

(http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/spirituality.aspx)

For the person who also has a religious belief, the health professional needs to support them by providing a place of privacy in which to pray and worship and reassurance that their beliefs are valued by staff and will not be undermined in any way.

Arts therapy

Art therapy has been used in treating mental illness for almost 100 years and encourages self-expression and self-discovery. Psychotherapists use this therapy to encourage the individual to visualise, and then create, the thoughts they have difficulty talking about. It is the creative process of art making that becomes the therapy and a way to understand the inner worlds of people with mental illness. You may be aware of the Rorschach Inkblot Test and the Holtzman Inkblot Test (HIT) which were used as a diagnostic tool to identify specific types of mental illness. These came about as it was felt that the symbolism of art work was useful in diagnosis.

Figure 3.3a Art therapy

Figure 3.3b Rorschach Inkblot Test

Physical activity and diet

Research into the effects of physical activity on depression and other mental illnesses has been carried out for a number of years and the NICE guidelines for the Management of Depression in Primary and Secondary Care support the notion that physical exercise is now a legitimate form of treatment in mental illness and can actually help a great deal (NICE, 2004).

Just as the state of our mind and how we think affects our body so too is the converse true: The mind cannot function unless the body is working properly. If we feel tired or depressed it is likely that we will do even less. This exacerbates the tiredness and makes us feel even worse.

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The Royal College of Psychiatrists offers the following advice:

'Broadly speaking, the less you do, the more likely you are to end up with:

• low mood/depression
• tension and worry.

If you keep active, you are:

• less likely to be depressed, anxious or tense
• more likely to feel good about yourself
• more likely to concentrate and focus better
• more likely to sleep better
• more likely to cope with cravings and withdrawal symptoms if you try to give up a habit such as smoking or alcohol
• more likely to be able to keep mobile and independent as you get older
• possibly less likely to have problems with memory and dementia.'

So too with nutrition. A poor diet contributes to poor physical health but can also lead to poor mental health as well. The absence of certain minerals and vitamins and the use of additives can both cause mental illness and hinder recovery. For example, think of the child who is hyperactive because of the food they are given.

By helping an individual with a mental health problem to look critically at their diet and the exercise they partake in and by encouraging some changes the condition can be helped considerably. Simple changes, such as the amount of caffeine or high energy snacks a person has in a day, can help enormously.

Self-management approaches and social prescribing

There are a number of support groups that can help individuals overcome problems and find support from others sharing similar issues. It may be alcohol or drug abuse, depression or being scared to go out of the house and often these groups are led by people who have suffered these issues and overcome them themselves. The format of the meetings involves the opportunity to share experiences, and learn from and encourage each other.

Alongside traditional approaches and self-help groups, non-medical interventions are becoming popular areas of help. Social prescribing or 'community referral' seeks to provide non-medical sources of support including opportunities for creative pursuits as well as physical activity. This is provided in a number of areas by the Green Gym initiative, volunteering, in addition to support with employment, or benefits, and legal advice if needed. The primary care team will usually deliver the prescription and examples include initiatives such as 'exercise on prescription' or 'prescription for learning' – all referral options to help improve mental health and wellbeing.

Bibliotherapy is another area which comes under this umbrella term and refers to directing the individual to appropriate books or other written materials to be read outside of normal sessions to deepen understanding of the particular problem that requires treatment. As an educative tool they help the individual to have a greater understanding about what is happening to them and can be a useful way of encouraging the individual to comply more fully with treatment.

Peer support

This has been defined by the Mental Health Foundation as:

the help and support that people with lived experience of a mental illness or a learning disability are able to give to one another ...'

(The Mental Health Foundation 2012)

Peer support plays an important role. The government is keen to emphasise this and believes that such support can provide 'improved access to timely information, positive role models and greater community resilience and capacity for self-help' which can result in increased prevention and early intervention in many health problems (Department of Health, 2011c, p14).

Peer support can be provided in number of ways:

- from one patient to another in a hospital ward;
- by peer mentors or informal peer groups in the community;
- by peer support workers formally employed by mental health or learning disability services to work alongside individuals.

The report prepared by the Mental Health Foundation entitled 'Peer support in mental health and learning disability' identified some key messages. The benefits of peer support for the individual receiving the support, the person giving it, and for services was seen to be widespread. These benefits include better mental health together with an increased sense of wellbeing and 'confidence, greater social connectedness, and improved recovery and coping skills and fewer hospital admissions.'

Work, education and volunteering

The benefit of this type of intervention is shown in Chapter 1 (see page 3).

There are a large number of interventions available for people with mental health issues and this in itself is a strength. We no longer have to rely on medication as the only way in which to treat mental illness. We now have a vast array of talking therapies and other less conventional or alternative approaches that may appeal to some individuals. Limitations of the interventions on offer often lie with availability and cost in a number of cases. Also the lack of available research as to the efficiency of some of the therapies is likely to lead to resistance by medical practitioners to refer to some of the more alternative types of treatment. In the next section we look again at the limitations with respect to the services that are offered.

Evidence Activity

3.4 Activity

Referring again to your case study, identify the interventions for this client and say how you think they are having a positive effect. Describe other interventions you think might be useful for this individual and give a rationale for your choice.

5 Explain the strengths and limitations of the main forms of service interventions in mental health

In-patient treatment

As we have seen throughout the book the care and treatment of people with mental health problems has undergone considerable change. As the understanding of the nature of mental illness has grown, together with advances in medical and psychological treatments, the move to community care has been a major advance.

Re-settling individuals from psychiatric hospitals into the community is now the preferred choice but there is still a place for in-patient treatment at times.

In support of in-patient treatment, the DoH in 2002 made the point that

'The purpose of an adult acute psychiatric in-patient service is to provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness. It should be available for the benefit of

'those service users whose circumstances or acute care needs are such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restricted residential setting.'

<div align="right">(DoH, 2002)</div>

For those individuals who find they need a safe environment in which to engage with the mental health services and who cannot live solely independently for a period of time, in-patient treatment is the best choice. However, over the last ten years or so changes have had to be made to improve these services. Weaknesses identified by service users were published in the government paper of 2002: Mental Health Policy Implementation Guide; Adult Acute Inpatient Care Provision. They reported:

● Poor physical and psychological environments for care.
● A lack of basic necessities and arrangements for safety, privacy, dignity and comfort.
● Insufficient information on their condition and treatment.
● Lack of involvement and engagement in the planning and reviewing of their own care.
● Inadequate staff contact, particularly one-to-one contact.
● Insufficient attention to the importance of such key factors as ethnicity and gender and protection from harassment/abuse.
● Lack of 'something to do', especially activity that is useful and meaningful to recovery.

(DoH, 2002)

This somewhat negative engagement with in-patient services led to individuals in crisis avoiding contact with mental health services for fear of admission; and this in itself posed a significant risk factor and a weakness in the previous organisation of many services.

The changes put into place led to the amendment of the Mental Health Act and newer government initiatives being put into place to address the above complaints. These are covered in more depth in Chapter 5.

Home treatment and crisis services

One of the key elements in the 1999 National Service Framework for Mental Health; the NHS Plan (2000) made the provision of Crisis Resolution Home Treatment (CRHT) services a national priority. With more individuals with mental health problems receiving treatment in the community from their GP or a Community Mental Health Team these acute services were set up to provide care for those experiencing a severe crisis and requiring emergency treatment. Previously, such treatment would have been provided by admitting the individual to an in-patient ward.

Although the CRHT reduced in-patient admissions, the main aim was to provide individuals with the most appropriate and beneficial treatment possible in the community. The service also ensured that earlier discharge from in-patient wards could be achieved and these were the strengths of this type of service.

Some of the weaknesses of this service have been shown up in the regional variations in the way in which the teams are run.

The National Audit Office in its 2007 publication: Helping People Through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services reported that the CRHT staffing is 10 per cent below that required nationally as estimated by the Department of Health, and that

'many teams lack dedicated input from key health and social care professionals, particularly consultant psychiatrists'

restricting their ability to provide comprehensive, multidisciplinary care, which is integrated within local mental health services.

Assertive Outreach

Assertive Outreach was described in the National Service Framework for Mental Health and is aimed at people with severe mental illness who are at risk of recurrent hospitalisation and who experience difficulties with more traditional services.

The teams – usually made up of a range of staff, including psychiatrists, psychologists, community psychiatric nurses (CPNs), social workers, mental health workers and other specialised staff – focus on the delivery of community support, using community resources including family, neighbours, friends, employers, voluntary services and educational establishments. The main aim is to maintain the social inclusion of the individual with the support of professional and paraprofessional staff to ensure that the individual is able to maintain a place in the community without having to constantly refer to other departments or agencies for support.

Assertive Outreach workers then need to work in a flexible way in order to provide a seamless service that enables the individual to carry on with their daily life. This team approach allows closer supportive working by involving relevant people and helping them to understand the individual and develop tolerance and coping strategies. In addition to this the teams work with the individual to help them to take responsibility for their own behaviour in order to control their symptoms. This has been helpful in reducing law breaking and friction within the community.

6 Explain the barriers an individual may face in accessing interventions and identify factors that may underpin the choice of intervention from the point of view of service users and mental health practitioners

In addition to the stigma, prejudice and discrimination that people with mental health issues are subject to (we cover this in Chapter 2) many individuals may also face other barriers, by which we mean the numerous factors which can prevent an individual from getting the care they need or instead receiving inferior health care. In accessing any intervention the service user and the health professional may also have different ideas about what can be offered or is available. The preferences of the service user for a particular intervention must be considered since compliance with a treatment is of paramount importance for it to work. But in addition the health professional must also take into consideration the availability of a service, the budget and resources and staff available to deliver.

These factors underpinning such choice include the following barriers:

- physical
- socio-economic
- cultural and language
- geographical and availability
- service or professional bias
- equality issues.

A physical barrier might be as simple as a mobility problem which causes the person to be unable to walk very far and therefore not be able to get to an appointment. Additionally, the person using a wheelchair may have trouble accessing clinics with steps.

A socio-economic barrier refers to a lack of education or knowledge about the services available, in addition to economic factors which include inability to pay for prescriptions or transport. These may all lead to a person not being able to access health care.

Cultural and language barriers are primarily related to social, linguistic and religious issues. With the increase in the number of immigrants to the UK, cultural difference is a major barrier. The language difference, as well as the other socio-economic factors that these individuals face, may well cause issues with access.

The Rethink Mental Illness group identify black and minority ethnic groups (BME) as facing issues of stigma, acceptance in society and finding work much the same as their white counterparts but with the additional language and cultural differences there are reports of higher rates of mental illness in some communities which they believe are due to the social disadvantage some groups experience. (Rethink.org)

They also make the point that surveys looking at mental illness in the UK rely on western definitions of mental illness which could lead to a greater number of people from BME communities being labelled as having mental illness than white groups due to the way in which symptoms are interpreted.

In addition, Rethink highlight the fact that BME communities are mostly concentrated residentially within inner city areas, where more people are likely to experience higher incidents of mental illness.

(http://www.rethink.org/about_mental_illness/index.html)

Geographical and availability barriers refer predominantly to the impact of the rural-urban divide. Individuals who live in rural areas where facilities and transport are limited may find travel difficult and therefore be disadvantaged. In addition to which the availability of specialist services may be restricted to urban areas and be difficult to get to.

Service or professional bias.

As a barrier to care the views of the health professional in dealing with somebody with a mental health condition are crucial. If professionals hold stereotypical views of groups or they approach individuals with set ideas about the response they are likely to get then bias may creep into their diagnosis. As we saw above with BME groups a lack of understanding about how symptoms are being presented may well lead to inaccurate judgments being made leading to decisions and actions being taken which are not effective. In addition bias may be displayed in the choice of intervention made by the professional. If they favour a particular approach or intervention they may ignore the personal preference of the individual and limit their choice of treatment. We all hold prejudices and from this can develop a biased view of life which can result in unequal treatment and service provision if we are not mindful of this.

Equality issues

Mental health problems lead to employment issues, social exclusion and discrimination and these things in turn lead to negative feelings/ states that can affect mental health and physical health. (This is covered more fully in Chapter 2, see page 25).

Evidence Activity

3.5 **3.6** **Activity**

Referring to the client in your case study, describe the strengths and limitations of the main service interventions for their care and explain the barriers an individual may have faced in accessing interventions.

Reflect on how other interventions may have been more appropriate and comment upon how you as a care worker helped to diminish the barriers to access for them.

7 Explain the importance of applying key principles in selecting interventions in relation to: individual needs and wants, avoiding unwanted effects, equality of opportunity, promoting social inclusion, a collaborative approach, sharing information, strengthening networks of support, anticipating setbacks and promoting problem solving, focusing on recovery

This section constitutes a self-directed activity in which you are expected to engage in a case study to cover the above listed factors.

Underpinning good practice in mental health interventions and promotion are the principles of person-centred care. With respect to the areas identified above, it is the human value of people with mental health issues that is the most important principle in determining how interventions are selected. There are many interventions used today to help mental ill health, and because people are unique it is important to make sure that the correct treatment is given in order to achieve the best possible results for the individual involved. Whilst one treatment may work well for one individual it may transpire that the same treatment could be a source of potential damage to another. Variables such as age, gender and type of mental illness, amongst other factors such as family and community support available, need to be taken into account in order to establish the best treatment to use with the individual.

By ensuring that health professionals respect the individuality of people with mental health problems and by adopting a collaborative approach with families and local communities, the care an individual receives will support them to 'adopt and maintain healthy lifestyles which in turn will create supportive living conditions or environments for health' (WHO, 2004).

Collaboration within the CMHT and the community in which the individual lives requires the sharing of information and developing good support for the whole family.

The key recommendations outlined in the WHO 2004 summary report are worthy of note here:

> 'Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. Promotion of mental health contributes towards overall health and should form an essential component of health promotion.'

Evidence Activity

3.7 Activity

With respect to the client in your case study, explain the importance of the key principles in selecting interventions in relation to:

- Individual needs and wants
- Avoiding unwanted effects
- Equality of opportunity
- Promoting social inclusion
- A collaborative approach
- Sharing information
- Strengthening networks of support
- Anticipating setbacks and promoting problem solving
- Focusing on recovery

Bullet-point each of the points above and say how your clients needs are met within each one.

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